

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS FIRST 15 DAY PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.8 (2)	<p>Commenter states that regulations should be clarified regarding whether or not ACOEM applies to chronic conditions. Commenter proposes the following language: “While ACOEM guidelines apply primarily to acute and subacute conditions, general philosophies set out in Chapter 6 do provide some helpful insight around chronic care and should be appropriately used, in conjunction with consideration of generally recognized medical treatment and supplemental nationally recognized guidelines and evidence as available. However, in and of itself, the principles found in Chapter 6 shall not be used as a primary or sole reason to justify a coverage denial.”</p>	<p>N. William Fehrenbach Director, State Government Affairs Medtronic, Inc. June 2, 2005 Written Comment</p>	<p>Disagree. We do not agree with the recommendation that section 9792.8(a)(2) be amended to state that treatment cannot be denied “solely on the basis of the general philosophies provided in Chapter 6” of the ACOEM Guidelines. We believe that the general philosophies set forth in Chapter 6 of the ACOEM Guidelines are very pertinent to treatment because the general philosophies set forth in Chapter 6 of the ACOEM Guidelines support the concept of functional recovery. Moreover, the issue of chronic conditions and their relationship to ACOEM will be addressed in the Medical Treatment Utilization Schedule Regulations as we believe the issue is beyond the scope of this rulemaking.</p>	<p>None.</p>
<p>Section 9792.6 (g) (now re-lettered 9792.6(h)) Section 9792.6 (l) (now re-lettered 9792.6(o))</p>	<p>Commenter states that the revised definitions of "expert physician reviewer" and "physician reviewer" in the proposed regulations are inconsistent with the Labor Code. Commenter believes that the definition would permit an expert physician reviewer or a physician reviewer to be licensed in any U. S.</p>	<p>Carl Brakensiek, Executive Vice President California Society of Industrial Medicine & Surgery (CSIMS) June 5, 2005 Written Comment</p>	<p>Agree in part. Labor Code section 4610 requires the medical director of the utilization review program to have a California license. Section 4610(d) states, in relevant part, “[t]he employer, insurer, or other entity shall employ or designate a medical</p>	<p>Section 9792.6(h) has been amended. The term “expert physician reviewer” has been changed to expert reviewer, and the definition now states as</p>

	<p>jurisdiction to practice medicine in the state of California. Commenter states that pursuant to Labor Code Section 4610(e) the reviewer must be licensed in California.</p>		<p>director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code.” The section further provides that the medical director “shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section.” Further the Labor Code section 4610(d) provides that “[n]othing in this section shall be construed as restricting the existing authority of the Medical Board of California.” Thus, it is clear from the statute that the medical director must have a California license, is responsible for compliance with the requirements of the statute, and his responsibilities are not construed to restrict the existing authority of the Medical Board of California.</p> <p>On the other hand, if a reviewer is going to make decisions “for reasons of medical necessity to cure or relieve” the reviewer must be a “licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician’s</p>	<p>follows: “expert reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of practice, as defined by the licensing board, who has been consulted by the physician reviewer, the health care reviewer or the utilization review medical director to provide specialized review of medical information.”</p> <p>The new term “health care reviewer” has been added to the regulations and is now set forth in Section 9792.6(j), which defines the term as follows: “Health care reviewer means a medical doctor, doctor of osteopathy, psychologist,</p>
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		<p>practice.” This physician may then “approve, modify, delay, or deny requests for authorization of medical treatment” and as indicated above, for “reasons of medical necessity to cure and relieve.” (Labor Code, §4610(e). This is consistent with business practices allowing UR to be conducted by physicians throughout the US.</p> <p>Thus, it is clear from the statute that while the medical director is required to have a California license, the reviewing physician is not required to have a California license, and in order to require compliance with the “existing authority of the Medical Board of California,” the medical director is responsible to ensure compliance with the requirements of the statute.</p> <p>However, we agree that the regulations as written may be confusing. In order to assist the public, the utilization review framework envisioned by the statute has been clarified in the proposed regulations. Sections 9792.6(h), 9792.6(j), and 9792.6(o), provide definitions consistent with the utilization review framework in the statute and are consistent with the definition of physician in Labor Code section 3209.3. Moreover, a definition of the “medical director”</p>	<p>acupuncturist, optometrist, dentist, podiatrist, and chiropractic practitioner licensed by any state or the District of Columbia except California, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the individual’s practice.”</p> <p>The new term “medical director” has been added to the regulations and is now set forth in Section 9792.6(m), which defines the term as follows: “Medical Director is the physician and surgeon licensed by the Medical Board of the State of California or the Board of Osteopathic Examiners of the State of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.”</p>
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			<p>has been added to the regulations at section 9792.6(m) to clarify that the medical director is responsible for all decisions made in the utilization review process. Further changes have been made throughout the regulations to reflect the use of the new term "health care reviewer" in the proper context of the regulations.</p>	<p>Section 9792.6(o) now contains the term "physician reviewer" which has been amended. To states as follows: "Physician reviewer means a physician as defined in section 3209.3 of the Labor Code, holding an active California license, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the physician's practice as defined by the licensing board."</p> <p>Sections 9792.7(b)(2), 9792.9(b)(2), 9792.9(b)(2)(A), 9792.9(f), 9792.9(g)(1)(B), and 9792.9(k) have been amended when appropriate to refer to the new term "health care reviewer."</p>
Section 9792.6	<p>Commenter states that the revised definitions of "expert physician reviewer" and "physician reviewer" in the proposed regulations are inconsistent with the Labor Code. Commenter believes that the definition would permit an expert physician reviewer or a physician</p>	<p>Bruce Lehnert Written Comment June 8, 2005 (Commenter submitted the same argument as Carl Brakensiek)</p>	<p>Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005</p>	<p>None.</p>

	reviewer to be licensed in any U. S. jurisdiction to practice medicine in the state of California. Commenter states that pursuant to Labor Code Section 4610(e) the reviewer must be licensed in California.			
Section 9792.6 (g) (now re-lettered 9792.6(h))	Commenter disagrees with the definition of an expert physician reviewer. Commenter states that one can be an expert about a procedure or intervention even when it is not within the scope of his/her practice. To be a physician reviewer one has to be an expert in relationship to the indications for the intervention. Commenter gives the example that he is a Board Certified Occupation Physician and is an expert in the indications for facet injections, epidural injections, etc, even though he does not do these interventions nor are they within the scope of an occupational physician's practice. Commenter suggests that an expert should be defined as one that has expertise by training or experience with the indications for the intervention in question.	Steven Rosen, MD Medical Director CompPartners Written Comment June 7, 2005	Agree in part. We do not agree with the comment that the term “scope of practice” should be part of the definition of the “expert physician reviewer.” However, commenter is correct that a physician can, in addition to his practice, be an expert on a procedure or intervention even when that procedure or intervention is not within the scope of his/her practice based on his license. The definition of expert physician reviewer has been amended, in relevant part, to clarify that the services must be within the scope of practice, as defined by the licensing board.	Section 9792.6(h) has been amended. The term “expert physician reviewer” has been changed to expert reviewer, and the definition now states as follows: “expert reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of practice, as defined by the licensing board, who has been consulted by the physician reviewer, the health care reviewer or the utilization review medical director to provide specialized review of medical

Section 9792.7(b)(2)	<p>Commenter states that the above argument applies to Section 9792.7(b)(2) as this issue relates to the issue of competence to evaluate clinical issues. Commenter further states that scope of practice is also mentioned in this section and pursuant to the above argument should be omitted.</p>		<p>Agree in part. See response to comment immediately above. Section 9792.7(b)(2) will be amended, in relevant part, to clarify that the services of the physician reviewer or the health care reviewer must be within the scope of practice, as defined by the licensing board.</p>	<p>information.”</p> <p>Section 9792.7(b)(2) has been amended. The section now states: “A physician reviewer or a health care reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of practice as defined by the licensing board, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.”</p>
§9792.9(k)	<p>Commenter disagrees with the requirement of Section 9792.9(k) requiring that the written decision contain the name and telephone number of the reviewer, and the requirement the there be a minimum of 4 hour period per week of availability of a reviewer or medical director to accept calls. Commenter believes that this is not feasible because: (1) Before a negative decision can be reached reviewers must make a reasonable attempt to discuss the case with the requesting physician; (2) In all situations, an appeal process should be given and all clients that they service allow for at</p>		<p>Agree in part. The written utilization review decision should disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision. It is believed that a minimum of four (4) hours per week Pacific Time is appropriate time to allow for the attending physician to discuss the utilization review decision with either the physician reviewer or the medical director. Section 9792.9(k) is</p>	<p>Section 9792.9(k) is amended to read as follows: “The written decision modifying, delaying or denying treatment authorization provided to the physician shall also contain the name and specialty of the physician reviewer, health care reviewer or expert reviewer, and the telephone number in the</p>

	<p>least one telephonic appeal; and (3) Once a report is completed, subsequent phone calls do not change the report. Commenter states that the only way a decision can be changed is via the appeal process or a request for a reconsideration being delivered to the adjuster or UR nurse.</p> <p>Commenter states that having a 4 hour window of availability is impossible for a peer reviewer who is in clinical practice. Commenter further states that availability is determined by surgical schedules and clinical appointments. Moreover, commenter states that requiring a medical director available to answer questions about reviews done by expert reviewers makes no sense. Medical directors typically do not have the range of expertise to make secondary decisions about many of the highly technical issues raised in surgical reviews.</p>		<p>intended to facilitate communication between the reviewer and the requesting physician. Just as the reviewers are in active practice, so are the requesting physicians. Numerous complaints have been submitted by the requesting physicians stating that the UR reviewers call and requests that the requesting physician get back to them immediately (or within the hour) or the request will be denied. Some of these requesting physicians are for example practicing surgeons who cannot come to the phone immediately. Moreover, pursuant to the statute, the medical director is responsible that all medical decisions comply with the requirements of the statute, and pursuant to his license and the statute is subject to the authority of the Medical Board of California.</p> <p>However, the proposed section is amended to allow the requesting physician and the reviewing physician and/or medical director to agree upon a scheduled time to discuss the decision with the requesting physician.</p>	<p>United States of the reviewer. The written decision shall also disclose the hours of availability of either the physician reviewer, the health care reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours a per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician.”</p>
Section 9792.6	Commenter opposes the requirement allowing outside-of-California-licensed physicians to perform utilization review.	Maureen Milner, M.D. President Elect – CA Society of Physical Medicine & Rehab. Written Comment June 8, 2005	Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005.	None.

