INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Recommendation	Commenter recommends eliminating any reference to a deadline of "24 hours" in favor of "one business day". Commenter opines that a deadline of "one business day" is likely to engender less litigation than a "24 hour period" where parties can dispute timing by minutes. In addition the latter definition of "24 hours" has the potential to require employees to work evenings, weekends and holidays, far beyond their usual and customary schedule. Commenter states that a stringent deadline inevitably creates an undue burden on claims examiners which need to be primarily responsible for ensuring benefits are timely processed. Commenter recommends that the Division eliminate all deadlines based on document receipt in favor of time limits contingent on document issuance. Commenter opines that a time limit contingent on the receipt of documentation is unreasonable because one cannot control the numerous circumstances that can cause delay such as weather, acts of god, power outages, or technological difficulties at the receiving party's	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	24-hours is used in the regulations when expressly required by statute. See, for example, Labor Code section 4610(g)(3)(A). Deadlines in the regulations take into account the statutory language and any additional time that may be allowed under Code of Civil Procedure section 1013.	No action necessary.

	end.			
General Recommendation	Commenter recommends that the Division eliminate the term "delay" from most regulations regarding "disputed medical treatment" pursuant to regulation 9792.6.1(h). Commenter opines that given that disputed medical treatment is no longer inclusive of delayed decisions, then naturally it follows these "delayed decisions" should be deleted from regulations referencing disputed medical treatment as identified in the following regulations: 9785(b)3**,** 9792.10.1(b)(1), 9792.10.1(b)(2)(A)(ii), 9792.10.1(b)(2)(B), 9792.10.1(c)(2), 9792.10.5(a)(1)(B), 9792.10.1(a)(1)(E), 9792.12(c)(2), 9792.12 (c)(3) and (c)(4).	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	The language is consistent with that of Labor Code section 4610.5(f). While the current and proposed regulations do not contain a provision for a "delay" determination necessitating the need for an IMR application, future rulemaking may either establish such a determination or, if there is evidence of confusion regarding the term, the deletion of the term.	No action necessary.
9785(a)(2)	Commenter states that the treating physician should be the requesting physician for an IMR. Commenter opines that the term "Secondary Physician" is unclear and unnecessary if the physician who is treating makes the request.	Bruce Carlin Senior Vice President CompPartners December 12, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.
9792.10.1(d)	Commenter recommends that it be mandatory that an internal appeal happen before a request can go to an IMR. Often, the request can be further	Bruce Carlin Senior Vice President CompPartners December 12, 2013	A mandatory internal appeal is not authorized by Labor Code sections 4610 or 4610.5.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	considered through the organization doing the appeal, thereby avoiding an unnecessary and much more costly (two to three times more costly) IMR. Commenter opines that IMR should only be allowed after the internal appeal process is exhausted. Commenter states that the appeal should come from the treating physician, and not from the injured worker.	Written Comment		
9792.10.1(d)	Commenter notes that the current timeframe to request an internal appeal is 10 days. Commenter recommends that it be extended to 20 days.	Bruce Carlin Senior Vice President CompPartners December 12, 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.	No action necessary.
9792.10.3	Commenter seeks clarification of the process related to denial of a requested intervention due to lack of receipt of requested information. Commenter opines that such denials should not be subject to an Independent Medical Review until the requested	Bruce Carlin Senior Vice President CompPartners December 12, 2013 Written Comment	A UR denial based on the failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	information is reviewed by the requester and a denial or modification of the request is communicated to the treating physician. Commenter opines that the language around "conditional denials" is somewhat unclear. Commenter would like a statement making this very clear such as… "The URO has the right to issue a denial solely on the basis that a request for additional information was made, which is required to make the determination, and the requesting provider did not provide the requested information." When the URO has requested additional information, which is required to make the determination, and that information is not provided, the AD shall deny any request for an IMR. The requesting provider must first provide the requested information to the URO and allow the URO to issue a determination prior to submitting a request for IMR.		a utilization review determination, for additional required examinations or tests, or for a specialized consultation, is not eligible for IMR. Section 9792.10.3(a)(6).	
9785.5 DWC Form RFA	Commenter opines that the physician needs to be paid for time to prepare records sent to IMR as added administrative time for doctor and staff is making it fiscally impossible to continue to treat work comp patients.	Anonymous December 13, 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	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter state that the RFA form and the peer to peer calls are already adding about 10 [time is not specified, i.e., seconds, minutes, hours, days] time to his treatment without reimbursement. Commenter states that IBR has also added to administrative costs without any payment. Commenter opines that if payment is allowed the fee needs to be set to avoid overcharges by doctor and/or fee disputes. Commenter opines that many new ideas are good but not economically feasible for the doctor.		nature of treatment requests such that number of requests for IMR may be reduces. The form 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.	
9792.12(a)(12), (a)(13), (a)(14)	Commenter recommends striking these sections. Commenter states that in section 9792.9.1(c)(2), the AD has created a process by which a request for treatment may be made in any manner making it possible for a claims administrator to have "accepted" a request for authorization without ever having seen it. Under these sections, the penalty for failing to discover a hidden request for authorization is $2,000. Commenter opines that such a penalty is only reasonable if the regulations continue to require that the	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	A request for authorization cannot be made in "any manner." 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	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	request for authorization be stated in the appropriate, readily identifiable DWC Form RFA. Commenter states that it is not reasonable to penalize a claims administrator for failing to identify a request that is not provided on the standard form. As written, a request not on the standard form may not be identified as a request for authorization. Commenter opines that it is preferable that the DWC request for authorization form continue to be used but if the AD retains the provisions of section 9792.9.1(c)(2), then the proposed penalty should be reduced to $100 if the treating physician clearly meets the criterion for using the alternative means of requesting treatment in section 9792.9.1(c)(2)(B). Commenter notes that a similar problem exists with the $100 penalties contained in section 9792.12(b)(4)(C) and (D) for the same reasons. Commenter opines that a claims administrator should not be penalized for procedural failures that may be caused by a request for treatment that is not readily identifiable.		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 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).	
9792.9.1(e)(3), (e)(4), (e)(5), (e)(5)(H)	Commenter recommends the following revised language: (3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician~~,~~ and the injured worker~~, and if the injured worker is represented by counsel, the injured worker's attorney~~ within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request. (4) For retrospective review, a written decision to deny part or all of the	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 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. 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 absence may reflect a Legislative intent that	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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. (5) The written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, and 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: …. (H) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an		represented employees and their attorneys are subject to the subdivision's mandate.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	objection to the utilization review decision must be communicated by the injured worker~~,~~ or the injured worker's representative~~, or the injured worker's attorney~~ on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision. Commenter states that the statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. Labor Code section 4610(g) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney. Commenter states that applicant attorneys are nowhere included in the Labor Code section 4610 and 4610.5 language and have no role in the UR dispute/IMR processes unless and until an IMR decision is challenged			

	when a verified appeal may be filed with the appeals board. Commenter opines that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the process.			
9792.9.1(d)(2); (e)(3); (e)(4); (f)(5)	Commenter notes that this section indicates that specified UR decisions shall be communicated to the requesting physician "within 24 hours of the decision…" Commenter opines that the term "decision" is ambiguous as a marker to reckon timeframes. Additionally, 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 recommends that this section be changed to delete the 24 hour limit, and to stipulate that the communication to the requesting physician shall be *on the next business day* following the "decision." Commenter also recommends this change for 9792.9.1 (f)(4). Commenter recommends that 9792.9.1	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.

	(e)(3) and (f)(5) stipulate that an expedited determination should be communicated *on the next business day* if the 72 hour limit falls on a weekend or holiday.			
9785(b)(3)	Commenter notes that the proposed modification to section 9785(b)(3) deletes: "No other primary treating physician shall be designated by the employee unless and until the dispute is resolved." Commenter opines that the deleted language represents a necessary safeguard against abuse of IMR and could lead to an increase in attempts to change treating physicians in order to circumvent the IMR process. Commenter recommends that the division retain the previous language.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	MPN dispute resolution procedures are mandated by Labor Code sections 4616.3 and 4616.4. The Division recognizes the right of the employee to change their treating physician under Labor Code sections 4600 and 4601. A claims administrator's decision to deny a treatment recommendation should not preclude an employee from seeking another physician. Based on the expedient process of resolving medical necessity disputes through IMR, the restriction regarding the designation of a new primary treating physician is not necessary.	No action necessary.
9785(3)	Commenter states that the regulation as written appears to conflict with the established case law Tenet Centinela v. WCAB. Commenter notes that while Tenet has been held inapplicable in a case involving an MPN, it does	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers'	The restriction regarding the designation of a new primary treating physician is not necessary. These regulations are not about medical control or Labor Code section 4062.9	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	not appear to have affected in non-MPN Cases. In order to ensure uniformity between this regulation and established case law, commenter recommends except in cases where treatment is rendered with the MPN, the sentence stricken be reinstated- "no other primary treating physician shall be designated by the employee unless and until the dispute is resolved via Labor Code sections 4061 and 4062".	Compensation December 20, 2013 Written Comment	which was abolished by AB 749 (2002), SB 228(2003) and SB 899(2004), as discussed in the 2000 case of the Tenet/Centinela Medical Center v. WCAB (Rushing)	
9785(b)(3)	Commenter objects to the deletion of the following sentence: No other primary treating physician shall be designated by the employee unless and until the dispute is resolved. Commenter opines that removing the prohibition to change the primary treating physician (PTP) before a dispute is resolved will result in confusion, disputes delays, and additional costs. If there are disputes over issues such as TD, PD, P&S status, or medical necessity, and the PTP is changed before the dispute is resolved, it is not clear whether	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See above response to State Compensation Insurance Fund regarding this subdivision .	No action necessary.

