

**Independent Medical Review/Qualified Medical Evaluator/Independent Bill Review
Public Comments - October 2, 2012**

Independent Medical Review

Division should report and track IMR decisions and whether California doctors produce any different results than those out of state.

There should be an appeal process if IMR denies necessary treatment.

IMR doesn't question the diagnosis, only the treatment for the reported diagnosis. Should there be a physical examination of the patient?

IMR should be provided ALL medical records. If there is any problem with timeliness, a delay in any regard at any point in the process, then the treatment should be provided. The carrier chooses the MPN doctor and the UR, so if they fail to comply with IMR, or they delay or lapse, treatment should be authorized.

There should be a review done annually to make sure that the cases are being properly reviewed, and if there are problems, there should be significant penalties. If the reviewers are violating standards, the Medical Director should refer the reviewer to the California Medical Board. Suggestion of a CHSWC study on whether decisions of California reviewers differ from those out of state. Recommend that the reviewers be specialty matched and subspecialty matched to body part.

When a physician submits an incomplete or illegible report and the physician fails to respond to a request for specification, there should be a way to hold the physician responsible to prevent unnecessary IMR expense.

Doctors should provide adequate information about what they want; the Division should mandate a complete and standardized Request for Authorization Form. To ensure the parties know what has been reviewed and what has been decided, there should be a standardized form for UR. There should be an opportunity to rebut IMR by providing medical evidence and allowing the treating doctor to provide medical evidence or peer reviewed studies.

Doctor of Podiatric Medicine (DPM) is not mentioned in SB 863; such a specialty is overlooked. There should be a specialty match with doctors who know California law. There is concern that IMR reviewers may not be familiar with peripheral nerve injuries and their proper treatment by podiatrists.

Appreciate that IMR can reduce frictional cost, but by being too open-ended, the process could invite just as much frictional cost. There should be clear criteria about when IMR is triggered, how to avoid repeat requests for same treatment, and how to deal with incomplete RFA. There should be random audits of IMR for quality control.

This will be much different from group health, with many times as many cases. There should be as much detail as possible in the RFA to provide a full and complete substitute for a live, in person exam. If the MTUS applies to an issue, you don't go to the other guidelines, which is too strong a position for a mere 'guideline.' The provision for treating physician to be an advocate for the patient needs to be accompanied by an incentive, including fee schedule increases for the First Report of Injury and the PR-2 with an RFA.

Time frame of 10 days to provide records is very challenging; sometimes all the relevant records are not quickly obtained from the providers.

Chiropractic reviewers should make determinations on chiropractic care, just like in a QME exam. IMR is like a second UR, where there isn't an independent, impartial doctor. There should be clarification of when IMR is in effect, such as when there has been an invalid (untimely) UR determination. That should go back to the courts.

There is confusion about the requirements for documentation, since different UROs have different requirements. Who is responsible for seeing that all documentation is sent to UR? Is the doctor required to re-submit the whole medical history, which employer already has?

If treatment already done, we have 20 days to pay per statute, where we have 60 days for normal bill payment. If treatment was done already, and had to wait for IMR, why not wait for normal payment time?

Qualified Medical Evaluator

When DWC was trying to limit QME locations, it was observed that the limitation could make people drive too far to get to a QME in the underserved areas. Request that the Division not count locations in the underserved areas. Some people already are driving over 3 hours for an appointment.

There have always been problems getting QME panels out on time. There should be a standardized form for the request for panel that allows us to request all the necessary specialties at once. Another problem is that doctors are not getting the reports out in 30 days; there should not be a delay of having to go back for another panel. Parties should be able to get their own QMEs; the parties don't want to have to wait in the panel track forever.

Ex-parte communication rules are sometimes unknown to injured worker; the Division should consider a method by which injured worker is informed of such prohibitions early on.

The Division has already sent out a letter about the reduction to 10 QME locations; clarification is needed on whether the injured worker is responsible for rescheduling his appointment location.

