

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS SECOND 15-DAY PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.6(j)	Commenter opposes the inclusion of out of state licensed chiropractors being able to do utilization review on California based patients. Commenter opines that out of state licensed chiropractors have little to no understanding of the California workers' compensation regulations, Senate Bill 228 and the ACOEM guidelines.	Jo Ann Marsh, DC Written Comment June 30, 2005	Disagree. Labor Code section 4610 does not require the UR reviewer to have a California license. Medical treatment should be fairly standard around the country and not specific to California.	None.
Section 9792.6(m) (now re-lettered to section 9792.6(l))	Commenter would like to clarify that the Board of Osteopathic Examiners has changed their name to "Osteopathic Medical Board of California" and the division should reflect this change in the regulation.	Kathleen S. Creason, MBA/Executive Director Osteopathic Physicians & Surgeons of California Written Comment June 30, 2005	Agree. Section 9792.6(l) has been corrected for clerical error.	Section 9792.6(l) has been amended for clerical error. The section now states: "Medical Director is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board 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."
Section 9792.6(h) Section 9792.6(j) Section 9792.6(o) Section 9792.7(b)(1) Section 9792.7(b)(2)	Commenter states that the proposed regulations allow reviews to be performed by "physician reviewers" or "health care reviewers." Commenter further states that reviewers should be California licensed, not any state licensed. Commenter further states that the reviews themselves should be	Garrett Casey, DC Medical Bureau IME UR Consultant Written Comment July 2, 2005	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	Section 9792.6(h) now states: "Expert reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist,

	<p>conducted within California by those who best know their neighbors not those separated by state boundary.</p> <p>Commenter also states that it appears that the intent of 4610 was to keep reviews basically peer-to-peer. Commenter states that confusion exists between requestor vs. provider. Commenter alleges that those in the chiropractic/acupuncture community are routinely denied care by MD's with no clinical training or inclusion within their scope to render decisions of this nature.</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 UR reviewer is going to make decisions “for reasons of medical necessity to cure or relieve” the UR 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</p>	<p>podiatrist, or 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 individual’s scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.”</p> <p>Section 9792.6(j) setting forth the definition of “health care reviewer has been deleted.</p> <p>Section 9792.6(o) setting forth the definition of “physician reviewer has been deleted.</p> <p>New section 9792.6(q) has been added to the regulations defining the term “reviewer” as a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic</p>
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		<p>scope of the physician’s 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).</p> <p>The same analysis applies to the “expert reviewer” pursuant to Labor Code section 4610(g)(5).</p> <p>This is consistent with business practices allowing UR to be conducted by physicians throughout the nation.</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. Therefore, a definition of the “medical director” is contained in the proposed regulations, at section 9792.6(l), clarifying that the medical director is responsible for all decisions made in the utilization review process, and any out-of-state reviewer performing reviews for the claims administrator is acting as the agent of the California medical</p>	<p>practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer’s practice.</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 “reviewer.”</p>
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		<p>director with a California license.</p> <p>Moreover, Labor Code section 3209.3 defines “physician” as “include[ing] physicians, and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by state law and within the scope of their practice as defined by California state law.” This definition does not include the term “nurse,” and it cannot be extrapolated from this definition that a nurse would assume the responsibilities of a physician.</p> <p>Thus the definition of “reviewer” and “expert reviewer” in the proposed regulations have been carefully crafted based on the requirements of Labor Code section 4610, and the provisions of Labor Code section 3209.3, with the exception of the requirement of a California as the license is not required under Labor Code section 4610.</p> <p>We disagree with commenter’s statement that the statute requires peer-to-peer review. The statute does not indicate the requirement of peer-to-peer review but clearly states the review is within the scope of practice. That is, if the physician can act within his or her license, then the</p>	
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			<p>review may be conducted because it is within the scope of the license.</p> <p>However, we agree that the regulations as written are confusing to the public. In order to clarify the definitions, the utilization review framework envisioned by the statute has been clarified in the proposed regulations. The definition of the term “expert reviewer” contained in section 9792.6(h), has been amended; the definitions of “health care reviewer” contained in section 9792.6(j), and “physician reviewer” contained in section 9792.6(o), have been deleted, and the terms have been consolidated under a single definition of “reviewer” now contained in section 9792.6(q).</p> <p>These terms and definitions are now consistent with the utilization review framework in the statute and are consistent with the definition of physician in Labor Code section 3209.3.</p> <p>Further changes have been made throughout the regulations to reflect the use of the amended terms in the proper context of the regulations.</p>	
Section 9792.6(h) Section 9792.6(j)	Commenter states that these proposed sections would terminate California’s ability to regulate and police medical professionals in this state. Commenter states that it is important that “health care reviewers” be	James E. Lessenger, MD FACOEM Written Comment July 4, 2005	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.

	<p>licensed in the State of California and not just the “medical directors.” Commenter further states that other state medical boards in the United States are lax in their enforcement of laws and would not be predisposed to investigate a health care provider based upon a complaint of a California physician.</p> <p>Commenter also opines that true peer review means that only California physician peers perform evaluations of treatments recommended by California doctors. Commenter states that there is a plentiful supply of well qualified UR reviewers within the state of California. Commenter objects to a state agency sending business out of state and believes that the division should keep this business and tax revenue within the state of California.</p>			
Section 9792.6(h)	<p>Commenter believes that it is very important to have California physicians, not out of state physicians perform utilization review.</p>	<p>Richard F. Thompson, MD Medical Director Written Comment July 4, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>
Section 9792.6 et al	<p>Commenter states that this version of the regulations is more confusing to him that they were before. Commenter is especially confused by the definition of who can perform utilization review.</p>		<p>Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>See action taken in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>
Section 9792.6(j)	<p>Commenter questions the need to add the term “health care reviewer” because he finds this more confusing.</p>		<p>Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>See action taken in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>

Section 9792.6(h)	<p>Commenter objects to the language that allows a non-California licensed physician to be able to practice medicine in the state of California by performing utilization review on California patients. Commenter further objects to the inclusion of psychologists, dentists, acupuncturists, chiropractors and other non-physician health care providers in the definition of “physician.”</p>	<p>Doug Chiappetta AFSCME/UAPD Union of American Physicians & Dentists Written Comment July 5, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	None.
<p>General comment Section 9792.6(h) Section 9792.6(j) Section 9792.6 (m) Section 9792.6 (o)</p>	<p>Commenter states that to perform an evaluation that leads to the modification, delay or denial of medical treatment is an act of diagnosing for the purpose of providing a different mode of treatment for the patient. Commenter states that only a physician and surgeon licensed in California is allowed to override treatment decisions.</p> <p>Commenter contends that several sections of the proposed language, specifically sections 9796.6(h) and (j) would allow a medical doctor licensed “by any state” to engage in the practice of medicine. Commenter contends that DIR does not have the statutory authority to redefine who may practice medicine in this state. Commenter states that although the division has now included language which limits those services to the scope of practice as defined by the licensing board, those limits are not geographic in nature. Commenter states that it is unclear if this language was meant to address the Medical Board’s concerns about in-state licensure but contends that it does not.</p> <p>Commenter states that the language used in Section 9792.6 (m) closely uses the accurate reference to physicians and surgeons licensed</p>	<p>David T. Thornton Executive Director Medical Board of California Written Comments July 7, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	None.

