STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Thursday, April 4, 2013
Elihu Harris State Office Building
1515 Clay Street
Oakland, California

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I N D E X

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OAKLAND, CALIFORNIA

THURSDAY, APRIL 4, 2013

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MR. PARISOTTO: Good morning. Thank you for coming on this rather wet day. This is the public hearing on the Division of Workers' Compensation Qualified Medical Evaluator and Independent Medical Review proposed regulations. My name is George Parisotto. I am the Acting Chief Counsel for the Division; and joining me today on my right, your left, Maureen Gray, our Regulations Coordinator, and on my left and your right, our Acting Administrative Director, Destie Overpeck; Jim Fisher, Counsel for the Division; Karen Pak, also Counsel for the Division; and Rupali Das, the Division's Medical Director.

Our Court Reporters today are Peggy Scavone and Lori Carson. Please remember when you do offer your oral comments today to talk in very measured, reasonable tones so they can get everything down that you're saying. Sometimes people come up and talk extremely fast. It's very hard for them to capture all of your words.

As you know, emergency regulations are currently in effect and have been in place since January the 1st. The emergency regulations for both of these subject matters will be in effect for six months unless we ask for an extension or unless we complete the current rule making process before then.

This public hearing is part of the process generally known as our certificate of compliance that we need to file, and it's to complete the rule making action and develop our permanent regulations.

Copies of the proposed regulations and the supporting documentations are on the desk right over here to my right. Everything we have is also posted on the Division's website. Please make sure you signed in. By signing in, you can tell us whether you want to offer oral comments today; and also by signing in, we can keep you informed of any additional developments we have in the rule making process.

This hearing will continue as long as there are people present who wish to comment on the regulations but will close at 5:00. If the hearing does continue into the lunch hour -- and it might -- we will probably take an hour break.

Written comments, if you have any, will be accepted up until 5:00 today at the Division's office on the 17th floor of this building.

The purpose of our hearing is to receive comments on the proposed amendments to the QME and IMR regulations, and we would welcome any comments you have about the regulations. All of the comments, both given here today and those submitted in writing, will be considered by the Acting Administrative Director in determining whether to adopt the regulations as permanent or to change them. Please restrict the subject of

your comments to the regulations and any suggestions you have for changing them.

We will not enter into any discussions this morning, although we may ask you for clarification or ask you to elaborate further on any points you are presenting.

When you do come up to give your testimony, please give Maureen, our Regulations Coordinator, your business card if you have one so we can get the correct spelling of your name in the transcript. It's also helpful to spell your name when you do come up to help out our Court Reporters. Please speak into the microphone before starting your testimony; and, as I say, identify yourself for the record.

So, with that, we'll go with our first speaker. Since we're doing two sets of regulations, the QME regulations and the IMR regulations, I think we will start first with the QME regulations. So let me go to the sign-up sheet, and the first person who wishes to offer testimony is Mark Gearheart.

MARK GEARHEART

MR. GEARHEART: Good morning. Mark Gearheart -- it's G-e-a-r-h-e-a-r-t. I'm here on behalf of the California Applicants' Attorneys Association, and I wanted to -- we submitted written comments electronically yesterday, but I just wanted to comment on one particular point that we are concerned about, and that relates to rule 35.5(g)(2). As you know, that rule provides that -- that proposed rule provides that any

evaluation on or after July 1, 2013, by a QME or AME, the QME or AME is going to be restricted as far as providing an opinion about disputed medical treatment issues. And the problem with that that we believe needs to be looked at is, first of all, it's inconsistent with existing WCAB Rule 10606 and proposed new WCAB Rule 10606. The proposed rule 10606 says that in order to be substantial evidence, a QME or AME report must, among other things, discuss past, present, and future medical care. The rule also provides that the report of an AME or QME is admissible for the purpose of making a general award of medical treatment, for assessing the adequacy of a Compromise and Release, or for determining disputed lien or cost issues. The problem created by proposed rule 35.5(g)(2) is that it would appear to require QME's and AME's to do reports that are incomplete and not substantial evidence which could not be relied upon by the Appeals Board. AME's and QME's that are going to have to discuss past, present, and future medical care -- it's part of doing their report because those issues are fundamental to determining issues like periods of temporary disability, whether the worker's at maximum medical improvement, and whether they need future medical treatment.

In fact, case law requires consideration of those factors; and I'm sure that the panel is well aware of this, but cases like City of Glendale, the Norton case, say that you're not at maximum medical improvement until all reasonable healing

modalities have been attempted and all reasonable diagnostic testing has been completed. If your AME's and QME's can't discuss that, they can't decide if somebody is at MMI; and, if they do, the report is not substantial evidence. Supreme Court cases like General Foundry v. WCAB and the Braewood Convalescent Hospital case say the permanent and stationary status is a question of fact, and it has to be based on substantial medical evidence.

So I understand the rule was an attempt to deal with some of the statutory language in 863 that's intended to restrict the AME and QME from talking about current disputed issues for medical treatment because we want that to go through, or the statute wants that to go through, UR and IMR. I understand that problem. The issue is how to work that out so that we can comply with the statute and, yet, still give the Board and the parties substantial medical evidence. It's kind of a challenge. But I think one possibility might be to tweak the rule a bit -- the proposed rule to say that AME's and QME's are to discuss past, current, and future treatment, as required, to address temporary disability, maximum medical improvement, and permanent disability; but they are not to directly address any medical treatment dispute that's currently in the UR or IMR process. That would be a little more specific. I think it would be consistent with 863 and the new statute, but it wouldn't conflict with the Board Rules and long

standing appellate and Supreme Court authority.

So CAAA would appreciate it if maybe we can take another look at the details of that rule.

Thank you.

MR. PARISOTTO: Thank you.

Jay Garrard?

UNIDENTIFIED VOICE: My apologies. I meant to sign up on the IMR list.

MR. PARISOTTO: Okay. Nagar Matian.

NAGAR MATIAN

MS. MATIAN: Thank you for giving me the opportunity to testify today. My name is Nagar Matian. I have been practicing as attorney for eleven years. I represent the opinions of large self-insured employers, franchisees, and small businesses throughout California.

I do believe that 863 will have an influential effect on increasing benefits to injured workers, as well as provide treatment in a more efficient manner with less overall legal friction. I also believe that if we focused on one area of the legislation, 31.7, and made some modifications, we can ensure an even less litigious system.

Pursuant to the new regulations, 31.7(2) has been stricken. It indicates that, before, it allowed us the opportunity to request information from the Panel QME as to whether an additional Panel QME would be necessary. That has

been taken out. The process now for obtaining a new Panel QME has been eased. The problem, we believe, with that is in cases that are litigated with multiple injuries, there is an opportunity for the applicants' attorneys or the employees to seek numerous Panel QME's; and, as you may know, at this point the process for obtaining a Panel QME can take anywhere from four to six months, drawing out litigation in the area, drawing out issues that can't be resolved that are generally reserved for the Panel QME. We believe that if we put section two back into the regulations and created a more formal process to obtain additional Panel QME's by leaving it where it should be, the original Panel QME, we can expedite issues and only obtain Panel QME's when they need to be obtained.

MR. FISHER: Can I ask you a question?

MS. MATIAN: Yes.

MR. FISHER: What process do you think is currently in place and should be put back into the rule? I'm not exactly sure I understand what you're saying should be restored.

MS. MATIAN: Section two. It used to be the -- you would go back to -- the Panel QME would decide based on their own clinical experience whether an additional Panel QME would be necessary. Now, because we've taken that out, now an attorney can obtain an additional Panel QME by just going to the Judge and saying, "I want an additional Panel QME." And in practice, what I've noticed is that when there's such an easy way to get

multiple Panel QME's, we delay any type of resolution to the case because we'll get an orthopedic report; and then the attorney will say, "I want to now bring internal into the case," and this could be a year after the case has been litigated. And they would go to the Judge and say, "Okay. I want an internal Panel QME." We wait six months for that Panel QME list to come. When we get that report, the attorney can say, "I want to bring psyche into the matter." They go to the Judge. They get an Order for a psyche Panel QME. We wait another year. This draws out resolution to the case, which, you know, the longer the case stays open, it's more costly to the employees. It doesn't bring any resolution to the employee.

So we would request that there's a more stringent process to obtain additional Panel QME's and leave that with the original Panel QME that's been selected in the first place.

I think I just hit the keyboard. That was me.

I hope you feel that this opinion expressed really goes to the spirit and purpose of SB 863, which is really streamlining benefits in a more quick and expeditious manner.

Thank you.

MR. PARISOTTO: Thank you.

Bruce Hector?

BRUCE HECTOR, M.D.

DR. HECTOR: Pardon me. I left without my card, and I had

to doctor one up. My name is Dr. Bruce Hector. I'm the Medical Director for Parthenia Medical Group. I've been that since 1990. I'm currently Medical Director and Quality Insurance Officer for Exam Works California.

