

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

NOTICE OF RULEMAKING AFTER EMERGENCY ADOPTION

Workers' Compensation – Utilization Review Standards

NOTICE IS HEREBY GIVEN that the Administrative Director of the Division of Workers' Compensation (hereinafter "Administrative Director"), exercising the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, has adopted regulations on an emergency basis to implement the provisions of Labor Code sections 4610 and 4604.5, as amended by Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004), and Labor Code section 4062 as amended by Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). The former section 9792.6 of the California Code of Regulations was repealed effective January 1, 2004, by Senate Bill 228 (Chapter 639, Stats. of 2003, section 49).

The regulations adopted constitute Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9792.6 through 9792.11. The regulations govern utilization review standards. The regulations implement, interpret, and make specific sections 4610 and 4604.5 of the Labor Code.

The emergency regulations listed below became effective on December 13, 2004, and will remain in effect for a period of 120 days from December 13, 2004. The purpose of this rulemaking is to adopt the emergency regulations on a permanent basis.

PROPOSED REGULATORY ACTION

The Department of Industrial Relations, Division of Workers' Compensation, proposes to adopt Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9792.6:

Section 9792.6	Utilization Review Standards—Definitions
Section 9792.7	Utilization Review Standards—Applicability
Section 9792.8	Utilization Review Standards—Medically-Based Criteria
Section 9792.9	Utilization Review Standards—Timeframe, Procedures and Notice Content
Section 9792.10	Utilization Review Standards—Dispute Resolution
Section 9792.11	Utilization Review Standards—Penalties

TIME AND PLACE OF PUBLIC HEARING

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, either orally or in writing, with respect to the subjects noted above. The hearing will be held at the following time and place:

Date: March 22, 2005
Time: 10:00 a.m.
Place: Auditorium
The Governor Hiram Johnson State Office Building
455 Golden Gate Avenue
San Francisco, California 94102

The State Office Building and its Auditorium are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or any other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the Statewide Disability Accommodation Coordinator, Adel Serafino, 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.

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation or 5:00 p.m., whichever is earlier. If public comment concludes before the noon recess, no afternoon session will be held.

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

AUTHORITY AND REFERENCE

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, 5307.3, 4610, and 4604.5.

Reference is to Labor Code sections 129, 129.5, 4062, 4600, 4600.4, and 4610.

INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW

These regulations are required by a legislative enactment - Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). Senate Bill 899 included Labor Code sections 5307.27, requiring the Administrative Director to adopt a medical treatment utilization schedule on or before December 1, 2004, section 4604.5, providing that the medical treatment utilization schedule pursuant to Labor Code section 5307.27 is presumptively correct on the issue of extent and scope of medical treatment, and that until such schedule is adopted the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines), is presumptively correct on the issue of extent and scope of medical treatment, and section 4610, requiring employers to establish and maintain a utilization review process.

Labor Code section 5307.27 provides that on or before December 1, 2004, the Administrative Director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule. The utilization schedule shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.

Labor Code section 4610 requires employers to establish and maintain a utilization review process, effective January 1, 2004, consistent with the utilization schedule developed by the Administrative Director pursuant to section 5307.27, and prior to the adoption of that schedule, consistent with the ACOEM Practice Guidelines.

Labor Code section 4604.5 provides that upon adoption by the Administrative Director of a medical treatment utilization schedule, pursuant to section 5307.27, the recommended guidelines set forth in that schedule shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to section 5307.27. The presumption is rebuttable and may be controverted by a preponderance of the

evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Labor Code section 4604.5 further provides that prior to the adoption of a utilization schedule by the Administrative Director, and three months after the publication date of the ACOEM Practice Guidelines, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the ACOEM Practice Guidelines. The ACOEM Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to section 5307.27. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Section 4604.5 further provides that for all conditions or injuries not covered by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

Labor Code section 4062 provides that if the employee objects to a decision made pursuant to section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement.

The former section 9792.6 of the California Code of Regulations is repealed effective January 1, 2004, by Senate Bill 228 (Chapter 639, Stats. of 2003, section 49).

The proposed regulations define the terms used in the controlling statutes, set forth the applicability of the utilization review process, identify the medically-based criteria required pursuant to the statute, set forth the timeframes, procedures and notice contents required pursuant to the statute, set forth the dispute resolution process, and identify the penalties which may be assessed for violations of the statute.

