

Utilization Review and Independent Medical Review Regulations

Title 8, California Code of Regulations Chapter 4.5 Division of Workers' Compensation Subchapter 1 Administrative Director – Administrative Rules

Article 5 Predesignation of Personal Physician; Request for Change of Physician; Reporting Duties of the Primary Treating Physician; Petition for Change of Primary Treating Physician

§9785. Reporting Duties of the Primary Treating Physician.

(a) For the purposes of this section, the following definitions apply:

(1) The “primary treating physician” is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616.

(2) A “secondary physician” is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(3) “Claims administrator” is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) “Medical determination” means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) “Released from care” means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) “Continuing medical treatment” is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

(7) “Future medical treatment” is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) “Permanent and stationary status” is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.

(b)(1) An employee shall have no more than one primary treating physician at a time.

(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or

(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061, 4062, 4600.5, 4616.3, or 4616.4. If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061, 4062, and 4610.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the

treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination in accordance with subdivision (e)(1).

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is released from care;

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury;

(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in

paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the “Primary Treating Physician's Progress Report” form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled “Primary Treating Physician's Progress Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: “I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3.”

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the “Request for Authorization,” DWC Form RFA, contained in section 9785.5. A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment.

(h) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the “Primary Treating Physician's Permanent and Stationary Report” form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

(i) The primary treating physician, upon finding that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, shall complete the “Physician’s Return-to-Work & Voucher Report” (DWC-AD 10133.36) and attach the form to the report required under subdivision (h).

(j) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(k) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4061, 4061.5, 4062, 4600, 4600.3, 4603.2, 4604.5, 4610.5, 4658.7, 4660, 4662, 4663 and 4664, Labor Code.

§9785.5. Request for Authorization Form, DWC Form RFA.

Request for Authorization, DWC Form RFA

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4061, 4061.5, 4062, 4600, 4604.5, 4610, 4610.5, and 4610.6, Labor Code.

Article 5.5.1 Utilization Review Standards

§ 9792.6. Utilization Review Standards—Definitions - For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

The following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013 if the decision on the request is communicated to the requesting physician prior to July 1, 2013.

- (a) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.
- (b) “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.
- (c) “Claims Administrator” is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.
- (d) “Concurrent review” means utilization review conducted during an inpatient stay.
- (e) “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.
- (f) “Dispute liability” means an assertion by the claims administrator that a factual, medical, or legal basis exists that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
- (g) “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(h) “Expedited review” means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, 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 worker's permanent ability to regain maximum function.

(i) “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.

(j) “Health care provider” means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

(k) “Immediately” means 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.

(l) “Material modification” is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

(m) “Medical Director” is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board 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.

(n) “Medical services” means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(o) “Medical Treatment Utilization Schedule” means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

(p) “Prospective review” means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.

(q) “Request for authorization” means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both

the written confirmation of an oral request and the written request must be set forth on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

(r) "Retrospective review" means utilization review conducted after medical services have been provided and for which approval has not already been given.

(s) "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.

(t) "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

(u) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.

(v) "Written" includes a facsimile as well as communications in paper form.

Authority cited: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.6.1. Utilization Review Standards—Definitions – On or After January 1, 2013.

The following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(a) "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 either a completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if that form was initially submitted by the treating physician.

(b) "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). "Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

(c) "Concurrent review" means utilization review conducted during an inpatient stay.

(d) "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, found at California Code of Regulations, title 8, section 14006, 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.

(e) "Delay" means a determination, based on the need for additional evidence as set forth in section 9792.9.1(f), that the timeframe requirements for the utilization review process provided in section 9792.9.1(c) cannot be met.

(f) "Denial" means a decision by a physician reviewer that the requested treatment or service is not authorized.

(g) "Dispute liability" means an assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the

claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

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

(i) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(j) "Expedited review" means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, 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 worker's permanent ability to regain maximum function.

(k) "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.

(l) "Health care provider" means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

(m) "Immediately" means within one business day.

(n) "Material modification" is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

(o) "Medical Director" is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board 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.

(p) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(q) "Medical Treatment Utilization Schedule" means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

(r) "Modification" means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.

(s) "Prospective review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services

(t) "Request for authorization" means a written request for a specific course of proposed medical treatment.

(1) Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a "Request for Authorization (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.

(2) "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

(u) "Retrospective review" means utilization review conducted after medical services have been provided and for which approval has not already been given.

(v) "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.

(w) "Utilization review decision" means a decision pursuant to Labor Code section 4610 to approve, modify, delay, or deny, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

(x) "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

(y) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in

part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

(z) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail.

Authority cited: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.7. Utilization Review Standards--Applicability

(a) Effective January 1, 2004, every claims administrator shall establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury, in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The name, address, phone number, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) 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. The treatment protocols or standards governing the utilization review process shall be consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27.

(4) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

(5) 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.

(b)(1) The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations.

(2) 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.

(3) A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this

exceed the time limitations imposed in section 9792.9 (c)(1), (c)(2), or (d), or section 9792.9.1(c) and (d). Any time beyond the time specified in these sections is subject to the provisions of section 9792.9(h) or section 9792.9.1(f).

(c) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. 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.

(d) Upon request by the public, the claims administrator shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process.

(1) The claims administrator may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means. If a member of the public requests a hard copy of the utilization review plan, the claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed \$0.25 per page plus actual postage costs.

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

§9792.9. Utilization Review Standards--Timeframe, Procedures and Notice Content – For Injuries Occurring Prior to January 1, 2013, Where the Request for Authorization is Received Prior to July 1, 2013.

This section applies to any request for authorization of medical treatment, submitted under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013, where the request for authorization is received prior to July 1, 2013.

(a) The request for authorization for a course of treatment as defined in section 9792.6(e) must be in written form.

(1) 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. If there is no electronically stamped date recorded, then the date the request was transmitted. A request for authorization transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day as defined in Labor Code section 4600.4 and in section 9 of the Civil Code. The copy of the request for authorization received by a facsimile transmission shall bear a notation of the date, time and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted. The requesting physician must indicate the need for an expedited review upon submission of the request.

(2) Where the request for authorization is made by mail, and a proof of service by mail exists, the request shall be deemed to have been received by the claims administrator five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service. Where the request for authorization is delivered via certified mail, return receipt mail, the request shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt. In the absence of a proof of service by mail or a dated return receipt, the request shall be deemed to have been received by the claims administrator on the date stamped as received on the document.

(b) Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

(1) If the claims administrator disputes its liability for the requested medical treatment under this subdivision, it may, no later than five (5) business days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment, unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall only contain the following information specific to the request:

(A) The date on which the request for authorization was first received.

(B) A description of the specific course of proposed medical treatment for which authorization was requested.

(C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.

(D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

(E) The following mandatory language advising the injured employee:

"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

(2) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.

(c) The utilization review process shall meet the following timeframe requirements:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for authorization.

(2) 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 reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written request

for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.

(A) 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 reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

(3) 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 a request 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 for prospective review.

(4) Decisions to modify, delay or deny 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 initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review. 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.

(5) For purposes of this section “normal business day” means a business day as defined in Labor Code section 4600.4 and Civil Code section 9.

(d) When review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and 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. 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.

(e) 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.

(f) Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:

(1) When the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or

(2) The normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(g) 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.

(h) (1) The timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may only be extended by the claims administrator under the following circumstances:

(A) The claims administrator is not in receipt of all of the necessary medical information reasonably requested.

(B) The 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.

(C) The claims administrator needs a specialized consultation and review of medical information by an expert reviewer.

(2) If subdivisions (A), (B) or (C) above apply, the claims administrator shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the claims administrator cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The claims administrator shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. This notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim, Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10252.1. 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.

