INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
139.5	Commenter states that under the current system of utilization review, one of the greatest areas of concern is that reviewers often do not have the same or similar qualifications as the physician who is requesting the treatment or procedure. Commenter opines that this has had the effect of creating unnecessary delays in treatment for the injured worker; oftentimes leading to the AME /QME process Commenter states that under the current system, the most complex medical treatment decisions and disputes are decided by Agreed Medical Examiners or Qualified Medical Examiners. Commenter opines that it was the not the legislative intent to have the IMR process under SB 863 cause the injured worker to have any lesser benefit from the system of medical care offered to them through the workers' compensation arena; rather it envisioned that the IMR process would substantially benefit the injured worker by allowing disputed treatment decisions to be decided both expeditiously and sagaciously. Commenter opines that the IMR	Timothy Hunt, M.D. President Allied Medical Group April 2, 2013 Written Comment	Reviewing physicians utilized by the Independent Medical Review Organization (IMRO) are required to be entirely competent and capable of determining medical necessity, as defined by Labor Code section 4610.5(c)(2), in the independent medical review (IMR) . Labor Code section 139.5(d)(4)(A) provides that medical reviewers conducting independent medical review (IMR) shall "be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review." Under section 139.5(d)(4)(B), the physician "must hold a nonrestricted license in any state of the United States, and for physicians and surgeons holding an M.D. or D.O. degree, a current certification by a recognized American medical specialty board in the area or areas appropriate to the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	process must assure that physician reviewers have the same or similar credentials, experience and licensure as current Agreed Medical Examiners and Qualified Medical Examiners, including licensure in the State of California, and subspecialty distinction. Commenter opines that disallowing current Qualified Medical Examiners from performing IMR reviews will substantially limit the pool of well - qualified physicians for both IMR reviews. Thus, a system designed to expedite medical treatment decisions could indeed become overburdened and fail to meet this core goal. Commenter opines that if a Qualified Medical Examiner is willing to perform IMR reviews, then they should be all owed to do so. These physicians are experienced in making complex treatment decisions; the very types of decisions that will be central to the IMR process. The product of the IMR process is the final treatment decision; which again should be based on medical review of the pertinent medical information by a similarly qualified physician. Commenter		condition or treatment under review." Further, IMRO "shall give preference to the use of a physician licensed in California as the reviewer." The qualifications of the reviewer are not hidden; they must be provided to the parties in the IMR determination. Labor Code section 4610.6(f). The requirement that an IMR reviewer not be a QME is statutory. Labor Code section 139.5(d)(4)(D) provides that "[c]ommencing January 1, 2014, the physician shall not hold an appointment as a qualified medical evaluator pursuant to Section 139.32.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	opines that there is nothing to be gained by disallowing Qualified Medical Examiners to make IMR decisions, and certainly much to be lost.			
9785	Commenter opines that the definition of "adequate med records" for UR and IMR needs to be consistent. If 6 months of medical history is adequate to make the original UR decision why should IMR require 12 months? Commenter recommends a maximum of the immediately prior 6 months of medical history be required for both and that the IMR may ask for more if required.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	Agreed. There is no time limited regarding the submission of past medical records in the utilization review setting. However, regarding IMR, 12 months of past medical records may prove too burdensome for the provider and allow for the submission of irrelevant documents.	No action necessary. The initial version of proposed section 9792.10.5(a)(1)(A) reduced the period for past relevant medical records from one year to six months.
9785 9785.5	Commenter notes that a study recently published in the *Journal of Health Affairs* by Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison and Wendy Levinson of the Division of Outcomes and Effectiveness Research, Weill Cornell Medical College, in New York City, (http://content.healthaffairs.org/ content/28/ 4/w5 3 3 .full) found that: "When time is converted to dollars, practices spent an average of $68,274	Stephen J. Cattolica Director of Government Relations AdvoCal April 4, 2013 Written Comment	The Division finds that for the purpose of utilization review, communication between the employer's treating physician and the claims administrator is crucial. The request for authorization form, DWC Form RFA set forth at section 9785.5, will remove many ambiguities regarding the scope of recommended medical treatments. Clarity in treatment recommendations at the beginning of the UR	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	per physician per year interacting with health plans." Commenter opines that the completion of the RF A represents a new and additional cost within the studied realm that will add to that overhead. Commenter urges the Division to include reimbursement for this work so critical to the welfare of California's injured workers. Commenter understands that the Division received comments to the contrary from the employer community saying in effect, that this activity is a "cost of doing business." Their written testimony was corroborated in verbal testimony by their representative who stated that like other businesses, these costs must simply be absorbed. Commenter states that no business owner, including those advocating for no reimbursement, can absorb increasing costs indefinitely without raising prices. However, physicians in work comp have a fee schedule that effectively caps reimbursement for their services at the lowest rate in the nation (WCRI Study, 2012).		process will reduce disputes and may preclude the need for IMR later on. Further, since UR and IMR obligations carry extensive administrative penalties for non-compliance, it is important for the Division to create a clear guideline – in this case a mandatory form - as to what is or is not a valid treatment request. Only necessary information is requested in the RFA form; the use of a fillable form will reduce administrative burdens placed on the physician completing the form.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that there is little, if any room to absorb more costs without having a detrimental effect on access to care. This represents a result that is the exact opposite of the goal stated earlier. Commenter notes that the California Workers' Compensation Institute (CWCI) recently published a study of MPN coverage reporting that more than 80% of the treatment provided in the California comp system is provided by MPN member physicians. Commenter opines that employers have very little respect for these "best of the best" physicians because they want to withhold reimbursement from the very physicians they have designated within their MPN s as those who provide the best care. Commenter notes that at the public hearing, the Division heard the employer representative testify on this subject by saying, in part, that it doesn't make any sense to reimburse physicians for "pursuing their own enrichment" and that this remark further demonstrates the complete lack of understanding behind the request for no reimbursement.			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9785(b)(3)	Commenter states that this section begins by stating that if the employee disputes a **medical determination** this dispute must be resolved pursuant to 4061, 4062 and 4610.5. However, this section ends by stating that "No other primary treating physician shall be designated by the employee unless and until the dispute is resolved." Commenter opines that this appears to be in conflict with the second opinion process within the MPN as described in 4616 et al. Under 4616 if the employee disputes a **diagnosis or treatment** issue, the employee can get a 2nd opinion within the MPN and if that doctor supports the employee's position, this new doctor can serve as the new primary treating physician. Commenter states that 4616 should be included in this subsection as a vehicle for disputing treatment issues, otherwise commenter opines that the employee could successfully challenge the MPN diagnosis or treatment under 4616 and still be forced to litigate the same issue under 4061 – 4062 or 4610 prior to changing primary treatment physicians.	John Don February 20, 2013 Written Comment	Agreed. Given the MPN dispute resolution procedures mandated by Labor Code sections 4616.3 and 4616.4, and the expedient process of resolving medical necessity disputes through IMR, the restriction regarding the designation of a new primary treating physician is not necessary.	Delete the last sentence from section 9785(b)(3): "No other primary treating physician shall be designated by the employee unless and until the dispute is resolved."

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9785(b)(4)	Commenter states that this paragraph defines how a dispute may be resolved when a claims administrator disputes a medical determination, and references Labor Code section 4062. However, only subdivision (a) of Labor Code section 4062 is applicable where the claims administrator disputes a medical determination. Subdivisions (b) and (c) apply only where the employee objects. Commenter recommends that the reference to section 4062 be amended to include only section 4062(a).	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	The statutory reference in the subdivision is sufficient to understand which procedures may or may not be applicable.	No action necessary.
9785(g)	Commenter notes that this subdivision requires all RFAs to include "as an attachment documentation substantiating the need for the requested treatment." Commenter opines that while everyone involved understands the importance of well substantiated requests for authorization, to require a separate attachment is unnecessary if the requested treatment is found within the MTUS. Instead, commenter suggests that the requesting physician place a simple reference within the RFA chart found in its "Requested Treatment" section referring to the appropriate MTUS guideline.	Stephen J. Cattolica Director of Government Relations AdvoCal April 4, 2013 Written Comment and Oral Comment	A request for authorization should include all facts and substantial medical evidence substantiating the need for the recommended medical treatment. A simple reference to the MTUS guidelines may be insufficient; there is no assurance that the UR physician reviewer is in possession of the employee's relevant medical records to make a sound decision regarding medical necessity.	No action necessary.

	Commenter opines that this should be sufficient when the request is within those guidelines.			
9785(g)	Commenter recommends the following revised language: (g) ~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations), a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the "Request for Authorization of Medical Treatment," DWC Form RFA, contained in section 9785.5. A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment. Commenter suggests that the Administrative Director may make the request for authorization form effective on a going-forward basis.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The subdivision provides that the DWC From RFA should be used "[a]s applicable in section 9792.9.1…." That section expressly provides that the Form RFA is required on January 1, 2013, for all injuries occurring on and after that date, and on July 1, 2013, for all injuries, regardless of the date of injury. These effective dates correspond to the effective dates of the IMR process; the RFA Form is meant to assist employees and claims administrator in transitioning to the new dispute resolution procedure.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Having a bright-line effective date that applies to all requests for authorization on a going-forward basis will simplify the process by having a single standard in place, instead of two that depend on dates of injury and submission. Commenter opines that if this recommendation is accepted, the standards that apply to requests will be clear to requesting physicians and claims administrators alike, averting the confusion and disputes that will otherwise arise regarding which form is a request for authorization.			
9785(g)	Commenter states that the proposed regulation adds a new subsection (g) to the existing code requiring that a request for medical treatment must be submitted on the "Request for Authorization of Medical Treatment," DWC form RF A. Commenter opines that the implementation of this form could benefit physicians by standardizing the prior authorization process across multiple payers. However, the proposed new subsection requires that physicians must attach *"documentation substantiating the need for the requested treatment"* (emphasis added). Commenter states that neither	Lisa Folberg Vice President Medical & Regulatory Policy California Medical Association March 13, 2013 Written Comment David Ford California Medical Association April 4, 2013 Written Comment	The proposed DWC Form RFA, found at section 9785.5 expressly provides at the top that the form "must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment."	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the regulation nor the form includes any guidance on what the DWC would consider appropriate documentation to be included with the RFA. Commenter's organization has assisted member physicians with dozens of cases through the years where payors used continual requests for additional documentation as a means of delaying needed care. Commenter opines that the DWC has an opportunity through this new proposed form to eliminate these wasteful administrative barriers by stipulating, in the regulation, what information would constitute the required documentation. Commenter notes that later in the proposed regulation, in the new §9792.10.5, DWC does list what documentation is needed for the IMR process. In order to provide consistency throughout the treatment, commenter recommends that the documentation needed for the RF A should closely mirror that which will possibly be needed later for IMR.			
9785(i)	Commenter notes that this subdivision stipulates that the evaluator must	Stephen J. Cattolica Director of	The requirement is statutory. Labor Code section 4658.7	No action necessary.

	"declare the injured worker permanent and stationary for **all** conditions .... " (emphasis added). Commenter opines that there will be a number of situations when an injured worker is P & S for an orthopedic injury (sprained ankle for instance) but not for another, compensable consequence (i.e. a gait derangement). Isn't the injured worker eligible for the voucher based on any injury that causes permanent partial disability? Commenter suggests that "all" should be replaced with "any accepted ...."	Government Relations AdvoCal April 4, 2013 Written Comment	(a)(1) provides that a job offer must be made "no later than later than 60 days after receipt by the claims administrator of the first report received from either the primary treating physician, an agreed medical evaluator, or a qualified medical evaluator … finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability.	
9792.9.1(e)(5)(G)	Commenter would like to point out a typo – that there are two periods at the end of the first sentence in this subsection.	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	Agreed.	Remove duplicate period at end of first sentence in section 9792.9.1(e)(5)(G).
9792.10	Commenter recommends the following revised language: **§9792.10. Utilization Review Standards--Dispute Resolution– For Utilization Review Decisions ~~Issued~~ Communicated Prior to July 1, 2013**	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013	Agreed in part. The heading of the section should be consistent with the new IMR timelines set forth in Labor Code section 4610.5(a). "Communicated" should be used instead of "Issued." The	Substitute "communicated" for "issued" in heading of section 9792.10.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	for Injuries Occurring Prior to January 1, 2013. This section applies ~~to~~ if the decision on any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013, ~~if the decision on the request~~ is communicated to the requesting physician prior to July 1, 2013. Commenter opines that the proposed language suggests that the section applies to certain requests for authorization. According to Labor Code section 4610.5(a), however, IMR applies to injuries occurring on or after January 1, 2013, and to any injury where the decision on requests for authorization is "communicated to the requesting physician on or after July 1, 2013." The changes that the commenter recommends clarify that the section applies where those IMR conditions do not apply.	Written Comment	introductory paragraph is consistent.	
9792.10	Commenter states that as written the decision handed down as the product of the IMR process is subject to rebuttal or appeal only under very	Timothy Hunt, M.D. President Allied Medical Group April 2, 2013	The limited grounds upon which an IMR determination may be appealed is mandated by statute. See Labor Code	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	limited circumstances such as cases of obvious factual error. Commenter opines that while he understands that carriers should not be burdened with the cost of many rounds of back and forth between a requesting physician and the IMR reviewer as has been seen in the past with the UR process; the outright disallowance of any rebuttal or appeal has the effect of being castigatory. Commenter states that it is important to note that the injured worker will bear all of the consequences of this proposal while having little real understanding of or control over the process. Commenter opines that if the requesting physician is given the burden of assuring adequate documentation is submitted to the IMR reviewer, and the review process is protected from the influence of bias, then there should be no fear of or need to protect from, rebuttal or appeal of the decision that is the product of the process.	Written Comment	section 4610.6(h).	
9792.10	Commenter opines that the regulations should clearly state that if the carrier misses the 5 working day window to Modify, Delay, or Deny a treatment, it	William J. Heaney III April 4, 2013 Written Comment	The consequences of an untimely UR decision by a claims administrator has been addressed by the California	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	should be stated that that request will not be subject to IMR. Commenter can envision that carriers will fail to get UR in a timely fashion or at all, then six months later have a UR produced and state that the patient never took it to IMR. Commenter strongly suggests including language in the regulations that actually enforces the timeframes that have been in effect since 2004.		Supreme Court in State Compensation Insurance Fund v. WCAB (Sandhagen) (2008) 44 Cal.4th 230. Since Labor Code section 4610 is silent as to the effect of an untimely decision, the Division believes that determinations regarding this issue are best left to the Legislature or the judicial process.	
9792.10.1	Commenter states that this section includes a rule, subdivision (b)(2), that defines the parties who are eligible to file a request for independent medical review, including the employee, and if the employee is represented, the employee's attorney. Section 9792.10.5 then requires that any party identified in section 9792.10.1(b)(2) may provide additional documents to the IMRO [subdivision (b)(1)]; requires those same parties to serve any such documents on the claims administrator [subdivision (b)(2)]; and requires those parties to also provide any newly discovered documents to the IMRO and the claims adjuster [subdivision (b)(3)]. These proposed provisions will help assure that IMR	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Agreed. The Division recognizes that effective communication with an employee's counsel will assist in the expeditious resolution of disputes through the IMR process.	Amend sections 9792.10.1 through 9792.10.6 to provide that all notifications and determinations be sent to the injured worker's counsel, if represented.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	works expeditiously and efficiently by assuring that the represented worker's attorney is fully involved in delivering appropriate documentation to the IMRO. Commenter opines that other references in these proposed regulations are less clear regarding the responsibility of the claims adjuster and the IMRO with regard to providing notification and documents to a represented worker's attorney. Commenter recommends that the IMR regulations be amended to be consistent with the attorney notice requirements in the regulations applicable to UR. For example, section 9792.9, subdivisions (c) and (k), and section 9792.9.1, subdivision (e), paragraphs (4) and (5), require that notice of a decision to modify, delay, or deny a treatment request must be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Commenter opines that, as permitted by these regulations, in virtually every case in which an employee is			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	represented the IMR application will be submitted by the attorney and that the failure to provide the attorney with subsequent notices and documents can only result in confusion, delay, and added costs. Commenter strongly advises that the proposed regulations be clarified to specifically state that all required IMR notices and documents must be provided to the employee and, if represented by counsel, to the employee's attorney. Commenter opines that it is critically important to amend section 9792.10.6(e) to mandate that the IMRO shall provide notice of its decision to the employee's attorney, if the employee is represented by counsel, just as the UR notice of delay or denial must be provided to the attorney under the previously cited sections.			
9792.10.1	Commenter recommends the following revised language: This section applies ~~to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for~~ either: (1) regardless of the date any request for authorization of medical treatment, made under Article 5.5.1 of this	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Agreed in part. IMR does apply to any request for medical treatment where the date of injury is on or after January 1, 2013. For dates of injury prior to that date, the trigger point for IMR is the date the utilization review decision is communicated to the requesting physician.	Amend the introductory paragraph to section 9792.10.1 to revert back to the language of the

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Subchapter, is communicated to the requesting physician in regard to an occupational injury or illness occurring on or after January 1, 2013; or (2) if the ~~request~~ decision on any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, is ~~made~~ communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury. Commenter opines that the proposed language suggests that the section applies to requests for authorization. Commenter states that her recommended changes clarify that the section applies in either of the two circumstances specified in Labor Code section 4610.5(a).			
9792.10.1	Commenter suggests a 60 day period to appeal a denial.	Jeffrey Stevenson, M.D. April 4, 2013 Written Comment Irv Hirsch April 4, 2013 Written Comment	The 30-day requirement is statutory. See Labor Code section 4610.5(h)(1).	No action necessary.
9792.10.1(a)	For consistency, commenter recommends the follow revised language:	Bennett L. Katz Assistant General Counsel and Vice	The language used by the Division in subdivision (a) more accurately characterizes	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(a) If the request for authorization for medical treatment is delayed, denied or modified . . .	President Regulatory Affairs The Zenith April 4, 2013 Written Comments	utilization review decisions issued under Labor Code section 4610.5. Currently, the regulations have no provision for a delay decision.	
9792.10.1(a)	Commenter suggests the following revised language: (a) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6, except if the delay or denial was based on the lack of information reasonably requested from the pursuant to section 9792.9.1 (f)(1)(A) and (f)(2}, or (g). Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a UR decision unless the UR decision is overturned by IMR or the Workers' Compensation Appeals Board under this Article. Commenter opines that the proposed	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The Division agrees that IMR is inappropriate for utilization review denials that are based on the failure of the requesting physician to respond to a reasonable request for information. See proposed section 9792.10.3(a)(6), which finds such decisions ineligible for IMR. However, it is necessary for DWC to review such decisions at the initial IMR review stage to determine if, in fact, the decision was legitimately made on the basis that the requesting physician failed to provide information.	No action necessary.

	change is necessary in order to prevent unwarranted Applications for IMR.			
9792.10.1(a)	Commenter recommends the following revised language: If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6, except if the delay or denial was based on the lack of information reasonably requested from the physician that is necessary to make a determination pursuant to section 9792.9.1(f)(1)(A) and (f)(2), or (g). Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board only pursuant to Labor Code section 4610.6(h) ~~under this Article~~.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	See the above response regarding denials based on the failure to produce information. The Division notes that it does not have authority to determine or otherwise limit the jurisdiction of the Workers' Compensation Appeals Board.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that resources must not be wasted on IMR if the physician failed, when requested pursuant to section 9792.9.1(f) or (g), to supply medical information necessary to make a determination. Commenter states that the Workers' Compensation Appeals Board may only overturn the decision pursuant to Labor Code section 4610.6(h).			
9792.10.1(a)	Commenter requests that the phrase "under the article" be removed and replaced by "pursuant to Labor Code section 4610.6(h)." Commenter opines that this would be more clear and consistent with the statute.	Debra Russell Schools Insurance Authority April 4, 2013 Oral Comment	See the above response. The Division notes that it does not have authority to determine or otherwise limit the jurisdiction of the Workers' Compensation Appeals Board	No action is necessary.
9792.10.1(b)(1) And DWC Form IMR	Commenter supports the current proposed language on the "Application For Independent Medical Review" stating: *"A copy of the utilization review (UR) decision that either denies, delays, or modifies a treating physician's request for authorization of medical treatment must be attached."* Commenter opines that similar language needs to be inserted into the "Instructions for the Employee",	Dale Clough Sr. Compliance Consultant Travelers Insurance April 4, 2013 Written Comment	Agreed. The IMR application should expressly state that a copy of the UR decision must be attached.	Amend the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, to expressly require a copy of the UR determination.

	warning them that failure to include it could result in the application be rejected or delayed. Commenter strongly recommend that the DWC revise Rule 9792.10.1(b)(1), stating that submission of an IMR application without the UR decision is considered invalid or incomplete. Commenter opines that it is imperative that the IMRO receive the UR decision with the application in order to properly assess it.			
9792.10.1(b)(1)	Commenter recommends the following revised language: b)(1) A request for independent medical review must be communicated by an eligible party by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director's designee, within 30 days of service of the utilization review decision and concurrently copied to the claims administrator. The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Agreed. Early notification to the claims administrator of the initiation of the IMR process by the employee may expedite the resolution of the medical treatment dispute.	Amend section 9792.10.1(b)(1) to provide that at the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment, to the claims administrator.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that it is important that the claims administrator know as soon as a request is filed for the following reasons: The claims administrator can notify the Administrative Director of any circumstances that have changed and that may affect IMR eligibility. This will avoid some unnecessary independent reviews and the associated administrative burdens and costs Because the timeframes for submitting documents for independent medical review are so short, the early notice is necessary to will allow additional time for the claims administrator to prepare documents for timely submission The claims administrator can verify that the form has not been changed The requirement will deter alterations to the completed form and submission of inaccurate information Commenter requests that if this recommendation is not accepted, that			

	the Administrative Director could instead notify the claims administrator of the IMR request on the same day the form is received.			
9792.10.1(b)(1)	Commenter states that in his experience of the appeal/denial process for medical treatment through WC a 30 day window from the time the form is mailed is to short. Commenter opines that 45 days is more realistic time-frame. In his case, he had to move in with relatives because he couldn't afford his own residence anymore. First, he forwarded mail to his new address which then took an additional 5 days for him to receive his mail. Commenter suggest that time should be calculated from the time it is received. His case became complicated due to a surgeon accidently cutting the artery to his left leg causing permanent damage, therefore it required more time for the person looking at the request to understand the situation completely and accurately. Third, if an attorney is involved commenter opines that adds a week. Commenter notes that the postal service is considering cutting back mail delivery from 6 days a week	Samuel Jackson April 4, 2013 Written Comment	The thirty day time period in which to file a request for IMR is statutory. See Labor Code section 4610.5(h)(1).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to 5 days (that's 4 days in a 30 day window there). Commenter opines that 30 days is simply not a realistic time for a form to pass through all of the steps involved.			
9792.10.1(b)(1) and (b)(2)(B)	Commenter recommends that the following sentence be added to subsection 9792.10.1(b)(1): A copy of the Application for IMR along with any attachments must be sent simultaneously to the Claims Administrator. Commenter recommends that the following sentence be added to subsection 9792.10.1(b)(2)(B): A copy of the Application for IMR along with any attachments must be sent concurrently to the Claims Administrator. Commenter states that he proposed language changes are intended to ensure that the Claims Administrator is advised that an Application is being filed so that there is time to consider approving the treatment before the referral to the IMR is made. These decisions are very likely in that the	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Agreed in part. See response to above comment regarding the provision of a copy of the IMR application to the claims administrator. An amendment to section 9792.10.1(b)(2)(B) is not necessary since the requirement of sending a copy is included in the broader subdivision (b)(1)(B) of that section.	Amend section 9792.10.1(b)(1) to provide that at the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment, to the claims administrator

