

State of California  
DEPARTMENT OF INDUSTRIAL RELATIONS  
Division of Workers' Compensation

**NOTICE OF MODIFICATION TO TEXT OF  
PROPOSED REGULATIONS**  
(Permanent Adoption of Emergency Regulations)

**Workers' Compensation – Utilization Review Standards**  
**Title 8, California Code of Regulations Section 9792.6 et al.**

**NOTICE IS HEREBY GIVEN** that the Administrative Director of the Division of Workers' Compensation (hereinafter "Administrative Director"), pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3 proposes to modify the text of the following sections of Title 8, California Code of Regulations:

Section 9792.6	Utilization Review Standards—Definitions
Section 9792.7	Utilization Review Standards—Applicability
Section 9792.8	Utilization Review Standards—Medically-Based Criteria
Section 9792.9	Utilization Review Standards—Timeframe, Procedures and Notice Content
Section 9792.10	Utilization Review Standards—Dispute Resolution

**PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS**

Members of the public are invited to present written comments regarding these proposed modifications. **Only comments directly concerning the proposed modifications to the text of the regulations will be considered and responded to in the Final Statement of Reasons.**

Written comments should be addressed to:

Maureen Gray, Regulations Coordinator  
Department of Industrial Relations  
Division of Workers' Compensation  
Post Office Box 420603  
San Francisco, CA 94142

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than **5:00 p.m. on Friday, August 5, 2005**. Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (415) 703-4720. Written comments may also be sent electronically (via e-mail), using the following e-mail address: [dwcrules@hq.dir.ca.gov](mailto:dwcrules@hq.dir.ca.gov).

**AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE**

Copies of the original text and modified text with modifications clearly indicated, and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 455 Golden Gate Avenue, 9th Floor, San Francisco, California.

Please contact the Division's regulations coordinator, Ms. Maureen Gray, at (415) 703-4600 to arrange to inspect the rulemaking file.

## DOCUMENTS SUPPORTING THE RULEMAKING FILE

Comments from various interested parties concerning the Division's proposed changes have been added to the rulemaking file.

## FORMAT OF PROPOSED MODIFICATIONS

### Proposed Text Noticed for This Third 15-Day Comment Period on Emergency Regulatory Text:

Plain text is the emergency regulatory text proposed for permanent adoption.

Underlined text indicate changes to codified emergency regulatory text at the time of the Notice of Rulemaking after Emergency Adoption, thus: underlined language.

Deletions from the codified emergency regulatory text after the 45-day period comment and public hearing are indicated by double strike-through, thus: ~~deleted language~~.

Additions to the codified emergency regulatory text after the 45-day period comment and public hearing are indicated by double underlining, thus: double underlined language.

Deletions from the codified emergency regulatory text after the 1<sup>st</sup> 15-day period comment are indicated by single strike-through italic text, thus: ~~*single strike-through italic text*~~.

Additions to the codified emergency regulatory text after the 1<sup>st</sup> 15-day period comment are indicated by single underlined italic text, thus: *single underlined italic text*.

Deletions from the codified emergency regulatory text after the 2<sup>nd</sup> 15-day period comment are indicated by double strike-through italic bold text, thus: ~~***double strike-through italic bold text***~~.

Additions to the codified emergency regulatory text after the 2<sup>nd</sup> 15-day period comment are indicated by double underlined italic bold text, thus: ***double underlined italic bold text***.

## SUMMARY OF PROPOSED CHANGES

### 1. Modifications to Section 9792.6 Utilization Review Standards—Definitions

This section provides definitions for key terms in the regulations.

**Section 9792.6(b)** The definition of “authorization” was amended to add the phrase “pursuant to section 4600 of the Labor Code after the phrase “medical treatment to cure or relieve the effects of the industrial injury,” and to substitute the word “in” for the phrase “on a” in before the phrase “narrative form,” thus the phrase now reads “in narrative form.” The amended definition of “authorization” 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 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.”

**Section 9792.6(e)** The definition of “course of treatment” was amended to substitute the word “on” for the word “in” before the phrases “the Doctor’s First Report of Occupational Injury or Illness,” and “Primary Treating Physician’s Progress Report,” and to delete the word “a” before the phrase “narrative form.” The amended definition of “course of treatment” now states: “‘Course of treatment’ means the course of medical treatment set forth in the treatment plan contained on the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.”

**Section 9792.6(h)** The term “expert physician reviewer” was amended to substitute the word “or” for the word “and” before the phrase “chiropractic practitioner.” The term was further amended to delete the phrase “as defined by the licensing board,” and to substitute the term “reviewer” for the terms “physician” and “health care reviewer.” Thus the amended definition now states: “Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, 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.

**Section 9792.6(j)** The definition of the term “immediately” is now contained in section 9792(j). The term “health care reviewer” was deleted from the proposed regulations.