(3) Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, and (b)(2)(A), the claims administrator shall make the decision to approve, and the reviewer shall make a decision to modify or deny the request for authorization within five (5) working days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivisions (b)(3) or (b)(4).

(4) Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, and the reviewer shall make a decision to modify or deny the request for authorization within thirty (30) days of receipt of the information for retrospective review.

(i) Every claims administrator shall maintain telephone access from 9:00 AM to 5:30 PM Pacific Time, on normal business days, for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section "normal business day" means a business day as defined in Labor Code section 4600.4 and Civil Code section 9. In addition, for purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number for after business hours requests.

(j) A written decision approving a request for treatment authorization under this section shall specify the specific medical treatment service approved.

(k) A written decision modifying, delaying or denying treatment authorization under this section, when the decision is communicated prior to July 1, 2013, shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:

(1) The date on which the decision is made.

(2) A description of the specific course of proposed medical treatment for which authorization was requested.

(3) A specific description of the medical treatment service approved, if any.

(4) A clear and concise explanation of the reasons for the claims administrator's decision.

(5) A description of the medical criteria or guidelines used pursuant to section 9792.8, subdivision (a)(3).

(6) The clinical reasons regarding medical necessity.

(7) A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney on behalf of the injured worker to the claims administrator in writing within 20 days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state that the injured worker may file an Application for Adjudication of Claim, Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10252.1.

(8) (A) Include the following mandatory language:

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.”

(B) Instead of the mandatory language stated in subdivision (k)(8)(A), the following language may be used:

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

“For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”

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.

(9) Details about the claims administrator's internal utilization review appeals process, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

“If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.”

(I) A written decision modifying, delaying or denying treatment authorization under this section, sent on or after July 1, 2013, shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:

(1) The date on which the decision is made.

(2) A description of the specific course of proposed medical treatment for which authorization was requested.

(3) A list of all medical records reviewed.

(4) A specific description of the medical treatment service approved, if any.

(5) A clear, concise, and appropriate explanation of the reasons for the claims administrator's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify, deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(6) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator. The written decision provided to the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.

(7) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of

the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision.

(8) Include the following mandatory language advising the injured employee:

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster’s or appropriate contact’s name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

“For information about the workers’ compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers’ Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”

(9) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(m) The written decision modifying, delaying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the review, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. 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.

(n) 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.

(o) A utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013.

This section applies to any request for authorization of medical treatment, submitted under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(a) The request for authorization for a course of treatment as defined in section 9792.6.1(d) must be in written form set forth on the “Request for Authorization (DWC Form RFA),” as contained in California Code of Regulations, title 8, section 9785.5.

(1) For purposes of this section, the DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator’s utilization review organization. A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall 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 copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA.

(2) (A) Where the DWC Form RFA is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

(B) Where the DWC Form RFA is delivered via certified mail, with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt.

(C) In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

(3) Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from

health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

(b) Utilization review of a medical treatment request made on the DWC Form RFA may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

(1) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall contain the following information specific to the request:

(A) The date on which the DWC Form RFA was first received.

(B) A description of the specific course of proposed medical treatment for which authorization was requested.

(C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.

(D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

(E) The following mandatory language advising the injured employee:

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

“For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”

(2) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

(c) Unless additional information is requested necessitating an extension under subdivision (f), the utilization review process shall meet the following timeframe requirements:

(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

(2)(A) Upon receipt of a request for authorization as described in subdivision (c)(2)(B), or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

(B) The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of the document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

(3) Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA.

(4) Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured

worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3).

(5) Retrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

(d) Decisions to approve a request for authorization.

(1) All decisions to approve a request for authorization shall specify the specific the date the complete request for authorization was received medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

(2) For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. 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 (2) business days for prospective review.

(3)(A) For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

(B) Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth in subdivision (c)(5), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

(e) Decisions to modify, delay, or deny a request for authorization.

(1) 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.

(2) Failure to obtain authorization prior to providing 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 may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

(3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

(4) For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

(5) The written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the following information specific to the request:

(A) The date on which the DWC Form RFA was first received.

(B) The date on which the decision is made.

(C) A description of the specific course of proposed medical treatment for which authorization was requested.

(D) A list of all medical records reviewed.

(E) A specific description of the medical treatment service approved, if any.

(F) A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify, deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(G) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee. Prior to March 1, 2014, any version of the DWC Form IMR adopted by the Administrative Director under section 9792.10.2 may be used by the claims administrator in a written decision modifying, delaying or denying treatment authorization.

(H) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days after service of the decision.

(I) Include the following mandatory language advising the injured employee:

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

“For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”

(J) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(K) The written decision modifying, delaying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. 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.

(6) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:

(A) Medical care shall not be discontinued until the requesting physician 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 employee.

(B) Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

(f)(1) The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

(A) The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.

(B) The 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.

(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

(2) (A) If the circumstance under subdivision (f)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

(B) If any of the circumstances set forth in subdivisions (f)(1)(B) or (C) are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered

(3) (A) If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

(B) If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under subdivision (f)(1)(C), that is requested by the reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

(4) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision

to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in section 9792.9.1(d) or (e), whichever is applicable.

(5) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received and be communicated pursuant to subdivisions (d)(2) or (e)(3), whichever is applicable.

(6) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for retrospective review, shall make the decision to approve, modify, delay, or deny the request for authorization within thirty (30) calendar days of receipt of the information requested. The decision shall include the date it was made and be communicated pursuant to subdivisions (d)(3) or (e)(4), whichever is applicable.

(g) Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

(h) A utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.10. Utilization Review Standards--Dispute Resolution– For Utilization Review Decisions Communicated Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

This section applies to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013 if the decision on the request is communicated to the requesting physician prior to July 1, 2013.

(a)(1) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code section 4062.

(2) An objection to a decision disapproving in whole or in part a request for authorization of medical treatment, must be communicated to the claims administrator by the injured worker or the injured worker's attorney in writing within 20 days of receipt of the utilization review decision. The 20-day time limit may be extended for good cause or by mutual agreement of the parties.

(3) Nothing in this paragraph precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the injured worker and if the injured worker is represented by counsel, the injured worker's attorney have been notified of the 20-day time limit to file an objection to the utilization review decision in accordance with Labor Code section 4062.

(4) Additionally, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and request an expedited hearing and decision on his or her entitlement to medical treatment if the request for medical treatment is not authorized within the time limitations set forth in section 9792.9, or when there exists a bona fide dispute as to entitlement to medical treatment.

(b) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the requesting physician 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. 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.

(2) Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.1. Utilization Review Standards--Dispute Resolution – On or After January 1, 2013.

This section applies to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(a) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board under this Article.

(b)(1) A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.1(e)(5). The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment, to the claims administrator.

(2) A party eligible to file a request for independent medical review includes:

(A) The employee or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.

(i) An unrepresented employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf in filing an application for independent medical review under this subdivision. A designation of an agent executed prior to the utilization review decision shall not be valid.

(ii) The physician whose request for authorization of medical treatment was delayed, denied, or modified may join with or otherwise assist the employee in seeking an independent medical review. The physician may submit documents on the employee's behalf pursuant to section 9792.10.5 (b) and may respond to any inquiry by the independent review organization.

(B) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review under this section on its own behalf within 30 days after the service of the utilization review decision

that either delays, denies, or modifies the provider's retrospective request for authorization of the emergency medical treatment.

(3) If expedited review is requested for a utilization review decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j).

(c)(1) If at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit an application for independent medical review under subdivision (b)(1) is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(2) If the claims administrator provides the employee with a written utilization review determination modifying, delaying, or denying a treatment request that does not contain the required elements set forth in section 9792.9(1) or section 9792.9.1(e) at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review under subdivision (b)(1) shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

(d)(1) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the 30-day time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision.

