STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers’ Compensation

**NOTICE OF PROPOSED RULEMAKING**

**Subject Matter of Regulations:**

**Workers’ Compensation – Utilization Review**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS**

**AMEND, ADOPT, OR REPEAL SECTIONS 9767.6, 9781, 9785, 9785.6, 9786, 9792.6, 9792.6.1, 9792.7, 9792.7.1, 9792.8, 9792.9, 9792.9.1, 9792.9.2, 9792.9.3, 9792.9.4, 9792.9.5, 9792.9.6, 9792.9.7, 9792.9.8, 9792.9.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.8, 9792.11, 9792.12, 9792.13, & 9792.15, 9792.27.1, & 9792.27.17**

**NOTICE IS HEREBY GIVEN** that the Administrative Director of the Division of Workers' Compensation, Department of Industrial Relations (hereinafter “Administrative Director”), pursuant to the authority vested in him by Labor Code sections 59, 133, 4603.5, 4610, 5307.3, and 5307.27, proposes to amend sections 9767.6 through 9727.27.17, to establish and implement legislative changes under Senate Bill 1160 relating to utilization review (“UR”) and related rules.

## PROPOSED REGULATORY ACTION

The Administrative Director proposes to amend, adopt, or delete, as specified, the following regulations into Article 3.5, Article 5, Article 5.5.1, and Article 5.5.2 of Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations:

**Article 3.5 Medical Provider Network**

Amend section 9767.6 Treatment and Change of Physicians within MPN

**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**

Amend section 9781 Employees Request for Change of Physician

Amend section 9785 Reporting Duties of the Primary Treating Physician

Adopt section 9785.6 DWC Form PR-1: “Treating Physician’s Report” Mandatory

for Services On or After 1/1/19

Amend section 9786 Petition for Change of Primary Treating Physician

**Article 5.5.1 Utilization Review Standards**

Delete section 9792.6 Utilization Review Standards—Definitions – For Utilization

Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013

Amend section 9792.6.1 Utilization Review Standards—Definitions – On or After

January 1, 2013

Amend section 9792.7 Utilization Review Standards—Applicability

Adopt section 9792.7.1 DWC Form UR-01: “Application for Approval as Utilization

Review Plan”

Amend section 9792.8 Utilization Review Standards – Medically-Based Criteria

Delete section 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**

Amend section 9792.9.1 Utilization Review Standards - - Timeframe, Procedures and

Notice – On or After July 1, 2013

Adopt section 9792.9.2 Utilization Review — Dispute of Liability; Deferral

Adopt section 9792.9.3 Utilization Review — Timeframes

Adopt section 9792.9.4 Utilization Review — Decisions to Approve a Request for

Authorization

Adopt section 9792.9.5 Utilization Review — Decisions to Modify or Deny a Request

for Authorization

Adopt section 9792.9.6 Utilization Review — Extension of Timeframe for Decision

Adopt section 9792.9.7 Utilization Review – Medical Treatment – First 30 Days of

the Date of Injury

Adopt section 9792.9.8 Utilization Review — MTUS Drug Formulary

Amend section 9792.10.1 Utilization Review -- Dispute Resolution -- On or After

January 1, 2013

Amend section 9792.10.2 Application for Independent Medical Review, DWC Form IMR

Amend section 9792.10.3 Independent Medical Review – Initial Review of Application

Amend section 9792.10.4 9792.10.4. Independent Medical Review – Assignment and

Notification

Amend section 9792.10.5 Independent Medical Review – Medical Records

Amend section 9792.10.6 Independent Medical Review – Standards and Timeframes

Amend section 9792.10.8 Independent Medical Review – Payment for Review

Amend section 9792.11 Investigation Procedures: Labor Code § 4610 Utilization

Review Violations

Amend section 9792.12 Administrative Penalty Schedule for Utilization Review and

Independent Medical Review Violations

Amend section 9792.13 Assessment of Administrative Penalties – Penalty

Adjustment Factors

Amend section 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

**Article 5.5.2 Medical Treatment Utilization Schedule**

Amend 9792.27.1 Medical Treatment Utilization Schedule (MTUS) Drug

Formulary – Definitions

Amend section 9792.27.17 Formulary – Dispute Resolution

**TIME AND PLACE OF PUBLIC HEARING**

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, oral or in writing, with respect to the proposed regulatory action, as follows:

**Date: Thursday, July 25, 2024**

**Time: 11:00 a.m. – 5:00 p.m.**

**Place: Elihu Harris State Office Building – Auditorium**

 **1515 Clay Street**

 **Oakland, CA 94612**

The State Office Building and its Auditorium are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the Statewide Disability Accommodation Coordinator, Maureen Gray, at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.

**Public comment will begin promptly at 11:00 A.M. and will conclude when the last speaker has finished his or her presentation or at 5:00 p.m., whichever is earlier. If public comment concludes before the lunch recess, no afternoon session will be held.**

The Administrative Director requests, but does not require, that any person who makes oral comments at the hearing also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

**WRITTEN COMMENT PERIOD**

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Department of Industrial Relations, Division of Workers’ Compensation. The written comment period closes at the **end of the day on Thursday, July 25, 2024.** The Division of Workers’ Compensation (Division) will consider only comments received at the Division by that time. Equal weight will be accorded to oral comments presented at the hearing and written materials.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Maureen Gray

Regulations Coordinator

Division of Workers’ Compensation, Legal Unit

P.O. Box 420603

San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail) using the following e-mail address: dwcrules@dir.ca.gov.

All written comments must be received by the regulations coordinator **by the end of the day on Thursday, July 25, 2024**.

**AUTHORITY AND REFERENCE**

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in him by Labor Code sections 59, 133, 4603.5, 4610, 4616, 5307.3, and 5307.27.

Reference is to Labor Code sections 4600, 4600.4, 4601, 4603, 4603.2, 4604.5, 4610, 4610.5, 4610.6, and 5307.27.

**INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW**

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation (“DWC”), to compensate an employee for injuries sustained in the course of their employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Existing law further defines medical treatment reasonably required to cure or relieve the injured worker from the effects of the work injury as meaning treatment based upon the guidelines adopted by the Administrative Director under Labor Code section 5307.27, i.e., the medical treatment utilization schedule (“MTUS”).

Prior to January 1, 2018, Labor Code section 4610 required employers to establish a utilization review (“UR”) process either directly or through its insurer (or an entity with which an employer or insurer contracted with for these services) to be governed by written policies and procedures designed to ensure that decisions were consistent with the MTUS. This UR process required treating physicians to submit their treatment recommendations (prospectively, concurrently, or retrospectively) along with supporting documentation to the claims administrator who would then review the recommendations to determine medical necessity according to rules adopted by the Administrative Director (“AD”) of the DWC. Except under very specific circumstances or unless they fell within a claims administrator’s own prior authorization list, treatment requests were generally required to be submitted prospectively (i.e., prior to treatment) for approval or authorization, or else risk non-payment if the treatment was later determined by UR to have not been medically necessary.

This process was tweaked under AB 1124 (Statutes 2015, Chapter 525), which amended Labor Code section 5307.27 to require the Administrative Director to adopt and incorporate an evidence-based drug formulary (Drug Formulary) into the MTUS by July 1, 2017. Generally, under the Drug Formulary, drugs classified as exempt can be dispensed as prescribed without undergoing prospective review so long as they are prescribed in accordance with the medical treatment utilization schedule. Unlisted drugs or drugs classified as non-exempt are still subject to the general rule requiring authorization via prospective UR. The legislation’s aim was to speed up delivery of medications proven to be appropriate and effective. Claims Administrators were still allowed to perform retrospective UR on exempt drugs for which payment may be withheld if determined to have been not medically necessary, but they cannot withhold the medication pending prospective UR if the drug was exempt on the Drug Formulary.

Senate Bill 1160 (Statutes 2016, Chapter 868) (“SB 1160”), effective January 1, 2018, amended Labor Code section 4610 to exempt from prospective review treatment rendered within thirty days of the initial date of injury (unless an exception applied) so long as the treatment was rendered by an appropriate physician, and the physician complied with specified reporting and billing requirements. This “30-day exemption” rule would apply to exempt drugs (but not non-exempt) on the formulary as well. Claims administrators could still perform retrospective UR but solely for the purpose of determining if the treatment was medically necessary. If such review reflected that the treatment was not medically necessary, a number of remedies other than withholding payment becomes available to the claims administrator.

A retrospective review showing that the rendered treatment was not medically necessary would constitute good cause allowing the claims administrator to petition for a change of physician and could serve as grounds for termination of the physician from its medical provider network or health care organization. Further, if a physician was found to have a pattern and practice of rendering treatment under the 30-day exemption period that was inconsistent with the MTUS, a claims administrator, after appropriate notice, could prohibit the physician from rendering treatment under the 30-day exemption period for any employee entirely. Additionally, for the lesser offense of failing to submit the report required under Labor Code section 6409 and a complete request for authorization, an employer could remove the physician’s ability to provide further exempt treatment to the particular employee.

SB 1160 also imposed a faster UR timeframe for (non-exempt) formulary medications than for other treatment requests. Instead of allowing for an extension of time (of up to fourteen days) where additional information or an additional consultation or examination is required as is generally the case for prospective treatment requests, a UR decision in response to a request for a formulary drug is required to be completed within five normal business days from receipt of the request. This expedited timeframe also applies through the UR appeals process: for formulary disputes, an injured worker has 10 days from service of the adverse UR decision letter to submit an application for independent medical review (“IMR”), and the IMR organization has 5 working days from receipt of the IMR application and supporting documentation to issue a final determination.

