FINDING OF EMERGENCY
OF THE
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REGARDING THE CALIFORNIA LABOR CODE
CALIFORNIA CODE OF REGULATIONS,
TITLE 8, ARTICLE 5.5.1
UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

Government Code Section 11346.1 requires a finding of emergency to include a written statement with the information required by paragraphs (2), (3), (4), (5) and (6) of subsection (a) of Section 11346.5 and a description of the specific facts showing the need for immediate action.

The Acting Administrative Director of the Division of Workers' Compensation finds that the adoption of these regulations is necessary for the immediate preservation of the public peace, health and safety, or general welfare, as follows:

FINDING OF EMERGENCY

Basis for the Finding of Emergency

- On September 18, 2012, the Governor signed Senate Bill (SB) 863 (Statutes of 2012, Chapter 363), the major provisions of which take effect on January 1, 2013.

- SB 863 has created substantial changes in the manner by which medical treatment decisions are made for employees who suffer occupational injuries. These changes take effect for those who are injured after January 1, 2013. Some of the changes will also impact those who are injured prior to January 1, 2013.

- In passing SB 863, the Legislature expressly found in Section 1(d), that the current system of resolving disputes over the medical necessity of requested treatment, set forth in the mandatory utilization review process of Labor Code section 4610, is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, thereby adversely affecting the health and safety of workers injured in the course of employment.

- The Legislature further found in Section 1(e) that having medical professionals – rather than administrative law judges - ultimately determine the necessity of requested treatment furthers the social policy of this state that promotes using evidence-based medicine to provide injured workers with the highest quality of medical care. The Legislature unequivocally stated that the best manner to implement this policy was by establishing a system of independent medical review.

- The Legislature additionally found in Section 1(f) that independent medical review is a new state function of such a highly specialized and technical nature that it must be contracted out since the necessary expert knowledge, experience, and ability are not available through the civil service system. See Government Code section 19130(b)(2) and (3).

- An independent medical review system, as also found by the Legislature in Section 1(f), using independent and unbiased medical expertise of specialists, can issue timely and medically sound determinations of disputes over appropriate medical treatment. This system is far superior to the existing process of appointing qualified medical evaluators (QME) to examine patients and resolve treatment disputes, a process which is costly and time-consuming, and prolongs disputes and causes delays in medical treatment for injured workers. (The current system can take up to 18 or 24 months for a decision. Independent Medical Review conversely, can be completed within 2 -3 months.) Further, the process of selection of QMEs can bias the outcomes.

- Action is necessary in order to implement, on an emergency basis, the provisions of Labor Code sections 4610, 4610.5, and 4610.6, as either amended or enacted by SB 863. Regulations to implement independent medical review are necessitated by Labor Code section 4610.5(f), which mandates the Administrative Director to prescribe a form for initiating the independent medical review process, section 4610.5(i) which authorizes the Administrative Director to establish administrative penalties for employer conduct in delaying the review process, and section 4603.5, which requires the Administrative Director to adopt necessary to make effective the requirements of Article 2 of the Labor Code (commending at section 4600).

- An employee who is injured on or after January 1, 2013 will have no regulatory procedures available to have an adverse utilization review decision by their employer's claims administrator - to delay, deny, or modify a medical treatment request by the employee's treating physician - reviewed and ultimately decided by an unbiased independent medical evaluator applying a hierarchy of objective, evidence-based medical treatment guidelines.

- The Emergency Regulations will insure, for those having been injured on or after January 1, 2013, the delivery of quality medical care in the most efficient, effective manner possible.

Background

- The Division of Workers' Compensation develops regulations to implement, interpret, and make specific the California Labor Code. (See Labor Code section 5307.3)

- SB 863 was signed into law by Governor Brown on September 18, 2012 to become effective January 1, 2013.

- On October 2, 2012, the DWC held a working group meeting open to the public to obtain input from the stakeholders.

- Draft regulations were posted on the DWC public forum from December 3 through December 7, 2012, to allow for informal public comment.