(2) A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

(3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) must indicate that the decision is a modification after appeal.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.2. Application for Independent Medical Review, DWC Form IMR.

[Placeholder for Form]

Authority: Sections 133, 4603.5, 4610.5, and 5307.3, Labor Code.

Reference: Sections 4600, 4610, and 4610.5, Labor Code.

§ 9792.10.3. Independent Medical Review – Initial Review of Application.

(a) Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. In making this determination, the Administrative Director shall consider:

- (1) The timeliness and completeness of the Application;
 - (2) Any previous application or request for independent medical review of the disputed medical treatment;
 - (3) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.
 - (4) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician.
 - (5) The employee’s date of injury.
 - (6) The failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation.
- (b) The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, if the employee is represented by counsel, the employee’s attorney, and the requesting physician, as appropriate, by the most efficient means available.
- (c) The parties shall respond to any reasonable request made pursuant to subdivision (b) within five (5) business days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review under section 9792.10.4.

(d) If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the claims administrator agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

(e) The parties may appeal an eligibility determination by the Administrative Director that a disputed medical treatment is not eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board.

(f) The Administrative Director shall retain the right to determine the eligibility of a request for independent medical review under this section until an appeal of the final independent medical review determination issued under section 9792.10.6(e) that determines the medical necessity of the disputed medical treatment has been filed with the Workers' Compensation Appeals Board, or the time in which to file such an appeal has expired.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.4. Independent Medical Review – Assignment and Notification.

(a) The independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 (IMRO) may consolidate two or more eligible applications for independent medical review by a single employee for resolution in a single determination if the applications involve the same requesting physician and the same date of injury.

(b) Within one business day following receipt of the Administrative Director's finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 shall notify the employer, employee, if the employee is represented the employee's attorney, and the requesting physician in writing that the dispute has been assigned to that organization for review. The notification shall contain:

(1) The name and address of the independent review organization;

(2) Identification of the disputed medical treatment, including the date of the request for authorization (if available), the name of the requesting physician, and the date of the claims administrator's utilization review decision.

(3) The date the Application for Independent Medical Review, DWC Form IMR, was received by the Independent Review Organization.

(4) A statement whether the independent medical review will be conducted on a regular or expedited basis.

(5) For regular review, a statement that within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically, the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to \$5,000.00.

(6) For expedited review, a statement that within twenty-four (24) hours following receipt of the notification the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to \$5,000.00.

(c) Review conducted on a regular basis shall be converted into an expedited review if, subsequent to the receipt of the Application for Independent Medical Review, DWC Form IMR, the independent review organization receives from the employee's treating physician written

certification with supporting documentation verifying that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j). The independent review organization shall immediately notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.5. Independent Medical Review – Medical Records.

(a) (1) Within fifteen (15) days following the mailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for expedited review within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the claims administrator all of the following documents:

(A) A copy of all reports of the physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination. If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy of all reports relevant to the employee's current medical condition produced within the described six month period by any prior treating physician or referring physician.

(B) A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.1(e)(5), which notified the employee that the disputed medical treatment was denied, delayed or modified. Neither the written determination nor the application's instructions should be included.

(C) Other than the written determination by the claims administrator issued under section 9792.9.1(e)(5), a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.

(D) A copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment.

(E) A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity.

(F) The claims administrator's response to any additional issues raised in the employee's application for independent medical review.

(2) The claims administrator shall, concurrent with the provision of documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).

(3) Any newly developed or discovered relevant medical records in the possession of the claims administrator after the documents identified in subdivision (a) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The claims administrator shall concurrently provide a copy of medical records required by this subdivision to the employee, or the employee's representative, or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law.

(b) (1) Within fifteen (15) days following the mailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for expedited review, within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the employee, if represented the employee's attorney, or any party identified in section 9792.10.1(b)(2), any of the following documents:

(i) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(ii) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(iii) 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.

(2) The employee, if represented the employee's attorney or any party identified in section 9792.10.1(b)(2) shall, concurrent with the provision of documents under subdivision (b), forward the documents provided under subdivision (b) on the claims administrator, except that documents previously provided to the claims administrator need not be provided again if a list of those documents is served.

(3) Any newly developed or discovered relevant medical records in the possession of the employee, if represented the employee's attorney, or any party identified in section 9792.10.1(b)(2), after the documents identified in subdivision (b) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The employee, if represented the employee's attorney, or any party identified in section 9792.10.1(b)(2), shall concurrently provide a copy of medical records required by this subdivision to the claims administrator, unless the offer of medical records is declined or otherwise prohibited by law.

(c) At any time following the submission of documents under subdivision (a) and (b), the independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

(d) The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.6. Independent Medical Review – Standards and Timeframes.

(a) The independent medical review process may be terminated at any time upon notice by the claims administrator to the independent review organization that the disputed medical treatment has been authorized.

(b)(1) Upon assignment of the disputed medical treatment for independent medical review, the independent review organization shall designate a medical reviewer to conduct an examination of the documents submitted pursuant to section 9792.10.5 and issue a determination, using plain language where possible, as to whether the disputed medical treatment is medically necessary. For the purpose of independent medical review, “medically necessary” means medical treatment that is reasonably required to cure or relieve the employee of the effects of their injury and based on the standards set forth in Labor Code section 4610.5(c)(2).

(2) If a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may, issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.1(e)(5), and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review determination shall issue based solely on the information provided by a utilization review determination.

(c) The independent review organization, upon written approval by the Administrative Director, may utilize more than one medical reviewer to reach a determination regarding the medical necessity of a disputed medical treatment if it is found that the employee’s condition and the disputed medical treatment is sufficiently complex such that a single reviewer could not reasonably address all disputed issues.

(d) The determination issued by the medical reviewer shall state whether the disputed medical treatment is medically necessary. The determination shall include the employee’s medical condition, a list of the documents reviewed, a statement of the disputed medical treatment, references to the specific medical and scientific evidence utilized and the clinical reasons regarding medical necessity.

(e) The independent review organization shall provide the Administrative Director, the claims administrator, the employee, if represented the employee’s attorney, and the employee’s provider with a final determination regarding the medical necessity of the disputed medical treatment. With the final determination, the independent review organization shall provide a description of the qualifications of the medical reviewer or reviewers and the determination issued by the medical reviewer.

(1) If more than one medical reviewer reviewed the case, the independent review organization shall provide each reviewer’s determination.

(2) The recommendation of the majority of medical reviewers shall prevail. If the reviewers are evenly split as to whether the disputed medical treatment should be provided, the decision shall be in favor of providing the treatment.

(f) The independent review organization shall keep the names of the reviewer, or reviewers if applicable, confidential in all communications with entities or individuals outside the independent review organization.

(g) Timeframes for final determinations:

(1) For regular review, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

(A) If two (2) or more requests for independent medical review are consolidated under section 9792.10.4(a), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the last filed application for independent medical review that was consolidated for determination and the supporting documentation and information for that application.

(B) If, under section 9792.10.1(d)(3), an internal utilization review appeal modifies a utilization review determination for which an application for independent medical review was previously filed under section 9792.10.1(b), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the application for independent medical review requesting review of the modified treatment, and the supporting documentation and information for that application.

(2) For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

(3) Subject to the approval of the Administrative Director, the deadlines for final determinations from the independent review organization, involving both regular and expedited reviews, may be extended for up to three days in extraordinary circumstances or for good cause.

(h) The final determination issued by the independent review organization shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.

(i) Upon receipt of credible information that the claims administrator has failed to comply with its obligations under the independent medical review requirements set forth in Labor Code sections 4610.5 or in sections 9792.6 through 9792.10.8 of this Article, the Administrative Director shall, concurrent or subsequent to the issuance of the final determination issued by the independent review organization, issue an order to show cause under section 9792.15 for the

assessment of administrative penalties against the claims administrator under section 9792.12(c).