SB 1160 further purported to improve oversight of UR companies by authorizing the DWC to have approval authority over UR plans and by requiring UR entities performing modifications or denials of treatment requests to obtain accreditation with an independent, nonprofit organization. The legislature designated URAC as the accrediting organization until or unless further rules changed such designation.

The regulations proposed in this notice of rulemaking are intended to cement, implement, and enforce the legislative mandates in SB 1160 with the aim of expediting treatment to injured workers; improving oversight of UR plan entities; and supporting the use of industry best practices. Additionally, the DWC has taken this opportunity to make changes to some existing regulations to improve or fix issues related to medical treatment that have been problematic in the workers’ compensation system. Significantly, this includes the addition of a physician reporting form, the PR-1, which combines the PR-2 (physician progress report) and the RFA (request for authorization) form, and adds information fields for the reporting of occurrences currently required by law of a primary treating physician. Further, references in the regulations to the word “delay” have been deleted in the proposed rules to comply with the legislative deletion of that word in Labor Code section 4610 and related sections.

**A closer look at the changes in the proposed rulemaking by subject matter follow:**

Improvements to care coordination and changes to medical treatment processes

* When an employee is required to obtain health care for an occupational injury through a medical provider network (MPN), the employer or insurer is obligated to take specific actions to assist the injured employee in obtaining medical care. This includes arranging for an initial medical evaluation with an MPN physician, and notifying the injured employee of his/her right to be treated by any physician of choice within the MPN after the initial visit. The same types of obligations apply for when treatment is obtained outside of the MPN system.

The proposed regulations add to the employer or insurer’s obligations to better coordinate care by requiring delivery of all relevant medical records relating to the claim to the initially selected physician within 20 days of notice of the employee’s selected physician. The employer or insurer must advise any subsequently selected physician, whether in an MPN or not, that any medical records deemed relevant by the provider shall be delivered upon request. Additionally, all selected physicians must be advised by the employer or insurer of the relevant MPN identification number if applicable, name, telephone number, fax number, email address, and mailing address of the person or entity to whom the request for authorization and bills should be sent. For treatment outside of an MPN, if applicable, the claims administrator must also provide the physician with a list of medical treatment services that can be rendered without the submission of a request for authorization. (See proposed section 9767.6(f) and 9781(d).)

* Existing law requires each new primary treating physician to file a report following the initial examination entitled, “Doctor’s First Report of Occupational Injury or Illness” with the employer or employer’s insurer and with the Division of Workers’ Compensation within 5 days of the initial examination in the manner prescribed by the Administrative Director.

The proposed regulation clarifies that only the initial primary treating physician, which may include physicians rendering first aid, are required to file such report. (See proposed section 9785(e).)

* Existing law sets forth a number of circumstances for which a PTP is required to issue a report within 20 days to the claims administrator. A report must be issued if the employee’s condition undergoes a significant change; if there is any significant change in the treatment plan; if the employee may return to modified or regular work; if the employee’s condition requires him or her to leave work or requires changes in working conditions; if the employee is released from care; etc. When a report is required, except for a response to a request for information, the PTP is required to make such report on a Primary Treating Physician’s Progress Report (Form PR-2) or in narrative form as prescribed. Alternatively, by mutual agreement between the claims administrator and physician, the PTP may make reports in any other manner and form. If a physician needs to make a treatment request, the physician must, in addition to the Form PR-2, file a Request for Authorization on the DWC Form RFA in the manner prescribed by the Administrative Director.

These regulations propose a new form, the PR-1, to be used whenever one of the conditions prompting the PTP to file a report within 20 days occurs and for requesting treatment. Essentially, the new PR-1 form combines the PR-2 and the DWC Form RFA. This form shall replace the need for both the PR-2 and DWC Form RFA, and be required after six months following the effective date of these regulations. However, a PTP will still have the option to file a narrative report to fulfill the reporting requirements as prescribed. The new PR-1 form retains many of the same attributes of the PR-2 and DWC Form RFA but will add fields to facilitate efficient and effective treatment. It will allow the physician to indicate the purpose of the form and then only fill out those relevant sections. The first section of the form will require basic information which can be saved and used again when the need for another report arises. If the purpose of the report is to request treatment, the physician will have the opportunity to indicate the specific MTUS/ACOEM guideline that supports the treatment request. (See proposed sections 9785(g) & (h); and 9785.6.)

* Under existing law, when a treating physician submits a request for authorization of treatment to a claims administrator, unless the request is exempt from prospective utilization review (UR), the claims administrator may approve the request or alternatively put the request through UR to determine whether the requested treatment is medically necessary. Existing law requires that a request for authorization be set forth on an RFA form (or as otherwise allowed), signed by the requesting physician, and sent to the claims administrator’s designated address, e-mail address, or fax number. In order for an RFA to be “complete,” the RFA must identify the employee and provider, specifically identify the recommended treatment(s), and be accompanied by supporting documentation.

The proposed regulations amend the definition of a “complete RFA” to include the requirement that the treatment recommendations be included in the specifically designated section of the form; that the documentation accompanying or substantiating the request have issued or been created no earlier than 30 days prior to the submission of the RFA; and that the request be signed by the requesting physician. The regulations also propose that electronic submission of an RFA be sent through the use of a secure, electronic e-mail system. (See proposed section 9792.6.1(u).)

The 30-day exemption to prospective UR

* Existing law requires employers to pay for necessary medical treatment arising from an occupational injury. In order to ensure the necessity of recommended medical treatment, existing law allows an employer or claims administrator to review treatment requests through a process called utilization review (“UR”). For payment of medical treatment to be guaranteed, a treating physician must obtain authorization for the treatment by submitting a request for authorization of treatment (“RFA”) prior to rendering the treatment.
* Existing law enacted under SB 1160, effective January 1, 2018, barring a dispute of liability and unless expressly excluded, exempts medical treatment rendered within 30 days of the date of injury from prospective utilization review (“30-day exemption”) if addressed by the Medical Treatment Utilization Schedule (MTUS) and if proper reporting requirements are met (i.e., timely submission of the report required under Labor Code section 6409 and a complete RFA) by an authorized provider.

The proposed regulations would require the treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, to be set forth in an RFA as specified in the regulations (see proposed 9792.9.7(a)(4) referring to section 9785(h)); and to be submitted concurrently with the Doctor’s First Report of Occupational Injury or Illness. The proposed regulations would require subsequent treating physicians who treat the injured worker within the first 30-day period to also submit an RFA indicating treatment being rendered following the initial visit.

* Existing law enacted under SB 1160 allows a claims administrator to bar a physician who does not comply with timely reporting requirements from providing further treatment to the employee under SB 1160’s 30-day exemption. Additionally, a claims administrator could perform retrospective UR for any treatment provided under the 30-day exemption to determine whether the provider has a pattern and practice of rendering treatment inconsistent with the MTUS. If so, a number of remedies become available to the claims administrator, including removal of the provider’s ability to render treatment under the 30-day exemption, termination of the provider from the claims administrator’s network of providers (whether medical provider network or health care organization), or substantiation as good cause of a claims administrator’s petition for a change of physician.

The proposed regulations would allow a claims administrator to remove a physician’s ability to provide treatment under the 30-day exemption for the remainder of the 30-day period to an injured worker for whom the physician failed to timely submit the DFR or RFA as required by law by issuing written notice to the physician which identifies the specific reporting failure, informs the physician that they can no longer render exempt treatment for the particular injured worker and that any such treatment is subject to prospective utilization review. (See proposed section 9792.9.7(d).)

Where a PTP has been found to have a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule (MTUS), the proposed regulations would allow the claims administrator to remove the ability of the physician to render treatment under the 30-day exemption to all claims administered by the claims administrator by (1) providing written notice to the physician that documents, via retrospective review, the physician’s pattern and practice of failing to render treatment that is consistent with the MTUS (including the MTUS Drug Formulary); (2) advising the physician that they can no longer render exempt treatment to any injured worker whose claims are administered by the claims administrator; and (3) advising of the requirement that all subsequent medical treatment is subject to prospective utilization review. (See proposed section 9792.9.7(c)(1)(A).)

Where a PTP has been found to have a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule (MTUS), the proposed regulations would allow a claims administrator to petition for a change in primary treating physician (PTP) under “good cause” despite the PTP’s membership in the claims administrator’s MPN. (See proposed section 9786(b)(6) and 9792.9.2(c)(1)(B).) If the petition is granted, the regulations propose that the replacement PTP be chosen from within the MPN listing and shall meet the MPN access standards. (See proposed section 9767.6(g).)

Where a PTP has been found to have a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule (MTUS), the proposed regulations would allow a claims administrator to terminate the physician from the claims administrator’s or employers medical provider network or health care organization. (See proposed section 9792.9.7(c)(1)(C).)

The proposed regulations would define “pattern and practice” as used in this context to mean when treatment is rendered inconsistent with the MTUS (including the MTUS Drug Formulary) for 20 separate and unrelated, recommended medical services or goods with 10 or more injured workers over the course of 3 months; or for eight separate and unrelated medical services or goods with 2 or less injured workers within one month. (See proposed section 9792.9.7(c)(2).)

The proposed regulations would further require any disputes between the treating physician and the claims administrator regarding these provisions to be resolved by the Workers’ Compensation Appeals Board. (See proposed section 9792.9.7(e).)

* Existing law enacted under SB 1160 limits the application of the 30-day exemption to prospective UR to expressly exclude the following: (1) pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary; (2) nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services; (3) psychological treatment services; (4) home health care services; (5) imaging and radiology services, excluding X-rays; (6) all durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule; (7) electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies; and (8) any other service designated and defined through rules adopted by the administrative director.