The described regulations were adopted as emergency regulations, effective December 13, 2004. This rulemaking would make the regulations permanent. These proposed regulations implement, interpret, and make specific Sections 4610 and 4604.5 of the Labor Code as follows:

1. Section 9792.6 Utilization Review Standards—Definitions

This section provides definitions for the following key terms: “ACOEM Practice Guidelines,” “claims administrator” (*this definition has been amended for clarity*), “concurrent review,” “course of treatment,” “emergency health care services,” “expedited review,” “expert reviewer,” “health care provider,” “medical services,” “prospective review,” “request for authorization,” “retrospective review,” “utilization review plan,” “utilization review process,” and “written.” The definitions are provided to ensure that their meaning, as used in the regulations, will be clear to the public.

2. Section 9792.7 Utilization Review Standards—Applicability

This section sets forth the applicability of the utilization review rules.

(a) This subdivision provides that effective January 1, 2004 every claims administrator shall establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury, in compliance with Labor Code section 4610. The subdivision further identifies, as listed below, the information required in the utilization review process as set forth in the utilization review plan.

(1) This subdivision requires the claims administrator to specify in the utilization review plan the name and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) This subdivision requires the claims administrator to specify in the utilization review plan a description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) This subdivision requires the claims administrator to specify in the utilization review plan a description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process. It further requires a description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria. It also indicates that prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the ACOEM Practice Guidelines. It further indicates that the Administrative Director incorporates by reference the ACOEM Practice Guidelines, Second Edition (2004), published by OEM Press, and provides that a copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempres.com).

(4) This subdivision requires the claims administrator to specify in the utilization review plan a description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

(b)(1) This subdivision requires the medical director to ensure that the utilization review process is set up in a manner that complies with this Labor Code section 4610 and these implementing regulations.

(2) This subdivision provides that no person, other than a licensed physician who is 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, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) This subdivision provides that a non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. It further provides that a non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. In addition, it provides that a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9 subdivisions (b)(1), (b)(2) or (c). Any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (f)(1)(A) through (f)(1)(C) of section 9792.9.

(c) This subdivision provides that the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. This subdivision further provides that in lieu of filing the utilization review plan, the claims

administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director.

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

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

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

This section sets the medically-based criteria required in the utilization review process which is to be reflected in the utilization review plan.

(a)(1) This subdivision provides that the criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the ACOEM Practice Guidelines. It further provides that the guidelines set forth in the ACOEM Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to Labor Code section 5307.27. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

(2) This subdivision provides that for all conditions or injuries not covered 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.

(3) This subdivision provides that the criteria or guidelines used shall be disclosed in written form to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, if used as the basis of a decision to modify, delay, or deny services in a specific case under review. The claims administrator may not charge an injured worker, the injured worker's attorney or the injured worker's physician or the provider of goods for a copy of the criteria or guidelines used to modify, delay or deny the treatment request.

(A) This subdivision provides that the claims administrator is required to disclose the criteria or guidelines used as the basis of a decision to modify, delay, or deny services for the specific procedure or condition requested in a specified case under review.

(B) This subdivision provides that a written copy of the relevant portion of the criteria or guidelines used shall be enclosed with the written decision to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney pursuant to section 9792.9, subdivision (i).

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

This section sets the timeframe, procedures and notices required in the utilization review process.

(a) This subdivision provides that the request for authorization must be in written form.

(1) This subdivision provides 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 transmitted. This subpart further provides that a request for authorization transmitted by facsimile after 5:30 PM Pacific Standard Time shall be deemed to have been received by the claims administrator on the following business day as defined in section 9 of the Civil Code. It also provides that the copy of the request for authorization received by a facsimile transmission shall bear a notation of the date and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted.

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

(b) This subdivision provides that the utilization review process shall meet the following timeframe requirements:

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

(2) This subdivision provides 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 within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of the original request for authorization by the health care provider.

(A) This subdivision provides 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 provider, the claims administrator may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

(3) This subdivision provides that decisions to approve, modify, delay or deny a physician's request for authorization prior to, or concurrent with, the provision of medical treatment services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve, modify, delay or deny a request shall be communicated to the physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the physician, the provider of goods, if any, the

injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours for concurrent review and within two business days for prospective review. For purposes of this section "normal business day" means a business day as defined in section 9 of the Civil Code.

(c) This subdivision provides that when review is retrospective, decisions shall be communicated to the physician who provided the medical services and the provider of goods, if any, the individual who received the medical services, and his or her attorney/designee, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. It further provides that failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services.

(d) This subdivision provides that prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. It further provides that the provider must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:

(1) This subdivision provides that decisions related to expedited review refer to situations when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function.

(2) This subdivision provides that decisions related to expedited review further refer to situations when the normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(e) This subdivision provides that the review and decision to deny, delay or modify a request for medical treatment must be conducted by a physician, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice.