Authority: Sections 133, 4603.5 4610.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.7. Independent Medical Review – Implementation of Determination and Appeal.

(a) Upon receiving the final determination of the Administrative Director that a disputed medical treatment is medically necessary, the claims administrator shall, unless an appeal is filed under subdivision (c) or liability for the treatment is disputed as described in subdivision (a)(3), promptly implement the determination.

(1) In the case of reimbursement for services already rendered, the claims administrator shall reimburse the provider or employee, whichever applies, within twenty (20) days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive.

(2) In the case of services not yet rendered, the claims administrator shall authorize the services within five (5) working days of receipt of the final determination, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(3) If, at the time of receiving the final determination, the claims administrator is disputing liability for the medical treatment on grounds other than medical necessity, implementation of the final determination shall be deferred until the liability dispute has been resolved.

(b) Upon receipt of credible information that the claims administrator has failed to implement the final determination as required in subdivision (a), the Administrative Director shall issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c).

(c) The parties may appeal a final determination of the Administrative Director by filing a petition with the Workers' Compensation Appeals Board.

(d) If the final determination of the Administrative Director is reversed by the Workers' Compensation Appeals Board, the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

(1) Submit the dispute to independent medical review by a different independent review organization, if available;

(2) If a different independent medical review organization is not available after remand, the Administrative Director shall submit the dispute to the original independent review organization for review by a different reviewer in the organization.

Authority: Sections 133, 4603.5, 4610.6 and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.8. Independent Medical Review – Payment for Review.

(a) The costs of independent medical review and the administration of the independent medical review system shall be borne by claims administrators. For each Application for Independent Medical Review, DWC Form IMR, assigned to an independent review organization for an independent medical review of a disputed medical treatment, the fee for the claims administrator shall be:

(1) For calendar year 2013:

(A) For regular review:

(i) \$560.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds an M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$760.00

(ii) \$495.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds a degree other than an M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$655.00

(B) For expedited review:

(i) \$685.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds an M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$850.00.

(ii) \$595.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds a degree other than an M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$760.00.

(C) For withdrawn reviews:

(i) \$215.00 for each application where review is terminated by the independent review organization prior to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer.

(ii) If the review of an application and documentation and information provided under section 9792.10.5 is terminated by the independent review organization during or subsequent to the review of by a medical reviewer, the cost will be the same as if a determination under section 9792.10.6(b) had been issued by the medical reviewer.

(2) For calendar year 2014:

(A) For regular review:

(i) \$550.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds a M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$740.00.

(ii) \$475.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds a degree other than an M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$635.00.

(B) For expedited review:

(i) \$645.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds a M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$830.00.

(ii) \$575.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who: (1) is a physician as defined by Labor Code section 3209.3; and (2) holds a degree other than an M.D. or D.O. degree. If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers as defined in this provision, the cost is \$740.00.

(C) For withdrawn reviews:

(i) \$215.00 for each application where review is terminated by the independent review organization prior to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer.

(ii) If the review of an application and documentation and information provided under section 9792.10.5 is terminated by the independent review organization subsequent to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer, the cost will be the same as if a determination under section 9792.10.6(b) had been issued by the medical reviewer.

(b) The independent medical review organization shall bill each claims administrator for payment in arrears for every independent medical review initiated under this Article that was completed or terminated prior to completion. Invoices shall identify each independent medical review, the fees assessed for each review, and the aggregate total fee owed by the claims administrator.

(c) The aggregate total fee owed by the claims administrator for the prior calendar month shall be paid to the independent medical review organization within thirty (30) days of the billing. If the aggregate total fee is not paid within ten (10) days after it becomes due, there shall be added an additional amount equal to 10 percent, plus interest at the legal rate, which shall be paid at the same time but in addition to the total aggregate fee.

(d) The fees paid by claims administrators for independent medical review under this section are non-refundable and not subject to discount or rebate. Any questions or disputes over the aggregate total fee and additional payments owed by the claims administrator under subdivision (c), late payments, and untimely determinations shall be submitted to the Administrative Director for informal resolution. Any request to resolve a dispute must be accompanied by a written statement setting forth the amount in dispute and the nature of the dispute.

Authority: Sections 133, 4603.5, 5307.3, and 4610.6, Labor Code.

Reference: Sections 4610, 4610.5, and 4610.6, Labor Code.

§ 9792.10.9. Independent Medical Review – Publishing of Determinations.

The Administrative Director may publish the results of independent medical review determinations after removing all individually identifiable information as defined in Labor Code section 138.7, including, but not limited to, the employee, all medical providers, the claims administrator, any of the claims administrator's employees or contractors, or any utilization review organization.

Authority: Sections 133, 4603.5, 5307.3, and 4610.6, Labor Code.

Reference: Sections 4610, 4610.5, and 4610.6, Labor Code.

§ 9792.11. Investigation Procedures: Labor Code § 4610 Utilization Review Violations.

(a) To carry out the responsibilities mandated by Labor Code Section 4610(i), the Administrative Director, or his or her designee, shall investigate the utilization review process of any employer, insurer or other entity subject to the provisions of section 4610. The investigation shall include, but not be limited to, review of the practices, files, documents and other records, whether electronic or paper, of the claims administrator, and any other person responsible for utilization review processes for an employer. As used in sections 9792.11 through 9792.15, the phrase 'utilization review organization' includes any person or entity with which the employer, or an insurer, or third party administrator, contracts to fulfill part or all of the employer's utilization review responsibilities under Labor Code section 4610 and Title 8 of the California Code of Regulations, sections 9792.6 through 9792.15.

(b) Notwithstanding Labor Code section 129(a) through (d) and section 129.5 subdivisions (a) through (d), the Administrative Director, or his or her designee, may conduct a utilization review investigation pursuant to Labor Code section 4610, which may include, but is not limited to, an audit of files and other records.

(c) The Administrative Director, or his or her designee, may conduct a utilization review investigation at any location where Labor Code Section 4610 utilization review processes occur, as follows:

(1) For utilization review organizations:

(A) A Routine Investigation shall be initiated at each known utilization review organization at least once every five (5) years. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(q) or section 9792.6.1(t), received by the utilization review organization during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(B) Target Investigations:

1. A Return Target Investigation of the same investigation subject shall be conducted within 18 months of the date of the previous investigation if the performance rating was less than eighty-five percent.

2. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

3. The Return Target Investigation and the Special Target Investigation may include: (i) a review of the requests for authorization previously investigated which contained violations; (ii) a review of the file or files pertaining to the complaint or possible violation; (iii) a random sample of requests for authorization received by the utilization review organization during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation; (iv) a sample of a specific type of request for authorization; and (v) any credible complaints received by the Administrative Director since the time of any prior investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(2) For a claims administrator:

(A) A Routine Investigation shall be initiated at each claims adjusting location at least once every five (5) years concurrent with the profile audit review done pursuant to Labor Code sections 129 and 129.5. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(q) or section 9792.6.1(t), received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the

previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(B) Target Investigations:

1. A Return Target Investigation of the same investigation subject shall be conducted within 18 months of the date of any previous investigation if the performance rating was less than eighty-five percent.

2. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

3. The Return Target Investigation and the Special Target Investigation may include: (i) a review of the requests for authorization previously investigated which contained violations; (ii) a review of the file or files pertaining to the complaint or possible violation; (iii) a random sample of requests for authorization received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation; (iv) a sample of a specific type of request for authorization; and (v) any credible complaints received by the Administrative Director since the time of any prior investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(d) The number of requests for authorization randomly selected for investigation shall be determined based on the following table:

Population of requests for authorization received during a three month calendar period Sample Size

5 or less	all
6-10	1 less than total
11-13	2 less than total
14-16	3 less than total
17-18	4 less than total
19-20	5 less than total
21-23	6 less than total
24	17
25-26	18
27-29	19
30-31	20
32-33	21
34-36	22

37-39	23
40-41	24
42-44	25
45-48	26
49-51	27
52-55	28
56-58	29
59-62	30
63-67	31
68-72	32
73-77	33
78-82	34
83-88	35
89-95	36
96-102	37
103-110	38
111-119	39
120-128	40
129-139	41
140-151	42
152-164	43
165-179	44
180-197	45
198-217	46
218-241	47
242-269	48
270-304	49
305-346	50
347-399	51
400-468	52
469-562	53
563-696	54
697-905	55
906-1,272	56
1,273-2,091	57
2,092-5,530	58
5,531 +	59

(e) Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers' Compensation using the sample complaint form that is posted on the Division's website at:

<http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf>

Complaints should be mailed to DWC Medical Unit-UR, P.O. Box 71010, Oakland, CA 94612, attention UR Complaints or emailed to DWCMangedCare@dir.ca.gov. Complaints received by

the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

(f) Administrative penalties may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, except that the penalties listed in section 9792.12(a)(6) through (14) and (b) shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process.

(g) In the event an investigation of utilization review processes is done at the claims administrator's adjusting location, concurrent with a profile audit review done pursuant to Labor Code section 129 or 129.5, the administrative penalty amounts for each violation of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, shall be governed by sections 9792.11 through 9792.15. Any such administrative penalty for utilization review process violations shall apply in lieu of the administrative penalty amount allowed under the audit regulations at section 10111.2(b)(8)[vi] of Title 8, California Code of Regulations. In addition, any report of findings from the investigation and any Order to Show Cause re: Assessment of Administrative Penalties prepared by the Administrative Director, or his or her designee, based on violations of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, shall be prepared separately from any audit report or assessment of administrative penalties made pursuant to Labor Code section 129 and 129.5. The Order to Show Cause re: Assessment of Administrative Penalties for violations of sections 9792.6 et seq. of Title 8 of the California Code of Regulations shall be governed by sections 9792.11 through 9792.15.

(h) The Administrative Director, or his or her designee, may also utilize the provisions of Government Code sections 11180 through 11191 to determine whether any violations of the requirements in Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, have occurred.

(i) Sections 9792.11 through 9792.15 of Title 8 of the California Code of Regulations shall apply to any Labor Code section 4610 utilization review investigation conducted on or after the effective date of sections 9792.11 through 9792.15 and for conduct which occurred on or after the effective date of sections 9792.11 through 9792.15.

(j) Unless the Administrative Director in his or her discretion determines that advance notice will render a Special Target or Return Target Investigation less useful, the claims administrator or utilization review organization shall be notified of its selection for an Investigation. Claims administrators and utilization review organizations shall be sent a Notice of Utilization Review Investigation. The Notice of Utilization Review Investigation shall require the investigation subject to provide the following:

(1) A description of the system used to identify each request for authorization (if applicable). To the extent the system identifies any of the following information in an electronic format, the claims administrator or utilization review organization shall provide in an electronic format a list of each and every request for authorization received at the investigation site during a three month

calendar period specified by the Administrative Director, or his or her designee, and the following data elements: i) a unique identifying number for each request for authorization if one has been assigned; ii) the name of the injured worker; iii) the claim number used by the claims adjuster; iv) the initial date of receipt of the request for authorization; v) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal); vi) the disposition (approve, deny, delay, modify, withdrawal); and, vii) if applicable, the type of person who withdrew the request (requesting physician, claims adjuster, injured employee or his or her attorney, or other person). In the event the claims administrator or utilization review organization is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed requests for authorization are sorted in the following order: by type of utilization review, type of disposition, and date of receipt of the initial request;

(2) A description of all media used to transmit, share, record or store information received and transmitted in reference to each request, whether printed copy, electronic, fax, diskette, computer drive or other media;

(3) A legend of any and all numbers, letters and other symbols used to identify the disposition (e.g. approve, deny, modify, delay or withdraw), type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal), and other abbreviations used to document individual requests for authorization and a data dictionary for all data elements provided;

(4) A description of the methods by which the medical director for utilization review ensures that the process by which requests for authorization are reviewed and approved, modified, delayed, or denied is in compliance with Labor Code section 4610 and sections 9792.6 through 9792.10.1 and

(5) The following additional information, may be requested by the Administrative Director or his or her designee, as applicable to the type of entity investigated: i) whether utilization review services are provided externally; ii) the name(s) of the utilization review organization(s); iii) the name and address of the employer; and iv) the name and address of the insurer.

(k) The utilization review organization or claims administrator shall provide the requested information listed in subdivision (j) within fourteen (14) calendar days of receipt of the Notice of Utilization Review Investigation. Based on the information provided, the Administrative Director, or his or her designee, shall provide the claims administrator or utilization review organization with a Notice of Investigation Commencement, which shall include a list of randomly selected requests for authorization from a three month calendar period designated by the Administrative Director and complaint files (if applicable) for investigation.

(l) For utilization review organizations: Within fourteen (14) calendar days of receipt from the Administrative Director, or his or her designee, of the Notice of Investigation Commencement, the utilization review organization shall deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether electronic or paper, for each request for authorization listed. Copies of the records shall be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held,

attesting that all of the records produced are true, correct and complete copies of the originals, in his or her possession. After reviewing the records, the Administrative Director, or his or her designee, shall determine if an onsite investigation is required. If an onsite investigation is required, fourteen (14) calendar days notice shall be provided to the utilization review organization.

(m) For claims administrators: The Notice of Investigation Commencement shall be provided to the claims administrator at least fourteen (14) calendar days prior to the commencement of the onsite investigation. The claims administrator shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.

(n) In the event the Administrative Director, or his or her designee, determines additional records or files are needed for review during the course of an onsite investigation, the claims administrator or utilization review organization shall produce the requested records in the manner described by subdivision 9792.11(k), within one (1) working day when the records are located at the site of investigation, and within five (5) working days when the records are located at any other site. Any such request by the Administrative Director or his or her designee also may include records or files pertaining to any complaint alleging violations of Labor Code sections 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations. The Administrative Director or his or her designee may extend the time for production of the requested records for good cause.

(o) If the date or deadline in sections 9792.9(b) and (c), or section 9792.9.1(c), to perform any act related to utilization review practices falls on a weekend or holiday, for the purposes of assessing penalties, the act may be performed on the next normal business day, as defined by Labor Code section 4600.4 and Civil Code section 9. This subdivision shall not apply in cases involving concurrent or expedited review. The timelines in sections 9792.9(b) shall only be extended as provided under section 9792.9(g); the timelines in sections 9792.9.1(c) shall only be extended as provided under section 9792.9.1(f).

(p) If the claims administrator or utilization review organization does not record the date a document is received, it shall be deemed received by using the method set out in section 9792.9(a)(2) or section 9792.9.1(a)(2), except that:

(1) where the request for authorization is made by mail through the U.S. postal service and no proof of service by mail exists, the request shall be deemed to have been received by the claims administrator, or utilization review organization on whichever date is earlier, either the receipt date stamped by the addressee or within five (5) calendar days of the date stated in the request for authorization or where the addressee can show a delay in mailing by the postmark date on the mailing envelope then: (A) within five (5) calendar days of the postmark date, if the place of mailing and place of address are both within California; (B) within ten (10) calendar days if the

place of address is within the United States but outside of California; or (C) within twenty (20) calendar days if the place of address is outside of the United States; and

(2) where the request for authorization is made by express mail, overnight mail or courier without any proof of service, the request shall be deemed received by the addressee on the date specified in any written confirmation of delivery.