**Section 9792.6(k)** The term “material modification” is now contained in section 9792.6(k).

**Section 9792.6(l)** The term “medical director” is now contained in section 9792.6(l).

**Section 9792.6(m)** The term “medical services” is now contained in section 9792.6(m).

**Section 9792.6(n)** The term “prospective review” is now contained in section 9792.6(n).

**Section 9792.6(o)** The term “request for authorization” is now contained in section 9792.6(o). The term has been amended for clarification to substitute the word “on” for the word “in” in the text of the definition, and to delete the word “a” before the phrase “narrative form.” The term “physician reviewer” has been deleted from the proposed regulations.

**Section 9792.6(p)** The term “retrospective review” is now contained in section 9792.6(p).

**Section 9792.6(q)** The new term “reviewer” has been added to section 9792.6(q). The definition states: “reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic 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.

**Section 9792.6(r)** The term “utilization review plan” is now contained in 9792.6(r).

**Section 9792.6(s)** The term “utilization review process” is now contained in section 9792.6(s).

**Section 9792.6(t)** The term “written” is now contained in section 9792.6(t).

## **2. Modifications to Section 9792.7 Utilization Review Standards—Applicability**

**Section 9792.7(a)(1)** This subdivision was amended for clarification purposes to delete the phrase “area(s) of certified specialty.”

**Section 9792.7(a)(3)** The second sentence of the subdivision was deleted as superfluous. The subdivision was further amended for clarification purposes to add the following sentence at the end of the subdivision: “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)** This subdivision was amended to delete the words “physician and health care reviewer” and delete the phrase “as defined by the licensing board.” Thus the section now states: “A reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer’s scope of practice, may, except as indicated below, delay, modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.”

**Section 9792.7(c)** This subdivision has been amended for clerical error to correct the word “make” to state “makes.”

### **3. Modifications to Section 9792.8 Utilization Review Standards—Medically-Based Criteria**

**Section 9792.8(a)(1)** This subdivision was amended for clerical error to insert the words “scientific medical” to the last sentence. Thus the last sentence of the subdivision now reads: “The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.”

**Section 9792.8(a)(2)** This subdivision was amended for clarify that 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. The subdivision was further amended to state that 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. Thus the subdivision now states: “For all conditions or injuries not addressed by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are 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.”

**Section 9792.8(a)(3)** This subdivision was amended to clarify that only the “relevant portion of the criteria or guidelines used” shall be disclosed in written form to the appropriate parties. Thus the subdivision 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 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.”

The subdivision was further amended to subsections 9792.8(a)(3)(A) and 9792.8(a)(3)(B) as duplicative.

#### **4. Modifications to Section 9792.9 Utilization Review Standards—Timeframe, Procedures and Notice Content**

**Section 9792.9(b)(2)** This subdivision was amended to delete the word “physician” and to delete the phrase “a health care reviewer or a non-physician reviewer.”

**Section 9792.9(b)(2)(A)** This subdivision was amended to delete the word “physician” and to delete the phrase “or health care reviewer.”

**Section 9792.9(b)(4)** This subdivision was amended to require that contact information of the physician provider of goods or services be provided in the request for authorization. Thus the last sentence of the subdivision was amended as follows: “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 for the decision.”

**Section 9792.9(c)** This subdivision was amended consistent with the requirement that contact information of the non-physician provider of goods or services be provided in the request for authorization. Thus the last sentence of the subdivision was amended as follows: “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 for the decision.”

The subdivision was further amended to move the last two sentences of the subdivision to section 9792.9(d) below.

**Section 9792.9(d)** This subdivision has been amended for clarification purposes. The subdivision now states: “Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services, however, may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.”

**Section 9792.9(f)** This subdivision was amended to delete the word “physician” and “physician’s” and to delete the phrase “or health care reviewer.” The subdivision was further amended to insert the word “individual’s” before the word practice. Thus the subdivision now reads: “The review and decision to deny, delay or modify a request for medical treatment must be conducted by a reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual’s practice.”

**Section 9792.9(g)(1)(B)** This subdivision was amended to delete the word “physician” and to delete the phrase “or health care reviewer.”

**Section 9792.9(g)(2)** This subdivision was amended consistent with the requirement that contact information of the non-physician provider of goods or services be provided in the request for authorization. Thus the last sentence of the subdivision was amended as follows: “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 to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with this subdivision. The written notification shall not include the rationale, criteria or guidelines used for the decision.”

**Section 9792.9(j)(8)** This subdivision was amended consistent with the requirement that contact information of the non-physician provider of goods or services be provided in the request for authorization. Thus the last sentence of the subdivision was amended as follows: “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 for the decision.”

**Section 9792.9(k)** This subdivision was amended to identify the physician in the first sentence as the “requesting” physician. The subdivision was further amended to delete the word “physician” and the phrase “health care reviewer” and refer to the reviewing person as the “reviewer.” The subdivision was also amended to allow for contact by the requesting physician and a “reviewer” working in the same company of the original “reviewer” in those situations wherein the first reviewer is not available to facilitate communication.

Further, in order to facilitate communication between the requesting physician and the reviewer, the following sentence has been added to the subdivision: “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.”

#### **5. Section 9792.10 Utilization Review Standards—Dispute Resolution**

This subdivision was amended consistent with the requirement that contact information of the non-physician provider of goods or services be provided in the request for authorization. Thus the last sentence of the subdivision was amended as follows: “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 for the decision.”