The proposed regulations would clarify the nonemergency inpatient and outpatient surgery category limitation to the 30-day exemption to include such services provided in any setting (inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician’s office), and to services and treatments necessary and routinely furnished for the purpose of surgery, before, during, and after a procedure; including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. The proposal would further define “surgery” to mean: (1) any procedure set forth in the Surgery section of the American Medical Association’s *Current Procedural Terminology (CPT®)* pursuant to the physician and non-physician practitioner fee schedule at section 9789.12 et seq., and (2) any Healthcare Common Procedure Coding System (HCPCS) procedure code defined as “surgery” in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule at section 9789.30 et seq. (See proposed section 9792.9.7(b)(2).)

The proposed regulations would also clarify that the limitation regarding psychological treatment services includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider; and includes psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary. . (See proposed 9792.9.7(b)(3).)

The proposed regulations would also clarify that the limitation regarding home health care includes medically necessary health care as well as associated services provided to the injured worker in the residential setting. . (See proposed 9792.9.7(b)(4).)

The proposed regulations would further clarify that the limitation regarding durable medical equipment extends to prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 as determined by the DWC Official Medical Fee Schedule (OMFS) or, for an unlisted item, where the billed amount will be greater than $250.00. (See proposed 9792.9.7(b)(6).)

The proposed regulations would, with respect to the electrodiagnostic medicine limitation, define it to be a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This would include, but is not limited to, procedures set forth in the American Medical Association’s *Current Procedural Terminology (CPT®)* Medicine section, under the subheading “Neurology and Neuromuscular Procedures,” and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis. (See proposed 9792.9.7(b)(7).)

The proposed regulations would expressly add the following to the list of services or treatments for which the 30-day exemption does not apply: spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections. (See proposed 9792.9.7(b)(8).)

UR Relating to the MTUS Drug Formulary

Existing law requires medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury to mean treatment that is based upon the MTUS guidelines adopted pursuant to Labor Code section 5307.27. Existing law requires all prescribers and dispensers of medications in the workers’ compensation system to adhere to an evidence-based drug formulary (“MTUS Drug Formulary”) that was incorporated into the MTUS under Assembly Bill 1124 (Statutes 2015, Chapter 525), and which became effective January 1, 2018. Existing law under the MTUS Drug Formulary exempts expressly listed medications from prospective UR while requiring it for others.

Senate Bill 1160 (Statutes 2016, Chapter 868), in addition to creating the 30-day exemption to prospective utilization review (UR), amended Labor Code section 4610 to require that all prospective decisions regarding requests for treatments covered by the formulary be made in no more than five normal business days from the receipt of a request for authorization. Although other, non-formulary treatment requests may warrant an extension of time under specified circumstances, no such extension was allowed for treatments covered by the formulary. Additionally, the 30-day exemption to prospective UR (and concomitant rules regarding claims administrators’ right to retrospective UR and applicable remedies) would only apply to medications that were exempt on the MTUS Drug Formulary.

* The proposed regulations would incorporate these statutory changes within the regulatory scheme starting with the inclusion of a definition for “MTUS Drug Formulary.” (See proposed section 9792.6.1(s).)
* The proposed regulations would further expressly indicate that existing utilization review timeframes apply so long as they do not contravene the timeframes relating to formulary disputes, which follow the timeframes set forth specifically for those types of disputes under proposed section 9792.9.8. (See proposed section 9792.9.3(e).)
* The proposed regulations would clarify that drugs identified as “exempt,” identified as subject to the Special Fill policy, or identified as subject to the Perioperative Fill policy on the MTUS Drug List would be exempt from prospective UR. (See proposed section 9792.9.8(a).)
* The proposed regulations would instruct that, for a drug that did not qualify as exempt on the MTUS Drug Formulary, regardless of whether such drug was requested within the 30-day exemption time period, a request for authorization via prospective UR is required in the manner set forth in the regulations or in a manner agreed upon by the treating physician and the claims administrator. (See proposed section 9792.9.8(b).)
* The proposed regulations would reiterate the statutory mandate that prospective UR decisions to approve, modify, or deny an request for authorization (RFA) for a drug that does not qualify as exempt on the MTUS Drug Formulary must not exceed 5 business days from the date of receipt of the RFA. Where additional information is required on an RFA for medication not qualified as exempt on the MTUS Drug Formulary, the proposed regulations would require that a request for such information to be made within 2 business days from the date of receipt of the RFA. If the information is not received within 5 business days from the date of the RFA, the request may be denied in accordance with applicable regulations. (See proposed section 9792.9.8(b)(1).)
* The proposed regulations would require UR for any medication not listed on the MTUS Drug Formulary to be processed pursuant to rules applicable to treatment not exempt under the 30-day exemption and not covered by the MTUS Drug Formulary. This means that the “default” timeframe for UR, which applied to all treatment before the formulary and 30-day exemption were created, would apply to such unlisted medications. (See proposed section 9792.9.8(d).)
* The proposed regulations would clarify that, except for medications that qualified as exempt from prospective UR under the 30-day exemption, a UR decision to deny an RFA for a drug that would otherwise be exempt because it fell into an exempt category under the MTUS Drug Formulary, may be cause for denial of payment. (See proposed section 9792.9.8(e).)
* The proposed regulations would clarify that disputes over the medical necessity of medications covered under the MTUS Drug Formulary are to be resolved either via a claims administrator’s voluntary internal UR appeals process or by independent medical review (per Labor Code section 4610.5 and 4610.6). With respect to a decision to modify or deny a request for authorization because of a reason other than medical necessity, the proposed regulations would clarify that such disputes would be resolved only through the claims’ administrator’s voluntary internal appeals process or by the Workers’ Compensation Appeals’ Board. With respect to disputes based on both medical necessity and a reason other than medical necessity, the proposed regulations would require the non-medical necessity reason to be resolved first. (See proposed section 9792.9.8(f).)
* The proposed regulations would clarify the rules that would apply when an initial treating physician dispenses or prescribes a drug listed on the MTUS Drug Formulary within the first 30 days of the date of injury (i.e., under proposed section 9792.9.7(a)). The proposal would require the physician to include all drugs being prescribed or dispensed to treat the injured worker in the treatment plan section of the DFR and to list them also on the RFA. Additionally, subsequent primary treating physicians would also be required to submit an RFA on which all drugs being prescribed or dispensed are indicated following their first visit with the injured worker. (See proposed section 9792.9.8(g)(1).)
* The proposed regulations would allow [or repeat the statutory mandate that?] a treating physician to prescribe or dispense a drug identified as exempt on the MTUS Drug List without the need to obtain authorization through prospective review. (See proposed section 9792.9.8(g)(2).)
* The proposed regulations would require a treating physician who prescribes a drug not identified as exempt on the MTUS Drug List to request authorization through prospective UR by submitting an RFA as prescribed by law or in a manner agreed upon by the physician and the claims administrator. (See proposed section 9792.9.8(g)(3).)
* The proposed regulations would allow a claims administrator to conduct retrospective review of an exempt drug prescribed or dispensed to the injured worker within 30 days of the date of injury solely for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the MTUS. (See proposed section 9792.9.8(g)(4).) Where such retrospective review results in a determination that the use of the exempt drug was inconsistent with the MTUS, the proposed regulations would prohibit the denial of payment, but would allow such determination to be included as a basis to find that the physician has a pattern and practice of failing to render treatment consistent with the MTUS. (See proposed section 9792.9.8(g)(4)(A) & (B).)

UR Appeals

Under existing law, a UR decision that modifies or denies a treatment request may be appealed via independent medical review (“IMR”). To do so, an injured worker (or other eligible person) must submit an IMR application to the IMR organization within 30 days of receipt of the adverse UR decision letter. Under SB 1160, however, an IMR application pertaining to medications prescribed under the drug formulary adopted under AB 1124, must be submitted within 10 days of service of the written UR decision letter.

* The proposed regulations would require that the expedited 10-day timeframe for submitting an IMR of a medication covered under the drug formulary apply where a UR decision letter only modifies or denies a medical treatment request for a drug listed on the MTUS Drug List. (See proposed section 9792.10.1(a)(2).)

Existing law allows a claims administrator or UR entity to offer an internal appeals process so long as it does not preclude the availability of IMR. Existing law requires that a request for an internal UR appeal be made within 10 days after receipt of a UR decision letter, and for a determination to be issued by the claims administrator within 30 days of receipt of the request.

* The proposed regulations would require, for a UR decision that only modified or denied a request for a drug listed on the MTUS Drug List, that any internal UR appeal decision to be completed and issued within 10 days after receipt of a request for an internal UR appeal. (See proposed section 9792.10.1(f)(2).)

After a request for IMR has been deemed eligible, existing law requires an IMR organization (“IMRO”), within one business day, to send out a written notice of the case assignment to the employer, employee (or employee’s representative), and the requesting physician. The notice must indicate that, among other things, the claims administrator has 15 calendar days to submit medical records pertinent to the dispute. The notice must also warn that failure to comply with such requirement may result in fines, penalties or other remedies, up to $5,000. The same applies to expedited review cases except that the submission of records must be made within 24 hours following receipt of the notice.

* The proposed regulations would add a requirement that, for a dispute only involving a drug or drugs listed on the MTUS Drug Formulary, the submission of records must be made within 10 calendar days of the date of the notice. The submission of records for all other disputes would remain at 15 calendar days. (See proposed section 9792.10.4(b)(5).)
* The proposed regulations would delete the $5,000 cap. (See proposed section 9792.10.4(b)(5) & (6).)

Existing law authorizes the IMRO to reasonably request appropriate additional documentation or information necessary to make a determination of medical necessity. When such a request is made, the party to whom the request was made must submit the requested documentation within 5 business days after the request is received in routine cases, or 1 calendar day in concurrent or expedited cases.