(q) Upon initiating a Special Target Investigation, the Administrative Director, or his or her designee, shall provide to the claims administrator or the utilization review organization a written description of the factual information or of the complaint containing factual information or a copy of the complaint that triggered the utilization review investigation, unless the Administrative Director or his or her designee determines that providing the information would make the investigation less useful. The claims administrator or utilization review organization shall have ten (10) business days upon receipt of the written description or copy of the complaint to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further investigation to determine whether a violation exists and whether to impose penalty assessments.

(r) For utilization review organizations: The files and other records, whether electronic or paper, that pertain to the utilization review process shall be retained for at least three (3) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later. Claims administrators shall retain their claim files as set forth in section 10102 of Title 8 of the California Code of Regulations.

(s) Upon receipt of a notice of Routine or Target Investigation or any other request from the Administrative Director, or his or her designee, to review all files and other records pertaining to the employer's utilization review process, whether electronic or paper, that are created or held outside of California, the claims administrator or utilization review organization shall either deliver all such requested files and other records to an address in California specified by the Administrative Director, or his or her designee, or reimburse the Administrative Director for the actual expenses of each investigator who travels outside of California to the place where the records are held, including the per diem expenses, travel expenses and compensated overtime of the investigators.

(t) A preliminary investigation report will be provided to the claims administrator or utilization review organization. The preliminary investigation report shall consist of the preliminary notice of utilization review penalty assessments, the performance rating, and may include one or more requests for additional documentation or compliance. A conference to discuss the preliminary investigation report shall be scheduled, if necessary, within twenty-one calendar days from the issuance of the preliminary findings. Following the conference, the Administrative Director or his or her designee shall issue an Order to Show Cause Re: Assessment of Administrative Penalty (which shall include the final investigation report), as set forth in section 9792.15.

(u) The claims administrator or utilization review organization may stipulate to the allegations and final report set forth in the Order to Show Cause.

(v) Within forty-five (45) calendar days of the service of the Order to Show Cause Re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or utilization review organization shall provide the following:

(1) A notice, which shall include a copy of the final investigation report, the measures actually implemented to abate such conditions, and the website address for the Division where the performance rating and summary of violations is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report.

(2) For utilization review organizations: the notice must be served on any employer or third party claims administrator that contracted with the utilization review organization and whose utilization review process was assessed with a penalty pursuant to section 9792.12, and any insurer whose utilization review process was assessed with a penalty pursuant to section 9792.12.

(3) For claims administrators: the notice must be served on any self-insured employer and any insurer whose utilization review process was assessed with a penalty pursuant to section 9792.12.

(4) The notice shall be served by certified mail.

(5) Documentation of compliance with this section shall be served on the Administrative Director within thirty calendar days from the date the notice was served.

Authority: Sections 11180-11191, Government Code; and Sections 133, 4610 and 5307.3, Labor Code.

Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

§ 9792.12. Administrative Penalty Schedule for Utilization Review and Independent Medical Review Violations.

(a) Mandatory Utilization Review Administrative Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty amount that shall be assessed for each failure to comply with the utilization review process required by Labor Code section 4610, and sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, is:

- (1) For failure to establish a Labor Code section 4610 utilization review plan: \$ 50,000;
- (2) For failure to include all of the requirements of section 9792.7(a) in the utilization review plan: \$ 5,000;
- (3) For failure to file the utilization review plan or a letter in lieu of a utilization review plan with the Administrative Director as required by section 9792.7(c): \$ 10,000;
- (4) For failure to file a modified utilization review plan with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan as required by section 9792.7(c): \$ 5,000;
- (5) For failure to employ or designate a physician as a medical director, as defined in section 9792.6(l), of the utilization review process, as required by section 9792.7(b): \$ 50,000;
- (6) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): \$ 25,000;
- (7) For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in Labor Code section 4604.5(c): \$ 25,000;
- (8) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request without documenting the amended request as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: \$ 1,000;
- (9) For failure to communicate the decision in response to a request for an expedited review, as defined in section 9792.6(g), in a timely fashion, as required by section 9792.9 and section 9792.9.1: \$ 15,000;
- (10) For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the medical treatment utilization schedule adopted pursuant to section 5307.27 of the Labor Code: \$ 5,000;

(11) For failure to discuss or document attempts to discuss reasonable options for a care plan with the requesting physician as required by Labor Code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical care, in the case of concurrent review: \$ 10,000;

(12) For failure to respond to a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: \$ 2,000;

(13) For failure to respond to a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted for authorization by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: \$ 1,000;

(14) For failure to respond to a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, in the case of a retrospective review: \$ 500;

(15) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines to the public, as required by Labor Code section 4610, subdivision (f)(5) and section 9792.7(d) of Title 8 of the California Code of Regulations: \$ 100.

(16) For failure to timely serve the Administrative Director with documentation of compliance pursuant to section 9792.11(v)(5): \$ 500.

(17) For failure to timely comply with any compliance requirement listed in the Final Report, if no timely answer was filed or any compliance requirement listed in the Determination and Order after any and all appeals have become final: \$ 500.

(b) Additional Utilization Review Penalties and Remediation.

(1) After conducting a Routine or Return Target Investigation, the Administrative Director, or his or her designee, shall calculate the investigation subject's performance rating based on its review of the randomly selected requests. The investigation subject's performance rating may also be calculated after conducting a Special Target Investigation. The performance rating will be calculated as follows:

(A) The factor for failure to make and/or provide a timely response to a request for authorization shall be determined by dividing the number of randomly selected requests with violations involving failure to make or provide a timely response to a request for authorization by the total number of randomly selected requests.

(B) The factor for notice(s) with faulty content shall be determined by dividing the number of requests involving notice(s) with faulty content by the total number of randomly selected requests.

(C) The factor for failure to issue notice(s) to all appropriate parties shall be determined by the number of requests involving the failure to issue notice(s) to all appropriate parties by the total number of randomly selected requests.

(D) The investigation subject's investigation performance rating will be determined by adding the factors calculated pursuant to subsections (b)(1)(A) through (b)(1)(C), dividing the total by three, subtracting from one, and multiplying by one-hundred.

(E) If the investigation subject's performance rating meets or exceeds eighty-five percent, the Administrative Director, or his or her designee, shall assess no penalties for the violations listed in this subdivision. If the performance rating is less than eighty-five percent, the violations shall be assessed as set forth below in (b)(2) through (b)(5):

(2) For the types of violations listed below in (b)(4) and (b)(5), each violation shall have a penalty amount, as specified of \$ 100 in (b)(4) or \$ 50 in (b)(5). The penalty amount specified in (b)(4) and (b)(5) shall be waived if the investigation subject's performance rating meets or exceeds eighty-five percent, or if following a Routine Investigation the claims administrator or utilization review organization agrees in writing to:

(A) Deliver to the Administrative Director, or his or her designee, within no more than thirty (30) calendar days from the date of the agreement or the number of days otherwise specified, written evidence, tendered with a declaration made under penalty of perjury, that explains or demonstrates how the violation has been abated in compliance with the applicable statute or regulations and the terms of abatement specified by the Administrative Director; and

(B) Grant the Administrative Director, or his or her designee, entry, upon request and within the time frame specified in the agreement, to the site at which the violation was found for a Return Target Investigation for the purpose of verifying compliance with the abatement measures reported in subdivision 9792.12(b)(1)(A) above and agree to a review of randomly selected requests for authorization; and

(C) Reinstatement of the penalty amount previously waived for each such instance, in the event the violative condition is not abated within the time period specified by the Administrative Director, or his or her designee, or in the event that such abatement measures are not consistent with abatement terms specified by the Administrative Director, or his or her designee.