	<p>in California and the use of this language throughout the proposed regulations when anytime referring to a physician and surgeon would provide consistency and remove the Medical Board’s objections. [Under the governing statutes of the Medical Board of California and the Osteopathic Medical Board of California, the correct term for our licenses is “physician and surgeon.”]</p> <p>Commenter requests that these sections be amended to delete the references to “medical doctor,” “doctor of osteopathy,” and/or “physician” and replace those term with the phrase: “. . .a physician and surgeon license by the Medical Board of California or the Osteopathic Medical Board of California.”</p>			
<p>Section 9792.6 (h) Section 9792.6(j) Section 9792.6(o) Section 9792.7(b)(2) Section 9792.9(b)(2) Section 9792.9(b)(2)(A) Section 9792.9 (f)</p>	<p>Commenter states that the term physician can be extrapolated to apply to a nurse practitioner or physician’s assistant working under the protocols of a physician. Commenter fears that there is a loophole where the reviewer may not be an actual medical doctor, psychologist, acupuncturist, etc., but a nurse practitioner acting under the jurisdiction of one. Commenter suggests reinstatement of the stricken language in this section.</p> <p>Commenter states that this section violates the Business and Professions Code and the Medical Board requirements by allowing out of state professionals to practice medicine in California without a valid state license.</p> <p>Commenter states that there is no way to monitor out of state professionals for competency or to discipline them when they</p>	<p>James E. Lessenger, MD FACOEM Written Comment July 11, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>

	<p>are in error. Commenter requests that the division remove this section or make physicians subject to California licensure.</p> <p>Commenter objects to the language in this section that excludes California physicians from participating as a “health care reviewer.” Commenter state that this contrary to “peer review” as required by the legislature. Commenter continues to argue that there is no licensure, no standards, no way of discovering or correcting errors or omissions made by out of state physicians.</p> <p>Commenter finds the terms and definitions of health care reviewer, physician reviewer and expert reviewer to be unnecessary, offensive and irresponsible for the following reasons: (1) It takes the money for UR out of state, making worse the economic situation in the state; (2) It eliminates true “peer” review in California; (3) It opens the door for unqualified nurses and physicians assistants to be defined as “physicians” and allowed to do “peer” review of physicians; (4) It allows workers’ compensation companies to substitute physicians for “peer” review without a system for licensure or overview of those physicians’ actions, conduct, and abilities. Commenter further states that these physicians would be the equal or “peer” of the California physicians who are under the purview of the Medical Board.</p>			
<p>Section 9792.6 (h) Section 9792.6(j) Section 9792.6(o) Section 9792.7(b)(2)</p>	<p>Commenter states that the term physician can be extrapolated to apply to a nurse practitioner or physician’s assistant working under the protocols of a physician. Commenter fears</p>	<p>Jim D. Emery, MD Written Comment July 13, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>

<p>Section 9792.9(b)(1) Section 9792.9(b)(1)(A) 9792.9 (f)</p>	<p>that there is a loophole where the reviewer may not be an actual medical doctor, psychologist, acupuncturist, etc., but a nurse practitioner acting under the jurisdiction of one. Commenter suggests reinstatement of the stricken language in this section.</p> <p>Commenter states that this section violates the Business and Professions Code and the Medical Board requirements by allowing out of state professionals to practice medicine in California without a valid state license.</p> <p>Commenter states that there is no way to monitor out of state professionals for competency or to discipline them when they are in error. Commenter requests that the division remove this section or make physicians subject to California licensure.</p> <p>Commenter objects to the language in this section that excludes California physicians from participating as a “health care reviewer.” Commenter state that this contrary to “peer review” as required by the legislature. Commenter continues to argue that there is no licensure, no standards, no way of discovering or correcting errors or omissions made by out of state physicians.</p> <p>Commenter finds the terms and definitions of health care reviewer, physician reviewer and expert reviewer to be unnecessary, offensive and irresponsible for the following reasons: (1) It takes the money for UR out of state, making worse the economic situation in the state; (2) It eliminates true “peer” review in</p>			
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	<p>California; (3) It opens the door for unqualified nurses and physicians assistants to be defined as “physicians” and allowed to do “peer” review of physicians; (4) It allows workers’ compensation companies to substitute physicians for “peer” review without a system for licensure or overview of those physicians’ actions, conduct, and abilities. Commenter further states that these physicians would be the equal or “peer” of the California physicians who are under the purview of the Medical Board.</p>			
<p>Section 9792.6 (h) Section 9792.6(j) Section 9792.6(o) Section 9792.7(b)(2) Section 9792.9(b)(1) Section 9792.9(b)(1)(A) 9792.9 (f)</p>	<p>Commenter states that the term physician can be extrapolated to apply to a nurse practitioner or physician’s assistant working under the protocols of a physician. Commenter fears that there is a loophole where the reviewer may not be an actual medical doctor, psychologist, acupuncturist, etc., but a nurse practitioner acting under the jurisdiction of one. Commenter suggests reinstatement of the stricken language in this section.</p> <p>Commenter states that this section violates the Business and Professions Code and the Medical Board requirements by allowing out of state professionals to practice medicine in California without a valid state license.</p> <p>Commenter states that there is no way to monitor out of state professionals for competency or to discipline them when they are in error. Commenter requests that the division remove this section or make physicians subject to California licensure.</p> <p>Commenter objects to the language in this</p>	<p>John F. Wilmer, DC Written Comments July 14, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>

	<p>section that excludes California physicians from participating as a “health care reviewer.” Commenter state that this contrary to “peer review” as required by the legislature. Commenter continues to argue that there is no licensure, no standards, no way of discovering or correcting errors or omissions made by out of state physicians.</p> <p>Commenter finds the terms and definitions of health care reviewer, physician reviewer and expert reviewer to be unnecessary, offensive and irresponsible for the following reasons: (1) It takes the money for UR out of state, making worse the economic situation in the state; (2) It eliminates true “peer” review in California; (3) It opens the door for unqualified nurses and physicians assistants to be defined as “physicians” and allowed to do “peer” review of physicians; (4) It allows workers’ compensation companies to substitute physicians for “peer” review without a system for licensure or overview of those physicians’ actions, conduct, and abilities. Commenter further states that these physicians would be the equal or “peer” of the California physicians who are under the purview of the Medical Board.</p>			
Section 9792.8(a)(2)	<p>Commenter approves of the addition of language aimed at prohibiting the misuse of ACOEM guidelines to deny coverage for treatments not addressed by the ACOEM guidelines. Commenter suggests further modifying the last sentence as follows: “Treatment may not be denied on the basis that the specific treatment for the indication in question is not addressed by the ACOEM</p>	<p>N. William Fehrenbach Director, State Government Affairs Medtronic, Inc. Written Comment July 11, 2005</p>	<p>Disagree. This comment was considered after the first 15-day notice of proposed modifications to the regulations, and rejected. The Division continues to believe that the general philosophies set forth in Chapter 6 of the ACOEM Guidelines are very pertinent to treatment because the general philosophies set</p>	<p>None.</p>

<p>Section 9792.8 Section 9792.9</p>	<p>Practice Guidelines, nor can it be denied on the basis of the general philosophies provided in Chapter 6.” Commenter states that denials often go beyond a literal use of “ACOEM silence” or confusion over specific treatment and indications which he believes warrant consideration and inclusion of further language.</p> <p>Commenter objects to the changes in these sections wherein the regulations require the claims administrator to notify the “non-physician provider of goods or services identified in the request for authorization” of the UR decision but may not be provided them with the “rationale, criteria, or guideline used for the decision.”</p> <p>Commenter states that most often the doctor delegates to key “non-physician staff” the role of interfacing with carriers regarding obtaining prior authorization. Commenter opines that this new language would unnecessarily prevent these key staff from directly obtaining needed information in order for them to fulfill their role in assisting the physician and patient obtain coverage.</p> <p>Commenter further states that in order to assist patients and physicians, many of whom practice in very small offices, in obtaining appropriate coverage, Medtronic Neurological and other manufacturers offer assistance to physicians in working to obtain authorization for services through their “Prior Authorization Service.” Commenter states that this newly proposed language would eliminate the ability</p>		<p>forth in that chapter support the concept of functional recovery as applicable to treatment and physicians are encouraged to use Chapter 6 to guide their treatment.</p> <p>Disagree. The revisions in these sections were based on public comments raising concerns about patient privacy. It was realized that to require that medical information be provided to these entities would constitute dissemination of medical information without consent from the patient. Although commenter states that his organization complies with the HIPPA requirements, the claims administrator will not always know which provider of goods or services complies with the HIPPA requirements or not. Therefore, in order to protect the medical privacy of the patients, it is appropriate to have the provider of goods or services obtain the medical information from the treating physician in accordance with their agreement, as the treating physician has direct access to the patient and can obtain a medical release from the patient. Further, the request for authorization itself may contain personal information which should be kept private.</p>	<p>None.</p>
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	<p>for their prior authorization staff, operating under a HIPAA compliant “business associate” agreement, from engaging in a fruitful discussion about why and how a denial or change is being granted.</p> <p>Commenter states that while our staff could indirectly still obtain this information from the treating physician, this approach clearly would inadvertently and unnecessarily create an additional administrative burden for the physician. Commenter believes that, reverting back to the originally proposed language which provides the same written notice to the non-physician provider of goods or services would add no additional administrative burden or cost to the carrier, and would allow key non-physician, clinic based staff, as well as our “prior authorization” staff to continue to work to appropriately resolve these issues. Ironically, this same draft specifically allows a “claims administrator” to delegate its authority to a contracted entity but unnecessarily and specifically prohibits the doctor and patient from doing the same. We respectfully ask for acknowledgement of these business complexities and subsequently for a level playing field for all involved.</p> <p>Commenter requests that the Division restore the originally proposed related language found in Section 9792.8 and 9792.9 which requires complete written notice to non-physician staff.</p>			
<p>Section 9792.6(j) Section 9792.6(o)</p>	<p>Commenter states that the health care reviewer under section (j) appears to be the same as the physician reviewer under section (o), except that the health care reviewer is</p>	<p>James W. Small, MD MPH, MMM, FACOEM, FACPM Senior Medical Director</p>	<p>Agree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>See action in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME,</p>