* The proposed regulations would require a party to submit the requested documentation in 2 business days where the dispute is only about a drug listed on the MTUS Drug Formulary. (See proposed section 9792.10.5(c).)

Existing law requires the IMRO to complete its review and make a final determination of a regular (i.e., not expedited) medical treatment dispute within 30 days of receipt of the application for IMR and supporting documentation.

* The proposed regulations would require the IMRO to complete its review and make a final determination of a non-expedited medical treatment dispute, other than a dispute that only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, within 30 days of receipt of the IMR application and supporting documentation and information. (See proposed section 9792.10.6(g)(1).)
* The proposed regulations would require the IMRO to complete its review and make a final determination of a dispute that only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List within 5 business days of receipt of the IMR application and supporting documentation and information. (See proposed section 9792.10.6(g)(4).)

Existing law sets forth costs for IMR, borne by the claims administrator, for years 2013 and 2014. The costs are distinguished based on whether the review is regular, expedited, or withdrawn. Expedited reviews are more costly than regular reviews and, for each type, more costly if performed by a physician as defined by Labor Code section 3209.3 who holds an M.D. or D.O degree (as opposed to a degree of another kind). Additional costs apply if a review requires two more medical reviewers to participate.

* The proposed regulations would omit all of the factors affecting cost except for withdrawn reviews. Under the proposal, all requests for IMR would cost $345.00 regardless of whether the review is regular or expedited, regardless of the reviewer’s credentials, and regardless of whether there were more than one reviewer who participated in the review. (See proposed section 9792.10.8(a)(1).)

Existing law requires a lesser payment (currently $215.00) for each application where review is terminated by the independent organization prior to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer. If, however, 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 review by the medical reviewer, the cost will be the same as if a determination had been issued.

* The proposed regulations would clarify that if the withdrawal of an IMR occurs during (and not only subsequent to) the receipt of documentation and information under section 9792.10.5 by the medical reviewer, it would not qualify for the lower fee associated with a withdrawal. (See proposed section 9792.10.8(a)(2).)

Under existing law, an IMR final determination may be appealed under Labor Code section 4610.6(h) if one or more specified legal findings are made. The remedy for such a finding is to remand the issue back to the same independent medical review organization (IMRO) for re-review with a different reviewer, or for re-review with a different IMRO. No cost is currently associated with ordered re-reviews.

* The proposed regulations would set forth that a first order for re-review would be performed by the independent review organization at no cost, but that any subsequent ordered re-reviews on the same IMR case after the first one would incur a cost of $295.00. (See proposed section 9792.10.8(a)(3).)

Existing law requires disputes over formulary rules, other than medical necessity disputes covered by UR and IMR, to be resolved through the procedure for non IMR/IBR disputes set forth in the applicable WCAB regulations.

* The proposal would amend the reference to the WCAB rule to align with recent changes. (See proposed section 9792.27.17(b).)

Greater Oversight: URAC Accreditation and DWC Approval

Prior to SB 1160, claims administrators or their contracted UR organizations were only required to file their UR plan with the DWC before operating in the California workers’ compensation system. The legislature determined that more oversight was required of UR entities to ensure industry best practices and to reduce frictional costs associated with disputes over treatment. As such, beginning July 1, 2018, SB 1160 required UR processes that modified or denied treatment requests to obtain accreditation with URAC (or other entity named by the Administrative Director) and approval of their UR plans with the Administrative Director (“AD”).

**DWC Approval of UR plans:**

Existing law requires every claims administrator to establish and maintain a UR process to be set forth in a UR plan. A claims administrator or an external UR organization contracted by the claims administrator to perform UR must file its UR plan, consisting of the policies and procedures and a description of the UR process, with the AD. A claims administrator who contracts with an external UR organization may, in lieu of its own plan, file a letter with the AD identifying its contracted UR organization with whom it contracts for UR services so long as that entity has filed its own complete plan with the AD.

The proposed regulations would require all UR organizations who modify or deny treatment requests to have their plan approved by the AD. The UR plan would be required to submit its plan for approval to the DWC on a new form, signed by the medical director, called the DWC Form UR-01, “Application for Approval as Utilization Review Plan.” (See proposed 9792.7.1.) The UR plan must be submitted in compact discs or flash drives in word-searchable PDF format. The hard copy of the completed, signed original shall be maintained by the applicant and made available for review by the AD upon request. (See proposed 9792.7(c)(2).)

The proposed regulations further indicate that the submission of an application for approval to the AD would release URAC from any obligation it may have to the UR applicant, contractually or otherwise, with respect to nondisclosure of any of URAC’s files relating to the applicant’s URAC accreditation or audits. The DWC may obtain such documentation from URAC for the purpose of ensuring compliance with UR rules. (See proposed 9792.7(c)(3).)

The proposed regulations further set forth the process for UR plan approval once an entity has submitted an application for approval of a UR plan. The proposal would allow the AD 30 days after receipt of an application to review and notify the organization as to the completeness of the UR plan. If the plan is incomplete, the AD shall specify the additional information or documents needed. (See proposed 9792.7(d).) Following receipt of a complete UR plan, the AD shall have 60 days to approve or deny the plan. If the plan is in substantial compliance except for specific deficiencies, a conditional approval may be granted for up to six months to allow the applicant the opportunity to correct those deficiencies. If the deficiencies are not corrected within the first period of conditional approval, the conditional approval may be extended for up to another six months if the applicant has shown a good faith effort and ability to correct the deficiencies. Unless the deficiencies are removed prior to the expiration of the conditional approval and an approval has been granted, a conditional approval expires at the end of its stated period and the application shall be deemed denied. (See proposed 9792.7(e)(1).)

The proposed regulations would require the AD to notify a UR plan applicant of a denial in writing, which shall include the reasons for non-approval. The denial shall be transmitted via certified mail and remain in effect for 12 months unless a lesser timeframe is agreed upon by the AD for good cause. (See proposed 9792.7(e)(2).)

The proposed regulations would allow a UR plan applicant whose plan has been denied by the AD 20 days to file an appeal with the Workers’ Compensation Appeals Board. Petitions shall be concurrently served on the AD. (See proposed 9792.7(f).)

The proposed regulations would allow the AD to require an organization to update its approved plan if needed for compliance. It would allow a plan who receives a Notice of Required Update from the AD 30 days to bring its plan into compliance. Failure to adopt and implement required changes could result in probation or suspension of a plan or revocation of its approval. (See proposed 9792.7(g).)

The proposed regulations would set forth the following reasons for which probation, suspension, or revocation for approved UR plans could occur: the plan is operating out of compliance with the terms of its approved plan or the law; the plan fails to timely adopt and implement updates to its UR plan as specified by the AD; the plan knowingly makes false statements or representations to the AD or fails to submit plan modifications or updates as required by this Article; the plan fails to respond to at least two or more repeated requests or inquires by the AD concerning plan compliance. (See proposed 9792.7(h)(1).)

If the AD determines that one or more of the preceding circumstances applies, the proposed regulations would require the AD to issue written notice of the violation after which the organization would have 14 days to correct the violation or respond with a plan to correct the violation. (See proposed 9792.7 (h)(2).)

The proposed regulations would allow the AD to place a UR organization on suspension, probation, or revoke its approval by issuing a Findings and Notice of Action to the organization specifying the time period for which such action will take place. For revocations, the proposed regulation would bar the organization from applying for UR plan approval for 12 months following the issuance of the Findings and Notice of Action unless a lesser timeframe is agreed upon for good cause by the AD. (See proposed 9792.7(h)(3)(A).)

The proposed regulations would require a UR plan who has been issued a Findings and Notice of Action for suspension or revocation to issue a copy of such Findings and Notice of Action to all organizations for which it performs UR. (See proposed 9792.7(h)(3)(B).

The proposed regulations would allow a UR plan that has been issued a Findings and Notice of Action to request a re-evaluation of the probation, suspension, or revocation notice within 14 days of its issuance by submitting to the AD, under penalty of perjury, a written explanation accompanied by documentary evidence supportive of the request for re-evaluation. (See proposed 9792.7(i)(1).)

The proposed regulations would require the AD to issue, within 45 days of the request for re-evaluation, a Decision and Order affirming, modifying, or rescinding the Notice of Action, which must include an explanation of the AD’s decision. The proposal would allow the AD to extend the time for issuing a Decision and Order for a period of 30 days and, at any time during re-evaluation, the AD could require the organization to submit additional documentation or information. (See proposed 9792.7(i)(2).)

As an alternative to requesting re-evaluation, the proposed regulations would allow a UR plan that has been issued a Findings and Notice of Action to appeal such notice to the Workers’ Compensation Appeals Board by filing a petition within 20 days of the issuance of the notice under California Code of Regulations, title 8, section 10560. The regulations would require that the petition be concurrently served on the AD. (See proposed 9792.7(j).)

The proposed regulations would clarify that the rules pertaining to probation, suspension, and revocation would not prevent the possibility of applicable penalties under regulation section 9792.12 (pertaining to UR investigations). (See proposed 9792.7(k).)

The proposed regulations would require the AD to post on the DWC’s website a list of all entities who have filed a complete UR plan and indicate their evolving statuses, which could include, but are not limited to, approved, denied, inactive, probation, suspended, or revoked. The proposal would authorize the AD to mark as inactive a utilization review plan entity that has not conducted UR under its own name for a period of 12 consecutive months following the last UR activity performed under its own name. (See proposed 9792.7(l).)

Existing law requires a UR plan to file a material modification of its UR plan within 30 days of the material modification, which is defined to be any change to the UR standards as specified in section 9792.7. The current definition of a “material modification” of a UR plan is whenever there is a change to UR standards as specified in section 9792.7.

