

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	Commenter suggests prison sentences in lieu of penalties for improper treatment denial.	Anonymous Injured Worker February 8, 2007 Written Comment	Disagree. The AD does not have authority to impose prison sentences.	None.
General Comment	<p>Commenter states that ‘stalling’ done by insurers and employers constitutes fraud. Commenter opines that unless the fines are swift and sufficient to actually hurt the deep pockets of the insurers and employers that things will not change. Commenter suggests replacing traditional workers comp treatment from insurance companies with either state health care or a state-run, single workers’ comp source.</p> <p>Commenter goes on to discuss that she lost everything due to unnecessary delays and denials, plus false accusations of fraud made by her supervisor to her friends and co-workers in regard to her work injury.</p>	Karol Ballard February 9, 2007 Written Comment	Agree that the penalties are necessary. The comments do not address a specific regulation or make a specific suggestion. The comments also go beyond the scope of these regulations.	None.
General Comment	<p>Commenter states that from a carrier perspective they often receive requests from physicians that are either unreadable, unintelligible, or simply do not contain sufficient information to determine what the physician hopes to accomplish by performing a test, or prescribing a treatment plan. A significant number of delays are blamed on the employer side, but commenter has seen so many cases where the physician is actually the kink in the hose.</p> <p>Commenter questions if the State has done any forensic work on determining where the breakdown occurs. While it is easy to penalize the carrier, the easy solution may still</p>	Dale Van Treese Zurich National Insurance Company February 9, 2007 Written Comment	<p>This comment does not address the proposed regulations and goes beyond the scope of these regulations.</p> <p>The requests for authorization must meet the requirements in the definition of section 9792.6(o). Labor Code section 4610 and the UR regulations allow the claims adjuster to request additional medical information, additional exams to be conducted, or specialized consultation and review. The division has been investigating UR complaints.</p>	None.

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	not produce the desired result on those cases where the physician is not diligent in providing information the carrier needs to make the best payment decisions.			
General Comment	<p>Commenter relates that his members have experienced many difficulties obtaining treatment since the workers' compensation reforms have taken effect.</p> <p>Commenter agrees that insurance companies should be penalized for denying treatment.</p>	<p>Pat Karinen Senior Field Representative Piledrivers Local Union Number 34 February 8, 2007 Written Comment</p>	<p>Agree. No specific recommendation made.</p>	<p>None.</p>
General Comment	<p>Commenter states that while utilization management is a component of the management of costs in the workers' compensation environment it is only one component and must be viewed in the context of the entire claims management process.</p> <p>In order to manage claims costs in the workers' compensation setting it is necessary for the physician to have incentive to provide quality care with an early and safe return to work. Quality care along with the early and safe return to work impacts not only the claim cost during the life of the claim but we were able to see an impact on the overall claim cost due to improved functional outcomes and therefore lower costs associated with permanency. Additionally, there must be pharmacy benefit management along with stringent review of bills for upcoding, unbundling, second surgeon, etc. as well as a reasonable reimbursement rate. If the approach is not comprehensive and does not consider what motivates the provider there is a tendency for providers to find ways to defeat</p>	<p>Cora Butler Compliance Officer Missouri Employers Mutual Insurance Company February 9, 2007 Written Comment</p>	<p>These comments go beyond the scope of these regulations and offer no specific recommendations.</p>	<p>None.</p>

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	<p>the individual components.</p> <p>Even though a utilization management process is an integral component the method must not be onerous or cumbersome. Many of the best providers, at least in Missouri, would prefer not to deal with workers' compensation claimants for many reasons. Among them being the legal questions that have to be addressed as well as some of the issues of workers' compensation claimant sense of entitlement and the secondary gain that some claimants/patients develop. As a result, those providers whose medical care could potentially result in the best outcomes both functionally and in terms of return to work are reluctant to accept such patients if either the process is too onerous or the fees too low.</p> <p>While the environment related to both competition and managed care is quite different in many parts of California than in Missouri, many of the issues are no doubt the same. It is critical to have primary providers who are cognizant of the value of an early and safe return to work not only as a cost saving measure but also as a therapeutic component of the care of the injured employee. Further, it is critical to ensure that the provider doesn't "churn" in order to increase revenues prior to referring the injured employee to a specialist or sub-specialist and that once such referrals are made unnecessary procedures are not performed by those providers. Sometimes this all becomes more difficult when the injured employee is in an outlying (rural) area because the availability of the best qualified</p>			
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	<p>providers is limited. Again, however, the utilization management process must be such that the best providers will not be deterred from seeing the injured employee. Ideally, the process should incorporate technology in order to expedite the process and should avoid reviewing minutiae focusing instead on those procedures where the incentive to perform unnecessary surgeries is greatest (the obvious and perennial question being of course, the back, although there are numerous others as well).</p> <p>The issue of cost management in workers' compensation is a much more complex issue than may be understood by those with a background in group managed care and those with a workers' compensation background may not fully understand the healthcare delivery system (who does?) or the economics that drive it. Further, the entire process plays out at the final adjudication of the claim and where there is a failure to understand how that occurs in the jurisdiction in which they are operating a significant impact can occur. Finally, the approach must be comprehensive in order to be effective and must include all stakeholders, employers, injured employees and providers in order to be effective.</p>			
General Comment	<p>Commenter states that it is a good idea to fine or punish in some way for stalling injured workers from getting medical treatment they need. There has to be some form of consequences for their irresponsible actions. Commenter opines that injured workers have little say in how their case is handled, and when they can get quality medical treatment.</p>	<p>Nancy Fisher February 14, 2007 Written Comment</p>	<p>Agree that the penalties are necessary. The comments do not address a specific regulation or make a specific suggestion.</p>	<p>None.</p>

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	<p>Commenter states that she was made to wait 18 months in constant indescribable pain for a surgery that was needed right away.</p> <p>Commenter states this type of treatment is inhuman and that animals are treated better and have more people fighting for them then the injured worker.</p>			
General Comment	<p>Commenter states that since the implementation of the "Workers' Compensation Reform Act," her husband, an injured worker, has been denied one treatment after another. Commenter finds that it is criminal how the insurance companies, along with their attorney's have found ways to circumvent medically necessary treatment to injured workers, all in an attempt to crunch numbers to show how the "reform" bill has worked.</p> <p>Commenter states that this has caused several documented deaths, and the insurance companies walk away with no liability whatsoever!</p> <p>Commenter believes that these companies need to face criminal charges.</p>	Dana Luby February 15, 2007 Written Comment	<p>Agree that the penalties are necessary.</p> <p>Disagree regarding criminal charges, which is beyond the AD's authority.</p>	None.
General Comment	<p>Commenter is firmly in favor of penalties and fines for insurance companies that drag their feet. Commenter currently has an active workers' comp claim. Commenter injured his neck/back on Dec. 20, 2005, and first saw a physician on Dec. 27, 2005. Commenter states that he was made to wait 71 days, from the date of injury, before he could obtain an imaging test for what is probably a ruptured disk in his neck. This is inexcusable.</p>	Sean House February 16, 2007 Written Comment	<p>Agree that the penalties are necessary. The comments do not address a specific regulation or make a specific suggestion.</p>	None.
General Comment	<p>Commenter thanks the Division for its efforts</p>	Robert L. Weinmann, MD	<p>Agree that the penalties are</p>	None.

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	<p>to clarify Utilization Review which is being misused to delay and deny care.</p> <p>Physical therapy is frequently delayed, even for post-operative neurosurgical and orthopedic patients where prompt physical therapy is part of the post-operative protocol. Common case examples include physical therapy prescribed post-operatively by neurosurgeons, orthopedists, and other primary care doctors. Physical therapy often gets denied by insurance companies and by compliant utilization reviewers. In a specific case physical therapy was delayed for so many months that when it was finally approved it was too late to get maximum restorative benefits. In the end, the deprived patient pays the price.</p> <p>Medication prescribed by doctors may be denied by pharmacies. The pharmacy tells the patient the medication isn't authorized. Meanwhile, the doctor believes the patient is getting treatment. The patient then goes to an emergency room, new medication is prescribed, and the patient is referred back to the treating doctor who may prescribe the original medication again. This problem is getting worse now that dispensing by doctors from their own offices has been increasingly restricted.</p> <p>Doctors without California licenses are often used for utilization review of injured workers in California. The Office of Administrative Law allows this process in defiance of California labor law. Wrongful and</p>	<p>President – Union of American Physicians and Dentists Independent Practice Association February 19, 2007 Written Comment</p>	<p>necessary. The comments do not address a specific regulation or make a specific suggestion. The comments also go beyond the scope of these regulations.</p>	

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	<p>harmful decisions by utilization review doctors without California licenses are not subject to discipline by the Medical Board of California. Some companies get around this inequity by making sure that somebody on their utilization review panel actually has a California license -- that person may then co-sign or approve a wrongful delay or denial of treatment by a non-California licensed physician.</p> <p>Sometimes utilization reviewers admit lack of knowledge about a particular treatment and then deny it on the grounds that they don't know about it although the California labor code specifies that utilization reviewers are supposed to have up-to-date knowledge on treatments they delay, deny, or approve.</p> <p>Utilization review companies may assert that treating doctors don't provide the right kind of peer-reviewed information, or that whatever was provided didn't comply with the commonly and wrongfully used consensus known as the ACOEM guidelines. By now most physicians and administrators know that the ACOEM Guidelines are consensus-based. Nonetheless the ACOEM Guidelines enjoy protection under the law. Many treatments not discussed by ACOEM are improperly denied. Denials seemingly based on deficient peer review or lack of ACOEM approval enhance corporate profit and executive compensation by eliminating treatment, thereby reducing corporate expenses. Patient-care and the ability of doctors to care for the sick and injured is also compromised</p>			
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	<p>by interminable requests for documentation which delay care.</p> <p>Utilization review as currently practiced easily disenfranchises injured workers from treatment. It needs to be converted into a process whereby patients are enabled to get treatment. Doctors should be enabled to prescribe treatment without being bedeviled by insurance companies that use a pseudo-documentation process to slow up the process.</p>			
General Comment	<p>Commenter relates the difficulties he personally experienced litigating and obtaining treatment for his workers' compensation injury.</p> <p>Commenter states that the delaying tactics and the abuse of the "utilization review process" that he experienced is outrageous and criminal and is tantamount to harassment. Commenter states that the penalty for this type of behavior should be at least \$25,000 as a deterrent to these abusive practices.</p>	Gino Pacini Retired Firefighter February 19, 2007 Written Comment	<p>Agree that the penalties are necessary. The penalties in subdivision (a), which address the most serious UR violations, range from \$50,000 to \$500.</p> <p>Disagree regarding criminal charges, which is beyond the AD's authority. The comments do not address a specific regulation or make a specific suggestion.</p>	None.
Section 9792.12(a)(7)	<p>Commenter states that there is a typo where the regulations reference section 9782.9(b)(2). The correct citation should be 9792.9(b)(2).</p>	<p>Sharon Douglas, CEO Rehab West</p> <p>David Ingram, Medical Director – Rehab West February 20, 2007 Written Comment</p>	We agree.	This will be corrected.
Section 9792.12(a)(8)	<p>Commenter suggests that the non-physician reviewer's file documentation serve as an amended written request as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: (\$25,000.)</p>	<p>Sharon Douglas, CEO Rehab West</p> <p>David Ingram, Medical Director – Rehab West February 20, 2007 Written Comment</p>	<p>We agree to reduce the penalty to \$1,000. However, as written, no penalty will be imposed if the written amended request is sent in after the approval. The subdivision only requires that the written amended request be in the file at the time of</p>	<p>The penalty amount will be reduced from \$25,000 to \$1,000.</p>

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	<p>It is unrealistic to require that the non-physician reviewer “possess” written documentation /requesting from the treating physician indicating that the treatment request has been withdrawn, amended and resubmitted, based on a verbal negotiation, typically over the telephone. There is no incentive to the treating doctor to generate such documentation, and it would easily be forgotten in the hustle of clinical practice, thereby penalizing the non-physician reviewer.</p> <p>Commenter finds this type of review to be uncommon, and when done, to typically involve issues of quantity with regard to relatively low consequence treatment requests, such as number of PT sessions. Commenter’s organization does not permit non-physicians to negotiate substantive treatment, such as the details of a surgical procedure. In this setting, the documentation of the conversation is straightforward, and the non-physician would enter the details into the review, a copy of which would be sent to the treating/requesting doctor. If the doctor disputes the documentation, then the doctor may respond in writing.</p> <p>Since the goal of this practice would seem to be to expedite treatment in situations where full physician review might not be necessary, the requirement to obtain written documentation of the amended treatment request from the requesting doctor would seem to be counterproductive, and unnecessarily burdensome on both the</p>		<p>the investigation. An amended written request is required by the statute. Labor Code section 4610(e)</p>	

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	<p>Likewise, clarifying that Utilization Review investigations will be limited to requests for authorization received after the effective date of the regulations provides clarity on this issue.</p> <p>Commenter supports the amendments concerning Utilization Review complaints that will consider only "credible complaints" and the review and investigation process to determine credibility.</p> <p>Commenter believes that the current modification does not meet the criteria for 15 Day comment period per Government Code Section 11346.8 (c). Commenter believes that the modifications here proposed are substantial, and few could have been anticipated by the regulated community based on the prior text and hearing or based on long experience with audits conducted by the DWC or examinations conducted by the Department</p>		<p>audit review program. The results are then combined with the 2004 and 2003 performance rating scores to develop the 2007 PAR/FCA standards. The PAR standard for 2007 is 1.83201 and the FCA standard is 2.21982. Profile audit review audits (PAR audits) commencing after January 1, 2007 use the new standards.” For the UR investigation, there is no history and therefore, it is not possible to do a similar ranking and pass rate.</p> <p>Agree.</p> <p>Agree.</p> <p>We disagree that revisions to the subdivisions go beyond the subject of these regulations. The proposed regulatory changes are “sufficiently related” to the original text because they relate directly to the same subject as the originally noticed regulations.</p>	<p>None.</p> <p>None</p> <p>None.</p>