	findings on those disputes will be valid when the opinions, decisions or requests of new PTPs conflict with the findings. Commenter states that removing the prohibition may also re-introduce or encourage the practice of doctor-shopping are she requests that the Administrative Director restore this language.			
9785(b)(3)	Commenter notes that the proposed permanent regulation strikes a long-standing provision that prevented the IW from changing primary treating physicians in instances where the PTP has recommended that treatment stop, and/or that the IW is P&S; and the IW disputes this. ("No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.") **Commenter recommends that this proposed redaction not be made. Commenter opines that the provision that has been recommended for redaction represents a necessary safeguard against abuse of the work comp system by employees who wish to prolong their claim for reasons of**	Robert Ward December 21, 2013 Written Comment	See above response to State Compensation Insurance Fund regarding this subdivision .	No action necessary.

	secondary gain.			
9785(g)	Commenter notes that the proposed modification to section 9785(g) appears to allow a request for authorization on other than the mandated RFA form so long as it is a written confirmation of an oral request clearly marked at the top that it is written confirmation of an oral request. Commenter recommends that this section be revised to specify that a written confirmation of an oral request must be on the required RFA form and be clearly marked at the top that it is written confirmation of an oral request.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.
9785.5 DWC Form RFA	The terms "requesting physician" and "treating physician" are both used in various parts of the DWC Form RFA (Request for Authorization) which may cause confusion. Commenter recommends using the term "requesting physician" throughout the DWC Form RFA. Commenter states that the form does not clearly emphasize the necessity of attaching the medical report to the RFA form. The form requires that the requesting physician indicate the	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	The terms are synonymous and are unlikely to be confused. Only a treating physician can request authorization for medical treatment; when the request is made they are the requesting physician. If the different terms prove confusing to either physicians or claims administrators, the Division will consider using the same term in future rulemaking	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	"Diagnosis" of the employee; however, the IMR form requires the "Primary Diagnosis" be listed. Commenter recommends the addition of the word “Must” to the top section of the RFA form. To promote consistency in the language used, commenter recommends changing the term “Diagnosis” to "Primary Diagnosis" or changing the term in the IMR form to “Diagnosis” so that the required information is consistent on both forms. Commenter opines that the instructions regarding requests for expedited review are insufficient and should clearly state the language in section 9792.9.1(c)(4). Instructions for routing information conflict with section 9792.6.1(z) which specifies that an employee’s health records may not be transmitted by electronic mail. Commenter recommends adding language in the instructions page for submitting an expedited review to coincide with section 9792.9.1(c)(4). Commenter recommends deletion of the language instructing that the RFA may be routed via electronic mail.		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.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9785.5 DWC Form RFA	Commenter notes that the requesting provider is not asked to specify a "primary diagnosis". However, the proposed IMR Application Form requires the claims administrator to indicate the provider's primary diagnosis. Commenter opines that it should be left to the treating physician, not the claims administrator, to decide which diagnosis is "primary". **Commenter recommends that the Form RFA be revised to include the primary diagnosis; or the IMR Application Form should be revised such that the claims administrator is not required to provide a primary diagnosis.** Commenter opines that instructions to the requesting provider with regard to requesting expedited review are insufficient, and should mirror the language found in proposed regulation 9792.9.1(c)(4). **Commenter recommends that the language on the Proposed Form RFA: " A request for expedited review must be supported by documentation substantiating the**	Robert Ward December 21, 2013 Written Comment	The primary diagnosis can likely be discerned by the UR physician reviewer who is determining whether the requested medical treatment is necessary under Labor Code section 4610. The Division finds that the language of the instructions is sufficient to advise the physician of need to request an expedited review.	No action necessary.

	employee's condition." should be updated to reflect the language in Proposed 9792.9.1(c)(4): "A request for expedited review [must be] 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."			
9792.10.5(b)(1), (b)(2) and (b)(3)	Commenter recommends the following revised language: b)(1) Within fifteen (15) days following the mailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for expedited review, within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2), any of the following	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	documents: …. (2) The employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2) shall, concurrent with the provision of documents under subdivision (b), forward the documents provided under subdivision (b) on the claims administrator, except that documents previously provided to the claims administrator need not be provided again if a list of those documents is served. (3) Any newly developed or discovered relevant medical records in the possession of the employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2), after the documents identified in subdivision (b) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2), shall concurrently provide a copy of medical records required by this subdivision to the			

	claims administrator, unless the offer of medical records is declined or otherwise prohibited by law. Commenter states that applicant attorneys are nowhere included in the Labor Code section 4610.5 language and have no role in the IMR process unless and until an IMR decision is challenged when a verified appeal may be filed with the appeals board. According to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent review organization, it removed applicant attorneys from the IMR process. Labor Code section 4610.5(j) states: "For purposes of this section, an employee may designate a parent,			

	guardian, conservator, relative, or other designee of the employee to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. …" Commenter states that if the employee is represented by an attorney prior to the time of a UR decision, that language indicates the applicant's attorney is not eligible to act on behalf of the employee for purposes IMR. Commenter opines that since the legislature moved the responsibility for deciding medically necessary treatment from the Board to the IMRO, there is no longer necessity for an attorney to argue on the medical necessity for treatment unless there is an appeal.			
9792.9.1(d)(3)(A) and (d)(3)(B)	Commenter recommends the following revised language: (3)(A) For retrospective review, a written decision to approve 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~~.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(B) 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)(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. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, ~~and his or her attorney/designee, if applicable~~, in lieu of a communication expressly acknowledging the retrospective approval. Commenter opines that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the IMR process. The statute does not authorize the Administrative Director			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. For example, Labor Code section 4610(g)(5) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney.			
9792.9.1(e)(5)	Commenter notes that this section was modified to require signatures on written decision letters that modify, delay or deny a treatment request. Commenter believes that signatures should be able to be affixed to the letter using electronic means rather than a wet ink signature. This will assist in administrative burden. Commenter recommends the following modification: The written decision shall ~~be signed~~ include either a manual or electronic signature of ~~by~~ either the claims administrator or the reviewer, and shall only contain the following information specific to the request:	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The Division does not believe that further regulation is necessary. Unless otherwise indicated, a claims administrator can sign a written decision in any manner authorized by law.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9.1(e)(5)(A)	Commenter notes that this section reads: The date on which the DWC Form RFA was first received. Commenter opines that this does not include Requests for Authorization that are submitted on forms other than the RFA as permitted under 9792.9.1(c)(2)(B). Commenter recommends the following modification: "The date on which the DWC Form RFA or other accepted Request for Authorization was first received.	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.
9792.10.1(d)(1) and (d)(3)	Commenter recommends the following revised language: (d)(1) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee ~~and, if the employee is represented by counsel, the employee's attorney, have~~ has been notified of the 30-day time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6. Any request by the injured worker or treating physician	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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 review decision. …. (3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, and the injured worker's representative~~,~~ ~~and if the injured worker is represented by counsel, the injured worker's attorney~~ according to the requirements set forth in section 9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) must indicate that the decision is a modification after appeal. Commenter states that the statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	either utilization review decisions or IMR. Labor Code section 4610(g) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney. Also, according to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." Commenter opines that the applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. Commenter opines that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent review organization, it removed applicant attorneys from the IMR process.			
9792.9.1(c)(2)(A) and (c)(2)(B)	Commenter states that this section indicates physicians are not required to use the DWC Form RFA which is inconsistent with Regulation 9785 requiring use of the form for all requests for treatment. Further, it allows a claims examiner to accept an	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation	These regulations are consistent with Regulation 9785(g) which provides, "As applicable in section 9792.9.1…"	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	incompliant form, which can then subject said a claims examiner to penalties should an error or omission occur. In order to promote consistency, commenter recommends that section (B) in its entirety be deleted, as well as the language in section (A) referencing section (B) ("Upon receipt of a request for authorization as described in subdivision (c)(2)(B).") If a physician prepares a request on any non-RFA form the claims examiner shall disregard such request as not compliant with the rules. Even suggesting that the claims examiner consider all types request could potentially create an appearance of bias or prejudice which would later be scrutinized and penalized. Deleting section B would avoid this unintended consequence and ensure compatibility within the regulations.	December 20, 2013 Written Comment		
9792.9.1(f)(4)	**Commenter state that the language in this section** is inconsistent with LC 4610(g)(1). The proposed language states that, "Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall	Robert Ward December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information." Commenter opines that without the addition of the 14 calendar day deadline imposed by LC4610(g)(1), there will be situations where a determination made within 5 business days of receipt of information is also made more than 14 calendar days from the RFA. This creates the potential for reviews to be timely by 9792.9.1(f), but untimely by LC 4610(g)(1). **Commenter state that if the language "but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA" is retained in this section as recommended, no further change is necessary. Otherwise commenter recommends that this section be amended to include a prohibition against making a determination on prospective, concurrent or expedited review more than 14 calendar days from the receipt of the RFA.**			
9792.10.1(d)(3)	Commenter states that this section does not address what happens to an	Anne Searcy, MD Sr. Vice President	See section 9792.10.6(g)(2). The modification would render	No action necessary.

