

**Qualified Medical Evaluator Public Meeting - October 2, 2012**  
**Division of Workers' Compensation**

Excerpts of Senate Bill 863

Labor Code section 139.2(h):

(h) (1) When requested by an employee or employer pursuant to Section 4062.1, the medical director appointed pursuant to Section 122 shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. Preference in assigning panels shall be given to cases in which the employee is not represented. If a panel is not assigned within 20 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice within a reasonable geographic area. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type requested by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall promulgate a form that shall notify the employee of the physicians selected for his or her panel after a request has been made pursuant to Section 4062.1 or 4062.2. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: "You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will consider the evaluation prepared by the doctor you select to decide your claim."

(3) When compiling the list of evaluators from which to select randomly, the medical director shall include all qualified medical evaluators who meet all of the following criteria:

(A) He or she does not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision (o).

(B) He or she is certified by the administrative director to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence. An evaluator shall not conduct qualified medical evaluations at more than 10 locations.

(C) He or she has not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the administrative director pursuant to subdivision (n) or for any other reason.

(4) When the medical director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

Labor Code section 4061(a)-(d):

This section shall not apply to the employee's dispute of a utilization review decision under Section 4610, nor to the employee's dispute of the medical provider network treating physician's diagnosis or treatment recommendations under Sections 4616.3 and 4616.4.

(a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made, whether there is need for future medical care, and whether an indemnity payment will be deferred pursuant to paragraph (2) of subdivision (b) of Section 4650.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine whether there will be the need for future medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable.

(b) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2.

(c) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and if the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. Either party may request a comprehensive medical evaluation to determine permanent disability or the need for future medical care, and the evaluation shall be obtained only by the procedure provided in Section 4062.1.

(d) (1) Within 30 days of receipt of a report from a qualified medical evaluator who has evaluated an unrepresented employee, the unrepresented employee or the employer may each request one supplemental report seeking correction of factual errors in the report. Any of these requests shall be made in writing. A request made by the employer shall be provided to the employee, and a request made by the employee shall be provided to the employer, insurance carrier, or claims administrator at the time the request is sent to the evaluator. A request for correction that is made by the employer shall also inform the employee of the availability of information and assistance officers to assist him or her in responding to the request, if necessary.

(2) The permanent disability rating procedure set forth in subdivision (e) shall not be invoked by the unrepresented employee or the employer when a request for correction pursuant to paragraph (1) is pending.

#### **Labor Code section 4062:**

(a) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

(b) If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5.

(c) If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the employer's medical provider network established pursuant to Section 4616, the objection shall be resolved only in accordance with the independent medical review process established in Sections 4616.3 and 4616.4.

#### **Labor Code section 4062.2:**

(a) Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation shall be obtained only as provided in this section.

(b) No earlier than the first working day that is at least 10 days after the date of mailing of a request for a medical evaluation pursuant to Section 4060 or the first working day that is at least 10 days after the date of mailing of an objection pursuant to Sections 4061 or 4062, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician. The party submitting the request form shall serve a copy of the request form on the other party.

(c) Within 10 days of assignment of the panel by the administrative director, each party may strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within 10 days of assignment of the panel by the administrative director, the other party may select any physician who remains on the panel to serve as the medical evaluator. The administrative director may prescribe the form, the manner, or both, by which the parties shall conduct the selection process.

(d) The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements. The employee shall not unreasonably refuse to participate in the evaluation.

(e) If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later ceases to be represented, he or she shall not be entitled to an additional evaluation.

(f) The parties may agree to an agreed medical evaluator at any time, except as to issues subject to the independent medical review process established pursuant to Section 4610.5. A panel shall not be requested pursuant to subdivision (b) on any issue that has been agreed to be submitted to or has been submitted to an agreed medical evaluator unless the agreement has been canceled by mutual written consent.

#### **Labor Code section 4062.3:**

(a) Any party may provide to the qualified medical evaluator selected from a panel any of the following information:

(1) Records prepared or maintained by the employee's treating physician or physicians.