AUTHORITY AND REFERENCE

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, proposes to amend Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9785, 9792.6, 9792.9, 9792.10, and 9792.12 and adopt Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9785.5, 9792.6.1, 9792.9.1, 9792.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.7, 9792.10.8, and 9792.10.9.

INFORMATIVE DIGEST

Summary of Existing Laws

Labor Code section 4610 requires utilization review for all requests for medical services to treat occupational injuries. Treatment requests, generally made by an injured worker's primary treating physician, must be reviewed to determine if the proposed treatment is medically necessary under the guidelines set forth in the Division of Workers' Compensation's (DWC) Medical Treatment Utilization Schedule (MTUS), which was adopted by the Administrative Director under Labor Code section 5307.27. Decisions to approve requests for treatment can be made by non-physician reviewers, such as claims adjustors, while decisions to delay, modify, or deny treatment requests must be made by a physician reviewer. A decision to delay treatment may be made if the physician reviewer has not received all information from the requesting treating physician that is necessary to make a decision, and such information has been requested but not yet provided. A decision to modify treatment may be made if the requested treatment is deemed necessary, but specific elements of the request are not within the guidelines of the MTUS or are not appropriate for the injured worker's condition. A decision to deny may be made if the requested treatment is not medically necessary under the MTUS guidelines or if a legal basis exists upon which to deny treatment (i.e., the requested treatment is for a denied body part).

Currently, an injured worker seeking review of an adverse utilization review decision must select a Qualified Medical Evaluator (QME) under Labor Code section 4062. The QME must examine the injured worker and then issue a comprehensive medical report which rules on the propriety of the initial treatment request. Either the injured worker or the claims administrator may object to the QME decision by litigating the issue before a Workers' Compensation Administrative Law Judge (WCALJ). It is generally recognized that the procedure by which to challenge an adverse UR decision, selecting a QME with possible litigation afterword, is both complex and time-consuming.

Labor Code sections 4610.5 and 4610.6, as enacted in SB 863, implement an independent medical review (IMR) process which is similar in structure to that used by the Department of Managed Health. See California Health and Safety Code, sections 1370.4 and 1374.30 through 1374.36. As of January 1, 2013 for injuries occurring on or after that date, and as of July 1, 2013 for all dates of injury, IMR will be used to decide disputes regarding medical treatment in workers' compensation cases.

In order to ensure that IMR decisions will only address the question of medical necessity, Labor

Code section 4610 was amended to allow claims administrators to defer utilization review on medical necessity decisions until other issues – such as those affecting liability – have been ultimately decided.

Under newly-enacted sections 4610.5 and 4610.6, IMR can only be requested by an injured worker following a denial, modification, or delay of a treatment request through the utilization review (UR) process. Employers and claims administrators cannot request review of treatment authorizations. With the adverse UR decision, the claims administrator must provide a form for the injured worker to request IMR. An injured worker can be assisted by an attorney or by his or her treating physician in the IMR process. Upon a finding that the request is eligible for IMR, i.e., has no unresolved liability issues, an assigned physician reviewer, selected under stringent standards by the contracted independent medical review organization, will review relevant medical records supplied by both parties and apply recognized treatment guidelines to determine if the requested medical treatment is appropriate for the injured worker's condition. Section 4610.5(c)(2) requires the application of a hierarchy of standards that are to be utilized, headed by the MTUS adopted by the Administrative Director as the highest source for evaluating the appropriateness of medical treatment.

Under section 4610.6(d), the IMR process must be completed within 30 days following receipt of all records. IMR appeals will be considered by a workers' compensation judge. However, the IMR physician reviewer's decision on the medical necessity of the medical treatment cannot be overturned by a judge. A decision can only be overturned on the basis of fraud, conflict of interest, or mistake of fact.

The proposed regulations will provide the public with clear guidelines for the mandated IMR process and set forth the obligations that injured workers and claims administrators must meet in order for the process to work. The regulations will ensure that medical treatment decisions in workers' compensation cases will be made by a conflict-free medical expert applying sound medical decisions that are based on a hierarchy of evidence-based medicine standards.