	IMR that was initiated on the original determination before the decision was modified on appeal. Failure to close out the original IMR could result in both IMRs moving forward. Commenter recommends adding the following sentence at the end of this subsection: "When an IMR is submitted as a Modification after Appeal, any existing IMR related to the original utilization review decision will be consolidated with any IMR submitted after appeal."	and Chief Medical Officer The Zenith December 20, 2013 Written Comment	the initial decision moot; on the request on the modified treatment would be decided.	
9792.6.1(t)(3)	This section states the request for authorization must be signed by the **"treating physician".** However the RFA form includes a signature line for the **"Requesting Physician Signature".** Commenter recommends that 9792.6.l(t)(3) be changed to **"requesting physician"** to mirror the RFA form.	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The terms are synonymous and are unlikely to be confused. Only a treating physician can request authorization for medical treatment; when the request is made they are the requesting physician. If the different terms prove confusing to either physicians or claims administrators, the Division will consider using the same term in future rulemaking.	No action necessary.
9792.6.1(t)(3)	Commenter states that the proposed addition of language in this section which indicates that the request for	Peggy Thill Claims Operations Manager, Claims	The Division has yet to determine that a uniform method for transmitting health	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	authorization form may be sent by email conflicts with the definition of "written" communication described in Section 9792.6.1(z) which prohibits health records from being transmitted by electronic mail. Commenter recommends that the DWC delete the provision allowing submission of the RFA by email.	Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	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.	
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, 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. Commenter appreciates the modification that will help ensure the request for authorization is submitted to the proper recipient. Commenter recommends requiring the treating	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, the Division does not believe the language is ambiguous	No action necessary.

	physician to not only sign the request, but to also submit the request to a designated address, fax number or e-mail address if any. Commenter opines that if this is not required, a treating physician would be permitted to ignore any designated address or fax number which may cause the injured employee's treatment to be delayed, and unfairly trigger penalties.			
9792.10.7(a)(3)	Commenter notes that this section states that if at the time of receiving the final determination, the claims administrator is disputing liability, then the claims administrator can defer implementation of the decision. Commenter agrees with this provision but wants to clarify that if that information is provided early in the process, the IMR will not proceed so that unnecessary expense for IMRs is not incurred.	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	If there is a documented dispute regarding liability, an IMR request is ineligible for a determination. Section 9792.10.3(a)(3) and (4).	No action necessary.
9792.10.7(a)(3)	Commenter notes that this section creates a new paragraph which defers implementation of the final determination if the claims administrator is disputing liability for the medical treatment on grounds other than medical necessity, until the liability dispute is resolved. Commenter recommends that this	Diane Worley California Applicants' Attorneys Association December 21, 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	No action necessary.

	subdivision be revised to also mandate that the claims administrator notify the employee and employee's attorney within five (5) working days of receipt of the determination that the treatment will be deferred until a determination issues regarding the dispute and that this notice also identify what the grounds are for disputing liability, so there is no confusion as to why there is a delay in providing the medical treatment. 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.		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.	
9792.9.1(e)(3)	Commenter states that this section conflicts directly with 9792.9.1(c)(4) and 9792.9.1(f), and Labor Code 4610. Commenter notes that this section	Robert Ward December 21, 2013 Written Comment	The extension of time for an expedited review where additional information is necessary is set forth in section 9792.9.1(f)(5). If data indicates this provision is causing	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	requires that notice of review determinations on expedited reviews be communicated to stakeholders "within 72 hours of receipt of the request". This section makes no provision to an extension of the 72-hour timeframe in the case where additional information is required by the reviewer to make a determination of medical necessity on an expedited review. Labor Code 4610(g)(2) and all other regulation sections referencing the 72 hour turn around time for expedited reviews (e.g. 9792.9.1(f)(5)) include language similar to: “not to exceed 72 hours after receipt of the written information reasonably necessary to make the determination.: **Commenter recommends that this section be amended to become consistent with LC4610(g)(2) by amending "within 72 hours of receipt of the request" to "not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.”**		confusion, the Division may revise the language in future rulemaking.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9.1(c)(3)	Commenter states that the redaction of "but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA." from this section brings the timeframes for prospective and concurrent review in the regulations in potential conflict with Labor Code 4610(g)(1). **Commenter recommends that the DWC retain the language "but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA."**	Robert Ward December 21, 2013 Written Comment	The extension of time should additional information be needed is set forth in subdivision (f).	No action necessary.
9792.9.1(f)(3)(B)	Commenter states that the timeframes outlined in this section conflict directly with the timeframes outlined in LC4610(g)(1). The proposed language of 9792.9.1(f)(3)(B) indicates that in instances where the reviewer has indicated a need for additional testing or specialty consultation prior to a determination of medical necessity, that the reviewer shall issue a denial of the results of the requested testing or consultation are not made "within thirty (30) days from the date of the request for authorization". However, LC4610(g)(1) states that	Robert Ward December 21, 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	No action necessary.

	determinations of medical necessity on all prospective and concurrent requests are to be made "in no event more than 14 days from the date of the medical treatment recommendation by the physician." **Commenter recommends that the language in this section be made consistent with LC4610(g) by amending to: "If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under subdivision (f)(1)(C), that is requested by the reviewer under this subdivision is not received within fourteen (14) days from the receipt of the request for authorization for prospective or concurrent review, or within thirty (30) days from the date of receipt of the request for authorization for retrospective review, the reviewer shall deny…."**		not believe that additional regulation in this area is necessary, although data indicating an abuse could result future rulemaking to address the matter.	
9792.9.1(d)(3)(B)	Commenter states that the proposed language in this section creates serious process confusion regarding the payment of billing for medical services, and is inconsistent with numerous sections of regulation:	Robert Ward December 21, 2013 Written Comment	The comments regarding payment of billing for medical services do not address the substantive changes made to the proposed regulations during the 2nd 15-day	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	"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." Commenter opines that a possible interpretation of this language is that any payment for any portion of billing creates a de facto authorization of the entire billing. Consider the common scenario where a provider requests a course of treatment; UR issues a modification; the provider ignores the determination and provides the services; and then sends billing. In this instance, the claims administrator is required to make timely partial payment for the portion of the services that has been determined to be medically necessary. However, making such payment then becomes a de facto authorization of all services billed, thereby requiring payment for		comment period.	

	all services and nullifying the UR modification. **Commenter recommends that the DWC review and revise the language in this section to ensure it is clearly articulating the DWC's intent.**			
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). 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 authorization for the requested examination or test. Commenter opines that this will help reduce delays because in practice most physicians	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	See above response to comment by Robert Ward regarding this subdivision.	No action necessary.

	will not proceed with the additional examination or testing until written authorization is received.			
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 or facsimile number…" Commenter states that this section does not prohibit an automated system, nor require that the system be staffed after business hours. Commenter opines that this section 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. Commenter recommends that this section stipulate that if the 72 hour timeframe starts, occurs or ends within a weekend or holiday that the response falls due *on the next business day*.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.
9792.12(c)(2)	Commenter opines that the proposed modifications to Section 9792.12(c)(2) impose an excessive amount of penalties against the claims administrator for failure to complete the specified fields on the IMR application sent to the employee when	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013	The Administrative Director recognizes the importance of meaningful administrative penalties and the express statutory language of section 4610.5(i). The amount of administrative penalties set	No action necessary.

	UR issues a decision to deny, delay or modify a treatment request. Commenter opines that Section 9792.12(c)(2)(E) is problematic as it refers to "any field not identified above", which may be interpreted as any and all other fields in the application, including applicant attorney information. Commenter recommends that the DWC delete the proposed language. The DWC may also consider revising the language to establish fair penalties relative to the significance of the infraction.	Written Comment	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.	
9792.12(c)(2)	Commenter notes that this section creates a new subdivision to establish administrative penalties for the failure of the claims administrator to complete all applicable fields of the Application for Independent Medical Review. Commenter recognizes and supports the need for an assessment of administrative penalties for the failure of the claims administrator to properly complete the IMR application; however, she continues to believe that the proposed penalties for other violations of the claims administrators' statutory obligations are woefully inadequate in light of the harm to the injured worker.	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	See above response to comment by State Compensation Insurance Fund. If a claims administrator asserts that the proposed amounts are excessive, and an employee representative asserts the amounts are inadequate, the amount should be considered reasonable.	No action necessary.

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	For example, when a claims administrator provides no medical records or other required documentation to the IMRO, or fails to serve the employee and their attorney with a list of what they have provided, either a determination cannot issue until the employee provides the necessary medical records(which often are not served on them), or a determination issues based on an inadequate medical record to which the employee has not been given the opportunity to supplement the record as they have no notice of what was provided for review. Commenter opines that it should be apparent that the imposition of the penalties as currently proposed would be a grossly inadequate response to such a flagrant violation of these rules. Commenter states that unless the penalty amounts are significantly increased she opines that the Division's enforcement efforts for the claims administrators failure to provide records will be futile, and significant delays will continue in the IMR process creating a greater medical treatment logjam.			

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	Commenter agrees that it is not appropriate to assess the maximum penalty in every instance, but opines 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 by the claims administrator to the IMRO.			
9792.10.1(d)(2)	Commenter agrees that an independent medical review decision should control and terminate any internal appeal that may be in process; however, the commenter opines that the IMR decision should control regardless of whether the IMR approves or denies the requested treatment. Commenter recommends the following revised language to clarify that the IMR determination will control: A request for an internal utilization review appeal must be completed, and a determination issued, by the claims	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The language of the regulation is sufficient: an IMR determination completes the internal review process.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be ~~considered~~ terminated complete upon the issuance of a final independent medical review determination under section 9792.10.6(c). ~~that determines the medial necessity of the disputed treatment and the independent medical review determination implemented.~~			
9792.10.1(b)(2)(A)	Commenter states that this section provides in relevant part, "If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation." Commenter opines that this conflicts with Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The notice of representation is served at the beginning of the attorney's representation of the injured worker. In most cases this will predate the utilization review decision. Commenter opines revising the	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	language as follows: "If the employee's attorney files the DWC Form IMR, the form must be accompanied by a written designation confirming representation executed after the utilization review decision."			
9792.10.1(b)(2)(A)	Commenter recommends the following revised language: The employee ~~or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.~~ Commenter states that applicant attorneys are nowhere included in the Labor Code section 4610.5 language and have no role in the IMR process unless and until an IMR decision is challenged when a verified appeal may be filed with the appeals board. According to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The applicant attorney is not a valid	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	designee if the designation of representation was executed prior to the utilization review decision. The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the IMR process. Labor Code section 4610.5(j) states "For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. …" Commenter states that if the employee is represented by an attorney at the time of a UR decision that language means the applicant's attorney is not eligible to act on behalf of the employee for purposes IMR. Commenter opines that since the legislature moved the responsibility for deciding medically necessary			

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	treatment from the Board to the IMRO, there is no longer necessity for an attorney to argue on the medical necessity for treatment unless there is an appeal. Commenter states that the statute also did not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. For example, Labor Code section 4610(g)(5) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney.			
9792.10.1(d)(2)	Commenter opines that this section is unclear from a process perspective. The proposed language states, "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 treatment." Commenter wonders if this is intended	Robert Ward December 21, 2013 Written Comment	The language of the regulation is sufficient: an IMR determination completes the internal review process. Meaningful communication between a claims administrator and its URO would ensure the URO is informed of IMR determination.	No action necessary.