In December 2012, Parthenia Medical Group was purchased by Exam Works at the international theater in IME evaluations. The practice of management expertise, we believe, added by Exam Works will ensure continued quality evaluations consistent with the highest DWC standards.

I wish to discuss briefly four issues of concern to many of our QME evaluators with whom I interact on a daily basis.

I presume you all have my written testimony. However, since I submitted that, there has been a modification in one small area; so with your permission, I'd like to pass out my written testimony again so that you could all follow it. The written testimony provides appropriate language inserted into the regulation discussed and is designated in red in the written testimony. We made a subsequent change in article 2.6 about office locations, which we've numbered item seven. What I will comment now upon are the areas of the written testimony that are titled "Our Reasoning".

So, first, I wish to address a recent rule regarding article 2.6, QME locations, section 26, office locations and changes of office locations. P.M.G. and Exam Works have no

objection to limiting offices to ten nor to allowing substitution twice per appointment year. That's not the problem. We note, however, that this regulation does not contain language that would prevent a QME from adding additional offices if he does not have ten offices that he's already going to. However, when we contacted the DWC Medical Unit, several of our QME's were informed that they may not add offices even though they don't have ten. So there appears to be an apparent contradiction in the regulation from the perspective of a medical director. Often our new evaluators want to learn the process before they begin taking on multiple locations, or as their practice changes they wish to add more offices; and, therefore, we would like to have language that would allow any physician and any QME at any time to add up to ten offices.

Next in the same section, 2.6, section 26, regarding locations and change of locations, it seems to us that limiting reasons for relocation of the office to natural or community disasters or lease termination seems rather onerous and places a rather special burden on the QME, the staff, and the claimants to tolerate distasteful circumstances like inadequately maintained property, bad odors, construction noise, or failure of the landlord to maintain a proper safe environment. We had one office that we've used for years in Long Beach that the tree roots grew into the toilet. We needed

a change. Within this constraint, we would not be able to do so. So we suggest that we -- we recommend that physicians be permitted to substitute one office for another within the same geographic area, within any 180 day period, providing under a penalty of perjury they offer good reason. We would also request that during the 30 to 60 day transition period when you're moving from one office to another office, that appointments that had been scheduled at the old office be allowed to be conducted at the new office. This will prevent all the need for parties to apply for a new panel on cases scheduled prior to the office closure but to provide completed exams after that date, avoiding potential doctor shopping.

Now I'd like to discuss the new addition noted as item seven under that section. Periodically, physicians are requested to perform reevaluation of a claimant; and the original evaluation took place in the old office which has not been vacated. By permitting the original evaluating physician to perform the reevaluation in a new location or an office closest to where the original evaluation took place will provide for continuity, remove the prospect of one side that's unhappy with the original report trying to shop for a new panel to get another report and, thereby, delaying the whole process.

Next, I'd like to discuss the QME report production time line. Dealing with physicians on a regular basis, this is one of the most difficult tasks for QME's and AME's. It's

difficult to complete their reports on a timely basis primarily because of clinical practice responsibilities that must take precedence over report completion since lives are often in the balance. Most of our physicians are doing QME work on a part-time basis. They have clinical practices. That's what we seek -- to have them active in medicine. Consequently, our work -- this type of work is never the highest priority to physicians unless they're retired. If there is an emergency, the physician deals with the emergency. He's got the best of intentions to do a report; but when he gets home, he's too tired and he fails to do so. The due date can often slip by before the evaluator knows it. For doctors, like most of the rest of us, the squeaky wheel gets the oil. When work -- when reports are nearing deadlines, often one party anticipating an adverse report may quickly seek to strike the target report, compelling all parties to initiate the whole process over again.

So what we would suggest is that when any report is not submitted by the 35th day post examination, a joint letter go out to the physician and all interested parties indicating that if the report is not submitted within the next ten days, they may not be allowed; and he may not receive payment. This will cause the evaluator to pay attention and remind him that he's got work to do, and he will suffer economic consequences if he fails to do so.

The last issue I wish to discuss concerns problems related to depositions. From the physician's perspective, our evaluators are dismayed by deposition cancellations or rescheduling at the last minute. It appears that, at times, attorneys are using this tactic to pressure one another to settle a case without regard for the doctor's time, scheduling but not paying in advance for the deposition, then cancelling and rescheduling again without payment. We would ask that this regulation be amended to require the deposing party to submit payment in accordance with 9795, ML 105, RV 5, a minimum of 21 days in advance of the deposition to assure that the deposing party is serious and will act responsibly. Payment may be refunded if a deposition is cancelled no later than 21 working days in advance. I would also like the physician to be reimbursed for the time spent reviewing the transcribed deposition at the end.

Thank you for your time. I'll take any questions if you have them.

Thank you.

MR. PARISOTTO: Thank you very much.

Debra Russell?

DEBRA RUSSELL

MS. RUSSELL: Good morning. Thank you for an opportunity to participate in the public hearing today. I'm with Schools Insurance Authority. We're a joint powers authority in

Sacramento, California, self-insured, self administered; and my comment today is in regard to regulation 37.

Regulation 37 sets forth the procedure to obtain correction of a factual error; and it appears to result in a delay of benefits to the injured worker potentially, as well as increased costs and promoting litigation. Currently, when we need additional information to be able to provide benefits to the injured worker, we are able to use the most direct manner, which is writing a report to the evaluator asking for clarification. We're able to do this when we're dealing with issues in Labor Code 4060 and 4062; but for some reason, in 4061 and those issues, we're now being proposed to use reg. 37 in that separate process, which serves to delay the information that we need to pay benefits to the injured worker. So it would be my recommendation and request that regulation 37 and the related form be deleted from the regulations.

MR. FISHER: So I have a question for you. When you're talking about this process, are you talking about trying to get verification of what is in the original report of the QME?

MS. RUSSELL: Yes.

MR. FISHER: And you think that 37 restricts you from doing that?

MS. RUSSELL: Yes, I do.

MR. FISHER: Okay.

MS. RUSSELL: Regulation 37 does not allow any additional

information be submitted to the evaluator. If there's information that is necessary to produce a report that's substantial evidence, we need to be able to provide that to the evaluator.

MR. FISHER: The reason why I bring it up is there's an additional section that we've been contacted about from a rater, and we pointed out to the rater that that section about getting a supplemental report hasn't been removed from the regulations. So I think that this is relatively narrow in terms of what the examiner looks to, which is a doctor who's not reviewed certain information that was originally sent to them; but it doesn't prohibit anyone from sending additional information, and that's going to render additional process. So that's why I was trying to get a clarification about what you were talking about.

MS. RUSSELL: I think there's some confusion in the regulation because the form itself specifically states that you cannot attach any other information. You can only set forth your concern in the box provided, so that's a concern.

Thank you.

MR. PARISOTTO: Thank you.

That's all the people who had signed up and indicated they wanted to speak on the QME regulations. Is there anyone else who would like to offer more comment?

CARLYLE BRAKENSIEK

MR. BRAKENSIEK: Good morning. Carl Brakensiek on behalf of CSIMS and CSPM&R. Thank you for this opportunity. I had not intended to speak, but just a brief comment -- I wanted to support the testimony regarding office locations that came from the Medical Director of Exam Works and to request that you reassess your proposed regulation 26(c), the one that requires that there be at least 30 days' notice of relocation of the QME office. We recently had a situation arise here in Oakland where a fairly large medical clinic that -- was given 15 days' notice of the termination of their lease, and there had been a number of exams scheduled at this location; and it -- it caused lot of inconvenience for injured workers and their employers. It has delayed the rescheduling of these applications, and so I would request that you reconsider the 30 day rule and maybe shorten it to ten days or something unless there's some very compelling reason that you need the full 30 days for what the process is.

Thank you.

MR. PARISOTTO: Thank you.

Anyone else like to offer comment on the QME regulations?

STEVE CATTOLICA

MR. CATTOLICA: Good morning. My name is Steve Cattolica. I don't usually get the opportunity to follow Carl. He usually

speaks up after me, so this is a unique situation; but I'd like to echo his comments and add a few more. We have written comments we'll submit to the organization but -- or to the Division, but I just want to caution you that I only have a 300 gigabyte hard drive; so the comments we're going to make are actually short.

Specifically, section 30, the QME panel request, subdivision E, allows for an alternate location for the development of a panel when an injured worker has moved out of state. We wonder what the value of that alternative actually is. First of all, it's based on mutual agreement; but what we would expect is that there'll never be an agreement if the injured worker doesn't happen to agree. I know that sounds redundant and sort of silly; but the point is that if the injured worker wants to have his residence be used, the employer won't do it. And the reason why is they can use their own location, but there's no guidance in the regulation as to especially under what circumstances that an alternative can actually be exercised; and if the employer has more than one location in the state, which location is supposed to be used? And, finally, who gets to make that decision in the first place? There's actually no guidance whatsoever as to who's making this decision, who is the arbiter of whether or not the alternative is used, or, again, the multiple location situation, which location might be the alternative.

