*Since this tip was issued, the WCAB issued its en banc decision in Dubon II ruling that a Utilization Review decision is invalid and not subject to Independent Medical Review (IMR) only when it is untimely.(See # 18 SB 863 Practice Tip, dated 11/21/2014)*

# CAAA Bulletin
## SB863 Practice Tips

**1303 J Street, Suite 420, Sacramento, CA 95814 Ph (916) 444-5155**

**#9 SB 863 Practice Tip: Utilization Review – Utilization Review Post SB863** July 22, 2013

This is the second in a series of four Practice Tips dealing with Utilization Review (UR) and Independent Medical Review (IMR) as set forth in SB 863. Although mandatory UR has been in place since 2004, there were a number of changes made in SB 863 that could help facilitate this process and reduce disputes over UR determinations. **This Tip describes the most important changes and reviews some key issues in the new UR process post-SB863.**

At this time the emergency regulations governing UR and IMR that were adopted January 1, 2013 are still in effect. Consequently, all of the rules and forms adopted January 1, 2013 are still in place. You can review a detailed description of these emergency regulations in #7 SB 863 Practice Tip, issued in January 2013. We anticipate that the permanent regulations will be adopted soon, and we will let you know of any major changes in those rules, but for now both UR and IMR should be conducted pursuant to the emergency regulations. Readers are strongly urged to carefully read both the current emergency regulations and the permanent regulations when issued. Both of these regulations can be found at: http://www.dir.ca.gov/dwc/Laws_Regulations.htm

It is important to understand the context for these changes. The legislative intent in SB 863 made it clear that the goal of these changes was to provide for "[t]imely and medically sound determinations of disputes over appropriate medical treatment." [See SB 863, Section 1(f).] To meet this goal, not only is it is imperative that a complete system of rules governing prompt, valid utilization review decisions be adopted, but those rules must be strictly enforced so that injured workers have prompt access to medical care.

Attached to this Tip is a comprehensive flow chart outlining the UR process as now set forth in statute and regulation. The steps in the UR process as shown on that chart are described below:

- **The Treatment Request**

One of the most significant procedural changes in SB 863 is that the UR process now begins with the submission of a Request for Authorization form, DWC Form RFA. As of July 1st, ***all*** medical treatment requests must be made using the new RFA form, regardless of the date of injury. [§9792.9.1(a)] A treatment request in a first report of injury, PR-2, or narrative report – without attachment of the RFA form – will ***not*** trigger the UR process. [§9792.9.1(c)(1)] ***Failure to include an RFA will result in delays in receiving medical treatment authorization.*** Currently, all treatment requests should include the RFA promulgated with the emergency regulations. An amended RFA

form will be required after adoption of the permanent regulations; we will provide further information regarding this change when the permanent regulations are finalized and adopted.

See the attached sample form letter to a treating physician advising them of this rule and providing them copies of the RFA and PR-2 forms.

- **The UR timeline**

SB 863 did not change the statutory timelines for UR, but did add a provision allowing UR to be deferred if the claims administrator disputes liability for an injury or the requested treatment. It remains to be seen how this will work, but deferral should not be used as a delaying tactic. Unless this is the first time an issue has been raised, there should have been a valid and timely objection under LC §4062. It is important to determine as soon as possible if there is a valid liability dispute regarding a date of injury or a part or parts of body in your case. This knowledge will help you make strategy decisions about how to proceed in your case, and decide whether the UR timeline is applicable to your case.

In order to defer UR the claim adjuster must, within five business days of receipt of the RFA, send a written notice deferring UR. [§9792.9.1(b)(1) – ***note that in #8 SB 863 Practice Tip this section was mis-identified.*** *#8 SB 863 Practice Tip has been corrected on the CAAA website.*]

For a prospective or concurrent expedited request, a determination must be made ***within 72 hours***. [§9792.9.1(c)(3)(A)] For a non-expedited request, the claims administrator must take some action ***within five business days*** of receipt of the RFA. Specifically, the claims administrator must either:

(1) approve, modify, delay, or deny the request [§9792.9.1(c)(3)],
(2) issue a written decision deferring the UR [§9792.9.1(b)(1)]; or
(3) request appropriate additional information needed to make the determination [§9792.9.1(c)(3)(B)].