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	to mean that if IMR is completed prior to completion of an internal UR appeal that the appeal should stop. If so, commenter opines that this is not possible, since the URO does not receive notice of the IMR determination. Commenter wonders if this language intended to indicate that if an IMR is completed prior to completion of the internal UR appeal, that the UR appeal has no standing. If so, commenter opines that this means that in the instance that an IMR upholds the original adverse determination and that the internal UR appeals overturns (authorizes), the authorization has no standing and the IMR denial is the final determination. **Commenter recommends that the DWC review and revise the language of this section to ensure it is clearly articulating the DWC's intent.**			
9792.10.1(d)(2)	Commenter previously commented on Section 9792.10.1, subdivision (d), paragraph (1), and the amendment that deleted the requirement that the internal UR review process be	Diane Worley California Applicants' Attorneys Association	Labor Code section 4610.5 does not allow an internal appeal to toll the timeframes for IMR.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	completed within 15 days. Commenter understands that it may be difficult to complete an internal UR review within 15 days; however, she opines that it is essential that the internal UR process be completed prior to the deadline for the worker to file an application for IMR. If the 30 day deadline for filing the IMR application is approaching and the internal UR process is not completed, the worker will have no choice but to file the IMR application. However, if the internal UR process subsequently resolves the dispute, the IMR application will have been a waste of time and money. Commenter recommends that this paragraph be revised to establish a deadline for completion of the internal UR process that gives the worker sufficient time to file for IMR after the internal review is completed. Commenter recommends going back to the original proposal that required completion within 15 days, but if that is not feasible we recommend that the process must be completed within 21 days.	December 21, 2013 Written Comment		
9792.10.1(d)(2)	Commenter notes this language says: "A request for an internal utilization review appeal must be completed, and	Workers' Compensation Section Executive	Labor Code section 4610.5 does not allow an internal appeal to toll the timeframes	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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 treatment." Commenter opines that this section requires clarification related to where this section falls in the timeline post **communication** of a UR non-certification from a URO entity that has previously published it's internal appeal guidelines. Does the time frame for requesting IMR stop while internal review is happening? Or can the Carrier or TPA conduct an internal review at the same time as IMR is requested by the Applicant or their designee, which happens simultaneous to a request for Expedited Hearing on issues of improper UR (timeliness, specialty, service etc.) by the Applicant's attorney?	Committee of the State Bar December 21, 2013 Written Comment	for IMR. The procedures run concurrently. That said, an authorization of treatment or modification of the initial UR denial will affect any pending request for IMR. See section 9792.10.6(g)(2).	
9792.10.5(a)(2)	Commenter recommends that the first sentence of this paragraph be amended	Diane Worley California	The employee's representative would include their attorney.	No action necessary.

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	to mandate that the claims adjuster shall forward a list of the documents submitted to the independent medical review organization to the employee, the employee's attorney, if represented, and the employee's representative.	Applicants' Attorneys Association December 21, 2013 Written Comment	If this provision results in confusion, the Division may amend the section in future rulemaking.	
9792.7(b)(2)	Commenter notes that this section refers to "reviewer's scope of practice," and recommends the inclusion of the wording "*as defined by the applicable licensure board*."	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	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 on the DWC Form RFA, ~~the request for authorization must~~ including information identifying both the employee and the provider, ~~and~~ identifying with specificity a recommended treatment or treatments and ~~be~~ accompanied by documentation substantiating the need for the requested treatment. Commenter opines that in order to	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	The language is sufficiently clear; the suggested language appears to be redundant.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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 notes that the RFA must identify requested treatment "with specificity." Commenter requests that the Division add language because "see attached report" is not specific enough, and is a basis for identifying the RFA as "incomplete."	D. A. Ingram, MD December 21, 2013 Written Comment	Identifying information, in combination with the supporting documentation, will produce adequate information to proceed with a treatment review.	No action necessary.
9792.10.6(b)(2)	Commenter states that the proposed changes to allow the IMR determination to issue without all relevant medical records being provided solely by the claims administrator, will achieve a denial of Applicant's Due Process rights. LC Sec. 4610.5(l) requires that "…the employer shall provide… (1) A copy of all of the employee's medical records in the possession of the employer or under the control of the	Ralph W. Mann Boxer & Gerson, LLP December 6, 2013 Written Comment	The goal of IMR is to expedite treatment for injured workers by having medical experts make the final determination regarding the medical necessity of treatment requests. If a claims administrator, after full notice, fails to participate in the IMR process in clear violation of their obligations, the IMR process should not be brought to a halt if, following	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

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	employer relevant to…." Commenter opines that shifting of the burden to require the applicant to provide medical records to IMR directly violates both statutory authority, and the State's Constitutional entitlement to an "unencumbered" system. Commenter asks why not just provide that the claims administrator's failure to provide all relevant medical records constitutes a reversal of the UR decision? Commenter states that this would create incentive to the claims administrator to fulfill their statutory requirements.		the submission of medical records by the employee and the requesting physician, sufficient evidence exists for the IMR reviewer to make a medical necessity determination. Given that adequate records must be in the possession of the IMR reviewer, the regulation should fully acknowledges the participation of the employee and state that an IMR determination will not be made solely based on the records summarized in the adverse UR determination. Certainly, the claims administrator will be subject to administrative penalties for a failure to comply.	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 determination shall issue based solely on the information provided by a utilization review determination.
9792.10.6(b)(2)	Commenter opines that the proposal to allow the IMRO discretion to issue a determination when the claims administrator has failed to meet its	Diane Worley California Applicants' Attorneys	See response to comment by Boxer and Gerson in response to this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	obligation to provide required records is well intentioned; however, she finds there are still serious problems with this proposal. Commenter states that it is unclear whether the IMRO will take any action if necessary medical records have not been received. Commenter supports proposal in the 3rd 15 Day Notice which provides that an IMR determination cannot be based solely on the information provided in the UR determination. To do otherwise would be a clear violation of the injured worker's due process rights. Commenter opines that the rule must also provide guidance where no records are provided to the IMRO. Commenter opines that if the rule is silent it is likely nothing will happen, and the IMR request will sit in limbo. An injured worker should not be penalized by a further delay in getting treatment because the claims administrator failed to provide the records. The intent of IMR was to expedite the delivery of appropriate medical treatment, and leaving this request in limbo will only cause further delay and lead to litigation and higher frictional costs.	Association December 21, 2013 Written Comment		

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter recommends that this regulation be amended to provide that where the claims administrator does not submit records within the statutory timeframe that the treatment request be deemed approved and the U.R. denial deemed reversed by operation of law. Commenter opines that any other result simply rewards the employer's failure to comply with their statutory obligation to send the medical file and delays treatment. Commenter is also asking for increased administrative penalties, and opines that penalties alone will not do the job, since they rely on an overworked medical unit staff and upon the willingness of the administration to actually enforce penalties. Commenter notes that the injured worker needs the treatment presently to physically rehabilitate and return to work, and while increased administrative penalties may deter bad claims behavior, the penalties may not be paid until months after the IMR application was filed. Commenter recommends that the regulation mandate that the IMRO must notify the employee, the			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	employee's attorney, if represented, and the employee's representative if medical records have not been submitted by the claim administrator within the statutory time limit. The regulation should also provide that where the IMRO has not received necessary medical records within a specified time limit, for example 60 days, the IMR application should be returned to the employee with a notice that the application may be refiled. Commenter recommends that the regulation specify that where an IMR application is returned to the employee under the circumstances described above, the IMRO shall notify the Administrative Director of this action and the AD shall immediately issue notice of intent to assess the maximum penalties as set forth in statute, $5,000 per day for each day of delay, which would be a total of $300,000 for a 60 day violation. Commenter recommends that this regulation be amended to require the IMR physician to itemize in the final determination all records received and reviewed from the claims			

	administrator. Commenter states that this will allow the employee to supplement the record or raise this issue on appeal.			
9792.10.6(b)(2)	Commenter notes this language says: "If a claims administrator fails to supply documentation**…**, a medical reviewer may, if possible, issue an IMR determination**…**based on a summary of medical records listed in the utilization review determination and any documents submitted by the employee or requesting physician**….**" Commenter opines that this rule is troubling. Instead of making a determination based on what might be considered multiple levels of hearsay commenter recommends that that the Rule mimic or refer back to the statute [LC 4610.5 and 4610.6] which requires that the IMR reviewer review very specific items and not someone's summary of them. This proposed Rule is **also** inconsistent with 9792.10.5(a)(1)(A) that mandates the claims administrator to send a "copy of all reports of the employee's treating physician....."	Workers' Compensation Section Executive Committee of the State Bar December 21, 2013 Written Comment	See response to comment by Boxer and Gerson in response to this subdivision.	No action necessary.
9792.9.1(c)(2)	Commenter opines that the change to allow a non-conforming request that	Geri Hart, RN, BSN, CDMS, CCM	See response to comment by California Workers'	No action necessary.