(f) (1) This subdivision provides that the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may only be extended by the claims administrator under the following circumstances:

(A) This subdivision provides that the timeframes specified in subdivisions (b)(1), (b)(2) or (c) of this section may be extended when the claims administrator is not in receipt of all of the necessary medical information reasonably requested.

(B) This subdivision provides that the timeframes specified in subdivisions (b)(1), (b)(2) or (c) may also be extended when the physician reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

(C) This subpart provides that the timeframes specified in subdivisions (b)(1), (b)(2) or (c) may further be extended when the claims administrator needs a specialized consultation and review of medical information by an expert reviewer.

(2) This subdivision provides that if subdivisions (A), (B) or (C) above apply, the claims administrator shall immediately notify the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's

attorney, in writing, that the claims administrator cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the expert reviewer consulted. The claims administrator shall also notify the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, of the anticipated date on which a decision will be rendered. This subdivision further provides that this notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with section 10136, subdivision (b)(1).

(3) This subdivision provides that upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, modify, or deny the request for authorization within five (5) days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivision (b)(3).

(4) This subdivision provides that upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, modify, or deny the request for authorization within thirty (30) days of receipt of the information for retrospective review.

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

(h) This subdivision provides that a written decision approving a request for treatment authorization under this section must specify the specific medical treatment service approved.

(i) This subdivision provides that a written decision modifying, delaying or denying treatment authorization under this section shall be provided to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, and shall contain the following information:

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

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

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

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

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

(6) The clinical reasons regarding medical necessity.

(7) A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney on behalf of the injured worker to the claims administrator in writing within 20 days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state that the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with section 10136, subdivision (b)(1).

(8) Include the following mandatory language:

"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.

"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."

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

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

(j) This subdivision provides that a written decision modifying, delaying or denying treatment authorization provided to the physician shall also contain the name of the physician reviewer, the specialty of the reviewer, the telephone number of the reviewer, and hours of availability.

(k) This subdivision provides 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 either by facsimile or mail.

5. Section 9792.10 Utilization Review Standards—Dispute Resolution

This section sets forth the dispute resolution process applicable to utilization review decisions.

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

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

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

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

(b) This subdivision provides that the following requirements must be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the injured worker's physician and provider of goods, if any, has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the injured worker.

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

6. Section 9792.11 Utilization Review Standards—Penalties

This section sets forth the penalties applicable in the utilization review process.

(a) This subdivision is reserved for a Labor Code section 4610 penalty rule.

(b) This subdivision provides that the Administrative Director, or his or her delege, may use the audit powers pursuant to Labor Code sections 129 and 129.5 to assess administrative and civil penalties for violations of this Article.

DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION

The Administrative Director has made the following initial determinations:

- Significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states: None.
- Adoption of this regulation will not: (1) create or eliminate jobs within the State of California; (2) create new businesses or eliminate existing businesses within the State of California; or (3) affect the expansion of businesses currently doing business in California.
- Effect on Housing Costs: None.

- Cost impacts on representative private person or business: The Administrative Director has determined that the proposed regulations will not have a significant adverse economic impact on representative private persons or directly affected businesses. These representative private persons or directly affected businesses are up to 10,000 businesses. All California employers will be required to establish and maintain a utilization review process through their claims administrator. Many of these employers have some type of utilization review process in place. A small number of these businesses who do not have a utilization review process in place or employers who need to update their utilization review process could experience a minor impact.
- There will be some small costs related to revising and updating computer systems in connection with the utilization review process/plan, and purchase of the ACOEM Practice Guidelines at the cost of \$195.00 per book.

FISCAL IMPACTS

- Costs or savings to state agencies or costs/savings in federal funding to the State: None.
- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The potential costs imposed on all public agency employers by these proposed regulations, although not a benefit level increase, are not a new State mandate because the regulations apply to all employers, both public and private, and not uniquely to local governments. The Administrative Director has determined that the proposed regulations will not impose any new mandated programs on any local agency or school district. The California Supreme Court has determined that an increase in workers' compensation benefit levels does not constitute a new State mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. See *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46. The potential costs imposed on all public agency employers and payors by these proposed regulations, although not a benefit level increase, are similarly not a new State mandate because the regulations apply to all employers and payors, both public and private, and not uniquely to local governments.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. (See "Local Mandate" section above.)
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed regulation does not apply to any local agency or school district. (See "Local Mandate" section above.)