Section 9792.6	<p>Commenter opposes the proposed revisions that will allow physicians who are licensed in another state to perform utilization review in the California Workers' Compensation system. Commenter states that this will impact on the health of the individual involved. Commenter states that there would be no specific authority or jurisdiction over that physician should there be any unlawful or improper behavior.</p>	<p>Joe Izzo, M.D. Written Comment June 8, 2005</p>	<p>Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005</p>	None.
Section 9792.6	<p>Commenter opposes the proposed modification that would allow physicians licensed in other states to serve as physician reviewers of California Workers' Compensation cases. Commenter states that this proposed change is a direct violation of existing California Labor Code, Section 3209.3, which states that physicians must be "licensed by California State Law". Commenter further states that it is illegal for physicians without a California Medical License to practice medicine in California in any capacity. The California Medical Board would have no jurisdiction to discipline a physician in the event of unprofessional conduct.</p>	<p>Anonymous (dasseen@cox.net) Written Comment June 8, 2005</p>	<p>Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005</p>	None.

Section 9792.6	Commenter states that from the perspective of a treating physician, the UR process has been a disaster that has bordered on corruption and collusion between evaluators and insurance companies. Commenter states that the system needs to be reigned in and regulated much more tightly. Commenter states that outsourcing UR out of the State would only make matters worse, and encourages further loss of objectivity and fairness in a system that already has little.	Pete Abaci, M.D. Written Comments June 8, 2005	Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005	None.
Section 9792.6	Commenter opposes modification to sections 9792.6(h) and 9792.6(l) of the proposed regulations that would allow physicians in "any U.S. Jurisdiction" to perform utilization review on California physicians concerning workers' compensation insurance for the following reasons: (1) there is no mechanization for assuring the person at the other end of the phone is indeed a physician and is qualified; (2) there is no way to report an incompetent or fraudulent physician to the Medical Board of California if they are calling from out of the State; (3) local physicians know who is competent and reliable and who is not; (4) California physicians know the terrain and where the doctors are practicing, and can suggest a better plan based on where the patient lives; and (5) we should keep the peer review business in California--California doctors paying California taxes.	James E. Lessenger, M.D. FACOEM Written Comments June 8, 2005	Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005	None.
Sections 9792.6 (c), 9792.7(b)(1), 9792.8 (a)(3), 9792.9(b)(3), 9792.9(b)(4),	Commenter states that section 9792.6(c) clarifies that a claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization	Jennifer Nicholson, WCCP Claims Administration Manager,	Agree in part. The definition of "claims examiner" contained in section 9792.6(c) is clear that the term includes the contracted UR	Section 9792.6(c) has been amended. The section now states: "Claims Administrator is

<p>9792.9(g)(1), 9792.9(g)(1)(A), 9792.9(g)(1)(C), 9792.9(g)(2), 9792.9(g)(3), 9792.9(g)(4) 9792.9(h)</p>	<p>review. Commenter recommends that all sections throughout the proposed regulations which reference the term “claims administrator” performing certain functions should also reference “or its contracted entity.” Commenter believes that this would enable compliance with the time frames in the regulations.</p>	<p>Farmers Insurance Group Written Comment June 9, 2005</p>	<p>vendor. DWC believes that it is unnecessary to repeat this through the proposed regulations as it may be unclear. However, we believe that the sentence could be clarified, thus the section has been now amended to read: “The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.”</p>	<p>a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.”</p>
<p>§9792.9(b)(2)(A)</p> <p>Section 9792.9(k)</p>	<p>Commenter disagrees with the revision in section 9792.9(b)(2)(A) requiring the physician reviewer to deny the request for authorization for lack of information. Commenter believes that referring a case to a physician reviewer to deny for lack of medical information adds a significant cost to an administrative function.</p> <p>Commenter states that she prefers not to have to give the provider contact information in their written adverse determination letters as required under section 9792.9(k). Commenter states that when the physician reviewer makes the call to the provider for peer contact, they</p>	<p>Anne Edson RN, LRC, CCM Vice President & Clinical Program Manager Sedgwick Claims Management Services Written Comment June 10, 2005 (letter states June 16th)</p>	<p>Disagree. The previously drafted regulations contained an inconsistency. Pursuant to the statute only the physician reviewer may deny a request for treatment authorization. Therefore, section 9792.9(b)(2)(A) has been amended to state that the physician reviewer is responsible to deny the request for treatment authorization for lack of information, not the claims administrator.</p> <p>Disagree. See response and action above in connection with comment submitted by Steven Rosen, MD, CompPartners, dated June 7, 2005.</p> <p>Further, it is noted that the contact</p>	<p>None.</p> <p>None.</p>

<p>Section 9792.6(b)</p>	<p>leave the hours available for a return call and give the provider's office a phone number and date by which they must respond. Commenter states that there should be one more attempt to establish contact by the provider before issuing a determination. Commenter further states that their letters specify the hours of availability to the UR department and direct the caller to the UR department which would be responsible to ensure the proper contact is established between the provider and the physician reviewer or to begin the appeal process.</p> <p>Commenter disagrees with the definition of authorization to mean that the appropriate reimbursement will be made. Commenter states that Utilization review refers to medical necessity not reimbursement, and this definition should not apply to UR at all, but belongs with claims.</p>		<p>should be directly between reviewer and requesting physician to expedite the services provided to the injured worker.</p> <p>Agree in part. Many complaints have been filed stating that claims administrators are denying payment of services after the services have been authorized by the claims administrator. It is believed that authorization is an agreement to reimburse. In order to prevent this problem the new definition of authorization was added to the proposed regulations to state that: "authorization means appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or in the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in a narrative form containing the same information required in the DWC Form PR-2."</p>	<p>Section 9792.6(b) has been amended for clarification purposes. The section now states: "authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury, subject to the provisions of section 5402 of the Labor Code, based on the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained</p>
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			Nevertheless, the definition has been further amended for clarification purposes.	in section 9785.2, or on a narrative form containing the same information required in the DWC Form PR-2.”
Section 9792.6	Commenter states that the fact that the reviewing physician does not have to be California licensed takes away a layer of protection from the patient and treating physician. Commenter further states that this results in the loss of the ability of the State Board of Medical Quality Assurance’s ability to review the behavior and ethics of reviewers. Commenter believes that these regulations will cause a direct outflow of funds generated in California to other states, and this appears to be contrary to current goals in the economy of California.	Richard Martin, M.D., M.P.H. Written Comment June 13, 2005	Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005	None.
Section 9792.8	Commenter objects to the requirement in 9792.8(a)(3) and in various other sections of the regulations that the UR report be disclosed to the provider of goods or services. Commenter states that the UR decision could contain much private medical information which would be illegal and inappropriate to disseminate to these parties.	Marianne J. McReynolds, CPA UP Finance Claims Management Inc. Horizon Medical Care Written Comments June 13, 2005	Agree. Commenter is correct that the UR report may contain private medical information and that without an appropriate signed waiver by the patient, this information may not be released to third parties. The proposed regulations will be amended to allow for the UR decision to be served on the provider of goods or services without the rationale, criteria or guidelines used for the decision.	Section 9792.8(a)(3) has been amended. The section now states: “The criteria or guidelines used shall be disclosed in written form to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney, if used as the basis of a decision to modify, delay, or deny services in a specific case under review. The claims

				<p>administrator may not charge an injured worker, the injured worker's attorney and the requesting physician for a copy of the criteria or guidelines used to modify, delay or deny the treatment request.”</p> <p>Section 9792.8(a)(3)(B) has been amended. The section now states: “A written copy of the relevant portion of the criteria or guidelines used shall be enclosed with the written decision to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney pursuant to section 9792.9, subdivision (j).”</p> <p>9792.9(b)(4) has been amended. The section now states: “Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be</p>
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				<p>communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.”</p> <p>9792.9(c) has been amended. The section now states: “When review is retrospective, decisions shall be communicated to</p>
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				<p>the requesting physician who provided the medical services to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. In addition, the non-physician provider of goods or services identified in the request for authorization shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision. Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Documentation for emergency health care services shall be made available to the claims</p>
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				<p>administrator upon request.”</p> <p>9792.9(g)(2) has been amended. The section now states “If subdivisions (A), (B) or (C) above apply, the claims administrator shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney in writing, that the claims administrator cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The claims administrator shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney of the anticipated date on which a decision will be rendered. This notice shall include a</p>
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				<p>statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408. In addition, the non-physician provider of goods or services identified in the request for authorization shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with this subdivision. The written notification shall not include the rationale, criteria or guidelines used for the decision.”</p> <p>9792.9(j) has been amended. The section now states, in relevant part, as follows: “A written decision</p>
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				<p>modifying, delaying or denying treatment authorization under this section shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:</p> <p style="text-align: center;">***</p> <p>In addition, the non-physician provider of goods or services identified in the request for authorization shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.”</p> <p>9792.10(b)(1) has been amended. The section now states: “In the case of concurrent review, medical care shall not be discontinued until the physician has been notified of the decision</p>
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				and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.”
Section 9792.9	Commenter objects to proposed revisions to Section 9792.9(b)(2)(A) requiring the physician reviewer to issue a denial when sufficient information is not received to make a decision. Commenter further states that this requirement will unnecessarily raise employers’ and insurers’ costs and potentially defeat the purpose of utilization review and the recent legislation. Commenter further states that the proposed amendment is inconsistent with URAC, the national organization that provides accreditation for workers’ compensation utilization review programs. Specifically, URAC Standard WC 47 (c) on page 124 requires that organizations implement processes by which an administrative non-certification is issued to a provider in cases of insufficient information.	Darrell Brown Vice President Worker’s Compensation Practice – Sedgwick Written Comments June 13, 2005	Disagree. See response and action above in connection with comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005.	None.