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reviews will be more costly than most of the treatment requests. Commenter has concerns about a lessening in medically evidenced medicine being provided to California's Workers' Compensation population. Commenter opines that without the proposed addition, the Claims Administrator's first notice would be the assignment notification and then the $215 fee for a termination prior to the receipt of records that would be incurred.			
9792.10.1(b)(1) and DWC Form IMR	Commenter notes that the request for IMR must be communicated by the injured worker within 30 days of the service of the utilization decision. Commenter notes that the form that is sent to the injured worker states that an application for IMR must be filed within 30 days from the mailing of the utilization review letter. Commenter states that there is an inconsistency here where the regulations appears to give a maximum of 35 days (30 days plus the 5 for normal mail service) but the instruction to the injured worker states that it's 30 days from the postmark. Commenter opines that this discrepancy could cause an injured worker to blow the deadline.	Carlyle Brakensiek CSIMS and CSPMR April 4, 2013 Oral Comment	Agreed. The provisions of Code of Civil Procedure section 1013 apply the IMR process and all timelines and deadlines created therein. The instructions to the IMR application will advise the employee that they have 35 days to file their application if the UR determination is sent by mail.	Amend the instructions to the DWC Form RFA, section 9792.10.2, to advise the employee that they have 35 days to file their application if the UR determination is sent by mail.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that in crafting SB 863, the legislature was clear that the treating physician is encouraged to be an advocate in assisting the injured worker resolve treatment issues. Commenter opines that it could be that once and injured worker received a denial or modification of treatment he would speak with his/her physician; however, commenter extrapolates that if the injured worker feel that they have less time to reply they may just request an IMR because they don't have the opportunity to discuss the issue with their physician, costing the employer even more money.			
9792.10.1(b)(2)(A)	The commenter objects to this subsection. Commenter opines that the Administrative Director does not have the authority to issue this specific regulation. In reading SB 863, the section dealing with the employee's right to designate another party to appeal the Utilization Review decision notes that the designation can only be given after the Utilization Review decision is handed down. This regulation suggests that the obtaining an attorney can get around the time	Dennis Knotts April 1, 2013 Written Comment	Disagree. An injured worker has the right to be represented by an attorney in the workers' compensation claim and appeal process. See, for example, Labor Code section 5700. Many injured workers have legal representation while they are receiving medical treatment for their occupational injuries; to require an additional designation by the employee for their attorney after a utilization review decision	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	frame for the employee to designate another party to appeal on his/her behalf and that somehow the applicant attorney is entitled to pre-decision designation status. This is not even implied under SB 863. Commenter opines that the Legislative Intent was to block anyone from appealing on behalf of the employee without the employee's knowledge and permission. This would avoid tying up the system with automatic appeals made by physicians and attorneys where the employee does not want the recommended treatment. Commenter opines that by adding the applicant attorney to the list of parties who can appeal without this designation violates the intent; and is not authorized by SB 863. Therefore, commenter opine that this section of the regulations needs to be amended to remove the attorney from the list of parties who can appeal and transfer the attorney to the list of those who can appeal once they have been designated to do so by the employee after the decision has been handed down by Utilization Review.		issued would be superfluous. It is telling that the statutory provision requiring the designation, Labor Code section 4610.5(j), does not mention attorneys as a party that an employee would designate to act on their behalf during the IMR process. This striking absence may reflect a Legislative intent that represented employees and their attorneys are subject to the subdivision's mandate. That said, proposed section 9792.10.1(b)(2)(A) does require that a notice of representation or other written designation confirmation representation accompany the IMR application.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.10.1(b)(2)(B)	Commenter recommends that for consistency within the regulations (such as 9792.10.5 which uses mailing) that the phrase **"after the service"** be replaced with **"of mailing."**	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	"Service" can be considered as the delivery of a document to a person who is notified of an action in which they are concerned and additional actions or steps to take. See http://thelawdictionary.org/service/. The term is acceptable here.	No action necessary.
9792.10.1(b)(3)	Commenter states that this paragraph requires that a request for an expedited IMR include a "certification" that the employee faces an imminent and serious threat to his or her health. Commenter opines that it is unclear what "certification" means in this instance. Is it a declaration under penalty of perjury? Commenter recommends that this term be defined or clarified.	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	To "certify" is to say officially that something is true, correct, or genuine. See http://www.merriam-webster.com/dictionary/certifying?show=0&t=1386962565. A physician should understand this word with sufficient clarity to comply. That said, documentation confirming the employee's serious condition should be provided to corroborate a written statement.	Amend section 9792.10.1(b)(3) to require a written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health.
9792.10.1(b)(3)	Commenter has the same concerns regarding the potential abuse of expedited reviews as discussed under the comment for 9792.6 and 9792.6.1. Commenter proposes that either the state or the IMR reviewer be tasked	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith	Labor Code sections 4610.5 and 4610.6 allow the Independent Medical Review Organization (IMRO) to examine the medical necessity of the disputed medical	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with a preliminary review to make a determination that the review should be processed and charged as an expedited review to better manage resources and costs associated with IMR. Commenter proposes that a paragraph allowing the expedited review to be converted to a standard review be added to mirror the ability of a standard review to be converted to an expedited review as set forth in 9792.10.4(g).	April 4, 2013 Written Comments	treatment. There is no corresponding section allowing the IMRO to question or otherwise reject a certification from a physician that an employee faces an imminent and serious threat to his or her health. That said, the IMRO has the right to reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Section 9792.10.5(c). If a certification is questionable, the IMRO can certainly confirm the matter with the physician.	
9792.10.1(b)(3)	Commenter suggests the following revised language: If expedited review is requested for a decision eligible for IMR, the Application for IMR, DWC Form IMR, shall include, unless the initial UR decision was made on an expedited basis, a certification from the employee's treating physician signed under penalty of perjury indicating that the employee faces an	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	See above response to Mark Gerlack of the California Applicants' Attorneys Association regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	imminent and serious threat to his or her health as described in section 9792.6.1 (j). Commenter understands that many UR RFA's are received stating inaccurately that there is an imminent and serious threat and that a large percentage of IMR requests are stating this, as well. In order to preserve this expedited routing for those who really need it, commenter believes that this addition might be helpful.			
9792.10.1(b)(3)	Commenter recommends the following revised language: (b)(3) If expedited review is requested for a decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, a certification from the employee's treating physician signed under penalty of perjury indicating that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j). Commenter opines that signing under	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	See above response to Mark Gerlack of the California Applicants' Attorneys Association regarding this subdivision.	No action necessary.

	penalty of perjury may discourage unwarranted expedited requests that are already being reported.			
9792.10.1(d)	Commenter is concerned that the internal UR Appeal process may not be used as often as desirable because it reduces the period for sending the Application for IMR to the Administrative Director. There is also a concern that sending the UR modification, delay, or denial document out with an offer for the Internal UR Appeal as well as the Application for IMR may be confusing to the Injured Worker. While it would add 15 days to the overall process, commenter recommends sending the UR decision to the Injured Worker with the offer for the Internal Review explaining that it is voluntary, will not prevent a subsequent request for IMR, and must be completed within 15 days. If the injured employee declines the Internal Review or continues to object to the Appeal decision, the Application would be sent to the employee with a 30 day deadline to apply for IMR.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The Division understands that having the IMR process and the UR internal appeal process run concurrently may result in some measure of confusion. However, Labor Code section 4610.5 does not allow for an extension of the IMR filing deadline so that an internal appeal may be conducted.	No action necessary.
9792.10.1(e)(1)	Commenter recommends the following revised language:	Brenda Ramirez Claims and Medical Director	Subdivision (e) has been deleted from section 9792.10.1 and relocated to section	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is consistent with the Medical Treatment Utilization Schedule and appropriate for the medical needs of the employee. Commenter states that medical care must be reasonably required as defined by Labor Code section 4600(b).	California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	9792.9.1(e)(6). Since medical care that is reasonable required to cure or relieve an injured worker from their occupational injury must be based on the Medical Treatment Utilization Schedule under Labor Code section 4600(b), the addition of the language here would be redundant.	
9792.10.1(e)(1)	Commenter recommends the addition of the following language: "…requesting physician that is consistent with the Medical Treatment Utilization Schedule and appropriate for the medical needs of the employee…" Commenter states that the Claims administrator is liable only for medical care that is reasonably required as defined by Labor Code section 4600(b).	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	See above response regarding the subdivision to Brenda Ramirez of the California Workers' Compensation Institute.	No action necessary.
9792.10.3	Commenter states that the current regulations do not specify the notification method for receipt of an	Lisa Anne Forsythe, Senior Compliance Consultant	Disagree. Section 9792.10.4 requires the IMRO to notify the parties "in writing" of an	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	IMR assignment, nor do the rules indicate if the assigned URA will be added to service list. Commenter suggests that the Division specify the process for notification of the parties of IMR assignment (U.S. mail, e-mail, etc.), and add the URA to the service list once notified of the URA's participation in a case.	Coventry Workers' Compensation Services April 4, 2013 Written and Oral Comment	IMR assignment. To further limit the notification process by setting forth express methods of delivery may hinder their ability to conduct IMR efficiently, especially in the course of an expedited review. Utilization review organizations (UROs) are included within the definition of "claims administrator" under section 9792.6.1(b). Since the URO is acting on behalf the claims administrator, there is no need to expend additional resources and notify both parties separately.	
9792.10.3(a) 9792.10.6(g)	Commenter states that there is not a provision for enforcement of timely review by the claims administrator or independent review organization. To address this, commenter recommends adding the following subsections: ***§****9792.10.3 (a)(6) Failure by the claims administrator to render a decision consistent with the provisions*	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	Disagree. There is no statutory authorization for the Administrative Director to grant a medical treatment request based on a procedural violation by the claims administrator.	No action necessary.

	of title 8, section 9792.9.1(c). ***§****9792.10.6 (g)(4) Should the independent review organization fail to complete its review and make its final determination within the specified timeframe, the Administrative Director may deem the independent medical review approved*.			
9792.10.3(a)	Commenter states that this subdivision requires that the Administrative Director make a determination of eligibility regarding a request for IMR within 15 days. Commenter appreciates that this subdivision has been amended to include this new time limit, however he believes that it is important to point out that in the group health IMR process the equivalent determination of eligibility is required within 7 days [see 28 CCR 1300.74.30(i)]. When SB 863 was introduced, proponents explained that the IMR process would resolve medical disputes in 30 days or less. Unfortunately, while there may be some instances where a 30 day resolution if achieved, the imposition of various time limits in these regulations mean that the usual case will take considerably longer.	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Labor Code section 4610.5(k) tasks the Administrative Director with the responsibility to determine whether a request for IMR is approved, i.e., eligible. Although the review is to be performed "expeditiously," there is no set time frame for conducting the review. (Note: the 30-day time limit runs from the filing of the application and the receipt of documents from the parties. See Labor Code section 4610.6(d). These documents are not requested until after the eligibility review and the assignment of the case. Labor Code section 4610.5(l). Given the anticipate volume of IMR application that will be filed in the contentious workers'	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that if the IMR form has been completely filled out by the claims administrator as required by these rules, and the form is properly signed, the review by your Division should be minimal. In order to meet the Legislative intent that the IMR process be expeditious commenter requests that the time limit in this subdivision be reduced to seven days to conform to the equivalent requirement in group health IMR.		compensation setting, 15 days is reasonable, although it is hoped that the review will be performed faster.	
9792.10.3(a)	Commenter suggests the following revised language: (a) Following receipt of the Application for IMR, DWC Form IMR, pursuant to section 9792.10.1 (b), the Administrative Director shall determine, within 15 days following receipt of the Application and all appropriate information to make a determination, whether the disputed medical treatment identified in the Application is eligible for IMR Any entity designated to initially receive and/or review the Application shall have no financial interest in the IMR. With respect to this subsection, commenter is concerned about being	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The revisions offered by the commenter would only serve to delay the IMR process. First, the task of determining the eligibility of a request for IMR has been solely delegated by statute to the Administrative Director or his or her designee. There is no statutory requirement that any entity delegated to receive a request for IMR have no financial interest in IMR. Regarding notice, see the response to comment by Brenda Ramirez of the California Workers' Compensation Institute regarding section	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	provided notice by the injured employee or their agent when an Application is filed. Commenter would like to see an affirmation on the Application that this occurred and that the affirmation be added to the list of criteria for determining eligibility. Alternatively, the Administrative Director could copy the Claims Administrator with the Application and any attachments and allow a specific number of days for reconsideration before assigning the case for IMR. Commenter is concerned about sending the IMR Application to the injured employee when liability is at issue. Commenter opines that it might set up an unrealistic expectation on the part of the injured employee. Commenter opines that a better alternative in this case might be a notice letter sent with the UR finding of modification, delay or denial.		9792.10.1(b)(1). The failure to provide an affirmation that a copy of the IMR application was sent to the claims administrator should not provide the basis upon with to delay or possibly deny medical treatment to the injured worker. Finally, Labor Code section 4610.5 requires the provision of an IMR application with every adverse UR decision. There is no exemption for cases in which liability is being disputed. It is hoped that in these situations UR is being deferred under section 9792.9.1(b).	
9792.10.3(a)	Commenter recommends the following revised language: Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI)	As to the financial interest of any designated designee, see above response to comment by Steven Suchil of American Insurance Association. To the extent the comment seeks a	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	9792.10.1(b), the Administrative Director shall determine, within 15 days following receipt of the application and all appropriate information to make a determination, whether the disputed medical treatment identified in the application is eligible for independent medical review and whether an expedited review is necessary under the standards in Labor Code sections 4610(g)(2) and 4610.5(n). Any entity designated to initially receive and/or review the application shall have no financial interest in the independent medical review. In making this determination, the Administrative Director shall consider: Commenter states that Labor Code section 4610.5(k) permits the Administrative Director to use a designee to review requests and to notify the employee and employer whether or not the request was approved. Commenter opines that the designee may have no financial interest in the Independent Medical Review. At present, the Independent Medical Review Organization (IMRO) is receiving and initially reviewing the	April 4, 2013 Written Comment	review of whether an expedited review is necessary, see response to comment of Bennett L. Katz of The Zenith regarding section 9792.10.3(b).	

	IMR application. Commenter states that this is clearly a conflict of interest because the IMRO has a direct financial interest in the review.			
9792.10.3(a)	Commenter is concerned that there may be a conflict of interest in determination of eligibility of the IMR application if completed by Maximus who stands to benefit financially from every eligible application. Commenter recommends clarification of how this potential conflict will be managed.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	As to the financial interest of any designated designee, see above response to comment by Steven Suchil of American Insurance Association.	No action necessary.
9792.10.3(a)(1)	Commenter recommends the following revised language: The timeliness, accuracy and completeness of the Application; Commenter opines that the application must be accurate as well as timely and complete.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The information on the IMR application is to be provided by the claims administrator. See section 9792.9.1(e)(5)(G). IMR should not be delayed if the information as provided by the claims administrator is not accurate.	No action necessary.
9792.10.3(a)(3) and (4)	Commenter notes that these subsections state, in relevant part, that the Administrative Director, when determining eligibility for IMR, may consider any assertion by the claims administrator that factual or legal basis exists that precludes liability on the part of the administrator for an	Brittany Rupley Defense Attorney April 4, 2013 Oral Comment	Agreed. The DWC Form IMR as proposed does not contain a field where a claims administrator can indicate that a liability dispute exists. The form should contain this essential information.	Revise the DWC Form IMR, section 9792.10.2, to include a field where a claims administrator can indicate as to whether a liability dispute exists.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	occupational injury or claimed injury to any part or parts of the body. Commenter opines that it is unclear as to how these assertions are to be communicated by the claims administrator.			
9792.10.3(a)(4)	To clarify this paragraph, commenter recommends that it be amended to add the phrase "other than for medical necessity" as follows: "Any assertion by the claims administrator that a factual or legal basis exists that precludes liability on the part of the claims administrator for the requested medical treatment other than for medical necessity."	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Agreed. The suggested phrase is an essential component.	Revise section 9792.10.3(b)(4) to include the phrase "other than medical necessity.
9792.10.3(b)	Commenter states that under this rule the Administrative Director may request additional appropriate information from the parties. Commenter recommends that the rule be amended to require that a copy of any such request by the AD be provided to the opposing party, and that a copy of any information submitted by a party pursuant to this request be provided to the opposing party, unless it has previously been provided.	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Eligibility determinations are based on either the contents of the application (i.e., the lack of a signature or the failure to provide a copy of the UR determination) or documents that in the possession of both parties (i.e., a letter denying the claim.) The intent of the provision is to have the Administrative Director expediently obtain the evidence necessary to determine whether a request of	No action necessary.

			IMR is eligible for review. It would be implicit in any response that copies of an documents not the possession of the other would be provided.	
9792.10.3(c) 9792.10.3(e) and 9792.10.4	Commenter states that this subsection 9792.10.3(e) states that parties may appeal an eligibility determination by the AD that a dispute of medical treatment is not eligible for IMR by filing a petition with the Workers' Compensation Appeals Board. Commenter opines that it would be helpful if the time frame for filing such a petition is stated within that particular subsection, 9792.10.3(c) and 10.4 dealing with when the AD is to make an assignment to the IRO. Commenter notes that subsection 9792.10.3(c) states, in relevant part, following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that the disputed medical treatment is not eligible for IMR or assign the request to the IMR review – an Independent Medical Review.	Brittany Rupley Defense Attorney April 4, 2013 Oral Comment	Disagree. Rules regarding the filing of petitions with the WCAB are within the exclusive jurisdiction of that agency. Regarding timeframes, it is recognized that requiring actions on the part of the Administrative Director to be accomplished within an hourly timeframe may create problems when accounting for weekdays and holidays. The Division finds it beneficial to define "immediately" as being within one business day.	Amend section 9792.6.1(m) to define "immediately" as within one business day.

	Commenter notes that the definition of "immediately" contained in section 9792.6.1(m) means within 24 hours after learning the circumstances that would require an extension of the time frame for decisions. Commenter notes that 9792.10.4 states that within one business day following a finding that the treatment is eligible for IMR, the IRO is to notify the parties in writing that the dispute has been assigned to that organization. Commenter opines that it is unclear whether the time frame for the Administrative Director to make that assignment to the IRO is one business day or 24 hours, regarding of whether the next day is, for example, a holiday.			
9792.10.3(e)	Commenter requests that notice be provided to the applicant of their right to appeal during each step in the process, including the provision of this subsection.	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	The right to appeal an eligibility decision is set forth in the regulation. It must be noted that parties are advised of their appeal rights as a matter of course in every administrative decision issued by the Administrative Director.	No action necessary.
9792.10.3(e)	Commenter recommends the	Brenda Ramirez	Disagree. Under Labor Code	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	following revised language: The parties may appeal an eligibility determination by the Administrative Director ~~that a disputed medical treatment is not eligible for independent medical review~~ by filing a petition with the Workers' Compensation Appeals Board. Commenter opines that the parties should also be permitted to appeal a determination that a dispute is eligible for independent medical review.	Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	section 4610.5(k), if the Administrative Director approves a request for IMR, the request is assigned to resolve the medical treatment dispute. Claims administrators are only allowed to defer IMR if there is a dispute regarding liability for the injury or the treatment (on grounds other than medical necessity). To allow an appeal of an eligibility determination would undermine the Legislature's intent that IMR provide an expedient resolution to medical treatment disputes. If a claims administrator believes that the Administrative Director did not have jurisdiction to proceed with IMR, they can appeal the IMR determination to the WCAB under Labor Code section 4610.6(h)(1).	
9792.10.4	Commenter recommends the following revised language: For expedited review, a statement that within ~~twenty-four (24) hours~~ <u>one business day</u> following receipt of the notification the independent review	Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 4, 2013 Written Comment	Disagree. The 24-hour requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	organization must receive the documents indicated in section 9792.10.5. Commenter opines that the proposed regulations create challenges to comply with the 24 hour time frame to serve records. Commenter states that the regulations should clarify the requirements for providing information on expedited IMR reviews within the specified time periods and address situations when the notification is received on a Friday or before a holiday, without resulting in automatic penalty situations. Commenter recommends that references to "twenty four (24) hours" and 3 "days" should be amended to reflect a timeframe consistent with business days.			
9792.10.4	Commenter appreciates that the intent of this section is to notify all parties to the case that the request for IMR has been referred to an organization. Commenter requests that an additional item be added to the notification. Labor Code § 139.5(c)(l) requires that all IMR organizations employ a Medical Director who must be	Lisa Folberg Vice President Medical & Regulatory Policy California Medical Association March 13, 2013 Written Comment David Ford	Section 9792.10.4(b)(1) provides that the name and the address of the IMRO be provided. That information should be sufficient to contact the organization if information, such as the name of the Medical Director, is needed. Certainly, anyone can also contact the Division for this	No action necessary.

	licensed by either the Medical Board of California or the California Osteopathic Medical Board. Commenter recommends that additional language be added to this regulation requiring that the notice to all parties identify the Medical Director, including a phone number and email address where that person can be reached.	California Medical Association April 4, 2013 Written Comment	information.	
9792.10.4	Commenter requests that the requirement to provide requested medical records to the IMRO within 24 hours for an expedited review be modified to one business day in order to recognize that departments are closed on weekends and holidays.	Ailene Dewar Rehab West, Inc. April 4, 2013 Oral Comment	See above response to comment by Peggy Thill of State Compensation Insurance Fund regarding this subdivision. The requirement is statutory.	No action necessary.
9792.10.4(e) 9792.10.5(a)	Commenter states that these rules allow the claims administrator either 15 or 12 days to submit information to the IMRO. Commenter does not believe the Administrative Director has the authority to establish a different time requirement than the 10 day statutory period specified in Labor Code section 4610.5(l). Commenter opines that there is neither a statutory nor a regulatory requirement that the notice to the claims administrator be served, and consequently the	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment Mark Gearheart California Applicants' Attorneys Association	As noted in the Initial Statement of Reasons, the 15 day deadline for the simultaneous submission of documents (24-hours for expedited review) by the parties is necessary to ensure that IMR is completed in an expeditious manner while affording all parties the right to submit those documents that are relevant to the case. The timeframe takes into	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	additional time periods provided under California Code of Civil Procedure section 1013(a) relating to service of documents are not applicable in this situation. Commenter notes that the regulations promulgated by the Department of Managed Health Care regarding implementation of IMR in group health require plans to submit the same required information to the IMRO within 3 business days for regular review [see 28 CCR 1300.74.30(j)]. Inasmuch as that extremely short time requirement has not caused problems in group health IMR, commenter does not believe that adoption of the statutory 10 day time requirement for workers' compensation IMR will be a problem.	April 4, 2013 Oral Comment	consideration two statutory mandates: The 10-day period of Labor Code section 4610.5 (*l*) and Code of Civil Procedure sections 1010.6 and 1013(a), which extend certain deadlines to act or respond to documents that are served by mail (5 additional days). The Division feels this extension is reasonable and necessary to obviate any prejudice resulting from a delay in the receipt of a request for additional documents.	
9792.10.4(e)	Commenter recommends the following revised language: For regular review, a statement that within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, fax or email ~~or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically~~, the independent review	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The timeframes set forth in Section 10507 applies to proceeding before the WCAB and do not apply in IMR proceedings. The Administrative Director finds the timeframe for filing documents in section 9792.10.5 to be reasonable.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to $5,000.00. Commenter states that five days are allowed for serving within California pursuant to CCR section 10507. Superior court provides for the proposed standard, however CCR 10507 applies to workers' compensation and the superior court standard does not.			
9792.10.4(e) and (f) and 9792.10.5(a)(1)	Commenter notes that in these proposed sections, the regulations set forth a notification to the claims administrator that requires listed documents to be "received" within specified time frames, and heavy fines for failures to comply. Commenter opines that the specific time frames proposed (15 days if the notice was	Peggy Sugarman Director of Workers' Compensation City and County of San Francisco April 4, 2013 Written Comment and Oral Comment	The 15-day deadline for providing the requested documents provides clarity to the parties without the additional responsibility of having to calculate mailing times. Further, it would not penalize claims administrators over any other method of	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	mailed, 12 if electronic) are designed to add in time for mailing based on the statutory language under Labor Code section 4610.5 that requires documents to be sent within 10 days. Commenter states that a claims administrator only has control over when documents are sent, not on when they are received. Commenter proposes that the Division use the statutory requirement and, if need be, include a statement that provides for the proper mailing time to be both consistent with the statute, clear to the parties about the time frames within which they must act, and to ensure that claims administrators are not penalized for things that are beyond their control. Commenter notes that the Division has adjusted the time frames to receive documents in earlier sections depending on how the claims administrator is notified, and provides for 12 days if notified electronically. Commenter states that there is no provision for the submission of documents electronically. Commenter suggests that such a process would greatly enhance and improve her		determining a document submission date. The Division envisions the electronic submission of documents when it can be assured that personal health information can be transmitted in a safe, secure method.	