If the claims administrator requests additional information within five business days, the timeline for non-expedited UR is extended to ***no more than 14 days after receipt of the RFA***. [§9792.9.1(c)(3)(C)]

The UR timeline ***begins the day after the receipt of the RFA***. [§9792.9.1(c)(1)] Thus, the key date is when the RFA is received. For UR decisions after July 1, 2013, that date is determined by §9792.9.1(a), as summarized in the chart below:

| | | |
|---|---|---|
| Non-Expedited Request: RFA faxed or emailed and transmission is electronically date stamped *before* 5:30pm PST [§9792.9.1(a)(1)] | Received on the date it was date stamped | UR five (and 14) day timeline starts ***the day after date of receipt*** |
| Non-Expedited Request: RFA faxed and transmission is sent *after* 5:30pm PST [§9792.9.1(a)(1)] | Received on the following ***business*** day | UR five (and 14) day timeline starts ***the day after date of receipt***, which is at least two days after date sent |

| | | |
|---|---|---|
| Expedited Request: RFA faxed or emailed and transmission is electronically date stamped [§9792.9.1(a)(1)] | Received on the date it was date stamped | UR 72 hour timeline starts ***from the time of receipt*** |
| Non-Expedited Request: RFA faxed or emailed and transmission is NOT electronically date stamped [§9792.9.1(a)(1)] | Received on the date the form was transmitted | UR five (and 14) day timeline starts ***the day after date of receipt*** |
| Expedited Request: RFA faxed or emailed and transmission is NOT electronically date stamped [§9792.9.1(a)(1)] | Received on the date the form was transmitted | UR 72 hour timeline starts ***from the time of receipt*** |
| Expedited and Non-Expedited Requests: RFA by mail, absent documentation of receipt [§9792.9.1(a)(2)(A)] | Received five ***business*** days after the deposit in the mail | UR five (and 14) day timeline starts ***the day after date of receipt, at least 6 days*** after the deposit in the mail |
| Expedited and Non-Expedited Requests: RFA by certified mail, with return receipt [§9792.9.1(a)(2)(B)] | Received on the date entered on the return receipt | UR five (and 14) day timeline starts ***the day after date of receipt*** |
| Expedited and Non-Expedited Requests: in the absence of documentation of receipt, evidence of mailing, or a dated return receipt [§9792.9.1(a)(2)(C)] | Received ***five days after the latest date*** the sender wrote on the document | UR five (and 14) day timeline starts ***the day after date of receipt, six days after*** the latest date the sender wrote on the document |

If the RFA is transmitted by either fax or email, the rules require that the RFA or the cover sheet accompanying the form ***must*** either (1) bear a notation of the date, time and place of transmission, and the fax number or email address to which the form was transmitted, or (2) the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or email transmission report which shall display the fax telephone number (or the email address) to which the form was transmitted. [§9792.9.1(a)(1)]

An incomplete RFA can be returned without starting the UR timeline. [§9792.9.1(c)(2)] There is a minor difference between the emergency regulations and the proposed permanent regulations regarding what is considered an incomplete RFA, but essentially the requirement is that the requesting physician must ***completely*** fill in the form.

