April 4, 2013

Division of Workers’ Compensation
P.O. Box 420603
San Francisco, CA 94142
Attn: Maureen Gray

RE: Coalition Comments: Proposed Independent Medical Review Regulations

Dear Ms. Gray,

The above-referenced organizations thank you for the opportunity to provide comments on the draft Independent Medical Review regulations. Combined, our organizations represent tens of thousands of insured and self-insured public and private California employers and insurance companies.

While there have been several estimates of the savings associated with SB 863 (De Leon, 2012), it is clear that the ultimate impact on employers (large and small, insured and self-insured) will depend largely on the regulatory framework that is constructed over the next several months. This is especially true of the savings associated with the new Independent Medical Review (IMR) process. We are, in essence, adding cost through the establishment of an IMR system in order to save costs associated with or resulting from long, drawn out disputes over medical treatment. If the implementation is unsuccessful then IMR could ultimately result in higher instead of lower overall costs. It is with that reality in mind that we offer the attached comments.

Sincerely,

Jeremy Merz
California Chamber of Commerce

Jason Schmelzer
California Coalition on Workers’ Compensation

Cc: David Lanier, Chief Deputy Legislative Secretary, Office of Governor Edmund G. Brown
Christine Baker, Director, Department of Industrial Relations
Destie Overpeck, Acting Administrative Director, Division of Workers’ Compensation

Attachment #1 – Revised DWC Form IMR
Attachment #2 – Revised DWC Form RFA
Electronic Communications
We are supportive of the expansion of electronic communications, but also well aware of the potential for unintended consequences. We urge the DWC to take time to tighten the rules related to electronic communications and work with the parties to ensure that implementation is seamless.

§9792.6.1(aa) defines the word "written" to include e-mail "by agreement of the parties". Our coalition is concerned that this definition leaves open the possibility of miscommunication or, worse yet, lost communication. We recommend that the regulations clarify what is meant by "agreement of the parties". One solution could be a requirement that there be a written agreement between the parties. In fact, this may also make sense for communications via facsimile. The required agreement should clearly identify e-mail addresses and fax numbers that are to be used in the electronic communication so that requests for medical treatment are not sent to out-of-date or inappropriate destinations.

Additionally, the proposed regulation has prohibited all electronic transmission of employee health records. As it is envisioned that eventually the IMRO will be accepting submissions via an electronic portal this regulation could create problems in the future. Consideration should be given to the creation of requirements for secure electronic transmission of such information.

§9792.6.1(u) allows for the submission of the RFA from via mail, fax or email. This definition should clarify the use of email can only occur when there has been a prior written agreement between parties as discussed above.

A DWC Form RFA transmitted by electronic mail after 5:30 PM Pacific Time should be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The same standards should be used for both facsimile or electronic mail transmission.

Notification of Assignment for IMR
§9792.10.5(a)(1) establishes a timeframe for a claims administrator to respond to notification from the Independent Medical Review Organization (IMRO) that disputed medical treatment has been assigned for IMR. The proposed regulations allow this notification to be sent either via mail or electronically. Our coalition is very concerned that the IMRO will send the notification to an unrelated fax number of e-mail address.

If notification of assignment of IMR is sent to the incorrect fax number or e-mail address, the claims administrator will be precluded from submitting a timely objection to the Administrative Director or, conversely, have an opportunity to authorize the non-certified medical treatment to avoid incurring the cost of IMR.

Our coalition strongly recommends that the DWC Form IMR, which is originally completed by the claims administrator, state the physical address, and appropriate fax number(s) and e-mail address(es) for notification of assignment of IMR.
Our coalition would request that the regulations be updated to require that the claims administrator be served with the DWC Form IMR upon submission. This could be done by requiring concurrent service by the injured worker’s attorney or designee. Additionally, the IMRO should be required to serve the submitted DWC Form IMR on the employer immediately upon receipt. The immediate receipt of a copy of this form is essential to allow the claims administrator enough time to submit a timely objection to the Administrative Director or authorize the non-certified treatment without having to incur the IMR fees associated with suspension of IMR prior to issuance of an IMR decision. Even though this is a lower fee it is still significant. Also, receipt of a copy of Form IMR when submitted will allow the claims administrator to begin preparing documents that are required for a timely and accurate IMR decision.

**Dispute Other Than Medical Necessity**

Several areas of the regulations require a claims administrator to respond to every RFA sent in by a provider when medical treatment is being disputed for a reason other than medical necessity [e.g. - §9792.9(b)(1) and §9792.9.1(e)(5)]. We appreciate modifications from the emergency regulations that soften this requirement. However, we still have concerns.