(3) In the event the Administrative Director, or his or her designee, returns for a Return Target Investigation, after the initial violation has become final, and the subject fails to meet the performance standard of 85%, the amount of penalty shall be calculated as described below and in no event shall the penalty amount be waived:

(A) The penalty amount for each violation shall be multiplied by two for a second investigation, but in no event shall the total penalties for the violations exceed \$ 100,000;

(B) The penalty amount for each violation shall be multiplied by five for a third investigation, but in no event shall the total penalties for the violations exceed \$ 200,000;

(C) The penalty amount for each violation shall be multiplied by ten for a fourth investigation, but in no event shall the total penalties for the violations exceed \$ 400,000.

(4) For each of the violations listed below, the penalty amount shall be \$ 100.00 for each instance found by the Administrative Director, or his or her designee:

(A) For failure to immediately notify all parties in the manner described in section 9792.9(h)(2) and section 9792.9.1(f)(2) of the basis for extending the decision date for a request for medical treatment;

(B) For failure to document efforts to obtain information from the requesting party prior to issuing a denial of a request for authorization on the basis of lack of reasonable and necessary information;

(C) For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, or receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(h)(3) and section 9792.9.1(f)(3) and section 9792.9.1(f)(4);

(D) For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, or receipt of the requested information, as required by section 9792.9(h)(4) and section 9792.9.1(e)(4), and (f)(6);

(E) Except as provided in subdivision (a), for failure to include in the written decision that modifies, delays or denies authorization, all of the items required by section 9792.9(k) and(l), and section 9792.9.1(e);

(F) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines, to the injured employee whose case is under review, as required by Labor Code section 4610(f)(5) and section 9792.8(a)(3) Title 8 of the California Code of Regulations.

(5) For each of the violations listed below, the penalty amount shall be \$ 50.00 for each instance found by the Administrative Director, or his or her designee:

(A) For failure by a non-physician or physician reviewer to timely notify the requesting physician, as required by section 9792.9(c)(2) or section 9792.9.1(f)(2), that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9(c) or section 9792.9.1(c);

(B) For failure to communicate the decision to approve to the requesting physician in the case of prospective or concurrent review, by phone or fax within 24 hours of the decision, as required by

Labor Code section 4610(g)(3)(A) and in accordance with section 9792.9(c)(3) or section 9792.9.1(d)(2);

(C) For failure to send a written notice of the decision to modify, delay or deny to the requesting party, and to the injured employee and to his or her attorney if any, within twenty four (24) hours of making the decision for concurrent review, or within two business days for prospective review, as required by Labor Code section 4610(g)(3)(A) and section 9792.9(c)(4) or section 9792.9.1(e)(3);

(D) For failure to send a written notice of the decision in the case of retrospective review as required by section 9792.9(d) or section 9792.9.1(d)(3) and (e)(4) within thirty (30) days of receipt of the medical information that was reasonably necessary to make the determination;

(E) For failure to document that one of the following events occurred prior to the claims administrator providing written notice for delay under Labor Code section 4610(g)(5):

(1) the claims administrator had not received all of the information reasonably necessary and requested;

(2) the employer or claims administrator has requested a consultation by an expert reviewer;

(3) the physician reviewer has requested an additional examination or test be performed;

(F) Reserved.

(G) For failure to explain in writing the reason for delay as required by section 9792.9(h)(2) or section 9792.9.1(f)(2) of Title 8 of the California Code of Regulations when the decision to delay was made under one of the circumstances listed in section 9792.9(h)(1) or section 9792.9.1(f)(1).

(6) After the time to file an answer to the Order to Show Cause Re: Assessment of Administrative Penalties has elapsed and no answer has been filed or after any and all appeals have become final, the Administrative Director, or his or her designee, shall post on the website for the Division of Workers' Compensation the performance rating and summary of violations for each utilization review investigation.

(c) Independent Medical Review Administrative Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty amount that shall be assessed for each failure to comply with the independent medical review process required by Labor Code sections 4610.5 and 4610.6, and sections 9792.6 through 9792.10.8 of this Article is:

(1) For the failure to provide the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1: \$2,000.

(2) For the failure to complete all applicable fields on the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, that is provided with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1:

(A) \$500 for a failure to provide the Employee Name, Address, Phone Number, and Date of Injury;

(B) \$500 for a failure to provide the Requesting Physician Name, Address, Specialty, and Phone Number;

(C) \$500 for a failure to provide the Claims Administrator Name, Adjustor/Contact Name, Address, and Phone Number;

(D) \$500 for a failure to complete any field under the section heading “Disputed Medical Treatment;”

(E) \$100 for a failure to provide any field not identified above.

(3) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1 a clear statement that advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, within 30 days of service of the utilization review decision: \$1,000.

(4) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1 a statement detailing the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis: \$1,000.

(5) For the failure to timely provide information requested by the Administrative Director under section 9792.10.3(b): \$500.00 for each day the response is untimely under section 9792.10.3(c), up to a maximum of \$5,000.00.

(6) For the failure to timely provide all information required by section 9792.10.5(a) and (c): \$500.00 for each day the response is untimely up to a maximum of \$5,000.00.

(7) For the failure to authorize services found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within either five (5) business days of receipt of the determination, or sooner if appropriate for the employee's medical condition, or five (5) business days from the date the determination is final,

if an appeal of the determination has been filed under Labor Code section 4610.6(h): \$1,000.00 for each day up to a maximum of \$5,000.00.

(8) For the failure to reimburse for services already rendered that has been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h), subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive: \$500.00 for each day up to a maximum of \$5,000.00

(9) For the failure to timely pay an invoice sent from the designated independent medical review organization under section 9792.10.8(c): \$250.00

(d) The Administrative Director, or his or her designee, may assess both an administrative penalty under either Labor Code sections 4610.5 and 4610.6, and a civil penalty under Labor Code section 129.5(e), based on the same violation(s).

(e) The penalty amounts specified for violations under this section may, in the discretion of the Administrative Director, be reduced after consideration of the factors set out in section 9792.13 of Title 8 of the California Code of Regulations. Failure to abate a violation found under section 9792.12(b)(4) and (b)(5), in the time period or in a manner consistent with that specified by the Administrative Director, or his or her designee, shall result in the assessment of the full original penalty amount proposed by the Administrative Director for that violation.

Authority: Sections 133, 4610, 4610.5, 4610.6 and 5307.3, Labor Code.

Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4610.5, 4610.6, and 4614, Labor Code.

§ 9792.15. Administrative Penalties Pursuant to Labor Code §§ 4610, 4610.5, and 4610.6 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure.

(a) Pursuant to Labor Code sections 4610(i), 4610.5(i), and 4610.6(k), the Administrative Director shall issue an Order to Show Cause Re: Assessment of Administrative Penalty when the Administrative Director, or his or her designee (the investigating unit of the Division of Workers' Compensation), has reason to believe that an employer, insurer or other entity subject to Labor Code sections 4610(i), 4610.5(i), and 4610.6(k), has failed to meet any of the requirements of this section or of any regulation adopted by the Administrative Director pursuant to the authority of sections 4610(i), 4610.5(i), and 4610.6(k),

(b) The order shall be in writing and shall include all of the following:

(1) Notice that an administrative penalty may be assessed:

(2) For administrative penalties assessed under section 4610(i), the final investigation report, which shall consist of the notice of utilization review penalty assessment, the performance rating, and may include one or more requests for documentation or compliance;

(3) For administrative penalties assessed under sections 4610.5(i) and 4610.6(k), the basis for the penalty assessment, including a statement of the alleged violations and the amount of each proposed penalty.

(4) A description of the methods for paying or appealing the penalty assessment.

(c) The order shall be served personally or by registered or certified mail.

