

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

FINAL STATEMENT OF REASONS

Subject Matter:

Workers' Compensation – Utilization Review Standards

Title 8, California Code of Regulations, sections 9792.6 through 9792.11

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority granted by Labor Code sections 59, 133, 4603.5, and 5307.3, has adopted Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9792.6, 9792.7, 9792.8, 9792.9, and 9792.10 and has repealed section 9792.11, as follows:

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
Section 9792.11	Utilization Review Standards—Penalties [Repealed]

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

As authorized by Government Code §11346.9(d), the Administrative Director incorporates the Initial Statement of Reasons prepared in this matter. There have been no changes to the statutes directly relating to this rulemaking.

The proposed regulation changes are summarized below.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (June 1, 2005 through March 22, 2005.)

1. Modifications to Section 9792.6 Utilization Review Standards—Definitions

This section provides definitions for key terms in the regulations.

Section 9792.6(b) A new subdivision (b) was added to the regulations to define the term “authorization” to mean that appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or in the “Primary Treating Physician’s Progress Report,” DWC

Form PR-2, as contained in section 9785.2, or in a narrative form containing the same information required in the DWC Form PR-2.

All of the subdivisions following new subdivision 9792.6(b) were alphabetically re-lettered after insertion of new subdivision 9792.6(b) in the emergency regulatory text.

Section 9792.6(c) The definition of “claims administrator” contained in subdivision 9792.6(c) was clarified to also include “an insured employer” and “other entity subject to Labor Code section 4610.” Further, the last sentence of the definition which was added at the time of the Notice of Rulemaking after Emergency Adoption was amended for clarity purposes to state that the claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities.

Section 9792.6(e) The definition of “course of treatment” was amended to provide that the “course of treatment” may be set forth in a narrative form containing the same information required in the DWC Form PR-2.

Section 9792.6(h) The definition of “expert reviewer” was amended for clarification purposes. The term was amended to substitute “expert physician reviewer” instead of “expert reviewer.” The subdivision now states that the term “expert physician reviewer” means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by any U.S. Jurisdiction, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the licensure and scope of the physician’s practice, who has been consulted by the physician reviewer or utilization review medical director to provide specialized review of medical information.

Section 9792.6(j) A new subdivision (j) was added to the emergency regulatory text to define the term “immediately” to mean within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) and (g)(1) of section 9792.9. The term “immediately” is used in section 9792.9(g)(2), and the public requested that the term be defined for clarity purposes.

All of the subdivisions following new subdivision 9792.6(j) were alphabetically re-lettered after insertion of new subdivision 9792.6(j) in the emergency regulatory text.

Section 9792.6(l) A new subdivision (l) was added to the emergency regulatory text to define the term “physician reviewer” as requested by the public. The section states that “physician reviewer” means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by any U.S. Jurisdiction, competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician’s practice.

All of the subdivisions following new subdivision 9792.6(l) were alphabetically re-lettered after insertion of new subdivision 9792.6(l) in the emergency regulatory text.

Section 9792.6(m) The definition of “prospective review” was amended for clarification purposes pursuant to public comments. The definition was amended to state that “prospective review” means any utilization review, except for utilization review conducted during an inpatient stay, conducted prior to the delivery of the requested medical services.

Section 9792.6(n) The definition of the term "request for authorization" was amended to clarify that a request for authorization may be submitted in a narrative form containing the same information required in the PR-2 form. The definition was further amended to state that if a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

Section 9792.6(o) The term “retrospective review” was amended to delete the word “services” for clarity purposes. The subdivision now states that “retrospective review” means utilization review conducted after medical services have been provided and for which approval has not already been given.

2. Section 9792.7 Utilization Review Standards—Applicability

Section 9792.7(a)(1) This subdivision was amended pursuant to public comments to require that the utilization review plan also set forth the address, phone number, area(s) of certified specialty, and area(s) of practice of the designated medical director in addition to the other requirements set forth in the subdivision.

Section 9792.7(a)(3) Pursuant to public comment this subdivision was amended to clarify that the utilization plan set forth 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, and to require that the utilization review plan also contain a description of the process used to review authorization for treatment requests which falls outside the specified routine criteria in addition to the other requirements set forth in the subdivision.

Section 9792.7(a)(5) This new subdivision was added to the emergency regulatory text to require that the utilization review plan also contain a description, if applicable, of any prior authorization process that will be used by the claims administrator in the utilization review plan.