The proposed regulations shall require that a filing of a material modification includes a statement certifying that the UR plan, as modified, continues to be in compliance with the rules governing UR. (See proposed 9792.7(c)(4).) The regulations shall also amend the definition of a material modification of a UR plan to include (in addition to changes to a UR plan’s standards under section 9792.7) changes to its medical director, address, company name, or corporate structure. (See proposed 9792.6.1(n).)

**URAC Accreditation:**

Existing law requires every utilization review process that modifies or denies requests for authorization of medical treatment to retain active accreditation by an independent, non-profit organization to certify that the UR process meets specified criteria aligned with industry best practices. Unless and until the AD designates another, URAC is statutorily designated as the accrediting organization.

* The proposed regulations define URAC by its physical address, or as designated on its website (see 9792.6.1(x)); and specifies that the type of URAC accreditation required for approval by the DWC of a UR plan that modifies or denies treatment requests is the Workers’ Compensation Utilization Management (WCUM) accreditation. (See 9792.7(a)(6)(A).)
* The proposed regulations expressly exempt a public sector internal UR plan that modifies or denies treatment requests from URAC accreditation if it provides in its plan submission a statement under penalty of perjury by the plan’s medical director that the plan meets or exceeds the standards established by URAC’s WCUM accreditation program. (See 9792.7(a)(6)(B).)

**UR Investigations - Process**

Existing law authorizes the Administrative Director (“AD”) to investigate utilization review (UR) processes of UR organizations and/or claims administrators and assess administrative penalties for failure to comply with applicable rules.

* The proposal would clarify that the AD’s authority to investigate UR processes would include not only entities who perform the full scope of the UR process, but also those that perform only a part of the UR process. (See proposed section 9792.11(a).)

Existing law establishes UR investigations as being either Routine or Target. A Routine Investigation must be performed at least once every 5 years and includes a review of a random sample of requests for authorization (RFAs) received by the investigation subject during the three most recent full calendar months preceding the date of the start of the investigation; and may also include any credible complaints received by the AD. Target Investigations may be either a Return Target or Special Target Investigation. A Return Target Investigation occurs 18 months following the Routine Investigation that resulted in a performance rating of less than eighty-five percent. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of UR rules.

Violations uncovered in a Routine or Return Target Investigation are associated with either “mandatory” or “additional” penalties. The performance rating, which is calculated based on a review of the randomly selected requests, is associated with “additional” penalties. These additional penalties are waived if the performance score meets or exceeds 85%. Waiver does not apply to mandatory penalties.

An investigation subject who does not receive a passing performance rating (i.e., a performance rating below 85%) may also obtain waiver of the additional penalty amounts under an abatement process though abatement is not available for the purpose of changing the performance rating. Abatement requires the investigation subject to submit in writing to the AD, written evidence, tendered with a declaration made under penalty of perjury, that explains or demonstrates how the violation(s) have been abated; grant the AD re-entry for a Return Target Investigation to verify compliance with the abatement measures; and agree to reinstatement of the previously waived penalty amounts at a multiplied rate if the violative condition(s) are not abated within the specified time period or if the abatement measures are not consistent with specified abatement terms. The abatement process requires the AD to conduct a Return Target Investigation in 18 months following the Routine Investigation. A Return Target Investigation is allowed for up to four times, with each subsequent investigation resulting in a higher multiplication of the penalty amounts if the abatement terms are not successfully met.

In addition to waiver and the abatement process, existing law also allows the AD discretion to mitigate UR investigation penalty amounts based on specified penalty adjustment factors. These include the medical consequences or gravity of the violations; documented good faith efforts of compliance by the claims administrator or UR organization; the history of previous penalties; the frequency of violations discovered pursuant to the investigation; and extraordinary circumstances when strict application of the mitigation guidelines would be clearly inequitable.

* The proposal would reorganize subdivisions within existing section 9792.11 so as to group together rules addressing the authority of the AD, the scope of UR investigations, and procedural rules of a general nature. (See proposed sections 9792.11(b), (c), (d), (e), and (f).) Some subdivisions were reorganized based on where they would make the most sense considering the investigation type, sequence, or process. (See proposed section 9792.11(h); and proposed section 9792.11(t).)
* The proposal would also combine text which separately addressed investigations for UR organizations versus claims administrators such that the focus would be on the type of investigation (routine or target) rather than the type of entity being investigated. This is not a substantive change. (See proposed section 9792.11(g).)
* The proposal would delete the assignment of a performance rating and all associated regulations, including the waiver and abatement process (and thereby the need for a Return Target Investigation and, thus, the need to differentiate between that and a Special Return Target). (See strikeout of applicable text in existing section 9792.11(c).) Instead, investigations would be simply either Routine or Target and would result in the assessment of penalties pursuant to violations uncovered in the investigation. Violations would be assessed based on a schedule of penalties categorized by the following subjects: violations related to UR plan requirements, violations related to UR plan operations, and violations relating to the UR investigation procedure and other miscellaneous provisions.
* The proposal would grow the population of files subject to investigation for UR organizations or claims administrators who process a greater number of requests for authorization in the specified three-month calendar period. Beginning with an organization that reviews 242 to 269 requests in the specified three month period, the sample file population subject to investigation would grow from 48 to 50 files; and, for organizations that process the largest number of authorization requests, i.e., reviews 531 or more files in the specified three month period, the sample file population would grow from 59 to 70 files. (Proposed section 9792.11(i).)

Additionally, the proposal would authorize the AD to request additional files where the files initially selected are incomplete or otherwise invalid. (See proposed section 9792.11(j).) For investigation subjects who perform modifications and denials of requests for treatment, the proposed regulations would also require 40% of the selection of investigation files (or as close to 40% as possible), to be comprised of files that modified or denied completed or accepted requests for authorization. In order to meet this goal, the proposal would authorize the AD to expand the scope of files subject to investigation to reach beyond the specified 3-month calendar period, up to a total of 6 months. (See proposed section 9792.11(n).)

* With respect to mitigation, the proposal would clarify that mitigation is appropriate for consideration prior to the issuance of the final investigation report. (See proposed section 9792.13(a).)

Existing law requires the AD to initiate an investigation by issuing a Notice of Utilization Review Investigation (“NURI”) to the investigation subject (unless the AD determines that advance notice will render the investigation less useful). The NURI requires the subject to provide data including a list of every RFA received by the investigation subject during the specified three month period and, for each RFA, include a number of data elements, including whether the UR determination approved, denied, or modified the request; or whether the request was withdrawn.

* With respect to a UR determination that denied a request, the proposal would require identification of the type of denial, i.e., whether it was due to a finding of no medical necessity or due to the requirement that additional information, tests, or consultation were required. (See proposed section 9792.11(k)(1).)

Existing statutory law requires all UR plan processes that modify or deny treatment requests to obtain and maintain accreditation with an independent, non-profit organization to ensure these types of UR plan processes are following industry best practices. Until and unless the AD names another accrediting organization, the legislature has designated URAC as the accrediting organization.

* The proposal would require a UR investigation subject to include in its NURI response a copy of the most recent accreditation document issued by URAC (or other named accrediting organization) which verifies that the UR plan organization meets the legislative accreditation requirement. (See proposed section 9792.11(k)(5).)

Existing law authorizes the AD to request any additional information during the UR investigation process including whether UR services are provided externally, the names of the UR organizations, the name and address of the employer, and the name and address of the insurer.

* The proposal would additionally authorize the AD to request documents relevant to the UR plans’ accreditation including but not limited to copies of audit or investigation reports, files, or documents generated between the plan and the accrediting organization. (See proposed section 9792.11(l).)

Existing law requires UR investigation subjects to provide required information within 14 calendar days of receipt of the NURI.

* The proposal would require that additional documentation requested by the AD from a UR investigation subject be provided within 5 business days unless an extension is granted in writing. (See proposed section 9792.11(m).)

Existing law requires a preliminary investigation report to be provided to the investigation subject following review of selected UR investigation files. The preliminary report consists of the preliminary notice of UR penalty assessments, the performance rating, and may include further requests for additional documentation or compliance. If needed, a conference to discuss the preliminary investigation report may be scheduled within 21 days of the issuance of the report.

* The proposal would add a requirement that the AD include in the preliminary report a notice of intent to place the UR plan on probation or withdraw approval of the plan, and the reasons therefore, where the investigation has uncovered the existence of a systemic problem in the operations, procedures, or policies of a UR plan organization. The proposal would delete the requirement that the subject’s performance rating be included in the preliminary report since it is being eliminated from the UR investigation process. (See proposed section 9792.11(v).)

Existing law requires the AD to issue an Order to Show Cause Re: Assessment of Administrative Penalty (“OSC”) when the AD has found that an entity has failed to meet any of the requirements of the law pertaining to UR. The order must be in writing and must include notice of the administrative penalty, a final investigation report to include the penalties assessed, and the performance rating. The OSC may also include, if necessary, one or more requests for documentation or compliance.

* The proposal would strike the necessity to include a performance rating as part of the OSC and add the requirement that, if applicable, a notice of the AD’s intent to place the subject on probation or to withdraw approval of the UR plan be included. (See proposed section 9792.15(b)(2).)