	does not use the DWC Form RFA appears to negate the original purpose of the RFA form. Allowing the medical report to serve as the request form, despite the requirement to list the requests on the first page, challenges the provider to include the information clearly identified on the DWC Form RFA. Most providers are using the new RFA form without too much difficulty. The new form allows for much easier identification of the specific request, the claim information, and the requesting provider information. This can sometimes be difficult even on the PR-2 form. Commenter recommends that the DWC continue the requirement of the requesting providers to utilize the DWC Form RFA when requesting any medical services.	Director, Managed Care InterMed Cost Containment Services December 6, 2013 Written Comment	Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	
9792.9.1(f)(2)	Commenter states that the proposed change to allow a "claims administrator" to request additional information is in violation and in direct contravention of LC Sec. 4610. Specifically, LC Sec. 4610(e) mandates that "No person other than a licensed physician who is competent	Ralph W. Mann Boxer & Gerson, LLP December 6, 2013 Written Comment	A non-physician reviewer may request information in limited circumstances. Section 9792.7(b)(3).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to evaluate the specific clinical issues…may modify, delay, or deny…." Commenter opines that the proposed regulation directly violates the statutory authority.			
9792.9.1(c)(2)	Commenter recommends that following revised language in order to correct a typographical error: "…the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either regard ~~the~~ 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…"	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	Agreed.	The duplicate "the" has been deleted.
9792.9.1(c)(2)(A) and (B)	Commenter notes that 9792.9.1(c)(2)(B) requires that a treatment request submitted for medical treatment that does not utilize the DWC Form RFA list the services, goods or items being requested on the first page. Commenter supports this requirement as it reduces administrative time and errors due to searching for treatment requests in reports. Commenter suggests this same language be included under 9792.9.1(c)(2)(A) and (B). The RFA form includes a section to populate	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The regulation is clear that a DWC Form RFA that does not identify a recommended treatment can be returned to the provider. Further restrictions in this area would amount to over-regulation.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with the treatment request. Commenter suggests that the regulation wording include that this section must be completed and any request not listed is not considered a treatment request for purposes of utilization review. Commenter is experiencing situations where the RFA is buried in the middle of a submission making it difficult to locate. To alleviate "hunts" for the treatment request, commenter proposes inserting the following sentence after the first in (c)(2)(A) as follows: "When a RFA form is used, requests that are not included on the front of the RFA form will not be considered valid treatment requests and do not require a response. The completed RFA form must be included as the first page of any submission that includes a request treatment so that it is readily visible to the recipient of the treatment request." Commenter recommends adding the following sentence to (c)(2)(B): "Any such "Request for			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Authorization" must be included as the first page of any submission that includes a request treatment so that it is readily visible to the recipient of the treatment request." Commenter also proposes that if an entity elects not to accept treatment requests on a form other than the RFA, the entity be allowed to publish as part of its utilization review plan and utilization review decision letters its requirement and therefore not be required to respond to each and every request submitted on the improper form. Commenter suggests it be clarified that no response is required to treatment requests that are not submitted on the RFA or, if the entity accepts non-RFA forms, on a properly labeled Request for Authorization. Commenter suggests the following new subsection and language: 9792.9.1(c)(2)(C) No response is required to any request for treatment that is not submitted as required under (A) or (B) above. If a Claims Administrator elects not to accept treatment requests of a form other than the RFA, the Claims Administrator			

	may include a statement in its utilization review plan that it will not accept treatment requests unless they are submitted on the RFA. The notice will also be included in utilization review decision letters as a reminder to providers. If these requirements are met, the Claims Administrator is not required to respond to each and every treatment request that is submitted on a form other than the RFA.			
9792.9.1(c)(2)	Commenter opines that this section adds language that unfairly places the responsibility on the claims administrator to reject within 5 business days requests for treatment where the DWC Form RFA is not utilized and where the request is not accompanied by documentation substantiating medical necessity. Commenter recommends that the DWC require the use of the DWC RFA form and remove the duty of the claims administrator to respond to a request that is not submitted on the mandated DWC Form RFA.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.
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	Brenda Ramirez Claims and Medical Director California Workers' Compensation	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.

	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.	Institute December 20, 2013 Written Comment		
9792.9.1(f)(2)(A)	Commenter notes that this section requires all requests for additional information must be made within 5 business days of the receipt of the RFA. This applies to all review types (prospective, concurrent, retrospective and expedited). Commenter opines that this creates a situation where delay could be made on expedited reviews after a decision and notice would typically be required. For retrospective reviews, this creates an unresolvable conflict for reviewers if they receive the review more than 5 business days after the claims	Robert Ward December 21, 2013 Written Comment	A request for additional information must be made within 5 business day from the date of the receipt of the request for authorization. For a review on an expedited basis, there is nothing prohibiting the claims administrator from requesting the information earlier. In fact, Labor Code section requires that the claims administrator act "immediately." If this section results in confusion or a delay in the expedited review	No action necessary.

	administrator received the request (a common occurrence) with insufficient information. They would be unable to request information without making the UR untimely; they would be unable to deny based on insufficient information; and would be effectively forced into issuing an authorization without knowing if the service were actually necessary. **Commenter recommends that the 5 business day timeliness requirement in this section be applied to prospective and concurrent reviews only; that the time limit on requesting information on expedited review be within 72 hours of the receipt of RFA; and that the time limit on retrospective review be within 30 days of receipt of RFA.**		process, the Division will consider a revision in future rulemaking.	
9792.9.1(c)(2)(A)	Commenter notes that there is an extra "the" which should be deleted.	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	Agreed.	The duplicate "the" has been deleted.
9792.9.1(f)(2)(B)	Commenter notes that this section stipulates that "the reviewer shall notify the requesting physician" if the	D. A. Ingram, MD December 21, 2013 Written Comment	Non-physician reviewers are included in "reviewer" and the proposed addition is	No action necessary.

	circumstances of (f)(1)(A) apply, namely that CA or reviewer is not in receipt of necessary information. Commenter recommends that this section instead state "the reviewer *or non-physician reviewer* shall immediately notify…"		unnecessary.	
9792.10.1(b)(1)	Commenter recommends the following revised language: The request must be made on the Application for Independent Medical Review, DWC Form IMR, 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 submitting a DWC Form IMR with a written decision delaying a decision is not necessary since the delay is pending additional information. Commenter opines that it is only appropriate to submit the form with a decision denying or modifying a request for authorization.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	The language is consistent with that of Labor Code section 4610.5(f). While the current and proposed regulations do not contain a provision for a "delay" determination necessitating the need for an IMR application, future rulemaking may establish such a determination	No response necessary.
9792.10.1(b)(1)	Commenter notes that this section requires that the employee send a copy	Robert Ward December 21, 2013	The purpose of the requirement is to put the	No action necessary.

	of the signed DWC Form IMR to the claims administrator. Commenter states that there is no indication as to what should occur, from a process perspective, if this requirement is not followed. **Commenter recommends that the process outcome of the employee's failure to send a copy of the DWC Form IMR to the claims administrator be clearly indicated; or that the requirement be removed from the regulation.**	Written Comment	claims administrator on notice of the initiation of the IMR process at the earliest point possible. Since this requirement does not directly relate to the underlying eligibility of the IMR request, the Division finds that a sanction to the employee for a violation of this provision is unwarranted. Upon evidence that employees are not complying with this requirement, the Division may revise the requirement in future rulemaking.	
9792.10.5(a)(1)(B)	Commenter notes that this section was modified to require that a copy of the Application for IMR that was transmitted with the original decision letter be included with the medical records. However, it states only the IMR application is to be submitted, not the instructions or determination letter. Systems generally will store the determination letter, IMR application and instructions as a single PDF image. Commenter opines that separating the PDF apart to send only the IMR application requires an additional manual administrative step	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	Only a copy of the IMR application is required however, the claims administrator will not be sanctioned if it chooses to provide the UR determination also.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that is unnecessary. If the IMR application is required, then the submitter should be permitted to submit the stored version without having to break the stored document apart. Commenter recommends striking the following sentence: "~~Neither the written determination nor the application's instructions should be included.~~"			
9792.10.5(a)(1)(B)	Commenter opines that this section, as written, is unintelligible. Commenter requests that this section be re-written so that the purpose of the regulation can be clearly understood.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	Regulations do not need to clearly state the purpose behind them. A copy of the IMR application is required while written determinations and instructions should not be included; this is clearly written.	No action necessary.
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	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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 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.			
9792.10.6(g)(1)(A)	Commenter notes that this section allows MAXIMUS to combine IMR requests for review. Commenter is concerned that there needs to be some limit as to how long decisions can be held. If IMRs are filed for multiple treatment requests over a period of a month, then at some point, the decision needs to be rendered and not delayed because additional IMR requests continue to be received. Commenter opines that this could be addressed by including language that states, "But in no event shall a	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The Division does not believe that further regulation in this area is necessary. As noted, if evidence shows that the consolidation provision of section 9792.10.4(a) serves to delay the IMR process, the Division may consider further restrictions in future rulemaking.	No action necessary.