Section 9792.7(b)(2) This subdivision was amended for clarification purposes to delete the phrase “no person, other than a licensed,” and to insert the word “reviewer” after the word “physician” to clarify that the “physician reviewer” is the only person authorized to 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(b)(3) This subdivision was amended to insert the word “requesting” in front of the word “physician” to clarify the reference to the requesting physician as opposed to the physician reviewer.

Section 9792.7(c) This subdivision was amended to add the new requirement that a new utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator either changes its utilization review plan or makes material modifications to the plan.

3. Section 9792.8 Utilization Review Standards—Medically-Based Criteria

Section 9792.8(a)(2) Pursuant to public comment this subdivision was amended to substitute the word “covered” with the word “addressed” in the first sentence of the subdivision. Thus the first sentence now reads: “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.” This subdivision was further amended to add the requirement that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines.

Section 9792.8(a)(3) Pursuant to public comment this subdivision was amended to clarify that the criteria or guidelines used shall be disclosed in written form to the requesting physician. Further, the subdivision was amended to clarify that that the criteria or guidelines used must also be disclosed in written form to the provider of goods or services that are identified in the request for authorization.

Section 9792.8(a)(3)(B) This subdivision was amended to clarify that a written copy of the relevant portion of the criteria or guidelines used must be enclosed with the written decision to the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney pursuant to section 9792.9, subdivision (i).

Section 9792.8(a)(4) This new subdivision was added to the emergency regulatory text to require that nothing in this section precludes authorization of medical treatment not included in the specific criteria disclosed under section 9792.7(a)(3).

4. Section 9792.9 Utilization Review Standards—Timeframe, Procedures and Notice Content

Section 9792.9(a) This subdivision was amended to clarify that the request for authorization refers to the request for authorization for a course of treatment as defined in section 9792.6(e).

Section 9792.9(a)(1) This subdivision was amended pursuant to public comments to clarify that for purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was received if the receiving facsimile electronically date stamps the transmission, or the date the request was transmitted. The subdivision was further amended to delete the word “standard” when referring to “Pacific Time,” and insert the reference to Labor Code section 4600.4 in reference to the definition of “business day.” Also, the subdivision was amended to require that the copy of the request for authorization received by a facsimile transmission bear a notation of the time at which the request was transmitted in addition to the date and place of transmission. Further, the subdivision was amended to require that the provider indicate the need for an expedited review upon submission of the request.

Section 9792.9(b)(2) This subdivision was amended pursuant to public comments to clarify that if appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a physician reviewer or a non-physician reviewer within the applicable timeframe.

Section 9792.9(b)(2)(A) This subdivision was amended to clarify that the claims administrator may not deny a request for authorization. The section now states that “if the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a physician reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.”

Section 9792.9(b)(3) This subdivision was amended pursuant to public comments to clarify that the statute only requires service of the decisions approving requests for authorization to the requesting physician. The subdivision now states: “Decisions to approve a physician’s request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review.

Section 9792.9(b)(4) This subdivision was added to the emergency regulatory text to clarify that the decisions to modify, delay or deny a physician’s request for authorization are the appropriate decisions which must be communicated to the parties listed in the subdivision.

Section 9792.9(b)(5) The emergency regulatory text was amended to separate this sentence from the original subdivision 9792.9(b)(3), and to place it in section 9792.9(b)(5). Further, the subdivision was amended to insert the reference to Labor Code section 4600.4 in reference to the definition of “business day.”

Section 9792.9(c) This subdivision was amended to clarify that when review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and the provider of goods or services identified in the request for authorization, to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. The subdivision was further amended to require that documentation for emergency health care services shall be made available to the claims administrator upon request.

Section 9792.9(d) Pursuant to public comments, a new subdivision (d) has been added to the emergency regulatory text to state that the delivery of emergency health care services shall not be delayed pending the physician’s request for authorization.

All of the subdivisions following new subdivision 9792.9(d) were alphabetically re-lettered after insertion of new subdivision 9792.9(d) in the emergency regulatory text.

Section 9792.9(e) Former subdivision (d) has been re-lettered to subdivision (e), and amended for clarification purposes to substitute the term “provider” with the term “requesting physician.”

Section 9792.9(f) This subdivision was amended pursuant to public comments for clarification purposes to refer to the physician as the “physician reviewer.”