<p>Section 9792.6(m)</p> <p>Section 9792.9 (b)(4) Section 9792.9(g)(2) Section 9792.9(j)(8) Section 9792.10(b)(1)</p>	<p>licensed in a state other than California, whereas the Physician Reviewer is licensed in California. Commenter questions why there is a distinction. Commenter points out that just as California uses a national guideline for reviews, i.e. ACOEM, physicians with nationally recognized board certification who have an unrestricted license in another U.S. state are able to apply evidence-based medical guidelines to treatment or procedure requests.</p> <p>Commenter notes that the Medical Director under section (m) is stated as "the physician and surgeon" licensed by the Medical Board of the State of California. Commenter questions if this means that only surgeons are permitted to be medical directors. Commenter states that if this is the case he submits that this be changed to read physicians or surgeon as non-surgeons are capable of being a medical director of a program. Commenter states that the medical director does not perform all reviews but directs the review to an appropriate specialty be it surgery or non-surgical.</p> <p>Commenter requests clarification as to why they are not to be provided the rationale, criteria or guidelines used for the decision to non-physician provider of goods or services. Commenter points out that the paragraphs state:</p>	<p>of Disability Management Written Comment July 11, 2005</p>	<p>Disagree. The title "physician and surgeon" is the title given to the licensed physician in California by the Medical Board. This does not preclude non-surgeons from acting as medical directors.</p> <p>Disagree. See response to comment submitted by N. William Fehrenbach, Medtronic, Inc., dated July 11, 2005, above.</p>	<p>dated July 2, 2005, above.</p> <p>None.</p> <p>None.</p>
<p>Section 9792.6 et al</p>	<p>Commenter recommends that the UR review should be limited to California licensed physicians only.</p>	<p>Syed F. Saquib, MD Written Comment July 12, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>

	<p>Commenter suggests that reasonable punishment be added to the regulations if some one misses the 5 day deadline. The fourteen days are too long.</p> <p>Commenter recommends that the UR physician be required to be adequately trained to perform this service.</p> <p>The UR physician should be actively participating in the practice of industrial medicine at least 50% of the time.</p>		<p>Disagree. The 14-day timeline is required by statute.</p> <p>Disagree. This requirement is beyond the scope of the statute.</p> <p>Disagree. This requirement is beyond the scope of the statute. Further, it is not required, for example, in the specialty of cardiology one cannot find a cardiologist practicing industrial medicine at least 50% of the time.</p>	<p>None.</p> <p>None.</p> <p>None.</p>
Section 9792.6(b)	<p>Commenter states that the addition of the phrase “to cure or relieve the effects of the industrial injury” the definition needs to be further clarified by adding “subject to the provisions of sections 4600(b), 4604.5 and 5402 of the Labor Code.”</p>	<p>Deborah J. Nosowsky DYN Consulting Written Comments July 12, 2005</p>	<p>Agree in part. A better reference is to the entire section of Labor Code section 4600. Section 9792.6(b) has been amended to include the phrase “pursuant to section 4600 of the Labor Code.” The Division believes that reference to this Labor Code section is sufficient to clarify the type of medical treatment involved.</p>	<p>Section 9792.6(b) has been amended. 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 pursuant to section 4600 of the Labor Code, 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</p>

<p>Section 9792.6(c)</p>	<p>Commenter states that the definition of “claims administrator” was expanded following the 45 day comment period to include an insured employer. Commenter states that this is inappropriate and inaccurate. Commenter states that insured employers contractually agree, under the terms of the insurance policy, to give the insurer full authority and responsibility to investigate and resolve claims against the policyholder and they do not administer their own claims.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.”</p> <p>None.</p>
<p>Section 9792.6(h) Section 9792.6 (j) Section 9792.6(o)</p>	<p>Commenter states that the proliferating definitions of reviewer are neither necessitated by Labor Code Section 4610, which governs utilization review programs, nor by anything in the implementing rules. Commenter further states that there is no distinction in Section 4610 among reviewing physicians. The sole requirement is that they hold a license to practice; the only person who must be licensed in California is the medical director. The proposed revised definition of a physician reviewer and the proposed additional definition of a health care reviewer are inconsistent with statutory requirements and add confusion rather than clarity to rules attempting to implement Labor Code Section 4610.</p>		<p>Agree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>See action in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>

<p>Section 9792.6(h) Section 9792.6(o)</p>	<p>Commenter states the purpose of the proposed additional phrase, “<i>as defined by the licensing board</i>” is unclear. If it is intended to limit review to review by specific types of practitioners, regardless whether the reviewer is competent to evaluate the specific clinical issue, then it fails the authority test. No such limitation exists in the statute. Under the statute, a board certified orthopedist may certainly review a proposed course of treatment for a back injury, even if the treating physician is a licensed chiropractor.</p>		<p>Agree. The phrase was not intended to limit review but to clarify the point that commenter is presenting. Because the language is confusing, it will be removed from the definition.</p>	<p>Section 9792.6(h) has been amended to delete the phrase “as defined by the licensing board.”</p>
<p>Section 9792.6 (m)</p>	<p>Commenter states that this proposed addition would impose responsibility—and potential liability—on the medical director, responsibility which does not exist in the statute itself. Commenter further states that section 4610 holds the medical director responsible for assuring the utilization review process complies with statutory requirements; it does not hold him responsible for each and every individual decision. Commenter points to the exact wording used in 4610(d), which is: “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.”</p>		<p>Disagree. Commenter is correct that section 4610(d) states, in relevant part, that the medical director is responsible that the UR program of the claims administrator complies with Labor Code section 4610. This entails complete compliance with the statute, including provision of medical care consistent with Labor Code section 4600 as set forth in section 4610(a).</p>	<p>None.</p>
<p>Section 9792.7(a)(3)</p>	<p>Commenter objects to new language added to this section as confusing. Commenter states that if the Division has something specific in mind, then it should be stated clearly arguing</p>		<p>Agree. After further review it has been determined that the language is confusing and it has been removed from the section.</p>	<p>Section 9792.7(a)(3) has been amended to delete the following language: “A description of the</p>

<p>Section 9792.9(b)(2) Section 9792.9(b)(2)(A) Section 9792.9(g)(1)(B) 9792.9(k)</p> <p>Section 9792.9(b)(4) Section 9792.9(c) Section 9792.9(g)(2) Section 9792.9(j)(8) Section 9792.10(b)(1)</p>	<p>that the regulated community should not be left to guess what was intended here.</p> <p>Comment states that consistent with the recommendation to eliminate the proposed change in the definition of a “physician reviewer” and the proposed new definition of a “health care reviewer”, there is no need to amend this subparagraph.</p> <p>Commenter states that if notice must also be sent to the non-physician provider of goods or services, then contact information for that provider must be included in the request for authorization. Commenter suggests that the language in these sections be amended to state: “In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision...”</p>		<p>Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p> <p>Agree. It is reasonable to require that contact information be provided in order to facilitate notice by the claims administrator to the provider of goods or services.</p>	<p>process used to review authorization for treatment requests which falls outside the specified routine criteria are not addressed in the treatment protocols or standards routinely used.”</p> <p>See action in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p> <p>Section 9792.9(b)(4), Section 9792.9(c), Section 9792.9(g)(2), Section 9792.9(j)(8), and Section 9792.10(b)(1) have been amended to reflect the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, 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</p>
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				for the decision.”
Section 9792.6(h) Section 9792.6(j) Section 9792.6(o)	Commenter appreciates the change of definition requiring physician reviewers to be licensed in the state of California. However, commenter objects to the creation of the category health care reviewer which specifies that they can be licensed in any state except California. Commenter also objects to the modification of the definition of expert reviewer to allow them to be licensed in any US jurisdiction. Commenter states the combined effect of these changes still allow UR functions to be shifted to out of state venues in which the DWC and Medical board have no control.	Robert J. Taber, MD MPH Written Comment July 13, 2005	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.
Section 9792.6	Commenter agrees with the comments submitted by Dr. James E. Lessinger on July 11, 2005. Commenter states that the medical practice and the review of medical practice utilization in the State of California should adhere to the standards and regulations set forth by the California Medical Board. Commenter further states that the proposed changes undermine the authority of the California Medical Board and those physicians that abide by the Board’s rules. Commenter also states that if out of state providers want to practice medicine in California that they should obtain a valid California Medical license.	Suzanne Sergile, MD MPH Written Comment July 13, 2005	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.
Section 9792.6 (b)	Commenter suggests that Labor Code section 4600(b) be also referenced in this section. Commenter states that it is important to reference here Labor Code section 4600(b) because this section delineates what medical treatment is reasonably required to cure or	Brenda Ramirez Medical & Rehabilitation Director – CWCI Written Comment July 14, 2005	Agree in part. With respect to the request to add Labor Code section 4600 to the definition of “authorization, see response to comment submitted by Deborah J. Nosowsky, DJN Consulting, dated July 12, 2005, above.	See action taken in connection with comment submitted by Deborah J. Nosowsky, DJN Consulting, dated July 12, 2005, above.