	ability to deliver documents to the IMR organization in a timely and efficient way. Commenter recommends that these changes also be incorporated with Section 9792.10.5(d).			
9792.10.4(f)	Commenter understands the need for an expeditious response to serious conditions but is concerned that 24 hours is an unreasonable time frame for gathering and transmitting the scope of documents required in CCR section 9792.10.5.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.
9792.10.4(f)	Commenter opines that this is an extremely tight timeframe to prepare paper records for submission via mail. Commenter recommends that expedited notices be faxed or emailed to the claims administrator and provide clarification that the timeframe of 24 hours occurs only during business hours Monday thru Friday and notices received from IMRO on Friday afternoon are considered received the following business day to start the 24 hour clock.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	See above response. As noted, the requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.
9792.10.4(f)	Commenter notes that this section requires that documents be received by the IMR within 24 hours. Commenter opines that this is a very	Linda Slaughter Chief Claims Officer Athens Administrators	See above response. As noted, the requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	tight time frame in which to prepare and submit documents that can very often be voluminous. Depending on how and where the request is received, there may be confusion regarding the exact time of the request. Commenter states that it is also not clear when documents must be delivered when a request is made the day before a weekend or holiday. Commenter requests clarification regarding the delivery of documents in this situation and suggests that consideration be given to changing the language from the due date to the end of the following business day and that there be a cutoff time of 5:30 p.m. to provide a request for documents.	April 4, 2013 Oral Comment		
9792.10.4(g)	Commenter recommends the following revised language: Review conducted on a regular basis shall be converted into an expedited review if, subsequent to the receipt of the Application for Independent Medical Review, DWC Form IMR, the independent review organization receives from the employee's treating physician a certification signed under penalty of perjury that the employee faces an imminent and serious threat	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	To "certify" is to say officially that something is true, correct, or genuine. See http://www.merriam-webster.com/dictionary/certifying?show=0&t=1386962565. An express requirement for a statement under penalty of perjury is not necessary in this regard. That said, documentation confirming the employee's serious condition should be provided to	Amend subdivision (c) (formerly subdivision (g)) to require a written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health. Further

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to his or her health as described in section 9792.~~10~~.6.1(j). 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. Commenter opines that signing under penalty of perjury may discourage unwarranted expedited requests that are already being reported. Commenter states that there is no section 9792. 10.6.1(j). This is likely just a typographical error and the section intended is 9792.6.1(j).		corroborate a written statement. The typographical error and noted and should be corrected.	amend subdivision to correct reference to section 9792.6.1(j).
9792.10.4(g)	Commenter is concerned that the physician may request expedited reviews when there is no actual imminent or serious threat. If the original RFA did not identify the request as expedited there should be only very rare occasions when the delay of 30 -40 days for /MR would change the treatment status to imminent threat. Commenter opines that treatment is already provided without resolution of the dispute or of the UR denial should never be considered for expedited review.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	The Division agrees that there should be only very rare occasions when a regular review would be converted into an expedited review. As to a penalty for physician abuse, the IMR statutes, Labor Code section 4610.5 and 4610.6, do not authorize the Division to penalize or otherwise take adverse actions against physicians. As noted above, the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter recommends that there should be some penalty for abuse of this section by the physician. Commenter states that there is no section 9792. 10.6. (j). Commenter states that this is likely just a typographical error and the section intended is to be 9792.6.1(j).		typographical error should be corrected.	
9792.10.5	Commenter requests that the requirement to provide additional documentation for expedited reviews one calendar day after receipt be modified to one business day after receipt in order to recognize that departments are closed on weekends and holidays.	Ailene Dewar Rehab West, Inc. April 4, 2013 Oral Comment	As previously noted, the requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.
9792.10.5(a)(1)	Commenter opines that this rule does not comply with the authorizing statute and must be amended. Labor Code section 4610.5(l) provides that the claim administrator must provide to the IMRO: "(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	The Division finds it reasonable to interpret Labor Code section 4610.5(*l*)(1)(A)'s mandate as meaning six months of medical records relevant to the employee's current medical condition. Six months of records provides an IMR reviewer in essentially every claim with sufficient medical evidence to make a medical necessity determination on a requested	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	following: (A) The employee's current medical condition. (B) The medical treatment being provided by the employer. (C) The disputed medical treatment requested by the employee." Commenter opines that as proposed, this rule requires that only reports of the requesting physician produced within the most recent six months are required to be provided, with reports from other physicians required only where the requesting physician has provided treatment for less than six months. Commenter opines that this limited requirement will significantly hamper the functioning of IMR. In a significant number of cases, employees have been receiving treatment for much longer than six months, and are receiving treatment from other physicians besides the requesting physician. If this limited requirement for submission of records is adopted,		treatment. To require all records, regardless of the date, may tax the resources of claims administrators, and may result in the IMR process becoming unwieldy, costly, and time consuming. It must be noted that if additional records are required for an IMR reviewer to reach a determination, they have the ability to request those records from the parties. See section 9792.10.5(c).	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	commenter believes that the IMR process will be as unwieldy, costly, and time consuming as the current UR process. Commenter states that under UR, far too frequently denials are based on faulty determinations caused by the claims administrator's failure to provide the reviewer with all relevant medical records. For example, a denial may state that the requested treatment is denied because there is no evidence of efficacy of the requested treatment, or that a surgery is denied because there is no evidence that more conservative treatment has been attempted; where in fact records from 9 months or a year earlier contain the necessary medical evidence. Commenter opines that the purpose of this rule should not be to make it as easy as possible for the claims administrator, but to assure that the IMRO has all necessary information to make a proper determination of medical necessity. Commenter opines that this proposed rule would be particularly harmful to unrepresented injured workers. Even though the worker will receive a summary of the medical records and			

	information provided to the IMRO, that worker will generally not know which records are important, and may not understand the importance of those records in the decision-making process. The end result will be incorrect determinations that help neither party. Commenter requests that this rule be amended to conform to the authorizing statute and require submission to the IMRO of *all relevant records in the possession of or under the control of the claims administrator.*			
9792.10.5(a)(1)	Commenter notes that this section specifies that an action must be taken within (15 days of mailing). Commenter would like to know how is the mailing date be determined? Does the state intend to require proof of service with each mailing? Commenter opines that if proof of service will be required, then consistency and clarification is needed in other sections of the regulations where the term "mailing" is used in place of "service".	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	Section 9792.10.4(b)(5) provides that the required records must be provided within 15 calendar days of the date designated on the notification. That date on the notification is the date to be used when computing the days for filing the records.	No action necessary.
9792.10.5(a)(1)	Commenter recommends the following revised language:	Peggy Thill Claims Operations Manager	As previously noted, the requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Within fifteen (15) days following receipt of the mailed 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~~ <u>one business day</u> following receipt of the notification, the independent medical review organization shall receive from the claims administrator all of the following documents: Commenter opines that the proposed regulations create challenges to comply with the 24 hour time frame to serve records. Commenter states that the regulations should clarify the requirements for providing information on expedited IMR reviews within the specified time periods and address situations when the notification is received on a Friday or before a holiday, without resulting in automatic penalty situations. Commenter recommends that references to “twenty four (24) hours” and 3 “days” should be amended to	State Compensation Insurance Fund April 4, 2013 Written Comment		

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reflect a timeframe consistent with business days.			
9792.10.5(a)(1)	Commenter recommends the following revised language: Within fifteen (15) days following the mailing, faxing or emailing 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 claims administrator all of the following documents: Commenter states that five days are allowed for serving within California pursuant to CCR section 10507. Superior court provides for fewer days for notification sent electronically, however CCR 10507 applies to workers' compensation and the superior court standard does not.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The Administrative Director finds the timeframe for filing documents in section 9792.10.5 to be reasonable. The different time periods correspond to those set forth in Code of Civil Procedure section 1013. As indicated in the response to the comment made by the commenter in regard to section 9792.10.4(e), the timeframes set forth in Section 10507 applies to proceeding before the WCAB and do not apply in IMR proceedings. .	No action necessary.
9792.10.5(a)(1)	Commenter recommends the following revised language:	Anita Weir, RN, MS Director, Medical & Disability	The Administrative Director finds the timeframe for filing documents in section	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	"Within fifteen (15) days following the mailing, faxing or emailing 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~~ 48 or 72 hours following receipt of the notification, the independent medical review organization shall receive from the claims administrator all of the following documents:" Commenter opines that with the advent of document image systems incoming documents are managed at the same time and in the same manner regardless of how they arrived via mail or fax or email. The scan date on the document is considered the receipt date. These different timelines for response seem arbitrary and unreasonable. Commenter state that someone would have to examine the envelope for postal date to know when the 15 day due date would be. Envelopes are not scanned in mast systems because the document is	Management April 4, 2013 Written Comment	9792.10.5 to be reasonable. The different time periods correspond to those set forth in Code of Civil Procedure section 1013. As noted above, the timeframe requirement for providing documents in an expedited review case is statutory. See Labor Code section 4610.5(n).	

	scanned on the day it arrives in the scan center and that date is stamped on the document. Commenter recommends the allowance of the same 15 business day processing time regardless of type of transmission as per example above and clarify the 24 hours for Friday to next business day for expedited reviews.			
9792.10.5(a)(1)	Commenter states that claims administrators have moved into a paperless and electronic environment. Commenter would like to see this subsection modified to allow 15 days for any method of notification.	Linda Slaughter Chief Claims Officer Athens Administrators April 4, 2013 Oral Comment	The Administrative Director finds the timeframe for filing documents in section 9792.10.5 to be reasonable. The different time periods correspond to those set forth in Code of Civil Procedure section 1013.	No action necessary.
9792.10.5(a)(1) and (a)(1)A)	Commenter notes that the changes made to the Emergency regulations have significantly reduced the available time to gather the copious documents required and transmit them to the IMRO. Commenter strongly recommends returning to the time allowed in the Emergency regulation. Commenter suggests the following revised language:	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The proposed regulations have not significantly reduced the time frame in which to provide documents; they have clarified that “shall provide” means that the documents must be received by the IMRO. The requirement that the medical records be relevant to the employee’s current medical	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(a)(1)(A) "A copy of all reports of the requesting physician relevant to the employee's ~~current medical condition~~ disputed treatment produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the UR determination. If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy of all reports relevant to the employee's ~~current medical condition~~ disputed treatment produced within the described six month period by any prior treating physician or referring physician. Commenter feels strongly that placing an arbitrary requirement for the production of reports is inappropriate. Commenter opine that for the vast majority of claims this would be a massive amount of irrelevant material, while in rare cases more than six months of reporting might be relevant. Commenter states that gathering and transmitting this amount of treating		condition is statutory. See Labor Code section 4610.5(*l*)(1)(A).	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	physician reporting as well as the numerous other required reports will be a challenge adding to administrative expense and potential penalties. Commenter opines that virtually every report could be said to be relevant to the employee's "current medical condition" while only a limited number of reports may be relevant to the employee's disputed treatment. Commenter recommends this change to reduce administrative expense as well as the creation of further disputes regarding the production of records.			
9792.10.5(a)(1)(B)	Commenter opines that the required documents are often created by date range either in images or paper files. Commenter opines that it will pose an operational cost to find and remove just that IMR application from the many pages of medical documents. Commenter understands not wanting to send duplicate documents; however her organization does not want to create another time and cost driver for the claims team. Commenter opines that this issue will be of less concern when IMRO accepts digital records where storage is not a problem.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	Agreed in part. If the employee submits the UR determination as part of the IMR application, then the submission of the document, even without a copy of the IMR application, would be duplicative and costly. Instead, a copy of the IMR application itself would be more significant, to ensure that the document filed by the employee is the same one provided by the claims administrator.	Amend section 9792.10.5(a)(1)(B) to only require a copy of the IMR application given to the employee with the adverse UR determination.
9792.10.5(a)(1)(B)	Commenter notes that this section	Linda Slaughter	See above response to	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	states that the claims administrator should not include previously provided application for IMR and instructions with the documents to be provided. Commenter opines that operationally it is going to take additional time for them to locate and remove those records and she requests that this requirement be removed.	Chief Claims Officer Athens Administrators April 4, 2013 Oral Comment	comment by Anita Weir.	
9792.10.5(a)(1)(F)	Commenter opines that this provision is unclear, as the Claims Administrator completes the Application leaving only the signature line for the Injured Worker to sign. Commenter notes that on the IMR Application Instructions sheet the injured employee is instructed to make any changes to information on the Application on an attached page, and is advised of additional documents that the employee submit. As stated previously, but there is no mention of the need to provide a copy to the Claims Administrator.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Generally, there would be no need for the claims administrator to provide any response to additional issues raised in the IMR application. That said, the information on the form may be changed or altered, thereby rendered the information as incorrect. Now that the application must be served on the claims administrator, see proposed section 9792.10.1(b)(1), it would be appropriate to allow a response.	No action necessary.
9792.10.5(a)(2)	Commenter is concerned with the following sentence: "The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	Agreed in part. The requirement to provide the employee with notification of the documents provided, with a copy of those documents not previously provided to the employee, is statutory. See	Amend section 9792.10.5(a)(2) to exclude mental health records withheld from the employee under Health and Safety Code section

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	employee's representative." Commenter opines that no obvious benefit is achieved by providing medical reports to the employee. Given the extent of the burden placed on the claims administrator for providing documentation and the short time to comply, it is generally assured that this requirement will result in a "dumping" of the entire file at each IMR, in order to avoid fines for failure to provide all required documents. Commenter states that the process of determining which ones had been previously transmitted to the employee would be onerous and opines that this will result in patients receiving reports that should not be in their possession, particularly psychiatric evaluations. Provision of such reports to the employee is required under the regulation as proposed. Commenter states that the frequency of providing such reporting to patients will be small; but the impact of each such instance is potentially very great. Commenter opines that if this		Labor Code section 4610.5(o). That said, subdivision (a)(2) does not take into consideration protected mental health records. The subdivision should be amended to exclude mental health records withheld from the employee under Health and Safety Code section 123115(b).	123115(b) from those category of documents that must be provided to the employee if not previously provided.

	requirement is left in place as written, it will not be long before principled mental health professionals refuse to take any work comp cases in California.			
9792.10.5(b)(1)	Commenter recommends the following revised language: 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~~ <u>one business day</u> following receipt of the notification, the independent medical review organization shall receive from the employee, or any party identified in section 9792.10.1(b)(2), any of the following documents: Commenter opines that the proposed regulations create challenges to comply with the 24 hour time frame to serve records. Commenter states that the regulations should clarify the requirements for providing information on expedited IMR	Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 4, 2013 Written Comment	As previously noted in the response to section 9797.10.5(a)(1), the requirement is statutory. See Labor Code section 4610.5(n).	No action necessary.

	reviews within the specified time periods and address situations when the notification is received on a Friday or before a holiday, without resulting in automatic penalty situations. Commenter recommends that references to "twenty four (24) hours" and 3 "days" should be amended to reflect a timeframe consistent with business days.			
9792.10.5(b)(1)	Commenter recommends the following revised language: Within fifteen (15) days following the mailing, faxing or emailing 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, or any party identified in section 9792.10.1(b)(2), any of the following documents: Commenter states that five days are	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	As noted in the response to section 9792.10.5(a)(1), the Administrative Director finds the timeframe for filing documents in section 9792.10.5 to be reasonable. The different time periods correspond to those set forth in Code of Civil Procedure section 1013. As indicated in the response to the comment made by the commenter in regard to section 9792.10.4(e), the timeframes set forth in Section 10507 applies to proceeding before the WCAB and do not apply in IMR proceedings	No action necessary.

	allowed for serving within California pursuant to CCR section 10507. Superior court provides for fewer days for notification sent electronically, however CCR 10507 applies to workers' compensation and the superior court standard does not.			
9792.10.5(b)(2)	Commenter states that this paragraph requires that the employee serve on the claims administrator any documents provided to the IMRO. However, commenter notes that under proposed section 9792.10.5(a)(2), the claims administrator must only "forward" documents to the employee. Commenter opines that the parties should have the same obligation and requests that this paragraph be amended to require that the employee "forward" documents to the claim administrator.	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Agreed. The terms should correspond.	Amend section 9792.10.5(b)(2) to substitute "forward" for "serve."
9792.10.5(d)	Commenter notes that this proposed section restates the statutory requirement that <u>"The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws."</u> To assist with the legislative and regulatory intent of these sections, commenter recommends that DWC	Peggy Sugarman Director of Workers' Compensation City and County of San Francisco April 4, 2013 Written Comment	The IMRO designated by the Administrative Director is bound to ensure the confidentiality of medical records. See Labor Code section 139.5(d)(3)(D). See Exhibit E to the contract between the Department of Industrial Relations and Maximus Federal Services,	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	require that the IMR organization make available a secure, encrypted method to electronically deliver medical records to the reviewer. Such a requirement would make the process much more efficient than mailing reams of documents to the reviewing organization, would ensure that such documents are submitted timely, would simultaneously protect the records as required by state and federal law, and would protect the savings provided by this administrative process. Commenter opines that the cost of copying and mailing these medical documents would significantly impact potential savings.		Inc., DIR Agreement No. 41230038. While the Division is confident that the IMRO is conducting any transfer of records in the most efficient and legally appropriate method, it cannot dictate the IMRO's business practices.	
9792.10.6	Commenter opines that the IMR reviewer should sign the report under penalty of perjury with declaration that he personally reviewed, authored, and came to the decision, and that the foots are true to the best of his knowledge, so he/she can be held accountable for any obviously biased decisions or decisions inconsistent with MTUS guidelines.	Kenn Shoji, D.C. Center for Interventional Spine April 4, 2013 Written Comment	The required elements of an IMR determination are set forth in Labor Code section 4610.6(c) through (f).	No action necessary.
9792.10.6(a)	Commenter states that as proposed this subdivision allows the claims administrator to terminate IMR for	Mark Gerlach California Applicants'	Agreed. The subdivision should align with the statute.	Amend section 9792.10.6(a) to provide that the IMR

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	any reason. The authorizing statute, Labor Code section 4610.5(g), allows IMR to be terminated only if the employer authorizes the requested treatment. Commenter requests that this subdivision be amended to conform to the statute.	Attorneys Association April 3, 2013 Written Comment		process may be terminated at any time upon notice by the claims administrator to the independent review organization that the disputed medical treatment has been authorized.
9792.10.6(a)	Commenter notes that this section as proposed states that the claims administrator can cancel the IMR process at any time by simple written notice, without any conditions. As written, this gives the claims administrator the option to pay the IMR cancellation fee; stop the IMR process; and have the UR denial stand. Commenter opines that the incentive to do so for expensive but appropriate treatment will be significant. Commenter opines that the condition that the disputed care must be authorized, as found in the emergency regulations, really should be retained.	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	See above response agreeing that the subdivision should align with the statute.	No action necessary.
9792.10.6(a)	Commenter recommends the following revised language: The independent medical review	Brenda Ramirez Claims and Medical Director California Workers'	Disagree. The claims administrator should only be allowed to unilaterally withdraw a IMR review if the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	process may be terminated at any time upon notice by the claims administrator to: 1) the Administrative Director or entity designated to receive and initially review the application for review before the review is determined eligible and assigned to the independent medical reviewer; or 2) the independent review organization after the assignment. Commenter opines that it is necessary to allow the opportunity for the claims administrator to terminate the review process before it is assigned to an independent medical reviewer to avoid an unnecessary independent review and the associated administrative burdens and costs.	Compensation Institute (CWCI) April 4, 2013 Written Comment	requested treatment has been authorized. If an IMR application has been withdrawn prior to the assignment of the request to an IMR reviewer, the amount of the review is lower to $215.00. See section 9792.10.8(a)(1)(C).	
9792.10.6(a)	Commenter notes that this version of the regulation proposes to make a change to subsection (a) of this new section, which previously allowed a claims administrator to cease the operation of IMR if they authorized the disputed medical treatment. Commenter opines that this is appropriate, since, if the payor approves the treatment, there is no dispute left to discuss.	Lisa Folberg Vice President Medical & Regulatory Policy California Medical Association March 13, 2013 Written Comment David Ford California Medical Association	See response to above comments regarding this subdivision. A claims administrator should be able to unilaterally withdraw a IMR request only if the requested treatment was authorized. The subdivision should be amended to reflect this.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter notes that although it may not have been the intention of DWC, the proposed edit of subsection (a) would give claims administrators unilateral ability to stop the IMR process simply by notifying the review organization, whether or not the treatment is authorized. Commenter states that this is contrary to the intent of the IMR process. Commenter strongly believes that the section proposed to be struck from subsection (a) be restored.	April 4, 2013 Written Comment		
9792.10.6(d)	Commenter recommends the following revised language: The determination issued by the medical reviewer shall state whether the disputed medical treatment is medically necessary. The determination shall include the employee's medical condition, a list of the documents reviewed, a statement of the disputed medical treatment, references to the Medical Treatment Utilization Schedule and specific medical and scientific evidence utilized pursuant to section 9792.6.1(r), and the clinical reasons regarding medical necessity.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Disagree. The standards for medical necessity are expressly set forth in Labor Code section 4610.5(c)(2). The statute is referenced in section 9792.10.6(b)(1) as the standard for an IMR reviewer to determine medical necessity. No further reference is necessary.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that Labor Code section 4610.5(c)(2) requires the MTUS to be applied and relied on unless it is inapplicable to the employee's medical condition. The determination must reference the Medical Treatment Utilization Schedule (MTUS) because it is the highest ranked standard, and if the MTUS is inapplicable to the employee's medical condition, the report should reference the reason it is inapplicable.			
9792.10.6(d)	Commenter recommends adding the following language: "…a statement of the disputed medical treatment, references to the Medical Treatment Utilization Schedule and any other specific evidence…." Commenter states that Labor Code section 4610.5(c}(2) requires the MTUS to be applied and relied on unless it is inapplicable to the employee's medical condition. The determination must reference the Medical Treatment Utilization Schedule (MTUS) because it is the highest ranked standard, and if the	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	See above response to comment regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	MTUS is inapplicable to the employee's medical condition, the report should reference the reason it is inapplicable. Commenter states that the Hierarchy of evidence for determining medical necessity should be the same for UR and IMR. Commenter opines that this concept could use more clarification in both sections.			
9792.10.6(e)(1)	Commenter proposes that only the final determination be released to the parties to avoid confusion and reduce the risk of error in applying the IMR decision. Commenter suggests the following modification: (1) If more than one medical reviewer reviewed the case, the independent review organization shall provide only the final determination. The decision will indicate if the decision was unanimous or divided. If divided, any party may request a copy of the other reviewers decision.	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	In a case involving multiple IMR reviewers, Labor Code section 4610.6(e) requires that the analysis provided by each reviewer be given in the final determination.	No action necessary.
9792.10.6(f)	Commenter opines that keeping the identity of the IMR reviewer secret in perpetuity is fundamentally wrong, on many levels. However, commenter opines that keeping that person's	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	The confidentiality of the IMR reviewer is mandated by Labor Code section 4610.6(f). There is no provision allowing the disclosure of the reviewer's	No action necessary.

	identity secret during the IMR process is an excellent idea. Commenter states that the basic professional ethics requires that person to stand behind their opinions once rendered. Commenter opines that failure to identify the IMR physician after their work is done will greatly complicate questions of conflict of interest.		name after the IMR determination issues.	
9792.10.6(f)	Commenter believes the name of the reviewers should be disclosed to the parties. This allows the parties to assess whether or not there could have been a conflict of interest or bias in the part of a reviewing party. Commenter recommends that the name of the reviewer be disclosed along with the reviewer's credentials.	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	See above response to comment regarding this subdivision.	No action necessary.
9792.10.6(f)	Commenter states that it is not clear whether the Administrative Director have access to the names of the IMR physician reviewers. Commenter notes that following January 1, 2014 IMR reviewers may not also be QME's, but if the Administrative Director does not have access to a list of reviewers, it is not clear how this can be enforced. Commenter notes that the regulation provides a limited number of reasons why an IMR decision can be set aside by the WCAB. Commenter opines that	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Labor Code section 4610.6(f) is clear that the name of the reviewer must be kept confidential “in all communications with entities or individual outside the [IMRO]. The Administrative Director does not have access to the names of reviewers on specific decisions.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	two of the five, namely bias and material conflict of interest, appear inaccessible however, due to the anonymity of the IMR reviewers.			
9792.10.6(f)	Commenter states that it has been suggested that the identity of IMR reviewers remain concealed from the requesting physician, the carrier and the attorneys. Commenter states that this proposal in and of itself appears arbitrary as there doesn't seem to be any identifiable benefit to the injured worker, the carrier, or even the DWC from this opacity. Commenter opines that unless the fairness of the process of the independent medical review is suspect from the outset, there is nothing inherent in the task of the IMR reviewer that would supplicate for the identity of that reviewer to remain anonymous. Commenter opines that if the anonymity of the reviewer is considered crucial to the success of the I MR process, then consideration must be given to making the entire process anonymous as in a double – blind review. Commenter opines that the requesting physician, the employer and the carrier or claims administrator	Timothy Hunt, M.D. President Allied Medical Group April 2, 2013 Written Comment	See response to comments regarding this subdivision. The requirement is statutory. See Labor Code section 4610.6(f)	No action necessary.