Section 34, letter H, talks about the inappropriate cancellation of an existing evaluation; and although this section has been part of the regulations for a number of years, it's never really meant a whole heck of a lot because there's no penalty for an inappropriate cancellation. And we would ask that the Division put some consideration to allowing for some defined no show fee, again, predicated on an inappropriate cancellation of perhaps an hour or maybe, in the case of a mental health evaluation, an hour and a half worth of time at the rate the physician is being compensated for that evaluation, so either QME or AME.

The rest of our comments are going to be put in writing, so thank you very much.

MR. PARISOTTO: Thank you. Anyone else on the QME regulations? I think we'll start taking testimony on the IMR regulations; and if anyone does have a comment on the QME regulations, we can take those at the end.

So at this point, I'd like to move to the independent medical review regulations and I think we'll start with Jay Garrard.

JERROLD (JAY) GARRARD

MR. GARRARD: I submitted these on line last night so I'll try to kind of paraphrase unless you read what I submitted on line last night and not take too much time up here now. I am Jay Garrard from GSG & Associates, and obviously, there has

been a lot of work that you all have put into writing SB863. We believe, certainly, there are going to be a lot of benefits for both employers and employees. We've been doing medical management including utilization review for a while, large self-insured employer in the State of California for about 20 years. One of the things that we've always brought forth with UR regulations and attempt to revise regulations are issues about what to do with requests that don't have appropriate medical information with them to make a clinical determination.

Obviously, SB863 attempted to address that with the ability to allow an examiner and adjuster to send back a request that is not complete, mark it incomplete, and send it back if the RFA isn't filled out properly, doesn't include a report; but one of the things that's still kind of poorly defined in our opinion is what constitutes a complete request. The RFA form says that the RFA form must be filled out completely and it must be accompanied by a PR-2 or a doctor's first report etc. but it doesn't say, for example, that we need objective clinical findings. We often see PR-2's that have a request for treatment but don't give you the reasons specifically what the reason for treatment in the objective findings.

There is a statute -- there's still a regulation section 9792.9.1.3c if the reasonable information requested by a reviewer non-physician within five days of the date of the

receipt of the completed DWC is not received within 14 days, the reviewer may deny the request for the stated condition and the request will be reconsidered upon receipt of the information requested or the reviewer may issue a delay. What you run into there is you're acknowledging that the request may come in with an RFA and PR-2 that's considered complete by regulatory standard, but poorly defined by clinical information as needed. We've requested reasonable information that doesn't come in and we still have to send an IMR application. The IMR the IRO is going to need that same clinical information that the UR organization would need. So why do we have to send a IMR application at that point through a request that if we've requested information that would not be IMR to actually make a clinical decision based on clinical information.

To put it in some sort of context, we've worked with a number of employers who have put all of their requests rather they're sending it to UR and their examiners are approving it and put all the requests into our software for tracking. About 10% of all requests come in without -- we see clinical information upon which without the clinical information, the provider is basing the treatment request on. When those get denied for lack of information, as you stated, there must be a statement in the review that says we will reconsider if the information is forthcoming. Of all those requests they get denied, about 10% of those actually come back. So 90% of the

treatment gets denied for lack of information. It doesn't come back for reconsideration and to have to send that to IMR is going to add significant amount of costs or potentially add significant amount of costs.

With one of our clients since 2012 came into play -- the 2013 came into play with the new regs that the examiners could mark some request as incomplete, that number has gone down to about 7%. They see from 7% to 10% that they can deny -- not deny, but defer UR until they have a complete request sent in. Even of those we still end up reviewing in UR sending in request for information we still have a dismal rate of things coming back for reconsideration.

So, again, if we've made a reasonable request for information, we would like to request that if it's documented what you've asked for and you've outlined what information is missing, it not be eligible for IMR until you receive this information and have a chance to make a clinical determination at UR.

MR. PARISOTTO: Thank you. David Ford.

DAVID FORD

MR. FORD: Good morning. David Ford, Noteware Government Relations, on behalf of my client California Medical Association.

The CMA filed comments previously on the emergency version of this regulation back in December. Those comments

still stand, but we'd like to point out a couple of additional issues this morning.

The first of which is going to echo much of what the gentleman right before me said. We're cautiously optimistic about standardizing the request for authorization that would make things administratively simpler for physicians dealing with multiple payers. But very much what that gentleman said, we'd like to see language in the regulation and or possibly on the form itself standardizing the documentation that is needed for requesting authorization. This has the promise of cleaning up the use of continual requests for additional documentation as a means of delay in the system.

And as similar as we can make the documentation needed for the request for authorization to the request for IMR, the better off we would be because it will keep things consistent throughout the process and also for physicians who have transitioned to electronic medical records systems, it would allow standardization into the systems for the documentation that they need to do these subsequent requests. So that's in section 9785.

Then in 9792.6.1 Utilization Review standards, the proposed subsection w of this section defines the reviewer as a medical doctor, etc. etc. licensed in any state but the District of Columbia. The Labor Code amended by SB863 gives a reviewer's licensed in the State of California. Everyone is

aware that this is something that is very, very important in the California Medical Association. We'd like that to be reflected again in the regulations and possibly some language about what the mechanism for the enforcement of that preference. CMA's preference would be for the use of an in state licensed practitioner unless if there's not an in state practitioner physician who is knowledgeable about the requested treatment.

In 9792.10.4 very similar issue 1 of the amendments that the CMA had requested that made its way into the Senate bill 863 for requirement of IMR organization employ an in state medical director who would be licensed by the medical Board or the California Osteopathic Medical Board. As part of the notice out to the parties when the IMR organization is selected, we'd like that notice to include contact information for that medical director so the practicing physician can contact that person colleague to colleague if need be.

And then, finally, in 9792.10.6a, we think that this section may need a little bit of work on the wording. We believe that the intention of the subsection is that the case is settled independent of the IMR process and that then the IMR process can be stopped by the claims administrator. But the subsection the way it's currently worded reads to allow the claims administrator to independently unilaterally stop the process. I think that was not the intention. So we'll just

voice that as a concern.

Thank you again for the opportunity to comment.

MS. OVERPECK: I have a question on your first point on the standardized documents. Do you give us recommendations for what documents you think would be appropriate?

MR. FORD: Not me, not in the written comments that were provided. We'd be happy to talk to you off line or possibly get recommendations from our workers' compensation physicians what they think would be appropriate.

MS. OVERPECK: That would be helpful.

MR. PARISOTTO: Thank you very much. Lisa Anne Forsythe.

LISA ANNE FORSYTHE

MS. FORSYTHE: Good morning. Lisa Anne Forsythe with Coventry Workers' Comp Services. Just a couple of things I wanted to comment on some of the things that the other commentators commented on. The first thing is for us when we've implemented the standardized IMR form within our system, we've had some slight variations in trying to make a standardized version of that that's electronic. We would like the regs to allow for minor modifications without any substantive changes to the form of the information on the form and be allowed to present that as long as the basic information that's required is present.

Secondly, we would like clarification on the URA wanting to know if URA is going to be added to the mailing

list once they are added as a party to the action. We're not sure whether we're going to be receiving more information secondhand from the carrier or whether the URA will be added to the mailing list.

Thirdly, we had a question on requiring the claimants to include the denial form along with their IMR request. We've got now into this loop because the regs don't require that where we get calls from the state after the fact saying where's the denial request that goes along with the IMR. We say we have to call them and wouldn't it be better if the regulations just required submission of that at the time IMR request goes in instead of going through the loop after the fact?

And the other thing I was going to comment on was the question that was being asked the point being raised substantive clinical determination including standardized information. We can submit thoughts on that as well. We had talked about that before. We had that same challenge that the other gentleman mentioned. It would be great for us if there were standards that had to be adhered to. We had diagnoses codes thrown out. We had a bunch of different suggestions that were thrown out. But they would be helpful if they came in on every RFA request because you would have a much better chance of making a determination as opposed to having go back after the fact and request supplemental information. Thank you.

MR. PARISOTTO: Thank you. Cyndy Larsen.

CYNDY LARSEN

MS. LARSEN: Good morning. I'm Cyndy Larsen here from Kaiser Permanente, Kaiser on-the-job, KOJ. KOJ arm of Kaiser Permanente provides work-related injury treatment and occupational health services to California injured workers. First of all, we wanted to thank the DIR and the DWC for working numerous hours to create workers' compensation law that we feel seeks to expedite medical care to the injured workers. We also wish to thank the DWC for putting together emergency regulations so injured workers can take benefit of SB863 by January 1st, 2013.

Kaiser Permanente is the largest provider of medical services in the State of California with over eight million members in the state. We provide occupational health services including treatment for work-related injuries to Kaiser members and nonmembers, and we treated over 85,000 California injured workers in the year 2012.

So we believe the spirit of SB863 is to expedite the benefits to the injured workers. However, we feel we found an area in the emergency regulations that is in conflict with the goal. That is specifically 9792.61u. We submitted our documentation already by fax and by email so I'll just hit the highlights.