EFFECT ON SMALL BUSINESS

The Administrative Director has determined that the proposed regulations will result in small initial costs to small businesses if they do not have a utilization review process in place already. These small businesses will have to develop their own utilization review process pursuant to the regulations or contract with an external utilization review organization. These small businesses may also have some costs related to revising and updating computer systems in connection with the utilization review process/plan, and may have to purchase the ACOEM Practice Guidelines at the cost of \$195.00/each.

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 actions are proposed, or would be as effective and less burdensome to affected private persons than the proposed actions.

The Administrative Director invites interested persons to present reasonable alternatives to the proposed regulation at the scheduled hearing or during the written comment period.

PUBLIC DISCUSSIONS OF PROPOSED REGULATION

Public discussion of the proposed regulations pursuant to Government Code section 11346.45 is not required to implement the proposed regulations because the issue addressed is not so complex that it cannot easily be reviewed during the comment period. The Administrative Director, however, prior to the emergency adoption of the regulations, held several stakeholder meetings to which the public was invited, at which proposed regulations were discussed, and at which a representative group of interested parties was present.

In addition, the text of the proposed regulations was made available for three pre-adoption public comment periods through the Division's Internet message board (the DWC Forum).

AVAILABILITY OF INITIAL STATEMENT OF REASONS AND TEXT OF PROPOSED REGULATION / INTERNET ACCESS

An Initial Statement of Reasons and the text of the proposed regulation have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below or a copy will be provided upon written request.

In addition, this Notice, the Initial Statement of Reasons, and the text of regulations may be accessed and downloaded from the Department of Industrial Relations' Internet site at www.dir.ca.gov under the heading "Rulemaking-proposed regulations." Any subsequent changes in regulation text, and the Final Statement of Reasons will be available at that Internet site when made.

PRESENTATION OF ORAL AND/OR WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present oral and/or written statements, arguments or evidence at the public hearing. If you provide a written comment, it will not be necessary to present your comment as oral testimony at the public hearing.

Any person may submit written comments on the proposed regulation, prior to the public hearing to:

Ms. Kathleen Llemos
Division of Workers' Compensation - 9th Floor
Post Office Box 420603
San Francisco, CA 94142

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

Unless submitted prior to or at the public hearing, all written comments must be received by the agency contact person, no later than 5:00 p.m. on **March 22, 2005**. Equal weight will be accorded to oral and written materials.

COMMENTS TRANSMITTED BY E-MAIL OR FACSIMILE

Due to the inherent risks of non-delivery by facsimile transmission and email transmission, the Administrative Director suggests, but does not require, that a copy of any comments transmitted by facsimile transmission or email transmission also be submitted by regular mail.

Comments sent to other e-mail addresses or other facsimile numbers will not be accepted. Comments sent by e-mail or facsimile are subject to the deadline set forth above for written comments.

AVAILABILITY OF RULEMAKING FILE AND LOCATION WHERE RULEMAKING FILE MAY BE INSPECTED

Any interested person may inspect a copy or direct questions about the proposed regulation, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file.

The rulemaking file, including the Initial Statement of Reasons, the complete text of the proposed regulation and any documents relied upon in this rulemaking may be inspected during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday, excluding public holidays) at the following location:

Division of Workers' Compensation
455 Golden Gate Avenue, Ninth Floor
San Francisco, California 94102

AVAILABILITY OF RULEMAKING DOCUMENTS ON THE INTERNET

Documents concerning this proceeding are available on the Division's website: www.dir.ca.gov. To access them, click on the "Proposed Regulations - Rulemaking" link and scroll down the list of rulemaking proceedings to find the "Utilization Review Standards" rulemaking link.

CONTACT PERSON:

Nonsubstantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulation, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be directed to the contact person. The contact person is:

Ms. Kathleen Llemos
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The telephone number of the contact person is (415) 703-4600.

**BACK-UP CONTACT PERSON / CONTACT PERSON FOR
SUBSTANTIVE QUESTIONS**

To obtain responses to questions regarding the substance of the proposed regulation, or in the event the contact person is unavailable, inquiries should be directed to: Minerva Krohn, Industrial Relations Counsel, at the same address and telephone number as noted above for the contact person.

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING

If the Administrative Director makes changes to the proposed regulation as a result of the public hearing and public comment received, 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 regulation is adopted. The modified text will be made available on the Division's website: www.dir.ca.gov and may be located by following the direction provided 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: www.dir.ca.gov by following the directions provided above.

AUTOMATIC MAILING

A copy of this Notice, including the Informative Digest, will automatically be sent to those interested persons on the Administrative Director's mailing list.

If adopted on a permanent basis, the proposed regulation will remain in effect at Title 8, California Code of Regulations, sections 9792.6 through 9792.11.