<p>Section 9792.6 (b), Section 9792.6 (q)</p>	<p>relieve the injured worker from the effects of an injury.</p> <p>Commenter also suggests that the language used in the narrative form should mirror the progress report format standards in section 9785. Commenter states that the progress report format already provides a location near the top of the page for the reason for submitting the form and language requiring the document to be “clearly marked at the top that it is a request for authorization,” appears, therefore, to be unnecessary and duplicative.</p>		<p>July 12, 2005, above.</p> <p>Disagree. The portion of the definition of authorization referring to the narrative form was specifically written as is to allow flexibility in the request, and thus the requirement that the request be properly labeled in 9792.6(q) is appropriate.</p>	<p>None.</p>
<p>Section 9792.6(c)</p>	<p>Commenter requests that the “insured employer” be removed from the definition of claims administrator, stating that the claims administrator for an “insured employer” is the insurer and that the proposed definition is inconsistent with Labor Code section 138.4, draft CCR section 9792.20 and other sections. Commenter says it defines both an employer and its insurer as claims administrators simultaneously and this creates confusion. Commenter opines it is important that there is consistency for common terms and it must remain clear that the insurer of an employer is the claims administrator and that the claims administrator is the party legally responsible for administering the claims.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p>
<p>Section 9792.6(e)</p>	<p>Commenter requests that the definition of “course of treatment” be amended to mirror the progress report format standards in section 9785. Commenter states that without this language it will not be clear that the narrative report must also duplicate the PR-2 heading</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p>

<p>Section 9792.6(h) Section 9792.6(j) Section 9792.6(o) Section 9792.7(b)(2) Section 9792.7(b)(2) Section 9792.9(b)(2)(A) Section 9792.9(f) Section 9792.9(g)(1)(B) Section 9792.9(k)</p>	<p>and layout and include the reason the report is submitted, as required by section 9785(f)(8). Commenter states the progress report format already provides a location near the top of the page for the reason for submitting the form and language requiring the document to be “clearly marked at the top that it is a request for authorization,” appears, therefore, to be unnecessary and duplicative.</p> <p>Commenter states that Labor Code section 4610 permits any licensed physicians to perform utilization review, but requires only the medical director to hold an unrestricted license to practice in this state. Commenter states that all licensed physicians, whether holding an active California license or not, may review for medical utilization. Commenter states that “Physician as defined in section 3209.3 of the Labor Code” is consistent with language in (o), and the term “health care reviewer” corresponds to the term “physician reviewer,” except for licensing state, and therefore the newly proposed term is confusing and unnecessary. Commenter the use of only one term, and the elimination of the term “health care reviewer.”</p> <p>With regard to the same definitions, commenter states that the activities of a utilization reviewer are appropriately defined by the term “scope of practice,” meaning those procedures, acts and processes permitted by law. Commenter alleges that the statute does not support a regulation restricting utilization review to that defined by a licensing board. Commenter states that the</p>		<p>Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p> <p>Agree in part. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p> <p>Disagree that there is no necessity to require disclosure of the reviewer’s specialty. To the contrary, the reviewer’s specialty is very relevant</p>	<p>See action in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p> <p>See action taken in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p>
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<p>Section 9792.6(k)</p>	<p>physician reviewer is conducting an analysis of the proposed treatment, not providing it. Further, the term “<i>as defined by the licensing board</i>” also adds no clarity, is confusing and unnecessary, and should also be removed.</p> <p>Commenter feels that there is no necessity to require disclosure of the reviewer’s specialty. Commenter requests that the definition of “request for authorization” be amended to mirror the progress report format standards in section 9785. Commenter states that without this language it will not be clear that the narrative report must also duplicate the PR-2 heading and layout and include the reason the report is submitted, as required by section 9785(f)(8). Commenter states the progress report format already provides a location near the top of the page for the reason for submitting the form and language requiring the document to be “clearly marked at the top that it is a request for authorization,” appears, therefore, to be unnecessary and duplicative.</p>		<p>to the type of review and should be made know to the parties.</p> <p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p>
<p>Section 9792.6(m)</p>	<p>Commenter states Labor Code section 4610(d) requires a medical director to “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.” Commenter states this section requires the medical director to ensure that the process complies with the requirements of the section. Commenter states that it does not support an interpretation that the medical</p>		<p>Disagree. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p>	<p>None.</p>

	director personally responsible for all decisions.			
Section 9792.7(a)(1)	Commenter states that there is no necessity for a utilization review plan to include a medical director's area(s) of certified specialty.		Agree. After further consideration, it was further determined that it is not necessary for the utilization review plan to include the medical director's area(s) of specialty.	Section 9792.7(a)(1) has been amended to delete the phrase "area(s) of certified specialty."
Section 9792.7(a)(3)	Commenter states that a description of the process to review requests for authorization is required in (a)(2), therefore the requirement here of the description of a process for a specific type of request is duplicative.		Agree. The language is duplicative. See also response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.	See action taken in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.
Section 9792.7(a)(3) (Continued)	Commenter also recommends incorporating the hierarchy of medical evidence in draft subsection 9792.22(c)(1) into this subsection.		Agree in part. Although we cannot incorporate language of a draft regulation which is still reviewed and amended, we can clarify that after the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in that schedule.	A new sentence has been added at the end of Section 9792.7(a)(3), which states: "After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in that schedule."
Section 9792.7(b)(2) Section 9792.9(b)(2)	Commenter states the reference to section 9792.9 is necessary to permit a non-physician reviewer to deny a request for authorization		Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.	None.

<p>Section 9792.7(c)</p>	<p>solely because reasonable information requested by the claims administrator is not received within 14 days of the provider's written request for authorization. Commenter also states that when the maximum 14 day timeline has run its course and there is no medical determination and the denial is because the requested information is not received by the end of the timeline that it is not necessary for a physician reviewer to make this non-medical decision. Commenter states that requiring a physician to do so is an inefficient use of resources that will raise the utilization review costs without any benefit to the injured employee or the employer.</p> <p>Commenter states that a less onerous alternative for both the Division and the claims administrator is to permit the filing of the changed portion of the plan when appropriate, rather than the whole plan.</p>		<p>Disagree. It is more resource effective for the Division to receive a complete revised UR plan as opposed to receiving portions of the plan and to have to figure out what are the most recent versions.</p>	<p>None.</p>
<p>Section 9792.8(a)(3)</p>	<p>Commenter states that this section needs to be clarified that only the "relevant portion" of the criteria" needs to be served on the relevant parties. Commenter states that this is stated in section 9792.8(a)(3), but is not clear in the beginning of the section. Commenter states that, as written, the language can be interpreted by some that a written copy of an entire set of guidelines must be supplied at no charge.</p>		<p>Agree. Although section 9792.8(a)(3) states that only the "relevant portion" of the criteria" needs to be served on the relevant parties, this is not clearly stated in the section. Further upon closer look at this section, it is determined that subsections 9792.8(a)(3)(A) and 9792.8(a)(3)(B) are duplicative of section 9792.8(a)(3), and therefore they are deleted from the text of the proposed regulations.</p>	<p>Section 9792.8(a)(3) has been amended. The section now states: "The relevant portion of 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</p>