Section 9792.9(g)(1)(C) This subdivision was amended pursuant to public comments for clarification purposes to refer to the expert reviewer as “expert physician reviewer.”

Section 9792.9(g)(2) This subdivision was amended to clarify that decisions pursuant to subparts (A), (B) or (C) of subdivision 9792.9(g)(1) and anticipated date of final decision are only required to be communicated by claims administrator to the provider of goods or services identified in the request for authorization, in addition to the other parties identified in the subdivision. The subdivision was further amended to require that the specialty of the expert physician to be consulted be disclosed in the notice. This subdivision was further amended to identify the “physician” as the “requesting physician.”

Section 9792.9(g)(3) This subdivision was amended pursuant to public comments for clarification purposes to identify the referenced five days as five “working” days.

Section 9792.9(h) The subdivision was amended to delete the word “standard” when referring to “Pacific Time,” and insert the reference to Labor Code section 4600.4 in reference to the definition of “business day.” In addition, the subdivision was amended to substitute the term “providers” with the term “requesting physicians.”

Section 9792.9(j) The subdivision was amended to clarify that a claims administrator is only required to provide a written decision modifying, delaying or denying treatment authorization under this section to the provider of goods or services identified in the request for authorization, in addition to the other parties identified in the subdivision. The section was further amended to identify the physician as the “requesting physician.”

Section 9792.9(j)(8) This subdivision has been amended pursuant to public comments to give the claims administrator a choice when providing notice of decisions modifying, delaying or denying requests for authorization. The emergency regulatory text requiring the following mandatory language was amended to stated:

Either

"If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

or

“If you want further information, you may contact the local state Information and Assistance office closest to you. Please see attached listing (attach a listing of I&A

offices and telephone numbers) or you may receive recorded information by calling 1-800-736-7401.”

and

“You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.”

Section 9792.9(k) This subdivision was amended to require that the written decision modifying, delaying or denying treatment authorization provided to the physician also contain the specialty in addition to the name of the physician reviewer. The subdivision was further amended to require that the telephone number provided be a telephone number in the United States. Further, the requirement has been added that the written decision disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours a week Pacific Time. The section was further amended to identify the reviewer as the “physician reviewer.”

Section 9792.9(l) This subdivision was amended to clarify that authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail.

5. Section 9792.10 Utilization Review Standards—Dispute Resolution

Section 9792.10(b)(1) This subdivision was amended to clarify that in the case of concurrent review, medical care shall not be discontinued until the requesting physician and provider of goods or services identified in the request for authorization, has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

6. Section 9792.11 Utilization Review Standards—Penalties

This section has been deleted from the emergency regulatory text. Penalties applicable in the utilization review process will be addressed by separate rulemaking process.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE FIRST 15 DAY COMMENT PERIOD AND CIRCULATED FOR A SECOND 15-DAY COMMENT PERIOD (June 29, 2005 through July 14, 2005.)

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 clarify that the term 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, 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 on a narrative form containing the same information required in the DWC Form PR-2.

Section 9792.6(c) The definition of “Claims Administrator” was amended for clarification purposes to delete the phrase “for an insurer, a self-insured employer, a legally uninsured employer, a joint powers authority” following the phrase “a third-party claims administrator” as superfluous, and to clarify the last sentence of the definition to state that the claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

Section 9792.6(h) The term “expert physician reviewer” was amended to change the term to “expert reviewer.” The definition was further amended to clarify that an expert reviewer is a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and 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 scope of practice, as defined by the licensing board, who has been consulted by the physician reviewer, the health care reviewer or the utilization review medical director to provide specialized review of medical information.

Section 9792.6(j) A new definition has been added in subdivision 9792.6(j). The term “health care reviewer” has been defined to mean a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and chiropractic practitioner licensed by any state or the District of Columbia except California, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the individual’s practice.

Section 9792.6(k) The term “immediately” was defined in subdivision 9792.6(j). The subdivision has been re-lettered 9792.6(k).

Section 9792.6(l) A new term has been added in subdivision 9792.6(l). The term “material modification” has been defined to mean when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

Section 9792.6(m) A new term has been added to subdivision 9792.6(m). The term “Medical Director” has been defined to mean the physician and surgeon licensed by the Medical Board of the State of California or the Board of Osteopathic Examiners of the State 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(n) The term “medical services” was defined in subdivision 9792.6(k). The subdivision has been re-lettered 9792.6(n).