	decision be rendered more than X days after receipt of the request for IMR." If experience shows this is not a concern, then no changes are needed.			
9792.10.6(g)(1)(A)	Commenter opines that tolling the 30 day time period for issuing a final determination when two or more requests for independent medical review are consolidated, will create more delays and confusion in the IMR process and therefore this amendment should be deleted in its' entirety. For example, if the last IMR filed is not "completed" as defined in section 9792.6.1 (t) (2) this could delay the IMR review for a indefinite period even if the first IMR application was "completed". Commenter recommends that this section be deleted.	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	See above response to comment by The Zenith regarding this subdivision.	No action necessary.
9792.10.6(g)(1)(B)	For the same reasons commenter discussed regarding section 9792.10.6(g)(1)(A), she recommends that this amendment be deleted in its' entirety as it will only create more delays and confusion in the IMR process. For example, if the last IMR filed and consolidated with an earlier application is modified after an	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	The provision applies a timeframe for an IMR determination when an IMR request is made on modified treatment decision following an internal appeal, one that renders the original UR decision moot. The provision is reasonable to provide that	No action necessary.

	internal utilization review appeal, the 30 days to start the IMR process doesn't begin until after an IMR application is filed for the modified treatment. Commenter states that this puts any IMR application which has been consolidated with the later filing in limbo for an indefinite period, and if an IMR is not filed for the modified treatment it would appear that the earlier applications may never be reviewed based on the language in this subdivision. Commenter recommends that both of these newly added subdivisions be deleted.		the timeframe runs from the filing of the last application.	
9792.9.1(c)(1)	Commenter opines that this section should further define what is considered the first day of receipt of the DWC Form RFA. Commenter recommends specifying that the first day in counting any timeframe requirement is considered to be the first "business" day after receipt of the DWC Form RFA.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, the regulation is sufficiently clear.	No action necessary.
9792.9.1(b)(1)	Commenter recommends the following revised language: The written decision must be sent to the requesting physician, and the injured worker~~, and if the injured worker is represented by counsel, the~~	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~injured worker's attorney~~. The written decision shall contain the following information specific to the request: Commenter opines that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the IMR process. The statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. For example, Labor Code section 4610(g)(5) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney.	Written Comment		
9792.9.1(a)(1)	Commenter notes that this section permits the submission of a request for authorization via email; however, 9792.6.1(z) specifically prohibits the emailing of any form of medical records. Because every request for authorization is required to contain documentation substantiating the need	Robert Ward December 21, 2013 Written Comment	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.

	for the requested treatment (e.g. medical records) per 9792.6.1(t)(2), commenter opines that emailing the request for authorization should be prohibited. **Commenter recommends that this section be amended so that there is no mention of the use of email to submit RFAs.**			
9792.9.1(b)(1)	Commenter notes that this section indicates that if the claims administrator has already issued a notice of dispute of liability to the requesting physician, that additional such notices are not required as "an explanation for the deferral of utilization review for a specific course of treatment." Commenter opines that by tying this exemption to a specific course of treatment, rather than a claimed injury or condition, the claims administrator is effectively required to issue a new notice of dispute of liability for every new request for authorization, even if the entire claim is being contested; as each new request is in effect a different "specific course of treatment". This could even be considered to be the case when the same medical services are requested at	Robert Ward December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, the claims administrator can only respond to the specific request provided. It would be hoped that the "clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment would preclude the submission of marginally different or related requests for authorization by the provider	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	a different frequency or duration; or for a different time period. Commenter doubts that this was the intent of the DWC. **Commenter recommends that the DWC review and revise the language in this section to ensure it is clearly articulating the DWC's intent.**			
9792.9.1(d)(1)	Because there may be disputes as to when an RFA is deemed complete by a claims administrator, commenter recommends that this paragraph should be amended to include that all decisions to approve a request for authorization *shall specify the date the RFA was first received* as well as the date the completed RFA was received.	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	Including the date the RFA was first received will not resolve disputes as to when an RFA is deemed complete. As such, the language is unnecessary.	No action necessary.
9792.12	Commenter notes that this section identifies all possible errors and omissions with respect to the review of treatment request. The cumulative effect of these violations can equate to up to $40,000 for just one request. Commenter opines that this has the potential to cause the reverse effect of treatment being authorized in order to avoid potential penalties for failing to properly manage the request.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	The Administrative Director recognizes the importance of meaningful administrative penalties and the express 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	No action necessary.

	Commenter proposes that the following language be added with regards to penalties: **A.** The maximum penalty for any actions or inactions allowed on a single request for treatment, from the start of the utilization review process through the conclusion of the IMR process, shall be limited to $10,000. **B.** Regardless of the number of omissions in one RFA request whether requests are combined or not, assessment of any penalty shall not exceed $2,000. **C.** Notwithstanding the foregoing, no penalty shall issue unless a delay of treatment of IMR eligibility is first shown.		resolution procedure in workers' compensation.	
9792.12	Commenter opines that the level of proposed penalties for utilization review and independent medical review enforcement is excessive and will impermissibly constrain the operation of section 4610, 4610.5, and 4610.6. Commenter states that the proposed penalty scheme under section 9792.12 narrows the scope of medical utilization review and is,	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	The Administrative Director recognizes the importance of meaningful administrative penalties and the express 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	No action necessary.

	therefore, in conflict with the statute. The current proposed regulations increase nearly every penalty, apply cumulative penalties, and fail to differentiate between harmless errors and material failures that have a significant adverse effect on the review of medical treatment. Commenter opines that the new proposed penalties have significantly exacerbated the problem. Commenter states that the problem is that the threat of excessive penalties will curtail legitimate medical utilization review activity that the statute permits. Commenter goes into greater detail in her letter [available upon request].		the specific violations and the fact that IMR is a new dispute resolution procedure in workers' compensation.	
9792.10.2 DWC Form IMR	Commenter notes that this form requests the employees to submit a copy of the UR determination letter in which the request for medical treatment was denied or modified but does not clarify what the ramifications may be if the employee fails to do so. Commenter recommends the DWC add language indicating the process and timeframes during which an IMR application may be rejected if the employee fails to submit a copy of the UR determination letter with the DWC	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	Section 9792.10.3(a)(1) allows the Administrative Director to consider whether an IMR application is timely and complete in deciding the eligibility of that application. In the absence of the UR determination, the application is not complete. It should be reasonably clear that the copy would go the address the claims	No action necessary.

	Form IMR. Commenter notes that this form does not specify where the employee should mail the copy for the Claims Administrator of the signed IMR application. Commenter recommends the DWC modify the instructions at the top of page 1 of the DWC Form IMR, as follows: "Mail or fax a copy of the signed application to your Claims Administrator's contact information listed below." Commenter notes that this form requires that the claims administrator input the employee's phone number. This may be problematic as the claims administrator does not always have this information in their possession. Commenter recommends the following language be added to the field for employee's phone number: "if known".		administrator provides on the form. If the information is not known, then it cannot be provided. The absence of a phone number should be documented by the claims administrator.	
9792.10.2 DWC Form IMR	Commenter recommends moving the section of the form where the injured employee may designate an individual as an agent to act on his or her behalf, to the DWC Form IMR.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute	The placement of the designation is reasonable given that the Administrative Director is limited to a one-page application. Labor Code section 4610.5(f). If evidence	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that requiring the injured employee's designation with signature and date on the DWC Form IMR that includes the disputed medical treatment will validate that the representative was designated after the UR decision. According to Labor Code section 4610.5(j), "a designation of an agent executed prior to the utilization review decision shall not be valid." Commenter states that if the designation is made on a page separate from the IMR application form that includes the list of the disputed medical treatment, there is no way to prevent post-dating of the designation. If it must be on the DWC Form IMR completed by the claims administrator with the disputed treatment, it cannot be post-dated. Commenter recommends changing the recipient of the application from Maximus to the Administrative Director or the Administrative Director's designee at the DWC. Commenter opines that the IMR application form must be reviewed for eligibility by the Administrative	December 20, 2013 Written Comment	indicates that employees are engaging in widespread backdating of the form, then additional restrictions may be considered in future rulemaking. There is no statutory prohibition from the IMRO acting as the entity receiving and processing all IMR applications.	

	Director or her impartial, disinterested designee before being assigned to the IMR contractor, which has a clear financial interest in the review. To avoid the financial conflict of interest described more fully in the introduction to these comments, commenter opines that the application must instruct the injured employee to submit the application either directly to the Administrative Director or to the Administrative Director's designee at the Division of Workers' Compensation.			
9792.10.2 DWC Form IMR	Commenter notes that the claims administrator is required to provide the requesting provider's primary diagnosis; but the requesting provider is not required to report it. Commenter opines that the selection of a primary diagnosis should be made by the treating physician; not by the claims administrator. **Commenter recommends that either the Form RFA should be revised to include the primary diagnosis; or the IMR Application Form should be revised such that the claims administrator is not required to provide a primary diagnosis.**	Robert Ward December 21, 2013 Written Comment	See above response to comment by Robert Ward regarding the DWC Form RFA.	No action necessary.