	should all remain anonymous in order to ensure that the product of the IMR process is a medical decision based solely on the available medical information. Double-blind studies and experiments are a respected and important tool of the scientific method.			
9792.10.6(f)	Commenter states that the regulations specify that two of the reasons an IMR decision could be thrown out are for reasons of bias and conflict of interest. Commenter opines that if he has no idea who the reviewer is, then how is it possible to prove either one of those issues. Commenter provides the following example: There are two reviewers who work for the IMRO and it becomes their personal opinion that Acupuncture is of no use. Then the two of them start to deny all acupuncture requests at a much higher percentage than other physicians, how can this be figured out. What if all Acupuncture requests get funneled to these two unnamed unidentifiable physicians and it	William J. Heaney III April 4, 2013 Written Comment	See response to comments regarding this subdivision. The requirement is statutory. See Labor Code section 4610.6(f). If bias or a conflict of interest is perceived in a decision, the matter should be brought before the WCAB and litigated under their rules and regulations.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	changes the overall percentage of Authorizations for that service. Commenter opines that since these folks are unidentifiable it just does not seem fair or transparent and they really have no one to be accountable too. Commenter suggests a coding system where they have a number which Identifies them in the case where a bias or possible conflict of interest exists. The number could be at the bottom of the denial and that way if you started to see trends where reviewer 11111 is denying Acupuncture 98 percent of the time, when maybe reviewer 22222 is authorizing it 65 percent of the time. Commenter strongly believes that if something like this is not done, there result will be IMRO companies determining standards of care. Commenter opines that the MTUS is a great tool but it is also abused sometimes. Commenter opines that almost every recommendation has a sentence or line, if standing alone that can be used to approve or deny almost anything.			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.10.6(g)(1)	Commenter notes that this subsection states that for regulator review, the IRO shall complete its review and make its final determination within 30 days of the receipt of application for IMR, the DWC form IMR, and the supporting documentation and information provided under section 9792.10.5. Commenter opines that while it appears as though the event that starts the clock for the 30 days would be all of the information above, it would be clearer to specify that the 30 days starts with all or either of the aforementioned.	Brittany Rupley Defense Attorney April 4, 2013 Oral Comment	The subdivision is clear; the 30 day period for a determination begins after receipt of the application and the supporting documentation provided under section 9792.10.5. No further clarification is necessary.	No action taken.
9792.10.6(g)(2)	Commenter recommends the following revised language: For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) business days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.	Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 4, 2013 Written Comment	The three day requirement is statutory. See section 4610.6(d).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that the proposed regulations create challenges to comply with the 24 hour time frame to serve records. Commenter states that the regulations should clarify the requirements for providing information on expedited IMR reviews within the specified time periods and address situations when the notification is received on a Friday or before a holiday, without resulting in automatic penalty situations. Commenter recommends that references to “twenty four (24) hours” and 3 “days” should be amended to reflect a timeframe consistent with business days.			
9792.10.7	Commenter notes that proposed section 9792.l0.7(a)(2) requires that the claims administrator "authorize the services within 5 working days of receipt of the final determination, or sooner if appropriate for the nature of the employees medical condition and shall inform the employee and provider of the authorization." Commenter opines that this is a small window of time for a claims administrator to act. Commenter	Peggy Sugarman Director of Workers’ Compensation City and County of San Francisco April 4, 2013 Written Comment and Oral Comment	The requirement for a claims administrator to authorize services found medically necessary through IMR within five working day of receipt of the determination is statutory. See Labor Code section 4610.6(j).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	agrees that authorization should be provided no later than 5 days consistent with other UR timelines; however, she suggests that DWC allow the claims administrator the opportunity **to pre-authorize the services** should the UR denial be overturned by the Independent Medical Reviewer. Such a pre-authorization could be embedded in the claims administrator's communication to the physician as described in Labor Code section 4610.5(/)(4). Commenter opines that such action would expedite the delivery of services and save the administrator from yet another step, as the proposed regulations in 9792.10.6(e) already require that the IMR organization serve a copy of the final determination on the provider.			
9792.10.7(a)	Commenter states that this rule provides that a claims administrator shall promptly implement a final determination that a requested medical treatment is medically necessary "unless the claims administrator has also disputed liability for any reason besides medical necessity." Commenter opines that the rule specifies timeframes for the claims	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Labor Code section 4610.6(j) provides that a claims administrator "shall promptly implement the [IMR] decision…unless the employer has also disputed liability for any reason beyond medical necessity." The regulation merely repeats the statutory exclusion of liability disputes	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	administrator to implement the determination, but provides no guidance on what is required if there is a dispute over liability. Commenter states that rule should require that the claims administrator notify the employee within 5 working days of receipt of the determination that there is a dispute over liability and that the treatment will be deferred until a determination is made regarding that dispute. Consistent with other rules, this rule should further provide that if the requested treatment is deferred and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the treatment shall be authorized within 5 working days of the date the determination of the claims administrator's liability becomes final.		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.	
9792.10.7(c)	Commenter opines that with respect to the parties' appealing final determination by the Administrative Director by filing a petition with the WCAB under 9792.10.7(a)(2), authorizations for services not yet	Brittany Rupley Defense Attorney April 4, 2013 Oral Comment	Both the timeframe for implementing an IMR decision for services not yet rendered and the timeframe for filing an appeal with the WCAB are statutory. See Labor Code	No action necessary.

	rendered are to be made within five days. Commenter notes that it is apparent that the petition, given the regulation, must be filed within five days, she opines that it would be helpful to include the time frame for filing an appeal within this subsection.		section 4610.6(h) and (j). In this regard, the Division does not have authority to dictate the WCAB's rules and procedures.	
9792.10.7(d)	Commenter recommends adding the following as number (3) to this subsection: *(3) The Administrative Director may revise the appealed final determination based on the review of the Workers' Compensation Appeals Board.* Commenter opines that the Workers' Compensation Appeals Board (WCAB) needs to be an option for and appeal of the decision and as a final remedy.	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	The avenues for resolution following a decision by the WCAB to reverse an IMR decision are limited by statute. Under Labor Code section 4610.6(i), the decision must either submit the dispute to another IMRO (if another exists), or to another IMR reviewer if there is only one IMRO. The WCAB cannot make a determination of medical necessity contrary to that of the IMRO.	No action necessary.
9792.10.8	Commenter has general concerns regarding the cost of reviews. Commenter states that the cost of reviews far exceeds the average paid by his organization for utilization review determinations with private review organizations. The commenter's organization currently pays below $300 for utilization	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	The cost of IMR was negotiated between the Administrative Director and the current IMRO, Maximus Federal Services, under Labor Code section 139.5(a)(2). The cost was based on an estimated number of IMR reviews, the administrative cost of selecting	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reviews done in California. Commenter opine that the time and work involved for an IMR report should be comparable to that of a utilization review, so it is unclear why the proposed rates are so high. Commenter states that the pricing also does not address how multiple requests on a single Request for Authorization will be priced. For example if a provider submits three treatment requests for the same body part or three different body parts, will that be considered a single review or three separate reviews with each occurring a separate fee? If this is the case, commenter opines that this will dramatically increase the cost of the IMR. Commenter proposes that the pricing be reevaluated and that industry average pricing be considered. Commenter proposes that pricing be clarified for situations where multiple requests are under review in a single IMR. Independent Medical Reviewers need to look at each proposed diagnostic test or treatment in context of the overall treatment plan, so commenter suggests that all requests from one date of service or all RFA's submitted		a sufficient number of IMR reviewers, and the cost of building a reliable infrastructure to conduct IMR for the California workers' compensation system. The Division notes section 9792.10.4(a), which allows the IMRO to consolidate several IMR requests if the application involves the same requesting physician and the same date of injury for the employee.	

	attached to the same report be treated as a single request as is done by UR organizations.			
9792.10.8	Commenter opines that the proposed fee schedule appears very high, many times that of UR physicians. Commenter expects that these fees will be reduced when the Division of Workers' Compensation is able to let the contract through competitive bidding. Commenter is concerned that with this level of fees, and no minimum threshold for applying for IMR, the projected savings of the reform will be jeopardized.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	See above response to comment by Bennett L. Katz of The Zenith.	No action necessary.
9792.10.8(i)	Commenter notes that if the employer wants to cancel the UR appeal that there is a $215 fee for doing so. Commenter states that at the DWC conference held in Los Angeles she heard that if the IMR1 form has been received by DWC and it is determined that it is eligible for review and assigned to s physician IMRO – if the employer cancels the review at that point there will be a full fee for the IMR whether it's one reviewer or multiple reviewers. Commenter notes that this can happen during the process if the injured worker sends in the IMR1 form the day after they receive	Ailene Dewar Rehab West, Inc. April 4, 2013 Oral Comment	The Division notes that the cost of IMR includes both the cost of review and the program costs to administer the IMR system. Labor Code section 4610.6(*l*). The fee was the product of negotiation between the Administrative Director and the IMRO and is reasonable for the termination of an otherwise eligible IMR request. It should also be noted that the IMR process and the internal appeal process run concurrently. There is no statutory authority for IMR to	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	it, as quickly as five days, whereas this regulation allows the URO requesting physician 15 days to complete a UR appeal. Commenter opines that it is unreasonable to require the injured worker to hold onto that form for 15 days until the employer and URO can conduct an appeal. Commenter opines that the IMRO should not be able to charge more than the $215 cancellation fee until the sixteenth day after the UR determination to give the physician URO and requesting physician the opportunity to resolve the process through an appeal.		be delayed subject to an internal appeal.	
9792.10.8(a)(1)(C)(i); (a)(2)(C)(i)	Commenter opines that the $215 cancellation fee is grossly excessive, and is predicted to create a significant cost driver in the work comp system. This fee will be applied in every instance in which a delay (no decision due to insufficient information) is resolved prior to completion of the IMR. Commenter opines that the cancellation fee being proposed here is known to be significantly in excess of the amount per IMR that the IMR vendor is offering the physicians that they are hiring as reviewers ($150).	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	See above response to comment by Bennett L. Katz of The Zenith. The Division notes that UR decisions may by claims administrators based on the lack of information submitted by the requesting physician will be ineligible for IMR. See section 9792.10.3(a)(6). The Division further notes that the cost of IMR includes both the cost of review and the program costs to administer the IMR system. Labor Code section 4610.6(*l*).	No action necessary.

	Thus, the proposed cancellation fee exceeds the actual cost of IMR completion. Commenter opines that cancellation fees, if any, should be tied to the actual costs of IMR process initiation, prior to receipt of documents from the claims administrator.			
9792.10.8(b)	Commenter opines that the optimal billing method would be individual bills on a per review basis. If that was not possible, the aggregate bills should be sorted and transmitted to each of a Claims Administrator's adjusting locations in order to expedite payment. Commenter states that the proposed regulation is unclear as to exactly where the aggregate bills are to be delivered. If these aggregate bills are not being sent to the individual adjusting locations they will require central identification and re-routing to the correct adjusting location for payment. This will, of course, take time. Commenter opines that if this is what is meant by Claims Administrator, the time for payment should be extended.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The Administrative Director has determined that the most efficient manner for claims administrator to pay for IMR reviews is by means of a single, monthly invoice containing a specific itemization of IMR reviews conducted during the past month and required by subdivision (b). Multiple bills to multiple adjusting locations will inevitably use addition resources, thus adding to program costs and reducing systems savings. While bills will be initially sent to the address that the claims administrators themselves put on the IMR application, the IMRO will certainly work with the claims administrator to	No action necessary.

	Commenter states that it is not clear as to how the reviews will be identified. Commenter opines that at the very least the Injured Employee's Name and Claim Number, as well as the amount for the review, should be present.		ensure the bill is sent to the correct billing location.	
9792.10.8(d)	Commenter notes that this subsection contains the first mention of the possibility of an untimely IMR determination. Commenter understands that this may be disputed with the Administrative Director, but it appears that no remedies or penalties are provided.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Labor Code section 4610.6 does not extend remedies for an untimely IMR determination to the parties. Any penalties for an untimely determination would be a matter of contract between the Administrative Director and the IMRO.	No action necessary.
9792.10.9	Commenter notes that this section states that the Administrative Director may publish the results of IMR. Commenter states that the use of the word "may" is consistent with the statutory language. Commenter strongly recommends that data be published to include, at the very least, total number of reviews, number of UR decisions that were overturned, what level of evidence the decision was based on, the number of reviewers per request, and the cost and timeliness of reviews.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Agreed. The Administrative Director has determined that posting redacted IMR determinations will assist the regulated community as to the types of medical treatments that could be considered medically necessary for specific conditions.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.12(a)(12) through (a) (15)	Commenter states that these sections are now not fully consistent with 9792.9.1(h), which specifically describes a subset of requests for authorization that require no further action. This explicitly means that no response is required. Commenter opines that 9792.12(a)(12) through (14) should be amended for this variance; or there must be a notification/response process indicated for 9792.9.1(h).	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	Subdivision (a) provides that penalties shall be assessed for each failure to comply with the utilization review process as required by Labor Code section 4610 and sections 9792.6 through 9792.12. The failure to take action on a request for treatment that had been previously denied within the last 12 months under section 9792.9.1(h) is not a failure to comply with the UR process and thus not subject to penalties.	No action necessary.
9792.12(a)(18); (22); (23); and (24)	Commenter notes that these paragraphs establish administrative penalties for violation of new IMR statutes and rules. Commenter opines that the proposed penalties fail to implement the intent of the authorizing statutes, Labor Code sections 4610.5(i) and 4610.6(k). Both of these statutory sections call for imposition of significant penalties of up to $5,000 per day for actions that delay the independent review process and the provision of medical treatment that has been determined to be medically necessary. Commenter states that the proposed rules establish	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment April 4, 2013 Oral 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 resolution procedure in workers' compensation. It must be noted that any violation of a claims	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	fines of only $100 to $500 per day. Commenter is even more disturbed by the fact that these paragraphs all establish a *maximum fine of only $5,000*. Commenter agrees that the statutory language gives the Administrative Director the authority to establish a penalty of less than $5,000 per day, but opines that it is unreasonable to interpret a statutory provision establishing a fine of up to $5,000 per day as a cap limiting the total penalty to $5,000. Commenter opines that it is also unreasonable to expect that multi-billion dollar insurance companies will consider a $100 fine a serious disincentive. Commenter opines that the penalty amounts in these paragraphs should be set at $1,000 per day at a minimum, and the cap in these paragraphs should either be eliminated or significantly increased. Commenter stresses that the penalties have to be large enough to be enough of a deterrent against non-compliance and the currently they are not. Commenter states that insurers write billions of dollars of business per day yet the fine for non-compliance is only		administrator that can be deemed a "general business practice" can subject a claims administrator to civil penalty under Labor Code section 129.5.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	$100.00 per day. Commenter states that the Department of Managed Care publishes their enforcement actions on their webpage (copies of examples were provided) and that their administrative penalty total $15,000 and $50,000. Commenter notes that the Knox-Keen Act – failure to correctly pay the claims administrative penalty is $350,000. Commenter requests that the Division increase the penalties in order to ensure compliance.			
9792.12(a)(20)	Commenter opines that this section is internally inconsistent. It states both that notice has to be provided with the written decision (correct standard?), or that it has to be provided within 30 days of the receipt of the decision. It is also not clear who is the intended receiving party, or how the date of receipt would be determined. Commenter states that it is generally only possible to determine when such letters are sent; not when they are received.	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	Agreed. The subdivision should be revised such that the statement must provide that the IMR application must be submitted within 30 days of service of the UR decision.	Amend the subdivision, now located at subdivision (c)((3), to provide that the statement in the UR decision must advise that an IMR application must be submitted within 30 days of service of the utilization review decision.
9792.12(b)(4)(C)	Commenter states that with the proposed removal of the phrase, "or	Robert W. Ward Clinical Director	Agreed. The phrase “or modify or deny” should be reinstated	Amend the subdivision to

	modify or deny" the penalty for failing to make a timely notice of authorization is retained; but penalties for failing to make a timely notice of modification or denial are no longer in effect. The penalty under consideration here is timely completion of the review process when requested information has been received. Commenter opines that the proposed redaction weakens the enforcement standard, and should be reconsidered.	CID Management April 4, 2013 Written Comment	in the subdivision.	reinstate the previously deleted term “or modify or deny.”
9792.12(b)(5)(D)	Commenter states this section contains the same infraction that is considered in 9792.12(b)(4)(D); even though referenced to different sections of regulation. Commenter would like to know why there are different fines for the same violation.	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	The separate penalty provisions distinguish between the obligation to make and communicate a retrospective decision within 30 days of receipt of the request for authorization (subdivision (b)(4)(D)), and accompanying information, and the necessity to send a written notification if required (subdivision (b)(5)(D).	No action necessary.
9792.6 9792.6.1	Commenter is concerned that the definition of Expedited Review creates opportunity for abusive practices. The definition states that an expedited review can include "an imminent and serious threat to his or	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith	The definition of “expedited review” corresponds with the express language of Labor Code section 4610(g)(2). If the employee’s condition does not meet the standard, then	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	her heath, including, but not limited to .... or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured workers' permanent ability to regain maximum function." Commenter believes that this creates a very broad category that could lead to IMR requests that should not qualify for expedited review and artificially raise the expense associated with IMR. Commenter recommends that either the definition be narrowed or a review process be implemented as part of the IMR process for either the state or the IMR reviewer to determine whether the definition of expedited has truly been met before the IMR is processed as expedited.	April 4, 2013 Written Comments	expedited review should not be conducted.	
9792.6	Commenter states that according to the dates specified in Labor Code section 4610.5, Independent Medical Review does not apply when the utilization review decisions on requested medical treatment are communicated prior to July 1, 2013 for injuries occurring prior to January 1, 2013. Senate Bill 863 provisions regarding utilization review do, however, apply to all issues that do	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	To implement the timeframes for IMR set forth in Labor Code section 4610.5(a), it was necessary that section 9792.6 remain in effect and that a new 9792.6.1 be put in place. While the Division recognizes that all treatment requests will now be under the requirements of sections 9792.6.1, 9792.9.1, and 9792.10.1, the existing	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	not have final resolution. Section 84 of Senate Bill 863 says: "This act shall apply to all pending matters, regardless of injury, unless otherwise specified in this act, but shall not be a basis to rescind, alter, amend, or reopen a final award of workers' compensation benefits, pursuant to Section 84 of Senate Bill 863" Commenter opines that the proposed section 9792.6 is confusing and unnecessary. Commenter recommends that the Administrative Director delete the currently proposed text in section 9792.6, and replace it with the modified text of the proposed section now numbered 9792.6.1.		regulation should remain in place to avoid confusion. At a later time it is anticipated that the regulation will be deleted.	
9792.6	Commenter recommends the following language change to the heading: **§ 9792.6. Utilization Review Standards—Definitions – For Utilization Review Decisions ~~Issued~~ Communicated Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.** Commenter recommends the term	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The preface to the section expressly provides that the section applies 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.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	"communicated" because that is the term used in the statute.			
9792.6(b)	Commenter recommends the following modified language: (b) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the request for authorization and course of treatment ~~Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2~~. Commenter states that the request for authorization and the course of treatment are defined in (q) and (e) of this section.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The subdivision was not amended during this rulemaking. While redundant, the language provides specificity as the evidence necessary for a claims administrator to make a utilization review decision.	No action necessary.
9792.6(d) 9792.6.1.(c)	Commenter recommends adding the following sentence to the end of both of these subsections:	Barbara Hewitt Jones Jones Research & Consulting	The definition of "concurrent review" was carried over from the existing UR regulations	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Utilization review for the purposes of discharge planning or transfer is an expedited review decision. Commenter opines that to ensure that a discharge is not delayed while the case undergoes utilization review an expedited review should be used when there is the need for discharge planning for either home care or a step-down level of care.	Regulatory Analyst for Tenet April 2, 2013 Written Comment	with no amendments made. That said, the existing definition would appear to sufficiently encompass the proposed suggestion.	
9792.6(g) 9792.6.1(i)	Commenter recommends the following revised language: "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that *would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe* the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy. Commenter states that the use of the emergency room in non-emergent situations is a recognized occurrence in our medical system. The prudent	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	The definition of "emergency health care services" was carried over from the existing UR regulations with no amendments made. That said, the suggestion, which appears to allow an emergency room decision as to whether utilization review could be conducted on a prospective basis, would add a significant layer of complexity and cost to the UR system. In such a situation, UR can be conducted prospectively. See section 9792.9.1(e)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	layperson standard has been adopted in most government and commercial health coverage. Commenter opines that workers' compensation needs to provide for similar occurrences. While this is a situation that should not give rise to an independent medical review, commenter states that it needs to be incorporated into coverage provisions. Further, in the situation of a workplace injury, it may be the employer directing the employee to the emergency room to ensure that the employer is prudent in seeking appropriate care for an injured employee or when after hour care is needed.			
9792.6(h) 9792.6.1(j)	Commenter recommends adding the following sentence to the end of both of these subsections: *Or during an inpatient stay where discharge planning or transfer is pending review.* Commenter opines that to ensure that a discharge is not delayed while the case undergoes utilization review an expedited review should be used when there is the need for discharge planning for either home care or a	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	Disagree. The definition of "expedited review" was carried over from the existing UR regulations with no amendments made. That said, the determination of what should be handled on an expedited basis should be in the hands of the employee's physician. There is no indication that the employee's health is at serious risk in the proposed suggestion.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	step-down level of care.			
9792.6(h)	Commenter states that the definition of "expedited review" is too loose and should be tightened up. Commenter opines that there is already a conspiracy in the workers' compensation community to make the process as painful as possibly for employers by turning every request into an expedited review thereby running up costs.	Jason Schmelzer California Coalition on Workers' Compensation and California Chamber of Commerce April 4, 2013 Oral Comment	The definition of "expedited review" was carried over from the existing UR regulations with no amendments made. That said the definition corresponds with the express language of Labor Code section 4610(g)(2). The Administrative Director has no evidence of a conspiracy regarding invalid requests for expedited review.	No action necessary.
9792.6(q)	Commenter suggests the following paragraph be added to this section: ~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations), a written	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013	As noted above, to implement the timeframes for IMR set forth in Labor Code section 4610.5(a), it was necessary that section 9792.6 remain in effect and that a new 9792.6.1 be put in place for injuries on	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, ~~must~~ shall be set forth on the "Request for Authorization of Medical Treatment," DWC Form RFA, contained in section 9785.5. A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment. Commenter states that the Administrative Director may make the request for authorization form effective on a going-forward basis. Commenter opines that having a bright-line effective date that applies to all requests for authorization on a going-forward basis will simplify the process by having a single standard in place instead of two that depend on dates of injury and submission. If this recommendation is accepted, the standards that apply to requests will be clear to requesting physicians and	Written Comment	or after January 1, 2013, and for all injuries where a UR decision is communicated on or after July 1, 2013. While the Division recognizes that all treatment requests will now be under the requirements of new sections 9792.6.1, 9792.9.1, and 9792.10.1, the existing regulations, including the definition of a request for authorization, should remain in place to avoid confusion. At a later time it is anticipated that the regulation will be deleted.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	claims administrators alike, averting the confusion and disputes that will otherwise arise regarding which form is a request for authorization. Commenter states that if the Administrative Director adopts the DWC Form RFA on the effective date of the regulations, the first paragraph of (q) and the initial phrase in the second paragraph "~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations)," will not be necessary and may be deleted.			
9792.6.1(r)(3) – (6)	Commenter opines that clarification is needed for items 3 -5 as they sound similar and it is difficult to determine how they are different. Commenter also proposes that expert opinion should be defined to include the concept of peer reviewed articles or other qualifications versus the opinion of any provider in the specific field of medicine. Commenter states that (6) is of concern due to its broad wording. Commenter opine that this creates opportunity for abuse within the	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	The definition of "medically necessary" and "medical necessity" is taken from Labor Code section 4610.5(c)(2) and sets forth the standard that must be applied by an IMR reviewer when determining whether a requested medical treatment is medically necessary. The subdivision does not expressly provide that this standard must be applied to claims administrators when conducting UR. As such, it should be removed from this	Delete proposed section 9792.6.1(r) which defines "medical necessity."