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Section 9792.11(j)	<p>of Insurance.</p> <p>The detailed list of information and records a Claims Administrator will have to produce, including data and information not required to be created or maintained by statute or the Administrative Director's own regulation governing utilization review standards, a list that, with benefit of community input, might have been modified and pared down.</p> <p>This Section also authorizes investigations to commence with no prior notice, something the regulated community could not have reasonably anticipated since no other audit process is conducted in that fashion.</p>	<p>Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment</p>	<p>We agree to reduce some of the information that will be requested.</p> <p>The only investigation that will go forward without advanced notice is a Special Target or Return Target that would be rendered less useful if advanced notice is given. To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter: the UR penalty investigation procedure.</p>	<p>Former subdivision (j)(4) will be deleted as the requested information does not need to be provided to the investigatory unit. That information can be determined from the information provided. Former subdivision (j)(5), which will now be (j)(4), will be revised for clarity. Former subdivision (j)(6), new subdivision (j)(5) will be revised. The words "data elements" are replaced with "information." Six of the formerly requested informational elements will be deleted, as the information will be provided in the requests for authorizations.</p> <p>None.</p>

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Section 9792.11(q)	Addition of a provision allowing the Administrative Director to withhold a written description of complaints against the claims administrator on which the director relied as the basis for a non-routine audit. Since absolutely nothing in statute or regulation mentions unannounced visits, the regulated community could not have anticipated that they would be subject to an investigation without having first been given an opportunity to validate the allegations of violations.	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	Some discretion must be allowed regarding disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records. To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter: the UR penalty investigation procedure.	None.
Section 9792.12(a)	While precise penalty amounts were subject to revision, the quintupling of penalties in some instances could not have been anticipated and the regulated community has been denied adequate opportunity to assess their impact on a statutorily mandated program.	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter: UR penalties. Disagree regarding increase in penalty amounts. None of the (a) penalties were increased in this revision and the (b) penalties can now be waived if the performance factor is 85% or better. There were some new (a) penalties added, but some of the (a) penalties were also reduced.	We will revise (a)(8). The penalty amount in subdivision (a)(8) is reduced from \$25,000 to \$1,000 because unlike the other \$25,000 penalty violations, in this case the request was approved and the failure is due to lack of documentation.
Section 9792.13(c)	The amendatory language in this Subdivision shifts the burden of proof to the claims administrator to demonstrate that a physician's refusal to cooperate has resulted in non-compliance with a requirement of statute or regulation. Subdivision (g) (5) of Section 4610 of the Labor Code reads, in part: "Upon receipt of all information	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter of section 9792.13(d) as it was originally proposed: Disagree that this section should be revised. This statement only applies	None.

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	<p>reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the Time frames specified in paragraph (1) or (2)."</p> <p>The regulated community might reasonably have expected that the requesting physician would be required to show that the requested information had been provided to the employer or the employer's insurer, but it could not have anticipated and had no opportunity to comment on the justification for the burden-shifting.</p>		<p>in the context stated in the subdivision: when the claims administrator or URO asserts that the injured worker or treating physician refused to cooperate and that the refusal prevented compliance.</p>	
Section 9792.11(j)	<p>Commenter opines this section does not comply with the Administrative Procedure Act's standards of authority and consistency, as required by government Code Section 11349.1.</p> <p>Section 9792.11 (j) requires a claims administrator, notified that an investigation will be conducted, to provide the Administrative Director with certain information. Paragraph (1) requires description of the system used to "identify each request for authorization (if applicable)". The implication, clearly, is that every treatment request must be tracked, not simply those referred for review under the process established in accordance with Labor Code Section 4610. However, as the WCAB and the 3rd District Court of Appeal held in SCIF v. WCAB (Sandhagen), (Third Appellate District, 048668 and 940286), nothing in Section 4610 requires a claims administrator</p>	<p>Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment</p>	<p>Disagree. The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information.</p> <p>The subdivision only requests a description of the system used to identify each and every request for authorization "(if applicable)" and "To the extent the system identifies any of the following..." If the claims administrator does not have a system that identifies the requests for authorization, it does not need to describe it. Further, the claims administrator is only required to provide the requested information to</p>	<p>Former subdivision (j)(4) will be deleted as the requested information does not need to be provided to the investigatory unit. That information can be determined from the information provided.</p> <p>Former subdivision (j)(5), which will now be (j)(4), will be revised for clarity.</p> <p>Former subdivision (j)(6), new subdivision (j)(5) will be revised. The words "data elements" are replaced with "information." Six of the formerly requested informational elements will be deleted, as the information will be</p>

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	<p>to refer every medical treatment request to utilization review. As the court said, "Section 4610, Section (b) requires the establishment of a UR process; it does not mandate use of that process for each and every medical treatment request.</p> <p>Penalties for failure timely to authorize any treatment request are already specified in Title 8 of the California Code of Regulations, Sections 10100 et. seq. Implicitly, this includes requests that are handled outside the utilization review process where timeliness can be identified from review of the claim files subject to audit.</p> <p>Also, while the modifications made to the data elements required for review have been significant, elements that remain in Subdivision (j) that are not necessary to manage the Utilization Review process may not be captured. As a result, setting up new tracking systems will engender increased Utilization Review costs and the possible slowing of the Utilization Review process.</p> <p>Commenter believes that a possible solution would be to not require the reporting of approved requests for authorization. A sufficient number of these types of responses would automatically be seen during the course of the PAR audit. Logging could then be truncated to the other types of responses.</p>		<p>the extent possible. Sandhagen is currently pending with the Supreme Court; however, the Appellate Decision does not eliminate Labor Code section 4610's requirement to have utilization review processes and procedures.</p> <p>Agree. Subdivision (j)(4) will be deleted.</p> <p>Disagree that (j) requires claims administrators to set up new tracking systems.</p>	<p>provided in the requests for authorizations.</p>
Section 9792.11 (o) and (p)	Commenter states that these subsections are in conflict with the deemed received sections of the Utilization Review regulations found in 9792.9 (a) and (b)(l) and need to be amended	Steven Suchil Assistant Vice President American Insurance Association	Disagree. Subdivision (o) does not change the timeframes for the required acts; it merely clarifies what will be allowed for purposes of	None.

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	to conform to them.	February 21, 2007 Written Comment	assessing penalties. The purpose of subsection (p) is to clarify when the request for authorization is deemed received if there is no proof of service. The UR regulations (section 9792.9(a)(2)) set forth when the request for authorization is deemed received when there is a proof of service attached.	
Section 9792.11(q)	Commenter opines that the language in this subsection permits the Administrative Director to withhold all complaint information that triggers a Non-Routine Investigation on the sole basis that the investigation might be "less useful." Nothing could be less useful than commencing an investigation before the claims administrator has been given an opportunity to respond. The conduct and violations being investigated here are not criminal actions, but the combination of no advance notice in Section 9792.11(j) and the withholding of basic information about the complaint treats claims administrators like suspects in criminal cases. At the very least, a description of the substance of the complaint and the Administrative Director's rationale for determining that the complaint was justified, must be provided, along with sufficient information for the claims administrator to identify and locate the claim file to which the complaint relates.	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	Disagree. The subdivision provides that the complaint or a description of the complaint shall be provided unless providing the information would make the investigation less useful. Some discretion must be allowed regarding disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.	None.
Section 9792.12	Commenter states that the increased penalty amounts will have a chilling effect on review of medical treatment services as claims administrators calculate the risk of penalties for even simple errors that would far outweigh the cost of simply approving these services, be	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	Disagree regarding increase in penalty amounts. None of the (a) penalties were increased in this revision and the (b) penalties can now be waived if the performance factor is 85% or better. There were	None.

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	<p>they reasonable and necessary or efficacious for that matter. To the extend the proposed penalties operate in this fashion the intent of lawmakers who enacted Labor Code section 4610 will be frustrated by the unintended consequences engendered by these regulations.</p>		<p>some new (a) penalties added, but some of the (a) penalties were also reduced.</p>	
Section 9792.11(c)	<p>Commenter states that aside from the additional costs to claim administrators who would have to prepare and submit information to the DWC, the cost of periodic investigations to the DWC or to employers who fund the DWC's operations through assessments were not even contemplated in the original notice which stated that there would be no cost or savings to the state in the fiscal impact statement.</p> <p>Commenter questions how may auditors will be required and what resources will be shifted from other essential agency functions.</p>	<p>Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment</p>	<p>DWC has adequate staffing to perform the audit and investigation functions, but has requested \$350,000 in contracting funds on an annual basis for potential contracting for out-of-state companies or complex audits where additional expertise is needed. These funds have already been requested beginning in fiscal year 2007/08 and were included in the Governor's Budget proposal that was released in January.</p>	None.
Section 9792.11 - Forms	<p>Commenter states that no form was made available at the time of the public hearing and that is has not been included in the proposed 15 day revised regulations.</p> <p>Commenter states that in the even that this form does come into use that a brief statement be added cautioning users against false reporting and citing Insurance Code section 1871.4 (a) and (b).</p>	<p>Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment</p>	<p>The complaint form is not within the scope of these regulations. The complaint form is not mandatory. Complainants may forward complaints in any manner, written or oral, with or without using the form. Therefore, it the form does not need to be part of the regulations. The investigating unit will confirm/investigate the allegations in the complaint to determine if it is credible prior to proceeding with an investigation.</p> <p>We disagree that a fraud warning is</p>	None.

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			needed. There is no required format or method for a complaint. They may be oral or written. Many injured workers are not aware of the legal; requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been an UR violation before an investigation is initiated.	
Section 9792.11(f)	Commenter states that the word “subject” should be changed to “subjected” as only request for authorization that require Utilization Review in keeping with a Claims Administrator’s Utilization Review plan should be subject to investigation.	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	Disagree. “Subject” is the appropriate verb in light of the fact that <i>Sandhagen</i> is pending review with the Supreme Court.	None.
Section 9792.11(j)	Commenter states that it appears that the “Routine” investigation is a typographical error and should be changed to “Return” investigation.	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	Agree.	The words “Target or Routine” will be stricken as they are unnecessary and Routine was incorrect.
Section 9792.11(j) and (m)	Commenter states that this section requires an exhaustive amount of material to be sent to the Division for review prior to an on-site investigation. In subdivision (m) the Claims Administrator is required to present true and complete copies of all requests for authorization requested by the Administrative Director or designee on the first day of the on-site investigation. Commenter recommends that subdivision (m) require all such information/copies/etc. <u>that has been not been previously provided.</u>	Steven Suchil Assistant Vice President American Insurance Association February 21, 2007 Written Comment	Agree to clarify these sections. However, this will have been the first time the list of the requests for authorization will have been given to the claims administrator and therefore, they would not have previously provided the requests for authorization.	The subdivisions will be revised to state: (k) The utilization review organization or claims administrator shall provide the requested information listed in subdivision (j) within fourteen (14) calendar days of receipt of the Notice of Utilization Review Investigation. Based on the information provided, the

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				<p>Administrative Director, or his or her designee, shall provide the claims administrator or utilization review organization, with a Notice of Investigation Commencement, which shall include a list of randomly selected requests for authorization from a three month calendar period designated by the Administrative Director and complaint files (if applicable), for investigation.</p> <p>(l) For utilization review organizations: Within fourteen (14) calendar days of receipt from the Administrative Director, or his or her designee, of the Notice of Investigation Commencement, the utilization review organization shall deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether electronic or paper, for each request for</p>
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				<p>authorization listed. Copies of the records shall be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that the all of the records produced are true, correct and complete copies of the originals, in his or her possession. After reviewing the records, the Administrative Director, or his or her designee, shall determine if an onsite investigation is required. If an onsite investigation is required, fourteen (14) calendar days notice shall be provided to the utilization review organization.</p> <p>(m) For claims administrators: The Notice of Investigation Commencement shall be provided to the claims administrator at least fourteen (14) calendar days prior to the commencement of the onsite investigation. The claims administrator shall produce for the</p>

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				Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.
Section 9792.12(a)(1)	This subsection states that a Utilization Review plan must be established consistent with Labor Code section 4610. Section 9792.7(5) mandates that “a description of the claims administrator’s practice, if applicable, of prior authorization process including but not limited to where authorization is provided without the submission of the request for authorization.” Commenter believes that this is an issue of the claims administrator to address. An independent utilization review company would not have access necessary to that information. Commenter believes that this should not be a requirement of the UR	Theodore Blatt, MD Medical Director Blue Cross of California February 21, 2007 Written Comment	Disagree. Section 9792.7(a) sets forth the requirements of the UR plan. If the URO is filing the plan on behalf of the claims administrator it is required to include this information.	None.