<p>Section 9792.9(b)(4) Section 9792.9(c) Section 9792.9(g)(2) Section 9792.9(j)(8) Section 9792.9(k)) Section 9792.10(b)(1)</p> <p>General comment.</p>	<p>Commenter states that if notice must also be sent to the non-physician provider of goods or services, then contact information for that provider must be included in the request for authorization. Commenter suggests that the language in these sections be amended to state: "In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision..."</p> <p>Commenter states that the Division has developed a separate, comprehensive scheme to enforce the utilization review timeliness standards, including auditing, administrative penalties, and fines. As commenter has previously suggested, she feels that the regulations should clarify that the AD has a process to enforce these regulations through audits and penalties and that the failure to meet the UR standards should not affect the usefulness of the utilization review records and reports.</p>		<p>Agree. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p> <p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>modify, delay, or deny services in a specific case under review. The claims administrator may not charge an injured worker, the injured worker's attorney or the requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify, delay or deny the treatment request."</p> <p>See action taken in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p> <p>None.</p>
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Section 9792.6(h)	<p>Commenter does not feel it is necessary, but may be advantageous to reviewing “physicians” to consult an expert “reviewer” outside of the boundaries of California in occasional and unusual circumstances. However, commenter believes this to be superfluous and will likely be used in extremely limited circumstance.</p>	<p>Colin L. Walker, M.D. Written Comments July 14, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	None.
Section 9792.6(j) Section 9792.7(b)(2)	<p>Commenter strongly objects to section 9792.6(j). Commenter believes that California has an ample supply of qualified physicians in the state of California to perform these services, and if not, with the loss of other primary and secondary care-givers in the system. Commenter does not see the need to extend the “Physician Reviewer” of 9792.7(b)(2) to out-of-state practitioners. Commenter states that persons out-of-state cannot contact CA physicians as readily due to time zone differences, do not understand the practice environment and patient care issues of CA, and are not subjected to the standards for licensure and qualification that are incumbent upon CA “physician reviewers.” Commenter states that although Section 9792.6(j) does not exclude CA physicians from the process, as we are already qualified as “physician reviewers,” it does invite corporate nationalized organizations to enter the fray, becoming another roadblock to individualized decision-making in the WC arena. Commenter would like Section 9792.6(j) eliminated along with subsequent references to this entity of “health care reviewer.”</p>	<p>Craig E. Morris, D.C. Written Comments July 14, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	None.

Section 9792.9(b)(1)(a)	Commenter approves of the language in Section 9792.9(b)(1)(a), but would eliminate “health care reviewer,” as redundant, and replace it with nurse reviewer. Commenter also suggests when a request is either illegible, or has too little information for a reviewing nurse familiar with reporting methods to identify a deficit required for the physician reviewer to make a decision regarding the requested treatment, a communication from this party should be allowed, as it appears to be in current regulations, to extend from 5 working days to 14 calendar days the period for physician review and decision making.		Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above. Further, it is noted that the statute does not allow for a non-physician reviewer to deny the request for authorization even for lack of information. However, the regulations allow for the non-physician reviewer to collect the information for the physician reviewer during the 14-days timeframe as long as the decision issue within the 14 days required by the statute.	None.
Section 9792.6(j)	Commenter strongly objects to section 9792.6(j) which authorizes out-of-state physician reviewers. Commenter believes that out-of-state reviewers are unfamiliar with practice standards in California and that the only parties that would benefit are multi-state insurance companies and out-of-state reviewers.	Janet E. O’Brien, M.D. Written Comments July 14, 2005	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.
Section 9792.6(o) Section 9792.6(j)	Commenter requests that the Division remove from Section 9792.6(o) “Physician Reviewer”, the requirement that such reviewers be licensed in California. Commenter is of the position that a licensed physician reviewer or health care reviewer regardless of state of licensure, is qualified to perform utilization review, where the physician reviewer or health care reviewer is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these service are within the licensure and scope of the physician reviewer’s or health care reviewer’s practice. Commenter states that	Kelly Weigand, Esq. Workers’ Compensation and Rental Division First Health Written Comment July 14, 2005	Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	See action taken in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.

<p>Section 9792.9(b)(4) Section 9792.9(c) Section 9792.9(f)(2) Section 9792.9(j)(8) Section 9792.10(b)(1)</p>	<p>because the utilization review program is overseen by a CA licensed physician, the necessity of having a CA licensed physician reviewer or health care reviewer is not necessary. Further, commenter notes that the proposed modifications now include a new term for "health care reviewer" (See Section 9792.6(j)) who performs the same functions as a physician reviewer yet the health care reviewer can be licensed by any state or the District of Columbia. Commenter believes this modification embraces the view that all issues of clinical training and expertise are met by a requirement of licensure in any state jurisdiction. Commenter request that if Section 9792.6(o) is adopted as written, companies be given a grace period of one (1) year from the date the final proposal is passed to allow utilization review vendors sufficient time to meet the requirements.</p> <p>Commenter requests the removal from Sections 9792.9 (b)(4),(c),(f)(2), (j)(8), and 9792.10 (b)(1) the requirement that when sending notification of a utilization review decision, the notice to the non-physician provider "...not include the rationale, criteria, or guidelines used for the decision". Commenter believes that to create a separate letter for a non-physician reviewer does not serve the interests of the parties involved because all providers need to understand the recommendation outcome and determine alternative treatment based on the support for the recommendation. Commenter feels that since all providers of treatment are held to the same standards within the regulations to</p>		<p>Disagree. See response to comment submitted by N. William Fehrenbach, Medtronic, Inc., dated July 11, 2005, above.</p>	<p>None.</p>
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<p>Section 9792.9(k)</p>	<p>provide treatment and services in accordance with ACOEM and other evidence-based guidelines, all providers should receive the same letter.</p> <p>Commenter requests that the Division revise Section 9792.9 (k) to limit the timeframe for discussion between the treating provider and the health care reviewer. Commenter states that the timeframe for this discussion should be restricted to within the 20-day limit allowed for disputing the utilization review decision. Commenter also proposes that an allowance be made under revised subsection (k), for any health care reviewer qualified to review the specific case to undertake the discussion with the treating provider. Commenter states that the initial reviewing health care reviewer may be unavailable due to illness, other unplanned absences as a result of their obligations to their own medical practices or out of the office on vacation. In order to expedite completion of the review process and avoid any unnecessary delays in treatment, commenter suggests that any health care reviewer appropriate for the case should be able to discuss the utilization review decision with the treating provider, in the event that the initial reviewer is unavailable to take the call.</p>		<p>Agree in part. We disagree with the comment regarding the hours of availability required from the reviewer to discuss the UR request with the requesting physician. Commenter appears to confuse the injured worker’s right to appeal under Labor Code section 4062 with the requesting physician’s right to appeal the UR decision to the UR reviewer. However, we agree with commenter’s suggestion that in the event the reviewer is unavailable, the requesting physician should be able to discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.</p>	<p>Section 9792.9(k) has been amended by adding the following sentence to the text of the regulations: “In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.”</p>
<p>Section 9792.9(b)(2)(A)</p>	<p>Commenter objects to the proposed changes to the current version of the regulations requiring that a physician issue a denial when sufficient information is not received to make a decision. Commenter believes that this will (1) unnecessarily raise employers’ and insurers’ costs and potentially defeat the</p>	<p>Darrell Brown Workers’ Compensation Practice – Vice President Sedgwick CMS Written Comment July 14, 2005</p>	<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice. However, we notice that this is required by statute.</p>	<p>None.</p>

<p>Section 9792.6(b)</p>	<p>purpose of utilization review and the recent legislation – SB 228 and SB 899; (2) create unnecessary delays and bottlenecks in the processing of utilization review requests; and (3) is inconsistent with URAC, the national organization that provides accreditation for workers’ compensation utilization review programs.</p> <p>Commenter objects to the definition of “authorization.” Commenter states that the generally accepted and customary definition of utilization review does not incorporate reimbursement issues. In fact the concept is to review treatment purely on the basis of medical necessity, uninfluenced by any other considerations including reimbursement. Commenter states that this proposed revision would also appear to conflict with 9792.6(q) 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>		<p>Disagree. We are aware that UR relates to review of treatment on the basis of medical necessity. However, there have been circumstances when the treatment has been authorized in accepted cases and the payment has been refused. This definition was added to the proposed regulations to prevent this practice and a reference was added to Labor Code section 5402 to protect claims administrators from having to pay when liability does not exist.</p>	<p>None.</p>
<p>Section 9792.9(k)</p>	<p>Commenter states that section 9792.10 allows parties to voluntarily participate in an internal utilization review appeal process. For this reason, commenter believes that the language contain in section 9792.9(k) would in effect create a mandatory appeal process. Commenter opines that if this section of the regulations is adopted, commenter’s organization would have to materially revise its utilization review plans to reflect the state’s mandatory appeal process.</p>		<p>Disagree. It is our intention to have the UR appeal processes to conform to the proposed regulations. Specifically, the proposed regulations are intended to encourage communication between the requesting physician and the reviewing physician with the goal to provide prompt, appropriate care to the injured workers in California.</p>	<p>None.</p>