	system and does not adequately consider the purpose of a medical necessity review as there is no requirement that the treatment have been proven to be effective for treatment of the condition. Instead it allows treatment if it is "likely to provide a benefit". Commenter opines that this subjects workers' compensation to payment of untried and experimental treatments that have not been proven to be effective or peer reviewed for safety and efficacy. Commenter states that it increases the risk of fraudulent and ineffective treatments proliferating within the workers' compensation industry. Commenter recommends that item 6 be removed or significantly narrowed and clarified.		section.	
9792.6.1 9792.6.1(z)	Commenter notes that this section does not include approvals in the definition of Utilization Review Decision. Commenter states that section 9792.6.1 (z) correctly defines the Utilization Review Process as including utilization management functions that prospectively, retrospectively or concurrently review	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	Agreed. The definition of "utilization review decision should be amended to include an approval.	Amend the definition of "utilization review decision" now at subdivision 9792.6.1(w) to include UR approvals.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	and **approve,** modify delay or deny treatment requests. However, the definition of Utilization Review Decision includes only decisions to modify, delay or deny requests for treatment. Commenter believes this is misleading as decisions to approve treatment clearly are part of the utilization review process and are a utilization review decision. Commenter recommends that the definition be modified to include "decisions to approve" treatment and that future sections using the definition be reviewed for potential impact. If the definition is not modified, commenter proposes that the state add a definition specific to "decisions to approve" to indicate they are decisions. This modification is necessary because later sections of the regulations, such as 9792.9(c)(3)(B) refer only to "a decision" and does not specify approvals. If a reader references back to the definition of Utilization Review Decision, they will only see that it includes decisions to modify, delay or deny. Commenter opines that additional information which this section deals with may also			

	be necessary in order for the reviewer to make a decision to approve a request as well.			
9792.6.1	Commenter recommends that the Division include a definition for "Treating Physician" within this section.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The definition of primary and secondary treating physician is found in section 9785.	No action necessary.
9792.6.1	Commenter recommends the following revision to the title of this section: **§ 9792.6.1. Utilization Review Standards—Definitions ~~– On or After January 1, 2013.~~** Commenter recommends the following revision to the first paragraph: The following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the ~~request for authorization of medical treatment~~ utilization review decision is ~~made~~	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Agreed. The first paragraph should conform to the statutory language.	Amend the first paragraph of section 9792.6.1 to reflect that the section applies to all dates of injury where the decision on the UR request is communicated to the requesting physician on or after July 1, 2013.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	communicated on or after July 1, 2013, regardless of the date of injury. Commenter states that if the Administrative Director deletes the currently proposed text for section 9792.6 as recommended and replaces it with the modified text in this section now numbered 9792.6.1, "On or After January 1, 2013" will need to be deleted from the description in the heading and references to the sections elsewhere in these regulations will need to be corrected.			
9792.6.1	Commenter concurs with the need for a standardized form as it relates to authorization requests and hopes that the use of this form will remove barriers to timely authorizations while protecting both the provider, payor and the injured worker in the process. Commenter states that the development, implementation and ongoing utilization of a standardized form has inherent costs associated with its use. Automation of forms within a physician practice management system is extremely costly , so much so, that often providers will choose the manual	Gregory M. Gilbert SVP Reimbursement & Governmental Relations March 15, 2013 Written Comment	The overriding purpose of the DWC Form RFA, as set forth in section 9785.5, is to reduce disputes between the requesting physician and the claims administrator over the nature of treatment requests such that number of requests for IMR may be reduces. The form, which only asks for CPT/HCPCS Codes if they are known, only requires basic identifying information and a plain statement of the treatment request. As such, the Administrative Director has determined that additional	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	approach which has its own obvious negative consequences, especially as the Division is moving towards as much electronic delivery of documents as possible. Commenter states that in order to mitigate these cost issues, many other States have assigned a fee for completion of required state forms. Commenter recommends that same consideration be contemplated for this new form. Commenter suggests a $15 fee. In addition, given the automation of these forms, commenter recommends that the Division allow for an electronic signature to be used or allow for "signature on file". Commenter opines that requiring the provider to have to stop and physically sign a document in this day of electronic health records certainly does not reduce the "hassle factor" that the Division has publicly stated they desire to reduce. Commenter states that will allow providers to take full advantage of system automation as well as electronic billing opportunities.		reimbursement for the form is not warranted. However, the Division, upon analysis of evidence and data, will revisit this determination in the future. Regarding electronic signatures, they may be used upon agreement of the parties.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter recommends that the Divisions allow for flexibility with respect to CPT/HCPCS that will may be required as part of the authorization request. Commenter stats that in some instances these CPT/HCPCS can be determined at the time of authorization but in many other cases it cannot because the Provider who is asking for Request for Authorization may not know the exact CPT or HCPCS that may be needed until the patient has been assessed. (e.g. physical therapy referral).			
9792.6.1(a)	Commenter notes that this definition includes "based on a completed Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5. Commenter opines that the inclusion of this language means that under the letter of the law as proposed, no authorization may be made for any request that is not found on a completed Form RFA. Commenter questions that if this means that if UR is conducted on a request that is not on a completed Form RFA; and found to	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	Agreed in part. Given the great shift in the request for authorization process made by these regulations, claims administrators should be given the option to accept non-conforming requests for authorizations.	Amend section 9792.9.1(c) to provide a claims administrator with an option to accept a request for authorization that does not utilize the DWC Form RFA.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	be medically necessary; that there is no assurance of appropriate reimbursement. Commenter suggests that reference to Form RFA be removed from this definition, such that authorization would be an assurance of payment no matter the form of the request.			
9792.6.1(a)	Commenter recommends the following revision: (a) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on a request for authorization and course of treatment ~~completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, that has been transmitted by the treating physician to the claims administrator~~. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8,	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The proposed regulations make the use of the DWC Form RFA (and now, a non-conforming request accepted by the claims administrator) a mandatory component of the UR process. For the purpose of clarity, the Division finds it necessary to state that a UR authorization should be based on a formal request under the regulations.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization for Medical Treatment," DWC Form RFA. Commenter states that the request for authorization and course of treatment are defined in (u) and (d).			
9792.6.1(a)	Commenter states that claims administrators have moved into a paperless and electronic environment. Commenter request that electronic mail be considered for transmitting medical records as there are now more secured methods available to do this.	Linda Slaughter Chief Claims Officer Athens Administrators April 4, 2013 Oral Comment	The Division has yet to determine that a uniform method for transmitting health records via e-mail, with necessary technical safeguards, exists such that their inclusion in the regulations would be appropriate. That said, the Division fully intends to further explore issues regarding the secure electronic transmission of health records and may propose changes to this definition in future rulemaking.	No action necessary.
9792.6.1(a)(a)	Commenter notes that this subsection defines "written" communication as paper or facsimile and adds that electronic mail may be used by "agreement of parties". Commenter opines that clarification is needed as to	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	Both the provider and the claims administrator must agree that communication can be made by e-mail. The Division does not feel it necessary to impose on the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	what" agreement" means. Would a simple "Notice to the physician" that claims office expects or accepts fax or email at specific address suffice? Must both parties sign the document? Should there be requirement that each party sending/receiving email or fax attest that secure systems are in use and access is secure? Commenter notes that the proposed regulation states that medical records "shall not" be transmitted electronically. Commenter opines that this broad statement opens confusion about definition of medical record which could include the UR decision that is currently faxed or emailed to the physician & applicant attorney office to facilitate timely care and cost containment. Commenter opines that electronic transmission via secure networks to the IMRO is the most timely and cost effective method of delivery. Commenter recommends that the phrase "shall not" be removed and creation of requirements for secure transmission of medical information be created.		parties a required method of agreement in this regard. See the above response to the comment about the use of e-mail. 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 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.6.1(aa)	Commenter states that as written the regulation does not allow for electronic transmission via electronic mail. Commenter opines that this is appropriate because email as widely implemented is an insecure transmission mechanism (the information is readable to anyone who intercepts the message). Commenter would like to stress that there are secure means of transmitting information (including via email). For example, the NIST has published a guide to electronic mail security (http://csrc.nist.gov/publications/nistpubs/800-45-version2/SP800-45v2.pdf) which includes specifications for encrypting electronic mail. There are also other electronic transmission mechanisms (e.g. emailing a link requiring authenticated log-in to a web site, electronic data interchange (EDI), etc.) that would preserve injured worker privacy while allowing the efficiency gains of electronic transmission. Commenter recommends revising this section as follows:	Raja Kapadia, CEO Healthonomy Inc. April 4, 2013 Written Comment	See the above response to the comment about the use of e-mail. While secure networks and encryption are in use, the Division has yet to determine a sufficient standard that would be appropriate for use in the regulations. The Division fully intends to further explore issues regarding the secure electronic transmission of health records, and may propose changes to this definition in future rulemaking	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	""Written" includes a communication transmitted by facsimile, paper, or secure electronic form. Electronic mail may be used by agreement of the parties. If an employee's health records are transmitted electronically, they must be transmitted via secure electronic means." Commenter also recommends that the DWC define secure as "authenticated and encrypted".			
9792.6.1(aa)	Commenter recommends the following revised language: (aa) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by prior written agreement of the parties ~~although an employee's health records shall not be transmitted via electronic mail~~. Commenter states that the parties that mutually agree to do so should be permitted to communicate in writing by electronic mail written agreement.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	See above response to comment regarding an "agreement." The Division does not feel it necessary to impose on the parties a required method of agreement in this regard.	No action necessary.
9792.6.1(b)	Commenter states that the following sentence in this subsection conflicts	Dennis Knotts March 24, 2013	The Division does not believe that the regulations of the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with Rule 2592.01 of the Department of Insurance: "Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities. Unless otherwise indicated by context, "claims administrator" also means the employer. Rule 2592.01 [Adjuster Certification Regulations] states: ... "Claims adjuster" does not include the medical director or physicians utilized by an insurer for the utilization review process pursuant to Labor Code section 4610." Commenter states that the Department of Insurance Regulations [which, he believes to have higher authority over the Administrative Rules and Regulations] created this Rule in 2006. Commenter opines that the purpose behind this Rule was to ensure than only a claim adjuster, who is certified by the Department of Insurance can make any decision on a	Written Comment	Department of Insurance conflict with the proposed regulation. It must be noted that: (1) Labor Code section 4610 does not distinguish between a claims administrator and any separate utilization review organization hired on the claims administrator's behalf; and (2) Labor Code section 4610(e) allows claims adjusters to approve requests for medical treatment. Only a physician may delay, deny, or modify a request.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	claim file that might eventually create a financial obligation for the employer. This Rule also specifically bars attorneys from assuming the status of claim adjuster. The intent was to clearly place decisions on claims files with Certified/Designated or Experience Claims Adjuster recognized under the Insurance Code promulgated by the Insurance Commissioner. Commenter opines that this subsection contradicts with an existing [and probably greater] legal authority and it is illegal to create this Rule until either Rule 9592.01 is amended to allow this re-defining of claims adjuster; or until the Administrative Director is given authority by the labor Code to over-ride the authority of the Insurance Commissioner.			
9792.6.1(b)	Commenter suggests the following revised language: (b) " Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Agreed in part. Including an employer in the definition of claims administrator may result in confusion in regard to the transmission of confidential health records. It is noted that Labor Code section 4610 does not distinguish between a claims	Amend the definition of "claims administrator" in section 9792.6.1(b) to delete the last sentence referencing the employer.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). ~~"Claims Administrator" includes UR organization under contract to provide or conduct the claims administrator's UR responsibilities. Unless otherwise indicated by context, "claims administrator" also means the employer. The claims administrator may contract with an entity to conduct its UR responsibilities.~~ Commenter is concerned that the inclusion of employer may lead to HIPAA protected records being sent to insured employers. Commenter believes that the description of the various categories of employer is adequately described at the beginning of this subsection. Commenter does not believe that the claims administrator definition should add entities not found in the definition of the term in other locations in the		administrator and any separate utilization review organization hired on the claims administrator's behalf.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Labor Code and Regulations.			
9792.6.1(b)	Commenter recommends the following revision: (b) "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). ~~"Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.~~ The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities. ~~Unless otherwise indicated by context, "claims administrator" also means the employer~~ The claims administrator stands in the shoes of the employer.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	As to the inclusion of an employer in the definition, see above response to comment regarding the subdivision. For the purpose of applying the utilization review regulations, the inclusion of a utilization review organization is appropriate. It is noted that Labor Code section 4610 does not distinguish between a claims administrator and any separate utilization review organization hired on the claims administrator's behalf.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that if the definition for claims administrator "also means the employer," documents and reports that include confidential medical information that must be submitted to the claims administrator pursuant to these UR and IMR regulations, may be sent to insured employers. This would be a violation of HIPAA and CMIA. The claims administrator is the entity that administers the claim. Commenter asks if it would suffice to clarify that the claims administrator stands in the shoes of an insured employer? If not, commenter states that the Administrative Director must add language that will prevent the submission of confidential medical information to an employer in violation of HIPAA or CMIA. Commenter opines that it is not necessary to include the utilization review organization in the "claims administrator" definition. A utilization review organization is not a claims administrator; it merely assists with a single aspect of a claim. Commenter states that retaining the current language is preferable, or alternatively a "utilization review			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	organization" could be separately defined. Commenter opines that documents may be inappropriately submitted to an employer or utilization review organization if either is defined as a claims administrator. If so, in addition to medical confidentiality breaches, this may delay medical treatment and other benefits, and trigger disputes and penalties.			
9792.6.1(d)	Commenter notes that the proposed definition for a "course of treatment" does not reference Form RFA. Commenter opines that this renders this definition inconsistent with the definition of "request for authorization" (subsection (u)).	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	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(d)	Commenter recommends the following revised language: (d) "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, found at California Code of Regulations, title 8, section 14006, or on the "Primary Treating Physician's	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	For a narrative report submitted as a regular progress report, section 9795(f)(8) requires that the report "must contain the same information using the same subject headings in the same order as From PR-2." Strict technical compliance with the format mandate of this section is unnecessary to support a	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Progress Report," DWC Form PR-2, as contained in section 9785.2 or in the equivalent narrative form containing the same information required in the DWC Form PR-2 as specified in section 9785(f). Commenter opines that adding the reference to section 9785(f) will clarify the requirements that apply.		request for authorization.	
9792.6.1(m)	Commenter opines that the definition of "immediately" has long been problematic, in that it creates process inconsistency between the DWC and the WCAB. The use of a 24-hour deadline requires staffing 365 days per year to insure compliance. Commenter states that in the performance of audits, the DWC has consistently used the next business-day standard. Commenter opines that the use of 24-hours creates situations where the DWC is satisfied; but the WCAB is not. UR notice may be simultaneously deemed to be timely by the DWC and untimely by the WCAB. Commenter opines that changing the time standard for the referenced actions to next business day satisfies the enforcement practices of the Audit Unit and	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	Agreed. The use of 24-hours may result in confusion regarding compliance. One-business day is a realistic definition of “immediately.”	Amend the definition of “immediately” in section 9792.6.1(m) to be within one business day.

	Medical Unit; and permits full compliance without requiring staffing 365 days per year.			
9792.6.1(r)	Commenter opines that it appears that the definition of "medical necessity" has been derived straight out of SB 863. Commenter opines that he wants a clearer definition since the last three evidence tiers of the MTUS are pretty nebulous.	Jason Schmelzer California Coalition on Workers' Compensation and California Chamber of Commerce April 4, 2013 Oral Comment	See above response to comment regarding the subdivision. The definition of "medically necessary" and "medical necessity" is taken from Labor Code section 4610.5(c)(2) and sets for the standard that must be applied by an IMR reviewer when determining whether a requested medical treatment is medically necessary. The subdivision does not expressly provide that this standard must be applied to claims administrators when conducting UR. As such, it should be removed from this section.	Delete proposed section 9792.6.1(r) which defines "medical necessity."
9792.6.1(r)(4) – (6)	Commenter opines that paragraphs 4 through 6 should be deleted. Commenter states that the UR hierarchy of evidence only includes the first three numbered categories of evidence as provided in Labor Code Sections 4600, 4610 (f) and 5307.27.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	See above comment regarding the subdivision.	No action necessary.
9792.6.1(r)(4)	Commenter recommends striking the	Brenda Ramirez	See above comment regarding	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
through (6)	current proposed language. Commenter states that pursuant to Labor Code sections 4600, 4610(f) and 5307.27, the standards for utilization review are those listed in (1), (2) and (3). Commenter opines that the additional, lower standards listed in (4), (5) and (6) apply to independent medical review pursuant to Labor Code section 4610.1(b)(2), but not to utilization review. Commenter states that if the Administrative Director does not delete these sections that the language be replaced so that the comply with the Labor Code section 5307.27 standards to be evidence-based, peer reviewed, and nationally recognized standards as follows: (4) Expert opinion that is based on evidence that is peer-reviewed and nationally recognized. (5) Generally accepted standards of medical practice that are nationally recognized, evidence-based, and published in peer-reviewed national journals.	Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	the subdivision.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(6) Treatments that are likely to provide a benefit to a patient, according to articles published in evidence-based, peer-reviewed and nationally recognized journals, for conditions for which other treatments are not clinically efficacious.			
9792.6.1(u)	Commenter has concerns regarding the required physician's signature on the "Request for Authorization for Medical Treatment (DWC Form RFA). Commenter notes that the Division of Workers' Compensation FAQS on UR for claims administrators in commenting on the type of signature required for an RFA indicates "the signature must be a written, original: a typed name without signature or a signature stamp is not sufficient. Electronic signatures have not yet been accepted in workers' compensation cases in California." Commenter states that the information provided in the FAQS for UR claims administrators strongly suggests that electronic signatures are not acceptable for completion of a request	Roman Kownacki, M.D., MPH, FOCOEM Chief, Occupational Medicine The Permanente Medical Group, Inc. March 29, 2013 Written Comment John T. Harbaugh. M.D., Physician Director Occupational Medicine The Permanente Medical Group, Inc. March 29, 2013 Written Comment Cyndy Larsen Kaiser Permanente April 4, 2013	Agreed in part. The use of electronic signatures is now common in many commercial settings, provided that the parties have sufficient means to verify signatures. The use of an electronic signature on the DWC Form RFA should be allowed provided the parties agree.	Amend the definition of "request for authorization," now subdivision (t), to allow electronic signatures by agreement of the parties.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	for authorization (RFA) in California workers' compensation based upon the lack of acceptance of electronic signatures in workers' compensation in California. Commenter requests that the Administrative Director Regulation 9792.6.1 (u) be modified to make it clear that electronic signatures are an acceptable form of completion of an RFA for purposes of complying with Labor Code § 4610. In his formal correspondence, commenter discusses his organizations electronic records security and protocol and opines that electronic signatures have long since reached a point where the reliability, efficiency and its safety of information is no longer an issue.	Oral Comment		
9792.6.1(u) 9792.9.1(a)	Commenter is concerned that the language in this subsection implies that the claims administrator may not consider, review or authorize any course of medical treatment that does not appear on the Form RFA. Commenter states that other proposed regulations on this subject permit the claims administrator to consider an	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	The Division envisions all treatment requests being made with the DWC Form RFA. However, given the great shift in the request for authorization process made by these regulations, the Division recognizes that claims administrators should be given	Amend section 9792.9.1(c) to provide a claims administrator with an option to accept a request for authorization that does not utilize the DWC Form RFA.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	incomplete form; but not a missing form. Commenter opines that if this was not DWC's intention, then some amendment should be made. Alternatively, commenter opines if this was DWC's intent, then the prohibition against considering a request that is not accompanied by the Form RFA should be made explicit. Commenter points out that the same absolute requirement appears is proposed 9792.9.1(a).		the option to accept non-conforming requests for authorizations.	
9792.6.1(u)	Commenter suggests the following revised language to the last sentence of this subdivision: The form must be signed by the physician and may be mailed, faxed or by agreement of the parties, e-mailed. Commenter opines that e-mail should not be utilized for sending time sensitive documents because staff may be out of the office for many reasons, some protracted, and incoming documents may go unnoticed as they cannot be accessed. The commenter requests that "by agreement" be added	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The subdivision should be read in conjunction with new subdivision (z), with provides that e-mail communication must be agreed upon by the parties. The Division will consider inserting this language within subdivision (t) in future rulemaking.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	as in subsection (a)(a) of this section to all such instances where e-mail is included as a means of communication.			
9792.6.1(u)	Commenter recommends the following revised language: "Request for authorization" means a written request for a specific course of proposed medical treatment. A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," accompanied by the Doctor's First Report or Primary Treating Physician's Progress Report, completed by ~~a~~ the treating physician, as contained in California Code of Regulations, title 8, section 9785.5. "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the form must identify the type of request by checking the appropriate box; ~~both~~ the employer; the employee as well as claim number or dates of birth and injury; ~~and~~ the provider, provider type, specialty, contact information; and identify with specificity ~~a~~ the recommended treatment or treatments. The form	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Agreed in part. The DWC Form RFA, set forth at section 9785.5, lists the types of supporting documentation that must be included with a request for authorization. It is unnecessary to repeat the list in this regulation. Further, a treatment decision can be made with identifying information for the employee and the requesting physician, a specific description of the treatment request, and supporting documentation. To delay treatment based on the failure to provide a date of birth, for example, is unreasonable. That said, a request for authorization should be communicated to the correct address; the claims administration should have the opportunity to designate the address or fax number.	Amend definition of "request for authorization," now subdivision (t) to allow the claims administrator to designate an address, fax number, or e-mail address for sending the request.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	must be signed by the physician and ~~may~~ shall be submitted to the fax number, mailing address, or email address designated by the claims administrator. Commenter opines that the added elements are also necessary and that fields that are not necessary should be removed from the form. Commenter states that forms sent to an inappropriate fax number, mail address or email address result in unnecessary delays for the injured employee, claims administrator, and provider.			
9792.6.1(u)	Commenter notes that this subsection allows submission of RFA via mail, fax or email. Commenter opines that this definition should clarify that use of email must meet requirements of 9792.6.l(aa) as she commented previously.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	The subdivision should be read in conjunction with new subdivision (z), with provides that e-mail communication must be agreed upon by the parties. The Division will consider inserting this language within subdivision (t) in future rulemaking.	No action necessary.
9792.6.1(w)	Commenter notes that the proposed subsection (w) proposes to define reviewer as *"a medical doctor. doctor of osteopathy. psychologist, acupuncturist. optometrist, podiatrist,*	Lisa Folberg Vice President Medical & Regulatory Policy California Medical	Labor Code section 4610 does not contain a provision requiring that a claim administration, when performing UR, give	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	or chiropractic practitioner licensed in any state or the District of Columbia .... " (emphasis added). Commenter states that Labor Code§ 139.5(d)(4)(B), which was added by SB 863, requires that the IMR organizations give a preference to reviewers licensed in the State of California. This preference is very important as utilization review is the practice of medicine and should be governed by state law and the Medical Board of California. Commenter recommends that this new subsection (w) should be amended to reflect this preference. A new sentence could be appended to the end of the new subsection to read: *"Preference shall be given to the use of practitioners licensed in the State of California.* " Commenter opines that the regulation should also provide guidance for the IMR organizations about how that preference should be administered. Commenter strongly recommends that IMR organizations only utilize out-of-state practitioners if there is not a	Association March 13, 2013 Written Comment David Ford California Medical Association April 4, 2013 Written Comment	preference to a reviewer licensed in California. Merit aside, the Division has no authority to impose this requirement. Labor Code section 139.5(d)(4)(B) requires the IMRO to "give preference to the use of a physician licensed in California as the [IMR] reviewer." Beyond statutory mandate, the relationship between the Administrative Director and the IMRO is contractual and not regulatory. See Labor Code section 139.5(a).	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	California-licensed practitioner who is knowledgeable about the requested treatment who is available in the required timeframe. Commenter opines that this would severely limit the use of physicians who are not licensed by California's Medical Board.			
9792.6.1(x)	Commenter opines that the definition of "Utilization review decision" should include the approval of a request for authorization. Approval of a treatment request, by either a claims administrator or a reviewing physician, is utilization review.	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	Agreed. The definition of UR decision should include an approval.	Amend new subdivision (w) to reinstate "approve."
9792.6.1(x)	Commenter recommends the following revised language: (x) "Utilization review decision" means a decision pursuant to Labor Code section 4610 to prospectively, concurrently, or retrospectively modify, delay, or deny a request for authorization, based in whole or in part on medical necessity to cure or relieve~~, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services~~ pursuant to Labor Code sections 4600 or 5402(c).	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The proposed definition in new subdivision (w) is sufficiently clear to accurately convey the meaning of the term.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that the request for authorization is defined in (u).			
9792.6.1(z)	Commenter is concerned about the following sentence: "Utilization review does not include determinations of the work-relatedness of injury or disease." Commenter states that the intent of this sentence is understood, but opines that in the context of the proposed definition of claims administrator, this creates significant process confusion. Since the "claims administrator" specifically includes the URA; and the claims administrator may dispute liability; it follows that the URA may issue a dispute of liability rather than complete UR. Commenter opines that this section should be amended to indicate that the URA may issue a dispute of liability based on causation in lieu of UR; or the definition of claims administrator should be amended to exclude the UR agent.	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	Agreed. While the primary focus of the utilization review process is to determine the medical necessity of recommended treatment, it may also involve identifying whether a dispute over liability occurs. The proposed language excluding liability disputes is overbroad and should be deleted.	Amend the definition of "utilization review process" at the new subdivision (y) to delete the provision that UR does not determine the work relatedness of the injury.
9792.9	Commenter recommends the following revised language: **9792.9. Utilization Review**	Brenda Ramirez Claims and Medical Director California Workers'	The regulation takes into consideration, for injuries occurring prior to January 1, 2013, utilization review	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Standards--Timeframe, Procedures and Notice Content – For Injuries Occurring Prior to January 1, 2013, Where the Utilization Review Decision ~~Request for Authorization~~ is Communicated ~~Made~~ Prior to July 1, 2013. This section applies to ~~any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for~~ an occupational injury or illness occurring prior to January 1, 2013 where the utilization review decision ~~request for authorization~~ is ~~made~~ communicated prior to July 1, 2013.	Compensation Institute (CWCI) April 4, 2013 Written Comment	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.	
9792.9(b)(1) 9792.9.1(b)(1)	Commenter notes that these sections have been modified to eliminate the need for the claims examiner to repeatedly respond to situations involving disputed claims or body parts. However, the current statement includes the addition of the words "specific course of treatment." Commenter opines that this seems to imply that different treatment plans would require additional objections each time. Commenter suggests that those words be deleted.	Linda Slaughter Chief Claims Officer Athens Administrators April 4, 2013 Oral Comment	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 (see (b)(1)(C) would preclude the submission of marginally different or related requests for	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			authorization by the provider.	
9792.9(b)(1)	Commenter recommends the following revised language: (1) If the claims administrator disputes its liability for the requested medical treatment under this subdivision, it may, no later than five (5) business days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment, unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review ~~for a specific course of treatment~~. Commenter opines that a single written deferral notice pursuant to Labor Code sections 3751(b) or 138.4 and CCR sections 9811 or 9812(i) will suffice.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	See the above response to the comment regarding this subdivision.	No action necessary.
9792.9(b)(1) and 9792.9.1(d)(5	Commenter notes that RFA objections for any and all non-medical disputes- in the emergency regulations require the claims examiner to respond to each and every RFA in some manner within 5 days. Commenter notes that the proposed final regulations soften	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	See the above response to the comment regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	this a bit saying no response to physician requests is required if previously notified about the dispute BUT it says for a "specific course of treatment". So if the physician sends RFA each week or even slightly different treatments to the same disputed body part we must send the same notice each week. Commenter recommends that the division remove the phrase "specific course of treatment" from 9792.9(b)(l)so that any and all treatment for the disputed issue would require only one (1) notice of dispute.			
9792.9(b)(2) 9792.9.1(b)(2)	Commenter states that these rules define when Utilization Review must start if UR is deferred because the claims administrator disputes liability for the claim or the treatment. Commenter opines that the rule is confusing regarding when the claims administrator must begin UR *for the treatment request that has been deferred*. The proposed language provides that the time period starts for a retrospective UR when the determination of liability becomes final, and that the time period for prospective UR starts with the receipt	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	The language of the subdivision follows the express language of Labor Code section 4610(g)(8). There is no timeframe by which the parties must resolve a liability dispute. The Legislature recognized that, given the varying timeframes, a new request for authorization should be submitted to account for a change in the employee's condition. Absent a demonstrated need, a new form, adding a level of	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	of a new RFA. Commenter states that it is unclear when the time period starts *for the deferred RFA*. That RFA was only *deferred*, it was not invalidated or otherwise annulled. Commenter request that the rule be clarified that the time period for UR on the deferred RFA starts when the determination of liability becomes final. Commenter opines that not only would it be unreasonable to require that this deferred RFA be resubmitted, as the requesting physician will have no way to know when the determination of liability becomes final, but such a requirement violates the entire intent of IMR – assuring the speedy resolution of treatment disputes. Commenter recognizes that deferral of UR is permitted, but the procedures established through these regulations must insure that the process is as expeditious as possible, regardless of any deferral. Commenter suggests that one way to assure that the claims administrator complies with the statutory time requirements is by creation of a new form to be completed by the claims administrator		complexity to this circumstance, is not necessary.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that documents the dates when the RFA was received, when the notice of deferral was sent to the employee, and when the liability determination became final. This form could be required to be provided to the employee within one working day of the date the determination of liability becomes final. Commenter opines that this will help reduce litigation by placing all parties on notice of the pertinent dates in the statutory UR timeline, and will also provide documentary evidence for the Division's audit unit of the claim adjuster's compliance with these timelines.			
9792.9(b)(2) and 9792.9.1(b)(2)	Commenter notes that the statutory changes allow a claims administrator to defer a decision on the medical necessity of requested treatment where there is a dispute over the liability for the treatment. Commenter opines that this cost-savings measure was intended to save UR costs for treatment that may or may not be the responsibility of the employer. Commenter states that the regulations require the claims administrator to commence retrospective review of all deferred treatment requests where	Peggy Sugarman Director of Workers' Compensation City and County of San Francisco April 4, 2013 Written Comment and Oral Comment	See above response to the comment regarding this subdivision. In the absence of evidence showing abuse or confusion regarding the application of this provision, the parties should be given flexibility as to the best manner by which to submit a deferred treatment request following a finding of liability.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	liability is finally resolved in favor of the employee. Commenter notes that this mirrors the statutory language in Labor Code section 4610. Commenter opines that there is some room for interpretation so as to prevent needless reviews that do not make sense in light of the employee's current condition. Commenter states that disputes on liability may not be resolved for extended periods of time. The prior treatment requests may no longer be applicable, or believed necessary by the treating physician. Commenter suggests that the division allow employers two options. First, employers could immediately request and review a treatment plan for the newly accepted body part that can be timely reviewed on a prospective basis - a process that is more efficient than requiring the employee to wait another 30 days for a decision on treatment recommendations that may no longer make any sense. Alternatively, employers could conduct retrospective review of the treatment requests n submitted within the past 60 days. In either case, retrospective review should be conducted on any treatment			