Existing law requires an investigated UR organization, within a specified time, to serve a notice, including a copy of the final investigation report, the measures implemented to correct such conditions, and the website address for the Division where the summary of violations is posted, to any employer, TPA, or insurer for whom the UR organization performs UR; and on any self-insured employer or insurer if the investigation subject is a claims administrator. If a hearing was conducted as a result of an appeal, the notice should contain the Final Determination in lieu of the final investigation report. Documentation of compliance must be served on the AD within 30 calendar days from the date the notice was served. The AD is required to post on the DWC website a summary of violations for each UR investigation 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 proposal would, for investigation subjects whose investigations resulted in the UR plan being placed on probation, require that the notice include a copy of the final investigation report, a statement indicating that the UR plan has been placed on probation by the Division, and the website address for the Division where the summary of violations and probationary status is posted. (See proposed section 9792.11(v)(1)(B).) For investigation subjects whose investigations resulted in a withdrawal of approval of its UR plan, the notice would include a copy of the final investigation report, a statement that the UR plan’s approval has been withdrawn by the Division, and the website address for the Division where the summary of violations and withdrawn status is posted. (See proposed section 9792.11(v)(1)(C).)
* The proposal would require the AD, where an investigation subject has been placed on probation, to commence another investigation of that UR plan in 180 to 360 days from the issuance of the previous final report or, if applicable, Final Determination. This return investigation would be conducted in the same manner as required for routine investigations. (See proposed section 9792.11(z).)
* The proposal would limit the amount of times a UR plan entity could be placed on probation to once per investigation. See proposed section 9792.11(aa).)

**UR Investigations – Penalties**

Existing law at section 9792.12 sets forth penalties that may be assessed during a UR plan investigation under section 9792.11. Penalties are either (a) Mandatory UR Administrative penalties, (b) Additional UR Penalties, or (c) IMR-related UR penalties.

* The proposal would comprehensively reorganize the penalty schedule to reflect, under subdivision (a), violations relating to UR plan requirements; under subdivision (b), violations relating to UR plan operations; under subdivision (c), violations relating to investigation procedures and miscellaneous violations; under subdivision (d), IMR administrative penalties; and, under subdivision (e), violations for any other act or failure not expressly identified.

*Changes under subdivision (a) (for violations relating to UR plan requirements):*

As aforementioned, existing law requires every claims administrator to establish and maintain a UR process to be set forth in a UR plan. A claims administrator or an external UR organization contracted by the claims administrator to perform UR must file its UR plan, consisting of the policies and procedures and a description of the UR process, with the AD. A claims administrator who contracts with an external UR organization may, in lieu of its own plan, file a letter with the AD identifying its contracted UR organization with whom it contracts for UR services so long as that entity has filed its own complete plan with the AD.

* The proposal would add a penalty of $30,000 under subdivision (a) for the failure to obtain approval of a UR plan that modifies or denies treatment requests from the AD prior to operation. (See proposed section 9792.12(a)(4).)

As aforementioned, existing law requires every utilization review process that modifies or denies requests for authorization of medical treatment to retain active accreditation by an independent, non-profit organization to certify that the UR process meets specified criteria aligned with industry best practices. Unless and until the AD designates another, URAC is statutorily designated as the accrediting organization.

* The proposal would add a penalty of $10,000 under subdivision (a) for failure to obtain or maintain URAC accreditation as required prior to commencing or continuing to function as a UR plan. (See proposed section 9792.12(a)(6).)

Existing law prohibits an employer, or any entity conducting UR on behalf of the employer from offering any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician.

* The proposal would add a penalty of $25,000 under subdivision (a) for failure to comply with laws prohibiting financial incentives or consideration to physicians conducting UR. (See proposed section 9792.12(a)(8).)

Existing law requires a utilization review organization to retain files and other records, whether electronic or paper, that pertain to the UR process for at least 3 years following either: (1) the most recent UR 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.

* The proposal would add a penalty of $20,000 under subdivision (a) for failure to retain records as required by law. (See proposed section 9792.12(a)(9).)

*Changes under subdivision (b) (for violations relating to UR plan operations):*

Under existing law, only a licensed physician may modify or deny requests for medical treatment.

* The proposal would clarify that only a physician reviewer may modify or deny a request for treatment whether it be based on an assessment of medical necessity, or the non-receipt of requested information, test, or examination without which a determination of medical necessity cannot be made. Additionally, only a physician reviewer may deny a request that would otherwise be exempt from UR under Labor Code section 4610(k) when the requesting physician has expressly and unequivocally stated or opined that there has been a change in the injured worker’s condition such as to warrant the repeat request. (See proposed section 9792.12(b)(1).)
* The proposal adds a penalty of $25,000 for each of these types of violations.

Existing law exempts from prospective UR certain treatment rendered within 30 days from the date of injury if specified conditions are met (“30-day exemption”).

* The proposal would add a penalty of $3,000 for requiring prospective UR for each medical treatment that was appropriately exempt under the 30-day exemption. (See proposed section 9792.12(b)(5).)

Existing law assigns a separate penalty for failure to respond to a complete DWC Form RFA or other request for authorization accepted by the claims administrator for non-expedited concurrent review, non-expedited prospective review, and retrospective review.

* The proposal would combine these violations under one subdivision. The proposal would also increase these penalties from $2,000 to $3,000 in the case of a non-expedited concurrent review; from $1,000 to $2,500 in the case of a non-expedited prospective review; and from $500 to $750 in the case of retrospective review. (See proposed section 9792.12(b)(6).)

Existing law imposes a penalty of $1,000 for the failure of a non-physician reviewer who approves an amended request to document such request as a result of a physician who has voluntarily withdrawn the request in order to submit an amended request.

* The proposal would delete this provision. (See strike thru of section 9792.12(a)(8).)

Existing law imposes a penalty for the failure to timely make a decision to approve, modify, or deny a valid request for authorization of treatment at a non-expedited concurrent or prospective level; and/or to timely communicate that decision as required by law.

* The proposal would increase the penalty associated with this violation from a flat amount of $100 to $250 per day up to a maximum of $5,000 after which the violation could be deemed a failure to respond at all to a complete or accepted request for authorization and the penalty associated with that failure would attach, as applicable. (See proposed section 9792.12(b)(7).)

Existing law imposes a penalty for the failure to timely make and communicate a decision in response to a request for expedited review as required by law.

* The proposal would increase the penalty associated with this violation from a flat amount of $15,000 to $250 for each hour the response is untimely up to a maximum of $18,000. (See proposed section 9792.12(b)(8).)

Existing law imposes penalties for the failure to timely make and communicate a decision in response to a retrospective request for treatment as required by law.

* The proposal would increase the penalty associated with this violation from a flat amount of $100 or $50 (depending on whether the decision is to modify or deny, or approve, respectively) to $150 per day up to a maximum of $3,000 after which the violation could be deemed a failure to respond at all to a complete or accepted retrospective request for authorization and the additional penalty associated with that failure would attach, as applicable. (See proposed section 9792.12(b)(9).)

Existing law imposes penalties for the failure to follow time, content, and manner rules pertaining to written communication that must issue when, after receipt of a valid RFA, additional information, tests or examinations, or consultations are required in order to make a determination of medical necessity of the requested treatment.

* The proposal would increase the penalties associated with this violation from a flat amount of $50 or $100 to $250 per day up to a maximum of $5,000 after which the violation could be deemed a failure to respond at all to a complete or accepted request for authorization and the additional penalty associated with that failure would attach, as applicable. (See proposed section 9792.12(b)(10).)

Existing law imposes a penalty of $50 for the failure to document the reason for denying treatment on the basis of lack of reasonable and necessary information.

* The proposal would increase this penalty from $50 to $200. (See proposed section 9792.12(b)(11).)

Existing law imposes a penalty of $100 for the 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.

* The proposal increases this penalty from $100 to $200. (See proposed section 9792.12(b)(12).)

Existing law imposes a penalty of $100 for failing to include all of the content requirements in a UR decision as prescribed by law that modifies or denies treatment.

* The proposal would increase this penalty from $100 to $300 for each failure. (See proposed section 9792.12(b)(13).)

Existing law requires each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for UR services, to submit a description of the UR process that modifies or denies RFAs and the written policies and procedures to the AD for approval.

* The proposal would add a penalty of $5,000 for the failure of a UR plan to operate its plan in accordance with the plan filed and, if applicable, approved with the AD. (See proposed section 9792.12(b)(14).)

*Changes under subdivision (c) (for violations relating to UR investigation procedures and miscellaneous violations):*

Existing law authorizes the AD to investigate UR processes of UR organizations and/or claims administrators and assess administrative penalties for failure to comply with applicable rules. During an investigation, the AD may request additional records or files needed for completing a UR investigation.

* The proposal would add a penalty for the failure to timely provide a complete copy of any document, file, or record whether electronic or paper, that was requested by the AD pursuant to a UR investigation. The penalty amount would be $500 for each day the failure is ongoing up to a maximum of $10,000 unless a greater penalty is warranted as specified. (See proposed section 9792.12(c)(1).)
* The proposal would add a penalty for providing a backdated, altered, or fraudulent document to the AD, or intentionally withholding a document, which would have the effect of avoiding UR-related liability or the assessment of an administrative penalty under this section. The penalty amount would be $500 for each backdated, altered, or withheld document unless a greater penalty is warranted (under proposed subdivision (e)), such as where the violation impedes the ability of the AD to conduct a full investigation of the issue. (See proposed section 9792.12(c)(2).)

Existing law imposes a penalty of $500 for the failure to timely comply with any and each compliance requirement listed in a 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.

* The proposal would clarify that the penalty amount attaches to each failure to comply as specified, and would also increase the penalty amount from a flat $500 to $500 each day the failure is ongoing up to a maximum of $20,000 unless a greater penalty is warranted under proposed subdivision (e) of this section. (See proposed section 9792.12(c)(3).)

Existing law imposes a penalty of $500 for the failure of an investigation subject to issue a notice of the final investigation report (or final determination if there was a hearing), of the measures implemented to abate identified violations, and the website address for the Division where the performance rating and summary of violations is posted. The notice must meet specified time and manner requirements and be issued to contracted parties for whom the investigation subject performs UR.