That particular section when we look at the FAQ's on the UR for the DWC, it says for claims administrators and

commenting on the type of signature required for an RFA indicates it must be a written original typed name without signature or a signature stamp is not sufficient. Electronic signatures have not yet been accepted in workers' compensation cases in California. The information also provided in the FAQ's on the DWC cite strongly suggest that electronic signatures are not acceptable for completion of a request for an RFA in California Worker's Comp. based upon lack of acceptance of the electronic signatures.

So Kaiser believes strongly that the AD regulation 9792.6.1u should be modified to make it clear that electronic signatures are an acceptable form of completion for an RFA for purposes of compliance with Labor Code section 4610. Electronic signatures are widely used in health care. They've been accepted in Medicare, U.S. Department of Labor and California's MediCal program for over 10 years.

We have spent at Kaiser Permanente billions of dollars in developing a unique medical record that is now the largest private electronic medical record in the United States and possibly the world. At this time, we store all of our medical information KOJ that treats injured workers' we store all of our medical information, requests for authorization and provide all our medical reports in electronic format. We transmit electronically. We don't think we are the only ones, by the way. We're just highlighting what we do. But I'm sure there's

many other California medical providers that do the same.

We also received many numerous awards and much of it if for quality care citing our use of electronic medical records, including six awards from being leadership five stars out of five possible from Medicare for quality and a very important part of that was the quality built in our electronic records in the safety of it and that's also experienced by every injured worker that comes to KOJ for their work-related injury. So we believe that the use of electronic signatures has long since reached a point where the reliability, efficiency and the safety of the information is no longer an issue.

And I'm not going to read how we make sure that security. That's in my written remarks. But I'm sure it would probably bore everybody here. You can read it.

So, additionally, in the adjudication management system -- I'm sorry. In the California Civil Code has also long since recognized electronic signatures as a valid means of executing a document and provides specifically Civil Code 133.7 that a record or signature may not be denied legal effect or enforceability solely because it is in an electronic form. Subsection d of the same Code provides that the law requires a signature electronic signature satisfies the law. We don't feel there's a current rational reason for the DWC to not accept electronic signatures for electronically submitted

records. Issues involving potential fraudulent access to records have long been addressed in the record keeping and transmission of electronic records that present no greater risk and perhaps substantially lower risk for abuse than do forms of medical record keeping and transmission of information in other forms.

So we propose a simple addition to regulation 9792.6.1u to include the following final sentence where the DWC form RFA and required reports are transmitted electronically, they may be signed electronically by the physician.

To provide otherwise would require medical systems such as ours to completely alter the way we handle medicine and also cause delays. We would have to figure out a way since we're totally paperless to print an RFA, stop the physician, obtain the signature. Fax or mail it to the requester. Those delays could cause delays in the case for the injured workers. It's also noted that the most recent revisions to ADR 9792.6.1aa prohibits electronic transmission of records. Such a limitation makes little sense if electronic transmission of RFA's is allowed with supporting medical records.

Thank you very much for your time and attention.

MR. FISHER: I have one question and that is in the testimony that you filed, do you have a description of those electronic signatures that you use? And I raise that because all electronic signatures are not equal. There are some

electronic signatures that are independently verifiable. I'm just wondering if you provided that.

MS. LARSEN: Actually, I have. I provided how they're secured. I also provided all the federal law that allows electronic signatures and the references for Medicare.

MR. FISHER: The issue I raise with Medicare is they have a particular way, as I understand it, that they use electronic signatures which is inconsistent with the other electronic signatures laws with the federal level.

MS. LARSEN: Okay. I'm not an RIT expert, but I provided how we authenticated it to you in the written comments.

MR. FISHER: Thank you.

MR. PARISOTTO: Thank you. I apologize for -- the next person who would like to testify -- I think the last name is Dewes, D-e-w-e-s, (sic) with Rehab West.

MS. DEWAR: Dewar.

MR. PARISOTTO: Sorry.

AILENE DEWAR

MS. DEWAR: My name is Ailene, A-i-l-e-n-e. Last name Dewar, D-e-w-a-r, and I'm with Rehab West, Inc. We are a managing care firm that's been in business for 35 years and we are also a URO. So today I wanted to talk a little bit about our perspective from the URO for the IMR.

First and foremost, our goal at the utilization review organization is to approve and modify appropriate treatment for

injured employees that is consistent with evidence based medicine. This provides the foundation for employees to receive treatment that is often noninvasive or less invasive enabling them to return to work sooner. The goal is to keep the treatment moving along, not to stall it.

So the first regulation I wanted to address is 9792.9 UR standards time frames, procedures and notice. This specifically addresses the UR appeal process or otherwise known as the internal review for UR denials, delays and modifications. Within the regulation, it states that if the employer wants to cancel the UR appeal as it's going on, that there's a $215 fee for doing so. However, for the IMRO, that is. We did hear at the DWC conference in Los Angeles though that if the IMR1 form has been received by the DWC and it's been determined eligible and then it's assigned to a physician IMRO that if the employer cancels at that point, that there will be the full fee for the IMR whether it's one reviewer or multiple reviewers. This can happen in this process if the injured worker sends in the IMR1 form the day after they receive it as quickly as five days whereas the regulation allow the URO requesting physician 15 days to complete a UR appeal.

We're requesting that you take that into consideration because we recognize, first of all, that the injured worker should not be required to hold onto that form for 15 days until the employer and URO can conduct an appeal. We don't think

that that's reasonable. It's too much burden on that injured worker. We know that the DWC has made clear it's not acceptable to make that kind of communication with the injured worker. However, we think 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 as well as the requesting physician the opportunity to resolve the process through an appeal.

Then the next regulation I wanted to address is 9792.10.4 the IMR assignment and notification. Basically, the regulation states that the claims administrator must provide requested medical records to the IMRO within 24 hours for an expedited review. I wanted to point out that all claims departments are closed on weekends as well as holidays. So we would recommend that the change should be for one business day.

Similarly, in regulation 9792.10.5 IMR medical records, it states that the IMRO may request additional documentation and that on expedited reviews the claims administrator has one calendar day after receipt. Again, claims departments are all closed on weekends and holidays. And so we would like to recommend that it be changed to one business day.

So that's all I wanted to share with you today. Thank you for the opportunity.

MR. PARISOTTO: Thank you.

Mark Gearheart?

MARK GEARHEART

MR. GEARHEART: Good morning again. As with our comments on the QME regulations, we've electronically submitted our comments on the IMR regulations. I appreciate this opportunity to comment. I'm just going to comment briefly on two points. The first is Labor Code Section 46 -- well, let me go back to the rule. It's Rule 9792.10.5, subdivision A; and our concern with that rule would be -- we further comment on this in our written comments -- the rule doesn't really comply with the authorizing statute. The rule says that for IMR, you send the last six months of medical treatment records; but the statute 4610.5 says you send a copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following: The employee's current medical condition, the medical treatment being provided, the disputed medical treatment requested. As proposed, this rule requires only reports of the treating physician within the most recent six months.

That's not going to do it in a lot of cases, and I can give you some examples with the UR system. For example, it's not uncommon for a treating physician to send in a request for authorization for surgery; and it's sent to UR, and UR denies it because there's no evidence in the materials they were sent that conservative treatment was not efficacious. Well, that's

because we only sent the last few months' worth of records. The conservative treatment was more than six months ago, but it's not in the material that was sent. The MRI may have been more than six months ago and was not in the material that was sent.

Another example, somebody has a TENS Unit, and it works but not perfectly; and they stop it, and they try some other treatment. And the doctor and the patient decide, you know, the TENS Unit actually was more effective than this other treatment, so they send in an RFA saying, "We want the TENS Unit." And it goes to UR; and UR says, well, there's no evidence that the TENS Unit would be effective. Well, yeah, that's because the evidence is more than six months ago when they used it before and it worked.

So I think if this system is going to work, we should comply with the statute; and you should have to send the whole medical file or at least everything that's relevant to the issue. That's what the statute requires; and the rule attempts to narrow that to a lesser amount of information which, (A), violates the statute and, (B), is not going to work.

The other point I wanted to touch on very briefly is section 9792.10.4 and section .5, which alternatively give the claims administrator either 15 or 12 days to submit information to the Independent Medical Review organization. I don't think the administration has the authority to give anything more than

the ten day period in the statute. Labor Code Section 4610.5 says that there's ten days to provide the information. Interestingly, it does not use the term of art "serve"; and, therefore, there's no five day extension for mail because if you look at the C.C.P., "serve" is a term of art. And if you're supposed to serve something, you get the five day mail extension. If you don't use the magic term of art "serve", you don't get it. The statute doesn't use that. The statute says ten days; and this regulation -- if it's allowed to stand this way, there's a thousand lawyers that represent injured workers in California -- I'd be one -- somebody is going to challenge this. It's obviously beyond the statutory authority.