§9792.6(b)	<p>Sedgwick CMS’ certification requires that the nurse issue the non-certification when there is insufficient information from the medical provider.</p> <p>Commenter objects to the definition of “authorization” to mean that appropriate reimbursement will be made. Commenter states that the generally accepted and customary definition of utilization review does not incorporate reimbursement issues as the concept is to review treatment purely on the basis of medical necessity, uninfluenced by any other considerations including reimbursement. Commenter states that adding reimbursement to the definition blurs the lines between utilization review, claims management and bill review. Commenter indicates that the proposed revision also appears to conflict with 9792.6(q), which states, in pertinent part, that utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.</p>		Disagree. See response to comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005, above.	None.
Section 9792.6(b)	<p>Commenter states that the portion of the definition of “authorization” set forth in section 9792.6(b), wherein it refers to the “specific course of proposed medical treatment set forth in written reports” could be construed to limit authorization to only treatment specifically requested in writing and may, in practice, exclude treatment which is either requested orally by telephone (as permitted by Labor Code Section 4610(h) or treatment which is necessary, but provided without a prior report. Commenter proposes</p>	<p>Dan Escamilla, J.D. Legal Service Bureau Written Comments Received June 13, 2005</p>	<p>Agree. Commenter is correct that the definition when referring to the course of proposed medical treatment should make reference to medical treatment to cure or relieve the effects of the injury pursuant to Labor Code section 4600.</p>	<p>Section 9792.6(b) has been amended for clarification purposes. The section now states: “authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the</p>

<p>§9792.6(h)</p>	<p>that the definition be amended to “authorization” means appropriate reimbursement will be made for a specific course of proposed medical treatment to cure or relieve the effects of the injury claimed by the applicant.</p> <p>Commenter states that permitting out-of-state physicians to act as “expert physician reviewers” violates the mandate of Section 4610(d) and invites a myriad of problems, including the application of another jurisdiction’s medical treatment standards or reportable “appropriate professional practices” (Section 4610(g)(3)(B)). Commenter further states that Labor Code 4610(d) prohibits, by implication, the use of out-of-state physicians, at least for the position of medical director, and that Section 4610(e) permits only licensed physicians to evaluate medical treatment services “within the scope of the physician’s practice...” Providing medical treatment within the State of California is not within the scope of an out-of-state physician’s practice, and restricts the authority of the Medical Board of California.</p>		<p>Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005</p>	<p>industrial injury, subject to the provisions of section 5402 of the Labor Code, based on the Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-2, as contained in section 9785.2, or on a narrative form containing the same information required in the DWC Form PR-2.”</p> <p>None.</p>
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Section 9792.7	<p>Commenter states that non-physician review of a request for utilization review is prohibited under the terms of the Labor Code 4610(e). Commenter suggests that section 9792.7(b)(3) be amended to allowing allow non-physician reviewers to approve requests, and to delete the portions relating to communications with the requesting physician regarding the request, and the collection of relevant medical information.</p>		<p>We disagree. Section 9792.7(b)(3) allows a non-physician to initially review the request for authorization of medical services and request additional information when necessary within the time limitations in the regulations. The proposed regulations do not allow the non-physician to modify, delay or deny a request for authorization based on medical necessity.</p>	None.
<p>Section 9792.8(3) Section 9792.9(b)(4) Section 9792.9(c) Section 9792.9 (g)(2)</p>	<p>Commenter states that no provision is made for disclosing information to a <i>representative of a physician</i>. Attorneys and agents of physicians may, especially in the case of retrospective review, participate in the utilization review process as authorized representatives of physicians or other medical providers. Commenter relates on Cal. Code Regs., tit. 8, section 10500 (WCAB Rule), which requires service of decisions on all attorneys or agents, including lien claimants.</p>		<p>Disagree. WCAB Rule 10500 refers to service on the lien claimants for purposes of bill collection. UR relates to provision of medical services and does not involve bill collection.</p>	None.
§9792.9(a)(2)	<p>§9792.9(a)(2): Commenter states that a request for utilization review may, in an unusual case, be made from an out-of-state provider and the presumption of receipt of five (5) days may be too short of a period. Commenter suggests that to provide the claims administrator with sufficient time to act, additional time to the date “deemed received” should be allowed if the written request is mailed from out-of-state. Commenter recommends an extension of 10 days if outside of the State of California but within the United States and 20 days if outside</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.</p>	None.

<p>§9792.9(b)(1)</p>	<p>of the United States.</p> <p>Commenter states that Labor Code Section 4610(g)(1) provides time periods which begin “from the receipt of the information reasonably necessary to make the determination...” Commenter further states that the proposed regulations should be amended to clarify that a claims administrator’s duty to act does not begin until all “reasonably necessary” information has been received pursuant to the language of Labor Code section 4610(g)(1).</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.</p>	<p>None.</p>
<p>§9792.9(k)</p>	<p>Commenter states that communication and dialog between medical professionals is critical to prevent disputes concerning the authorization of medical treatment and should be strongly encouraged to promote the smooth operation of the utilization review process. Commenter proposes that section 9792.9(k) be amended to increase the amount of hours the reviewer or medical director must be available for the treating physician to discuss the decision from 4 hours to 20 hours. Commenter further proposes language stating that if, during the ordinary period of availability, either the physician reviewer or medical director is not available to speak with a requesting physician, or his attorney or agent within five (5) minutes of the telephone call being answered, in-person or electronically, a call-back service must be provided by the physician reviewer or medical director within two (2) hours and also suggests language with respect to complaints.</p>		<p>Disagree. See response and action above in connection with comment submitted by Steven Rosen, MD, CompPartners, dated June 7, 2005. Also, it is noted that requiring availability of 20 hours a week from the reviewer is unreasonable for the reasons presented by Dr. Rosen when addressing this same issue. With regard to the penalties issue raised by the commenter, this will be addressed in the presently undergoing UR violation penalty regulations rulemaking.</p>	<p>None.</p>

§9792.10(a)(1)	<p>Commenter states that limiting the dispute resolution remedy to the QME process under Section 4062 may prevent an injured worker in an <i>admitted injury</i> case from receiving treatment which would be provided to an injured worker in a <i>denied injury</i> case. To prevent this problem, commenter suggests the following language: “Nothing in this section shall prohibit a physician or other medical service or goods provider from furnishing medical treatment which is reasonably required to cure or relieve from the effects of the claimed injury and then filing a lien claim under Section 4603.2(b) to recover its reasonable, usual and customary charges if the treatment is found to be provided in connection with a valid industrial injury claim.”</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.</p>	<p>None.</p>
§9792.11	<p>Commenter states that while a separate rulemaking process will address penalties applicable in the utilization process, the promulgation of a general penalty clause, even if on an interim basis, should be part and parcel of the utilization review regulations to encourage compliance at the outset. Commenter suggests that the original language of section 9792.11(b) be restored until further this section is amended by further rulemaking which specifically addresses the penalty provisions.</p>		<p>Disagree. With regard to the penalties issue raised by the commenter, this will be addressed in the presently undergoing UR violation penalty regulations rulemaking.</p>	<p>None.</p>

Section 9792.6	Commenter wants to express his concerns about allowing UR to be performed by "physicians licensed in any US jurisdiction". Commenter opines that such legislation would remove any ability that the Medical Board of California would have to regulate physicians outside of California performing UR.	Jay V. Westphal, M.D. State Compensation Insurance Fund Written Comments June 14, 2005	Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005	None.
Section 9792.6(b)	Commenter states that a definition for "appropriate reimbursement" would be valuable. We suggest it be defined as "the fee provided under the applicable Official Medical Fee Schedule, contract rate, or usual and customary fee, whichever is less."	David Mitchell Republic Indemnity Written Comments June 14, 2005	Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.	None.
Section 9792.6(c)	Commenter states that the definition of "Claims Administrator" appears to exclude workers' compensation insurer, public entity, CIGA, SISF, SCIF, and the State of California. This could not have been the intent.		Disagree. The definition of claims administrator includes the listed entities under the various categories set forth in the regulations.	None.
Section 9792.6(e)	Commenter states that ambiguous, generic and open ended treatment plans are commonplace. Commenter suggests that the definition of "Course of Treatment" include a limitation of duration before a new treatment plan must be submitted, and recommends 45 days.		Disagree. The suggested amendment is too restrictive. If a claims administrator finds the treatment plan ambiguous, the claims administrator does not have to approve the plan.	None.
Section 9792.6(f)	Commenter suggests that the definition of "Emergency health care services" is overbroad. Commenter proposes that the definition be amended to be consistent with B&P 2397, which states "situation... requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately		Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.	None.