* The proposal would increase this penalty amount from a flat $500 to $500 each day the failure is ongoing up to a maximum of $20,000 unless a greater penalty is warranted under proposed subdivision (e) of this section. (See proposed section 9792.12(c)(4).)

Existing law imposes a penalty of $100 for the failure to disclose or otherwise make available the utilization review criteria or guidelines upon request by a member of the public.

* The proposal would increase this penalty amount from a flat $100 to $200. (See proposed section 9792.12(c)(5).)

Existing law imposes a penalty of $100 for the failure to disclose or otherwise make available the approved utilization review process descriptions and accompanying written policies and procedures.

* The proposal would increase this penalty amount from a flat $100 to $200. (See proposed section 9792.12(c)(6).)

*Changes under subdivision (d) (for violations relating to UR investigation procedures and miscellaneous violations):*

Existing law imposes a penalty of $500 for each day a response is untimely up to a maximum of $5,000 after the AD has requested for information necessary to make a determination of IMR eligibility.

* The proposal would increase the maximum penalty amount associated with this violation from $5,000 to $7,500. (See proposed section 9792.12(d)(5).)

Existing law imposes a penalty of $500 for each day a response is untimely up to a maximum of $5,000 after the AD has requested for records or additional information necessary to make a determination of medical necessity of disputed treatment.

* The proposal would increase the maximum penalty amount associated with this violation from $5,000 to $7,500. (See proposed section 9792.12(d)(6).)

Existing law imposes a penalty of $1,000 for each day a claims administrator fails to timely authorize services found to be medically necessary by IMR up to a maximum of $5,000.

* The proposal would increase the maximum penalty amount associated with this violation from $5,000 to $10,000. (See proposed section 9792.12(d)(7).)

Existing law imposes a penalty of $1,000 for each day a claims administrator fails to timely reimburse for services found to be medically necessary by IMR up to a maximum of $5,000.

* The proposal would increase the maximum penalty amount associated with this violation from $5,000 to $10,000. (See proposed section 9792.12(d)(8).)

*Addition of penalty under subdivision (e):*

Existing law authorizes the AD to investigate UR processes of UR organizations and/or claims administrators and assess administrative penalties for failure to comply with applicable rules.

* The proposal would add a catch-all penalty provision for violations that are not expressly included in the penalty schedule. The penalty amount of up to $50,000 would be determined after consideration of the gravity of the violation; the characteristics or similarity of the violation to other violations listed in this penalty schedule; the history of previous violations; the frequency of violations uncovered during the investigation; the good faith behavior of the investigation subject; and other cause as determined by the AD. The penalty could also include suspension or revocation of the UR plan. (See proposed section 9792.12(e)(1).) Additionally, the aforementioned factors could substantiate the imposition of an additional penalty where a violation, expressly listed or not, impedes the ability of the DWC to conduct a full investigation of any complaint or issue. (See proposed section 9792.12(e)(2).)

Miscellaneous changes

Under existing law (Labor Code section 4610(k)), a UR decision to modify or deny a treatment recommendation remains effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician (or another physician within the requesting physician’s practice group) for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the UR decision. In practice, this rule excuses a claims administrator from having to perform UR on a repeated request for treatment that was modified or denied within the prior 12 months if it is from the same physician (or from the physician’s practice group), unless the request is supported by a documented change in facts that is material to the basis of the prior UR decision.

* The proposal would require claims administrators to respond to a request that falls under Labor Code section 4610(k) in accordance with rules set forth under deferral (i.e., proposed section 9792.9.2).
* The proposal would require UR, however, for a repeat request that would otherwise fall under Labor Code section 4610(k) if the requesting physician expressly and unequivocally states or opines that there has been a material change in the injured worker’s condition that supports the repeated request. Additionally, the proposal would require a physician reviewer to perform such review and comply with the requirements associated with a typical medical necessity UR.

Under existing law, when a claims administrator receives a complete request for authorization of treatment (RFA) from a treating physician, a claims administrator must respond in the manner, time, and form prescribed by regulations. Existing law defines a complete request for authorization as being one that identifies the employee and provider, specifically identifies the recommended treatments, is signed by the treating physician, and is accompanied by documentation substantiating the need for the requested treatment. Existing law allows a claims administrator who receives an incomplete RFA to have the option of either processing the request as if it were complete (and thereby subject to compliance with UR timeframes) or marking the request as incomplete and returning it to the physician with an explanation for the return within 5 business days from receipt. If a request for authorization of treatment was not submitted on the DWC Form RFA, existing law allowed a claims administrator to accept such request for the purpose of UR if (1) “Request for Authorization” was clearly written at the top of the first page, (2) all requested items or services were listed on the first page, and (3) the request was accompanied by documentation substantiating the need for the requested treatments.

* The proposed regulations tweak the definition of a complete request for authorization to require the use of the new PR-1 form (or a narrative report if specified formatting is followed) and to require that the documents substantiating the request for treatment be issued or created no earlier than 30 days before the date the treatment request is submitted. The proposal also clarifies that electronic submission of a request for treatment must be through the use of a secure encrypted email system. (See proposed section 9792.6.1(u).) The proposed regulations further explain that acceptance of an incomplete RFA means that a claims administrator (or its contracted utilization review organization) may be subject to investigation and/or assessment of penalties attached to such file (proposed section 9792.9.1(b)), and that a request for authorization may be made by either a primary or secondary physician. (Proposed section 9785(h).)

Existing law includes many levels of review in the UR context. A non-physician reviewer (e.g., nurse) may approve treatment requests but only physician reviewers may modify or deny treatment requests (which includes the decision that additional information is required before determining the medical necessity of requested treatment). When additional information is required prior to determining medical necessity, it may necessitate an additional consultation by an expert reviewer whose specialty makes the reviewer particularly suited to evaluate the issue.

* The proposed regulations would make amendments to clarify the roles of these different reviewers. It would clarify that an expert reviewer is a qualified reviewer, as specified, whose consultation for a specialized review has been requested by the claims administrator or UR organization, necessitating an extension of time, prior to the determination of medical necessity. It would clarify that a reviewer, synonymous with physician reviewer, is a qualified reviewer, as specified, who assists the claims administrator or utilization review organization to determine medical necessity of requested treatment, and, therefore, may modify or deny a treatment request. It would clarify that a non-physician reviewer is a person designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment but who cannot modify or deny a treatment request. (See proposed section 9792.6.1(k) and (w).)

Existing law requires that physician reviewers apply criteria consistent with the medical treatment utilization schedule (MTUS) to determine medical necessity of requested treatment.

* The proposed regulations would expressly indicate that, notwithstanding the instruction to determine issues of medical necessity under the MTUS, a claims administrator may still authorize treatment beyond what is covered in the MTUS or as supported by the best available medical evidence to account for circumstances that may warrant an exception. (See proposed section 9792.8.)

Existing law requires a retrospective UR decision to be made within 30 days of receipt of the RFA and medical information reasonably necessary to make a determination.

* The proposed regulations would require a retrospective UR decision to be made within 30 days of receipt of the RFA *or* information pertaining to rendered medical treatment that is reasonably necessary to make a determination. (See draft 9792.9.3(d).)

Existing law requires decisions approving a request for authorization (RFA) to specify the date the RFA was first received, the treatment requested, the treatment approved, and the date of the approval decision.

* The proposed regulations would account for acceptance of an RFA to include the situation in which an incomplete RFA is accepted as complete by the claims administrator; and, if an additional exam or consultation had been required, to include the date the request for such exam or consultation was made and the date of receipt of such results. (See proposed section 9792.9.4(a).)

Existing law requires a physician to include words such as “Do Not Substitute” or “Dispense as Written” on a prescription for a brand name drug if it is more costly than its generic equivalent where the specific brand (as opposed to its generic substitute) is being requested; and to document the medical necessity for the brand.

* The proposed regulations would require UR approvals of prescriptions for a brand name drug where the prescription does not include words such as “Do Not Substitute” or “Dispense as Written” to indicate “generic substitute authorized” or words to that effect and meaning on the approval. (See proposed section 9792.9.4(a)(2).)

Existing law defines “OTC Monograph” to mean a monograph established by the FDA setting forth acceptable ingredients, doses, formulations, and labeling for a class of OTC drugs.

* The proposed regulation would clarify that the acronym, OTC, stands for over-the-counter. (See proposed section 9792.27.1(r).)

Existing law requires a written UR decision that modifies or denies treatment requests to meet specific content requirements. It must include the date the RFA was first received; the date the UR decision was made; a description of the treatment requested; a list of medical records reviewed; a description of the treatment which was approved, if any; an explanation of the reasons for the decision; a description of the medical criteria or guidelines used to reach the decision; a statement advising the employee of the right to appeal via Independent Medical Review (“IMR”); a filled-in application form for IMR and an addressed envelope; specific mandatory language informing the employee of their rights; details about the claims administrator’s internal UR appeals process, if applicable; and the name, specialty, and United States telephone number of the physician or expert reviewer, and the time during which the reviewer can be telephoned.