(2) Medical and nonmedical records relevant to determination of the medical issue.

(b) Information that a party proposes to provide to the qualified medical evaluator selected from a panel shall be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to consideration of nonmedical records within 10 days thereafter, the records shall not be provided to the evaluator. Either party may use discovery to establish the accuracy or authenticity of nonmedical records prior to the evaluation.

(c) If an agreed medical evaluator is selected, as part of their agreement on an evaluator, the parties shall agree on what information is to be provided to the agreed medical evaluator.

(d) In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following:

(1) All information received from the parties.

(2) All information reviewed in preparation of the report.

(3) All information relied upon in the formulation of his or her opinion.

(e) All communications with a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.

(f) Communications with an agreed medical evaluator shall be in writing, and shall be served on the opposing party when sent to the agreed medical evaluator. Oral or written communications with physician staff or, as applicable, with the agreed medical evaluator, relative to nonsubstantial matters such as the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, do not constitute ex parte communication in violation of this section unless the appeals board has made a specific finding of an impermissible ex parte communication.

(g) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation.

(h) The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the medical evaluation, additional discovery costs, and attorney's fees for related discovery.

(i) Subdivisions (e) and (g) shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination.

(j) Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator.

(k) If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(l) No disputed medical issue specified in subdivision (a) may be the subject of declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

### Labor Code section 4063:

If a formal medical evaluation from an agreed medical evaluator or a qualified medical evaluator selected from a three member panel resolves any issue so as to require an employer to provide compensation, the employer shall,

except as provided pursuant to paragraph (2) of subdivision (b) of Section 4650, commence the payment of compensation or file a declaration of readiness to proceed.

#### Labor Code section 4064:

(a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms, except medical treatment recommendations, which are subject to utilization review as provided by Section 4610, and objections to utilization review determinations, which are subject to independent medical review as provided by Section 4610.5.

(b) For injuries occurring on or after January 1, 2003, if an unrepresented employee obtains an attorney after the evaluation pursuant to subdivision (d) of Section 4061 or subdivision (b) of Section 4062 has been completed, the employee shall be entitled to the same reports at employer expense as an employee who has been represented from the time the dispute arose and those reports shall be admissible in any proceeding before the appeals board.

(c) Subject to Section 4906, if an employer files a declaration of readiness to proceed and the employee is unrepresented at the time the declaration of readiness to proceed is filed, the employer shall be liable for any attorney's fees incurred by the employee in connection with the declaration of readiness to proceed.

(d) The employer shall not be liable for the cost of any comprehensive medical evaluations obtained by the employee other than those authorized pursuant to Sections 4060, 4061, and 4062. However, no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense. In no event shall an employer or employee be liable for an evaluation obtained in violation of subdivision (b) of Section 4060. All comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the appeals board except as provided in Section 4060, 4061, 4062, 4062.1, or 4062.2.

Section 4066 of the Labor Code is repealed.

#### Issues for Discussion

- The elimination of the Spinal Surgery Second Opinion Procedure (SSSOP) and the transition from SSSOP to QME for the period between 1/1/2013 to 7/1/2013.
  - Is a box or other indicator needed on the panel request forms for the period 1/1/2013 to 7/1/2013 to indicate this panel request concerns spinal surgery?
  - Should the Division consider the using the definition of spinal surgery in California Code of Regulations, title 8, section 9788.01(l) in this process?
  - Should we limit the choice of specialties in spine surgery cases?
- The factual correction rule in Labor Code sections 4061(d)(1) and (d)(2).
  - Is a timeframe for QMEs to respond to the request needed?
  - Suggestions for the definition of a "fact" for purposes of this section?
  - Are any changes needed to the notice requirements?

**Independent Medical Review Public Meeting - October 2, 2012**  
**Division of Workers' Compensation**

Excerpts of Senate Bill 863

The Legislature finds and declares all of the following:

(d) That the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers injured in the course of employment.

(e) That having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy.