The proposed language appears to relieve claims administrators of the duty to respond to repeated requests for a “specific course of treatment” when the physician has already been notified of a dispute over liability. Our coalition believes that the regulations should be modified to require only one notification of the dispute over liability for each physician. There should not be a need to for the claims administrator to have re-notify the physician who has made numerous prior requests for treatment that has been disputed for reasons other than medical necessity to have to respond again, when a request for a different specific course of treatment from what was originally requested has been submitted. Our coalition fails to see the benefit of this notice requirement to any party, and would seek to avoid the added administrative burdens of having to monitor each RFA that is received for changes in the course of treatment that might have occurred months earlier when a timely dispute had been raised, and the potential liability that would result from simple paperwork errors.

Our coalition recommends that the words “for a specific course of treatment” be deleted from §9792.9(b)(1).

**DWC Form IMR Envelope Requirement**

§9792.9(l)(6) requires a claims administrator to send the completed DWC Form IMR to the injured worker and, the injured worker’s attorney if represented, and possibly even the requesting physician. Included in this provision is a requirement that an addressed envelope be included with the DWC Form IMR. Our coalition is concerned that the regulation could be interpreted to require claims administrators to also send an addressed envelope to the applicant attorney or requesting physician, which would make no sense. We would request that the regulation be clarified to state that the requirement of providing an addressed envelope only be applicable to the injured worker.

**Fees for Completion of DWC Form RFA**

Medical providers will now be required to complete a DWC Form RFA for each treatment request. Our coalition strongly urges the DWC to specify in the regulations that there will be no separate reimbursement for completion of the DWC Form RFA. There is currently no reimbursement for
medical treatment requests and there is no reason for that to change. The new DWC Form RFA will provide an administrative benefit to both providers and claims administrators by streamlining the treatment request and approval process.

If the regulations fail to specify that no payment will be made for completion of the DWC Form RFA, then it is likely that providers will seek reimbursement under existing codes. According to our experts, physicians may be able to bill the completion of a DWC Form RFA under existing codes if not prohibited in the regulations. These charges could fall under code 99080 ($39.98), code 99358 ($36.34 per 15 minutes), or both. Reimbursement costs for this form could be as low as $39.98, or as high as $76.32.

If the DWC is unwilling to clarify that completion of the form is not a billable activity, then the regulations should include guidelines and possibly a fee schedule to protect employers against bad behavior and poor quality.

To avoid the potential disruption of providers who will seek to take advantage of a per-form reimbursement by submitting multiple RFAs for a single date of service we would recommend a limitation of one form being submitted for each office visit.

If providers are to be reimbursed for the simple act of requesting medical treatment, then payment should be tied directly to the full completion of the form, which should be the basis for a fee schedule. Also if providers fail to properly complete the form, then payment should not be required.

**Unnecessary Expedited Requests**

Our coalition is concerned that the definition of Expedited Review creates opportunity for abusive practices. The definition states that an expedited review can include “an imminent and serious threat to his or her health, including, but not limited to .... or the normal timeframe for the decision-making process would be detrimental to the injured worker’s life or health or could jeopardize the injured workers’ permanent ability to regain maximum function.” Our coalition believes this creates a very broad category that could lead to IMR requests that should not qualify for expedited review and artificially raise the expense associated with IMR. Our coalition recommends that either the definition be narrowed or a review process be implemented as part of the IMR process for either the state or the IMR reviewer to determine whether the definition of expedited has truly been met before the IMR is processed as expedited.

Our coalition is concerned that some medical providers will consistently make requests for expedited review when the injured worker’s medical condition does not qualify for expedited review. Our members report seeing this pattern of behavior develop soon after the emergency regulations were adopted and IMR was implemented. Our coalition believes that the regulations should be strengthened to protect against this type of behavior.

Our coalition recommends that either the state or the IMR reviewer be tasked with a preliminary review to make a determination that the review should be processed and charged as an expedited review to better manage resources and costs associated with IMR. We propose that a paragraph allowing the
expedited review to be converted to a standard review be added to mirror the ability of a standard review to be converted to an expedited review as set forth in 9792.10.4(g).

"Utilization Review Decision" Definition
§9792.6.1 does not include approvals in the definition of Utilization Review Decision. §9792.6.1(z) correctly defines the Utilization Review Process as including utilization management functions that prospectively, retrospectively or concurrently review and approve, modify delay or deny treatment requests. However, the definition of Utilization Review Decision includes only decisions to modify, delay or deny requests for treatment. Our coalition believes this is misleading as decisions to approve treatment clearly are part of the utilization review process and are a utilization review decision. Therefore, we recommend that the definition be modified to include “decisions to approve” treatment and future sections using the definition be reviewed for potential impact. If the definition is not modified, we propose the state add a definition specific to “decisions to approve” to indicate they are decisions.

