INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 3rd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	Commenter states that after reviewing the proposed regulations that she has no comment at this time.	Peggy Thill Claims Operations Manager December 26, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9785.5 DWC Form RFA	Commenter states that orthopaedic practices are requesting **several services on the Request for Authorization form** as allowed on the form. Services that are included in a single request are part of the related surgery such as the surgery, the post-surgical medications, and the required rehabilitative services needed post-surgically. Commenter states that utilization review companies often approve the surgery, but ignore the request for the other services. Commenter states that they don't deny the services, they just ignore them which leaves the physician wondering whether they should take the patient to surgery, not knowing whether the other needed services will be approved. Commenter recommends clarification to the regulations to require that utilization reviewers be required to address all services requested on the RFA. Commenter opines that it is	Diane Przepiorski Executive Director California Orthopaedic Association December 23, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period. That said, Labor Code section 4610 requires that all treatment requests go through the UR process. To duplicate this requirement in regulation is unnecessary.	No action necessary.

	most efficient for the injured worker, the payor, and the surgeon to request the required services all on one RAF, so that all parties are aware of the total expected services for the procedure. It also provides the payor the most predictability regarding the services that will are envisioned by the surgeon.			
9792.12(c)(6)	Commenter notes that this section now provides for a $500 a day penalty for failure to provide all medical records, that penalty is capped at $5000. Commenter opines that in many cases, this penalty will be inadequate to encourage the carrier to provide the records. Commenter recommends that the regulation be further revised to provide that the maximum penalty is the greater of (1) $5000 or (2) the anticipated cost of the requested treatment. In addition, if a judge finds that the claims administrator failed to provide all of the information required by Section 9792. 10.5(a), the requested treatment is approved if the employee makes a prima facie showing that the treatment is medically necessary.	Carlyle Brakensiek, MBA, JD Legislative Advocate AdvoCal December 24, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period. That said, 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 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.	No action necessary.
9792.9.1(c)(2)(a)	Commenter notes that these	Lisa Anne Forsythe	The Division appreciates the	No action necessary.

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and (c)(2)(b)	subsections have been modified to provide specific data elements that providers must submit to the URO when sending a Request for Authorization in a non-conforming format, and allow the claims administrator flexibility in accepting or denying the non-conforming RFA if the specified data elements are not included in the request. Commenter opines that this modification to the rules is helpful, in that it allows the claims administrator some limited discretion to accept a faulty RFA if enough information is present to take action on the request as submitted, but prevents a claims administrator from being *required* to take action on the request when insufficient information is provided.	Senior Compliance Consultant Coventry Workers' Compensation Services December 26, 2013 Written Comment	comment.	
9792.9.1(c)(4)	Commenter notes that this section as amended contains language that helps define criteria by which a request for "expedited review" is to be judged. This section provides that "…a request expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services December 26, 2013 Written Comment	The Division appreciates the comment.	No action necessary.

	subdivision (c) (3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c) (3).” Commenter is in support of the addition of this language, as it provides claims administrators/URO’s with some specific guidelines for determining if the obligation to meet expedited review timelines exists for a given request, and allows the URO to direct limited resources towards those claimants whose medical needs are truly urgent.			
9792.10.6(b)(2)	Commenter notes that this section has be amended "to provide that if a claims administrator fails to submit the documentation required under section 9792. l 0.5(a)(1), a medical reviewer may issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.1 (e)(5), and documents submitted by the employee or requesting physician	Carlyle Brakensiek, MBA, JD Legislative Advocate AdvoCal December 24, 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 the submission of medical records by the employee and	No action necessary.

	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." Commenter states that the purpose of independent medical review is to have a complete review of all information involved in the previous utilization review decision. That's why Labor Code Section 4610.6(b) requires that the independent medical review organization (Maxim us) "shall promptly review all pertinent medical records of the employee, provider reports, ... ", etc. [emp. added] Commenter opines that there is no statutory authority for the review organization to make a decision based on a mere summary of the medical records. Commenter opines that since the injured worker has the burden of proof on the issue of medical necessity, it is imperative that the IMR organization have 100% of the pertinent medical records, not just a summary thereof.		the requesting physician, sufficient evidence exists for the IMR reviewer to make a medical necessity determination. The regulation fully acknowledges the participation of the employee; an IMR determination will not be made solely based on the records summarized in the adverse UR determination.	
9792.10.6(b)(2)	Commenter notes that this section states: "If a claims administrator fails to submit the documentation required	Julius Young December 26, 2013 Written Comment	See above response to comment by AdvoCal regarding this subdivision.	No action necessary.