(f) That the performance of independent medical review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that independent medical review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code that will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations performed by qualified medical evaluators appointed pursuant to Section 139.2 of the Labor Code. The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of qualified medical evaluators can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise of specialists that are not available through the civil service system.

(g) That the establishment of independent medical review and provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review of such decisions.

Labor Code section 139.5:

(a) (1) The administrative director shall contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The independent review organizations shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state. The administrative director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4, that an organization shall be required to meet in order to qualify as an independent review organization and to assist the division in carrying out its responsibilities.

(2) To enable the independent review program to go into effect for injuries occurring on or after January 1, 2013, and until the administrative director establishes contracts as otherwise specified by this section, independent review organizations under contract with the Department of Managed Health Care pursuant to Section 1374.32 of the Health and Safety Code may be designated by the administrative director to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The administrative director may use an interagency agreement to implement the independent review process beginning January 1, 2013. The administrative director may initially contract directly with the same organizations that are under contract with the Department of Managed Health Care on substantially the same terms without competitive bidding until January 1, 2015.

(b) (1) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be consultants for purposes of this section.

(2) There shall be no monetary liability on the part of, and no cause of action shall arise against, any consultant on account of any communication by that consultant to the administrative director or any other officer, employee, agent, contractor, or consultant of the Division of Workers' Compensation, or on account of any communication by that consultant to any person when that communication is required by the terms of a contract with the administrative director pursuant to this section and the consultant does all of the following:

(A) Acts without malice.

(B) Makes a reasonable effort to determine the facts of the matter communicated.

(C) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to determine the facts.

(3) The immunities afforded by this section shall not affect the availability of any other privilege or immunity which may be afforded by law. Nothing in this section shall be construed to alter the laws regarding the confidentiality of medical records.

(c) (1) An organization contracted to perform independent medical review or independent bill review shall be required to employ a medical director who shall be responsible for advising the contractor on clinical issues. The medical director shall be a physician and surgeon licensed by the Medical Board of California or the California Osteopathic Medical Board.

(2) The independent review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent review organization shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(A) The employer, insurer or claims administrator, or utilization review organization.

(B) Any officer, director, employee of the employer, or insurer or claims administrator.

(C) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.

(D) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.

(F) The employee or the employee's immediate family, or the employee's attorney.

(d) The independent review organizations shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a workers' compensation insurer, claims administrator, or a trade association of workers' compensation insurers or claims administrators. A board member, director, officer, or employee of the independent review organization shall not serve as a board member, director, or employee of a workers' compensation insurer or claims administrator. A board member, director, or officer of a workers' compensation insurer or claims administrator or a trade association of workers' compensation insurers or claims administrators shall not serve as a board member, director, officer, or employee of an independent review organization.

(2) The organization shall submit to the division the following information upon initial application to contract under this section and, except as otherwise provided, annually thereafter upon any change to any of the following information:

- (A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.
- (B) The names of all holders of bonds or notes in excess of one hundred thousand dollars (\$100,000), if any.
- (C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.
- (D) The names and biographical sketches of all directors, officers, and executives of the independent review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, provider group, or board or committee of an employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, or provider group.
- (E) (i) The percentage of revenue the independent review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, utilization reviews, and bill reviews.
- (ii) The names of any workers' compensation insurer, claims administrator, or provider group for which the independent review organization provides review services, including, but not limited to, utilization review, bill review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.
- (F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.
- (G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.
- (H) A description of how the independent review organization ensures compliance with the conflict-of-interest requirements of this section.
- (3) The organization shall demonstrate that it has a quality assurance mechanism in place that does all of the following:
- (A) Ensures that any medical professionals retained are appropriately credentialed and privileged.
- (B) Ensures that the reviews provided by the medical professionals or bill reviewers are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.
- (C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.
- (D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.
- (E) Ensures the independence of the medical professionals or bill reviewers retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).
- (4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be licensed physicians, as defined by Section 3209.3, in good standing, who meet the following minimum requirements:

(A) The physician shall be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the physician shall hold a nonrestricted license in any state of the United States, and for physicians and surgeons holding an M.D. or D.O. degree, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer.