Section 9792.6(g)	<p>diagnosed and treated, would lead to serious disability or death.”</p> <p>Commenter states that he views the definition for “expedited review” as far too speculative and would suggest substituting the medical probability standard.</p>		Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.	None.
Section 9792.6(h)	<p>Commenter suggests relying on Section 3209.3 in the Labor Code (excluding the requirement for California licensure) as the source for the definition of “expert physician reviewer.”</p>		Agree. The definition did rely on section 3209.3 of the Labor Code, and it excluded the requirement of a California license.	None.
Section 9792.6(i)	<p>Commenter suggests that the definition of “health care provider” be amended as simply any person or entity providing medical services as defined in subparagraph (k).</p>		Disagree. The comment does not address proposed changes made to the regulations subject the first 15-day notice.	None.
Section 9792.7(a)(5)	<p>Commenter states that he does not understand what is involved in description of “... any prior authorization process that will be used by the claims administrator in the utilization review plan.” Commenter inquires as to what is the definition of “prior authorization.” Commenter questions as to whether if Republic Indemnity has contracted with an outside utilization review company to perform utilization review, will such a description be documented in the Plan they are required to file.</p>		Disagree in part. This section does not require the UR plan to document whether the claims administrator has contracted with a specific UR Vendor. The requirement is that the specific plan being used, whether the claims administrator’s or the UR vendor’s, must be submitted to the Administrative Director. Section 9792.7(a)(5) is intended to provide information on what are the approval of medical treatment practices of the claims administrator prior to requiring the doctor to file a request for authorization, i.e., does the claims administrator always allow 5 physical therapy treatments in certain specific diagnoses prior to the doctor	Section 9792.7(a)(5) has been amended. The section now states: “A description of the claims administrator’s practice, if applicable, of any prior authorization process, including but not limited to where authorization is provided without the submission of the request for authorization.”

Section 9792.7(c)	Commenter requests that the term “material modification” as used in this section be defined.		being required to submit a request for authorization. We agree, however, that the section needs to be amended for clarification purposes.	
Section 9792.9(b)(2)(A)	Commenter suggests that allowing only a physician reviewer to deny a request for services due to failure to provide “reasonable information” is very problematic. Commenter opines that it will be costly and unnecessarily increase the possibility of breakdowns in the review process. Commenter suggests substituting a “trained medical professional” for physician reviewer. Someone with the skill level of a Licensed Vocational Nurse (LVN) should be satisfactory.		Agree. A definition for the term “material modification” is now contained at 9792.6(1). Disagree. The previously drafted regulations contained an inconsistency. Pursuant to the statute only the physician reviewer may deny a request for treatment authorization. Therefore, section 9792.9(b)(2)(A) has been amended to state that the physician reviewer is responsible to deny the request for treatment authorization for lack of information, not the claims administrator.	New section 9792.6(1) states: “material modification is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.” None.
General Comment	Commenter suggests that it would be valuable to create a new section addressing “Admissibility in Evidence.” Commenter states that currently, utilization review related litigation is fraught with delays incident to obtaining AME’s and panel QME’s because of issues of admissibility due to recent case law. Commenter opines that the addition of this section would allow parties to resolve		Disagree. The comment is beyond the scope of these regulations and the issue of admissibility of evidence is a matter of the Workers’ Compensation Appeals Board’s jurisdiction.	None.

	issues on the merits rather than “gamesmanship,” and reduce the need for medical-legal evaluation, and encourage matters to be resolved according to the statutes. Commenter suggests the following language: “All records and reports resulting from utilization review, regardless of untimeliness, shall be admissible into evidence in all proceedings at the WCAB.”			
Section 9792.9(b)(2)(A)	Commenter objects to section 9792.9(b)(2)(A), the new requirement of peer advisor review in the case of denials for insufficient information to make a decision. Commenter states that this inserts an additional time consuming and expensive step into the utilization review process to accomplish a task that has always been satisfactorily performed by trained utilization review nurses and claim examiners. Commenter further states that this adds expense for the employer, who must pay the peer advisor (usually a physician) for what is essentially an administrative function. Commenter further states that this also delays notification to the claimant or treating physician so that it takes longer to remedy and resubmit the defective submission.	<p>Luisa Gomes Claims Manager Ross Stores Written Comment June 14, 2005</p> <p>David R. Holmquist, CPCU, ARM Los Angeles Unified School District Written Comments June 15, 2005 (Text is identical)</p>	Disagree. The previously drafted regulations contained an inconsistency. Pursuant to the statute only the physician reviewer may deny a request for treatment authorization. Therefore, section 9792.9(b)(2)(A) has been amended to state that the physician reviewer is responsible to deny the request for treatment authorization for lack of information, not the claims administrator.	None.
Section 9792.6(b)	Commenter objects to the definition of authorization in section 9792.6(b). Commenter states that the proposed revision of Section 9792.6(b) requires that utilization review nurses evaluate the appropriateness of the reimbursement for proposed treatments. Utilization review traditionally addresses only the medical appropriateness of a recommended course of treatment, not the		Disagree. See response to comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005, above.	None.

	accuracy of medical billings or the appropriateness of the amounts charged. That is the function of separate bill review specialists.			
Sections 9792.6(h), 9792.6(l)	Commenter requests the <i>occupational therapist</i> be added to the list of “expert reviewers.” Commenter states that the scope of occupational therapy service in the rehabilitation of injured workers is notably different from that of any of the listed physician and non-physician reviewers, yet vital to supporting “return to work” goals. Commenter further states that given that the ACOEM guidelines lack direction concerning occupational therapy treatment, commenter believes that it is vital to have occupational therapists as reviewers within their scope of practice.	V. Judith Thomas Director Reimbursement and Regulatory Policy American Occupational Therapy Association Written Comments June 14, 2005	Disagree. Labor Code section 4610(e) only authorizes physicians to “evaluate the clinical issues involved in the medical treatment services, ... [and] ... modify, delay or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.” Occupational therapists are not physicians and to add them to the list of expert reviewers will go beyond the scope of the statute.	None.
Sections 9792.8(a)(2)	Commenter appreciates the addition of the statement, “. . . treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines,” since this is not a source of evidence in regard to occupational therapy. Commenter further states that the parameters for rehabilitation services for the range of conditions that occupational therapists treat cannot be found in a single source at this time. For this reason, commenter believes it becomes doubly important that DWC include occupational therapists as expert reviewers to assure that the reviewer is familiar with specific occupational treatment protocols and the existing body of evidence.		Disagree. See response to comment immediately above.	None.

Section 9792.6(c)	<p>Commenter objects to the definition of “claims administrator,” stating that she is unable to understand the purpose of the inclusion of sentence, stating “the claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities.” Commenter finds the language confusing, asserting that the language appears to suggest that a claims administrator may be able to circumvent the requirements of 4610 if it is engaged in the performance of utilization review activity – either prospectively or retrospectively.</p>	<p>Nileen Verbeten Vice President Center for Economic Services California Medical Association Written Comments June 14, 2005</p>	<p>Disagree. The added sentence to the definition of claims administrator stating, “the claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities,” is intended to allow the employer or insurer to use the UR vendor as an agent to conduct its utilization review responsibilities. This is permitted by the statute and is a common business practice. Per the statute and the regulations, the employer is ultimately responsible for the UR process.</p>	None.
Section 9792.6(f)	<p>Commenter objects to the definition of “emergency health care services.” Commenter states that the exclusion of severe pain in the definition is inconsistent with existing State and Federal laws that define emergent medical care. Commenter recommends that the definition be revised as follows: "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy; (2) Serious impairment to bodily functions; and (3) Serious dysfunction of any bodily organ or part.”</p>		<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject the first 15-day notice.</p>	None.
Section 9792.6(g)	<p>Commenter objects to the definition of “expedited review” Commenter states that the definition of expedited review incorporates</p>		<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject</p>	None.

	<p>the definition of an emergency condition. Commenter states that this is confusing and implies that treating a patient with a medical emergency should be subject to Utilization Review processes rather than treated as an emergency for which no authorization is required prior to providing medical screening and/or stabilizing treatment. Commenter recommends the definition be changed to read: “expedited review” means utilization review conducted under an accelerated timeframe for a medical condition that does not require emergency health care services, but the normal timeframe for the decision-making process would be detrimental to the injured worker’s life or health or could permanently impair the injured worker’s ability to regain maximum function.”</p>		<p>the first 15-day notice.</p>	
<p>Section 9792.9(d) (now re-lettered §9792(e))</p>	<p>Commenter states that section 9792.9(e) of the proposed Utilization Review Standards provides up to 72 hours to respond to a request for Expedited Review. Commenter wishes to point out the inconsistency of imposing a delay of up to 72 hours for a condition that the law requires a provider to immediately address.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject the first 15-day notice. However, it is important to point out that the 72-hours timeline for expedited review for prospective or concurrent decisions related to an expedited review are provided for by the statute (Labor Code section 4610(g)(2).)</p>	<p>None.</p>
<p>Section 9792.6(h)</p>	<p>Commenter objects to the definition of “expert physician reviewer” because (1) the action of conducting prospective and concurrent utilization review that would modify, delay or deny requested medical treatment constitutes the practice of medicine and therefore must be licensed by the appropriate Board in the State</p>		<p>Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005</p>	<p>None.</p>

