RESOLUTION 12-07-2015

DIGEST

Workers Compensation: Utilization Review

Amends Labor Code sections 4610.5 and 4610.6 to provide that utilization review decisions which are procedurally deficient are not subject to exclusive independent medical review.

TEXT OF RESOLUTION

RESOLVED that the Conference of California Bar Association recommends that legislation be sponsored to amend Labor Code sections 4610.5 and 4610.6 to read as follows:

§4610.5

(a) This section applies to the following disputes:

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

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

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

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

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

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

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

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

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

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

(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402 that is in procedural compliance with Title 8 of the California Code of Regulations sections 9792.9, 9792.9.1 and 9792.6.

§4610.6

(a) Upon receipt of a case pursuant to Section 4610.5 that is in procedural compliance with Title 8 of the California Code of Regulations sections 9792.9, 9792.9.1 and 9792.6, an

independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

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

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

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

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

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

(g) The determination of the independent medical review organization <u>that is in procedural compliance with Title 8 of the California Code of Regulations sections 9792.9, 9792.9.1 and 9792.6</u> shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative

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

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

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

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

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

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

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

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

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

(l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the

independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

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

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

(Proposed new language underlined; language to be deleted stricken)

PROPONENT: San Diego County Bar Association

STATEMENT OF REASONS

The Problem: The current wording of Labor Code sections 4610.5 and 4610.6 provide that any disputes over a utilization review decision modifying, delaying or denying in whole or in part a request for authorization by a treating physician must be made through the independent medical review system. The procedural requirements as to both the treating physician's request for authorizations, and the Defendants decisions to modify, delay or deny, the treating physicians requests for authorization of treatment are set forth in Title 8of the California Code of Regulations sections 9792.6, 9792.9 and 9792.9.1., which require among other things, that the utilization review decisions of modification, delay or denial, must be (a) timely issued and communicated to the treating physician within 5 working days, (b) must thereafter be timely served on the injured worker, and the injured worker's attorney, within prescribed time periods, and (c) issued by a physician competent to evaluate the specific clinical issues in dispute who has been provided all of the pertinent medical records. The Workers' Compensation Appeals Board issued a decision known as Duhon I which determined that where a Defendant's utilization review decision to modify, delay or deny is procedurally deficient, namely noncompliant with the above cited regulations, the procedural disputes are to be decided by the Workers' Compensation Appeals Board rather than through the independent medical review process set forth in Labor Code section 4610.6.Unfortunately, Duhon I was subjected to a Petition for Reconsideration which led to the Workers' Compensation Appeals Board issuing an en banc decision in Duhon II, limiting and modifying the Duhon I decision by holding that only issues of timeliness fall under the jurisdiction of the Workers' Compensation Appeals Board, whereas all other utilization review decision disputes fall under the independent medical review system. In short, the Duhon II decision reinstitutes the ability of the Defendants to issue, with impunity, decisions to modify delay or deny requests for authorization that are procedurally non compliant with Code of Regulations sections 9792.6, 9792.9 and 9792.9.1 as long as the noncompliant decision of denial was communicated by facsimile transmission or telephone to the treating physician who issued the request for authorization within the five working day time limit. As a result, Defendants are able to thwart the provisions of Labor Code section 4600 that requires them to provide all forms of medical treatment reasonably necessary to cure or relieve the injured worker's symptoms and disabilities caused their industrial injury. This is clearly a case of the legislature exalting the economic interests of employers and the insurance carriers over the medical treatment needs of injured workers via an independent medical review system that condones gross procedural inadequacies.

The Solution: This resolution would amend Labor Code sections 4610.5 and 4610.6 to require that all utilization review decisions be compliant with the provisions of Code of Regulations sections 9792.6, 9792.9 and 9792.9.1 so that the procedural compliance of utilization review decisions fall under the jurisdiction of the Workers' Compensation Appeals Board rather than being required to be submitted to an independent medical review doctor who has no expertise in the procedural requirements of said regulatory codes, and whose identity is, by current statute, not discoverable by any of the parties.

IMPACT STATEMENT
This resolution does not affect any other law, statute, or rule.

CURRENT OR PRIOR RELATED LEGISLATION
Not known.

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RESPONSIBLE FLOOR DELEGATE: James W. Talley

RESOLUTIONS COMMITTEE RECOMMENDATION
APPROVE IN PRINCIPLE

History:
No similar resolutions found.

Reasons:
This resolution amends Labor Code sections 4610.5 and 4610.6 to provide that utilization review decisions which are procedurally deficient are not subject to exclusive independent medical review. This resolution should be approved in principle because it will ensure that the Workers' Compensation Appeals Board, a judicial body, will review procedural issues rather than a medical doctor whose identity is not discoverable by any of the parties.

Utilization review is the process used by employers or claims administrators to review treatment for an injured employee to determine if the treatment is medically necessary. Labor Code sections 4610.5 and 4610.6 provide that any disputes over a utilization review decision, including procedural disputes, must be made through the independent medical review process. The reviewer in this process is a medical doctor. The independent medical review is intended to resolve substantive medical disputes with a third-party medical expert in an efficient process rather than through the courts. It is inappropriate and a waste of resources for doctors to review procedural deficiencies.

The resolution will resolve this issue by directing all procedurally deficient utilization review decisions to the Workers' Compensations Appeals Board. Utilization review decisions will only be submitted to medical doctors through the independent medical review process if they are in procedural compliance.