(C) The physician shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(D) Commencing January 1, 2014, the physician shall not hold an appointment as a qualified medical evaluator pursuant to Section 139.32.

(5) Neither the expert reviewer, nor the independent review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The employer, workers' compensation insurer or claims administrator, or a medical provider network of the insurer or claims administrator, except that an academic medical center under contract to the insurer or claims administrator to provide services to employees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the employer or workers' compensation insurer or claims administrator.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the employee whose condition is under review.

(F) The employee or the employee's immediate family.

(6) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent review organization or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the employer to the independent review organization for the services required by the administrative director's contract with the independent review organization, nor does "material financial affiliation" include an expert's participation as a contracting medical provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(C) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent review organization. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(e) The division shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the administrative director, filed with it by an independent review organization under contract

pursuant to this section. The division may charge a fee to the interested person for copying the requested information.

(f) The Legislature finds and declares that the services described in this section are of such a special and unique nature that they must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code. The Legislature further finds and declares that the services described in this section are a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code.

#### Labor Code section 4610:

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

#### Labor Code section 4610.5:

(a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) "Disputed medical treatment" means medical treatment that has been modified, delayed, or denied by a utilization review decision.

(2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(A) The guidelines adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402.

(4) Unless otherwise indicated by context, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies, modifies, or delays a treatment recommendation, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision that denies, modifies, or delays a treatment recommendation, the employer shall provide the employee with

a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment.

(h) (1) The employee may submit a request for independent medical review to the division no later than 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to

the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (e) at the time of notification of its utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the plan to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall provide to the independent medical review organization all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employee's current medical condition.

(B) The medical treatment being provided by the employer.

(C) The disputed medical treatment requested by the employee.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the

documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

#### Labor Code section 4610.6:

(a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing

the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any

relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

## Issues for Discussion

- Utilization Review Regulations: The Division is considering revising the existing utilization review (UR) regulations (California Code of Regulations, title 8, section 9792.6 et seq.), for example requiring the use of a request for authorization form, in order to improve the efficiency and effectiveness of the Independent Medical Review (IMR) process.
- Labor Code section 4610 was amended to provide that utilization review of a treatment recommendation is not required “while the employer is disputing liability for injury or treatment of the condition for which the treatment is recommended pursuant to Section 4062.” (Section 4610(g)(7).) The Division is considering an express regulation stating the circumstances by which UR can be initially deferred.
- The Division is considering requiring the employee to send/serve a copy of the IMR Application on the claims administrator.
- The IMR Application must state that the employee has the right to provide additional information after the IMR request is accepted. The Division is considering requiring the employee to provide additional documents concurrent with the claims administrator. (Employer documents, outlined in 4610.5(l) must be submitted 10 days after notice of IMR assignment.)
- The cost of IMR is borne by employers/claims administrators through a fee system; DWC must establish a “reasonable, per-case schedule” to the pay the costs of IMR. The Division is considering a monthly, aggregate bill instead of a per-case invoice system. (The aggregate bill would likely include an itemization of cases. Are there additional elements that should be included?)
- DWC is planning on contracting with one IMRO for the implementation of SB 863. The Division is considering contracting with additional IMROs once the system is operational.
- DWC is considering posting either searchable individual case summaries of IMRO decisions or a summary table with condensed information on its website.

- What are the QME options in responding to the factual error correction request?
- Implementing section 4062.2(c); changes to the represented QME process.
  - Does the logic of *Messele* apply to add five days for service by mail?
  - Is a regulation needed that expressly provides who goes first in the striking process?
- The QME 10 office limitation rule.
  - The Divison will likely experience additional panel replacement requests that are the result of this change; are there any suggestions about handling these replacement panel requests?
- Should ML 103 Medical-Legal Code (8 C.C.R. § 9795) be modified to eliminate medical monitoring and issues of denial or modification of medical treatment following utilization review for dates of injury on or after 1/1/13?