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	under section 9792.10.5(a)(1) {comment: 9792.10.5(a)(1) requires the claims administrator to send a copy of all treatment reports within the last 6 months}, a medical reviewer may issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.1(e)(5), and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review determination shall issue based solely on the information provided by a utilization review determination." Commenter opines that this language is still problematic and references the below two scenarios: 1. If a claims administrator sends no records and the worker, attorney, or doctor send none, then what occurs? Is the treatment granted or rejected? The IMR reviewer could not rely solely on the UR determination. Does Maximus then send notice that it cannot do a			

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	determination? What is the protocol at that point? 2. What if a claims administrator does not send the required 6 months of records, but does send the treatment request report only? Or if the adjuster sends only a handful of reports, but not the full 6 months? Or the claims administrator cherry picks reports? In that event, proposed 9792.10.6.(b)(2) is unclear. The claims administrator will have sent SOME information, but NOT the documentation which is required under 9792.10.5(a)(1). Can Maximus then act on the limited information sent by the claims administrator plus the summary of medical records listed in the utilization review determination? A good argument could be made that it cannot. Proposed Reg 9792.10.6 seems to say that where a claims administrator fails to submit the REQUIRED DOCUMENTATION (emphasis added), documents submitted by the employee or requesting physician can combine with the UR summary as a basis for an IMR determination. Commenter opines that this is still			

	unclear. Can a partial submission by the claims administrator, combined with the UR medical document summary, constitute a basis for an IMR determination? If so, that is at odds with Labor Code 4610.5(l). Commenter states that unrepresented injured workers are at a disadvantage and will rarely have the medical documents to submit in a timely fashion. Commenter states that the attorneys for injured workers will often not have the documents either, since carriers routinely fails to serve medical reports on counsel. Commenter opines that this section allows Maximus to act based on partial document submissions by claims administrators and is therefore inappropriate and anti-worker.			
9792.10.6(a)(2)	Commenter recommends the following revised language: (a)(2) If a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may, if possible, issue a determination as to whether the disputed medical treatment is	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 26, 2013 Written Comment	See above response to comment by AdvoCal regarding this subdivision.	No action necessary.

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	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 any 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.~~ Commenter opines that while it is always preferable for the independent medical reviewer to have medical records on which to base its decisions, there is nothing in statute or regulation that prohibit the reviewer from making a determination based on a summary of records listed in a utilization review determination, if any (a denial may be based on the failure of the requesting physician to provide necessary medical documentation) and/or on medical treatment utilization guidelines. Commenter states that it is not necessary and not appropriate to deny the injured employee a determination on medical necessity if one is possible and appropriate.			

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9792.9.1(c)(2)(B)	Commenter notes that this section states that a claims administrator may accept a request for treatment that is not submitted on the DWC Form RFA under certain circumstances. Commenter is opposed to this type of exception because it creates an expectation on the part of providers. Commenter states that the proposed language is inconsistent with §9785.5, which clearly requires providers to use the proper form when submitting a request for medical treatment. Commenter requests that the DWC avoid infusing ambiguity into the regulations.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 26, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period. The option to allow a claims administrator to accept and process a request for authorization that did not utilize the DWC Form RFA was put into place on the request of claims administrators who, professing concern about delivering medical treatment to injured workers on a timely basis, wanted the ability to approve treatment requests without having to mechanically return them for not having a DWC Form RFA. The regulation was clear: if a claims administrator did not want to process a non-compliant request for authorization, i.e., one without a DWC Form RFA attached, it could return the form. The Division believed it would not take a claims administrator 3 business days to exercise that simple option.	No action necessary.

			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).	
9792.10.1(b)(1)	Commenter notes that the revised language states that "…a request for independent medical review must be filed within 30 days of service of the written utilization review decision	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period.	No action necessary.