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	plan filed by the utilization review company, but rather the responsibility of the claims administrator independent of the utilization review plan which is filed by the utilization review company.			
Section 9792.12(a)(8)	Clarification is needed as to specifically when the \$25,000 penalty is applicable. The proposed penalty seems to be in direct conflict with the Notice of Modification of Text of Proposed Regulations, page 9, which states: "This re-written version does not require the non-Physician reviewer to possess the written amended request prior to approving the request."	Theodore Blatt, MD Medical Director Blue Cross of California February 21, 2007 Written Comment	Disagree. The subdivision states the non-physician reviewer must possess the amended request. The words "at the time of approving the modification" were stricken. Therefore, the amended request may be sent in after the approval.	The penalty amount in subdivision (a)(8) will be reduced from \$25,000 to \$1,000 because unlike the other \$25,000 penalty violations, in this case the request was approved and the failure is due to lack of documentation.
Section 9792.12(b)(4)(c)	<p>Commenter believes that a "best practice" quality standard is to foster direct communication between a Provider and Reviewer if a requested service cannot be certified per guidelines. The intent of the UR process is clearly to make determinations on evidence based literature, by Reviewers who are acting in the scope of their practice and to allow for variances of the case to be taken into account by the reviewing Physicians in rendering the ultimate decision.</p> <p>This is mandated in Workers' Compensation Utilization Management by URAC, clearly an independent quality standard organization. URAC now mandates dialogue with the Provider at some point during the initial review or the appeal process. The California Workers' Compensation UR process does not necessarily provide for a Physician appeal process, so it is essential that every effort be made to foster this <u>best practice</u> on the <u>initial</u></p>	Theodore Blatt, MD Medical Director Blue Cross of California February 21, 2007 Written Comment	Disagree. The timeframes are set forth in Labor Code section 4610(g) and the UR regulations section 9792.9. These regulations simply enforce the requirements.	None.

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	<p><u>review</u>. In cases where the request is submitted with all accompanying medical information, and does not pass guideline, by mandating the "5 business day" response it is going to be difficult if at all possible to foster communication between the requesting Provider and the Reviewer. Commenter believes that this timeframe will allow at most one attempted contact before the determination is made. If the Provider is not readily available, the determination will be made and likely the request non-certified.</p> <p>Commenter believes that a penalty should not be imposed if the request is addressed within the 14 day period from date of receipt by the Claims Administrator if the case has gone to Physician Review.</p>			
General Comment	Commenter is an injured worker who relates his difficulty obtaining treatment for his workers' compensation injury. Comment does not address any specific section of the proposed regulations.	Anthony Harris February 22, 2007 Written Comment	The comments do not address a specific regulation or make a specific suggestion.	None.
General Comment	<p>Commenter alleges that there is a lack of accountability on the part of treating providers due to an increasing number of "hidden" or unclear treatment requests. Commenter believes that the regulations and penalties as currently written give physicians incentive to undermine utilization review.</p> <p>Commenter requests that penalties should be correlated to refusal to pay for the treatment that was requested in a clear and concise manner, not for simply missing and unclear or "hidden" request.</p>	Jay Garrard February 22, 2007 Written Comment	Disagree. The UR regulations (9792.6(o)) define a request for authorization. If the physician request meets the definition, the claims administrator or URO is required to respond in a timely manner. Although the division intends to revise regulations that would address how the physician's report, that subject matter goes beyond the scope of these UR penalty regulations.	None.
General Comment	While the administrative director (AD) has not placed the utilization review enforcement	Michael McClain General Counsel & Vice	Agree.	None.

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	<p>regulations directly under the umbrella of the Division’s audit authority (Labor Code section 129 and 129.5), the AD has borrowed significant aspects of the PAR audit process to make the proposed utilization review (UR) enforcement regulations more rational and reasonable.</p> <p>Section 9792.11(i) provides a bright line, making it clear that the UR investigations will focus on utilization review activity conducted after the effective date of the enforcement regulations.</p> <p>These amendments are a vast improvement over the open-ended process of the prior regulatory scheme. Relying on verified, credible evidence will ensure that the UR investigations are well founded and that the resources of both the Division and the regulated community are properly employed.</p>	<p>President California Workers’ Compensation Institute February 22, 2007 Written Comments</p>	<p>Agree.</p> <p>Agree.</p>	<p>None.</p> <p>None.</p>
<p>Utilization Review Complaint Form</p>	<p>Commenter recommends that the Division include a brief statement on the complaint form citing Insurance Code section 1871.4(a) and (b) should be added to discourage false reporting.</p> <p>Discussion The AD posted on the Division’s website a Utilization Review Complaint Form (DWC complaint form 1), which may be used to report problems to the Division. The form was included with the material distributed at the California Applicant's Attorneys Association convention in San Diego on January 25. Speakers at the convention encouraged CAAA members and treating physicians to report</p>	<p>Michael McClain General Counsel & Vice President California Workers’ Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree. We disagree that a fraud warning is needed. The complaint form is not part of these regulations as it is not mandatory. There is no required format or method for a complaint. They may be oral or written. Many injured workers are not aware of the legal requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been an UR violation before an investigation is initiated.</p>	<p>None.</p>

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	<p>inappropriate treatment denials and problems with utilization review to the AD immediately. Within a week, some CWCI members were reporting being inundated with, what they considered to be, false complaints.</p> <p>Any complaint-related review process must balance encouraging the presentation of legitimate grievances and preventing false accusations. The UR enforcement regulations still do not include a statement of the consequence of filing false or fraudulent objections by physicians, attorneys, or injured workers. The verification procedure now included in section 9792.11(e) will prevent unnecessary expenditure of resources, but the complaint fails to advise the complaining party of the consequences of filing a false or fraudulent complaint.</p> <p>The complaint form was not included in the public hearing process and should have been. There appears to be no APA exemption for this form, which is part and parcel of the enforcement regulations. Having had no public discussion of this form, it may be fairly characterized as an underground regulation.</p>			
Section 9792.11(c)(1)(B)	<p>Commenter recommends that the performance measure for a routine medical utilization review investigation should be the same as the performance measure in the profile audit review process, 80%.</p> <p>The Legislature has vested the administrative director with authority to review all aspects of workers' compensation claims administration and benefit delivery. The division's audit</p>	<p>Michael McClain General Counsel & Vice President California Workers' Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree. Creating a performance rating of 80% would not be the equivalent to the audit performance rating. The audit performance rating is not a straight 80% standard, it is based on a three year historical record of how audited claims administrators ranked. As explained in the annual audit report for 2006, the performance standard is</p>	<p>None.</p>

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	<p>authority is primarily contained in sections 129 and 129.5, which reflects the legislative policy regarding claim management practices, performance measures, and regulatory enforcement. In all other areas of claim management and benefit delivery, the performance measure, although calculated with regard to past performance, is 80%.</p> <p>The timely and appropriate delivery of medical care to the injured worker is as important as the efficient payment of TD and the correct determination of PD benefits. There appears to be no legislative policy, administrative rationale, or social policy supporting the bifurcation of the claims administration performance standards. AB 749 established the performance standards for all other aspects of benefit delivery and the standard for utilization review should mirror that benchmark.</p>		<p>recalculated yearly: “The PAR and FCA performance standards have been updated pursuant to Labor Code section 129(b) and Title 8, California Code of Regulations, section 10107.1(c), (d), and (e). This is accomplished by taking the 2005 audit results and using data for the five major keys subject to the profile audit review program. The results are then combined with the 2004 and 2003 performance rating scores to develop the 2007 PAR/FCA standards. The PAR standard for 2007 is 1.83201 and the FCA standard is 2.21982. Profile audit review audits (PAR audits) commencing after January 1, 2007 use the new standards.”</p> <p>For the UR investigation, there is no history and therefore, it is not possible to do a similar ranking and pass rate. 85% represents a good performance but allows some room for error.</p>	
Section 9792.12(a)(8)	<p>Commenter requests that the Division delete proposed section 9792.12(a)(8) or modify it as indicated and move it to section 9792.(b)(5), and renumber as appropriate:</p> <p>(H)(8)(5) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended</p>	<p>Michael McClain General Counsel & Vice President California Workers’ Compensation Institute February 22, 2007 Written Comments</p>	<p>We agree to correct the numbering, add the comma, reduce the penalty to \$1,000, since the amended request was approved and the violation is for failure to document.</p> <p>The statute does not allow a non-physician reviewer to modify a physician’s written request. Labor Code section 4610(e) states: “No person other than a licensed physician who is competent to</p>	<p>We agree to correct the numbering, add the comma, reduce the penalty to \$1,000, since the amended request was approved and the violation is for failure to document.</p>

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	<p>request; to possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request;</p> <p>To minimize medical treatment delays, non-physician reviewers frequently discuss authorization requests with the treating physicians by telephone, particularly when the proposed treatment is inconsistent with medical treatment guidelines. During these telephone discussions, the physician may agree to voluntarily withdraw the request and submit an amended request when the reviewer agrees to authorize an alternate, mutually agreed upon course of care or treatment.</p> <p>In accordance with the proposed regulation, if the physician fails to submit an amended request as promised, not only is the claims administrator subject to a \$25,000 penalty, the opportunity to submit the original request to a physician reviewer for timely review and modification or denial will be lost, due to the very tight timeframes. To avoid incurring such an excessive penalty, requests that appear to be inconsistent with the medical treatment guidelines, which could be handled with a phone call to the physician, may now be denied or modified by reviewers. The consequence will be treatment delays, disputes, and fewer approvals of mutually agreed upon plans.</p>		<p>evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician’s practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.” 8 CCR 9792.6(o) defines a request for authorization as a written confirmation or an oral request for a specific course of proposed medical treatment. “An oral request for authorization must be followed by a written confirmation of the request within 72 hours.” 8 CCR section 9792.7(b)(2) states: “A non physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization.” Thus, in order to be in compliance with the statute and UR regulations, unless the UR file contains an amended written request, the non-physician reviewer is in violation of the UR requirements.</p>	

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	<p>Setting the penalty for the failure to possess an amended written request for treatment at \$25,000 means that the claims organization will take no action in the case of a voluntary withdrawal unless and until an amended written request for treatment is received, because the reviewer can never be certain that the physician will submit the necessary paperwork as promised. By this regulation, the administrative director is “legislating” that result. The statute does not provide the AD with the authority to preclude what the statute allows.</p> <p>The regulation imposes a \$25,000 fine for essentially a “paper” violation. The regulation includes no mitigation when the failure to have an amended written request for treatment causes no delay in the receipt of the medical care. As such, the penalty for failure to possess the amended request properly belongs with the other documentation violations in subdivision (b)(5).</p> <p><u>Technical Note:</u> The prior paragraph number “(5)” was not deleted and should be. For clarity, a comma should follow the adjectival phrase “... a non-physician reviewer..., who approves an amended request,</p>		<p>Also, it may not be a paper violation. Without the documentation to show that the physician made an amended request, it could be that the non-reviewer physician denied or modified the physician’s request without approval from the physician.</p>	
Section 9792.13(c)	<p>Commenter recommends that the language be revised as follows:</p> <p>(c) Where an injured worker's or a requesting provider’s refusal to cooperate in the utilization review process has prevented the claims administrator or utilization review</p>	<p>Michael McClain General Counsel & Vice President California Workers’ Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree. The injured worker or provider’s refusal to cooperate may explain part of the reason for the failure to act in compliance with the UR regulations, but not completely excuse the failure. By using the word “may”, the AD has discretion to weigh all the factors involved.</p>	None.

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	<p>organization from determining whether there is a legal obligation to perform an act, the Administrative Director, or his or her designee, may <u>shall</u> forego a penalty assessment for any related act or omission.</p> <p>The regulation envisions that there may be interference with the utilization review process from either the injured worker or the provider and that this could affect the claims administrator's ability to conduct the process in a timely fashion. The proposed regulation is premised on such a finding, yet the application of an audit penalty is still discretionary. Where such interference is found, no penalty is warranted.</p>			
Section 9792.11(f)	<p>Commenter recommends the following change:</p> <p>(f) Administrative penalties may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, except that the penalties listed in section 9792.12 (a)(6) through (14) and (b) shall only be imposed if the request was <u>subjected</u> to the Labor Code section 4610 utilization review process.</p> <p>It appears that these penalties will be imposed only if the request was in fact presented to the formal utilization review process.</p>	<p>Michael McClain General Counsel & Vice President California Workers' Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree. "Subject" is the appropriate verb in light of the fact that <i>Sandhagen</i> is pending review with the Supreme Court.</p>	<p>None.</p>
Section 9792.11(j)	<p>Commenter recommends the following</p>	<p>Michael McClain</p>	<p>Agree that Routine was the wrong</p>	<p>The words target and</p>

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	<p>language:</p> <p>(j) Unless the Administrative Director in his or her discretion determines that advance notice will render a Special Target or Return Target Investigation less useful, the claims administrator or utilization review organization shall be notified of its selection for a <u>Special Target</u> or <u>Return Target Investigation</u>.</p> <p>The subject of the section is the Special Target or Return Target Investigation, so these corrections are necessary to ensure that the phrases refer to the same event.</p>	<p>General Counsel & Vice President California Workers' Compensation Institute February 22, 2007 Written Comments</p>	<p>word. The section will be corrected by deleted both words target and Routine as they are unnecessary in the sentence.</p>	<p>Routine will be deleted.</p>
<p>Section 9792.11(j)(1)</p>	<p>Commenter recommends the following language:</p> <p>(j)(1) A description of the system used to identify each request for authorization (if applicable). To the extent the system identifies any of the following information in an electronic format, the utilization review organization shall provide in an electronic format a list of each and every request for authorization; <u>and the claims administrator shall provide in an electronic format a list of each and every request for authorization that has been denied, modified, withdrawn, or submitted with a request to be expedited</u>; received at the investigation site during a three</p>	<p>Michael McClain General Counsel & Vice President California Workers' Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree that the requests for authorization should be randomly selected from the PAR files selected for audit. The PAR sample includes specific types of cases (indemnity files) over a three year period. There may be no files selected that would fall in the three month period following the effective date of the regulations. Also, the PAR sample would not be valid because it only seeks indemnity claims. The requested pool should include all requests for authorization in order for the sample to be valid.</p>	<p>None.</p>