	that had already been provided to ascertain whether the employer is liable for payment.			
9792.9(f)	Commenter recommends adding the following as number (3) to this subsection: *(3) During an inpatient stay where discharge planning or transfer is pending review.* Commenter opines that to ensure that a discharge is not delayed while the case undergoes utilization review an expedited review should be used when there is the need for discharge planning for either home care or a step-down level of care.	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	The regulatory language of this subdivision was not amended. That said, the determination of what should be handled on an expedited basis should be in the hands of the employee's physician. There is no indication that the employee's health is at serious risk in the proposed suggestion.	No action necessary.
9792.9(h)(2)	Commenter states that this subsection provides that a worker can file for an expedited hearing if there is a "bona fide dispute relating to his entitlement to medical care." The worker cannot file for an expedited hearing until after the UR denial is resolved by way of an AME or PQME report. Commenter states that the only time a worker can file for an expedited hearing prior to getting an AME or PQME report is when the UR was	John Don February 20, 2013 Written Comment	Outside of indicating the current form, the regulatory language of this subdivision has not changed from the prior version. That said, the section is no longer in effect; a further amendment is not necessary.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	done improperly. Commenter opines that the regulations should make this clear. Commenter recommends that the language state that "if the injured worker believes that a bona fide dispute exists related to the carrier's compliance with the UR regulations when denying and/or modifying care the worker or his attorney may file for an expedited hearing to challenge the way that the UR was conducted."			
9792.9(k)	Commenter recommends the following revised language: (k) A written decision modifying, delaying or denying treatment authorization under this section, when the decision is communicated prior to July 1, 2013, shall be ~~provided~~ communicated to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information: Commenter recommends the term "communicated" because that is the term used in the statute.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The language of the subdivision is sufficiently clear. That said, the section is no longer in effect; a further amendment is not necessary.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9(k)(7) 9792.10(4)	Commenter notes that both of these sections reference Declaration of Readiness – DWC-CA form 10208.3. Commenter states that the DWC website provides the DWC-CA form 10252.1 as the form for Declaration of Readiness to Proceed to Expedited Hearing (Trial). Commenter recommends that the form number be verified and that the regulations be corrected throughout if the incorrect form number has been used or if the correct form number has been used that the DWC forms library be updated with the correct form.	Bennett L. Katz Assistant General Counsel and Vice President Regulatory Affairs The Zenith April 4, 2013 Written Comments	The form as cited in the subdivision is correct. The Division must update its website to reflect the current forms.	No action necessary.
9792.9(*l*)(9)	Commenter stresses the importance of making it clear to injured workers that they are giving up their rights to IMR if they don't make a filing within 30 days since the injured worker who may elect to participate in an internal review may not understand this. Commenter gave the Division an example of a jury summons that is in large font and highlighted in red to illustrate that the notice required in this subsection should be overt and clear to be certain to alert the injured worker of their rights.	Mark Gerlach California Applicants' Attorneys Association April 4, 2013 Oral Comment	The Division finds that the language required in the proposed regulations is sufficient to advise an injured worker about their IMR rights. If IMR data collected as the program matures indicates that injured workers are failing to seek IMR based on confusion over their options, the Division may revisit this language in future rulemaking.	No action necessary.
9792.9(l)	Commenter states that according to the introduction of section 9792.9, this	Mark Gerlach California	The section accounts for the possibility that a request for	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	subdivision applies only to requests for authorization for injuries occurring before 1/1/13 where the request is made before 7/1/13. Commenter opines that it is inconsistent to include in this section proposed new subdivision (l) which states that it applies to written decisions "modifying, delaying or denying treatment authorization under this section, sent on or after July 1, 2013."	Applicants' Attorneys Association April 3, 2013 Written Comment	authorization sent before 7/1/2013 could be decided or after that date. Under Labor Code section 4610.5(a), this decision could be subject to IMR.	
9792.9(l)	Commenter recommends the following revised language: (*l*) A written decision modifying, delaying or denying treatment authorization under this section, ~~sent~~ communicated on or after July 1, 2013, shall be ~~provided~~ communicated to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information: Commenter recommends the term "communicated" because that is the term used in the statute.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The language of the subdivision is sufficiently clear. That said, the section is no longer in effect; a further amendment is not necessary.	No action necessary.
9792.9(l)(6)	Commenter recommends the following revised language:	Brenda Ramirez Claims and Medical Director	Agreed in part. As the section is no longer in effect a further amendment is not necessary.	Amend section 9792.9.1(e)(5)(G) to require that the

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(6) The Application for Independent Medical Review, DWC Form IMR, with all fields completed by the claims administrator, except for the signature of the employee and date signed, ~~to be completed by the claims administrator~~ shall be provided to the employee. The written decision provided to the injured worker~~, and if the injured worker is represented by counsel, the injured worker's attorney~~ shall include an addressed envelope, which may be postage-paid, for mailing the DWC Form IMR to the Administrative Director or his or her designee. Commenter states that there is not statutory authority for requiring an addressed envelope for the employee's attorney. There is only statutory authority requiring the form to go to the employee and to include an addressed envelope.	California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	That said, section 9792.9.1(e)(5)(G) will be amended to remove the requirement that the addressed envelope be provided to the injured worker's attorney.	addressed envelope only be provided to the injured worker.
9792.9.1	Commenter recommends the following revised language: **§9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – For Injuries Occurring On or After January 1, 2013.**	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Agreed. The trigger is the date the UR decision is communicated. The first paragraph should be amended to revert back to the original emergency regulation text.	Amend the first paragraph of section 9792.9.1 to indicate that the section applies to all dates of injury where the UR decision is communicated after

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	This section applies to ~~any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either~~: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the ~~request for authorization~~ utilization review decision is ~~made~~ communicated on or after July 1, 2013, regardless of the date of injury. Commenter opines that the trigger is the date a utilization review decision is communicated, rather than the date a request for authorization is made.			July 1, 2013.
9792.9.1	Commenter recommends that the Division administer and online, time of service, treatment authorization program with quality oversight provided by the Board of Medical Quality Assurance. Commenter opines that the patient should be able to walk out of the medical office already scheduled for the physical therapy, MRI, specialist consult or whatever treatment that may be appropriate. Commenter states this would be fast, efficient and get the insurance companies out of the conflict of interest about what agency	Jeffrey Stevenson, M.D. April 4, 2013 Written Comment Irv Hirsch April 4, 2013 Written Comment	While an on-line authorization process may be beneficial and ultimately cost-effective, it is not mandated by statute.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	or M.D. to send a request to in order to get it denied.			
9792.9.1(a)(1)	Commenter states that e-mail should not be utilized for sending out time sensitive documents unless agreed to by the parties – staff may be out of the office for many reasons, some protracted, and incoming documents go unnoticed because they cannot be accessed.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The subdivision should be read in conjunction with proposed section 9792.6.1(z), with provides that e-mail communication must be agreed upon by the parties.	No action necessary.
9792.9.1(a)(2)(C)	Commenter recommends adding "business" before days in this subsection. Commenter states that with this proposed change, this subsection will conform to subsection (a)(2)(A). Commenter opines that there may be occasions, however, where the document is sent long after the last date.	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Five calendar days, rather than business days, is reasonable given the complete absence of information as the when the request was mailed or received. A goal of UR is to expedite necessary medical treatment. If the document could be mailed long after the last date the sender wrote on the document, the Division questions whether the treatment request is, in fact, still valid.	No action necessary.
9792.9.1(a)(2)(C)	Commenter recommends the following revised language: C) In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013	See the above response to the comment regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	received by the claims administrator five days after ~~the latest date the sender wrote on the document~~ mailing. Commenter opines that the document could be mailed long after the last date the sender wrote on the document.	Written Comment		
9792.9.1(b)(1)	Commenter recommends the following revised language: 1) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment, unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review ~~for a specific course of treatment~~. Commenter opines that a single written deferral notice pursuant to Labor Code sections 3751(b) or 138.4 and CCR sections 9811 or 9812(i) will suffice.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	See above comment to section 9792.9(b)(1). 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 is necessary.
9792.9.1(b)(1)(D)	Commenter recommends the following revised language:	Brenda Ramirez Claims and Medical	The language is reasonable. The employee, either acting on	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	A plain language statement advising ~~the injured employee~~ that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board. Commenter opines that this advice is not only for the employee, but also for the provider and applicant attorney.	Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	their own or with the assistance of counsel, would be a party to any action seeking to resolve the liability dispute.	
9792.9.1(c)(1)	Commenter recommends the following revised language: The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA when counting calendar days, and the first business day after the receipt of the DWC Form RFA when counting business days, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA. Commenter opines that when counting business days, the business day	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Timeframes for issuing prospective and concurrent UR decisions are measured in business days. Expedited and retrospective reviews are measured in calendar days. These have no bearing on what should be considered the actual day of receipt.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	number one is the first business day after receipt.			
9792.9.1(c)(2)	Commenter suggests the following revised language: "If the DWC Form RFA does not identify the employee or provider, does not identify a recommended treatment with some level of specificity, is not attached to the Doctors First Report of Injury, a PR 2 or Narrative Report, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 ~~or reviewer~~ must either treat the form as complete and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete" no later than five (5) business days from receipt." Commenter opines that the non-physician reviewer may treat the incomplete RFA as complete or return it to the requesting physician, but are still concerned with the absence of any specificity to the request. According to the proposed regulation an RFA could be treated as complete with the following information: Employee-Jon	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	Agreed in part. A complete DWC Form RFA should include documentation substantiating the need for treatment. The subdivision should be amended to include the provision of documentation for a complete form. A specific treatment request is required on the form itself. If a treatment request cannot be discerned from the form, it should be returned as incomplete.	Amend section 9792.9.1(c)(2) to provide that a DWC Form RFA is not complete if it does not include documentation substantiating the medical necessity for the requested treatment.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Doe; Provider-John Smith, M.D.; Recommended Treatment-Open Heart Surgery. Commenter feels certain that this extreme example would be returned to the physician as incomplete, but opines that for a less serious condition inadequate specificity could well be passed over by the unwary.			
9792.9.1(c)(2)	Commenter recommends the following revised language: If the DWC Form RFA does not identify the employee, employee's claim, ~~or~~ provider, provider type and specialty and contact information, ~~does not identify a~~ specific recommended treatment~~,~~; or is not signed under penalty of perjury by the requesting physician~~,~~; or is not submitted together with a substantiating Doctor's First Report Form or Primary Treating Physician's Progress Report, a non-physician reviewer as allowed by section 9792.7 or reviewer must either treat the form as complete and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete" no later than five (5)	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Regarding the attachment of documents substantiating the need for the requested treatment, see the response to the above comment regarding this subdivision. As to the other specific data required on the form, see the response to the comment regarding section 9792.6.1(u). A goal of UR is to expedite necessary medical treatment; identifying information regarding the employee and the provider should be sufficient to initiate the UR process.	No action necessary.

	business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA. Commenter opines that the added information is also necessary.			
9792.9.1(c)(4) and (d)(2)	Commenter requests that where the timeframe is stated in hours that the division clarify that expedited requests for UR or IMR sent on Friday afternoon must be extended to the next business day to respond.	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	The requirement is statutory. See Labor Code section 4610(g)(2) and (3)(A).	No action necessary.
9792.9.1(c)(3)(B)	Commenter states that this subparagraph establishes the process under which a reviewer may request additional information in order to render a decision on a Request for Authorization. Although this subparagraph is a re-adoption of a current rule, commenter believes the implementation of the new Independent Medical Review process requires substantial revision to this rule. Under the IMR process, both the statute and the proposed rules specify in detail information that must be provided to the IMRO by the claims	Mark Gerlach California Applicants' Attorneys Association April 3, 2013 Written Comment	The Division agrees that the UR reviewer should have in their possession all documentation necessary to made a medically necessity determination on a requested treatment, and to the extent that a claims administrator has that information, the information should be transferred to the reviewer. That said, Labor Code section 4610(g)(1) and (2) expressly places the burden of providing that information on the requesting physician. A complete request for	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	administrator. The purpose of this requirement is to make certain that the process can be completed expeditiously, providing a quicker resolution of the medical dispute and allowing the case and the worker to move forward. Faster resolution of medical disputes represents the classic "win – win" situation, getting a quick decision to the worker and holding down costs for the employer. Commenter opines that there is no similar requirement in either the current or proposed rules that sets out the information that must be provided to a UR reviewer. The provision in this particular subparagraph provides a mechanism under which the reviewer can request submission of additional medical information, but commenter opines that this is akin to closing the barn door after the horses are already out. Commenter states that the goal of these rules should be to assure that the reviewer receives all needed medical information when he or she first receives the RFA for review. The proposed rules applicable to the RFA do specify that the requesting		authorization with all necessary supporting documentation is the best manner in which to expedite treatment.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	physician must provide "as an attachment documentation substantiating the need for the requested treatment." Commenter understands that the requesting physician has primary responsibility for providing all necessary documentation substantiating the request, and the commenter's organization will work with the medical community in outreach and educational efforts to make certain this responsibility is understood by treating physicians. Commenter states that in case after case, his organization's members find that a treatment request has been denied because the information needed by the UR reviewer – information that is in the possession or under control of the claims administrator – simply has not been provided to the reviewer. Commenter recommends that section 9792.9.1 be amended to include a new rule requiring that when a RFA is sent to a utilization reviewer, the claims administrator must attach to that document all relevant medical information necessary to make a			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	determination on the request in the possession of or under the control of the claims administrator. Commenter opines that adoption of this new rule will make the UR process consistent with the IMR process and that the failure to coordinate these two processes will seriously cripple one of the main goals of SB 863 which was to speed up the resolution of medical disputes.			
9792.9.1(c)(4)	Commenter opines that this timeliness requirement is poorly crafted, and has created many difficulties at the WCAB. Because there is no explicit extension of timelines for an information request; and no deadline for sending one; the WCAB's position has consistently been that any decision on a retrospective request made more than 30 days after receipt of request is untimely; even if there was insufficient information. Commenter opines that this results in a de facto 30-day completion deadline. In instance where the claims adjuster takes almost 30 days to send the request to the UR agent; and written request for information is sent; the UR	Robert W. Ward Clinical Director CID Management April 4, 2013 Written Comment	The requirement that a retrospective review be completed within 30 days of receipt of information that is reasonable necessary to make a determination is statutory, see Labor Code section 4610(g)(1), and the new subdivision (c)(5) should reflect this mandate. Subdivision (f)(3) allows a claims administrator to issue a denial within 30 days of a request for retrospective review is information requested from a physician is not provided.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	agent is forced to complete the review without giving the provider time to respond. Commenter opines that this is not in the interest of any stakeholders, and does not serve the injured worker or the provider well. Commenter states that these problems can be corrected by adding to the regulatory requirements: A) an explicit 30-day deadline for retrospective review completion when there is no additional information requested; and B) a limited completion extension process on request for information; modeled after the process used for prospective/concurrent review.			
9792.9.1(d)(3)(B)	Commenter recommends the following revised language: 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), shall be deemed a retrospective approval, even if a	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	The language of the subdivision implements the statutory mandate of Labor Code section 4610(g)(1). The language questioned by the commenter merely states that any document indicating a payment has been made for a treatment is sufficient acknowledgment of retrospective approval.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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 the receipt of partial payment cannot stand independently as approval. An acknowledgement of approval is necessary to ensure protection from take-backs later. Commenter states that the receipt of a partial payment should be deemed an approval and if the claims administrator requests a take-back for the funds the timing of the take-back notice should serve as an extension for the timeliness for filing an IMR.			
9792.9.1(d)(4)	Commenter recommends the following revised language: (d) Decisions to approve a request for	Brenda Ramirez Claims and Medical Director California Workers'	The provisions of subdivision (d)(3) address the manner in which a retrospective approval is communicated. It does not	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	authorization.: (4) Unless (d)(3) is applicable, rRetrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the medical information that is reasonably necessary to make this determination. Commenter states that Section 9792.9.1(d)(3) deems any timely payment or partial payment of a medical bill for services requested retroactively on the DWC Form RFA to be a retrospective approval.	Compensation Institute (CWCI) April 4, 2013 Written Comment	affect the 30-day timeframe in which a decision must be made.	
9792.9.1(e)(4)	Commenter recommends the following revised language: Unless (d)(3) is applicable, for For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of information that is reasonably necessary to make this determination.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The provisions of subdivision (d)(3) address the manner in which a retrospective approval is communicated. It does not affect the 30-day timeframe in which a decision must be made.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that section 9792.9.1(d)(3) deems any timely payment of a medical bill for services requested retroactively on the DWC Form RFA to be a retrospective approval.			
9792.9.1(e)(5)	Commenter recommends the following revised language: The written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, ~~the injured worker's representative,~~ and if the injured worker is represented by counsel, the injured worker's attorney and shall only contain the following information specific to the request: Commenter states that the injured worker may not designate a representative before the receipt of the decision pursuant to Labor Code section 4610.5(j).	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Disagree. An injured worker has the right to be represented by an attorney in the workers' compensation claim and appeal process. See, for example, Labor Code section 5700. Many injured workers have legal representation while they are receiving medical treatment for their occupational injuries; to require an additional designation by the employee for their attorney after a utilization review decision issued would be superfluous. It is telling that the statutory provision requiring the designation, Labor Code section 4610.5(j), does not mention attorneys as a party that an employee would designate to act on their behalf during the IMR process. This	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			striking absence may reflect a Legislative intent that represented employees and their attorneys are subject to the subdivision's mandate. That said, proposed section 9792.10.1(b)(2)(A) does require that a notice of representation or other written designation confirmation representation accompany the IMR application.	
9792.9.1(e)(5)(G)	Commenter requests that an additional sentence be added to the end of this subsection that states: "The addressed envelope need only be provided to the employee." Commenter states that newly added Labor Code §4610.5(f) states, "As part of its notification to the employee regarding an initial utilization review decision that denies, modifies, or delays a treatment recommendation, <u>the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope,</u>	Steve Kline, Esq. General Counsel EK Health Services April 3, 2013 Written Comment	Agreed; the Labor Code section only provides that the injured worker be provided with an addressed envelope. Section 9792.9.1(e)(5)(G) will be amended to remove the requirement that the addressed envelope be provided to the injured worker's attorney.	Amend section 9792.9.1(e)(5)(G) to require that the addressed envelope only be provided to the injured worker.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review." (underline added) Commenter states that the emergency regulation 8 CCR §9792.9.1 (e)(5) states, "The written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney and shall only contain the following information specific to the request: … (G) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator. The application, set forth at section 9792.10.1, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee." (underline added) Commenter opines that the statute			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	states clearly that for the IMR application only the employee is to be provided with addressed envelope to the DWC while the regulation mandates that not the employee, but the requesting physician, the injured worker's representative, and if necessary the injured worker's attorney shall be provided with that envelope. Commenter opines that the conflict between the statute and the emergency regulation must be revised in the final regulations in favor of the statutory mandate. Most UROs and Claims administrators provide the information mandated by facsimile, or by email in order to expedite their knowledge of the utilization review decision. By changing it to a regular post, so that an envelope is provided to all persons listed in the regulation slows the process and is a severely increased cost for the URO and/or the claims administrator.			
9792.9.1(e)(5)(G)	Commenter recommends the following revised language: G) The Application for Independent Medical Review, DWC Form IMR,	Brenda Ramirez Claims and Medical Director California Workers' Compensation	See response to above comment regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with all fields, except for the signature of the employee, to be completed by the claims administrator.~~.~~ The written decision provided to the injured worker ~~, and if the injured worker is represented by counsel, the injured worker's attorney,~~ shall include an addressed envelope, which may be postage-paid, for mailing the DWC Form IMR to the Administrative Director or his or her designee. Commenter opines that there is no statutory authority for requiring an addressed envelope for the employee's attorney. Commenter states that there is an unnecessary period and space on the second line.	Institute (CWCI) April 4, 2013 Written Comment		
9792.9.1(e)(5)(G)	Commenter opines that it is not clear whether or not a copy goes to the applicant attorney if they are represented. Commenter requests that the language be clarified.	Debra Russell Schools Insurance Authority April 4, 2013 Oral Comment	See above response to comment regarding this subdivision.	No action necessary.
9792.9.1(e)(5)(J)	Commenter opines that although the language of this subparagraph has been amended to provide that the notice of voluntary internal UR must tell the worker that this process does	Mark Gerlach California Applicants' Attorneys Association	The Division finds that the language required in the proposed regulations is sufficient to advise an injured worker about their IMR rights.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	not "delay" the 30 day time limit for requesting IMR, this change by itself may not be sufficient to protect employees. Commenter states that the worker will lose all right of appeal if the 30 day time limit for requesting IMR is not met. If the claim administrator offers a voluntary internal UR, the rules should require that notice of the 30 day deadline be prominently featured using a large, bolded, or colored font.	April 3, 2013 Written Comment	If IMR data collected as the program matures indicates that injured workers are failing to seek IMR based on confusion over their options, the Division may revisit this language in future rulemaking.	
9792.9.1(e)(H) and 9792.10.1.(b)(1)	Commenter states that there is a conflict between these two subsections with respect to when the Application for Independent Medical Review is sent. 9792.9.1(e)(H) states that an objection to the UR decision must be communicated on the enclosed Application for Independent Medical Review within 30 calendar days of receipt for the decision; whereas 9792.10.1(b)(1) states that it must be communicated to the Administrative Director within 30 days of service of the utilization review decision. Commenter points out the difference between the terms “service” and “receipt.” Commenter opines that the five day extension for mailing can post a practical problem because of	Brittany Rupley Defense Attorney April 4, 2013 Oral Comment	The intent of the subdivision (e)(5)(H) was to advise the injured worker in simplest terms possible about the deadline for filing the IMR application. Since the 5-day mailing period would run from the data the UR decision was mailed, it would be imperative that the IMR application be mailed within 30 days of receipt. That said, the Division understands that the regulation, as written, may result in some confusion on the part of claims administrators and therefore may revise the provision in future rulemaking.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the different times in which the date of service of the UR can be, which is different than the date of the receipt of the actual decision.			
DWC Form IMR	Commenter states that the form that is being provided to the injured worker when a request for treatment has been denied or modified only indicates the date of the UR and not what the request for treatment was. Often there are several UR request on the same date and it causes confusion. Commenter states that the instructions to the injured worker indicate that they are responsible for sending "relevant medical records as defined by California Code of Regulations to the IMRO" and it says that the IMRO may request records directly from the treating physician. Commenter is unclear if this negates the claims administrator from providing those records. Commenter opines that it is inappropriate for the IMRO to have more information than may have been provided to the UR company and she believes that the exact information used in making the original	Cathy Aguilar Cost Containment Manager Workers' Compensation Claims March 29, 2103 Written Comment	IMR is triggered by a UR decision, not by the treatment request. Labor Code section 4610.5(d). The Division notes that related treatment decisions can be consolidated under proposed section 9792.10.4(a). The ability of the parties to submit documents to the IMRO is a statutory requirement. See Labor Code section 4610.5(f)(3) and (*l*). The IMR process was established by the Legislature to create an efficient review system for medical treatment requests where decisions are made by medical experts. The express language of Labor Code section 4610.5 and 4610.6 requires claims administrators to provide relevant medical records regarding the employee's condition to the IMRO. Labor	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	determination should be what the IMRO sees. No matter how far back the medicals go that are used in the determination by the UR company, the same should go to the IMRO. Commenter states that if the provider or injured worker has additional information to support the request for treatment, they should be required to provide that information to the UR company upon requesting a reconsideration, which should be mandated just as a second bill review is required by the IBR process. Commenter also needs to know who to make the check payable to for the fees for the IMR process and the FIN for whom the payment is being issued, in addition to the address of where to send the check.		Code section 4610.5(*l*)(1). If claims administrators are reasonably providing an injured worker's medical records to their UR companies for use in UR reviews, this should not be an issue. Note that section 9792.10.5(i)(2) and (3) requires the injured worker to provide the claims administrators with any record nor previously provided. The IMRO will provide claims administrators with a monthly invoice showing the IMR reviews conducted and fees owed. The invoice will likely contain information necessary to make the payment.	
DWC Form IMR	Commenter requests that the final IMR Application include fields for Claims Administrator or URO's fax number and email address for communication back to the claims administrator or URO.	Steve Kline, Esq. General Counsel EK Health Services April 3, 2013 Written Comment	Agreed. The IMR application should contain a field for the claims administrator's fax number.	Amend the DWC Form IMR to include the claims administrator's fax number.
DWC Form IMR	Commenter concurs with the suggested modifications to the DWC Form IMR recommended by CWCI.	Steven Suchil Assistant Vice President	Agreed. A copy of the submitted form should be submitted to the claims	Amend the DWC Form IMR to state that a copy must be