As noted, UR can be deferred if the claims administrator disputes liability for the injury, a claimed body part, or the recommended treatment. The written notice deferring UR must include specific information, including the date the RFA form was originally received and a "clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability . . . ." [§9792.9.1(b)(1)] If the claims administrator is subsequently found liable or accepts liability, the treatment request then goes through UR. If the treatment has already been provided, retrospective UR must be completed within 30 days of the date the liability issue was resolved. [§9792.9.1(b)(2)]

However, if the treatment requested on the deferred UR has not yet been provided, the rules are unclear as to when the UR timeline starts. Section 9792.9.1(b)(2) provides that: "The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability." This rule is being interpreted by some as requiring the submission of a new RFA after the liability issue has been resolved. Others contend that the original RFA was only deferred, not annulled, and that the deferral ends when the liability issue is resolved. Under this interpretation, the original RFA is still valid and the timeline for conducting UR of that request starts the date the determination of the claims administrator's liability becomes final (*e.g.*, the date the deferral ends) and it is the claims administrator's responsibility to process the request at that time. This ambiguity will likely need to be resolved by the Board.

- **The UR Determination**

In the proposed permanent IMR regulations, §9792.7(a)(3) requires that "treatment protocols or standards governing the utilization review process ***shall be consistent with the Medical Treatment Utilization Schedule*** ...." The regulations define the "utilization review process" as determinations that approve, modify, delay, or deny treatment requests "***based in whole or in part on medical necessity to cure or relieve***." [§9792.6.1(y) / (z) in perm. regs] The proposed permanent regulations include a definition of "medical necessity" in §9792.6.1(r); that definition is based on the hierarchal list of standards set forth in Labor Code §4610.5(c)(2), with the MTUS applied first.

What these rules mean is that if the MTUS covers a requested medical treatment, both the UR and IMR determinations must be based on the MTUS guideline. Other standards will be considered (in the order listed) ***only*** where the MTUS is inapplicable to the employee's medical condition.

The rules governing notification of the UR decision are not changed. An approval must be communicated to the requesting physician within 24 hours of the decision. The initial communication must be by phone or fax, and written notification must be sent within two business days for a prospective review. Determinations to modify, delay, or deny a treatment request must also be communicated initially by phone or fax, and must also be followed by written notice within two business days of the decision. This written notice must be provided to the employee, the requesting physician, the employee's representative, if any, ***and the employee's attorney***, if represented. [§9792.9.1]

There are several important changes to the information that must be included with the written notice of modification, delay, or denial. [§9792.9.1(e)(5)] First, the decision must identify the date the RFA form was received by the claims adjuster, which allows you to quickly determine whether the notice is timely. Also, the notice is required to include a copy of the IMR application, completely

filled out except for the signature block, along with an addressed envelope and a clear statement to the employee that IMR must be requested within 30 days of receipt of the UR decision. According to some of our members, many UR non-certification notices have not included the IMR application, although this may change as claims administrators get more experience with these new procedures.

Also, members report that some IMR application have not been completely filled out, and others report receiving the wrong form – instead of the form adopted in the emergency regulations, the adjuster sent the form from the proposed permanent regulations. According to §9792.10.1(c)(2), the 30 day time limit to request IMR is tolled if the adjuster does not comply with all IMR rules, but the DWC has advised CAAA that an IMR application will not be rejected if you file a form that was not completely filled out by the adjuster or is the wrong version.

Section 9792.9.1(h) repeats the new statutory provision in Labor Code §4610(g)(6) that a UR decision to modify, delay, or deny a treatment request shall remain effective for 12 months from the date of the decision. This means the claims adjuster is under no obligation to do anything with an ***identical*** treatment request from the ***same physician***, unless the repeated treatment request is supported by a documented change in the facts material to the basis for the UR decision. If you believe your client's condition has changed at any time after receipt of a UR denial, you can ask the treating physician if there are any documented changes in the facts material to the basis for the UR decision that would allow for the request for treatment to be resubmitted, or if the treating physician can recommend an alternative treatment plan. Note that a UR approval of a treatment request is not covered by this rule, and does not remain effective for 12 months.

Section 9792.10.1(e) restates the current rule with regard to a concurrent review decision to deny authorization. Under this provision, medical care cannot be discontinued until a care plan has been agreed upon by the treating physician. Unfortunately, this rule is widely misunderstood. Concurrent review is defined in section 9792.6.1(d) as "utilization review conducted during an ***inpatient stay***." This is a very limited universe; namely, utilization review of treatment requests for a patient admitted into a hospital. Consequently, it does not appear that this rule has any application to the normal situation where the physician is requesting authorization for prospective treatment .