So I wanted to point those things out. Thank you for the opportunity to comment.

MR. PARISOTTO: Thank you.

John Swan?

JOHN SWAN

MR. SWAN: I'm John Swan. I'm with Comp Partners. We are a managed care company. We're certified IRO nationally and provide independent reviewer services in various states.

I think this bill is great -- 863. I think it's going to give us a chance to have medical decisions made by medical people. I think that the work you've done is wonderful. The only thing I'd add to that is I think that the internal -- getting the right documentation and giving the URO a chance to

make a decision based on accurate information is good. I also think that the IMR should have the ability to talk to the requesting physician because, oftentimes, information that's really important doesn't make it in; and you know conversations sometimes can solve somebody's problems. I think the idea that an independent panel makes the medical decision for -- you know, gives that employee a chance to say, "You know, I think I need that surgery," or, "I think I need that service." And having some independent, you know, without any financial attachments really gives them an ability to say, well, the evidence doesn't really show this or it does.

The only thing I'd add is I think that I like the way Texas does their IMR. If you're certified IRO, you're in Texas, then you can provide the services; and as the requests come in, they just cycle them through a various number of different organizations. And that would be something I would add -- is that more than one provider with California doctors -- I think it just makes sense, but that's my thoughts.

Thank you.

MR. PARISOTTO: Thank you.

Brittany Rupley?

BRITTANY RUPLEY

MS. RUPLEY: Good morning. My comments today -- sorry. My name is Brittany Rupley, spelled R-u-p-l-e-y; and I'm a defense attorney.

My comments today are limited specifically to just several technical aspects of the proposed regulations. Some of the regulations -- and there are too many to list -- are measured in days; and a lot of them don't have further specification as to whether these days are to be calendar days, business days, working days, etc. Some of the examples are contained in proposed regulations 9792.10.1(d), for example, 10.781, etc.

Also, some of the proposed regulations seem to conflict with one another with respect to when the Application for Independent Medical Review is sent. So, for example, 9792.91(e)(5)(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 of 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. And I believe this was somewhat touched on before, about the term of art and the difference between "service" and "receipt"; and also taking into account the five day extension for mailing can pose a practical problem because of 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.

There are certain regulations that require further specificity. For example, 9792.10.3(a)(3) and (4) states, 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 occupational injury or claimed injury to any part or parts of the body. However, it's unclear as to how these assertions are to be communicated by the claims administrator.

Also, the proposed regulation 9792.10.3(e) states that the parties may appeal an eligibility determination by the A.D. that a dispute of medical treatment is not eligible for IMR by filing a petition with the Workers' Compensation Appeals Board. 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 Administrative Director is to make an assignment to the IRO.

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 IMR review -- an Independent Medical Review. 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. And then there's also the regulation 9792.10.4 which talks about 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; but it's unclear whether the time frame for the Administrative Director to make that assignment to the IRO is one business day or 24 hours, regardless of whether the next day is, for example, a holiday.

And then 9792.10.6(g)(1) states that for regular review, the IRO shall complete its review and make its final determination within 30 days of receipt of the application for IMR, the DWC form IMR, and the supporting documentation and information provided under section 9792.10.5.

And while it appears as though the event that starts the clock for the 30 days would be all of the information above, it's perhaps made more clear that the 30 days starts with all or either of the aforementioned. We think that that would be helpful.

And then, also, finally, 9792.10.7(c), with respect to the parties' appealing final determination of the A.D. by filing a petition with the WCAB, under 9792.10.7(a)(2), authorizations for services not yet rendered are to be made within five days. While it's apparent that the petition, given that regulation, must be filed within five days, it would be helpful to contain within subdivision (c) of 10.7 the time frame for filing the appeal.

Thank you.

MR. PARISOTTO: Thank you.

Mark Gerlach?

MARK GERLACH

MR. GERLACH: Good morning. My name is Mark Gerlach, G-e-r-l-a-c-h. I'm a consultant with the California Applicants' Attorneys Association.

I'd like to start out with just a technical matter. There were a number of corrections made in this version, but each of these sections generally starts out with a description of effective date of the section. There was an attempt to make all of the wording of those sections equivalent. It still has not been done. I would urge you to take a look at it. There are some sections that talk about the July 31st -- July 1st date as being the date when it starts. There are other sections that use different language. So just take a look at the introductory language to these sections.

Secondly, I'd like to offer a copy of the jury summons I got. There are a number of times when we have in the past -- and there are recorded in our written comments this time -- a suggestion that certain information needs to be highlighted. I would point out the jury summons I got here has a large, typed, red notice on the front of it. I'll give it to Maureen here for the record. That's -- I'm representing an attorney; so, as you can imagine, I am fully supportive of the jury system and our rights to be on a jury. But it's just a jury summons.

When we're looking at some of the information that's being provided to injured workers, that's information that can affect the rest of their lives, their working life, their ability to support their family. So, for example, in this particular set of regulations, there's a notice that has to begin with the injured worker dealing with the right to utilize the internal utilization review process; but they have to be notified that participating in the internal process does not stop the clock on the 30 days that they have to participate in IMR. You have changed the regulations so that there is a requirement that they be notified of that. We believe that that notice should be highlighted, and this is an example of how you can highlight that type of notice. It's an extremely important notice to the injured worker that they are giving up their rights to IMR if they don't make a filing within 30 days, and an injured worker who participates in an internal process may not understand that. So it is important for them to understand it.

Lastly, I'd like to talk a little bit about enforcement of IMR. IMR was adopted because, basically, we had a system that was too expensive and took too long. Unfortunately, some of the delays in the QME process were caused by the delay in getting QME panels; and I just want to raise this because I've been told by a number of members of CAAA that there are, again, four to five month delays in getting represented panels. I know that's outside the scope of

this regulation, but you're here. I'm here. I'm telling you that's really unacceptable. We need to get panels out for represented cases sooner than four or five months, but a lot of the process -- if you step back and take a look at IMR, IMR is a process by which medical necessity of a request for authorization is going to be determined by a paper review by a physician using the treatment guidelines as the basis for that determination. That's IMR. That's also UR. The question is is IMR going to end up being just a duplicate of UR; and if it is, we've wasted a lot of time and money to do that. So the question is what can you, as regulators, do to make certain that this process works as intended. We're told in the group health area that IMR works because the parties learn what is acceptable and what is not acceptable; and, essentially, starting with the RFA, they don't ask for treatment that they know is going to be rejected. And on the other side of the coin, the provider -- the Blue Cross, Kaiser, etc. -- knows what's going to be accepted in IMR; so they will approve these things. The real success of IMR is if an IMR is not used very much.

So how do we get to that point? Well, one of the ways of getting to that point is to make UR work better and UR regulations. We have, in the IMR regulations, a requirement that certain documents be provided to an IMR reviewer. Mark Gearheart just spoke about that. There was some testimony

earlier by others talking about what sort of information physicians should be providing along with an RFA. I would agree that's a problem, and I think there is a role for CAAA, for the medical associations, etc., to educate physicians as to what is necessary; and I think it's an interesting question as to whether or not the Division could adopt some requirements for what sort of clinical evidence is necessary to be accompanying an RFA.

But the other side of the coin is in utilization review, too often -- as Mark Gearheart pointed out, too often a denial is based upon the fact that the UR reviewer just doesn't have the information. It's information that is in the possession of the claim administrator, but it never gets to the UR reviewer; and if that's going to be what happens in IMR, also, we go through this entire process twice. That's a waste of time. It's a waste of money. It's not how we pay anybody. So one suggestion we put in our letter is that, in addition to having requirements for the information that is submitted to the IMR organization, you also provide that the relevant medical information be provided by the claim adjuster to the UR reviewer. If that UR reviewer is not looking at all of the data that's eventually going to be submitted to the IMR reviewer, that's a failure of process. So that is one suggestion.

The second suggestion is to take a look at the intent

of the legislature in providing some fairly stiff penalties in the law. The incentives for the participants in the system right now, I believe, are totally biased against doing the right thing in many cases; and the adoption of penalties of up to $5,000 a day for delaying the IMR process were put in by the legislature to make sure that there is a meaningful disincentive against slowing down the process. The proposed regulations talk about section 9792.12 with the administrative penalties. Subsection (a)(18) goes up to $250 a day, up to a maximum of 5,000; (22), $100 each day the response is untimely, up to a maximum of 5,000; (23), $250 a day for each day the response is untimely, up to a maximum of 5,000. Here's one that I really don't understand: Failure to timely implement a final determination of the Administrative Director, $500 a day, up to a maximum of $5,000. I think the reason that the statute says the determination of the IMR reviewer is deemed to be a determination of the A.D. is precisely to make sure that you enforce that determination. $500 a day -- is that all you think your determination is worth? I find that hard to believe that a statutory provision that calls for up to $5,000 a day is fully implemented by adopting a maximum $5,000 penalty.