	<p>of California; and (2) CMA has received complaints that chiropractors (employed by the insurance carrier) are denying treatment authorization requests from physicians holding M.D. and D.O. degrees. Commenter further states that the Medical Board of California (MBC) established its Expert Reviewer Program in July 1994 as an impartial and professional means to assist the Board by providing expert reviews and opinions on Board cases, and believes that any physician acting as an “expert physician reviewer” should be held to the same or similar standards established by the MBC.</p>			
<p>Section 9792.7(a)(4)</p>	<p>Commenter requests that along with reporting of qualifications and functions of the personnel involved in the decision-making and implementation of the utilization review plan those individuals must provide, name, contact information including address and phone number and license number (if applicable).</p>		<p>Disagree. Disagree. The comment does not address proposed changes made to the regulations which are the subject the first 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(a)(1)</p>	<p>Commenter objects to the amended language in this section wherein it states that “the provider must indicate the need for an expedited review upon submission of the request.” Commenter believes that this language may be construed as reason for denial or delay of medically necessary care without review. Commenter believes that the decision to request an expedited review belongs solely to the requesting physician. Once the request has been made the process of expedited review must be completed within the 72 hour timeframe.</p>		<p>Disagree. Pursuant to previous comments it was agreed that the requesting physician should decide whether to request an expedited review. It was determined that it was incumbent upon the physician to indicate the request in some manner which would assist the UR reviewer in identifying the expedited nature of the request for authorization and comply with the strict timeline.</p>	<p>None.</p>

Section 9792.9(c)	<p>Commenter objects to the amended language contained in section 9792.9(c) wherein it states that “documentation for emergency health care services shall be made available to the claims administrator upon request.” Commenter states that she has received countless complaints from physicians stating that payments have been delayed pending receipt of documentation from sources not under their control. Commenter further indicates that while CMA agrees that supporting documentation for emergency services may be necessary it also believes that delay in payment under these circumstances is unacceptable.</p>		<p>Disagree. DWC believes that is reasonable for the claims administrator to request documentation for emergency health care services if necessary and the requesting physician is the more appropriate party to have control of that information. Moreover, a claims administrator cannot be expected to pay for services that are not documented.</p>	None.
Sections 9792.6(h), 9792.6(l)	<p>Commenter believes that all expert physician reviewers and physician reviewers should be licensed in the State of California. Commenter states that all primary treating physicians, consultant physicians, Agreed Medical Examiners and Qualified Medical Examiners who participate in the California Workers' Compensation system and whose requests for authorization will be reviewed by expert physician reviewers and physician reviewers, are required to be licensed in the State of California. Commenter opines that physicians licensed and practicing in California are much more likely to be familiar with local community medical standards. They are also much more likely to be familiar with local treating physicians, as well as their treatment patterns. Commenter believes that the amendments to the sections which will allow an expert physician reviewer or a physician reviewer to be a physician licensed by any U.S. jurisdiction will create a standard that is</p>	<p>Robert G. Taber, M.D. Written Comments June 15, 2005</p>	<p>Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005</p>	None.

	not consistent with the policies and regulations of the California Medical Board's Licensing Section, and will create a situation where the MBC will have no ability to protect the consumers of California from adverse UR decisions that may impact the health and well being of Californians.			
Section 9792.9	Commenter states utilization review “expert physician reviewers” and “physician reviewers” do not have access to the injured worker’s complete medical records. Commenter further states that generally, all that the reviewers have is the request for authorization of services, and the treating physician is constantly kept guessing what information the reviewer will have. Commenter recommends that the regulations state that it is the responsibility of the carrier/self-insured employer to make the injured workers’ complete medical record available to their utilization reviewers.	Diane Przepiorski Executive Director California Orthopaedic Association (COA) Written Comments June 15, 2005	Disagree. It is not necessary for the regulations to require that the claims administrator to make the injured workers’ complete medical record available to their utilization reviewers. The claims administrator is only required to provide records pertinent to the utilization review, and this varies on a case by case basis.	None.
Section 9792.6(h), 9792.6(l),	Commenter objects to the definitions of expert physician reviewer and physician reviewers. Commenter states deciding whether treatment is appropriate constitutes the “practice of medicine” and as such, individuals making those decisions must be licensed in California to ensure patient safety and appropriate decisions are made. Commenter states that this is supported by Labor Code section 4610 (e) and Labor Code 3209.3. Commenter further states that because Labor Code Section 4610 is silent on licensure issues, commenter believes it is unreasonable for the Division to decide that licensure in California is not required. Commenter further states that when		Disagree. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further issues relating to UR violations will be addressed in the UR rulemaking regulations which are in the process of being developed.	None.

	<p>her organization receives complaints from its members, they have attempted to reach these out-of-state physicians to confirm their specialty and practice area. Commenter states that the ones they have contacted do not have medical offices or staff and the phone number given is only an answering machine, and when they contact the Medical Board of California to obtain information on the physician, the Medical Board has no record of that physician practicing medicine or performing utilization review in California.</p>			
Section 9792.8	<p>Section 9792.8(a)(3) and (a)(3)(B) retain requirements that the UR entity provide copies of the criteria or guidelines used as the basis of the decision. This requirement, which is unique throughout the United States, creates an unreasonably time consuming and expensive mandate for utilization review agents and peer review doctors. The rule should instead adhere to the industry standard that an adverse determination letter must disclose the source of the criteria or guidelines that were used.</p>	<p>Harry Monroe, Jr. Director of Governmental Relations Concentra, Inc. Written Comments June 16, 2005</p>	<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject of the first 15-day notice. However, it is important to note that this is required by the statute.</p>	<p>None.</p>
Section 9792.9(j)(8)	<p>Commenter states that the new option presented as mandatory language for decisions modifying, delaying or denying treatment in this section requires enclosure of a complete list of Information and Assistance Offices. Commenter further states that this information is available by calling the toll-free number also required by this mandatory language. As such, the mandate for the enclosure is duplicative and unnecessary and should be omitted.</p>		<p>Disagree. The notice is required by statute. The option added as new language was added pursuant to comments from the public, and it is a second alternative to the first requirement of that section. If commenter does not want to comply with this second option, he can comply with the notice requirements by complying with the first requirement.</p>	<p>None.</p>

Section 9792.9(k)	<p>Commenter states that this section requires the written decision to include disclosure of a minimum of 4 hours a week when the physician reviewer or medical director must be available to discuss the decision with the treating physician. Commenter further states that because these physician reviewers can be expected to maintain an active practice in addition to their responsibilities as physician advisors, it would be difficult, if not impossible, to set aside blocks of time when they would be certain to be available. Commenter suggests that instead, the regulation could require a reviewer to schedule time to discuss the decision upon the request of the treating doctor.</p>		<p>Disagree. See response and action above in connection with comment submitted by Steven Rosen, MD, CompPartners, dated June 7, 2005.</p>	None.
Section 9792.9(k)	<p>Commenter requests that the revised language in section 9792.9(k) to limit the timeframe for discussion between the treating provider and the reviewing physician to “at a minimum four (4) hours a week” be restricted to within the 20-day limit allowed for disputing the utilization review decision. Commenter also proposes an allowance be made under revised subsection (k), for any physician reviewer qualified to review the specific case to undertake the discussion with the treating provider.</p>	<p>Julie Martin First Health Group Corp. Written Comments June 16, 2005</p>	<p>Disagree. Commenter confuses the requirement that the utilization reviewer and medical director be available to discuss the UR decision (section 9792.9(k)) with the requirement that the injured worker has 20 days from the date of decision to object to the UR decision (section 9792.10). These timelines are separate and distinct timelines. Further, it is very important that the physician reviewer familiar with the request for authorization be the one communicating with the requesting physician.</p>	None.
Section 9792.6(b)	<p>Commenter objects to the definition of “authorization.” Commenter states that the definition implies that appropriate reimbursement will be made for a specific course of treatment. Commenter states that this is not consistent with Labor Code §4610</p>	<p>Sam Sorich, President Association of California Insurance Companies Written Comments June 16, 2005</p>	<p>Disagree. See response to comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005, above.</p>	None.

<p>Section 9792.6(c)</p>	<p>which focus on “medical necessity.” Commenter further states that there may be questions about specific treatments provided as part of the course of treatment and the appropriateness of any reimbursement cannot be determined until the employer sees the charges and determines whether they are subject to the fee schedule or negotiated rate.</p> <p>Section 9792.6(c) Adding “insured employer” to the definition of “claims administrator” creates a potential conflict between an insurer and its employer/policyholder if the insurer has contracted with one utilization review firm and the employer without consulting his insurer hires a different firm.</p>		<p>Disagree. It has come to DWC’s attention that there are employers, although indicating to DWC that a UR vendor is conducting their UR review, conducting UR review on their own UR overflow. Thus, the term “insured employer” was added to the definition of claims administrator in order to bring the insured employers conducting their own UR review under the regulations, both under the UR regulations and the UR violation penalty regulations.</p>	<p>None.</p>
<p>Sections 9792.6(h), 9792.6(l)</p>	<p>Commenter states that sections 9792.6(h) and (l) are welcome clarifications.</p>		<p>Agree in part. See response and action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005.</p>	<p>None.</p>
<p>9792.7(c)</p>	<p>Commenter inquires as to reasons for the amendment in this section requiring the filing of a new utilization review plan within 30 calendar days after the claims administrator either changes its utilization review plan or makes material modifications to the plan.</p>		<p>Agree. A definition of the term “material modification” has been added to the regulations.</p>	<p>New section 9792.6(l) has added to the proposed regulations setting forth a definition for the term “material modification.” The section states:</p>