This modification is necessary because later sections of the regulations, such as §9792.9(c)(3)(B) refer only to “a decision” and does not specify approvals. If a reader references back to the definition of Utilization Review Decision, they will only see that it includes decisions to modify, delay or deny. However, additional information which this section deals with may also be necessary in order for the reviewer to make a decision to approve a request as well.

Medical Necessity
Our coalition believes that the definition of medical necessity, which is exactly the same as the authorizing statute, does not provide any clarification that is useful for the purposes of implementation. We would respectfully request that the DWC clarify what is meant by the more ambiguous terms used in §9792.6.1(r)(3) – (6).

DWC Form RFA and DWC Form IMR-1
The California Workers Compensation Institute (CWCI) submitted written comments to these proposed regulations along with modifications to the proposed forms. Our coalition is complete agreement with their comments and proposed forms and joins CWCI in requesting the modified forms that they have submitted should be adopted in the final regulations.
All fields must be completed by the Claims Administrator. A copy of the utilization review (UR) decision that either denies, delays, or modifies a treating physician's request for authorization of medical treatment must be attached.

**Type of Utilization Review (Required):** □ Regular □ Expedited

**Employee Information (Completion of this section is required)**

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**Medical Provider Physician Information (Completion of this section is required)**

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**Claims Administrator Information (Completion of this section is required)**

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**Requested Disputed Medical Treatment (Completion of this section is required)**

**Primary Diagnosis (Use ICD-Code where practical):**

Indicate the treatment as requested on the RFA, including diagnosis and ICD code. Attached additional pages if necessary. Services/goods disputed for reasons of medical necessity:

Indicate if those services/goods are also disputed for reasons other than medical necessity

Indicate if delayed/denied because requested medical information was not received from the physician

I request an independent medical review of the above-described requested disputed medical treatment.

**Original Employee/Applicant Signature:**

**Date:**

Consent to Obtain Medical Records / Designation Authorization

DWC Form SBR-1 (version 12/2012)
I am asking for an independent medical review to make a decision about the requested medical treatment that was delayed, denied, or modified by my claims administrator. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical and diagnostic imaging reports, and other medical and non-medical records related to my case, excepting records regarding HIV status. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

I Designate: ____________________________  Relationship: ____________________________  Date: ____________________________

Original Employee Signature: ____________________________

Filing Information
Mail or fax your application and any attachments the utilization review decision to: DWC-IMR, c/o Maximus Federal Services, Inc.
Box 138009
Sacramento, CA  95813-8009
FAX: (916) 364-8134

And send a copy to the claims administrator by fax to ____________________________ or by email to ____________________________ or by mail to ____________________________
Instructions for the Application for Independent Medical Review Form

Instructions for the Employee

You can request an independent medical review by signing and submitting this form. If your claims administrator denies, delays, or modifies your treating physician's request for medical services or treatment, you can request an Independent Medical Review (IMR) by a physician who is not connected to your claims administrator. The specialty of the reviewing physician will be matched to the specialty of your treating physician or the specialty most knowledgeable about the disputed medical services or treatment. The request must be made on this form. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested. You pay no costs for an IMR. Please be aware that the utilization review decision on your treatment is final unless you request IMR within 30 days of the date the utilization review decision was mailed to you. If you decide not to participate in the IMR process, you may be giving up your rights to pursue legal action against your claims administrator regarding the service or treatment you are requesting.

How to Apply

All of the information on the form, except for your signatures, is already completed by your claims administrator when you receive the form. Review the form to make sure that all the information provided by your claims administrator is correct. If you believe that any of the information on the form is incorrect, please submit a separate sheet that provides the correct information. Sign and date where indicated to request an independent medical review of described treatment request. Also, please review the consent to obtain medical records, then sign and date where indicated to indicate your consent. If you are seeking an expedited review and your claims administrator did not perform an expedited review on your physician's request, the form must be submitted with the physician's certification that you are facing an imminent and serious threat to your health. If you have or wish to designate an attorney, parent, guardian, conservator, relative, or other designee to act on your behalf in filing this application, please complete the attached authorized representative designation on the form and return it with your application. Your designee may sign the application for you (except for the medical records consent) and submit documents on your behalf. An application for IMR must be filed within thirty (30) days from the mailing date of the utilization review decision letter informing you that the medical services or treatment requested by your treating physician was denied, delayed, or modified. Please include a copy of the utilization review decision with your application.

Employee Right to Provide Information

You have the right to submit, either directly or through your treating physician, information and documentation to support the requested medical treatment. Such information and documentation may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Medical information or justification that the requested medical treatment, on an urgent care or emergency basis, was medically necessary for your medical condition.
- Reasonable information supporting the position that the disputed medical treatment is or was medically necessary including all information provided by the employee's treating physician or any additional material that the employee believes is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment is inapplicable or scientifically incorrect.