	Commenter opines that the instructions to injured worker for Form IMR may be difficult to employees to follow, and may lead to poor compliance with the intended process. **Commenter recommends that the DWC add to the instructions for employees a concise checklist of the elements required for mailing, as a component of the IMR form and/or form instructions.**			
9792.10.2 DWC Form IMR	Commenter recommends that the reference to "your attorney" in the "Instructions for Completing the Application for Independent Medical Review Form" be deleted from the IMR application to make it clear that workers do not have to designate their attorney in order to permit the attorney to file the IMR application. Commenter states that with a notice of representation, an attorney is already authorized to represent the worker on all issues pertaining to their workers' compensation case, including IMR.	Diane Worley California Applicants' Attorneys Association December 21, 2013 Written Comment	The attorney can either complete the designation form or submit a notice of representation. See section 9792.10.1(b)(2)(A).	No action necessary.
9792.10.3(a)	Commenter has experienced situations in which a provider through a peer to peer discussion has agreed to a	Anne Searcy, MD Sr. Vice President and Chief Medical	The Division does not believe that further regulation in this area is necessary. If there is	No action necessary.

	modified plan of treatment. The treatment plan is then authorized. However, although the provider has agreed to the change, the injured worker or applicant attorney files a request for IMR. Commenter does not believe this is appropriate since the treating physician has agreed to the modification. Commenter recommends adding a new provision that states: (a)(7) A written agreement showing the requesting physician has agreed to a modification of the original treatment request and the treatment request as modified was authorized without further modification.	Officer The Zenith December 20, 2013 Written Comment	meaningful communication between the provider and the employee, the application may be withdrawn. No application should be withdrawn without the consent of the employee.	
9792.10.3(c)	Commenter state that the proposed modification to Section 9792.10.3(c) to allow only 5 business days, rather than 15 days, to respond to requests for additional information made by the Administrative Director will pose an operational challenge for claims administrators. Commenter recommends that the language be reverted back to allow the parties 15 days to respond to the Administrative Director's request for additional information.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	Allowing 5 business days avoids lost days due to weekends and holidays and should be enough time for claims administrators to provide eligibility information.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.10.3(b)	Commenter recommends the following revised language: The Administrative Director shall advise the claims administrator, the employee, ~~if the employee is represented by counsel, the employee's attorney,~~ and the employee's provider requesting physician, as appropriate, by the most efficient means available. Commenter states that the statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. According to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. Commenter opines that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent review organization, it removed applicant attorneys from medical	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

	treatment dispute process.			
9792.10.3(c)	Commenter recommends the following revised language: The parties shall respond to any reasonable request made pursuant to subdivision (b) within five ~~business~~ (5) business days following receipt of the request. Commenter notes that the timeframe to respond to the request was previously reduced to five days from fifteen and now has been modified to five business days. Commenter opines that five business days provides inadequate 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. Commenter recommends allowing at least ten days for parties to respond. If, however, the Administrative Director decides to maintain the five working day time frame, commenter recommends correcting the typographical error as indicated.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	Agree in part. The typographical error will be corrected. Allowing 5 business days avoids lost days due to weekends and holidays and should be enough time for claims administrators to provide eligibility information.	The error will be corrected.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.10.3(f)	Commenter notes this language says: "The AD shall retain the right to determine the eligibility of a request for independent medical review**…**until an appeal of the final IMR determination**…**has been filed with the WCAB or the time for such an appeal has expired." Commenter opines that this is inconsistent with the Labor Code that mandates an initial determination by the AD [currently through MAXIMUS] for whether a UR appeal is subject to IMR. By implication, commenter states that this revised rule may prevent a WCJ from ordering treatment when the UR process is defective - and the IW is able to prove that the requested treatment is consistent with the MTUS. Commenter would like to know what happens if the UR process is defective (e.g. untimely, UR reviewer is outside scope of practice and not competent for issue, etc.) and a WCJ orders treatment at an expedited hearing - does this proposed rule still allow the matter to go to IMR despite the fact that a WCJ has ordered the treatment? Commenter recommends that if UR is	Workers' Compensation Section Executive Committee of the State Bar December 21, 2013 Written Comment	The right of an adjudicatory body to determine its own jurisdiction regarding any case or claim is well-settled. Should any facts arise during the IMR process indicating that the request is ineligible (i.e., the claim is denied), the Administrative Director must be able to deem the request ineligible. The Division notes that it has no authority to dictate rules and procedures to the WCAB.	No action necessary.

	found defective and treatment Ordered by a WCJ, then the IMR request should be dismissed.			
9792.10.4(b)	Commenter states that the modification to this section specifies that the IMRO notify all parties, but the claims administrator, of the eligibility for independent medical review. Commenter recommends that the DWC correct this possible oversight by including the claims administrator as an additional party that must be notified of the eligibility for IMR.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	Agreed. The claims administrator must be included.	To correct an inadvertent omission and comply with Labor Code section 4610.5(k), add "claims administrator" as a party to receive the notification of an IMR assignment. .
9792.10.4(c)	Commenter notes that this section states, in relevant part, that: "The independent review organization shall immediately notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review." However, it is not clear what may be defined as the most efficient means available. Left undefined, this could lead to confusion and misinterpretation. Commenter recommends that the language "most efficient means available" be clarified to avoid confusion. The DWC may wish to specify the methods of communication that are considered to	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	The language is sufficiently clear. Given the nature of the review, either regular or expedited, more than one means may be more appropriate.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	be the "most efficient means available".			
9792.10.4(a) and (b)	Commenter notes that this section allows requests to be combined in order to promote efficiency; however, he opines that the parameters identified need to be expanded to better accomplish their intended effect. Commenter states that for section (a) the consolidation of requests is limited to one date of injury and one physician. However commenter states that many employees suffer from multiple dates of injury involving overlapping treatment plans and require services from multiple physicians. Therefore, in order promote further efficiency the regulations should allow for consolidation of "all pending requests for the same individual received within 5 business days." Commenter states that section (b) does not require that the claims examiner be notified of the Administrative Director's finding. Commenter opines that this is denial of due process and therefore, notice to the claims examiner should be	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	The Division does not believe that over-regulation in this area is necessary. In fact, multiple dates of injury may suggest that a consolidation is not appropriate in such cases given that more than one reviewer in a different specialty may be needed. The claims administrator will be notified of the parameters of the IBR request in the notice of assignment under subdivision (b).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	included.			
9792.10.4(b)	Commenter recommends the following revised language: Within one business day following receipt of the Administrative Director's finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 shall notify the employee, the claims administrator, ~~if the employee is represented the employee's attorney~~, and the requesting physician in writing that the dispute has been assigned to that organization for review. The notification shall contain: Commenter recommends correcting the inadvertent typographical omission of "claims administrator" by adding it as indicated, or by restoring "parties." Commenter also recommends deleting the represented employee's attorney from those that must receive the notice as the statute did not provide authority	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	Agreed in part. The claims administrator must be included. Regarding counsel, See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	.No action necessary.

	for the Administrative Director to require such notice regarding IMR. Labor Code section 4610.5(k) requires the Administrative Director or his or her designee to notify the **employee and the employer** in writing as to whether the request for independent medical review has been approved.			
9792.10.4(b)	Commenter states that this section is inconsistent with 9792.10.5. The proposed language in 9792.10.4(b) changes the requirement that the notice of IMR assignment be sent to the "parties", and instead specifies that the notice is to be sent to the employee; the applicant attorney; and the requesting physician. However, there is no requirement in 9792.10.4(b) that this notice be sent to the claims administrator. Subsequently, 9792.10.5 becomes insensible; as it is entirely unreasonable to expect that the claims administrator would be able to respond to a notice of IMR eligibility that has never been sent to them. **Commenter recommends that the claims administrator be included in the list of parties to receive the notice of IMR eligibility in this**	Robert Ward December 21, 2013 Written Comment	Agreed in part. The claims administrator must be included.	No action necessary.

	section.			
9792.6(k)	Commenter recommends the following revised language: "Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions ~~(b)(l), (b)(2) or (c) and (g)(1)~~ (h)(2) of section 9792.9. This section defines the term "immediately" and references subdivisions (b)(l), (b)(2) or (c) and (g)(l) of section 9792.9. However, 9792.9 no longer appears to include the term "immediately". The term is used in 9792.9(h)2.	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 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 IMR program (see Labor Code section 4610.5(a)), the regulation is no longer in use and thus further amendment is unnecessary. This subsection was not changed as part of these amendments.	No action necessary.
9792.6(k) and 9792.6.1 (m)	Commenter notes that current emergency regulations define "immediately" differently depending on the date of injury and the timing of the utilization review determination. Commenter opines that the inconsistency may lead to conflicting interpretations which may require litigation to clarify. In order to promote	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	See above response to comment by The Zenith in regard to this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	uniformity within the regulations, commenter recommends that the definition of "immediately" read as currently set forth in § 9792.6.1 (m).			
9792.6.1(y)	Commenter states that this section contains a typorgraphical error and used the word "or" when if appear the work "for" was intended. Commenter recommends the following revised language: "…The utilization review process begins when the completed DWC Form RFA, or a request ~~or~~ for authorization accepted as complete under section 9792.9.l(c)(2), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	Agreed.	The typographical error has been corrected.
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	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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. Commenter strongly objects to modifications to the proposed revisions that will permit requests for authorization to be made in any form and to be presumed to be agreed to if the claims administrator fails to object within five working days. Commenter opines that if providers are not required to submit requests via a standard request form, the claims administrator may not be able to identify a request or may not be able to do so timely, which will generate unnecessary treatment delays, disputes and penalties. Many large claims administrators must rely on OCR (optical character recognition)			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	technology to timely identify requests. Requiring "Request for Authorization" to be clearly written at the top of the first page of a document does not mean it will be recognized as a request for authorization by OCR technology. Commenter states that additional staff and other resources will be necessary to review every piece of incoming mail, slowing the approval process and unnecessarily increasing costs and administrative expenses.			
9792.6.1(y)	Commenter recommends the following revised language: The utilization review process begins when the completed DWC Form RFA~~, or a request or authorization accepted as complete under section 9792.9.1(c)(2),~~ is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization. Commenter opines that if providers are not required to submit requests via a standard request form, the claims administrator may not be able to identify a request or may not be able to do so timely, which will generate	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.