As described in #8 SB 863 Practice Tip, in some situations a UR non-certification decision is invalid, and that Tip reviewed possible actions you may consider in that situation. If the UR determination meets all statutory and regulatory requirements and you dispute the decision, a request for IMR must be filed within 30 days of receipt of the UR determination. [§9792.10.1(b)(2) / (b)(1) in perm. regs] Unless a UR denial is overturned by IMR or the Board, neither the employer nor the employee is liable for medical treatment provided without authorization. [§9792.10.1(b)(1) / (a) in perm. regs]

## ***The Key to a Favorable UR Determination***

This one Tip cannot fully explain all of the nuances of the UR process, and as noted earlier readers are strongly urged to read both the actual regulations and #7 SB 863 Practice Tip. But this Tip does make it clear that the UR process as modified by SB 863 will be significantly different.

Possibly the most important change to UR was the introduction of IMR. Although UR decisions pre-SB 863 were supposed to be based on the MTUS, in practice many non-certifications had little or no connection to those guidelines. Of course, many non-certifications were ultimately overturned, but the inherent delay and cost of that process harmed both employees and employers.

The real impact of IMR is in the fact that all decisions throughout the approval process will be based on the same standards. Those standards, as set forth in Labor Code §4610.5(c)(2) and repeated in the proposed permanent regulations in §9792.6.1(r), start with the MTUS. Thus, the key to obtaining timely medical treatment will be the submission of a properly documented RFA; *i.e.*, documentation that specifically explains how and why the requested treatment is authorized under the MTUS. Of course, if the MTUS does not cover the requested treatment, then the documentation must explain how and why the requested treatment is authorized under the succeeding standards in LC §4610.5(c)(2) or CCR §9792.6.1(r).

The fourth tip in this series will provide a thorough review of the IMR decisions that have been posted on the DWC website. But for the purpose of this Tip it can be noted that the early decisions demonstrate a rigid adherence to the MTUS. If a treatment request included full documentation showing that the requested procedure or testing is MTUS compliant, the IMR decision overturned the UR denial. Conversely, if documentation showing compliance with the MTUS was missing or incomplete, the IMR decision upheld the UR denial.

These early results are limited and may not be representative of the long-term. However, if IMR is properly implemented, the uniform application of the MTUS guidelines in IMR will fundamentally change the UR process. If properly documented and MTUS-compliant treatment requests that are non-certified in UR are promptly overturned in IMR, the employer will be financially responsible not only for the requested treatment, but also for both the UR and IMR costs. The experience in other systems that have adopted IMR is that system participants – providers, patients, and payers – quickly learn which treatment requests will be approved and which will not. Providers tailor their requests, and payers modify their decisions; both based on an understanding of what will and will not be approved through IMR.

The next Tip in this series will include a flow chart and tips for dealing with the IMR process. But the lesson of this Tip is that the best outcome for all parties is to never get to IMR. Treatment requests need to be properly documented, showing how and why the requested treatment is MTUS compliant. Claim adjusters need to approve properly documented requests without sending them to an outsider reviewer. And outside reviewers need to base their decisions on the MTUS or other applicable standards.

This will require a shift in both attitude and process by everyone. To help both attorneys and treating physicians understand this new paradigm, CAAA is sponsoring a seminar on September 21, 2013, entitled "IMR INTENSIVE," that will provide a roadmap to obtaining appropriate care and getting UR approval. We will provide more information on this seminar in the coming weeks, but please mark your calendar now and reserve September 21st for this valuable learning experience.

Note: This practice tip is intended to be advisory only, and does not define or establish any new standard or duty for practitioners.