* The proposed regulations would expand the UR modification or denial decision content elements to include, if applicable, the information, exam, or consultation that was required prior to the UR modification or denial decision; the date these requests were made; and the dates when the pertinent information or results of the exam or consultation were first received. (Proposed 9792.9.5(e)(2).) If the UR modification or denial was due to a lack of information submitted by the requesting physician, the proposed regulations would additionally require identification of the missing information and a statement that the requested treatment would be reconsidered upon receipt of a new RFA containing the missing information, exam or test, or specialized consultation. In the event that the requesting physician opined that prerequisite criteria should be overlooked, the proposed regulations would require the UR reviewing physician to provide an explanation as to why the requesting physician’s explanation is insufficient. (Proposed 9792.9.5(e)(7).)
* The proposed regulations would also require the UR decision modifying or denying requested treatment to identify the entity accredited by URAC and approved by the Division of Workers’ Compensation who is responsible for the UR modification or denial decision. (Proposed 9792.9.5(e)(9).)
* The proposed regulations would also require the UR decision modifying or denying requested treatment to indicate the applicable timeframe (10 days for formulary disputes or 30 days for non-formulary disputes) for submitting an appeal via IMR on the last page of the IMR application form. (Proposed 9792.9.5(e)(11).)

Existing law allows for an extension of time for a UR decision under the following circumstances: the claims administrator or UR reviewer is not in receipt of all the information reasonably necessary to reach a decision; an additional examination or test that is reasonable and consistent with professional standards of medical practice is required in order to reach a determination of medical necessity; or the physician reviewer requires a specialized consultation and review with or by another expert. If an additional examination or test, or consultation with an expert is required, existing law requires the claims administrator or reviewer to provide notice in writing to the requesting physician, the employee, and the employee’s attorney of that need and of the anticipated date on which a decision will be rendered.

* The proposed regulations would delete the requirement that a UR reviewer notify the requesting physician, the employee, and the employee’s attorney, of the anticipated date of the UR decision (after receipt of the missing exam, test, or consultation). (Proposed at regulation 9792.9.6(b)(2).)

**Anticipated Benefits of the Proposed Regulations:**

The proposal would benefit injured workers by cementing the requirements under SB 1160 for expeditious delivery of reasonable medical treatment without administrative delay when it is most necessary, in the first month following an injury; and by hastening the delivery of necessary medications. Additionally, a new physician reporting form, which centralizes all of a claimant’s information, will aid in the efficient reporting of an injured worker’s medical status and the process of requesting necessary medical treatment with the benefit of reducing administrative confusion and delays in treatment.

Regulatory oversight provisions reinforcing and adding to the requirements for accreditation with a nationally recognized accreditation company and approval of UR plans by the Administrative Director, and a much needed update to the UR investigations’ process and penalties will further ensure that UR operations are complying with the law and are operating in accordance with industry best practices.

**Evaluation of Inconsistency/Incompatibility with Existing State Regulations:**

After conducting a search for other regulations on this matter, the Division found that these are the only regulations concerning utilization review changes under SB 1160 and AB 1124. Therefore, the Administrative Director has determined that the proposed regulations are not inconsistent or incompatible with existing regulations.

**DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION**

The Administrative Director has made the following initial determinations:

* Mandate on local agencies and school districts: None.
* Cost or savings to any state agency: None.
* Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None.
* Other nondiscretionary cost or savings imposed on local agencies: None.
* Cost or savings in federal funding to the state: None.
* Cost impacts on a representative private person or business: Cost impacts include a likelihood of reduced revenue for UR organizations and/or their vendors who generate income based on a price-per-review arrangement. Assuming that at least some of the treatment covered under the 30-day exemption to prospective UR will not be forwarded for UR, some loss of revenue is expected. However, based on consensus suggesting that a large percentage of requests received within the first 30 days of the date of injury is authorized, the revenue loss will likely be immaterial.
* Significant, statewide adverse economic impact directly affecting businesses (including the ability of California businesses to compete with businesses in other states) and individuals: This regulatory action will not have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.
* Significant effect on housing costs: None.

**Results of the Economic Impact Analysis/Assessment:**

Creation or Elimination of Jobs Within the State of California:

The Administrative Director estimates that there will be minimal impact on job creation or elimination within the state since any such impacts would have occurred upon the effective date of the legislation requiring URAC accreditation on July 1, 2018.

Creation of New Businesses or the Elimination of Existing Businesses within the State of California:

The Administrative Director has determined that the proposed regulations will not create or eliminate businesses within the State of California. Any such impacts would have occurred upon the effective date of the legislation requiring URAC accreditation on July 1, 2018. Any additional costs and benefits are expected to be borne by existing businesses and the regulations will not create or eliminate businesses.

Expansion of Businesses Currently Doing Business within the State of California:

The proposal is unlikely to cause the expansion of businesses currently doing business within the State of California. Any acquisition by larger UR organizations of smaller operations, who may not have been able to bear the cost of accreditation, have already taken place due to the effect of the legislation in July of 2018.

Benefits of the Proposed Action

The proposed regulations will benefit the health and welfare of California residents and worker safety. The proposed regulations will be beneficial by clarifying any residual uncertainties pertaining to the laws passed under SB 1160, which were established to eliminate delays and denials of necessary medical treatment and ensure the operation of utilization review (“UR”) systems in accordance with industry best practices.

Injured workers will benefit from regulations cementing the requirement for expeditious delivery of reasonable medical treatment without administrative delay when it is most necessary, in the first month following an injury; and by hastening the delivery of necessary medications. Additionally, a new physician reporting form, which centralizes all of a claimant’s information, will aid in the efficient reporting of an injured worker’s medical status and the requesting of medical treatment necessary to reduce administrative confusion or delays in treatment.

Regulatory oversight provisions requiring accreditation with a nationally recognized accreditation company, the grant of authority to the Administrative Director to approve of some UR plans, and an update to the UR investigations’ process and penalties will further ensure that UR operations are complying with the law and are operating in accordance with industry best practices.

The proposed regulations are not expected to affect the state’s environment.

Small Business Determination:

The Administrative Director has determined that the proposed regulation affects small businesses. The small businesses that will be impacted by the regulation are primarily physicians and physician practices. A few UR organizations may also be impacted.

**CONSULTATION WITH THE PUBLIC PER GOVERNMENT CODE §11346.45**

To comply with the public consultation requirements of Government Code section 11346.45, the Administrative Director has done the following:

* Conducted an online Public Forum entitled: “DWC Forums – Utilization Review Regulations” from December 13, 2018 through January 15, 2019. Posted documents for public comment included the following:
	+ Draft Text of UR Regulations
	+ Draft PR-1 Form
	+ Draft IMR Application Form
	+ Draft UR-01 Form

**CONSIDERATION OF ALTERNATIVES**

In accordance with Government Code section 11346.5(a)(13), the Administrative Director must determine that no reasonable alternative considered or that has otherwise been identified and brought to the Administrative Director’s attention would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The Administrative Director has not identified any effective alternative, or any equally effective and less burdensome alternative to the regulations at this time. Interested persons are invited to present reasonable alternatives to the proposed regulations during the written comment period, or at the public hearing.

**CONTACT PERSONS**

Inquiries concerning the proposed rulemaking action may be directed to:

Maureen Gray

Regulations Coordinator

Department of Industrial Relations

Division of Workers’ Compensation

P.O. Box 420603

San Francisco, CA 94142

E-mail: mgray@dir.ca.gov

Telephone: (510) 286-7100

The backup contact person for these inquiries is:

River Sung

Division of Workers’ Compensation

P.O. Box 420603

San Francisco, CA 94142

E-mail: rsung@dir.ca.gov

Telephone: (510) 286-7100

Please direct requests for copies of the proposed text (the “express terms”) of the regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file, to the contact person at the above address. Requests to be added to the mailing list for rulemaking notices may also be directed to the contact person.

**AVAILABILITY OF INITIAL STATEMENT OF REASONS,**

**TEXT OF PROPOSED REGULATIONS, AND RULEMAKING FILE**

The entire rulemaking file shall be available throughout the rulemaking process from the contact person named in this notice. Any interested person may inspect a copy or direct questions about the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers’ Compensation, 1515 Clay Street, 18th Floor, Oakland, California 94612, between 9:00 A.M. and 4:30 P.M., Monday through Friday. Copies of the proposed regulations, Initial Statement of Reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

As of the date this Notice is published in the Notice Register, the rulemaking file consists of the Notice, the proposed text of the regulations, the Initial Statement of Reasons, the Fiscal and Economic Impact Statement (Form STD 399), a new form PR-1, a new form UR-01, and an updated IMR Application form.

**AVAILABILITY OF CHANGED OR MODIFIED TEXT**

After considering all timely and relevant comments received, the Administrative Director may adopt the proposed regulations substantially as described in this notice. If the Administrative Director makes modifications which are sufficiently related to the originally proposed text, the modified text (with changes clearly indicated) will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted. The Notice of Modification of Proposed Rulemaking will be sent to persons who have submitted written comments to the agency during the comment period or at the public hearing, to persons who testified at the public hearing, and to persons who have requested notification of modifications to the proposal. Please send requests for copies of any modified regulations to the contact person at the address indicated above.

**AVAILABILITY OF THE FINAL STATEMENT OF REASONS**

Upon its completion, the Final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the Division’s website at [www.dir.ca.gov](http://www.dir.ca.gov).

**AVAILABILITY OF DOCUMENTS ON THE INTERNET**

Copies of the Notice of Proposed Rulemaking, the Initial Statement of Reasons, and the proposed text of the regulation, may be accessed from the Division’s website at www.dir.ca.gov. To access them, click on the “Laws and regulations” link, then the “Proposed Regulations” link and scroll down the list of rulemaking proceedings to find the “Utilization Review” rulemaking link.

**AUTOMATIC MAILING**

A copy of this Notice will automatically be sent to those interested persons on the Administrative Director’s mailing list.

If adopted, the regulations as amended will appear in California Code of Regulations, title 8, sections 9767.6 through 9792.27.17. The text of the final regulations also may be available through the website of the Office of Administrative Law at [www.oal.ca.gov](http://www.oal.ca.gov) .

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