Section 9792.6(o) The term “physician reviewer” was defined in subdivision 9792.6(l). The subdivision has been re-lettered 9792.6(o). The term has been amended for clarification purposes to mean a physician as defined in section 3209.3 of the Labor Code holding an active California license, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the physician’s practice as defined by the licensing board.

Section 9792.6(p) The term “prospective review” was defined in subdivision 9792.6(m). The subdivision has been re-lettered 9792.6(p).

Section 9792.6(q) The term “request for authorization” was defined in subdivision 9792.6(n). The subdivision has been re-lettered 9792.6(q). The term has been amended for clarification to add the name of Form DLSR 5021, “Doctor’s First Report of Occupational Injury or Illness.”

Section 9792.6(r) The term “retrospective review” was defined in subdivision 9792.6(o). The subdivision has been re-lettered 9792.6(r).

Section 9792.6(s) The term “utilization review plan” was defined in subdivision 9792.6(p). The subdivision has been re-lettered 9792.6(s). The word “review” has been inserted to clarify the last phrase of the sentence as “utilization review process.”

Section 9792.6(t) The term “utilization review process” was defined in subdivision 9792.6(q). The subdivision has been re-lettered 9792.6(t).

Section 9792.6(u) The term “written” was defined in subdivision 9792.6(r). The subdivision has been re-lettered 9792.6(u).

The Reference under this section was amended to insert section 3209.3 of the Labor Code as a reference.

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 practice.”

Section 9792.7(a)(3) The second sentence of the subdivision was amended for clarification purposes. The sentence now states: “A description of the process used to review authorization for treatment requests which are not addressed in the treatment protocols or standards routinely used.”

Section 9792.7(a)(5) This subdivision was amended for after public comments requesting clarification. The subdivision now requires that the utilization review plan contain 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.

Section 9792.7(b)(2) This subdivision was amended to state that a “health care reviewer” in addition to a physician reviewer, who is competent to evaluate the specific clinical issues

involved in the medical treatment services, may delay, modify or deny requests for authorization. Further, the subdivision was amended to clarify that the services of the “physician reviewer” or the “health care reviewer” must be within the scope of practice as defined by the licensing board.

Section 9792.7(b)(3) This subdivision was amended for clerical error. The last sentence of the subdivision now states: “Any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (g)(1)(A) through (g)(1)(C) of section 9792.9.

Section 9792.7(c) This subdivision was amended to clarify the new requirement that a new utilization review plan shall be filed with the Administrative Director. The last sentence of the subdivision now states: “A modified utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan.

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

Section 9792.8(a)(3) This subdivision was amended to delete two references to the phrase “the provider of goods or services that are identified in the request for authorization.”

Section 9792.8(a)(3)(B) This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” The subdivision was further amended for clerical error to correct the reference to section 9792.9, subdivision (j).

Section 9792.8(a)(4) This subdivision was amended for clerical error to delete the word “disclosed” and to correct the reference of section 9792.7(a)(3) to 9792.8(a)(3).

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

Section 9792.9(b)(2) This subdivision was amended to clarify that a “health care reviewer” in addition to the physician reviewer or a non-physician reviewer may request appropriate information necessary to render a decision within the applicable timeframe.

Section 9792.9(b)(2)(A) This subdivision was amended to clarify that the “health care reviewer” in addition to the physician reviewer may deny the request for authorization when the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request.

Section 9792.9(b)(3) This subdivision was amended for clerical error to insert the phrase “a request” which was mistakenly deleted from the previous text.

Section 9792.9(b)(4) This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” Further, the subdivision was amended to add the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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 to delete the phrase “the provider of goods or services that are identified in the request for authorization.” Further, the subdivision was amended to add the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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(d) This subdivision has been amended for clarification purposes. The subdivision now states that “[p]reauthorization shall not be required prior to provision of emergency health care services. Emergency health care services, however, may be subjected to retrospective review.”

Section 9792.9(f) This subdivision was amended to clarify that the review and decision to deny, delay or modify a request for medical treatment may be conducted by a health care reviewer in addition to a physician reviewer.

Section 9792.9(g)(1)(B) This subdivision was amended to clarify that the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may be extended when a health care reviewer, in addition to the physician reviewer, has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

Section 9792.9(g)(1)(C) This subdivision was amended to delete the word “physician” from the term “expert physician reviewer,” as the term was changed to “expert reviewer.”

