

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

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

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

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

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

The Administrative Director further proposes to repeal the following section to Title 8, California Code of Regulations:

Section 9792.11	Utilization Review Standards—Penalties
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**PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS**

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

Written comments should be addressed to:

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

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than **5:00 p.m. on Thursday, June 16, 2005**. Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (415) 703-4720. Written comments may also be sent electronically (via e-mail), using the following e-mail address: [dwcrules@hq.dir.ca.gov](mailto:dwcrules@hq.dir.ca.gov).

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

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

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

## **DOCUMENTS SUPPORTING THE RULEMAKING FILE**

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

ACOEM's Copyright Statement has been added to the rulemaking file and posted on the Division's website at: [http://www.dir.ca.gov/dwc/UR\\_Main.htm](http://www.dir.ca.gov/dwc/UR_Main.htm).

## **FORMAT OF PROPOSED MODIFICATIONS**

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

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

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

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

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

## **SUMMARY OF PROPOSED CHANGES**

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

This section provides definitions for key terms in the regulations.

**Section 9792.6(b)** A new subdivision (b) was added to the regulations to define the term "authorization" to mean that appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or in the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in a narrative form containing the same information required in the DWC Form PR-2.

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

**Section 9792.6(c)** The definition of "claims administrator" contained in subdivision 9792.6(c) was clarified to also include "an insured employer" and "other entity subject to Labor Code section 4610." Further, the last sentence of the definition which was added at the time of the Notice of Rulemaking after Emergency Adoption was amended for clarity purposes to state that

the claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities.

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

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

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

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

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

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

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

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

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

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

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

**Section 9792.7(a)(3)** Pursuant to public comment this subdivision was amended to clarify that the utilization plan set forth a description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process, and to require that the utilization review plan also contain a description of the process used to review authorization for treatment requests which falls outside the specified routine criteria in addition to the other requirements set forth in the subdivision.

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

**Section 9792.7(b)(2)** This subdivision was amended for clarification purposes to delete the phrase “no person, other than a licensed,” and to insert the word “reviewer” after the word “physician” to clarify that the “physician reviewer” is the only person authorized to delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

**Section 9792.7(b)(3)** This subdivision was amended to insert the word “requesting” in front to the word “physician” to clarify the reference to the requesting physician as opposed to the physician reviewer.

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

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

**Section 9792.8(a)(2)** Pursuant to public comment this subdivision was amended to substitute the word “covered” with the word “addressed” in the first sentence of the subdivision. Thus the first sentence now reads: “For all conditions or injuries not addressed by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.” This subdivision was further amended to add the requirement that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines.

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

**Section 9792.8(a)(3)(B)** This subdivision was amended to clarify that a written copy of the relevant portion of the criteria or guidelines used must be enclosed with the written decision to

the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney pursuant to section 9792.9, subdivision (i).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Either

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

or

"If you want further information, you may contact the local state Information and Assistance office closest to you. Please see attached listing (attach a listing of I&A offices and telephone numbers) or you may receive recorded information by calling 1-800-736-7401."

and

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

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

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

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

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

## **6. Section 9792.11 Utilization Review Standards—Penalties**

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