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter would also like to see a field added to affirm that a copy of the Application and any revisions/attachments were sent to the Claims Administrator. Commenter references his comments in CCR Section 9792.10.1. Commenter opines that this should be the one criteria used to determine if the Application is valid.	American Insurance Association April 4, 2013 Written Comment	administrator.	sent to the claims administrator.
DWC Form IMR	Commenter notes that instructions on the IMR Request form used by the injured worker to begin the IMR process are in conflict with CCR Title 8, Section 9792.10.1(b)(1). The regulation stipulates to 30 days from the date of service of the UR decision. This implies that the total time is understood to be 35 days including 5 days for mailing. However, the Request Form stipulates to 30 days from the date of mailing. Commenter opines that this difference can mean a loss of as much as 10 days for the injured worker to request IMR. Commenter requests that the instructions found within the IMR Request Form be made to conform to the regulation.	Stephen J. Cattolica Director of Government Relations AdvoCal April 4, 2013 Written Comment	Agreed. The intent of form was to advise the injured worker in simplest terms possible about the deadline for filing the IMR application. The form should be revised to reflect that the total time is 35 days from the mailing of the UR determination.	Amend the DWC Form IMR to instruct that the application must be received by the IMRO within thirty-five (35) days from the mailing date of the UR decision.
DWC Form IMR	Commenter provided a mock-up of her suggested changes in an	Brenda Ramirez Claims and Medical	Agreed in part.	Revise DWC Form IMR to: (1) state on

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	attachment to her comments. However the following is a summarized list of the recommended changes to this form: *Relocating the instruction to submit a copy of the utilization review decision with the application to the bottom of the form where the employee is instructed on submitting the application will increase the likelihood that both forms are submitted together as required.* *If expedited utilization review was necessary, expedited independent review is also presumed necessary. It is useful to include on the form whether or not the utilization review was expedited.* *"Completion of this section is required" is unnecessary verbiage that should be removed from the form.* *It is not clear why the EAMS case number and the 22 digit WCIS Jurisdictional claim number (JCN) are required. They are not necessary*	Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	The form should plainly state that a copy of the UR decision should be attached. The "type of utilization" review check box should account for this. Agreed. Claims administrators should have easy access to these identifying numbers, especially the WCIS numbers since practically all claims in	the face of the form that a copy of the UR decision should be included; (2) only require the disputed medical treatment; (3) state that a copy of the form should be sent to the claims administrator; and (4) advise the employee that in bold letters, that they may lose the right to challenge the UR denial if they do not pursue IMR.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	in the application process for independent review, nor are they useful for performing independent review. It has been suggested that they are necessary as replacements for the social security number here, however the social security number is also unnecessary. The claim number, or the employee name, date of birth and date of injury, which are included on the form, provide the identification that is necessary, are less burdensome, and can and are used by the Division to crosswalk to the EAMS and JCN numbers in the event they are necessary. If the Administrative Director retains these requirements, the additional time and expense needed to provide that information must be considered and disclosed in the regulatory process. *Some of the fields and information has been relocated on the form to more efficiently utilize space on the form.* *Only disputed medical treatment needs to be included on this form. All the requested medical treatment is on the Request for Authorization and the Utilization Review decision.*		California must be reported to the WCIS. See 8 C.C.R. section 9702. The numbers will assist the Division in linking databases and conducting research regarding medical treatment in the workers' compensation system. Agreed. The form should only require the disputed medical treatment as defined by the UR decision.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Recommended changes are necessary to clarify that the disputed treatment is to be entered as described by the physician on the request for authorization. *Provide additional space to identify services or goods.* *It is necessary to identify services or goods:* *whose medical necessity is disputed during utilization review but that are also disputed for reasons other than medical necessity because this will alert the Administrative Director that IMR must be delayed until the non-medical necessity dispute is resolved delayed or disputed because the physician did not submit the reasonably requested medical information that is necessary to review the request for authorization, because the IMR application should be ineligible until the necessary information is timely submitted for a request for authorization and the claims administrator completes the*		Addition pages can be used to describe the disputed medical treatment, including goods and services. An IMR application must be provided to the injured worker with every UR decision to deny or modify treatment. Labor Code section 4610.5(f). Upon receipt of the application and a copy of the UR decision, the Administrative Director, under section 9792.10.3, will determine whether the application is eligible for review.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	utilization review. *These circumstances can be submitted on the form as proposed or may be more efficiently supplied on this form in a table similar to the one in the Requested Treatment section of the RFA form.* *Requiring the injured employee's original signature when requesting the review will ensure that the employee is aware of, and wishes this independent review.* *Incorporating employee's designation authorization and designee relationship into the Consent to Obtain Medical Records section under one original employee signature is efficient, and will associate the designee with the consent to obtain medical records indicated on the form.* *Specifying in the Consent to Obtain Medical Records and Designation section that the consent applies to the disputed treatment identified on this application form will prevent any potential misunderstanding over what may be included or whether the*		The Administrative Director is limited to a one-page IMR application. Labor Code section 4610.5(f). The revised form reasonably captures all necessary information to proceed with the IMR process. The injured worker may designate a representative to act on their behalf. Labor Code section 4610.5(j). The Administrative Director is limited to a one-page IMR application. Labor Code section 4610.5(f). While incorporating the designation into the consent, it would force the form to exceed one page. The consent on the revised form only allows disclosure of "medical records and information relevant for review of the disputed treatment identified on this form…."	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	consent or designation can apply to other treatment. *In the Filing Information section, "together with the utilization review decision" is recommended to replace "and any attachments" to clarify that the utilization review must be submitted with the application form and so that the injured employee is not led to believe he or she should submit supporting medical records with the application.* *The deletion of Maximus as the destination of the application for initial review is recommended because there is an evident financial conflict of interest as described elsewhere in this testimony. The Institute believes the application must instead instruct the injured employee to submit the application either directly to the Division of Workers' Compensation or to a designated entity that has no such conflict of interest.* *The direction to send a copy concurrently to the claims administrator and reference to the preferred notification method will*		The form and the instructions should clarify that only a copy of the written UR decision must be included with the application. Disagree. The Administrative Director can designate the IMRO as the location for filing and conducting an initial review of the application. Labor Code section 4610.5(k). The Administrative Director retains the right to make eligibility determinations. Section 9792.10.3. Agreed. To be informed of the initiation of the IMR process, the claims administrator should receive a copy of the form that	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	ensure the claims administrator is informed as quickly as possible that an application has been submitted as described elsewhere in this testimony. *The employee needs to be warned in the instructions that the utilization review decision is final unless IMR is requested within 30 days of the date the utilization review decision was mailed.* *Commenter recommends deleting the Employee Right to Provide Information section from the Instruction page because that information will be provided in the notice of eligibility letter and it is not necessary to provide it twice.* *Commenter also recommends removing duplicate and unnecessary language from the Instruction and Designation pages so that the content can fit into one page for efficiency and clarity. If the Administrative Director retains the third page, the additional expense for producing and mailing the additional page must be considered and disclosed in the regulatory process.*		was filed by the injured worker. Agreed. The form should advise the employee, in bold letters, that they may lose the right to challenge the UR denial if they do not pursue IMR. The section is included to make clear to the injured worker of their right to further participation in the IMR process. In its final form, the DWC Form IMR will be two pages; the form and the instructions.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
DWC Form IMR	Commenter opines that an electronically-produced replica of the IMR form should be acceptable if the required substantive information is contained therein. Commenter states that requesting the exact IMR Form from the DIR's website is cumbersome, and is causing unnecessary delays in the IMR process, thus causing delays in treatment determinations. Commenter opines that if there is no substantive change in the contents of an electronically-replicated version of the IMR Form set forth by the state, the IMR form should be accepted by the state as a valid IMR application. Using an electronically-reproduced version would allow applications to be processed, populated, and sent out much more expeditiously.	Lisa Anne Forsythe, Senior Compliance Consultant Coventry Workers' Compensation Services April 4, 2013 Written and Oral Comment	For consistency and to ensure that all required elements are contained on the form, especially since the IMR process introduces a new method of medical treatment dispute resolution, a standard paper form is necessary. The Division is working on an electronic application and hopes to have it available in the first quarter of 2014.	No action necessary.
DWC Form IMR	Commenter opines that claimants should be required to submit UR denial in tandem with IMR application form. Commenter states that the current regulations only require the injured employee to sign and submit the IMR form they received from the carrier	Lisa Anne Forsythe, Senior Compliance Consultant Coventry Workers' Compensation Services April 4, 2013 Written and Oral Comment	See response to above comment by CWCI regarding the DWC Form IMR.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with the UR denial, without also including the UR Denial letter itself, which delays the result when the state inevitably has to contact the Carrier/URA to request a copy of the UR Denial Letter after-the-fact. Commenter suggests that the claimant be required to include a copy of their original UR Denial Letter along with the completed IMR Form when submitting to the state.			
DWC Form IMR	Commenter opines that there is ample room for improving the instructions on the form to make the process clear to the employee. In the instruction box on page 1: "All fields must be completed by the Claims Administrator. A copy of the utilization review (UR) decision that either denies, delays, or modifies a treating physician's request for authorization of medical treatment must be attached." Commenter opines that the instructions should be specifically directed to the employee rather than the claims administrator. First, it needs to be clear that the form is provided as	Peggy Sugarman Director of Workers' Compensation City and County of San Francisco April 4, 2013 Written Comment and Oral Comment	See response to above comment by CWCI regarding the DWC Form IMR. Agreed. The form should be directed the employee rather than the claims administrator.	Revise instructions to DWC Form IMR to simplify language.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	a courtesy and that action is only required if the employee wishes to pursue the issue. Once that decision is made, the employee only needs to sign the medical release and the form itself. The instruction should therefore point out these relevant issues, as the claims administrator certainly cannot fill in the signature field for the employee. Commenter suggests that the instruction include a clear message that submission of the form is at the discretion of the employee and not required. Commenter suggests the following language: "The information on this form was completed by your claims administrator to assist you if you decide you would like an independent doctor to review a delay, denial, or modification of your treating physician's request for medical treatment. If you wish to proceed, carefully review the instructions on the next page of the form and sign where indicated. Include a copy of the decision that delayed, denied or modified your treating physician's request."		The instructions on the DWC Form IMR are sufficiently clear that the submission of the form is optional.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	OR "Please review and follow the instructions on the form for information on the Independent Medical Review Process before deciding whether you wish to request a review." In the instructions under Employee Right to Provide Information: Commenter opines that the instructions are clear. However, the bullet-point instructions mix second person ("you" and "your") with third-person ("the employee") references. Commenter suggests keeping the communications consistent and believes that the second person instructions are preferable.		Agreed. The instructions should be kept as simple as possible.	
DWC Form IMR	Commenter requests that the division make it clear that if the injured worker fails to attach a copy of the UR decision with the application that their request will be rejected.	Carlyle Brakensiek CSIMS and CSPMR April 4, 2013 Oral Comment	See response to above comment by CWCI regarding the DWC Form IMR.	No action necessary.
DWC Form IMR	Commenter requests that a specific fax number or e-mail address be provided for the IMRO in order to transmit notification when treatment was	Linda Slaughter Chief Claims Officer Athens Administrators	See response to above comment by EK Health Services regarding the DWC Form IMR.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	submitted for review that has been paid so that the process can be stopped before any additional expenses are incurred.	April 4, 2013 Oral Comment		
DWC Form IMR	Commenter requests more clarity regarding the instructions to the injured worker. Commenter notes that paragraph one of the instructions address the utilization review decision – that the decision on treatment is final unless the injured worker requests IMR but does not mention the thirty day deadline to do so. Commenter states that paragraph two of the instructions states that an application for IMR must be filed within 30 days from the mailing date of the utilization review decision letter but does not state that the decision becomes final if no action is taken. Commenter recommends that both of these points be stressed in each paragraph.	Debra Russell Schools Insurance Authority April 4, 2013 Oral Comment	See response to above comment by the City and County of San Francisco regarding the instructions to the DWC Form IMR.	No action necessary.
DWC Form IMR and 9792.10	Commenter opines that the rules for the IMR process must represent an understanding that the IMR decision, by definition, is more complex than the UR decision and that by design, the ascension to the IMR itself should sift out the more routine matters.	Timothy Hunt, M.D. President Allied Medical Group April 2, 2013 Written Comment	The manner in which medical records are provided to the IMR reviewer are set forth in Labor Code section 4610.5 and implemented in proposed section 9792.10.5. The IMR reviewer may request	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states there are several possible choices of whom should submit medical documentation to the IMR reviewer. 1. Have carriers and claims professionals decide what to submit to the IMR reviewer. Commenter opines that this choice begs for the IMR process to suffer the same failures of the UR process because of lack of necessary test results or chart notes. Suggestions that the carrier's entire medical file for one year prior to the request be submitted automatically will cause the review process to become overburdened with the obligation of the IMR reviewer to spend extra time reviewing superfluous and redundant medical documentation that is not fundamental to their decision. 2. Have attorneys decide what to submit or be allowed to add to the submitted documentation; but again, this leaves open the possibility that necessary		additional records if necessary. Labor Code section 4610.6(b).	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	medical information may be omitted or unnecessary information may be included. But the greater risk with this choice is the possibility that the IMR reviewer will be asked to consider nonmedical documentation submitted through the attorneys for either side. Commenter opines that the IMR process itself has been designed to put an end to jurists making medical decisions, and yet asking physicians to consider non-medical information when deciding if a treatment is medically necessary, arguably asks these physicians to act as jurists. 3. The best choice is to have the requesting medical provider choose, compile and submit the medical documentation that will be considered with an IMR request. This is the only way to ensure that medical decisions sought from independent medical reviewers will be based on pertinent medical information crafted			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	solely by the medical professionals most closely involved in the care and treatment of the injured worker. Such a system can allow the IMR reviewer and the treating physician to be partners in assuring that the injured worker receive the reasonable medical treatment necessary to cure and relieve the effects of the industrial injury.			
DWC Form IMR and General Comment	Commenter would like to have an electronic version of this form. Commenter also recommends that they be allowed to fax the provider and applicant attorney instead of having to mail the form.	Jay Garrard April 3, 2013 Written Comment April 4, 2013 Oral Comment	The Division is currently working on an electronic application process, where an injured worker can submit the form on-line rather than by mail. That said, Labor Code section 4610.5(f) requires that an addressed envelope accompany the IMR application, so mailing of the form is necessary.	No action necessary.
DWC Form RFA	Commenter requests that this form include an option to designate the request for authorization for inpatient discharge. Commenter opines that to ensure that a discharge is not delayed while the	Barbara Hewitt Jones Jones Research & Consulting Regulatory Analyst for Tenet April 2, 2013 Written Comment	There is no need to specialize the form for this circumstance. The requesting physician should complete the form as required and provide support for an expedited review.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	case undergoes utilization review an expedited review should be used when there is the need for discharge planning for either home care or a step-down level of care.			
DWC Form RFA	Commenter concurs with the suggested modifications to DWC Form RFA proposed by CWCI. In addition, commenter recommends that the following addition should be made for clarity as the claims administrator does not communicate the request but responds to it. Re: Claims Administrator Response Section on Instruction page: "(Use of the DWC Form RFA is optional when communicating responses to requests; a claims administrator may utilize other means of written communication."	Steven Suchil Assistant Vice President American Insurance Association April 4, 2013 Written Comment	The Division agrees that the use of the word "requests" in the instructions may result in confusion and will clarify the term in future rulemaking.	Amend the DWC Form RFA instructions in future rulemaking to clarify the word "requests" in the Claims Administrator/URO Response section.
DWC Form RFA	Commenter is concerned about the general confusion surrounding what an "RFA" actually represents. Commenter states that the acronym represents the form itself, but questions if it defines its best and proper use. Commenter questions if each form represents a request for authorization for a single diagnostic	Stephen J. Cattolica Director of Government Relations AdvoCal April 4, 2013 Written Comment and Oral Comment	The Division is unaware of any confusion regarding what an "RFA" actually represents. As plainly stated on the form, more than one treatment request can be listed; additional sheets can be used. Regarding reimbursement, the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	test, treatment modality or procedure, or is the form better put to use as a tool to efficiently request the entire treatment plan (as it is contemplated at the time of submission) thought medically necessary to cure or relieve of the effects of a workplace injury or illness under Labor Code Section 4600? Commenter states that employers advocate that only one request (a single procedure, test or modality) be allowed per office visit. Commenter opines that this is unrealistic, but reflects their concern that a RFA that contains the entire plan (as it is was contemplated at the time of submission) might engender multiple, costly, requests for IMR if all or even a few of the items are denied. Commenter opines that providers cannot be limited to just one RFA submittal per visit without severely and unethically compromising their duty to treat the patient. Commenter strongly urges the Division to carefully consider the practical use of the RFA as a two-way communication tool. Commenter		form requests identifying information and a listing of treatment requests which may be derived from other compensable reports. At this time, the Division believes that additional reimbursement for this form is not supported. The Division may revisit this issue if data collected after the form is in use justifies reimbursement.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	opines that the RFA should facilitate clear and concise communication of as much information as possible in a single transaction. This means that the RFA must be versatile and capable of all communication deemed necessary. Commenter recognizes that accompanying documentation used to substantiate the requested treatment should be standardized to the degree possible. Commenter also requests that the Division consider that cost involved and the appropriate reimbursement for the physician.			
DWC Form RFA	Commenter provided a mock-up of her suggested changes in an attachment to her comments. However the following is a summarized list of the recommended changes to this form: *To substantiate the requested treatment, the Doctor's First Report or Primary Treating Physician's Progress Report is attached to the Request for Authorization, as opposed to the Request being attached to the Report.*	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) April 4, 2013 Written Comment	Agreed. The supporting documentation should be attached to the form.	Amend DWC Form RFA to: (1) clarify the top paragraph regarding supporting documentation; (2) replace "procedures" with "services and goods;" (3) delete "facility" from the other information field in the requested treatment section. Amend section