Section 9792.9(g)(2) This subdivision was amended to delete two references to the phrase “the provider of goods or services that are identified in the request for authorization.” The subdivision was further amended to delete the word “physician” and properly refer to the new term “expert reviewer.” Moreover, the subdivision was further amended to insert the following new language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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(g)(3) This subdivision was amended for clerical error to clarify that the decision shall be communicated pursuant to subdivisions (b)(3) or (b)(4).

Section 9792.9(j) This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.”

Section 9792.9(j)(7) This subdivision was amended for clerical error to insert the word “that” in the last sentence.

Section 9792.9(j)(8) This subdivision was amended to add the following language at the end of the subdivision: “In addition, the non-physician provider of goods or services identified in the request for authorization 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 require that the written decision modifying, delaying or denying treatment authorization provided to the physician contain the name and specialty of the health care reviewer and expert reviewer in addition to the physician reviewer. Further, the subdivision was amended to require that the written decision disclose the hours of availability of the health care reviewer or expert reviewer in addition of the physician reviewer or the medical director for the treating physician to discuss the decision. The language describing the hours of availability has been clarified to state that the time “shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time” or that the parties can reach “an agreed upon scheduled time to discuss the decision with the requesting physician.”

5. Section 9792.10 Utilization Review Standards—Dispute Resolution

Section 9792.10(a)(3) This subdivision was amended for clerical error to insert a coma between the words “and” and “if” in the sentence.

Section 9792.10(b)(1) This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” The subdivision was further amended to include the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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 FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE SECOND 15 DAY COMMENT PERIOD AND CIRCULATED FOR A THIRD 15-DAY COMMENT PERIOD (July 21, 2005 through August 5, 2005.)

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). The term was correct for clerical error to reflect the correct name of the Medical Board of California and the Osteopathic Board of California.

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 delete 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.”

THE FOLLOWING NON-SUBSTANTIVE / CORRECTIONS WITHOUT REGULATORY EFFECT WERE MADE TO THE TEXT OF THE REGULATIONS AFTER THE CLOSE OF THE FINAL COMMENT PERIOD

Modifications to Section 9792.9 Utilization Review Standards—Timeframe, Procedures and Notice Content

Section 9792.9(a)(1) The last sentence of this subdivision has been amended for clerical error to substitute the word “provider” with the term “requesting physician.”

Section 9792.9(b)(2) This subdivision was amended after the second 15-day comment to delete the word “physician” and to delete the phrase “a health care reviewer” Due to clerical error the phrase “or a non-physician reviewer” was also deleted. The intent of the modification was to delete the words “physician” and “health care reviewer” as these terms had been consolidated into the term of “reviewer.” The phrase “or a non-physician reviewer” has been restored to the text of the section 9792.9(b)(2) consistent with the entire regulations allowing non-physician reviewers to gather information to assist the reviewer in the UR decisions. See section 9792.7(b)(3).

UPDATE OF MATERIAL RELIED UPON / DOCUMENTS ADDED TO RULEMAKING FILE

In addition to the documents identified in the Initial Statement of Reasons the following documents were relied upon by the Division and were made available to the public as required by Government Code Section 11347.1.

Title of Document Added to Rulemaking File Dates of Availability for Public Comment

Comments received by the Division of Workers’ Compensation concerning the Division’s proposed changes.	February 1, 2005 through March 22, 2005 June 1, 2005 through June 16, 2005 June 29, 2005 through July 14, 2005 July 21, 2005 through August 5, 2005
Pre-Notice comments from DWC Forum	February 27, 2004 through March 12, 2004 April 14, 2004 through April 30, 2004 August 23, 2004 through September 7, 2004
ACOEM’s Copyright Statement—posted on the Division’s website at: http://www.dir.ca.gov/dwc/UR_Main.htm .	April 12, 2005

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed amendments do not apply to any local agency or school district.

- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts.

The public comment period was as follows:

Initial 45-day comment period on proposed regulations:

February 1, 2005 through March 22, 2005.

First 15-day comment period on modifications to proposed text:

June 1, 2005 through June 16, 2005.

Second 15-day comment period on modifications to proposed text:

June 29, 2005 through July 14, 2005.

Third 15-day comment period on modifications to proposed text:

July 21, 2005 through August 5, 2005.