Lastly, I would just point out IMR is adopted from the group health area. So I think it's informative to see what the Department of Managed Health Care does. They put their enforcement actions on the web. These are all public

documents. I'll give you a copy. I took them off their website -- Department of Managed Health Care. Here's a letter of agreement in which the -- I won't read the name of the firm -- but the firm failed to issue a clear and concise initial denial letter and also interfered with the enrollee's ability to timely obtain an Independent Medical Review. These violations subjected the provider to an administrative penalty in the amount of $15,000. It's not a maximum of $5,000. It's not $250 a day. It's a $15,000 penalty. We have -- Health and Safety Code prohibits the plan from engaging in conduct which has the effect of prolonging the Independent Medical Review process. The Department has ruled that an administrative penalty of $50,000 is warranted in this procedure. This is a little bit off subject, but it is still a violation of the Knox-Keene Act -- failure to correctly pay the claims administrative penalty of $350,000. We're dealing with insurance companies that write billions of dollars of business. You're talking about fining them $100 a day. I strongly urge that you revise those penalties in line with what I believe was the intent of the legislature to be a meaningful disincentive against bad behavior.

Thank you.

MR. PARISOTTO: Thank you.

I think I'd like to take a ten minute break right now, so we can come back at twenty to twelve. We'll reconvene at

that point.

(A recess was taken at 11:28 a.m., and proceedings resumed at 11:45 a.m.)

MR. PARISOTTO: We'll start up again. Our next speaker on the IMR is Peggy Sugarman.

PEGGY SUGARMAN

MS. SUGARMAN: It seems like it's a little too close to the speakers. Good morning. It's still morning. My name is Peggy Sugarman, and I'm the Director of Workers' Compensation for the City and County of San Francisco. So thank you for the opportunity to comment on these regulations for independent medical review and utilization review. So I'm here today to comment not only on behalf of the City and County of San Francisco but these comments are also representative and approved by the San Francisco Municipal Transit Authority and the Community Colleges of San Francisco. So together that compromises almost 29,000 employees.

So a couple of comments today just mainly on process issues. I want to talk a little bit about the deferral of utilization review pending resolution of disputed liability over a particular body part. So both the statute and regulations allow us to defer utilization review where we're objecting to liability for treatment for that particular body part and the regulations also along with the statutes say that once liability is resolved in favor of the employee for that

liable for the treatment for that body part that we conduct a retrospective review of the deferred request. So when you think about that process, you can think about it could take a substantial period of time to resolve that dispute over whether or not we're responsible for that treatment up to and including going through the QME process. You can imagine that request for treatment could be stacking as we go and that at the end of the time, we may have deferred a number of treatments that at the point in time where the dispute is resolved, those treatments may not be appropriate anymore given the worker's condition. So we are suggesting that you take another look at that and that you offer us the opportunity to once the dispute is resolved over liability in favor of the employee, that you allow us to immediately go and get a new treatment plan from the treating doctor. That is probably going to be a more efficient and faster appropriate process for the worker that we could do that quicker than a 30 day retrospective review on every single request that has come in to date that we've deferred and that retrospective review being limited to those treatments that have already been provided during the disputed time frame to determine whether they are liable for the payment for that.

Moving to submission documents and reports to the independent medical reviewer organization, you have a 15 day time frame for most of them. The statute in 4610.5 says 10

days to be sent. You actually have the language that it must have been received by the organization within 15 days. I think that's a little bit confusing to add a 15 day time frame where in claims, we have certain time frames that we all understand -- 3 days, 5 days, 14 days, 45 days, all of these different time frames and now we throw in a 15 day which if you're adding up the time frame for mailing, I guess makes some sense. I get where you're going with that. We think it should be clearer and more appropriate to just mirror the statute language and then add in the provision for mailing if you think that's appropriate. The thing about that we don't have control when we mail things about when the documents are received. We only have control over when they're sent. On that note, as documents are sent and sent with the Division of Workers' Compensation policy on efiling and electronic records, the City and County of San Francisco is a paperless operation and so we think it would be much more efficient if you make a provision in the regulations for us to be able to submit the documents to the independent medical review organization electronically. Again, the way it says if we have to mail it, print everything out, package it up, and it's a lot of extra costs. It would be more efficient cost effective if you could allow us to do that electronically.

That would require a little change to section 9792.10.5d confidentiality where you say that the

confidentiality of medical reports shall be maintained pursuant to applicable state and federal laws. Having a system where we could submit them through a secure portal to the IMR would be very much appreciated.

Okay. So, again, working through the process, we are at the point of sending in documents to the independent medical review organization. We will be sending in something to the treating doctor to let them know what records we're sending in, right. And then when the decision comes out by the utilization review organization, it's pretty much going to be a done deal that that's a final decision. I think the possibility of us trying to appeal something through the narrow window that we have available to us is probably never going to happen. So the decision comes out. It's also sent to the treating doctor. In the regulations you indicate that once the decision is received, we have a narrow window of five days to authorize the treatment. So it would make more sense to me to eliminate that step and allow us at least the opportunity to preauthorize the provision of those services should the IMR organization go ahead and reverse the UR determination. So instead of saying within five days, you could say no later than five days so we could put that preauthorization back into the original notice to the treating doctor when sending documents in. It would save us a step and maybe some peace and more importantly it expedites the treatment which we're all trying to do anyway.

Lastly, I want to comment on the form that is sent to the employee when utilization review denies a particular treatment or delays or modifies that and so I really would think that form should be pretty much directed -- all the instructions should be directed to the employee. As a claims administrator in all the UR organizations, we know that you're requiring us to fill out most of that form on behalf of the injured employee and that what they need to do is understand why they're getting that form, sign the medical release, sign it and send it in within a certain period of time. So we think that the instructions should be more geared towards the employee and not the claims administrator.

We also note that this is a decision time for the employee. So getting this sort of formidable form from the claims administrator that is pre-filled out with self-addressed envelope to the independent medical review organization would say to me if I didn't know any better "this is something that I have to do," and it could be that there are other options that the worker wants to pursue.

So I think it would be better to have at least some communication to the injured employee that they have a decision to make here. You can continue on with your current treatment, talk to your doctor. You don't have to submit this form unless you decide that you want to pursue this treatment.

And consistent with that just some sort of form issues

of the communications. We note on the second page of the form the instructions to the employee that it's written in both second and third person. So when you say "you" and "your treatment", you go onto another bullit point and say "the employee". So we'd suggest that that be consistent in the communications in using the second person so it's clear to the employees. That's all I have. Thank you.

MR. PARISOTTO: Thank you. We've gone through the list of everyone who indicated they wanted to speak on the IMR regulations. Is there anyone else who would like to comment?

CARLYLE BRAKENSIEK

MR. BRAKENSIEK: Good morning again. Carlyle Brakensiek on behalf of CSIMS and CSPMR. First of all, I just want to comment I really enjoyed listening to the testimony today because I think there's a common theme that all the different interest groups are really trying to make this work and the suggestions that have been made are in that vein that the legislature has spoken, and now we want to do whatever we can and make any suggestions we can to make the process efficient.

I was particularly enamored with Mr. Gerlach's comments about making UR successful. That message says a lot that if we can make UR work better, then we wouldn't have to go to that expensive IMR process. But I wanted to comment on the IMR process and specifically about the form, the employee's request for IMR because some of the language in it does not

appear to be consistent with your proposed regulation and specific I'm talking about your regulation 9792.10.1b1 and in that, it says that the request for IMR must be communicated by the injured worker within 30 days of the service of the utilization review decision.

Now, my first thought 30 days of service, what does service mean? Mr. Gearhart answered that this morning. It's a word of art and that normally when something is served, there's an additional 5 days to respond to that. Unfortunately, in the form that is sent to the injured worker, it says an application for IMR must be filed within 30 days from the mailing of the utilization review decision letter. There's an inconsistency here where the regulation appears to give a maximum of 35 days, 30 days plus the 5 for normal mailing for service. But the instructions to the injured worker says it's 30 days from the postmark that comes out and that could cause confusion. It could cause the injured worker to blow a deadline and equally important the legislature in SB863 was quite clear that the treating physician is encouraged to be an advocate to assist the injured worker in resolving treatment issues including IMR.

It could very well be that once the injured worker received this denial or modification of the request of treatment, the appropriate thing to do would be to speak to his or her physician to say "Okay. We've got this modification. Should we reevaluate the request? Should I make that really

make that request?" If you shorten the time or if you convince the injured worker that he or she has less time than is allowed by the regulation, you're going to end up with the situation where they say "I'm going to request IMR because I've run out of time and I have not have an opportunity to talk to my doctor to resolve, so I'm going to request IMR." That's going to cost the employers more money.

I'm suggesting that in this form that you be as close as possible to what your regulation says so that we don't mislead the injured worker. One other example in the same regulation it just says when they make the request for IMR, they're required under the reg to attach a copy of the denial or modification that they received. Under the form, it just says please include a copy of the UR decision with your application. So it's a request. It doesn't tell them if you don't attach it, we're going to reject your request for IMR. So, again, I urge you to reevaluate your instructions so that we're being as clear and as simple informing the injured worker of their rights as possible. Thank you.