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	<p>month calendar period specified by the Administrative Director, or his or her designee and the following data elements: ...</p> <p>For the Routine UR Investigation of the claims administrator, the AD should limit the initial review to the examination of the requests for authorization contained in claims randomly selected for PAR audit and restrict the data element list to those requests for authorization that were modified, withdrawn, denied or submitted with a request to be expedited.</p> <p>While the revisions made to the request for data elements during the UR review have made a significant improvement to the process, flexibility is still the key. As we have noted in previous testimony, claims administrators track data necessary to manage the UR process. Data demands listed in subsection (j) that are not necessary to manage the utilization review program may not be captured or may only be available through a manual tracking system required only for the audit.</p> <p>Since the majority of treatment requests are authorized, the files selected for a PAR audit will contain a good sample of authorized requests for the purposes of a Routine Investigation. Because the statute and the UR Standards Regulations mandate prompt review and action on treatment requests, many claims administrators do not capture information regarding routinely authorized requests.</p>			
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	Setting up new data tracking systems, whether automated or manual, in order to facilitate the Routine UR Investigation would slow the delivery of medical care, limit the statutory options presently in place to conduct medical utilization review, and increase the cost of UR without improving the efficiency.			
Section 9792.11(m)	<p>Commenter recommends the following language:</p> <p>(m) The claims administrator shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation <u>if not previously provided</u>, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.</p> <p>There is an indication elsewhere in the proposed regulations that this material may have been requested prior to the commencement of the investigation and may be provided in advance.</p>	<p>Michael McClain General Counsel & Vice President California Workers' Compensation Institute February 22, 2007 Written Comments</p>	<p>Agree to clarify these sections. However, this will have been the first time the list of the requests for authorization will have been given to the claims administrator and therefore, they would not have previously provided the requests for authorization.</p>	<p>The subdivisions will be revised to state: (k) The utilization review organization or claims administrator shall provide the requested information listed in subdivision (j) within fourteen (14) calendar days of receipt of the Notice of Utilization Review Investigation. Based on the information provided, the Administrative Director, or his or her designee, shall provide the claims administrator or utilization review organization, with a Notice of Investigation Commencement, which shall include a list of randomly selected requests for authorization from a three month calendar period designated by the Administrative Director and complaint files (if</p>

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				<p>applicable), for investigation.</p> <p>(1) For utilization review organizations: Within fourteen (14) calendar days of receipt from the Administrative Director, or his or her designee, of the Notice of Investigation Commencement, the utilization review organization shall deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether electronic or paper, for each request for authorization listed. Copies of the records shall be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that the all of the records produced are true, correct and complete copies of the originals, in his or her possession. After reviewing the records, the Administrative Director, or his or her designee,</p>
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				<p>shall determine if an onsite investigation is required. If an onsite investigation is required, fourteen (14) calendar days notice shall be provided to the utilization review organization.</p> <p>(m) For claims administrators: The Notice of Investigation Commencement shall be provided to the claims administrator at least fourteen (14) calendar days prior to the commencement of the onsite investigation. The claims administrator shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian</p>

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				of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.
Section 9792.11(o) and (p)	<p>Commenter recommends that these sections be deleted.</p> <p>Proposed subsections (o) and (p) must be deleted because they are in conflict with the “deemed received” specifications in the Utilization Review Standard regulations, sections 9792.9(a) and (b)(1).</p>	<p>Michael McClain General Counsel & Vice President California Workers’ Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree. Subdivision (o) does not change the timeframes for the required acts; it merely clarifies what will be allowed for purposes of assessing penalties. The purpose of subsection (p) is to clarify when the request for authorization is deemed received if there is no proof of service. The UR regulations (section 9792.9(a)(2)) set forth when the request for authorization is deemed received when there is a proof of service attached.</p>	None.
Section 9792.11(q)	<p>Commenter recommends the following language:</p> <p>(q) Upon initiating a Target Investigation the Administrative Director, or his or her designee, shall provide to the claims administrator or the utilization review organization a written description of the <u>credible</u> factual information or of the complaint containing <u>credible</u> factual information that triggered the utilization review investigation unless the Administrative Director or his or her designee determines that providing the information would make the investigation less useful</p>	<p>Michael McClain General Counsel & Vice President California Workers’ Compensation Institute February 22, 2007 Written Comments</p>	<p>Disagree. The subdivision provides that the complaint or a description of the complaint shall be provided unless providing the information would make the investigation less useful.</p> <p>It is unnecessarily duplicative to add the word credible in this section. (See 9792.11(c) and (e).)</p> <p>Some discretion must be allowed regarding disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.</p>	None – except the extra words “such person” will be stricken.

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	<p><u>adversely affect the outcome of the investigation. The Administrative Director's rationale for this determination shall be provided to the subject of the investigation.</u> The claims administrator, or utilization review organization such person shall have ten (10) business days upon receipt of the written description to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further investigation to determine whether a violation exists and whether to impose penalty assessments.</p> <p>With regard to the decision not to provide the audit subject with the relevant, credible information contained in the complaint, it is imperative that the AD articulate the reasoning behind this conclusion in order to avoid an impasse and allow the claims organization to defend itself against the accusations of misconduct. There must also be a provision to waive the demand for a written response within 10 days.</p>		<p>Also, the pilot investigations have taken only a few days each. If the response from the investigation subject is going to require more than ten days, then it would be faster to go forward with the investigation.</p>	
Section 9792.13(d)	<p>Commenter recommends that the Division delete this section and renumber the subdivisions.</p> <p>The regulation is redundant, as subdivision (b) already notes the administrative director's</p>	<p>Michael McClain General Counsel & Vice President California Workers' Compensation Institute February 22, 2007</p>	<p>Agree.</p>	<p>This subdivision will be deleted.</p>

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	dual authority under Labor Code section 129.5(e).	Written Comments		
Section 9792.11(c)(1)(A)	This section requires that a utilization review organization be subject to a Routine Investigation at least once every three years. A provision later in the text subjects a claims adjusting location to such an investigation at least once every five years. A utilization review organization need not be subject to mandatory routine investigations any more frequently than a claims adjusting located. As such, commenter requests that the text be amended to require routine investigations at least once every five years for utilization review organizations.	Harry Monroe, Jr. Director of Governmental Relations Concentra Inc. February 22, 2007 Written Comment	Disagree. There are less URO companies than claims adjusted locations (approximately 60 versus 500) and they handle more of the requests for authorizations so they should and can be investigated more often. Plus, the claims administrators are already audited at least once every five years, so it is logical to tie the UR investigation to the PAR audit.	None.
Section 9792.11(c)(1)(B)(2)	This section provides that a Special Target Investigation may be conducted “at any time based on credible information indicating the existence of a violation...” While the language has been improved by the addition of the word “credible” in the amended text, the provision still grants overly broad discretion for the opening of a “Special Target” investigation. A Special Target investigation should only be appropriate if the investigation of the complaint finds a violation that would justify the opening of a wider inquiry. Commenter requests that the text should be changed accordingly.	Harry Monroe, Jr. Director of Governmental Relations Concentra Inc. February 22, 2007 Written Comment	Disagree. It will be necessary to review the URO or claims administrator files to determine if a violation exists. That cannot be determined before reviewing the records, which is done during the UR investigation.	None.
Section 9792.12(a)(2)	This section provides for a mandatory penalty of \$5,000 for failure to meet all of the requirements of section 9792.7(a) for a utilization review plan. This provision fails to acknowledge that a failure to fully meet the requirements of that section may be the result of a good faith oversight or misunderstanding that occurred when preparing the plan for	Harry Monroe, Jr. Director of Governmental Relations Concentra Inc. February 22, 2007 Written Comment	Disagree. The UR plan is the backbone of the UR process. It must meet the statutory requirements. The statute does not require the AD to approve or disapprove the plans. Nonetheless, the division has reviewed all of the UR plans on file and communicated to the claims	None.

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>mandatory submission to the Division. Commenter believes that these fines should only apply if the utilization review organization fails timely to correct a deficiency identified by the Division in its review of submitted plans.</p>		<p>administrators or URO that filed the plan if there were any inadequacies. Therefore, at this point, if discrepancies exist it is because the URO or claims administrator failed to correct a deficiency.</p>	
<p>Section 9792.11(n)</p>	<p>This section proposes that if the AD determines that additional records or files are needed for review during any onsite investigation, the claims administrator or UR organization shall produce the requested records within one calendar day when the records are located onsite and within five calendar days when the records are located at any other site.</p> <p>Recommendation Commenter recommends extending this timeframe to allow up to two or three <u>working</u> days, instead of calendar days, when the records are onsite. If the AD requests several additional files or several pieces of information, one calendar day is not sufficient. Older files and other additional records (e.g. investigation records, subpoena medical records) are often kept in storage and may take more time to locate even though they are kept onsite.</p>	<p>Jose Ruiz Claims Operations Manger State Compensation Insurance Fund (SCIF) February 22, 2007 Written Comment</p>	<p>Disagree. Audits performed pursuant to 129.5 require additional files to be produced within 1 day (see 8 CCR 10107.1(i)). There have been no problems with this requirement. Also, the pilot investigations only lasted a few days. Allowing three working days would unnecessarily extend the amount of time the investigators would need to be at the site and delay the completion of the investigation. Finally, the subdivision allows the AD to extend time for the production of the requested records upon good cause.</p>	<p>None.</p>
<p>Section 9792.12(a)(8)</p>	<p>This section proposes a penalty of \$25,000 where a non-physician reviewer has approved an amended request but does not possess the amended written request for authorization from the requesting physician.</p> <p>Recommendation Commenter is concerned that this proposed regulation may penalize claims administrators</p>	<p>Jose Ruiz Claims Operations Manger State Compensation Insurance Fund (SCIF) February 22, 2007 Written Comment</p>	<p>We agree to correct the numbering, add the comma, reduce the penalty to \$1,000, since the amended request was approved and the violation is for failure to document.</p> <p>The statute does not allow a non-physician reviewer to modify a physician's written request. Unless</p>	<p>We agree to correct the numbering, add a comma, and reduce the penalty to \$1,000, since the amended request was approved and the violation is for failure to document.</p>

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	<p>and UR organizations for the requesting physician's failure to submit an amended written request.</p> <p>A common practice is for a non-physician reviewer to triage UR requests for authorization. As part of this process, sometimes it is necessary to contact the requesting physician to clarify the treatment plan and medical necessity. In some instances, the requesting physician may agree to voluntarily withdraw his or her request and submit an amended request. The non-physician reviewer may authorize the amended request based on the physician's verbal agreement to submit an amended written request in order to expedite the process. However, where the physician fails to submit the amended written request, this proposed subsection would assess a fine of \$25,000 against the claims administrator or UR organization.</p> <p>Commenter recommends that if documentation exists that indicates that the requesting physician has voluntarily withdrawn the original request, this penalty should not be applied. The following language is offered for consideration:</p> <p>(8) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request to possess an amended written request for treatment</p>		<p>the file documents an amended written request, the non-physician reviewer is in violation of the statute.</p>	

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	<p>authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request, <i>unless other documentation exists to indicate that the requesting physician has withdrawn the original request for authorization</i>: \$25,000.</p>			
Section 9792.14(b)	<p>Recommendation The UR regulation, CCR §9792.6(c), provides a definition of “claims administrator” which includes an insured employer. Page two of The Addendum to Final Statement of Reasons dated September 20, 2005 explains:</p> <p>“First, the definition includes the term “an insured employer” because throughout the regulatory process it was determined that some insured employers were conducting some of the utilization review on their own. By including the “insured employer” in the definition of claims administrator it has been assured that if they choose to conduct utilization review on their own, they would be required to comply with the requirements of the regulations, and be subject to penalties for failure to comply with the requirements of the regulations.”</p> <p>Commenter is concerned that where the employer is acting independently from the claims administrator, and by doing so, performs a violation of UR standards, the claims administrator may be jointly and severally liable</p>	Jose Ruiz Claims Operations Manger State Compensation Insurance Fund (SCIF) February 22, 2007 Written Comment	Disagree. The subdivision states: “except that if the subject of the investigation or audit is acting as an agent, the agent and principal are jointly and severally liable...” Thus, if the insured employer is not acting as an agent, the claims administrator will not be jointly liable for the insured employer’s penalty assessments. The recommended language is duplicative of the language in the regulation. However, the parties can insert similar language in their URO contracts if desired.	None.