(d) Within thirty (30) calendar days after the date of service of the Order to Show Cause Re: Assessment of Administrative Penalties, the claims administrator or utilization review organization may pay the assessed administrative penalties or file an answer as the respondent with the Administrative Director, in which the respondent may:

(1) Admit or deny in whole or in part any of the allegations set forth in the Order to Show Cause;

(2) Contest the amount of any or all proposed administrative penalties;

(3) Contest the existence of any or all of the violations;

(4) Set forth any affirmative and other defenses;

(5) Set forth the legal and factual bases for each defense.

(e) Any allegation and proposed penalty stated in the Order to Show Cause that is not contested shall be paid within thirty (30) calendar days after the date of service of the Order to Show Cause.

(f) Failure to timely file an answer shall constitute a waiver of the respondent's right to an evidentiary hearing. Unless set forth in the answer, all defenses to the Order to Show Cause shall be deemed waived. If the answer is not timely filed, within ten (10) days of the date for filing the answer, the respondent may file a written request for leave to file an answer. The respondent may also file a written request for leave to assert additional defenses, which the Administrative Director may grant upon a showing of good cause.

(g) The answer shall be in writing and signed by, or on behalf of, the claims administrator or utilization review organization and shall state the respondent's mailing address. It need not be verified or follow any particular form.

(1) The respondent must file the original and one copy of the answer on the Administrative Director and concurrently serve one copy of the answer on the investigating unit of the Division of Workers' Compensation (designated by the Administrative Director). The original and all copies of any filings required by this section shall have a proof of service attached.

(h) Within sixty (60) calendar days of the issuance of the Order to Show Cause Re: Assessment of Administrative Penalty, the Administrative Director shall issue the Notice of the date, time and place of a hearing. The date of the hearing shall be at least ninety calendar days from the date of service of the Notice. The Notice shall be served personally or by registered or certified mail. Continuances will not be allowed without a showing of good cause.

(i) At any time before the hearing, the Administrative Director may file or permit the filing of an amended complaint or supplemental Order to Show Cause. All parties shall be notified thereof. If the amended complaint or supplemental Order to Show Cause presents new charges, the Administrative Director shall afford the respondent a reasonable opportunity to prepare its defense, and the respondent shall be entitled to file an amended answer.

(j) At the Administrative Director's discretion, the Administrative Director may proceed with an informal pre-hearing conference with the respondent in an effort to resolve the contested matters. If any or all of the violations or proposed penalties in the Order to Show Cause, the amended Order or the supplemental Order remain contested, those contested matters shall proceed to an evidentiary hearing.

(k) Whenever the Administrative Director's Order to Show Cause has been contested, the Administrative Director may designate a hearing officer to preside over the hearing. The authority of the Administrative Director or the designated hearing officer shall include, but is not limited to: conducting a pre-hearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere within the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas duces tecum for the production of documents and things at the hearing; presiding at the hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing pre-hearing orders; and preparing a Recommended Determination and Opinion based on the hearing.

(l) The Administrative Director or the designated hearing officer shall set the time and place for any pre-hearing conference on the contested matters in the Order to Show Cause, and shall give sixty (60) calendar days written notice to all parties.

(m) The pre-hearing conference may address one or more of the following matters:

(1) Exploration of settlement possibilities;

(2) Preparation of stipulations;

(3) Clarification of issues;

(4) Rulings on the identity of witnesses and limitation of the number of witnesses;

(5) Objections to proffers of evidence;

- (6) Order of presentation of evidence and cross-examination;
- (7) Rulings regarding issuance of subpoenas and protective orders;
- (8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing;
- (9) Any other matters as shall promote the orderly and prompt conduct of the hearing.
- (n) The Administrative Director or the designated hearing officer shall issue a pre-hearing order incorporating the matters determined at the pre-hearing conference. The Administrative Director or the designated hearing officer may direct one or more of the parties to prepare the pre-hearing order.
- (o) Not less than thirty (30) calendar days prior to the date of the evidentiary hearing, the respondent shall file and serve the original and one copy of a written statement with the Administrative Director or the designated hearing officer specifying the legal and factual bases for its answer and each defense, listing all witnesses the respondent intends to call to testify at the hearing, and appending copies of all documents and other evidence the respondent intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the written statement and supporting evidence are not timely filed and served, the Administrative Director or the designated hearing officer shall dismiss the answer and issue a written Determination based on the evidence provided by the investigating unit of the Division of Workers' Compensation. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence. The Administrative Director or the designated hearing officer may grant the request, upon a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.
- (p) Oral testimony shall be taken only on oath or affirmation.
- (q)(1) Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.
- (2) In the absence of a contrary order by the Administrative Director or the designated hearing officer, the investigating unit of the Division of Workers' Compensation shall present evidence first.
- (3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious

affairs, regardless of the existence of any common law or statutory rule which might make the admission of the evidence improper over objection in civil actions.

(4) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but upon timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case to the Administrative Director or to the designated hearing officer.

(r) The written affidavit or declaration of any witness may be offered and shall be received into evidence provided that (i) the witness was listed in the written statement pursuant to section 9792.15(n); (ii) the statement is made by affidavit or by declaration under penalty of perjury; (iii) copies of the statement have been delivered to all opposing parties at least twenty (20) days prior to the hearing; and (iv) no opposing party has, at least ten (10) days before the hearing, delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing. The Administrative Director or the designated hearing officer shall disregard any portion of the statement received pursuant to this regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible. Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted. If the Administrative Director or the designated hearing officer determines that good cause exists that prevents the witness from appearing at the hearing, the declaration may be introduced in evidence, but it shall be given only the same effect as other hearsay evidence.

(s) The Administrative Director or the designated hearing officer shall issue a written Determination and Order Assessing Penalty, if any, including a statement of the basis for the Determination and each penalty assessed, within sixty (60) days of the date the case was submitted for decision, which shall be served on all parties. This requirement is directory and not jurisdictional.

(t) The Administrative Director shall have sixty (60) calendar days to adopt or modify the Determination and Order Assessing Penalty issued by the Administrative Director or the designated hearing officer. In the event the recommended Determination and Order of the designated hearing officer is modified, the Administrative Director shall include a statement of the basis for the Determination and Order Assessing Penalty signed and served by the Administrative Director, or his or her designee. If the Administrative Director does not act within sixty (60) calendar days, then the recommended Determination and Order shall become the Determination and Order on the sixty-first calendar day.

(u) The Determination and Order Assessing Penalty shall be served on all parties personally or by registered or certified mail by the Administrative Director.

(v) The Determination and Order Assessing Penalty, if any, shall become final on the day it is served, unless the aggrieved party files a timely Petition Appealing the Determination of the Administrative Director. All findings and assessments in the Determination and Order Assessing

Penalty not contested in the Petition Appealing the Determination of the Administrative Director shall become final as though no petition were filed.

(w) At any time prior to the date the Determination and Order Assessing Penalty becomes final, the Administrative Director or designated hearing officer may correct the Determination and Order Assessing Penalty for clerical, mathematical or procedural error(s).

(x) Penalties assessed in a Determination and Order Assessing Penalty shall be paid within thirty (30) calendar days of the date the Determination and Order became final. A timely filed Petition Appealing the Determination of the Administrative Director shall toll the period for paying the penalty assessed for the item appealed.

(y) All appeals from any part or the entire Determination and Order Assessing Penalty shall be made in the form of a Petition Appealing the Determination of the Administrative Director, in conformance with the requirements of chapter 7, part 4 of Division 4 of the Labor Code. Any such Petition Appealing the Determination of the Administrative Director shall be filed at the Appeals Board in San Francisco (and not with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.

Authority: Sections 133, 4610, 4610.5, 4610.6, and 5307.3, Labor Code.

Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4610.5, 4610.6, 4614, and 5300, Labor Code.