Section 9792, et al	<p>Commenter states that utilization review is best performed by a health care reviewer located in the state of California. Commenter would like to see the proposed regulations changed or eliminated.</p>	<p>David H. Colton, MD State Fund DOHC Written Comment July 14, 2005</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	None.
Section 9792.8(a)(1) Section 9792.8(a)(2)	<p>Commenter is in support of the DWC approving patient treatments outside of the ACOEM guidelines when supported by evidence-based medicine and accepted clinical practice. Commenter would like to address the process by which treating physicians will be required to submit evidence to validate a treatment not supported by the ACOEM Practice Guidelines. Currently, based on Section 9792.8 Utilization Review Standards-Medically Based Criteria, commenter states that the treating provider must submit evidence-based medicine for each patient that is treated outside of the ACOEM guidelines. Commenter believes, in some cases, this may prove an arduous process for both the provider and the claims reviewer, creating in excessive amount of work on both sides, and ultimately delaying patient treatment.</p> <p>Commenter is requesting that DWC define treatment guidelines for categories of off-label procedures currently not addressed by the ACOEM Practice Guidelines, but for which extensive evidence-based medicine is available. Specifically, commenter proposes BOTOX[®] treatment in occupational injury management is one of the categories for which the Division should consider predefining treatment guidelines.</p>	<p>Alan Ackerman, Ph.D. Allergan, Inc. Written Comment July 13, 2005</p>	<p>Disagree. Commenter's comments will be taken into consideration in drafting the regulations for the medical treatment utilization schedule. The comments herein are outside the scope of the statute and this rulemaking.</p>	None.

Section 9792.6(b)	Commenter believes that the definition of authorization should include a reference to Labor Code §4600(b) which provides a definition for treatment required to cure or relieve the effects of the injury.	Jose Ruiz, Assistant Claims Rehab Manager State Compensation Insurance Fund Written Comment July 14, 2005	Agree in part. A more appropriate reference is to Labor Code section 4600. See also, response to comment submitted by Deborah J. Nosowsky, DJN Consulting, dated July 12, 2005, above.	See action taken in connection with comment submitted by Deborah J. Nosowsky, DJN Consulting, dated July 12, 2005, above.
Section 9792.6(c)	The claims administrator for an “insured employer” is the insurer. Commenter recommends deleting “insured employer” which would be consistent with Labor Code section 138.4.		Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.	None.
Section 9792.6(m)	Commenter objects to the definition of “medical director.” Commenter states that Labor Code section 4610(d) requires the medical director to ensure that the utilization review process complies with the requirements of the section. It does not support the portion of the definition stating that the medical director is responsible for all decision made in the utilization review process.		Disagree. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.	None.
Section 9792.8(a)(3)	Commenter believes that clarification is needed to indicate that only the relevant portions of the criteria or guidelines must be disclosed as described in section 9792.8(a)(3)(B).		Agree. See response to comment submitted by Brenda Ramirez, CWCI, dated July 14, 2005, above.	See action taken in connection with comment submitted by Brenda Ramirez, CWCI, dated July 14, 2005, above.
Section 9792.9(b)(4) Section 9792.9(c), Section 9792.9(g)(2), Section 9792.9(j)(8), Section 9792.10(b)(1).	Commenter states that these sections contain language which requires that the claims administrator notify a non-physician provider of goods or services in writing of the UR decision. Commenter recommends deleting the related language in all the sections.		Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice. The language relating to notice of the UR decision to the “provider of goods or services” was	None.

	<p>Commenter further states that Labor Code §4610(g)(3)(A) requires the claims administrator to communicate the UR decision to the physician and the employee. Commenter states that the statute does not require that this notification be sent to non-physician providers of goods and services.</p>		<p>the subject of notice in the first 15-day notice. The specific amendment in the second 15-day notice relates to not providing the criteria forming the basis for decision as it may contain private medical information. The requirement of notice of the decision has not changed.</p>	
<p>Section 9792.6(c)</p>	<p>Comment objects to the language in this section wherein it is stated that the claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.</p>	<p>Nileen Verbeten Vice President California Medical Association Written Comment July 14, 2005</p>	<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice. Commenter submitted the same objection during the first 15-day comment. Commenter does not object to revised language but to the overall concept.</p>	<p>None.</p>
<p>Section 9792.6(f)</p>	<p>Commenter has previously asked for the inclusion of wording to assure severe pain is considered when evaluating claims for emergency services so there would be no risk of inconsistency with other Federal and California laws and regulations. Commenter prefers clarity in the regulation to assure that decisions for coverage of services properly rendered would not be in conflict with existing laws that require physicians to render care. Commenter recognizes that the language proposed is the exact language of the statute and recognizes that this language is broad. Commenter expects diligence in assuring that physicians are not penalized for their good faith rendering of emergency services when such services involve severe pain.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p>
<p>9792.6(g)</p>	<p>Commenter objects to the definition of expedited review as confusing and implying</p>		<p>Disagree. The comment does not address proposed changes made to</p>	<p>None.</p>

<p>Section 9792.6(h) Section 9792.6(j) Section 9792.6(o)</p>	<p>that treating a patient with a medical emergency is subject to utilization review.</p> <p>Commenter finds these definitions to be highly confusing. Commenter states that it is not clear what constitutes an expert reviewer, a health care reviewer and a physician reviewer. Commenter points out three areas of significant concern with the proposed language. (1) The authority to allow individuals licensed by any State to practice medicine in California; (2) Non-physicians and surgeons modifying, delaying or denying the medical decisions made by physicians and surgeons as defined pursuant to Section 2050 or Section 2450 of the Business and Professions Code; (3) the use of the term “expert.” Commenter strongly recommends the Division simplify its language. Commenter is aware of many complaints of denial, modification or delay of requests for authorization by individuals who do not have the requisite training or licensure to practice medicine in the State of California. Commenter states that it is the Division’s responsibility to make crystal clear that such practice is against the law. Commenter states that there are sufficient numbers of physicians and surgeons skilled and capable of reviewing proposed treatment plans that employers have no excuse to circumvent the law. Commenter points out that the proposed overlapping definitions do not provide clarity on this point and would seem to only encourage the quibbling over which definition a reviewer is functioning under without prohibiting the unlawful practice of medicine that is occurring</p>		<p>the regulations subject the second 15-day notice.</p> <p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>
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<p>Section 9792.6(h) (Continued)</p>	<p>today in the Workers' Compensation program. Commenter recommends that the Division eliminate the overlapping definitions and simplify the matter by including language that prohibits the delay, modification, or denial of services and treatment authorization requests by physicians and surgeons (M.D.s and D.O.s) by anyone that is not licensed as a physician and surgeon by the Medical Board of California or the Osteopathic Medical Board of California consistent with Section 2050 or Section 2450 of the Business and Professions Code.</p> <p>Commenter states that there is a need for a definition of an expert reviewer; commenter offers the following criteria as consistent with the concept of "expert": (1) Holds an unrestricted license in good standing to practice medicine in this State, with no prior discipline with in the last 10 years; (2) 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 practice; (3) Has an active practice (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care) or have been non-active or retired from practice no more than two years; (4) A physician and surgeon holding an M.D. or D.O. license by this state acting as an Expert Reviewer shall have Board certification in one of the 24 ABMS specialties (the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the</p>		<p>Disagree. Pursuant to the statute the "expert reviewer" is not required to have a California license. Further, some experts and not others, have a Board certification. For example, California does not recognize Board Certification for psychologists, yet they may be used as experts. Further, an "expert reviewer" may be a researcher. The regulations are not intended to limit the qualifications of an "expert reviewer."</p>	<p>None.</p>
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<p>Section 9792.(a)(4)</p> <p>9792.9(a)(1)</p> <p>9792.9(C)</p>	<p>American Board of Sleep Medicine and the American Board of Spine Surgery are also recognized) with a minimum of three years of practice in the specialty area after obtaining Board certification.</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>Commenter objects to the requirement in this section stating that the provider must indicate the need for an expedited review upon submission of the request.</p> <p>Commenter objects to language in this section stating that documentation for emergency health care services shall be made available to the claims administrator upon request.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p> <p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p> <p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p> <p>None.</p> <p>None.</p>
<p>Section 9792.7(a)(3)</p> <p>Section 9792.8(a)(1)</p> <p>Section 9792.8(a)(2)</p>	<p>Commenter states that during the development of these regulations, the DWC also proposed regulations regarding the medical treatment utilization schedule. Commenter states that there are terms common to both that are not set forth verbatim. For example, 8 CCR § 9792.8(a)(1) does not set forth the same criteria regarding treatment at variance with the ACOEM Guidelines as does proposed 8 CCR § 9792.22(a). The provision in the UR Guidelines is also at variance with subdivision (a) of Labor Code § 4604.5.</p>	<p>Mark E. Webb Assistant General Counsel American International Companies Written Comments July 14, 2005</p>	<p>Agree in part. Commenter is correct that UR regulations language should be consistent with the medical treatment utilization schedule proposed regulations. Inasmuch as the medical treatment utilization schedule is in a rulemaking in process, the proposed UR regulations have been drafted relying more on the language of the statute as opposed to the drafted language of the medical treatment utilization schedule regulations which is still in</p>	<p>Section 9792.7(a)(3) has been amended. The section now states: “A description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. A description of the personnel and other sources used in the</p>