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	The term "<u>equivalent</u> narrative report" refers to the requirement in section 9785(f) for the narrative report to be equivalent to a PR-2. The section requires the narrative report to be entitled "Primary Treating Physician's Progress Report" in bold-faced type, to indicate the reason for the report, and contain the same information under the same headings in the same order as the Form PR-2. *The name of the DWC Form PR-2 is "the <u>Primary</u> Treating Physician's Progress Report."* *"<u>Physician</u>" replaces "provider" on the form because the physicians have the responsibility for recommending treatment for injured employees. For example, Labor Code section 4610(a) says in pertinent part "…utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by <u>physicians</u>…."*		For a narrative report submitted as a regular progress report, section 9795(f)(8) requires that the report "must contain the same information using the same subject headings in the same order as From PR-2." Strict technical compliance with the format mandate of this section is unnecessary to support a request for authorization. The DWC Form PR-2 is correctly titled the "Primary Treating Physician's Progress Report." While the form is reasonably identified such that few would be confused, the name will be corrected in future rulemaking. Physician has replaced "provider" on the revised form.	9792.6.1 (t)(3) to provide that the request for authorization must be faxed, mailed, or e-mailed to the address designated by the claims administrator. Amend section 9792.9.1(c)(4) to allow claims administrators to convert an expedited UR review to a regular review if supporting evidence is not provided with the DWC Form RFA.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<u>Expedited review</u> is requested on many requests for authorization even though injured employees in many of those cases are not facing an imminent and serious threat to their health. This unfairly slows the process for others who truly need immediate action. Requiring the requesting physician to certify imminent and serious threats to health under penalty of perjury and the reminder of consequences will discourage unwarranted requests for expedited Utilization Review and Independent Medical Review and help ensure emergency action for those who need it. If, by checking the Expedited Review box, the requesting physician is certifying under penalty of perjury that the employee has an imminent and serious threat to health, and is reminded of the potential consequences for not doing so in good faith, unwarranted requests for expedited Utilization Review and Independent Medical Review will be discouraged. This will help ensure emergency action for those who need it. Requiring the requesting physician to attach a written certification that		The documentation supporting the DWC Form RFA must provide evidence that the injured worker's condition is of such a serious nature that expedited review is warranted. If the documentation does not supporting this finding, a claims administrator should convert the request to a regular review.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the employee has an imminent and serious threat to health is a possible alternative, however checking the box and signing the form under penalty of perjury is less burdensome for the physician. *<u>Physician type</u> needs to be identified on the form in addition to specialty to efficiently assign the appropriate type of physician reviewers and thereby speed the review process.* *Indicating on the form "the specific page number(s) of the accompanying medical report on which the requested treatment can be found" will not work for this form. If the physician does not state the requested treatment on the form, checking the "approved" box will be meaningless and the form will not accomplish its dual goals of facilitating communication between the physician and the claims administrator, and furnishing a verification of authorization for the requesting physician. The problem is understood – it is inefficient for the Primary Treating Physician (PTP) to enter elements of a treatment plan, or changes thereto more than once. The*		The physician specialty and the type of treatment requested is sufficient for a claims administrator to assign an appropriate UR reviewer. A goal of the DWC Form RFA is to reduce medical treatment disputes by defining the requested treatment with a measure of specificity. This can be accomplished by either listing the treatments on the form or identifying the location of the treatment request in the supporting documentation. The purpose of the latter is to avoid the duplication of effort on the part of physicians if the treatment request is spelled out in the accompanying report. That said, the Division does	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	problem cries out for a single form to be used by the PTP for both a progress report and request for authorization. This could be accomplished by defining the progress report as a request for authorization (RFA) only if the RFA box is checked on that form. Many hundreds of stakeholder hours went into developing such a multi-use form several years ago. Inexplicably the form was not adopted. *"Services and goods" is more accurate for requested treatment than "procedures." Procedures do not cover the universe of requests.* *Likewise, the term "OMFS Codes" covers the whole universe of California workers' compensation medical services and goods. OMFS (Official Medical Fee Schedule) codes including CPT, HCPCS, DRGs, NDCs and others. OMFS codes must be used to bill for the medical service, so to the extent they are entered on the RFA form, there will be fewer billing disputes over codes billed and paid if the billing documentation supports those billed codes.*		recognize the benefits of a combined progress report/request for authorization and intends to promulgate such a form as regulation in future rulemaking. Agreed. The CPT or HCPCS codes should capture many of the services or goods that will be requested by physicians and assist in describing the requested treatment with the necessary specificity. If data proves that these codes are insufficient or that the field is underutilized, the Division will clarify the field as suggested in future rulemaking.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	. *"Facility" is best deleted because the facility may have to belong to a Medical Provider Network. Listing "Facility" in the heading may give the false impression the choice of facility is entirely his or hers.* . *If liability for treatment is denied, for example because the claim is denied, certain language and rules apply when notifying employees and providers of the claim denial, and that notification is made in a separate letter.* . *It is important to notify providers of the phone number, fax number and/or email address designated by a claims administrator for requesting authorization for medical treatment and related questions and tasks. Using designated contact information will ensure the most efficient communications and avoid delays and frustrations.*		Agreed. Use of the term may lead to treatment denials based on grounds other than medical necessity. Agreed. Allowing the claims administrator to designate an address or fax number may reduce delays in conducting utilization review.	
DWC Form RFA 9785	Commenter states that it is unclear which provider is responsible for requesting the authorizations. For services being rendered by the primary	Diane Przepiorski Executive Director California Orthopaedic	The requirement of Labor Code section 4610(a) is clear: utilization review determines the medical necessity of	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	treating physician or secondary physician or by ancillary staff in their office, the commenter understands that the physician is required to obtain authorization for the service. Commenter has been receiving complaints that carriers are requiring orthopaedic offices to obtain authorization for all services that they order even if they are provided by other entities. For example: 1) When they make a referral to an independent physical therapist for rehab, the carrier is requiring the orthopaedic office to obtain authorization for the rehab – previously the physical therapy office would obtain the authorization. 2) When they write a prescription for a medication and send the injured worker to a pharmacy to have the prescription filled, the carrier is requiring the orthopaedic office to obtain authorization for the medication – not the pharmacy who has obtained the authorization in the past. 3) UR entities are not addressing all	Association April 4, 2013 Written Comment	treatment requests "by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600." UR is conducted based on requests made by treating physicians; requests made by other providers are not required to be reviewed. Labor Code section 4610 does not set forth remedies for a claims administrator's failure to review all treatment requests or to issue an untimely UR decision. The Division would be exceeding its statutory authority by allowing unreviewed medical treatment based on these violations. Remedies for these violations, if they occur, should be sought before the WCAB. See, for example, the decision in State Comp. Ins. Fund v. WCAB (Sandhagen) (2008) 44 Cal. 4th 230.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	services requested on the RFA form. They approve or deny some of the services requested and ignore others such as post-op medications. Commenter states that the new UR process is adding a tremendous amount of work to orthopaedic practices. Commenter is unsure what the Division intended in these examples – - Who is responsible to obtain the authorizations for the service? Is it the ordering physician or the provider rendering the service? - What happens if the carrier fails to address services that are requested? Are the services deemed approved because they failed to respond in the designated timeframe? - In the IMR process, what happens when the reviewer fails to respond in the allotted timeframe? All of these day-to-day issues need to be clarified in the regulations.			
DWC Form RFA	Commenter states that there is a lack of specificity in the definition of what clinical evidence is required to be submitted in conjunction with an	Lisa Anne Forsythe, Senior Compliance Consultant Coventry Workers'	The DWC Form RFA is clear that medical evidence substantiating the treatment request must be included the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	RFA. Commenter notes that the DWC form RFA suggests but does not *require* pertinent medical records to be submitted with the completed RFA. Commenter opines that this lack of submitted medical records causes a preventable delay in review of the requested treatment. Commenter suggests that the Division modify the IMR Request Form to require that medical records be submitted in conjunction with the RFA, as well as specifically define what other documentation must accompany an RFA. Commenter notes that at the public hearing, several stakeholders (including Coventry) testified that they would welcome the opportunity to partner with the state in further off-line meetings to help define what evidentiary requirements should accompany an RFA, and commenter is reiterating that point.	Compensation Services April 4, 2013 Written and Oral Comment	form. The evidence, as has always been the case since UR was implemented almost a decade ago, consists of the Doctor's First Report, the Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.	
DWC Form RFA	To save time for physicians, commenter encourages the reduction of duplicate demographic info between PR-2 and RFA forms. Commenter recommends that only	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013	Basic identifying information on the DWC Form RFA is necessary since physicians may submit supporting documentation on reports other	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	basic identifying info is needed on the RFA as it must be attached to PR-2 which contains the complete demographic data and providers have already automated use of this form. [ex. patient name, claim number, date of birth, physician name and phone/fax numbers and date of office visit, employer name and phone number.] If the PR-2 or narrative report become separated from the RFA that basic info should allow matching or requesting the needed medical report for a UR decision to be made. Commenter opines that this should make completion of RFA more efficient and reduce the providers concern that they need additional fees to process the requests. Commenter also suggests that it would be helpful to make the layout of forms consistent for auto-fill capability and allowing us to use computer generated forms. Commenter states that there is as need to identify specifically on the RFA where physician sent the RFA. i.e. fax, email, or PO Box. Commenter opines that this will reduce the use of out of date fax and address locations.	Written Comment	than the DWC Form PR-2. As noted above, the Division does recognize the benefits of a combined progress report/request for authorization and intends to promulgate such a form as regulation in future rulemaking. Further, the Division would prefer that the form be computer generated with auto-fill capability and hopes physicians are working in that direction. As noted in the response to the above comment by CWCI, section 9792.6.1(t)(3) will be amended to allow claims administrators to designate an address or fax number for the DWC Form RFA to be sent.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Requested Treatment section – Commenter recommends that this section require all requests for each visit both on RFA and IMR application forms. Commenter opines that medical care is often provided in associated procedures and the treatments may not be easily justified as standalone procedures. Commenter opines that time and cost control is needed in this process and that IMR should only charge one review for all requested treatments in dispute from a single physician office visit. Commenter recommends that CPTs be required for surgeries and that others can be optional.		The DWC Form RFA allows for more than one treatment request to be made on the form. The face of the form allows 5 treatment requests and more can be made on an attached page. It is noted that the IMRO can combine related requests for IMR into a single decision. See section 9792.10.4(a). CTP should be listed on the form, if they are known.	
DWC Form RFA	Commenter, addressing comments may by Steve Cattolica, does not feel it is appropriate to pay for completion of this form. Commenter opines that every business has a cost of doing business and that this should also apply to doctors.	Jason Schmelzer California Coalition on Workers' Compensation and California Chamber of Commerce April 4, 2013 Oral Comment	The Division agrees that for the present the DWC Form RFA should not be reimbursable.	No action necessary.
DWC Form RFA	Commenter notes that the requirement for the claims administrator to respond to every RFA has been softened; however there is still a requirement that if there is a different course of	Jason Schmelzer California Coalition on Workers' Compensation and California Chamber	Please see responses to comments regarding section 9792.9(b) and 9792.9.1(b). The claims administrator can only respond to the specific request	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	treatment requested by a medical provider, the administrator must object to and resend information that has already been provided. Commenter opines that if a medical provider already has information that a claim is being contested for a reason other than medical necessity that the decision should stand.	of Commerce April 4, 2013 Oral Comment	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 (see (b)(1)(C) would preclude the submission of marginally different or related requests for authorization by the provider.	
DWC Form RFA and 9792.9.1(c)(3)(C)	Commenter states that one of the biggest issues he has is incomplete Treatment Requests that in the past have had to go to Physician Review for Denial for Lack of Information, was addressed by SB863. Provisions of the Bill made it clear that the Legislature doesn't intend to make employers pay for Physician UR if the requesting provider hasn't provided any, or enough appropriate Clinical Information upon which to base a review. Commenter states that the Legislation and the Regulations now have a provision that state if a request is "not Complete" it may be returned by the Claims Administrator without having	Jay Garrard April 3, 2013 Written Comment April 4, 2013 Oral Comment	Agreed in part. UR denials based on the lack of information provided by the requesting physician should not be eligible for IMR. Under this circumstance, there is no medical treatment dispute to resolve since the claims administrator has not had the opportunity to review records and make a UR decision. Allowing a claims administrator to reject an incomplete DWC Form RFA at the outset of the UR process will allow for the faster correction of errors on the initial submission of the form	Amend section 9792.10.3(a) to deem an IMR request ineligible based on the failure of a physician to provide requested medical records to the claims administrator for a UR determination.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to go to Physician Review. Commenter opines that the Regulations are not clear enough as to what constitutes a complete request, and also still demand that a request that was Denied for lack of Clinical Information to be accompanied by an Application for IMR. Commenter opines that both of these areas can be addressed by simple changes to the Regulations, and the Instructions that go with the Request for Authorization form. Comments states that on the RFA form and Instructions – there is a list of several things that are considered necessary for a request to be considered complete – but glaringly absent, is any language specifically asking for "most recent Exams, Objective Findings, Results of Diagnostic Tests, Radiology Reports," etc. This would be very easy to add to the instructions. Commenter states that the regulations state in Section 9792.9.1(c)3(C) that if the reasonable information requested by a reviewer or non-physician reviewer within five (5) business days		and ultimately improve the quality of requests that eventually do make it to a UR reviewer. To require additional clinical evidence does not appear to be necessary; as the commenter's statistics show, the current requirement for supporting documentation produces a small number of requests for additional information. Finally, the requirement that a DWC Form IMR accompany every adverse UR decision, regardless of the basis for that decision, is statutory. Labor Code section 4610.5(f).	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	from the date of receipt of the completed DWC Form RFA is not received within 14 days from receipt of the completed DWC Form RFA, the reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested, OR the reviewer may issue a decision to delay as provided in subdivision (f)(1)(A). Commenter opines that there are two problems with this. First, again the Regulations indicate that a request without sufficient clinical information to make a determination must go to a Physician for "Denial, when the request should be able to be deferred until the Clinical information is provided. The second problem is the Regulations then go on to state this "Denial" must be accompanied by an IMR application. Commenter states that this actually creates additional frictional cost for employers instead of reducing it. To illustrate the scale of the problem, commenter states that his organization			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	has reviewed over a million requests for treatment since the original UR Regs were enacted. In his experience, about 10% of all requests received by his clients were denied for lack of information where little or no information was provided by the requesting physician, even after we specifically request information be provided for review. Of these Denials for Lack of Information, only about 11% of those actually end up being reconsidered. In the three months since the Regulations for SB863 have allowed a Claims Administrator to return a request for being incomplete the percentage of Denials for LOI is now down to about 7% across all of our clients, but the proportion of reconsiderations of Denials for LOI is still dreadfully low. To illustrate this more specifically, one their clients puts every request for authorization into their software, for tracking purposes. Even the requests that are approved by their examiners get tracked in their software. In 2012, this client received an			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	average of 408 RFAs per month. Of those, 39 (or 9.5%) were Denied for Lack of Information. Of the 468 RFAs that were Denied for Lack of Information in 2012, only 50 (or 10.7%) came back with information for Reconsideration. In the three months since the new Regulations came into play, and Claims Administrators have been able to defer incomplete requests, the client has received 964 RFAs, and has still had 66 RFAs Denied for Lack of Information because they qualified as "complete" under the new regulations, but were missing clinical information necessary to make a decision. That still amounts to 7% of all requests received are being denied for Lack of Information – Information that is necessary to make a Clinical UR Decision, based on objective clinical information. This is information that the IRO would also require to make a decision. Even though these 66 requests have cost the client less than $100 each, on average for a the Physician Denial that the regulations still require, this is still			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	about $6000, or $2000 per month, that I believe they shouldn't have to spend. Further complicating this, and adding the potential burden of IMR cost of $560, or more, to each of these Denials could add an addition cost of over $12,000 per month to send RFAs without appropriate Clinical information to IMR. Commenter opines that this is a waste of money that helps neither the injured worker, nor the employer, and it shouldn't be forced on system by the Regulations.			
DWC Form RFA and 9792.9.1(c)(3)(C)	Commenter agrees with the comments made by Jay Garrard.	Mary Ellen Szabo Director of Clinical Services – Paladin Managed Area Care Services April 4, 2013 Oral Comment	See above response to comments by Jay Garrard.	No action necessary.
DWC IMR Form	Commenter opines that the IMR should only charge one review for all requested treatments in dispute from a single physician office visit. Commenter notes that the IMR Application form has two checkboxes at the top right side for "type of UR review: regular or expedited". Commenter would like clarification	Anita Weir, RN, MS Director, Medical & Disability Management April 4, 2013 Written Comment	Agreed that related treatment requests should be consolidated. Under proposed section 9792.10.4, the IMRO may consolidate may consolidate two or more eligible applications for independent medical review by a single employee for resolution in a single	Amend proposed section 9792.10.4, to allow the IMRO to consolidate related requests for IMR. Amend section 9792.10.1(b)(1) to require that the employee send a

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that these choices identify how the original RFA was identified by the physician? Concurrent, prospective and retro reviews are considered "regular" UR review and only if the physician requested expedited originally would this box be checked? Some in the community believe that these boxes are indicators of the type of IMR review being requested. The IMR instruction page suggests it does relate to the type of /MR being requested due to the requirement of having a physician statement that the situation needs an expedited review. Commenter opines that if this area relates to the type of IMR being requested, it should not be completed by the claims administrator. Commenter recommends clarifying in the instruction that "type of UR" means how the original RFA was identified. Commenter notes that section 9792.10.S(a)(l) sets timeframe for claims administrator to respond to IMRO. The application form does not provide advice to the DWC/ Maximus where notices should be sent and		determination if the applications involve the same requesting physician and the same date of injury. IMR may be conducted on an expedited basis if: (1) the underlying UR was conducted on an expedited basis; or (2) if the requesting physician certifies, with supporting documentation, that the employee's health is at risk such that a regular review should be converted to an expedited review. See section 9792.10.1(b)(3); Labor Code section 4610.5(n). The IMR application is sufficiently clear for the claims administrator to indicate the type of UR conducted on the request. Additional information that may convert an IMR review from regular to expedited may subsequently be provided by the requesting physician or submitted medical records. Upon a determination of eligibility, the IMRO will send	copy of the IMR application to the claims administrator.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	commenter is concerned that notices may go to unrelated or incorrect locations. Commenter has already had a notice faxed to the URO because that was the only fax number in the record. Commenter recommends adding a space for the claims admin. to identify fax/email info so notices are sent to the correct location and in the preferred manner to allow timely response. Commenter recommends deleting the WCIS JCN number. Commenter questions that value/purpose against time/cost for claims and error rates due to length of the number when there is one. Commenter notes that in section 9792.10.1 (b)(l) a request for IMR must be sent to AD ..... Commenter recommends adding and concurrently copied to the claims administrator		a notification of assignment and request for information to the parties. See section 9792.10.4. The notification will provide the claims administrator with contact information. The current version of the DWC Form IMR contains a field for the claims administrator to fill in a fax number. The WCIS JCN number should be provided, if it was assigned. The number will assist the Division in linking databases and conducting research regarding medical treatment in the workers' compensation system. Section 9792.10.1(b)(1) has been amended to require that the employee send a copy of the IMR application to the claims administrator.	
Economic Impact Analysis/Assessment	Commenter opines that he would not be surprised if the savings to SCIF or any carrier is not as high as	Kenn Shoji, D.C. Center for Interventional Spine	The Division cannot reasonably respond to hypothetical scenarios. A goal	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	anticipated. Commenter states that IMR is half the cost of a QME, but in his experience actually working in the work comp field, there are 3 basic scenarios and savings reflected in the proposed report only appears to one of the scenarios. The scenarios are: l) a correctly denied service in the first place, where the correctly denied services costs more than the cost of a QME. 2) a correctly denied service, where the service costs less than the IMR, 3) incorrectly denied service. Commenter opines that the savings only occur with the first scenario 1) a correctly denied service in the first place, where the denied service costs more than cost of the QME for example, a $5000 surge1y is unnecessary, but then it goes to the IMR for $650 to deny it, or to a $1200 QME to deny it. The savings between IMR to QME is about $600, and the carrier does not pay the $5000 surgery. Scenario #2 will still cost the carrier. Paying $650 to deny $12· TENS pads, or $120 prescription medications, or a $55 TP injection will still represent a	April 4, 2013 Written Comment	of IMR is to educate the workers' compensation community regarding treatments that are medically necessary for various conditions. As the IMR process matures, and the community gains knowledge of the Medical Treatment Utilization Schedule, it is hoped that the number of treatment disputes in the system will be reduced, thereby resulting in overall system costs.	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	loss. Scenario #3 causes delays, and still costs the carrier, as this case, UR incorrectly denied service, IMR overturns it, the carrier pays the wasted UR costs and IMR costs as well as the service. It doesn't matter if the service is more than a QME or less than the IMR. Commenter opines that the first case that would save costs, is extremely rare. If there is a correctly denied service, physicians would likely not appeal, since it would not be worth their time. Commenter states that the 2nd and3rd scenarios are far more common.			
General	Commenter does support IMR but opines that it needs to be staffed with the finest M.D.'s available and overseen by the Medical Board.	Jeffrey Stevenson, M.D. April 4, 2013 Written Comment Irv Hirsch April 4, 2013 Written Comment	Agreed. The Division is confident that its IMRO, Maximus Federal Services, Inc., will obtain experienced, knowledgeable reviewers as authorized by Labor Code section 139.5.	No action necessary.
General	Commenter states that the effective dates of the various sections should be uniform.	Mark Gerlach California Applicants' Attorneys	Agreed. The Division believes the regulations accurately reflect the effective dates set forth in authorizing Labor	No action necessary.

		Association April 4, 2013 Oral Comment	Code section.	
General	Commenter is concerned about the enforcement of the IMR program. Commenter points out the reason for the adoption of the IMR program is due to the fact that the current system is too expensive and time consuming. Commenter notes that there is currently a four to five month delay in obtaining QME panels. Commenter is concerned that the IMR program will end up as ineffective at the UR program if it is not implemented correctly. Commenter stresses the importance of obtaining the appropriate medical documentation in order to expedite the decision process.	Mark Gerlach California Applicants' Attorneys Association April 4, 2013 Oral Comment	The Division believes that the regulations will effectively implement the IMR program as authorized by Labor Code sections 4610, 4610.5, and 4610.6.	No action necessary.
General Comment	Commenter opines the SB 863 is great because it is going to provide medical decisions made by medical professionals. Commenter opines that the work done on these regulations is wonderful. Commenter's would like to stress the importance of getting the correct documentation so that the URO has the opportunity to make a decision based upon accurate information. Commenter also opines that the IMR should have the ability to	John Swan Comp Partners April 4, 2013 Oral Comment	Labor Code section 4610.6(b) allows an IMR reviewer to request information from the parties as they relate to the medical necessity of the related treatment. The statute does not expressly provide for any other type of communication. Given that IMR reviewers are to remain anonymous (see Labor Code section 4610.6(f)), the Division	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	talk to the requesting physician in order to resolve any questions and/or problems. Commenter recommends that the division examine the way that Texas does their IMR. If you're a certified IRO, you can provide the services and as the requests come in, they can by cycled through various numbers of different organizations.		believes that allowing for direct communication would exceed the scope of the statute.	
General Comment	Commenter states that many of the sections in these regulations are measured in days and many don't have further specification as to whether these days are to be calendar days, business days, working days, etc.	Brittany Rupley Defense Attorney April 4, 2013 Oral Comment	The Division has aligned its regulatory timeframes with those expressly set forth in authorizing statutes.	No action necessary.
General Comment	Commenter agrees with the comments made by John Swan that the IMR should have the ability to talk to the requesting physician in order to resolve any questions and/or problems.	Mary Ellen Szabo Director of Clinical Services – Paladin Managed Area Care Services April 4, 2013 Oral Comment	See above response to comments by John Swan.	No action necessary.
General Comment	Commenter states that he supports the expansion of electronic communications for the transmission of required forms and medical reports in reference to these regulations. However commenter cautions the	Jason Schmelzer California Coalition on Workers' Compensation and California Chamber of Commerce	The Division intends to analyze this issue carefully and intends not to issue regulations in the absence of uniform standards with the necessary technical safeguards.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	division to set the parameters carefully so that materials are not lost or sent to the wrong e-mail or fax destinations.	April 4, 2013 Oral Comment		