MR. PARISOTTO: Thank you. Anyone else?

LINDA SLAUGHTER

MS. SLAUGHTER: Good morning. My name is Linda Slaughter, S-l-a-u-g-h-t-e-r, and I'm the chief claims officer for Athens Administrators who are third party administrators with offices in Concord, Sacramento, and Irvine and handle

claims for insured and self-insured clients throughout the state.

First of all, I'd like to thank-you for the opportunity to speak today. As you can imagine, we've been carefully watching reform changes and the resulting emergency regulations. We thank you for your very hard work which you've done so far and especially thank you and appreciate the speed in which you have brought about the emergency regulations. We are in support of the new IMR process. We hope that the new regulations will promote faster resolution of medical disputes and will result in timely provision of medical treatment and prevent litigation.

As a claims administrator, it's our goal to ensure the provision of timely and appropriate benefits while controlling unnecessary costs. To accomplish this, it's important that the new IMR process be as streamlined as possible with the elimination of any unclear or unnecessary operational steps.

To that end, I've got a few comments and I'll keep them very brief. Most claims administrators have moved into a paperless and electronic environment. In our offices, all correspondence whether received as paper, fax or email is up-loaded into our electronic system and delivered to the claims staff in the same manner. Once documents are scanned or uploaded into the system, the method of delivery is no longer evident. Electronic correspondence is not received or

processed any faster than paper.

So to that end, we'd like to see 9792.10.5a1 modified to allow 15 days for any method of notification. Similarly, in 9792.6.1aa, we would like to suggest that electronic mail be considered for transmitting medical records as there are now more secured methods available to do that.

In 9792.10.4f, documents must be received by the IMR within 24 hours. This is a very 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. It is also not clear when documents must be delivered when a request is made the day before a weekend or holiday. We would appreciate clarification regarding the delivery of documents in this situation and also suggest that there be consideration given to changing the language from the due date to the end of the following business day and there be a cutoff time of 5:30 p.m. to provide a request for documents.

In 9792.10.5a1b, it states that the claims administrator should not include previously provided application for IMR and instructions with the documents to be provided. Operationally, that is going to take additional time for us to locate and remove those records, and we'd like to suggest that the language regarding items that should not be included be removed.

We'd also like to suggest either a specific fax number or email address be established for the IMRO in order to receive notification when treatment was submitted for review that has been paid so that the process can be stopped before any additional costs are incurred. We're looking to try and eliminate any additional costs because of confusion or delay in where that request or information should be sent.

Lastly, in 9792.9b1 and 9792.91b1 the most recent language has 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." This seems to imply that different treatment plans would require additional objections each time and we'd like to suggest that those words for a specific course of treatment be deleted.

Thank you very much.

MR. PARISOTTO: Thank you. Do we have anyone else?

STEVE CATTOLICA

MR. CATTOLICA: Steve Cattolica, C-a-t-t-o-l-i-c-a. I represent the California Society of Industrial Medicine and Surgery and California Society of Physical Medicine and Rehab as well as the California Neurology Society. I apologize for not having said all that the first time. I also wanted to thank the division for its responsiveness to comments that were made -- everybody made in what seemed like a rush to make sure

there were some rules surrounding all of these different packages. I know everyone worked pretty hard to provide input to the Division and I want to thank you for the responsiveness that you showed at that point in time. I'm sure that would continue I think in the same vein that Mr. Brakensiek was commenting on, all the witnesses today.

I've got two comments with respect to the IMR regulations. The first is 9785g, the subdivision requires all RFA's include as an attachment documentation submitting substantiating the need for requested treatment and we would also like to be part of that conversation that perhaps provides some guidance with respect to the kind of documentation that may be necessary so that that can be a well-known quantity.

But at the same time, certainly, as we have come to find out requests for even treatment that's within the MTUS needs an RFA. It seems more work than it's worth to require an attachment when the request is already in compliance with MTUS. However, because the burden is with the physician to substantiate their request, we would expect them to put in the field that is available for duration of frequency the larger field in the RFA document the reference to the MTUS that they happened to be using to substantiate so rather than attachment in that case. So the requirement to always have an attachment should be reconsidered.

The second comment is a little bit more meaty in that

I think there's still some confusion of exactly what an RFA is. We all know that the piece of paper with the instructions on the back is an RFA, but as a physician who submits an RFA and has more than one request to be made, do they turn in multiple documents or a document with attachments? Now, I believe that it's relatively well understood that attachments are allowed. But what do the attachments have to be to substantiate -- or not to substantiate -- but to enumerate the number of treatments that may be requested at that point in time. We believe that it's efficient and certainly from a cost perspective if any of them are denied may be appropriate to include with the RFA multiple requests so perhaps a second page might be taking that field where the CPT code, all of that plus documentation or reference be able to attach in some of a free form as a separate page without having to fill out a whole other and stapling them together.

I don't see any place in the regulation where there's any guidance with what happens when a multiple modality treatment request for let's say it has five items being requested, and three are denied and two are approved. The three that are denied the injured worker may very well want to submit to IMR. Is that submitting a request for IMR or is that three? Does it matter? Some guidance needs to be provided to the community for the injured workers' sake on one hand and also for the employers who are going to have to foot the bill.

But as you might hear to require or to restrict the treating physician to only one request per treatment visit is counterproductive. That's a wholly impractical way to look at it even though it does answer the question that I'm posing. It's just a sledge hammer method to what needs a scapel.

The other is reimbursement and while this is not anything about fee schedules, we think this is important that the division consider the amount of work that is going to go into creating RFA's that are in addition to and over and above what might have been always been provided to a PR-2 prior to this. And as an index to the cost, we understand there's a study in the Journal of Health Affairs that has pegged the annual cost to each physician nationally $67,000 worth of their time and effort to fill out similar kinds of requests in the general health care realm and so it's not something that is trivial and it certainly should if you want to have the physician be that advocate that you expect them to be for the welfare of the injured worker, they need to be able to be compensated for the costs of being that advocate. I'm not talking about making hand over fist or profits nor am I advocating for cottage industry helping fill out RFA's. What I'm talking about is appropriately reimbursing them for the costs that is continuing to grow for providing health care in the workers' compensation system. That's different than what they experience in the general health care going back to 2002.

The Lumen study that studied that issue put a premium of like 32 to 33 percent over and above the costs of running a general health care practice. It's not less today. And here is another example of why it's growing. So we would want to make sure that the division continued to make it possible for the physician to participate and the injured workers (inaudible).

Thank you very much.

MR. PARISOTTO: Thank you.

MARY ELLEN SZABO

MS. SZABO: My name is Mary Ellen Szabo, S-z-a-b-o, and I'm the director of clinical services for Paladin Managed Area Care Services. My history has been doing utilization review conducting educating since this whole thing began in January of 2004. So I've been through all the bumps and humps. So I've always worked on behalf of the employer and the self-insured and the insured and TPA. That's always been my focus. However, while we really appreciate all the work done on this IMR process -- we think it's going to work -- I think we need to go back also consider the foundation of why UR began. I know some individuals here have said we need to make UR better, and I can't agree more. It's supposed to not only do cost savings, but supposed to make sure that the treatment that is necessary for the injured worker to rehabilitate properly is provided and with the process as we see it and I want to back

what Jay mentioned in the beginning needing extra information having that additional time possibly before we do submit to the IMR I think is a really good change that we would like very much for you to consider.

One of the things that John mentioned that I had in my notes that I thought might be something that you can do to tweak it a little bit. We know as we went to the DWC conference and we heard from that date forward from January to the date of the conference and the end of February, you already had 30 submitted to IMR and 28 were rejected and one upheld UR and one turned down UR. The reason at the point I think -- it wasn't really explained -- but I think probably adjusters were probably overzealous and they didn't look at the date of injury and were submitting those that were before January 1st, 2013. But that was just the beginning point of everyone wants to do what's right. But as John mentioned and what I know to be true in all the years of practice when you get a peer-to- peer conversation between the physician reviewer and the treating physician, you get a lot more accomplished. We all know that the PR-2's and progress reports we've said many times poorly written and even the doctors who is treating thinks he said what he said, it really isn't as clear as it could be. So that peer-to-peer conversation really helps.

So maybe although you have made it very clear that you want to keep that IMR confidential and, therefore, if you kept

it confidential, you wouldn't want that call to go out between the IMR and the treating physician, perhaps you would allow part of that added information from the URO to be to allow if no peer-to-peer was successful during the initial review, to allow that period of time after the first denial for a peer-to-peer conversation to be accomplished. So that that conversation can be submitted to the IMR as well. A lot of clarity can be achieved at that point, and I think the additional medicals the matching specialties at that point might provide you a little bit more than what you need. Thank you very much.

MR. PARISOTTO: Thank you.