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	determination issued by the claims administrator under section 9792.9.1(e)(5)". Commenter opines that it is unclear if this language was intended to state that the 30-day timeline begins from the date the that claims administrator initially sends the adverse determination to the claimant (which, would, therefore, result in the claimant actually having less than 30 days to respond), OR the date that the claimant actually receives the notice of adverse determination. Commenter requests that this section clarify whether the IMR timeline begins upon issuance and sending of the adverse determination, or whether it begins upon receipt of the adverse determination by the claimant. (Default of 5 days after the decision has been mailed or actual return receipt confirmation).	Services December 26, 2013 Written Comment		
9792.10.5(a)(1)	Commenter recommends that in order to ensure that a claims administrator has adequate time to respond to a request for service of medicals, the 15-day timeframe should begin upon receipt *by the claims administrator* of the Notice of Assignment, and should end on the day that the claims	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services December 26, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period.	No action necessary.

	administrator places the medicals in the mail to the IMRO (or electronically submitted, if appropriate). Commenter opines that this removes the uncertainty of the mailing process and ensures that the claims administrator is not unduly penalized for errors that may occur in the mail.			
9792.11	Commenter objects to the change that would only require an audit of a Utilization Review company every 5 years, rather than every 3 years. Commenter states that even at every three years, the UR company will be handling thousands of requests during that timeframe. Until the utilization review problems are resolved, commenter recommends that the utilization review companies be audited more often than every 3 years, not less often. Commenter opines that a change to every 5 years, will make the UR problems even worse as the companies do not have to fear a DWC audit and oversight of their operations as often.	Diane Przepiorski Executive Director California Orthopaedic Association December 23, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period.	No action necessary.
9792.12	Commenter is questioning why the Division is recommending that many audit penalties regarding the Utilization Review and Independent	Diane Przepiorski Executive Director California Orthopaedic	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day	No action necessary.

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	Medical Review violations be eliminated. Commenter opines that at a time when inappropriate utilization review decisions are resulting in countless delays to treatment for injured workers, delays to providers, and increased costs to payors, that the penalties should be increased, not decreased and/or eliminated. Commenter fails to understand how the utilization review industry will be incentivized to improve their systems without administrative oversight and penalties. Commenter recommends that the penalties in (18) - (25) be retained.	Association December 23, 2013 Written Comment	comment period. That said, the penalties deleted in subdivision (a) have been moved to subdivision (c).	
9792.12	Commenter opines that the proposed penalty structure creates such an extensive list of penalties that the cumulative penalty for technical violations could easily exceed intentional behavior such as completely ignoring a properly executed medical treatment request. Commenter recommends that the DWC instead create a maximum penalty for technical violations instead of allowing the cumulative effect of those violations to eclipse the punishment for disregarding a request.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 26, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period. That said, 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 forth in proposed section 9792.12 is reasonable given	No action necessary.

			the nature and scope of the specific violations and the fact that IMR is a new dispute resolution procedure in workers' compensation.	
9792.10.1	Commenter notes that several rules have been added that address the issue of informal internal UR appeals that run concurrently with formal IMR appeals. Commenter opines that allowing both of these processes to run concurrently has created a number of issues that will only be exacerbated by the expedited timelines contained in Subsection (d)(1). Commenter states that under the current rules (and timeframes), it is completely possible that a claimant may receive an internal appeal decision *and* an IMR decision, potentially with differing results, at the exact same time. This would be confusing for the claimant, and would result in an inefficient use of resources on the part of both the claims administrator/URO as well as the DIR. Commenter recommends that the rules be modified to add a ***mandator***y internal appeals process prior to obtaining jurisdiction to file for IMR. Commenter opines that this would afford the parties a reasonable	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services December 26, 2013 Written Comment	The procedure suggested in the comment, while reasonable, is not authorized by Labor Code section 4610.5. The Division notes that under proposed section 9792.10.1(d)(2), an IMR determination would preclude the issuance of an internal appeal decision.	No action necessary.

	timeframe to resolve their disputes informally without intervention of the DIR, would serve to reduce IMR applications arriving at the DIR, and would make most efficient use of resources for all parties concerned. Commenter states that under the mandatory internal appeals process, the claimant would have 15 days from receipt of an adverse determination to file an internal appeal. The URO would then have 15 days from receipt of the internal appeal to send a formal decision on the appeal. If the original decision is upheld (*i.e.*, the treatment is still denied by the claims administrator), then jurisdiction for the current IMR process would proceed (using the current the 30-day timeframes). Using this process the claimant would not be faced with confusing, and potentially conflicting UR internal appeals and IMR decisions, and would not lose his/her right to avail themselves of the traditional IMR process in the event that the UR internal appeal is not successful.			
9792.10.2 DWC Form IMR	Commenter recommends the following revised language:	Steven Suchil Assistant Vice President/Counsel	The language is consistent with that of Labor Code section 4610.5(f). While the	No action necessary.

	IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, ~~DELAY~~, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW. Commenter states that deleting the delay decision will make the instructions consistent with the rest of the regulations and will help to prevent precipitous requests for IMR as most delays are due to a lack of records.	American Insurance Association December 26, 2013 Written Comment	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.	
9792.10.2 DWC Form IMR	Commenter recommends the following revised language: ~~**IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL**~~	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute December 26, 2013 Written Comment	See response to comment by American Insurance Association regarding this form. The Division finds that bold, uppercase text is reasonable to insure that injured workers understand the consequence of a failure to apply for IMR.	No action necessary.

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	~~**REVIEW.**~~ If you decide not to participate in the IMR process you may lose your right to challenge the denial~~, delay~~ or modification of medical treatment referred to on page one of the application for independent medical review. Commenter recommends deleting the reference to "delay" to remain consistent with rest of the regulations. Commenter opines that it is easier to read and comprehend text that is in upper and lower case than text that is all in caps. It is not necessary for the text to be capitalized.			
9792.10.4(b)	Commenter notes that this section states that the Independent Medical Review Organization (IMRO) shall notify the employee, applicant attorney, and requesting physician within one business day following receipt of the Administrative Director's finding that the disputed medical treatment is eligible for IMR. Commenter recommends that the language be modified to also require the IMRO to provide that same notice to the claims administrator. Commenter notes that the previous version of the regulations required that notice be given to all of the parties,	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation December 26, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period.	No action necessary.

	but the revisions excludes claims administrators.			
9792.10.4(b)	Commenter requests that in order to ensure that a URO/claims administrator is prepared to respond to an IMR request in a timely fashion, this section be modified to add claims administrator as a "party" for notification purposes upon assignment of an IMRO.	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services December 26, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 3rd 15-day comment period.	No action necessary.
9792.10.6	Commenter points out that Labor Code 4610.5 states "the employer SHALL provide to the independent medical review organization" within 10 days a copy of ALL medical records that are relevant to the employee's current medical condition, the medical treatment being provided and the disputed medical treatment. Commenter states that otherwise claims adjusters and the IMR doctor would make decisions without the necessary information for an appropriate decision. Commenter recommends that if the insurance company provides insufficient records the care should be authorized. The IMR process should mirror the UR process such that if there is no decision or the decision cannot happen due to a lack of records, then the	Eric Mumbauer, D.C. Chief Financial Officer Industrial Relations Chair California Chiropractic Association December 26, 2013 Written Comment	See above response to comment by AdvoCal regarding this subdivision.	No action necessary.

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	care would be authorized so as not to penalize the injured worker. Commenter states that in the time frame between the end of UR and the beginning of IMR the injured worker may have a previously scheduled appointment with a specialist or for a diagnostic test. Further, during this time frame the injured worker's condition may have deteriorated due to lack of appropriate treatment to cure or relieve the effects of the industrial injury. Additionally in some post surgical cases the UR process can last for at least 120 days at which point it can take another 30-60 days before the IMR process begins. Commenter opines that these changes to the current utilization review process only serve to delay care and extend the recovery time of injured workers. This is especially true for the unrepresented workers and puts them at a disadvantage and even workers who have hired an attorney might not have access to medical reports and records in time to submit them to Maximus. Commenter opines that since due process for medical treatment has been			

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	removed, the standard for dispute resolution in a medical dispute should not be lowered. Doing so would place the injured worker at a severe disadvantage and could be considered anti-injured worker, which is not the legislative intent of SB 863. All provider stakeholders in prior comment periods have warned that these changes would only serve to delay care. Commenter questions why the QME process is being taken out of the equation in favor of IMR. Commenter opines that the proposed IMR process flies in the face of the intent of the QME process in place to resolve disputes for injured workers. Commenter notes that the Division already has QUALIFIED QMEs who are required to treat patients at least 25% of their practice. Commenter opines that the proposed changes bring in NON treating physicians to make determinations on treatment based on an inadequate history with only a summary of knowledge which can hardly be based on the concept of substantial evidence. Commenter states that the QME still has the most			

	complete picture of the patient/claimant in that he /she is actually performing a physical exam and able to ask pertinent questions rather than simply reviewing records that may not be complete.			
9792.10.6(i)	Commenter states that this section states that administrative penalties may be assessed against claims administrators who do not comply with their IMR obligations, and such penalties can be "concurrent or subsequent to the issuance of the final determination issued by the independent medical review organization". But in such an instance, commenter opines that this section would appear to allow an IMR determination based on limited information to remain in place.	Julius Young December 26, 2013 Written Comment	As indicated above, an IMR determination will issue if there is sufficient evidence in the record to reach a reasoned decision regarding medical necessity.	No action necessary.