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	<p>due to the language in the UR Enforcement Regulations subsection 9792.14(b) despite the fact that the employer is not an authorized agent of the claims administrator. State Fund believes that it may be contrary to public policy for an insurer to pay penalties on behalf of an employer who has stepped out of its role as policyholder, whose claims by contract are to be adjusted by the insurer. Therefore, commenter proposes the following language to address penalties resulting from an insured employer's unlawful and independent actions:</p> <p>(b) The claims administrator or utilization review organization is liable for all penalty assessments made against it, except that if the subject of the investigation or audit is acting as an agent, the agent and the principal are jointly and severally liable for all penalty assessments resulting from a given investigation or audit. This paragraph does not prohibit an agent and its principal from allocating the administrative penalty liability between them. Liability for civil penalties assessed pursuant to Labor Code section 129.5(e) for violations under Labor Code section 4610 or sections 9792.6 through 9792.10 of Title 8 of the California Code of Regulations shall not be allocated.</p> <p><u>When an insured employer acts independently of the insurers responsibility for the Utilization</u></p>			

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	<u>Review program as described in Labor Code §4610, the insurer will not be liable for any penalty assessments for those actions.</u>			
Complaint Form	Commenter recommends incorporating the Utilization Review Complaint Form into these regulations so that the public has time to provide feedback.	Jose Ruiz Claims Operations Manger State Compensation Insurance Fund (SCIF) February 22, 2007 Written Comment	Disagree. The complaint form is not mandatory. Complainants may forward complaints in any manner, written or oral, with or without using the form. Therefore, it the form does not need to be part of the regulations.	None.
Sections 9792.11(c)(1)(A) and 9792.11(c)(2)(A)	<p>Proposed § 9792.11(c)(1)(A) and § 9792.11(c)(2)(A) outline how requests for authorization will be selected for the purposes of the investigation. The language in both proposed sections is identical but for the description of the facility subject to the investigation:</p> <p><i>“The investigation shall include a review of randomly selected requests for authorization, as defined by section 9792.6(o), received by the utilization review organization (or claims administrator) during a three month calendar period specified by the Administrative Director. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation.”</i></p> <p>Commenter’s concern with this language is based on the fact that facilities under</p>	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	Agree to revised subdivision 9792.12(b)(1) to clarify that the performance rating will be based only on the randomly selected requests for authorization.	Subdivision 9792.12(b)(1) will be revised to clarify that the performance rating will be based only on the randomly selected requests for authorization.

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>investigation will have a performance rating that will determine whether or not penalties are applied. The performance rating outlined in the regulations is 85%. Because the investigation will include two types of requests for authorization – a random sample and specific authorization requests selected due to complaints – we are concerned that the performance rating will not be a true reflection of the investigation subject’s business practices. Commenter firmly believes that the performance rating which ultimately determines punitive action should be based solely on a random sample of authorization requests because it is meant to reflect the overall business practice of the facility under investigation. This does not mean that the Division should not also review or assess penalties on requests for authorization audited due to injured worker’s complaints; just that those requests for authorization should not be included in the calculation of a performance rating that is meant to accurately reflect overall business practices upon which a facility may be penalized.</p>			
Section 9792.11(j)	<p>Commenter is concerned that “or other person performing utilization review processes for an employer will” has been deleted. Boeing currently uses Nurse Case Managers to perform the UR duties for instances where there is no discrepancy of the recommended treatment plan. Boeing uses their UR physicians for UR decisions which are being denied and/or contested. Relegating the duties of our NCM’s to the UR physician is both unnecessary and costly. Commenter notes that it is in other parts of the proposed</p>	<p>Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment</p>	<p>Disagree. The definition of URO in 9792.11(a) includes any person or entity with which the employer, or an insurer, or third party administrator, contracts to fulfill part or all of the employer’s utilization review responsibilities under Labor Code section 4610 and Title 8 of the California Code of Regulations, sections 9792.6 through 9792.15. Nurse Case Managers would fall under that definition.</p>	<p>None.</p>

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	regulation and recommends that it be added back into the entire document.			
Section 9792.11(o)	This subsection would be more appropriately placed in the Utilization Review regulations (Section 9792.6) already completed by the Division. While the section does specifically apply to application of penalties, it is fundamentally a rule that dictates how a utilization review organization or claims administrator must operate in the context of utilization review.	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	Disagree. The subdivision is required for these regulations to clarify the date for purposes of assessing penalties.	None.
Section 9792.11(q)	This subsection should be amended to require the Administrative Director, in all target investigations, to provide the utilization review organization or claims administrator subject to investigation with a copy of the factual information which has triggered the investigation.	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	Disagree. Some discretion must be allowed regarding disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.	None.
Section 9792.11(v)	<p>This section requires a utilization review organization or claims administrator to perform certain actions in the event that no answer is filed to the Order to Show Cause, or if all appeals have become final. Specifically, it requires the utilization review organization or claims administrator to provide specific information regarding the results of the investigation to all employers whose utilization review process was subject to penalties.</p> <p>Commenter believes that this subsection should be amended to provide a window of time between the date that an answer would be due and the time when these obligations must be met. This is because the utilization review organization or claims administrator may not</p>	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	Agree.	This subdivision will be revised to allow 45 days instead of 31. This subdivision will also be revised to require notice to be given to the insurer, TPA or employer.

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	<p>decide to forego an appeal until the last minute. If that is the case, then they will need additional time to fulfill their obligations under this subsection. There should be a distinct period for an utilization review organization or claims administrator to consider or prepare an appeal, and a separate period of time in which to comply with provisions requiring notice to employers.</p> <p>The requirements for notification under this subsection are limited to the employer whose claims are being subject to penalties. However, in many cases a utilization review organization or claims administrator will be administering utilization review for an insurance company. Commenter believes that, in this situation, the utilization review organization or claims administrator should be required to notify the insurer as well as the employer. If this is not the case, then an insurer would be lacking information pertinent to their claims and will not be able to respond in an informed manner to concerned policyholders.</p>			
Sections 9792.12(a)(1) through 9792.12(a)(15)	The mandatory administrative penalties outlined in this section have been amended to remove the word “maximum” from the penalty amounts. Considering that the penalty amounts were already substantially increased in previous versions of the regulations, some by 500%, there is no reason to remove the term “maximum” from the penalty description. While it is clear through proposed § 9791.12(c) that reduction of penalties in these sections are allowed under proposed § 9792.13, the term “maximum”	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	Disagree regarding the term “maximum.” The term as previously used appeared to allow discretion in the amount of the assessment below the listed maximum amount. The penalty amounts still cannot be more than the amount listed, however, it is clearer that they may only be decreased if one of the factors listed in 9792.13 applies. Disagree regarding increase in	We will revise (a)(8). The penalty amount in subdivision (a)(8) is reduced from \$25,000 to \$1,000 because unlike the other \$25,000 penalty violations, in this case the request was approved and the failure is due to lack of documentation.

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	<p>should remain because the amounts listed are indeed maximum penalty amounts.</p> <p>The mandatory administrative penalties do not contain a provision discussing a “performance rating”. Commenter believes that a performance rating should be applied to all of the penalty provisions outlined in these regulations.</p>		<p>penalty amounts. None of the (a) penalties were increased in this revision and the (b) penalties can now be waived if the performance factor is 85% or better. There were some new (a) penalties added, but some of the (a) penalties were also reduced.</p> <p>Disagree that the (a) penalties should be allowed an 85% pass rate. There is simply no reason why there should be a waiver of a penalty for failure to establish a UR plan, or failure to hire a medical director, or any other of the violations listed in (a), no matter how well the investigation subject does regarding the other UR requirements.</p>	
Section 9792.12(a)(6)	This subsection was previously one that applied a penalty when a reviewer made a decision to modify or delay a treatment request that is outside of his or her scope of practice. While the goal of this subsection does not seem to have changed, the amended language is very unclear and should be reviewed and restated. Considering the \$25,000 fine imposed by this subsection, clarity in language is vital to utilization review organizations and claims administrators.	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	We agree to revise.	Subdivision (a)(6) will be revised to state: (6) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer’s scope of practice (as set forth by the reviewer’s licensing board): \$25,000
Section 9792.12(a)(8)	This subsection is unclear in the context of	Christine D. Coakley	We agree to reduce the penalty to	The penalty amount will

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	§9792.7(b)(3), which outlines how a non-physician reviewer may interact with a requesting physician. Commenter believes that this subsection needs to be amended for purposes of clarity. Considering the \$25,000 fine imposed by this subsection, clarity in language is vital to utilization review organizations and claims administrators.	Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	\$1,000. However, as written, no penalty will be imposed if the written amended request is sent in after the approval. The subdivision only requires that the written amended request be in the file at the time of the investigation. An amended written request is required by the statute. Labor Code section 4610(e)	be reduced from \$25,000 to \$1,000.
Section 9792.12(a)(11)	This subsection penalizes a utilization review organization or claims administrator for “failure to discuss with the requesting physician options for a care plan as required by labor code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical care, in the case of concurrent review”. Commenter feels that this subsection does not take into account a situation where a reviewing physician attempts to contact a physician without success. According to this section, a requesting physician could simply ignore attempts to discuss a care plan from a physician reviewer and the utilization review organization or claims administrator would be unable to act for fear of a \$10,000 fine.	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	We agree.	Subdivision (a)(11) will be revised to state: (11) For failure to discuss or document attempts to discuss reasonable options for a care plan with the requesting physician as required by Labor Code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical care, in the case of concurrent review: \$10,000;
Section 9792.15(b)(3)	This subsection requires the date of the hearing to be at least 90 days from the date of service of the Order to Show Cause. In order to expedite medical services to employees we recommend that the 90 days be reduced to 60 days. Commenter believes that the UR regulations in Section 9792.6 should be updated and clarified in order to promote understanding of responsibility between these proposed	Christine D. Coakley Legislative & Regulatory Analyst The Boeing Company February 22, 2007 Written Comment	Disagree. An employee may file an expedited hearing with the WCAB district office immediately upon determining that there is a problem or dispute. Alternatively, the medical dispute may be resolved by the QME/AME process – not this process. These hearings will concern the assessed penalties. The requests for authorizations included in the investigation are already from a	None.

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	regulations to interacting regulatory sections; specifically, adding terminology to the UR enforcement regulations which would create a need to update the “definitions” portion or the UR regulations in Section 9792.6.		previous three month calendar period and any medical issue owed to the employee should have been resolved by then.	
General Comment	Commenter questions whether the Division is exceeding its statutory authority. Commenter states that a routine investigation looks as though it is a performance audit which is governed by Labor Code section 129. Commenter notes that the Division has constructed a procedure that parallels that for a performance audit, but is not identical. For example, the standard for a performance audit is 80 percent while the proposed rules establish an 85 percent standard.	Samuel Sorich, President Association of California Insurance Companies February 22, 2007 Written Comment	We disagree that the UR investigation is a Labor Code section 129 audit. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. Labor Code section 4610(i) provides authority for the AD to impose penalties for failure to comply with the UR requirements. Initiating regular investigations is a fair and equal way of determining if the claims administrators and UROs have violated the time frames and requirements of section 4610.	None.
Section 9792.11(g)	Commenter states that the Division is exceeding its authority by substituting a penalty schedule other than that set forth in Labor Code section 129.5.	Samuel Sorich, President Association of California Insurance Companies February 22, 2007 Written Comment	Disagree. Labor Code section 129 and 129.5 were designed to address claims handling by claims administrators – not UR violations. (Labor Code section 4610, as amended in 2003, was enacted ten years after Labor Code section 129 and 129.5, and fails to require limits on penalties as set forth in Labor Code sections 129 and 129.5.) Labor Code section 129.5 prohibits the assessment of any penalties if the audit subject passes the PAR and caps penalties that can be assessed at \$5,000. The audit regulations (8 CCR 10107.1 et seq.) provide that	None.

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			the only violations addressed in the PAR audit are failure to pay indemnity payments, late first payments of TD, PD etc., and failure to issue benefit notices. Just like Labor Code section 5814.6, Labor Code section 4610 provides authority independent from Labor Code section 129 and 129.5 to assess penalties.	
Section 9792.12(a)(5)	Commenter states that some words in this section appear to have been inadvertently deleted, so there is no complete sentence.	Samuel Sorich, President Association of California Insurance Companies February 22, 2007 Written Comment	Disagree that words are missing.	None.
Section 9792.12(a)(8)	Commenter is puzzled by the Division's treatment of a common situation where a low level reviewer calls a doctor and points out that his treatment plan is inconsistent with the ACOEM Guidelines, and the doctor then modifies this treatment plan accordingly and it is approved over the phone. Commenter questions why this would warrant a penalty of \$25,000. Commenter feels that an informal approach that quickly resolves a request for authorization so that the injured worker promptly receives treatment should be favored, not penalized, and feels this section is prioritizing paperwork over prompt treatment. Commenter also states that the wording in this section is not clear.	Samuel Sorich, President Association of California Insurance Companies February 22, 2007 Written Comment	We agree to reduce the penalty to \$1,000. However, as written, no penalty will be imposed if the written amended request is sent in after the approval. The subdivision only requires that the written amended request be in the file at the time of the investigation. An amended written request is required by the statute. Labor Code section 4610(e)	The penalty amount will be reduced from \$25,000 to \$1,000.
Section 9792.14(b) and 9792.14(c)	Commenter believes that the joint and several penalty liability in these sections are bad public policy. Commenter feels that penalties should be imposed on those that fail to comply with the utilization review standards.	Samuel Sorich, President Association of California Insurance Companies February 22, 2007 Written Comment	Disagree regarding (b). The claims administrator and UR agent may clarify liability responsibilities within the contract; however, per the UR regulations at 9792.6 et seq. it is the claims administrator's responsibility	None.

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			to maintain the UR process and meet the time frames of UR. Disagree regarding (c). The purpose of this section is to prevent a claims administrator from simply changing its name or merging with another entity to avoid paying for the UR penalties that were assessed against it.	
Section 9792.11(c)(1)(B)(3)	In order to keep parallel construction, the word “credible” should be inserted before complaint in (2).	Samuel Sorich, President Association of California Insurance Companies February 22, 2007 Written Comment	Disagree. The word is unnecessary and would be duplicative.	None.
General Comment	<p>Commenter believes that the current draft regulations are a vast improvement over the previous version except for the following:</p> <p>The record keeping requirements are still burdensome at best. Commenter believes these requirements are unnecessary and will significantly increase the cost of utilization review.</p> <p>Although the division has provided a mechanism for mitigating penalties, the base amounts of these penalties are still over and beyond what they need to be. Commenter is concerned that these penalties will kill the use of utilization review.</p>	Philip M. Vermeulen Governmental Relations February 22, 2007 Written Comment	<p>Agree to delete 9792.11(j)(4) and additional data in (j)(5).</p> <p>Agree to reduce the penalty in 9792.12 (a)(8) from \$25,000 to \$1,000. Disagree that the remaining penalties are too high. The penalties must have a deterrent aspect or there is not point in assessing them.</p>	<p>Subdivision 9792.11(j)(4) and additional data in (j)(5) will be deleted.</p> <p>The penalty amount in 9792.12(a)(8) will be reduced to \$1,000.</p>
Section 9792.11(c)	Commenter is supportive of changes under this section that differentiate between utilization review organization and claims administrators for the purposes of investigation. For the purposes of these regulations, which are to ensure that the utilization review process is performed	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	Agree.	None.