<p>Sections 9792.9(b)(2), 9792.9(b)(3)</p> <p>Section 9792.9(b)(4)</p> <p>Section 9792.9(c)</p>	<p>Petitioner requests that a definition for material modification be added to the regulations.</p> <p>Commenter states that section 9792.9(b)(2) should be clarified so that it will not be interpreted as being inconsistent with section 9792.7(b)(3).</p> <p>Commenter states that section 9792.9(b)(4) goes beyond the statute when it adds the employee's attorney to the list of those to be notified.</p> <p>Commenter states that in retrospective reviews, there usually is not a "requesting" physician.</p>		<p>Disagree. Commenter offers no explanation as to how these two sections might appear to be inconsistent, or in which way they should be clarified.</p> <p>Disagree. Attorneys are for the most part entitled to be served with workers' compensation documents when representing their clients.</p> <p>Disagree. If there is a requesting physician, then there must be service of the decision.</p>	<p>"material modification is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7."</p> <p>None.</p> <p>None.</p> <p>None.</p>
<p>Section 9792.6(h), 9792.6(l)</p>	<p>Commenter objects to the proposed definitions for "expert physician reviewer" and "physician reviewer," stating that the proposed regulatory language under these definitions would allow for physician and surgeons licensed by any U.S. jurisdiction, to evaluate the clinical issues in the medical treatment prescribed by the California licensed physician. Commenter further states that this same reviewer is then allowed, under section 9792.7(b)(2) to delay, modify or deny requests for treatment. Commenter states that only physicians and surgeons licensed in</p>	<p>David T. Thornton Executive Director Medical Board of California Written Comments June 16, 2005</p>	<p>Agree in part. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, based on Labor Code section 3209.3, and based on commenter's suggestions.</p>	<p>See Action above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005.</p>

	<p>California are allowed to override treatment decisions. Commenter believes that the definitions are against Business and Professions code section 2052(a), which defines when a California medical license is required. Commenter further states that the Medical Board will be unable to carry out its over-viewing obligations.</p> <p>Commenter further opposes the language in these sections, which include the terms psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractors. Commenter believes the law and case law are clear that only individuals licensed as physicians and surgeons by the Medical Board of California or the Osteopathic Medical Board of California may be called physicians.</p> <p>Commenter believes that a viable alternative to use instead of the terms “physician reviewer” and “expert physician reviewer” would be the term “expert healthcare reviewer.”</p>			
Section 9792.9(b)(2)(A)	<p>Commenter objects to the amendment in the proposed regulations requiring a physician to deny a request for authorization of medical treatment on the basis of lack of information. Commenter believes that this will unnecessarily raise employers’ and issuers’ costs, and potentially defeating the purpose of utilization review and of recent applicable legislation.</p>	<p>David J. Farber American Association of Independent Claims Professionals (AAICP) Written Comments June 16, 2005</p>	<p>Disagree. See response to comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005, above</p>	<p>None.</p>
Section 9792.6(b)	<p>Commenter objects to the amendment to the definition of “authorization.” Commenter states that “authorization” should not be</p>		<p>Agree in part. See response and action in connection with comment submitted by Anne Edson, Sedgwick</p>	<p>See Action above in connection with comment submitted by Anne</p>

	<p>defined to mean “appropriate reimbursement will be made for a specific course of proposed medical treatment.” The currently accepted definition of “utilization review” does not include reimbursement and including reimbursement would blur the line between utilization review, claims management and bill review. Commenter further states that the definition is in conflict with section 9792.6(q) which defines “utilization review process,” which states, in relevant part, that the definition does not include bill review for the purpose of determining whether the medical services were accurately billed.</p>		<p>Claims Management Services, dated June 10, 2005, above.</p>	<p>Edson, Sedgwick Claims Management Services, dated June 10, 2005.</p>
<p>Section 9792.6(h)</p>	<p>Commenter requests that the definition of “expert physician reviewer” be corrected so that it is in the singular format as is the word being defined. Commenter further states that the clarification of the term, “physician reviewer,” is very needed and useful. Also, commenter raises the concern about whether the California Board of Medical Examiners definition of expert reviewer should be applied here.</p>	<p>Peggy S. Hohertz Regulatory Compliance Analyst Fair Isaac Corporation Written Comments June 16, 2005</p>	<p>Agree in part. The definition of expert reviewer has been amended for clerical error pursuant to commenter’s suggestion. We disagree that the definition should be consistent with the California Board of Medical Examiners’ definition of expert reviewer as the definition is based on the statute and Labor Code section 3209.3.</p>	<p>Section 9792.6(h) has been amended. The section now states: “Expert reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of practice, as defined by the licensing board, who has been consulted by the physician reviewer, the health care reviewer or</p>

<p>Section 9792.7(a)</p>	<p>Commenter states that the information filed in the UR plan is public information. Based on that premise, commenter suggests that the personal information required by the medical director be limited to that information which is publicly available on the Medical Board of California website, or the Osteopathic Medical Board of California website, i.e. practice location and type of medical license.</p>		<p>Agree in part. The phone number is required by statute for communication purposes. However, there is no requirement that the areas of practice be listed. The section will be amended accordingly.</p>	<p>the utilization review medical director to provide specialized review of medical information.”</p> <p>Section 9792.7(a)(1) requiring information on the medical director is amended to read as follows: “The name, address, phone number, area(s) of certified specialty, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.”</p>
<p>Section 9792.7(a)(5)</p>	<p>Commenter requests that the Division clarify the new provision contained in section 9792.7(a)(5). Commenter offers the following language: “A list, if applicable, in the utilization review plan of any non-emergency treatments or non-emergency diagnostic services requiring preauthorization by the claims administrator.”</p>		<p>Agree in part. Section 9792.7(a)(5) has been amended for clarification purposes. However, we disagree with commenter’s suggested language. Section 9792.7(a)(5) is intended to provide information in the UR plan on what are the approval of medical treatment practices of the claims administrator prior to requiring the doctor to file a request for authorization, i.e., does the claims administrator always allow 5</p>	<p>Section 9792.7(a)(5) has been amended. The section now states: “A description of the claims administrator’s practice, if applicable, of any prior authorization process, including but not limited to where authorization is provided without the submission of the request for authorization.”</p>

<p>Section 9792.7(c)</p>	<p>Commenter states that the requirement to file a new copy of the utilization review plan when there are material modifications needs clarification. Commenter requests that the term “material modification” be defined. Commenter agrees with the modifications made to §9792.9(b)(3) and the addition of §9792.9(b)(4) as this brings the proposed UR regulations into compliance with LC §4610 (g)(4) concerning who needs to be provided copies of authorization, modification, delay and denial determinations.</p>		<p>physical therapy treatments in certain specific diagnoses prior to the doctor being required to submit a request for authorization.</p> <p>Agree. A definition for the term “material modification” is now contained at 9792.6(l).</p>	<p>New section 9792.6(l) states: “material modification is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.”</p>
<p>Section 9792.9(d)</p>	<p>Commenter suggests if the Division believes it necessary to emphasize the concept of emergency services in relation to UR review, the language in the section 9792.9(d) should be re-worded as follows: “Preauthorization shall not be required prior to provision of emergency health care services. Emergency health care services, however, may be subject to retrospective review.”</p>		<p>Agree. Commenter’s amended language is accepted as it presents the concept more clearly.</p>	<p>Section 9792.9(d) has been amended. The section now states: “Preauthorization shall not be required prior to provision of emergency health care services. Emergency health care services, however, may be subjected to retrospective review.”</p>
<p>Section 9792.9(g)(3)</p>	<p>Commenter agrees with the change to section 9792.9(g)(3) as it brings the regulation into conformance with the applicable section of the Labor Code section 4610(g)(5).</p>		<p>Agree.</p>	<p>None.</p>

Section 9792.9(j)(8)	Commenter believes section 9792.9(j)(8) is a good change as it now offers some flexibility in the type of notification regarding the Information and Assistance offices.		Agree.	None.
Section 9792.9(k)	Commenter believes the proposed changes to section 9792.9(k) go above and beyond the applicable Labor Code requirement of Section 4610(h) which requires telephone accessibility for physicians to request authorization for treatment. There is nothing in this section of the Labor Code to require physician reviewer accessibility information such as a phone number of the physician reviewer or the hours of availability.		Disagree. See response and action above in connection with comment submitted by Steven Rosen, MD, CompPartners, dated June 7, 2005.	None.
Section 9792.6	Commenter is concerned about the proposal to allow physicians "out of state" to perform UR as reviewers. Commenter fears the "out of state" physicians will have no direct experience/knowledge with workers' compensation practice in California, and thus, other than the law and access to ACOEM Guides, they will be limited in their scope to make decisions.	Jonathan M. Dietz, D.O. Written Comments June 16, 2005	Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.	None.
Section 9792.6	Commenter believes that to change the performance requirement from a California licensed physician, to a US licensed physician weakens the UR system by allowing physicians to practice in California who are no subject to any of the licensing, discipline or CME requirements. Commenter further states that out of state physicians are also not likely to be aware of the specific California statutes and regulations as well as the local standards. Commenter urges the Division to retain the	Thomas Reaper, M.D. Written Comments June 16, 2005	Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.	None.

	requirement for UR physicians to have a California license.			
Section 9792.6	Commenter is concerned about the new regulations allowing physicians outside of California to review care in California. Commenter believes that it is not appropriate to have physicians that have not met California credentialing procedures to review those who have been licensed. Commenter states that the quality of care in California may be at risk by allowing inferior quality review from physicians who may never have practiced medicine and may have received insufficient education overseas. Allowing outside physicians to review that are not California licensed, removes them from examination and responsibility to our medical board. Commenter further states that the medical board would not have any ability to review them or place restrictions if difficulties arise.	Jeanne V. Hamel, M.D. Written Comments June 16, 2005	Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.	None.
Section 9792.6	Commenter opposes the proposal to allow physicians "out of state" to perform UR as reviewers because workers' compensation laws and practices are considerably different in California than in many other states. Commenter states that even the present system that allows out of state and unlicensed (in California) specialty reviewers to review requests, contact providers and write recommendations, and then have the paperwork countersigned as reviewed and agreed to by a California licensed physician, (who may have no qualification other than California licensure) is, in the commenter's opinion, not in the spirit of the way the regulations were written.	Colin L. Walker, M.D. Written Comments June 16, 2005	Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.	None.