Independent Bill Review

Request for CHSWC to review the IBR process and specifically asking physicians how IBR is working. The up-front fee should be as low as possible. IBR should support consolidation when possible.

A graduated schedule for consolidating small bills could be by volume or by cost. Timeframes should have consequences; if a deadline is missed, the bill should be considered payable. If the provider bills for one level of service, and the payor contends it should be another, is that IMR or IBR? Bill review companies have software that incorporates the client's business rules; for IBR to work, those business rules would need to be stripped – leaving just a fee schedule to apply.

Success of IBR will depend on the quality and fairness of the reviewers. For liens that are outstanding, is there a mechanism for lien claimant to withdraw lien and move the dispute into IBR?

The issue regarding IBR is to write the regulations in a way to make certain that the deadlines that are given for both parties are enforced. If provider doesn't make certain dates, then the provider loses the right to continue in the process. The other side of the coin is that if the bill should be paid, then there should be a mechanism to be sure it will be paid. Penalties have been reduced, audits are a joke, and there is no deterrent to payors denying bills that should be paid. Make sure there are enforcement mechanisms that work.

Depositions are a burden on providers and they are not being paid in full, especially when the time goes over a standard billable hour. Attorneys move on and disregard adjusted compensation.

The provider bills according to the fee schedule and sends the documentation, but the payors reduce the level of service by one level. The second level review is kicked back as a duplicate bill, even though we check the box on the 1500 form.

Request that if someone is representing a provider claimant, the representative should be copied with the EOR.

Concern that 90-day appeal deadline and 30-day IBR deadline are too short when compared to the deadlines in other healthcare systems. Appeal deadline is 90 days to bill the employer and 30 days for IBR. DMHC allows a year, and Medical allows 180 days.

There are certain services for which there is no fee provided. The Division should consider a way to determine appropriate fee for those

For hospitals, 90 days for billing is woefully inadequate. Clarification is needed of when IBR goes into effect, and when does the provider have option to go to lien or to IBR. There is a sentence about independent medical review taking effect for injuries after 1/1/13; is that for IBR, as well?

The Division should consider screening the data in IBR for frequent fliers/problem companies.

There are a number of billing codes that are “by report,” and we want regulations to clarify how reviewer will determine the fee. It appears that the statute may apply to service providers such as copy companies, other than medical providers.

Every bill review company and software system has a different procedure for how bill reconsideration operates. The Division has the opportunity to standardize so that the 2nd review is uniform, and that payors can't overlay additional requirements and rules.

Responding to the suggestion to collect data on frequent flyers, the Division should be really objective about how is that analyzed. If certain providers show up more often, that doesn't necessarily mean that the treatment by that provider is inappropriate.

The key is to set strong timelines for carriers to act. The Division should consider the need for a strong penalty for disregarding time frames.

Concern that doctors are being asked to provide QME reports after attorneys are on board; because of the attorneys, those reports are more complicated and of the level of AME work without being paid for such work.

Request that more predictability be crafted into the system – authorizations and electric billing will help. Once treatment is authorized, that should mean that when the treatment is provided, it will be paid timely. But that doesn't happen.

Concern if the IBR dispute has to do with a PPO discount. When physician opts out of PPO, will PPO continue taking the discount until they get around to removing the provider from the PPO list? Resignations are slow to work through the system.

Statute allows limited ex parte communication with AME. Should it also be allowed with QME?

What happens to a bill that is not paid after going through IBR – does it still end up as a lien? Concerns about conflicts of interest between providers of review services and those claims adjusters/insurers that may have ties to those services.

IMR physicians should be licensed in California, and should be industrial medicine practitioners. Concern that the IMR physician may be paid more than the treating physician.

IMR is costly and will prolong delivery of benefit to the injured worker. The Division should tighten up the UR process. The UR process can be done in-house; there is no need to send out for UR of routine things like medications. There should also be regulation of the termination of medications, such as withdrawal of pain medications. Standardization for the forms will help the whole process.