	<p>Similarly, commenter points out that in regulatory proposals, the ACOEM Guidelines and the medical treatment utilization schedule are used interchangeably. In some instances there is a clear reason for this distinction. [8 CCR § 9792.8(a)(1)] In others, however, there is not. Proposed 8 CCR § 9792.8(a)(2) states that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines. Commenter wonders if this same prohibition holds true of treatment that is not addressed by the schedule once the schedule includes more than ACOEM.</p> <p>Commenter states that it is also unclear how the medical treatment utilization schedule regulation affects the UR regulations as it relates to the guidelines used by a claims administrator to delay, deny, or modify a request for authorization. Specifically, proposed 8 CCR § 9792.22 sets forth a hierarchy of evidence that is, it appears, designed to provide direction to claims administrators when evaluating whether to approve treatment requests that are either not covered or are at variance with ACOEM. Proposed 8 CCR § 9792.7(a)(3), however, appears to give great latitude to claims administrators to develop guidelines. Even when viewed in conjunction with proposed 8 CCR § 9792.8(a), the regulations do not require the claims administrators to develop treatment guidelines that follow the proposed hierarchy of scientific medical evidence that is set forth in the proposed medical treatment</p>		<p>draft form and has not been finalized. Pursuant to commenter's suggestions, the UR regulations have been revised to reference the medical treatment utilization schedule when appropriate.</p>	<p>development and review of the criteria, and methods for updating the criteria. Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), Second Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempres.com).</p>
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	<p>utilization schedule. Commenter states that UR plans should not be out of compliance upon the adoption of the medical treatment utilization schedule.</p>			<p>After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in that schedule.”</p> <p>Section 9792.8, subdivisions (a)(1) and (a)(2) have been amended as follows:</p> <p>“(a)(1) The criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine’s (ACOEM) Practice Guidelines, Second Edition. The guidelines set forth in the ACOEM Practice Guidelines shall be</p>
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<p>Section 9792.6(h) Section 9792.6(o) Section 9792.7(b)(2)</p>	<p>Commenter states that starting with the proposition that Labor Code § 4610 does not require a physician to hold a California license in order to delay, deny, or modify treatment, commenter states the definition of “physician reviewer” in proposed 8 CCR § 9792.6(o) is defective for lack of statutory authority. Commenter believes that the proposed regulations appear to be intended to require review of requests by those who hold the same license as the physician requesting the authorization. Commenter states that this is not supported by a reading of Labor Code § 4610. Commenter believes that all that § 4610 provides is that decisions must be made</p>		<p>Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>scientifically based. Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5307.27. After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, treatment may not be denied on the sole basis that the treatment is not addressed by that schedule.”</p> <p>None.</p>
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<p>9792.9(g)(1)(B) Section 9792.9(k)</p> <p>Section 9792.9(b)(4) Section 9792.9(c), Section 9792.9(g)(2), Section 9792.9(j)(8), Section 9792.10(b)(1).</p> <p>9792.6(l)</p> <p>Section 9792.7(a)(3)</p> <p>Section 9792.8(3)</p>	<p>Commenter recommends the language “and for whom contact information has been included” be added to these sections when referring to the provider of goods or services.</p> <p>Commenter recommends the definition of “Medical Director” be amended to delete the requirement that the Medical Director is responsible for all decisions made in the utilization review process.</p> <p>Commenter recommends that the sentence “[a]description of the process used to review authorization for treatment requests which falls outside the specified routine criteria are not addressed in the treatment protocols or standards routinely used,” be removed from this section as it is confusing.</p> <p>Commenter recommends inserting the language The “relevant portion of the” criteria shall be consistent..., at the beginning of the section.</p>		<p>Agree. See response to comment submitted by Jose Ruiz, State Compensation Insurance Fund, dated July 14, 2005, above.</p> <p>Disagree. This is required by the statute.</p> <p>Agree. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p> <p>Agree. See response to comment submitted by Brenda Ramirez, CWCI, dated July 14, 2005, above.</p>	<p>See action taken in connection with comment submitted by Jose Ruiz, State Compensation Insurance Fund, dated July 14, 2005, above.</p> <p>None.</p> <p>See action taken in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p> <p>See action taken in connection with comment submitted by Brenda Ramirez, CWCI, dated July 14, 2005, above.</p>
<p>Section 9792.6(b)</p>	<p>Commenter states that Labor Code §4610 provides for determinations for “medical necessity” not the guarantee of payment. Commenter points out that after the treatment is provided, the insurer may find that specific treatments within the course of treatment were not the result of the work injury or there may be a legitimate payment dispute, particularly if the specific treatment is not covered by the fee</p>	<p>Keith T. Bateman Vice President PCI on behalf of ACIC Written Comments July 14, 2005</p>	<p>Commenter is correct. This is why the definition contains a reference to Labor Code section 5402.</p>	<p>None.</p>

<p>Section 9792.6(1)</p>	<p>schedule or whether it is, or is not, included in a global code.</p> <p>Commenter states that it would be helpful if the reference to “utilization review standards as specified in section 9792.7” could be clarified. Commenter wonder if this is limited to standards other than the ACOEM Guidelines or other standards promulgated by the Administrative Director?</p>		<p>Disagree. The regulations are clear that the definition refers to the standards in the regulations as listed in section 9792.7.</p>	<p>None.</p>
<p>Section 9792.7(a)(5)</p>	<p>Commenter does not understand what this means and what purpose this language is intended to serve.</p>		<p>Disagree. This section requires that the claims administrator provide in its UR plan, “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.” This sentence is clear that if the claims administrator has practices, outside of the UR plan regarding the provision of treatment, this information would have to be released in that plan.</p>	<p>None.</p>
<p>Section 9792.7(c)</p>	<p>Commenter agrees with the comment submitted be CWCI and wonders why the Division does not just require the material modification to be filed.</p>		<p>Disagree. See response to comment submitted by Brenda Ramirez, CWCI, dated July 14, 2005, above.</p>	<p>None.</p>
<p>Section 9792.9(b)(2)(A)</p>	<p>Commenter states that every time claims administrators are being required to provide notices there should be a parallel requirement that any request include the necessary contact information.</p>		<p>Agree. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p>	<p>See action taken in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.</p>

Section 9792.9(b)(2)(A) (continued)	Commenter states that there appears to be concerted efforts by providers to limit utilization reviewers to those having California licenses. This is not what the statute provides. Commenter encourages the DWC to continue to resist these efforts.		Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	See action taken in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.
Section 9792.6 et al	Commenter objects to permitting physicians who are not licensed in the state of California to delay, modify or deny request for prior authorization.	Carl Brakensiek Legislative Advocate CSIMS Written Comment July 14, 2005	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.
Section 9792.6(j)	Commenter requests that the Division broaden the definition of “health care reviewer” to include registered nurses because they are allowed to perform utilization review in their scope of practice.	Glenda Garrard RN MBA – CEO/CFO GSG Associates Inc. Written Comment July 14, 2005	Disagree. This is not permitted by the statute. The statute only licensed physicians to delay, deny or modify requests for authorization on the basis of medical necessity.	None.
Section 9792.6(b)	Commenter states that once a provider has gone through the utilization review process set up by the carrier/self-insured employer and an authorization is issued, the carrier/self-insured employer is committed to pay the provider for that service. Commenter states that an “assurance” of payment is undefined and will only add confusion. Commenter states if they are unsure whether the procedure should be approved, those issues should be resolved before authorization is issued. Commenter further urges the deletion of the word “assurance” from the definition of “authorization,” and recommends that it be revised to state that, “authorization means that appropriate reimbursement will be made for an approved course of medical treatment....”	Diane Przepiorski Executive Director California Orthopaedic Association July 14, 2005	Disagree. As previously indicated 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. This definition was added after the 45-day comment period, and commenter to address these problems.	None.
Section 9792.6(c)	Commenter agrees that a claims administrator may utilize an entity to conduct its UR activities. Commenter suggests adding that,		Disagree. The use of an agent does not transfer the responsibility and the addition of the suggested comment is	None.