	<p>Commenter further states that much of the work in UR is not covered in any direct “Guideline” such as ACOEM Guidelines, so knowing the local community patterns is part of what is weighed in making a decision, when guidelines are not sufficient or if they do not address the specific issues requested by the treating physician. Commenter also states that when discussing his decisions with providers at times when requests become contested, there is usually a sense of a shared responsibility to reign in unnecessary costs in workers’ compensation yet provide efficacious care (as opposed to an adversarial atmosphere) that often is smoother knowing on both sides we are each residing and doing business, as well as caring for patients, here in California.</p>			
Section 9792.6	<p>Commenter seconds Dr. Colin Walker’s comments (given above) and would like to add that Chiropractors are limited scope providers and guidelines vary drastically from state to state.</p>	<p>David J. Paris, DC, QME Active Care Chiropractic Written Comments June 16, 2005</p>	<p>Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.</p>	<p>None.</p>
Section 9792.6	<p>Commenter is concerned about allowing out-of state physicians to perform utilization review. Commenter states that what has made the largest impact for reviewers is the fact that they are on-site with access to the actual case files with all the information available to review before making a determination. Commenter has performed off-site reviews which many times require additional calls to</p>	<p>Mike J. Laubach, D.C. Written Comments June 16, 2005</p>	<p>Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code</p>	<p>None.</p>

	<p>the insurance carrier (adjuster, nurse) to obtain the necessary information or contacting the provider because the adjuster cannot be reached. Commenter states that on-site reviews have been extremely successful in streamlining the case review process and are far more efficient and effective. Commenter hopes the Division considers the benefits of having physicians in the local area that are familiar with state workers' compensation laws and the benefits to the injured workers and carriers adjusting their claims in getting the most expeditious and appropriate reviews done which is consistent with current accepted guidelines and reviewed on a case by case basis. Each provider that has a request that is not to be authorized is contacted by the physician advisor reviewing the request. This dialogue is helpful in getting authorized treatment outside current guidelines that is appropriate in that instance.</p> <p>Commenter also states California has tight time frames that the reviewer needs to meet. In off-sight reviews there is increased time spent in organizing medical records and faxing them which adds to already difficult to meet turn-around time.</p>		section 3209.3.	
Section 9792.6	<p>Commenter objects to the definition of "authorization." Commenter requests that the definition be amended to state, "Authorization means the requested treatment is medically necessary to cure and relieve..." or be deleted in its entirety. Commenter states that Labor Code section 4610(a) does not suggest that payment is guaranteed by utilization review,</p>	<p>Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual Written Comments June 16, 2005</p>	<p>Agree in part. See response and action in connection with comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005, above.</p>	<p>See Action above in connection with comment submitted by Anne Edson, Sedgwick Claims Management Services, dated June 10, 2005.</p>

<p>Section 9792.6(r)</p>	<p>only that the treatment is medically necessary to cure and relieve. Commenter further states that payment issues are determined separately and independently by other persons in the workers' compensation system.</p> <p>Commenter continues to object to the unmodified definition of "written." Commenter continues to hold the position that all written documentation should include the optional use of secured electronic means, such as web or email submission in order to accommodate those parties that prefer this form of written communication.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject the first 15-day notice.</p>	<p>None.</p>
<p>Section 9792.7(a)(5)</p>	<p>Commenter objects to amendments to section 9792.7(a)(5). Commenter is does not understand what the language of the regulation means and under what circumstances this would apply. Commenter requests that the language be more specific or removed from the regulations.</p>		<p>Agree in part. See response to comment submitted by Peggy S. Hohertz, Fair Isaac Corporation, dated June 16, 2005</p>	<p>See action taken in connection with the comment submitted by Peggy S. Hohertz, Fair Isaac Corporation, dated June 16, 2005.</p>
<p>Section 9792.7(c)</p>	<p>Commenter objects to the amendments to section 9792.7(c). Commenter states that although many states do require that notice of a material change be submitted within 30 days, no other state requires that a new Plan be filed after a material change occurs. Commenter believes that the best approach would allow for the notice within 30 days. Commenter further states that if the Division desires to establish criteria when a new Plan should be filed, she recommends that a clear definition of "material change" should be included in the regulations.</p>		<p>Agree in part. See response to comment submitted by Peggy S. Hohertz, Fair Isaac Corporation, dated June 16, 2005</p>	<p>See action taken in connection with the comment submitted by Peggy S. Hohertz, Fair Isaac Corporation, dated June 16, 2005.</p>

	<p>providing physicians various evaluation, treatment, and reporting practices will function more efficiently; (3) The United States has essentially 50 unique (plus the District of Columbia, and the territories of Puerto Rico, Guam, American Samoa, Virgin Islands, etc) Worker's Compensation laws. While there are similarities between many of these laws, there are substantial differences in some states; (4) Treatments reviewed in California may differ significantly from other states; (5) Physician reviewers from California are likely to be much more familiar with alternative durable medical equipment requests and new therapies that have not been tried routinely in South Dakota, for example; (6) Physician reviewers in California (who frequently provide reviews in-house at insurance providers offices) will have a greater access to the complete medical record; (7) Reviews for utilization of services for California State employees are likely to be subtly different than in other states and jurisdictions.</p>			
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<p>Section 9792.6(b)</p>	<p>Commenter states that he is concerned that situations may arise where a medical treatment procedure may be appropriately authorized per utilization review. However payment for the procedure performed during the delay status of the claim prior to denial may result in medical payments in excess of \$10,000, which would be inconsistent with Labor Code §5402(c). Commenter recommends that the section be amended to add the phrase at the end of the definition, “subject to the \$10,000 limit for claims on delayed status pursuant to LC §5402(c).”</p>	<p>Jose Ruiz Assistant Claims Rehabilitation Manager State Compensation Insurance Fund Written Comments June 16, 2005</p>	<p>Agree in part. The definition has been amended to include a reference to Labor Code section 5402.</p>	<p>Section 9792.6(b) has been amended for clarification purposes. The section now states: “authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury, subject to the provisions of section 5402 of the Labor Code, based on the Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-2, as contained in section 9785.2, or on a narrative form containing the same information required in the DWC Form PR-2.”</p>
<p>Section 9792.6(c)</p>	<p>Commenter states that the definition of “claims administrator” has been revised to include an insured employer. Commenter further states, that, however, the claims administrator for an “insured employer” is the insurer. Commenter recommends deleting “insured employer” which would be consistent with Labor Code §138.4.</p>		<p>Agree in part. With regard to commenter’s objection to the definition of claims administrator including the “insured employer” as part of the definition, it is noted that it has come to DWC’s attention that there are employers, although indicating that a UR vendor is</p>	<p>Section 9792.6(c) has been amended. The section now states: "Claims Administrator is a self-administered workers' compensation insurer, an insured employer, a self-</p>

Section 9792.6(n)	<p>Furthermore, commenter states that it is unclear from this subsection that the phrase “a third-party claims administrator for” applies to each entity that follows it. This subsection also incorrectly limits permissible contracting for utilization review to employers and insurers. Commenter further recommends that the last sentence of the definition be amended to read as follows: “The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.”</p> <p>Commenter states that this subsection should be revised to specifically indicate that the primary treating physician has the sole responsibility for submitting requests for authorization, in accordance with section 9785.</p>		<p>conducting its UR review, conducting UR review of its own UR overflow. Thus, the insured employer was added to definition of claims administrator in order to bring the insured employers conducting their own UR review under the regulations, both the UR regulations and the UR penalty regulations. It is further noted that the definition of claims administrator includes the listed entities under the various categories set forth in the regulations, however, Commenter is correct that the definition contains grammatical errors which will be corrected. Finally, commenter’s suggestion regarding the last sentence of the definition is accepted to clarify the language in the definition.</p> <p>Disagree. A secondary physician may also file a request for authorization.</p>	<p>administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.”</p> <p>None.</p>
Section 9792.6(d)	<p>Commenter requests that the term “concurrent review” also be used to define “ongoing in-office treatment”. Commenter states that this would include treatment that has not ended but is continuing, such as physical therapy.</p>	<p>Barry Adelman US Health Works Written Comments June 16, 2005</p>	<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject the first 15-day notice.</p>	<p>None.</p>
Sections 9792.6(h), 9792.6(l)	<p>Commenter states that these new definitions are inconsistent with California law. Commenter further states that in order to</p>	<p>J. David Schwartz President California Applicants’</p>	<p>Disagree. See response above in connection with comment submitted by Carl Brakensiek, California</p>	<p>None.</p>

<p>Section 9792.8(a)(2)</p>	<p>assure medical competence through state jurisdiction over these physicians, he strongly urges that this provision be amended to require that all physician reviewers and expert physician reviewers must possess a California license.</p> <p>Commenter strongly supports the addition of the last sentence to this paragraph, but believe that the language should be amended to provide that it also applies to treatment not addressed by the medical treatment utilization schedule adopted by the AD pursuant to section 5307.27.</p>	<p>Attorneys Association Written Comments June 16, 2005</p>	<p>Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.</p> <p>Disagree. This comment will be revisited in connection with the medical treatment utilization schedule regulations which are the subject to another rulemaking process.</p>	<p>None.</p>
<p>Section 9792.8(a)(3)(B)</p>	<p>§9792.8(a)(3)(B): Commenter believes the reference in this subparagraph should be revised to refer to “Section 9792.9, subdivision (j).”</p>		<p>Agree. The section has been corrected for clerical error.</p>	<p>Section 9792.8(a)(3)(B) has been amended for clerical error. The section now states: “A written copy of the relevant portion of the criteria or guidelines used shall be enclosed with the written decision to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney pursuant to section 9792.9, subdivision (j).”</p>
<p>Section 9792.9(a)(1)</p>	<p>Commenter supports the amendment to this paragraph because it is extremely important to clearly identify the date a request for authorization is received. However, in order</p>		<p>Disagree. It is sufficient to require that for purposes of this section, the written request for authorization shall be deemed to have been received by</p>	<p>None.</p>