Determining Your Eligibility for IMR

Your Application will be initially screened to determine if it is eligible for IMR. If the Application is found eligible, you will be sent written notification of the contact information of the Independent Medical Review Organization (IMRO). You must then send to the IMRO, as instructed, the relevant medical records as defined by California Code of Regulations, title 8, section 9792.10.5. Please review California Code of Regulations, title 8, sections 9792.10.1, et seq., for additional requirements regarding the IMR process. Note that your claims administrators are responsible for the costs of will pay for the IMR. If the IMRO requests medical records from your treating physician, it is important that your treating physician provides the records promptly.

The IMRO designated by the Division of Workers' Compensation will review your application and send you a letter telling you that you qualify for an IMR. The letter will include instructions as to how to submit your information and records. If your application for a regular, non-expedited review is determined to be eligible for IMR, the IMRO is required to reach a
decision on your application for a regular, non-expedited review within thirty (30) days from the date they received all necessary documents and information.

Do Not File this page with your request for IMR
Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name:

I wish to designate

Name of Individual:

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designed by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designed by the Division of Workers' Compensation to review my application.

In addition to designated the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature: Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

I am a/an:

(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)

Representative Address/P.O. Box:

City: State: Zip Code:

Representative Phone Number:

Representative Signature: Date:
State of California  
Division of Workers' Compensation  
REQUEST FOR AUTHORIZATION  
DWC Form RFA - California Code of Regulations, title 8, section 9785.5

Attach the Doctor's First Report of Occupational Injury or Illness, a Form DLSR 5021, a Primary Treating Physician's Progress Report, DWC Form PR-2, or its equivalent narrative report that must substantiate the requested treatment.

- New Request  - Resubmission – Change in Material Facts
- Expedited Review: Check By checking this box, physician certifies that if employee faces an imminent and serious threat to his/her health. A request for expedited review not made in good faith may result in civil or criminal penalties & removal from a MPN.
- Check box if request is a written confirmation of a prior oral request.

Employee Information

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Provider Physician Information

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Requested Treatment (see instructions for guidance; attached additional pages if necessary)

Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional requests on a separate sheet.

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<tr>
<th>Diagnosis (required)</th>
<th>ICD-Code</th>
<th>Procedure Service/Good Requested</th>
<th>CPT/HCPCS Code (recommended, but required for surgery)</th>
<th>Other Information: (Frequency, Duration, Quantity, Facility, etc.)</th>
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Treating Physician Signature under penalty of perjury:

Date:

Claims Administrator Response

- Approved
- Denied or Modified (See separate decision letter)
- Delay (See separate notification of delay)
- Requested treatment has been previously denied
- Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):  

Date:

Authorized Agent Name:  

Signature:

DWC Form SBR-1 (version 12/2012)
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<th><strong>Designated</strong> Phone:</th>
<th><strong>Designated</strong> Fax Number:</th>
<th><strong>Designated</strong> E-mail Address:</th>
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Comments:
Instructions for Request for Authorization Form

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment – DWC Form RFA. The form can only go to other treating providers physicians and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required to initiate the utilization review process required by Labor Code section 4610. This form is used as an attachment to the The Doctor’s First Report of Occupational Injury – Form DSLR 5021, the Primary Treating Physician’s Progress Report – DWC Form PR-2, Doctor’s First Report of Occupational Injury – Form DSLR 5021, or an it's equivalent narrative report must be attached to this form to request authorization for treatment. The intent of the form is to facilitate communication back and forth between the provider physician and the claims administrator, and also to furnish a verification of authorization for the requesting provider physician. Additional sheets should be used as appropriate.

Checkboxes: Please check the appropriate box(es) at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee’s condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee’s current condition. Include documentation supporting your claim.
- An expedited review is requested based on an imminent and serious threat to the employee’s health.
- The request is a written confirmation of an earlier oral request.

Routing Information: The DWC Form RFA can either be mailed or faxed together with the required reports to the claims administrator. The requesting provider must complete all identifying information regarding the employee, the claims administrator, and the provider.

Requested Treatment: The DWC Form RFA and reports must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis, the ICD Code, the procedure service/good requested, and applicable CPT/HCPCS code.
- Include, as necessary if applicable, the frequency, duration, quantity, facility, etc. Reference specific guidelines used to support treatment should also be included.

For requested medical treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

Treating Physician Signature: Signature/Date line is located under the requested treatment box. An original signature made under penalty of perjury by the treating physician is mandatory.

Claims Administrator Response: Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.9 or 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating requests; a claims
administrator may utilize other means of written notification. If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.