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	<p>according to law, it is vital that investigations of utilization review organizations be separate from those of the claims administrators who contract with them. They must be separate because the two organizations have a relationship with respect to the behavior being audited. The revisions have led to a significant increase in clarity of purpose and process, which we believe will lead to a fairer and streamlined audit process.</p>			
<p>Sections 9792.11(c)(1)(A) and 9792.11(c)(2)(A)</p>	<p>Commenter notes that the language in both proposed sections is identical but for the description of the facility subject to the investigation:</p> <p>“The investigation shall include a review of randomly selected requests for authorization, as defined by section 9792.6(o), received by the utilization review organization (or claims administrator) during a three month calendar period specified by the Administrative Director. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation.”</p> <p>This language is based on the fact that facilities under investigation will have a performance rating that will determine whether or not penalties are applied. The performance rating outlined in the regulations is 85%. Because the investigation will include two types of requests for authorization – a random sample and specific authorization requests selected due to complaints –</p>	<p>Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment</p>	<p>Agree to revise subdivision 9792.12(b)(1) to clarify that the performance rating will be based only on the randomly selected requests for authorization.</p>	<p>Subdivision 9792.12(b)(1) will be revised to clarify that the performance rating will be based only on the randomly selected requests for authorization</p>

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	<p>commenter is concerned that the performance rating will not be a true reflection of the investigation subject's business practices. The performance rating which ultimately determines punitive action should be based solely on a random sample of authorization requests because it is meant to reflect the overall business practice of the facility under investigation. This does not mean that the Division should not also review or assess penalties on requests for authorization audited due to injured worker's complaints; just that those requests for authorization should not be included in the calculation of a performance rating that is meant to accurately reflect overall business practices upon which a facility may be penalized.</p>			
Section 9792.11(d)	<p>This section outlines the number of requests for authorization to be audited during an investigation. The number of requests for authorization is driven solely by the size of the facility under investigation. Commenter is concerned about the uneven weighting for small facilities. Commenter understands the difficulty weighting facilities of disparate size, but is concerned that some organizations will have 70% of their authorizations requests audited while others will have 1% of their authorization requests audited. Commenter offers to work with the Division and other stakeholders on devising a more equally weighted system of determining the number of authorization requests to be audited.</p>	<p>Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment</p>	<p>Disagree. The sample is based on the number of requests for authorization during a three month period. Subdivision (d) was added to set forth a statistically valid sample size for the randomly selected requests for authorization from a three month calendar period. This table was originally developed for the audit regulations (Title 8, California Code of Regulations, section 10107.1(c)(1)) with the assistance of the Audit Simplification Subcommittee and Dr. Neil Maizlish, Research Manager for DWC. The numbers are based on an expected violation rate (expected frequency) not over 10%, reliability plus or minus 5%, and a confidence level of 80%. The sample size for each of</p>	None.

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			<p>the population ranges in the table was generated using a software program obtained from the Centers for Disease Control (CDC) called Epi Info (latest release is version 3.3.2). The application within the program used to generate the numbers is titled <i>Population Survey</i>, which is found under the Utilities Menu by selecting StatCalc, Sample Size & Power, Population Survey. The Epi Info software verifies an expected frequency of 10%, worst acceptable result of plus or minus 5%, and a confidence level of 80% for these numbers. Epi Info is public domain software that can be downloaded for free from the CDC's website at: http://www.cdc.gov/epiinfo/.</p>	
Section 9792.11(g)	<p>This section prohibits the Division from “double dipping” on penalties in the event that the utilization review investigation is conducted concurrently with Section 129 or 129.5 audits. Commenter supports this addition because the Division should not be permitted to double-penalize an employer for a utilization review violation under two different sections of law. Additionally, the potential double dipping could only apply to claims administrators and not to utilization review organizations that are not subject to audits under Section 129 and 129.5. This addition creates uniform application of penalties between the two different types of facilities subject to these regulations.</p>	<p>Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment</p>	<p>Agree.</p>	<p>None.</p>

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.11(j)(1) through 9792.11(j)(6)	<p>The term “or other person performing a utilization review processes” has been removed from this section, while it has been left in others. Commenter is concerned that removing this phrase from the regulations creates inconsistencies that may complicate utilization processes for some employers.</p> <p>Portions of this subsection outline data elements that must be provided by a utilization review organization or claims administrator in the event of an investigation. Commenter believes that this version of the regulations does a much better job recognizing that not all organizations have the capacity to provide certain data elements – many times because their computer systems simply do not contain those data elements. Commenter states that this is a positive change to the proposed regulations.</p>	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	<p>Agree to remove the phrase throughout the regulations.</p> <p>Agree. Also, subdivision (j)(4) and parts of (j)(5) will be deleted.</p>	<p>The term “or other person performing a utilization review processes” will be removed from the regulations.</p> <p>Subdivision (j)(4) and parts of (j)(5) will be deleted.</p>
Section 9792.11(o)	This subsection would be more appropriately placed in the Utilization Review regulations (Section 9792.6) already completed by the Division. While the section does specifically apply to application of penalties, it is fundamentally a rule that dictates how a utilization review organization or claims administrator must operate in the context of utilization review.	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	Disagree. The subdivision is required for these regulations to clarify the date for purposes of assessing penalties.	None.
Section 9792.11(q)	This subsection should be amended to require the Administrative Director, in all target investigations, to provide the utilization review organization or claims administrator subject to investigation with a copy of the factual information that has triggered the investigation.	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	Disagree. Some discretion must be allowed regarding disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.	None.

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Section 9792.11(v)	<p>This section requires a utilization review organization or claims administrator to perform certain actions in the event that no answer is filed to the Order to Show Cause, or if all appeals have become final. Specifically, it requires the utilization review organization or claims administrator to provide specific information regarding the results of the investigation to all employers whose utilization review process was subject to penalties.</p> <p>Commenter believes that this subsection should be amended to provide a window of time between the date that an answer would be due and the time when these obligations must be met. This is because the utilization review organization or claims administrator may not decide to forego an appeal until the last minute. If that is the case, then they will need additional time to fulfill their obligations under this subsection. There should be a distinct period for an utilization review organization or claims administrator to consider or prepare an appeal, and a separate period of time in which to comply with provisions requiring notice to employers.</p> <p>The requirements for notification under this subsection are limited to the employer whose claims are being subject to penalties. However, in many cases a utilization review organization or claims administrator will be administering utilization review for an insurance company. In this situation, the utilization review organization or claims administrator should be required to notify the</p>	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	Agree.	This subdivision will be revised to allow 45 days instead of 31. This subdivision will also be revised to require notice to be given to the insurer, TPA or employer.

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	<p>insurer as well as the employer. If this were not the case, then an insurer would be lacking information pertinent to their claims and will not be able to respond in an informed manner to concerned policyholders.</p> <p>Despite the specific recommendations for amendments to this subsection, commenter believes the notice requirements to be a positive aspect of the regulations. While notice of such violations may be required in the contractual agreement between parties, this requirement promotes transparency.</p>			
Section 9792.12(a)(1) through 9792.12 (a)(15)	<p>The mandatory administrative penalties outlined in this section have been amended to remove the word “maximum” from the penalty amounts. Considering that the penalty amounts were already substantially increased in previous versions of the regulations, some by 500%, there is no reason to remove the term “maximum” from the penalty description. While it is clear through proposed § 9791.12(c) that reduction of penalties in these sections are allowed under proposed § 9792.13, the term “maximum” should remain because the amounts listed are indeed maximum penalty amounts.</p> <p>The mandatory administrative penalties do not contain a provision discussing a “performance rating”. Commenter believes that a performance rating should be applied to all of the penalty provisions outlined in these regulations.</p>	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	<p>Disagree regarding the term “maximum.” The term as previously used appeared to allow discretion in the amount of the assessment below the listed maximum amount. The penalty amounts still cannot be more than the amount listed, however, it is clearer that they may only be decreased if one of the factors listed in 9792.13 applies.</p> <p>Disagree regarding increase in penalty amounts. None of the (a) penalties were increased in this revision and the (b) penalties can now be waived if the performance factor is 85% or better. There were some new (a) penalties added, but some of the (a) penalties were also reduced.</p> <p>Disagree that the (a) penalties should be allowed an 85% pass rate. There is simply no reason why there should</p>	We will revise (a)(8). The penalty amount in subdivision (a)(8) is reduced from \$25,000 to \$1,000 because unlike the other \$25,000 penalty violations, in this case the request was approved and the failure is due to lack of documentation.

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			be a waiver of a penalty for failure to establish a UR plan, or failure to hire a medical director, or any other of the violations listed in (a), no matter how well the investigation subject does regarding the other UR requirements.	
Section 9792.12(a)(6)	This subsection was previously one that applied a penalty when a reviewer made a decision to modify or delay a treatment request that is outside of his or her scope of practice. While the goal of this subsection does not seem to have changed, the amended language is very unclear and should be reviewed and restated. Considering the \$25,000 fine imposed by this subsection, we feel that clarity in language is vital to utilization review organizations and claims administrators.	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	We agree to revise this subdivision.	Subdivision (a)(6) will be revised to state: (6) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): \$25,000
Section 9792.12(a)(8)	This subsection is unclear in the context of §9792.7(b)(3), which outlines how a non-physician reviewer may interact with a requesting physician. Commenter believes that this subsection needs to be amended for purposes of clarity. Considering the \$25,000 fine imposed by this subsection, clarity in language is vital to utilization review organizations and claims administrators.	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	We agree to reduce the penalty to \$1,000. However, as written, no penalty will be imposed if the written amended request is sent in after the approval. The subdivision only requires that the written amended request be in the file at the time of the investigation. An amended written request is required by the statute. Labor Code section 4610(e)	The penalty amount will be reduced from \$25,000 to \$1,000.
Section 9792.12(a)(11)	This subsection penalizes a utilization review organization or claims administrator for "failure to discuss with the requesting	Jason Schmelzer Policy Advocate Cal Chamber	We agree.	Subdivision (a)(11) will be revised to state: (11) For failure to discuss

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	<p>physician options for a care plan as required by labor code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical care, in the case of concurrent review”. Commenter believes that this subsection does not take into account a situation where a reviewing physician attempts to contact a physician without success. According to this section, a requesting physician could simply ignore attempts to discuss a care plan from a physician reviewer and the utilization review organization or claims administrator would be unable to act for fear of a \$10,000 fine.</p>	<p>February 22, 2007 Written Comment</p>		<p>or document attempts to discuss reasonable options for a care plan with the requesting physician as required by Labor Code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical care, in the case of concurrent review: \$10,000;</p>
<p>Section 9792.12(b)(1)</p>	<p>The addition of a performance standard in the regulatory framework is a positive development. While strict adherence to the utilization review regulations must be the goal, we must understand that perfection is simply too high a standard. The “performance rating” concept amended into this version of the regulations is very similar to the audit standards in Section 129 and 129.5 audits. Indeed, the standard of compliance in this version of the utilization review enforcement regulations is higher. Commenter is in full support of the “performance rating” concept as proposed.</p>	<p>Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment</p>	<p>Agree.</p>	<p>None.</p>
<p>Section 9792.13</p>	<p>Amendments to this section provide further clarity on penalty adjustment factors. Commenter believes that good behavior should not be penalized. With that in mind, commenter believes that reductions in penalties due to good-faith actions, abatement and low rates of violation will promote good practices by utilization review organizations</p>	<p>Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment</p>	<p>Agree.</p>	<p>None.</p>

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General Comment	<p>and claims administrators.</p> <p>Commenter believes that the utilization review regulations in Section 9792.6 need to be updated and clarified in order to promote understanding of responsibility between these to interacting regulatory sections. Specifically, the addition of terminology to the utilization review enforcement regulations creates a need to update the “definitions” portion of the utilization review regulations in Section 9792.6.</p> <p>Specifically, the Division of Workers’ Compensation needs to create a specific form for providers to use when requesting medical treatment. Currently a provider can request treatment in a PR2, through a narrative report, through a phone call, or even a hand written and faxed note.</p> <p>Unfortunately, this creates a mess for claims administrators who are trying to keep these treatment requests in order. The responsibilities on employers to perform accurate and timely UR reviews necessitate a streamlined treatment request process. The Division should create a single form, distinguishable from all others, which must be submitted by providers when requesting treatment. If treatment is not requested using this form, the timelines for utilization review should not toll. Targeting claims administrators and utilization review companies with significant penalties, while not requiring providers to request treatment in a streamlined fashion would be a step in the wrong direction.</p>	Jason Schmelzer Policy Advocate Cal Chamber February 22, 2007 Written Comment	This comment goes beyond the scope of these regulations. The division intends to revise the UR regulations in a separate rulemaking.	None.
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UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS 2nd 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	Commenter has a strong objection to the amount of the individual assessments. Commenter believes that if these proposed regulations are adopted as written, it will discourage the use of utilization review.	Darrell Brown, Vice President – Workers’ Compensation Practice Sedgwick CMS February 22, 2007 Written Comment	Disagree. None of the (a) penalties were increased in this revision and the (b) penalties can now be waived if the performance factor is 85% or better. There were some new (a) penalties added, but some of the (a) penalties were also reduced. Claims administrators may allow the physicians to have authority up to whatever limits they choose – and this can be incorporated into the UR plan. More than three years have passed since Labor Code section 4610 was amended and the division is receiving two complaints a day. Penalties are necessary to force compliance and unless the penalties make an impact, they will not serve as a deterrent.	None.
Section 9792.11(j)(l)	Commenter recommends that this section specify that the electronic formatted information requested should be limited to those claims for which utilization review has occurred or, when utilization review has not occurred, only when a denial, modification or delay has resulted from a non-UR claim. Most claims administrators do not capture or collect the data elements specified in this section for claims that do not involve utilization review. Mandating the electronic formatting and data reporting as described in this section is unnecessary, would be very costly to implement and would provide no information on which to base penalties for non compliance under Labor Cod section 4610.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual February 22, 2007 Written Comment	Disagree. The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information or it has the data. By providing the information to the AD, the AD will be able to select the random UR files for investigation. The section is not mandating electronic formatting.	None.
Section 9792.12(b)	Commenter recommends that this section be amended to recognize that faulty content on	Kathleen Bissell, CPCU Assistant Vice President	Disagree. Although it may be one mistake in the mind of the creator of	None.