SAMPLE LETTER TO TREATING PHYSICIAN

July 12, 2013

Dr. Do Good
1234 Help Lane
Any City, CA 90010

**RE:** **Robert B. Test vs. TROUBLE CO.**
**WCAB No:** **ADJ 123456**
**DOI:** **July 1, 2013**
**Claim No:** **WC78901240-22**

Thank you for serving as a treating physician in this matter.

As of July 1, 2013, all requests for medical treatment must be submitted on a new "Request for Authorization Form" promulgated by the state's Division of Workers' Compensation.[1] A blank RFA form is enclosed, for your convenience. **Failure to use this form will result in delays in authorization for medical treatment.**

This new law requires that you **use this form for each and every treatment request**; we recommend that you put a copy of any completed RFA on top of any completed PR-2 form (or PR-2 compliant narrative report) that requests authorization for medical treatment. Furthermore, to enable proof that the RFA was submitted, it is best if you keep any fax confirmations of your medical treatment requests; the law requires that the claims administrator make a determination regarding the medical treatment request within 14 days,[2] and a Workers' Compensation Judge can order authorization if the insurer fails to act in a timely manner.

In order to prove that you properly submitted the RFA form, or in order to prove that the adjuster's denial was untimely, I will need a paper trail. Therefore, in the future, in addition to

[1] "[A] written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, **must be set forth on the 'Request for Authorization of Medical Treatment,' DWC Form RFA, contained in section 9785.5**…The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment." (California Code of Regulations § 9785 (g).)

[2] UR decisions must be made "in a timely fashion…, 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." (Cal. Lab. Code § 4610(g)(1).)

serving us with your reports, **please also serve us with all RFA forms and any relevant proofs of service.**

Even with this change, **the law still requires you to use a PR-2 form** (or a narrative report entitled "Primary Treating Physician's Progress Report" in bold-faced type that clearly indicates the reason that the report is being submitted and that contains the same information using the same subject headings in the same order as a PR-2 form). I recommend that you fill out both forms and attach the RFA to the top of the PR-2. I have also enclosed a blank PR-2 for your use.

If you have any further questions about this process, please do not hesitate to contact my office. Thank you again for your service in this case.

Very truly yours,

Applicant's Attorney

Enclosed:
Blank 9785.5 RFA form
Blank 9785 PR-2 form

cc: Injured Worker

## UTILIZATION REVIEW: CONCURRENT AND PROSPECTIVE REVIEW, No Liability Dispute
## Labor code section 4610

Dr requests tx, PR-2 with proper boxes checked, with RFA form attached, cites MTUS in support; LC 5307.27

72 hours

If imminent & serious threat to health, LC 4610(g)(2)

5 working days, but no longer than 14 calendar days

UR decision to deny OR modify tx recommendation LC 4610(g)(1)

UR determination VALID?

NO → File DOR to enforce treatment recommendation

YES → 30 days to request IMR or lose right → Employee or designee requests IMR LC 4610.5(h)(1) SEE IMR FLOWCHART

## UTILIZATION REVIEW: RETROSPECTIVE REVIEW, Liability Dispute
## Labor code section 4610

LC 4610(g)(7) UR not required "while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062."

Determination of Employer Liability

- 30 days Retrospective UR
- Prospective UR upon receipt of tx request

LC 4610(g)(8) if determined employer "is liable for treatment of the condition for which treatment is recommended...time for retrospective UR in accordance with paragraph (1) shall begin on the date the determination of the employer's liability is final. [Paragraph (1) "within 30 days of receipt of information that is reasonably necessary to make determination"]

",and the time for the employer to conduct prospective UR shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability"

## UTILIZATION REVIEW: EFFECT OF DECISION
## Labor code section 4610(g)(6)

"A UR decision to modify, delay or deny a treatment reccomendation SHALL remain effective for **12** months from the date of the decision" unless....

1. Further recommendation for same treatment by a DIFFERENT* physician *could be an MPN second or third opinion DR

2. Further recommendation for same treatment by a SAME physician SUPPORTED by a documented change in the facts material to the basis of the UR decision