<p>Section 9792.9(b)(4)</p>	<p>to assure that this process is fully transparent, and to prevent disputes and possible delays in treatment over this issue, commenter strongly urges that these regulations be amended to require the identification of this date by the claim adjuster. Specifically, commenter recommends that subdivision (i) of this section be amended to require that the date of receipt of the request for authorization be included in all written decisions approving, modifying, delaying, or denying the requested treatment.</p> <p>Additionally, in order to prevent disputes over this issue, commenter recommends these regulations be amended to require the identification of the date and time of notification of the requesting physician. Commenter also recommends that subdivision (i) of this section be amended to require that the date and time of any telephone or fax notice to the requesting physician of a decision regarding a request for treatment be included in all written decisions.</p> <p>Commenter states that this paragraph should be deleted because it does not conform with the underlying statute LC §4610(g)(3)(A) which provides that all decisions, whether decisions to approve, modify, delay, or deny authorization prior to the provision of treatment, must be communicated to the requesting physician within 24 hours of the decision.</p>		<p>the claims administrator by facsimile on the date the request was received if the receiving facsimile electronically date stamps the transmission, or the date the request was transmitted. Further it is noted, that the facsimile request also requires the time of the receipt. However, it is not necessary to require the claims administrator to identify the receipt date or time in the UR report. If the date or time becomes a contested issue, the proper procedure is to follow the procedures pursuant to section 9792.10.</p> <p>Disagree. This section was amended after the 45-day comment period to reflect the accurate interpretation of Labor Code section 4610(g)(3) to reflect that while the decisions to modify, delay or deny the request for authorization must be communicated in writing to the requesting physician and employee, the decision to approve the request for authorization need only to be communicated to the requesting physician. Thus, section</p>	<p>None.</p>
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<p>Section 9792.9(k)</p>	<p>Commenter supports the amendment to this subdivision to require that the written decision include the specialty of the physician reviewer. However, commenter urges that these regulations be amended to require that the written decision must include a copy of the determination by the physician reviewer. Commenter states that in some cases these notices are, at best, summaries or restatements of the physician reviewer’s analysis, signed only by the non-physician claim adjuster with a notice that the physician’s signature is “on file” with the adjuster. Commenter also states that in this limited notice often leads to unnecessary delays of treatment.</p>		<p>9792.9(b)(3) was accordingly amended and new section 9792.9(b)(4) was added to the proposed regulations to reflect the correct interpretation of the statute.</p> <p>Disagree. Pursuant to the statute the notice as required in the regulations is the only requirement.</p>	<p>None.</p>
<p>Section 9792.9(k)</p>	<p>Commenter suggests that the last sentence in this section should be amended as follows: “The written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the requesting physician to discuss the decision. The hours of availability shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 a.m. to 5:00 p.m., Pacific Time.</p>		<p>Agree. The recommended sentence is clarifies the requirement of availability of the UR reviewer.</p>	<p>Section 9792.9(k) has been amended. The section now states: “The written decision modifying, delaying or denying treatment authorization provided to the physician shall also contain the name and specialty of the physician reviewer, health care reviewer or expert reviewer and the telephone number in the United States of the</p>

				reviewer. The written decision shall also disclose the hours of availability of either the physician reviewer, the health care reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours a per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician.”
Section 9792.6(c)	Commenter states that the claims administrator for an “insured employer” is the insurer. If “insured employer” is deleted, this definition is consistent with the one in Labor Code section 138.4. Commenter further states that it is not clear that the phrase “a third-party claims administrator for” applies to each entity that follows it. Other language in this subsection incorrectly limits permissible contracting for utilization review to employers and insurers. Commenter further recommends that the last sentence of the definition be amended to state: “The claims administrator may utilize an entity with which an employer or insurer contracted to conduct its utilization review responsibilities.”	Brenda Ramirez Medical and Rehabilitation Director California Workers’ Compensation Institute Written Comments June 16, 2005	Agree in part. See response to comment submitted by Jose Ruiz, State Compensation Insurance Fund, dated June 16, 2005, on the same issue above.	See action taken in connection with comment submitted by Jose Ruiz, State Compensation Insurance Fund, dated June 16, 2005, on the same issue above.

Section 9792.6(e)	<p>Commenter states that language that mirrors the progress report format standards in section 9785 is necessary for consistency. The progress report standards provide for check-boxes to indicate the reason for the form. There is a check-box for “Request for authorization.” This makes it unnecessary and duplicative to add language to these utilization review regulations requiring the document to be “clearly marked at the top that it is a request for authorization.”</p>		<p>Disagree. If the course of treatment is set forth in “a narrative form containing the same information required in the DWC Form PR-2,” it is important to have this document appropriately labeled “Request for Authorization” for proper handling.</p>	None.
Section 9792.6(i)	<p>Commenter states that section 9792.6(i) refers to the medical goods and services provided pursuant to Labor Code section 4600. Commenter believes that it is not necessary to attempt to enumerate the providers in the definition.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations which are the subject the first 15-day notice.</p>	None.
Section 9792.6(k)	<p>Commenter requests that this section be amended to request that the request for authorization be only submitted “by the primary treating physician.” Commenter opines that this modification clarifies that the primary treating physician has the responsibility for submitting a request for authorization, in accord with section 9785.</p>		<p>Disagree. The request may be submitted by a secondary treating physician.</p>	None.
Section 9792.7(a)(1)	<p>Commenter states that the areas of certified specialty and areas of practice are not germane and are therefore unnecessary. Commenter recommends they are deleted from the section.</p>		<p>Agree in part. The request to state the areas of practice is not necessary and will therefore be deleted from the requirements. However, we believe that is important to know areas of certified specialties of the medical director, and we note that that is public information.</p>	<p>Section 9792.7(a)(1) requiring information on the medical director is amended to read as follows: “The name, address, phone number, area(s) of certified specialty, and medical license number of the</p>

<p>Sections 9792.7(b)(2), 9792.9(b)(2)(A)</p> <p>Section 9792.7(c)</p>	<p>Commenter states that modifications to these two sections are necessary to permit a non-physician reviewer to deny a request for authorization because reasonable information requested by the claims administrator is not received within 14 days of a written request. This modification clarifies that a non-physician reviewer may deny the request if the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the provider.</p> <p>Commenter states that term “utilization plan” in the amended sentence in this section is ambiguous. Commenter recommends the following that the section be changed to state: “A new utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator either changes its utilization review entity or makes material modifications to the plan.” Commenter states that this modification is necessary to clarify that a new plan needs to be filed if the claims administrator changes its “utilization entity.”</p>		<p>Disagree. Pursuant to the statute the regulations do not allow the non-physician reviewer to deny a request for authorization for lack of information.</p> <p>Agree in part. The requirement is meant to apply to all material modifications, including but not limited to, a change in UR vendor. The sentence has been re-worded for clarification purposes.</p>	<p>employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.”</p> <p>None.</p> <p>The last sentence of section 9792.7(c) has been amended. The sentence now states: “A modified utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan.”</p>
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General comment.	<p>Commenter states that the proposed utilization review regulations should make it clear that the Administrative Director has set forth a process to enforce these regulations and that the failure to meet the UR standards will not affect the usefulness of the utilization review records and reports. Commenter recommends the following that a new subdivision be added to section 9792.9, stating “[t]he failure to meet the timeliness standards of utilization review, as set forth in the regulations, shall not affect the utility of the reports or records produced in the utilization review process.”</p>		<p>Disagree. Issues relating to the admissibility of evidence before the workers’ compensation appeals board are matters that do not fall within the jurisdiction of the Administrative Director but fall with the jurisdiction of the Workers’ Compensation Appeals Board.</p>	None.
Section 9792.6	<p>Commenter states that the proposed new rule changes include the expanded statement that UR doctors can be "licensed in any US jurisdiction." Commenter interprets this to mean that UR can now be done by doctors anywhere in the US; doctors who are not licensed in California; doctors who do not know the work climate or California workers' compensation laws. Commenter states that he has already dealt with this phenomenon and feels strongly that UR needs to be performed by doctors licensed in California, preferably working in the local community. Commenter encourages the Division to strike this phrase from the new regulations.</p>	<p>Richard F. Thompson, M.D. Written Comments July 17, 2005</p>	<p>Disagree. See response above in connection with comment submitted by Carl Brakensiek, California Society of Industrial Medicine & Surgery, dated June 5, 2005. Further, it is noted that the amended definitions of these terms have been crafted, in relevant part, based on the statute, and based on Labor Code section 3209.3.</p>	None.

<p>Section 9792.892)</p>	<p>Commenter believes that section 9792.8(2)(a) should be amended to state that “[t]reatment may not be denied on the sole basis that the specific treatment for the specific indication in question is not addressed by the ACOEM Practice Guidelines.” Commenter further states that the section should be amended to state that treatment cannot be denied solely on the basis of the general philosophies provided in Chapter 6.</p>	<p>N. William Fehrenbach Director, State Government Affairs Medtronic, Inc. June 2, 2005 Written Comment</p>	<p>Agree in part. The section already provides that treatment not addressed by the ACOEM Guidelines may be provided if the treatment is in accordance with other evidence-based, medical treatment guidelines that are generally recognized by the national medical community and are scientifically based. However, the section may be further clarified by stating that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines.</p>	<p>Section 9792.8(a)(2) has been amended by adding the following sentence at the end of the text of the section: “Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines.”</p>
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