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	one letter can inadvertently be included in preformatted letters. These preformatted letters are used to expedite the process and should not be counted individually as separate "faults." Commenter recommends that a fault should be defined as one incident rather than based on each notice or letter that contains the same fault.	Public Affairs Liberty Mutual February 22, 2007 Written Comment	the letter, it is a failure to every recipient of the faulty notice. However, the 85% performance rating may help address this problem as it allows for some margin of error.	
Section 9792.11(c)(1)(B) and 9792.12(b)(1)(E)	In both of these sections a performance measurement standard of 85% has been used. Commenter recommends that the historical compliance standard of 80% used for profile audit review also to be the standard for Utilization Review.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual February 22, 2007 Written Comment	Disagree. Creating a performance rating of 80% would not be the equivalent to the audit performance rating. The audit performance rating is not a straight 80% standard, it is based on a three year historical record of how audited claims administrators ranked. As explained in the annual audit report for 2006, the performance standard is recalculated yearly: "The PAR and FCA performance standards have been updated pursuant to Labor Code section 129(b) and Title 8, California Code of Regulations, section 10107.1(c), (d), and (e). This is accomplished by taking the 2005 audit results and using data for the five major keys subject to the profile audit review program. The results are then combined with the 2004 and 2003 performance rating scores to develop the 2007 PAR/FCA standards. The PAR standard for 2007 is 1.83201 and the FCA standard is 2.21982. Profile audit review audits (PAR audits) commencing after January 1, 2007 use the new standards."	None.

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			For the UR investigation, there is no history and therefore, it is not possible to do a similar ranking and pass rate. 85% represents a good performance but allows some room for error.	
Section 9792.11(j)(6)	<p>Commenter requests that the Division insert “last known” before address.</p> <p>The requested language is to clarify that, in the event the claim adjuster in question is no longer employed by the claim administrator or other utilization review entity, the current address of the claim adjuster may not be known by the requested party.</p>	Steward J. Brooker Associate Counsel Property & Casualty Department CNA February 22, 2007 Written Comment	Agree to revise. The requirement to identify the claims adjuster will be deleted.	Subdivision (j)(6) will be revised by deleted subsections vii through xi – which includes the requirement to identify the claims adjuster.
Section 9792.11(q)	Commenter requests that this section provide full notice to parties under investigation of the facts surrounding any complaints for a targeted audit. Commenter request that any language allowing the Administrative Director to withhold this information from a subject of a target audit be removed. Without full disclosure of information leading to a target audit, subjects would not be in possession of enough information to properly and adequately respond.	Steward J. Brooker Associate Counsel Property & Casualty Department CNA February 22, 2007 Written Comment	Disagree. Some discretion must be allowed regarding disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.	None.
Section 9792.11(r)	Commenter supports the inclusion of language requiring the claims administrator to retain their claim file as set forth in section 10102 of Title 8 of the CCR. Commenter recommends additional language requiring that the amount of time the utilization review organization must retain records also be in accordance with the requirements in the referenced section.	Joseph L. Dunn CEO/Executive Vice President California Medical Association (CMA) February 22, 2007 Written Comment	Disagree. Since the UROs will be investigated once every three years, they only need to retain the records for three years.	None.
Section 9792.12(a)	Commenter supports the addition of language to impose “Mandatory Administrative Penalties” for each failure to comply with the	Joseph L. Dunn CEO/Executive Vice President	Agree.	Agree.

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	utilization review process required by Labor Code section 4610 and sections 9792.6 through 9792.12 of Title 8 of the CCR.	California Medical Association (CMA) February 22, 2007 Written Comment		
Section 9792.12(a)(1) and (a)(5)	Commenter agrees with the Division that “the complete failure to establish a plan” is the “most egregious violation,” but questions whether the \$50,000 proposed penalty is an adequate deterrent. Commenter urges the Division to impose the maximum penalty possible as a means to deter this conduct. In addition, commenter urges the imposition of a daily escalating penalty upon notice of non-compliance and for continued failure to comply with this provision. Commenter agrees that the failure to have a medical director is “one of the most severe violations possible” and urges the Division to adopt his recommendation for the failure to establish a plan as an appropriate penalty for the failure to have a medical director.	Joseph L. Dunn CEO/Executive Vice President California Medical Association (CMA) February 22, 2007 Written Comment	Disagree regarding increasing the penalties and adding a daily fine. Subdivision 9792.11(t) is amended to state that the preliminary report will include compliance items, which will address violations that need to be corrected. Section 9792.15(b)(2) will also be revised to state that the Final Report will contain compliance items. Section 9792.12(a)(17) will be added as a penalty for failure to comply. Subdivision 9792.11(v) will be revised to require the claims administrator or URO to notify the entities that contract with them of the final report and the division will post a summary of the violations on its web. Finally, the division will pursue injunctive relief against the URO if it does not correct the violation.	Subdivision 9792.11(t) will be amended to state that the preliminary report will include compliance items, which will address violations that need to be corrected. Section 9792.15(b)(2) will also be revised to state that the Final Report will contain compliance items. Section 9792.12(a)(17) will be added as a penalty for failure to comply. Subdivision 9792.11(v) will be revised to require the claims administrator or URO to notify the entities that contract with them of the Final Report.
Section 9792.12(a)(12), (a)(13) and (a)(14)	<p>Commenter urges the Division to impose penalties greater than those currently proposed for violations that have been characterized as “less severe.”</p> <p>In particular, the penalties for sub-divisions (a)(12), (a)(13) and (a)(14) relating to the failure to respond to the treating physician’s request for authorization should be greater than those currently proposed. However, commenter supports withholding penalties in cases where there is a good faith effort to</p>	Joseph L. Dunn CEO/Executive Vice President California Medical Association (CMA) February 22, 2007 Written Comment	Disagree. The current penalties are fair in light of the need to be a deterrent, to be in relation to the seriousness of the violation, and to be related consequences to the public.	None.

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	<p>discuss the case in a timely fashion with the treating physician.</p>			
General Comment	<p>Commenter requests that the Division include language that describes the process for filing complaints. Commenter believes this process should include standardized forms and written acknowledgement of receipt of all complaints.</p> <p>Commenter requests that the most egregious violations of these sections be referred to the Department of Insurance for other possible administrative action.</p>	<p>Joseph L. Dunn CEO/Executive Vice President California Medical Association (CMA) February 22, 2007 Written Comment</p>	<p>Disagree that the complaint form should be part of the regulations. The complaint form is not mandatory. Complainants may forward complaints in any manner, written or oral, with or without using the form. Therefore, the form does not need to be part of the regulations. The investigating unit will confirm/investigate the allegations in the complaint to determine if it is credible prior to proceeding with an investigation. Also, as set forth in 9792.11(q), upon initiating an investigation based on a complaint, a description of the complaint or the information contained in the complaint will be forwarded to the investigation subject who shall ten days to respond.</p> <p>Disagree that the regulations should include a requirement that the division will acknowledge all complaints. Although the division generally does do this, it is not always possible due to lack of information.</p> <p>The Labor Code provides for additional remedies for egregious violations, such as a civil penalty per Labor Code section 129.5(e). Upon a second civil penalty finding, the AD shall refer the insurer to the</p>	None.

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General Comment	<p>Commenter states that there is no mention of acceptable timeframes and or responsibilities for timely interaction between claims administration and Utilization Review. Routinely, the claims administrator will receive a request for treatment, which is then forwarded with all appropriate medicals to Utilization Review. Clarification of responsibility when, for example, the request is forwarded by the claims (insurer/TPA) for review with at most 24 hours allowed for the review and or without medical documentation in support of request that may be in the possession of the referrer, therefore making the time frames impossible.</p> <p>Commenter requests that the Division define the responsibilities to include timeframes for each of the parties that may be involved and explain how the Division views this issue in applying the responsibility of penalties for failing to timely issue determinations or inappropriate adverse determinations for lack of information.</p>	<p>Andrew Rymer Chief Operating Officer Total HealthCare Management February 22, 2007 Written Comment</p>	<p>Department of Insurance. Disagree. These issues need to be decided upon between the claims administrator and URO, most likely in contract. As provided in section 9792.14(b), the claims administrator and URO will be held jointly and severally liable.</p>	None.
Section 9792.11(e) and 9792.11(f)	<p>This section establishes a process for submitting complaints to the Division via the DWC complaint form 1, which is already available on the Division’s website. While the intent of this form is to facilitate the submission of “credible” utilization review complaints, the form lacks in clarity and direction. In its present format the form opens the door for excessive, inappropriate, intentionally misleading, potentially abusive and false complaints. Many medical providers remain unaware of the mandated</p>	<p>Stephen Festa Senior Vice President Chief Claims Officer February 21, 2007 Written Comment</p>	<p>The complaint form is not within the scope of these regulations. The complaint form is not mandatory. Complainants may forward complaints in any manner, written or oral, with or without using the form. Therefore, it the form does not need to be part of the regulations. Because the form is not part of the regulations, the division will be able to modify it as the UR process evolves without having to go through</p>	None.

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	<p>method for requesting treatment authorization. Claims administrators continue to receive verbal requests for treatment authorization with the provider failing to submit written confirmation of their verbal request within 72 hours or at all. While providers are encouraged to submit their request in writing their failure to do so can result in a delay in the provision of medical care. The provider then files a complaint for failure to render a UR decision within the required time limit.</p> <p>Commenter also questions how this form can be in active use at this time when 9792.11(f) purports applicability to conduct which occurred on or after the effective date of Sections 9792.11 through 9792.15 which are not in effect yet.</p> <p>Commenter recommends that the form, if maintained, should specify what constitutes an appropriate "Request for Authorization." For example: where the cover sheet for the form defines "supporting documentation," the Division should change this to "Request for Authorization" and add the definition as defined in CCR section 9792.6(o).</p> <p>Commenter also would like the Division to develop and incorporate into these regulations, and subsequently the form itself, consequences for filing a false or inappropriate complaint.</p>		<p>rulemaking. The investigating unit will confirm/investigate the allegations in the complaint to determine if it is credible prior to proceeding with an investigation. Also, as set forth in 9792.11(q), upon initiating an investigation based on a complaint, a description of the complaint or the information contained in the complaint will be forwarded to the investigation subject who shall ten days to respond.</p> <p>We disagree that a complaint must be verified or provide consequences for false filings. There is no required format or method for a complaint. They may be oral or written. Many injured workers or physicians are not aware of the legal requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been a UR violation before an investigation is initiated.</p> <p>Currently the division is receiving two complaints a day. The division contacts the parties and deals with the complaints – either helping to correct the UR problem or helping the complainant understand the process. Although penalties are not being assessed, the public's problems are being addressed.</p>	
Section 9792.11(j)(5)	Commenter states that the Division has, by	Stephen Festa	Agree to revise (j)(5).	Subdivision (j)(5) will be

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	<p>requiring a medical director who is not an employee of the claims administrator, exceeded its authority by requiring the medical director to ensure compliance for an entity for which he or she has no legal oversight or power to ensure compliance with Labor Code section 4610 and sections 9762.6 through 9762.10. In addition, sections 97962.6 through 9762.10 do not exist. If remains unclear which sections the Division was attempting to cite.</p> <p>Commenter recommends that a claims administrator who does not maintain on staff reviewers or expert reviewers can only authorize treatment authorization requests or discuss applicable criteria which will enable the requesting physician to determine whether he or she will modify or withdraw a request. As such, section 9792.11(j)(5) should be broken down as follows:</p> <p>A description of the methods by which the claims administrator ensures compliance that the process for approving treatment authorization requests complies with Labor Code section 4610 and section 9792.6 through 9792.10 or a description of the methods by which the medical director for a utilization review organization ensures compliance that the process for approving, modifying or delaying treatment authorization requests complies with Labor Code section 4610 and section 9792.6 through 9792.10 as required by sections 9792.6(i) and 9792.7(b) of Title 8 of the CCR.</p>	<p>Senior Vice President Chief Claims Officer February 21, 2007 Written Comment</p>		<p>revised as follows: (4) A description of the methods by which the medical director for utilization review ensures that the process by which requests for authorization are reviewed and approved, modified, delayed, or denied is in compliance with Labor Code section 4610 and sections 9792.6 through 9792.10, as required by sections 9792.6(l) and 9792.7(b) of Title 8 of the California Code of Regulations;</p>

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Section 9792.12(a)(8)	<p>Commenter states that the amended version of this section lacks clarity. In addition, the Division needs to strike through reference to (5) to eliminate confusion.</p> <p>This provision proposes a penalty of up to \$25,000 if a non-physician reviewer (person other than a reviewer, expert reviewer or medical director, as defined in section 9792.6 of Title 8 of the CCR) modifies a request for treatment without possessing at the time of approving the modification an amended written request for treatment authorization as provided under section 9792.7(b)(3) or Title 8 of the CCR.</p> <p>This section sets up claims administrators for failure and supports continued delays in authorizing medical care. CCR section 9792.9(b)(1) requires prospective or concurrent decisions be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed (5) working days from the date of receipt of the written request for authorization. Non-physician reviewers endeavor to authorize medical care as quickly as possible. Non-physician reviewers initiate verbal communications with the requesting physician to discuss applicable criteria. The requesting physicians are given the option of modifying their treatment authorization request. In instances where the requesting physician concurs with the modification, approval is granted verbally followed by written notice within 24 hours.</p>	Stephen Festa Senior Vice President Chief Claims Officer February 21, 2007 Written Comment	We agree to reduce the penalty to \$1,000. However, as written, no penalty will be imposed if the written amended request is sent in after the approval. The subdivision only requires that the written amended request be in the file at the time of the investigation. An amended written request is required by the statute. Labor Code section 4610(e)	The penalty amount will be reduced from \$25,000 to \$1,000.