<p>Section 9792.6(h) Section 9792.6(j)</p>	<p>“The use of an entity to conduct its utilization review activities, does not transfer the claims administrator’s responsibility to act on requests for medical services in compliance with Labor Code 4610.”</p>		<p>superfluous.</p>	
<p>Section 9792.6(h) Section 9792.6(j)</p>	<p>Commenter is opposed to these definitions. Commenter does not believe that Labor Code Section 4610 (e) allows the Division to create additional categories of individuals who are empowered to deny, modify, or delay a request for authorization. Commenter believes that the Labor Code requires the utilization reviewer to be a “physician” as defined by Labor Code 3209.3, someone who is licensed in California acting within their scope of practice. In addition, commenter notes that Labor Code 4610 specifically states that “Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.” Commenter states that the Medical Board’s ability to investigate activities of out-of-state physicians is extremely limited if perhaps even beyond their jurisdiction. Commenter requests that these definitions be deleted and that reference to “expert reviewer” or “health care reviewer” be deleted throughout the regulations.</p>		<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>
<p>Section 9792.6(u)</p>	<p>Commenter states that “Written” should also include electronic transmission of information.</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9 et al Section 9792.10</p>	<p>Commenter states that in several sections of 9792.9, and in section 9792.10, the regulations</p>		<p>Disagree. See response to comment submitted by N. William Fehrenbach,</p>	<p>None.</p>

Section 9792.9(k)	<p>expressly state that non-physician providers shall be notified of the decision to modify, delay, or deny a request, but that they not be given the “rationale, criteria or guidelines used for the decision.” Commenter believes that the non-physician provider should also be given the rationale, criteria, or guidelines on which the change or denial is based.</p> <p>Commenter notes that this subsection only requires that the physician reviewer or medical director be available 4 hours per week. Commenter opines that it is an unreasonable amount of time when the reviewer might be receiving hundreds of calls during that short timeframe. Commenter suggests the following pertinent language: “The written decision shall also disclose the hours of availability, which must be at a minimum of 2 hours each day between the hours of 9:00 am to 6:30 pm Pacific Time or an agreed upon scheduled time for the treating physician to call to discuss the decision.”</p>		<p>Medtronic, Inc., dated July 11, 2005, above.</p> <p>Disagree. See response in connection with comment submitted by Kelly Weigand, Esq., Workers’ Compensation and Rental Division, First Health, dated July 14, 2005. It is further noted that although the regulations provide for four hours per week, the regulations also provide “for an agreed upon schedule time” between the physicians. Thus the regulations contain sufficient flexibility in the schedule.</p>	None.
Section 9792.6 et al	Commenter objects to the inclusion of out-of-state reviewers to participate in the utilization review process.	<p>Paul Manchester, MD Qualified Medical Examiner –UR Physician State Compensation Insurance Fund Written Comment July 14, 2005</p>	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.
Section 9792.6(m)	Commenter states that Labor Code section 4610(d) requires a medical director to ensure that the process complies with the requirements of the section. Commenter states that it does not support holding the medical director personally responsible for all decisions.	<p>Peggy Hohertz Regulatory Compliance Analyst Fair Isaac Corporation Written Comment July 14, 2005</p>	Disagree. See response in connection with comment submitted by Deborah J. Nosowsky, dated July 12, 2005, above.	None.

Section 9792.9(k)	Commenter has concerns about the listing of physician reviewer actual availability 4 hours per week to discussion determinations. Commenter states that her company uses physician reviewers who are in active practice for a large majority of their utilization review determinations and the practice of actually listing the hours of availability is not practical.		Disagree. See response in connection with comment submitted by Kelly Weigand, Esq., Workers' Compensation and Rental Division, First Health, dated July 14, 2005. It is further noted that although the regulations provide for four hours per week, the regulations also provide "for an agreed upon schedule time" between the physicians. Thus the regulations contain sufficient flexibility in the schedule.	None.
Section 9792.6 et al	Commenter objects to the inclusion of out-of-state reviewers to participate in the utilization review process.	Leslie Kim, MD Medical Director Access Medical Provider Network Written Comment July 14, 2005	Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	None.
Section 9792.6(p)	Commenter states that the definition of "prospective review" has been modified to exclude utilization review conducted during an inpatient stay. Commenter states that there is no statutory authorization for this limitation. Commenter states that any utilization review conducted "prior to the delivery of the requested medical services" is prospective review, whether the treatment involves inpatient care or any other treatment. Commenter requests that this exclusion should be deleted.	Mark Gerlach Consultant California Applicants' Attorneys Association Written Comment July 14, 2005	Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.	None.
Section 9792.7(b)(2)	Commenter states that this is one of several sections that use the term "health care reviewer." Commenter believes that the use of multiple terms to refer to the physician reviewer will cause confusion; in particular, the use of this term, in contrast to the term		Agree in part. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.	See action taken in connection with comments submitted by See response in connection with comment submitted by Garrett

<p>Section 9792.7(b)(3) Section 9792.9(g)(1)(B)</p>	<p>"physician reviewer," suggests that a "health care reviewer" need not be a physician. Commenter does not see the need to use multiple terms for the same reviewer and suggests that the regulations be amended to use a single term to identify the physician reviewer.</p>			<p>Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>
	<p>Commenter states that there is no statutory authority to extend the time deadlines set up in Labor Code § 4610(g)(1). Commenter believes that these specific time deadlines, "not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician," have been upheld in numerous decisions of the Workers' Compensation Appeals Board. Accordingly, commenter states that these regulations must be amended to reflect the statutory requirement that utilization review be completed "in no event more than 14 days from the date of the medical treatment recommendation by the physician." Commenter states that similar changes need to be made in § 9792.9(g)(1)(B).</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(k)</p>	<p>Commenter notes that this subdivision now requires that the written decision modifying, denying or delaying treatment must include the name and specialty of the reviewing physician. Commenter strongly suggests that additional information be required, including the telephone number and address of the reviewing physician. Also, information regarding any board certification and state licenses held by the reviewing physician</p>		<p>Disagree. The comment does not address proposed changes made to the regulations subject the second 15-day notice. These comments were considered during the first 15-day comment period.</p>	<p>None.</p>

<p>Section 9792.9(k) (Continued)</p>	<p>should be provided. Commenter believes that including this information will allow the requesting physician to quickly contact the reviewing physician.</p> <p>Commenter believes that the 4 hour window for contacting the reviewing physician should be expanded. Commenter believes that restricting contact with the reviewing physician to just 4 hours is counter to the goal of assuring an efficient process. Commenter suggests that the regulation require the reviewing physician to be available for at least 4 hours on each of at least two non-consecutive weekdays. Commenter believes that this subdivision should be expanded to cover other situations. For example, a typical situation might involve an initial denial of a treatment request for 12 physical therapy sessions, but after a discussion by the treating physician and the reviewing physician, approval may be given for 6 sessions. Unfortunately, in many cases this approval is not confirmed in writing, and the adjuster denies this treatment. This may be interpreted as a modification of the initial request, which already should be confirmed in writing, but this apparently is unclear. Thus, commenter requests that the regulations be amended to confirm that such decisions be required to be confirmed in writing.</p>		<p>Disagree. See response in connection with comment submitted by Kelly Weigand, Esq., Workers' Compensation and Rental Division, First Health, dated July 14, 2005. It is further noted that although the regulations provide for four hours per week, the regulations also provide "for an agreed upon schedule time" between the physicians. Thus the regulations contain sufficient flexibility in the schedule.</p>	<p>None.</p>
<p>Section 9792.6(m)</p>	<p>Commenter interprets this proposed language to limit the opportunity for allowing the same category of licensed providers to determine medical necessity of care for oversight of utilization review activities. Commenter requests the elimination of this proposed</p>	<p>R. Lloyd Friesen, DC Director Professional & Governmental Affairs American Specialty Health</p>	<p>Disagree. See response in connection with comment submitted by Garrett Casey, DC, Medical Bureau IME, dated July 2, 2005, above.</p>	<p>None.</p>

	language to allow utilization review oversight and responsibility to be made by peers of the same category of licensure, consistent with the definition of provider in LC 3209.3.	Written Comment July 14, 2005		
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