	unnecessary treatment delays, disputes and penalties.			
9792.6.1(d)	Commenter opines that this section as proposed is inconsistent with 9792.6.1(t)(1); 9792.9.1(a); and other subsections. Commenter notes that this section defines a course of treatment as that described on Form 5021; PR-2; or equivalent narrative. Commenter opines that this introduces significant confusion as to which document is to define the treatment that is being requested; and also provides a basis for legal challenge to the validity of every UR conducted where the treatment described in Form RFA differs in any way from the supportive medical reporting. **Commenter recommends that the definition of a course of treatment in 9792.6.1(d) be amended to indicate that the course of treatment is the treatment outlined on Form RFA; consistent with other subsections.**	Robert Ward December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, the employee's course of treatment, as defined by subdivision (d), must be set forth in the documentation accompanying the DWC Form RFA. The form must contain the specific course of proposed treatment.	No action necessary.
9792.6.1(e)	Commenter opines that this section conflicts with 9792.7(b)(3); and causes 9792.7(b)(3) to conflict with LC4610(e). Previously, "delay" was defined as "a decision by a reviewer	Robert Ward December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that no determination based on medical necessity may be made within the 14-day time limit". Delay was thus a form of adverse determination; issued by a reviewer. Commenter states that the proposed definition is now "a determination, based on the need for additional evidence as set forth in 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 opines that the problem arises with this change in that a reasonable person could interpret this as indicating that the act of requesting information is itself the "delay"; effectively preventing any person other than a "reviewer" from requesting information. Commenter states that whenever personnel other than a reviewer makes a determination that there is insufficient information; and issues a written request for information; there has been a delay as described by the newly proposed definition. Commenter states that 9792.7(b)(3) specifically permits the process that is now described by the proposed			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	definition of "delay" to be performed by a non-physician. Commenter states that LC4610(e) specifically prohibits "delay" by any person other than " other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice". Commenter opines that because "delay" has now been defined as a determination that the review cannot be completed on time due to a need for information, testing, or a specialist consultation; and as LC4610.5(c)(1) requires the opportunity for IMR following denial, delay or modification; under the proposed definition, the mere act of asking for information triggers IMR eligibility. Commenter opines that proposed **9792.6.1(e)** requires that an opportunity for IMR be provided with every request for information, testing or specialist consultation. **Commenter recommends that the proposed change to the definition of "delay" in 9792.6.1(e) not be**			

	adopted.			
9792.6.1(a)	Commenter notes this section strikes "Approval" as a decision. Commenter opines 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"). See for example 9792.7 (b)(3), and 9792.9.1 (f) (4), (5) and (6). Commenter recommends that the terms "approved" and "approval" be retained.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.
9792.6.1(e)	Commenter notes 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." Commenter opines that is it not clear whether this is intentional or inadvertent.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, 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.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.6.1(j)	Commenter states this section indicates that Expedited Review is appropriate for serious medical conditions, i.e. "imminent and serious threat…" etc. Commenter states that it is unclear that Expedited Review in fact needs to exist as an option. Commenter references 9792.9.1 (e) (2) which stipulates that emergency services may be subjected to retrospective review. Treater thus has the option of providing the treatment and submitting the request for retrospective review, and expedited timeframe is actually unnecessary. If Expedited Review is preserved, commenter requests that 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*.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.
9792.6.1(m)	Commenter notes that change in the definition of "Immediately" from 24 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	D. A. Ingram, MD December 21, 2013 Written Comment	The definition is consistent with the use of the work throughout the regulations now in effect.	No action necessary.

	during these times. Commenter recommends that this change be applied throughout the regulations, as noted elsewhere in these comments, in view of the futility of communicating a decision to voice recordings in requesting physician offices, which are also typically closed during non-business hours.			
9792.6.1(v)	Commenter notes that this section indicates that treatment services must be "within the scope of the reviewer's practice." Commenter recommends that this section additionally clarify as follows: "…scope of the reviewer's practice *as defined by the applicable licensure board*."	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.
9792.6.1(w)	Commenter notes that this section defines "Utilization Review Decision," but opines that it also should specify when in the URO work flow process the decision occurs. This is particularly important when the date of the decision is used to reckon time frames for notification of the requesting physician, etc. Commenter recommends that this section indicate that the date of the "Decision" is the date on the UR decision letter to the treating physician and the parties.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.6.1(z)	Commenter notes this section prohibits transmission of "employee's health records" via electronic mail. Commenter states that the term "employee's health records" is not defined, and presumably does not include medical reports applicable to the injury, such as PR-2s, etc. Commenter states that 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 opines that this is puzzling in view of the encouragement of communication of UR determinations and other documents by electronic mail. Commenter recommends that this section be rescinded. If preserved, commenter requests transition period, with the statute formally taking effect at some future date.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, 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. 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.
9792.10.6(e)	Commenter recommends the following revised language: The independent review organization shall provide the Administrative Director, the claims administrator, the employee, ~~if represented the employee's attorney,~~ and the	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.9.1(e)(3), (e)(3), (e)(4), (e)(5), and (e)(5)(H)	No action necessary.

	employee's provider with a final determination regarding the medical necessity of the disputed medical treatment. With the final determination, the independent review organization shall provide a description of the qualifications of the medical reviewer or reviewers and the determination issued by the medical reviewer. Commenter recommends deleting the represented employee's attorney from those that must receive the final determination as the statute did not provide authority for the Administrative Director to require such notice regarding IMR. Labor Code section 4610.6(f) requires the independent review organization to provide **the administrative director, the employer, the employee and the employer's provider** with the final determinations.			
9792.9	Commenter notes that the language in the introductory paragraph has not changed. Commenter states that under the emergency regulations that have been in effect, the paragraph read: This section applies to any request for	Anne Searcy, MD Sr. Vice President and Chief Medical Officer The Zenith December 20, 2013 Written Comment	The sections conform to the triggering dates found in the authorizing statutes.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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. Commenter states that actions have already been taken in reliance on this paragraph and similar paragraphs that are included throughout the emergency regulations. Commenter opines that we cannot now retroactively "change" the actions and decisions that were taken in reliance on the emergency regulations. Commenter recommends that the language from the Emergency Regulations be readopted to avoid creating additional issues. Commenter states that, as written, this section now conflicts with 9792.9.1 which states: This section applies to any request for authorization of medical treatment submitted under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where **the decision on the**			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury. Commenter states that subsection 2 of this paragraph implies that regardless of the date of injury, if the decision was communicated after July 1, then 9792.9.1 applies. However, 9792.9 makes it appear that it would control since the request was received before July 1, 2013. Commenter opines that it cannot be both ways and since we are now months beyond July 1, 2013, these provisions should be kept consistent with the emergency regulations since that is what everyone was using to determine which letters got sent to the injured worker at the time the decisions were rendered. This is key because the letters that were sent instructed the injured workers as to what rights they had for review of an adverse determination. Commenter opines that changing the emergency regulation language at this point would create more confusion and compliance issues because it is impossible to correct what was already done during that time frame.			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.10.8	Commenter notes that this section describes the fees associated with IMR; however, fees are not addressed relating to the following: consolidated IMR requests, situations in which IMR is assigned when the claims administrator objects to eligibility and cases where the requesting party has withdrawn the request for IMR. In an effort to provide further clarity and avoid billing disputes, commenter recommends that the DWC specify the fees for consolidated requests, situations where IMR is assigned when the claims administrator objects to eligibility of IMR and when the requesting party has withdrawn the request for IMR.	Peggy Thill Claims Operations Manager, Claims Regulatory Division State Compensation Insurance Fund December 20, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, one fee will apply for a consolidated application and determination.	No action necessary.
9792.9.1(c)	Commenter recommends the following revised language: Upon receipt of a ~~**request for authorization as described in subdivision (c)(2)(B), or a**~~ DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 20, 2013 Written Comment	See response to comment by California Workers' Compensation Institute regarding section 9792.12(a)(12), (13), and (14).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	non-physician reviewer as allowed by section 9792.7 or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete**,**" specifying the reasons for the return of the request**,** no later than five (5) business days from receipt. 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; however, to avoid the delay and additional expenses associated with requesting and waiting for missing information, the Institute suggests the Administrative Director require a request for authorization to be complete. Commenter opines that it is unreasonable to delay the injured employee's medical care and to penalize the claims administrator for a			

	delay caused by the physician's failure to provide necessary information. Commenter states that if requests for authorization are not confined to a standard form, then it may not be possible to identify it within five working days, if at all.			
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 recommends clarification by the inclusion of the wording, "*no notification of the parties is required in this circumstance*," or similar language.	D. A. Ingram, MD December 21, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 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.
9792.10.9	To fully maximize the usefulness of this section commenter requests that any distribution of IMR determinations be transmitted in a digital and searchable format allowing easy and efficient examination of decisions. Commenter opines that the goal here is to help identify common patterns, concerns or issues	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment	The Division is exploring this suggestion.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	immediately.			
9792.6; 9792.9 and 9792.10	Commenter notes that these three legacy regulations no longer govern any ongoing processes, effective 7/1/13. Commenter states that the only purpose for the continued existence of these regulations is to provide a historic record of the required process for UR and IMR that was conducted between 1/1/13 and 6/30/13, for dates of injury prior to 1/1/13. This historical record is necessary for use by triers of fact (WCAB) in disputes regarding process conducted during the first 6 months of 2013. Commenter opines that making any amendments to the current emergency regulations will create a false historical record and that such changes can only result in significant confusion during process dispute resolution, and can have no benefits whatsoever. **Commenter recommends that the current emergency regulations for 9792.6; 9792.9; and 9792.10 be adopted into the permanent regulations without any amendments of any kind.**	Robert Ward December 21, 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.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General comment	Commenter asks if substantial evidence is no longer necessary. Commenter would like to know why the Division writes regulations that let the insurance carriers manipulate the facts. Commenter opines that the Division fails to understand that applicant attorneys are forced to send all UR denials to IMR or face legal malpractice lawsuits. Commenter states that there is no regulation to control carriers from sending cases to IMR for $100.00 treatment. Commenter states that Maximus Federal Service is going in take $10 million a month (20,000 x $560.00) and questions how this is going to save money.	Jeffrey Gaines December 10, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.	No action necessary.