JASON SCHMELZER

MR. SCHMELZER: Thank you. My name is Jason, J-a-s-o-n, Schmelzer, S-c-h-m-e-l-z-e-r. I'm here representing the California Coalition on Workers' Compensation, as well as just for today the California Chamber of Commerce, as their lobbyist couldn't make it. He had a family emergency. So I'll try and stay pretty high level. I think we're almost out of here, and I'll spare you all of the minutia. You can read that in our comments when you're trying to go to sleep at night.

First of all, I want to thank you and your team for all the work that's being done to implement SB 863. Based on the amount of work just keeping up with you, paying attention to what you're doing, I can't imagine being on the other side

actually having to write this, field all the comments, and make this work. So you're doing yeoman's work, and we really appreciate that; so thank you.

IMR, we feel like, is one of the most important pieces of SB 863 because of how far reaching it is. The impact on the system is going to be substantial, and so what we would really urge you to do is take your time. The emergency regulations that are there certainly aren't optimal. There are some changes we'd like to see, but they're workable until this final regulation is where everybody needs it to be.

I want to go back to the comments made by CSIMS earlier. I actually really appreciate the tone and the tenor of the comments made by everyone here today. They have been very constructive, and it's not always like that; so I think that's something that should be acknowledged, as well.

The California Coalition on Workers' Compensation is a small trade association representing employers -- large, small, public, private, insured, self-insured. We have a few hundred members, some of them large, like Safeway and Berkeley Farms and UPS, and small, mom and pop shops.

I do want to respond quickly before I get into the few points that I was going to make to something that was said specifically about payment for the completion of the form RFA. We certainly don't concur that it is something that should be paid for. Every business, frankly, has a cost of engaging in

business. There is a -- if I have a client, you know, a potential client, there's a cost to me for putting together a proposal and doing all the work to actually engage in the practice of business. That is the same for doctors. It's the same for anybody else. I tried to think of another business that would actually get paid for pursuing their own enrichment, and I can't think of one. This would be kind of a diversion just from the normal business practice; and, ideally, that's something that should be done. However, either way, I don't necessarily think that silence on the subject is a good thing. So if there is going to be no payment, we would like to see the regulations indicate that there is no payment. If you do go down the road to the point to provide some reimbursement, then I think there should be some kind of clarification as to what type reimbursement under what circumstances, etc., provide some clarity to all of the parties involved. I think that is always a good thing in our workers' comp system.

So, generally, on the subject of electronic communications, we certainly support the expansion of electronic communications; and we support kind of streamlining all of these processes. We do really want to be careful to ensure that the IMRO and the physicians and claims administrators all have very clear and defined routes of communication. We don't want RFA's being lost or sent to strange destinations, fax numbers, email addresses, etc. The

same is true for notifications of IMR. So we would really caution against moving too quickly here. Let's really take a step back, take a look, and make sure that what we're doing is consistent not only with kind of being of sound reason and logic but with the practices of employers and the Division and the IMRO and the UR organizations, etc. Let's just kind of get it all tightened up to make sure that we're doing what we need to be doing.

Something that you heard earlier I'll go ahead and echo. The current emergency regulations would require a claims administrator to respond to every RFA. That's been softened in the current version where there's a dispute other than medical necessity. That's softened; but there is still that requirement that if there's a different course of treatment requested by a medical provider, that you would, again, have to object and kind of send, you know -- send information that they already have. We're a little bit baffled by this. If the medical provider already has information that the claim is being contested for a reason other than medical necessity, we think that that should just stand. A lot of the purpose behind what was done in SB 863 was streamlining, getting out some of the unnecessary steps, cutting down on the administrative costs of workers' compensation, which is a good thing; and we hope that the regulations, everywhere they can, would reflect that desire and reality. So we would urge you to revisit that.

The last point -- I think maybe one extra that I'll make is on the topic of expedited review requests. The definition of expedited review and the regulations, we feel, is a little bit loose. We'd like to see it tightened up. Our concern is -- and, again, this doesn't apply to most physicians or every physician or every attorney -- but there's already been chatter out there in the workers' compensation world about how to make this process painful for employers. One of the philosophies says, "Hey, let's make everything an expedited review and, you know, run up the costs of doing IMR and basically try to kind of kill this thing from the inside so we can go back to the good old ways of doing business." And even though it's not a pervasive attitude, even though it's not something that we expect to see from most or even a lot of physicians, what we've learned in the workers' comp system is that it only takes a few bad apples to spoil the whole bunch. So we would really request that the DWC look at the definition of expedited review. Maybe consider a scenario where either the IMRO or the DWC has kind of a first shot at clearing out or just, you know, downgrading the request based on the facts of the case. So we would kind of urge you to move in that direction.

So the one other point I'll make is on the definition of medical necessity. Based on our review, it looks like it's just pulled straight out of the Labor Code -- out of 863. I

think what we're hoping for -- the first few tiers and kind of the decision making process are pretty clear, right? You've got the MTUS. You've got other evidence based peer review, etc.; but the items three through six are pretty nebulous. They're kind of open ended. I think what we'd like to see is a little bit of direction from the Division on what those terms really mean, how you're going to want to see them interpreted -- the IMR process -- and just try to provide a little bit of definition. I think it will help. It's been indicated in everything leading up to the IMR process and maybe could do what was discussed earlier, which is stop so many things from going through the process in the first place.

So, with that, I'd be happy to answer any questions; and we'll be submitting formal comments today when I get back to the office.

So, with that, thank you. Appreciate it.

MR. PARISOTTO: Thank you very much.

DEBRA RUSSELL

MS. RUSSELL: Hi. Debra Russell with Schools Insurance Authority. I just have a couple of points to bring up, areas that are perhaps a bit confusing.

The first one is section 9792.9(1)(6), and this is the area that talks about the IMR not going to the injured worker, and it's not clear as to whether or not a copy goes to the applicant attorney if they're represented or not. So if the

language could be clarified to specify --

The second area is 9792.10.1(a). This is an area where the text is talking about -- excuse me. It's better if I read it. 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 UR decision unless -- and this is the area -- unless the utilization review decision is overturned by IMR or the Workers' Compensation Appeals Board under this article. And it would be our suggestion that the phrase "under the article" be removed and, pursuant to Labor Code 4610.6(h), be inserted there. It's more clear and consistent with statute.

And my last comment has to do with the IMR instructions to the injured worker. I echo some of the other comments that we want to be very clear to the employee what their responsibilities are and, if they don't take action, what happens. So in the form, itself, paragraph one talks about the utilization review decision on your treatment is final unless you request IMR, but it does not say anything about the thirty day deadline. In paragraph two, the text talks about an application for IMR must be filed within 30 days from the mailing date of the utilization review decision letter informing you, but it doesn't say anything about it becoming final if you don't take action. So our suggestion would be to

make sure both points -- that they have to take action within 30 days or it becomes final -- be consistent in both paragraphs.

Thank you.

MR. PARISOTTO: Thank you.

JERROLD (JAY) GARRARD

MR. GARRARD: Just a couple of quick follow-up points. Jay Garrard again from GSG.

We would like to request, if we could, an electronic copy of the IMR form, which I know somebody else has already mentioned that, as well; but a lot of us are doing electronic letters out of our systems. And it would be a whole lot easier for everybody if we could get that letter that we could upload into our systems and fill out automatically when we're making a determination for the IMR application. As a practical matter, we understand why we're mailing an envelope, the IMR application to the injured worker; but we've always been allowed to fax the provider, fax the applicant attorney if they're represented. And now we have to mail -- if the regs stand as they are now, we have to mail the applicant attorney so that we apparently can send them an envelope, as well. We'd like that clarified so that we could continue to fax. We're certainly happy to send an IMR application, but do we have to mail it to the applicant attorney when we've been able to fax for the last eight years?

So those are the two follow-ups. Thanks.

MR. PARISOTTO: Thank you.

Is there anyone else who would like to speak to the IMR regulations?

Well, let me go back and ask if there's anyone who would like to speak on the QME regulations.

All right. If there's no one else who's going to testify, this hearing will be closed.

The opportunity to file written comments will stay open until 5:00 this afternoon. These comments should be delivered up to the Division's office on the 17th floor of this building.

On behalf of the Acting Administrative Director, I'd like to thank you for attending this hearing and the input you've given us. I'd like to remind you that the hearing on the independent bill review regulations will be next Tuesday here at 10:00.

Thank you very much. This hearing is now closed.

(Whereupon, the hearing was concluded at 12:28 p.m.)

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R E P O R T E R ' S C E R T I F I C A T E

I, Lori Carson, Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that: Official Hearing Reporter Peggy Scavone and I stenographically reported the public hearing identified on the cover page of this transcript and, with the aid of backup audio recording, transcribed the proceeding via computer aided transcription, to create this full, true, and correct transcript of the proceedings.

Lori A. Carson
Official Hearing Reporter
Workers' Compensation Appeals Board

Date:
Santa Rosa, California