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	<p>The above section, however, will delay approval of medical care as a non-physician reviewer will now be required to request and possess a written confirmation of the requesting physician's agreement to voluntarily withdraw a portion of all of the treatment prior to approving. Given the five day requirement, non-physician reviewers will be forced, pursuant to CCR section 9792.2(b)(2), to extend the time frame up to 14 days and will likely seek to assistance of a reviewer in the vent the requesting physician is not responsive in providing written modification. Furthermore CCR section 9792.2(3) is vague in that it does not establish a specified time frame in which the requesting physician is required to submit an amended request.</p> <p>Commenter suggests requiring the written notice of approval, pursuant to CCR section 9792.9(3), to clearly illustrate the treatment requested, the agreed modification, and contain language requiring the requesting physician to submit a written modification of the treatment authorization within a specified time frame. The regulation should state that if the physician does not submit a written modification or a request for utilization review within the time frame, the written notice of approval is deemed approved.</p>			
General Comment	<p>Commenter is an injured worker who relates her difficult experience obtaining treatment for her workers' compensation injury. Commenter agrees that here should be penalties.</p>	<p>Grace Carone February 20, 2007 Written Comment</p>	<p>Agree.</p>	<p>None.</p>

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General Comment	Commenter is an injured worker who relates her difficult experience obtaining treatment for her workers' compensation injury. Commenter agrees that here should be penalties.	Janie Kent February 20, 2007 Written Comment	Agree.	None.
Section 9792.11(e)	This subdivision sets forth how complaints may be submitted to the Division and provides that the Division will review and investigate the complaint if credible. Commenter suggests that this provision be amended to provide that the Division will acknowledge receipt of all complaint forms received and will provide the person making the complaint with a description of the action taken by the Division after closure (either closure without investigation or after investigation).	Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment	Disagree that the regulations should include a requirement that the division will acknowledge all complaints. Although the division generally does do this, it is not always possible due to lack of information. Further, during the investigation process, the complainant usually is advised of the investigation outcome. The division will post a summary of the results of UR investigations on its website.	None.
Section 9792.12(a)(6)	<p>Commenter states that the new format used to describe the penalty amounts is an improvement. However, this paragraph is somewhat confusing. The action being penalized in this paragraph is a violation of Labor Code § 4610(e) which states:</p> <p>(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where those services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.</p> <p>Commenter believes that paragraph (6) should</p>	Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment	Agree.	Subdivision (a)(6) is revised to state: (6) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): \$25,000

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	<p>be rewritten to more accurately reflect these statutory requirements. The current wording begins, "For failure to issue a decision," but that wording confuses the issue. The real issue is the "failure" of the reviewing physician to be "competent to evaluate the specific issues" or the "failure" of the requested services to be "within the scope of the physician's practice." We suggest the most effective way to conform this proposed penalty to the statutory requirements of § 4610(e) would be to copy the statutory requirements in to proposed language, as follows:</p> <p style="padding-left: 40px;">(6) For failure of the reviewer to be competent to evaluate the specific clinical issues involved in the requested medical treatment, procedure, service or product, or where the requested treatment, procedure, service or product is not within the scope of the reviewer's practice as set forth by the reviewer's specialty board, upon issuance of a decision to modify, delay, or deny a request for authorization of medical treatment: \$25,000.</p> <p>Commenter recognizes that the language above is still awkward, but it is difficult to describe this particular violation using the introductory wording "For failure of." Although this syntax does not fit the general format of this section, an alternative might be:</p> <p style="padding-left: 40px;">(6) For issuance of a decision to modify, delay or deny a request for authorization</p>			
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	<p>of a medical treatment, procedure, service, or product by a reviewer who is not competent to evaluate the specific clinical issues involved in the request for authorization, or where the requested treatment, procedure or service is not within the scope of the reviewer's practice as set forth by the reviewer's specialty board: \$25,000.</p> <p>However if this paragraph is modified, two changes are imperative. First, the provision must include the statutory requirement that the reviewer be "competent to evaluate the specific clinical issues involved in the medical treatment." This requirement is set by statute, and the Division does not have the authority to ignore it. Second, the proposal currently defines the scope of practice by the explanatory clause, "(as set forth by the reviewer's licensing board)." Most states, including California, issue a single license to all physicians and surgeons. Consequently the "scope of practice" as set by the licensing board encompasses <u>all</u> medical specialties. Commenter recommends, as included in the suggested language above, that this phrase be modified to refer to "the reviewer's specialty board."</p> <p>This second change is critically important in the area of spinal surgery. Commenter hopes that the Supreme Court will set clear rules that do not allow insurers to choose to object to treatment requests under § 4062, under current case law insurers do have this option. Where a carrier chooses to object to a request for spinal</p>		<p>Disagree. While the commenter is correct that the statute requires that the physician be "competent," the standard is too difficult to determine in terms of a record review for purposes of the UR penalties. It would require a deposition to determine and the determination would be subject to dispute.</p> <p>Disagree. Even though a reviewer may have a different specialty, it is still within his or her scope of practice to review other specialist's requests for authorization. Also, these penalty regulations only apply to requests for authorization that are subject to the Labor Code section</p>	

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	surgery using § 4062(a) instead of § 4062(b), we believe it is imperative that the reviewer be competent to evaluate the spinal surgery request. Labor Code § 4062(b) requires that a second opinion physician be "a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon." Unless paragraph (6) of these proposed regulations is revised to refer to "the reviewer's specialty board," the reviewer in a spinal surgery case where the carrier elects to use § 4062(a) could be of a completely different specialty.		4610 UR process.	
Section 9792.12(a)(11), (12) and (13)	Under paragraph 11, a penalty of \$10,000 is established for failure to discuss reasonable options for a care plan in the case of concurrent review. However, under paragraph (12), the failure to respond to a request for treatment in the case of non-expedited concurrent review is penalized only \$2,000. Commenter believes that a failure to respond is as egregious as a failure to discuss treatment options, and recommends that the penalty for both be set at \$10,000. Commenter likewise recommends that the penalty under paragraph (13) be increased to \$10,000. The failure to respond to a non-expedited prospective treatment request is a very severe violation and the penalty should be set accordingly.	Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment	Disagree. Concurrent review cases are those where the employee is currently hospitalized. Denying care to a hospitalized employee without discussing reasonable options for a care plan can have serious and immediate consequences. Although (a)(11) is also egregious, it does not involve a denial of care. A failure to respond to a non-expedited prospective review is less egregious, and therefore the penalty amount is even less.	None.
Section 9792.12(b)(1)	There is a technical problem with the methodology set forth for calculation of the performance rating under this paragraph. Under subparagraphs (A) though (E) the rating is computed by dividing the number of violations by the total number of randomly selected requests. However, in subparagraph (D), the final step in the calculation of the performance rating involves "multiplying by	Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment	Disagree. A percentage is expressed as a whole number. The calculation is correctly set forth.	None.

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	<p>one-hundred." This calculation will generate a whole number, not a percentage figure. However, subparagraph (E) uses the term "eighty-five percent." Commenter suggests that either the instruction to multiply by one-hundred be deleted from subparagraph (D), or the word "percent" be deleted from subparagraph (E).</p> <p>Also, the word "dividing" should be added to subparagraph (C) between the words "by" and "the."</p>			
Section 9792.12(b)(1)(E)	<p>Commenter opines it is the intent of these regulations that a performance rating will <u>not</u> be computed in the case of a Special Target Investigation. If this is correct, the following sentence of subparagraph (E) should be moved to a new paragraph (2): "The Administrative Director, or his or her designee, may assess penalties as set forth below following a Special Target Investigation." Commenter also recommends that the word "may" be changed to "shall."</p> <p>According to the introductory language in paragraph (1), the provisions of subparagraphs (A) through (E) describe how a performance rating will be calculated for a Routine or</p>	Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment	<p>Agree to clarify.</p> <p>Agree to clarify (E).</p>	<p>Subdivision 9792.12(b)(1) will be revised to state: (1) After conducting a Routine or Return Target Investigation, the Administrative Director, or his or her designee, shall calculate the investigation subject's performance rating based on its review of the randomly selected requests. The investigation subject's performance rating may also be calculated after conducting a Special Target Investigation. The performance rating will be calculated as follows: (E) will be clarified by deleting the words: The Administrative Director,</p>

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	<p>Return Target Investigation. Accordingly, the reference to a Special Target Investigation should be moved to a different paragraph. Moving this sentence will also clarify that the last sentence of subparagraph (E), specifying the penalties to be assessed where the performance rating is less than 85%, applies only to Routine and Return Target Investigations.</p> <p>If it is the intent of these regulations to compute a performance rating for a Special Target Investigation, the language of paragraph (1) should be amended to add a reference to this type of investigation.</p>			<p>or his or her designee, may assess penalties as set forth below following a Special Target Investigation.</p>
<p>Section 9792.12(b)(4) and (5)</p>	<p>The revised syntax of these paragraphs is an improvement; however, commenter continues to believe that the penalty amounts for the violations listed in this section are too low. For example, consider a large firm that has a performance rating of 50%. This means that the firm had violations in half of the treatment requests examined. However, under the new procedure set forth in these regulations, the maximum number of requests to be examined will be 59. That means the firm had 30 violations. Even where the \$100 penalty is assessed, this will total just \$3,000! It is simply inconceivable that a major UR firm will consider a \$3,000 penalty anything other than a cost of doing business.</p> <p>Commenter recognizes and supports the changes made to paragraph (3) under which the penalty amount can be steeply increased where a subject fails to meet the 85% performance standard in successive</p>	<p>Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment</p>	<p>Disagree. In addition to the penalties, the performance standards and summary of the violations will be listed on the division's website and the investigation subject will be required to send the final report to those entities that contracted with it. Also, a failure of the 85% performance rating means that there will be a return investigation within 18 months. Finally, there may be multiple violations with each request for authorization.</p>	<p>None.</p>

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	<p>investigations. However, as noted earlier, commenter does not support higher penalties simply as a punishment. The point is that the penalty amounts should be high enough for a first violation to create a strong disincentive against the improper behavior. Just as importantly, if the initial penalty amounts are low, even application of the multipliers set forth in paragraph (3) will have little effect. In the example cited in the paragraph above, if this firm failed its <i>fourth successive investigation</i> and again had 30 violations out of 59 requests investigated, the application of the 10X multiplier will increase this penalty only to \$30,000. If a UR organization fails to meet the 85% standard four successive times, we believe it should be put out of business. However, in any case it is clear a \$30,000 penalty in this circumstance is grossly inadequate.</p>			
Section 9792.12(c)	<p>This subdivision provides that the Administrative Director may reduce the penalties assessed under § 9792.12(a) after consideration of the factors in § 9792.13. This appears to conflict with the wording of § 9792.13(a) which allows the AD to "mitigate" any penalty under § 9792.12 (which would include both subdivisions (a) and (b)).</p> <p>Commenter recommends that these provisions be amended to allow mitigation of only the penalties assessed under § 9792.12(b). Clearly the factors listed in paragraphs (1) through (5) of § 9792.13(a) apply to the investigation of the handling of individual treatment requests. Furthermore, the violations listed in §9792.12(a) are the most severe infractions</p>	Linda F. Atcherley President via Mark Gerlach, Consultant for California Applicants' Attorneys Association February 22, 2007 Written Comment	Agree that the two sections should be harmonized. If it is appropriate to apply the mitigation factors, it should not matter if the penalty falls under the (a) or (b) subdivisions.	Subdivision 9792.12(c) will be revised to include reference to the penalties listed in 9792.12(b).

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	<p>considered in these regulations, and in general these violations have nothing to do with a UR firm's handling of individual requests for treatment. These violations, such as the failure to have a medical director, or the failure to even file an UR plan with the Division, represent profound and fundamental failures by the UR firm to comply with the statutory mandates. Commenter does not believe that the penalty amounts for these egregious violations should be reduced for any reason and recommend that these regulations be amended to specify that only § 9792.12(b) penalties can be mitigated.</p>			
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