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS RELIED UPON

- Department of Industrial Relations' contract (DIR Agreement # 41230038) with Maximus Federal Services, Inc. to provide Independent Medical Review Services.
- WCIRB's Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012.

SUMMARY OF PROPOSED REGULATIONS

The Administrative Director adopts and amends administrative regulations regarding independent medical review. These regulations implement, interpret, and make specific sections 4610, 4610.5, and 4610.6 of the Labor Code as follows:

Item 1 – Section 9785. Reporting Duties of Primary Treating Physician.

- The section sets forth the reporting duties of the employee's primary treating physician. The section is amended to expressly provide that IMR is the procedure for disputing adverse medical treatment decisions, rather than the QME process of Labor Code sections 4061 and 4062.

- The reference to repealed Labor Code section 4636 is deleted in subdivision (f)(6).

- Added subdivision (g) expressly provides that a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the Request for Authorization of Medical Treatment," DWC Form RFA, contained in section 9785.5

- In compliance with Labor Code section 4658.7, and corresponding emergency regulations filed by DWC, added subdivision (i) provides that a primary treating physician, upon finding that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, shall complete the "Physician's Return-to-Work & Voucher Report" (DWC-AD 10133.36) and attach the form to a permanent and stationary medical report.

Item 2 – Section 9785.5. Request for Authorization Form, DWC Form RFA.

- This section is the form to be used by treating physicians to request the authorization of proposed medical treatment under Labor Code section 4610. The form contains identifying information regarding the injured worker, the provider, and the claims administrator, and requires specific information regarding the proposed treatment (i.e., diagnosis, frequency, duration, quantity). The form will assist in defining treatment requests and will promote communication between the provider and the claims administrator, thereby reducing disputes that could be subject to IMR.

Item 3 – 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.

- Based on Labor Code section 4610.5 (a), the regulation is amended to provide that the definitions for an occupational injury or illness occurring prior to January 1, 2013 if the request is made prior to July 1, 2013.

Item 4 – Section 9792.6.1. Utilization Review Standards—Definitions – On or After January 1, 2013.

- Based on Labor Code section 4610.5 (a), the regulation is added to provide definitions for key terms regarding utilization review (UR) standards for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the request is made on or after July 1, 2013, regardless of the date of injury.

- Definitions that vary from section 9792.6 include "authorization," which now specifies the completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5 (subdivision (d)), "claims administrator," which includes the Uninsured Employers Benefits Trust Fund (UEBTF) and any utilization review organization (subdivision (c)), "disputed liability," which means an assertion by the claims administrator that a factual or legal basis exists that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment (subdivision (h)), and "request for authorization," which requires that a request be made on the DWC Form RFA (subdivision (s)).

- Definitions of “delay,” “deny,” and “modification” are added to ensure that their meaning, as used in the regulations, will be clear to the regulated public.

Item 5 - Section 9792.9. Utilization Review Standards--Timeframe, Procedures and Notice – For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

- This section was amended to reflect its application to an occupational injury or illness occurring prior to January 1, 2013 if the request is communicated to the requesting physician prior to July 1, 2013.

- Subdivision (b) is added to conform to amended Labor Code section 4610(g)(7) and (8), which allows UR to be deferred if there is a dispute regarding liability. The subdivision sets forth the procedure by which to defer UR and, upon a determination regarding liability, when the UR procedure recommences.

- Renumbered subdivisions (h)(2) and (k) deletes references to obsolete forms.

- Subdivision (*l*) sets forth the requirements of a written UR decision modifying, delaying or denying treatment authorization, if the decision is sent on or after July 1, 2013. The letter must include the postage-paid Application for Independent Medical Review, DWC Form IMR-1, with all fields, except for the signature of the employee, to be completed by the claims administrator. This application is mandated under Labor Code section 4610.5(f). The mandatory language in subdivision (*l*)(8) is revised to be in plain language, as required by Labor Code section 138.4.

- Subdivision (o) is added to comply with Labor Code section 4610(g)(6), which mandates that, absent a change in material facts, a UR decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator

Item 6 – Section 9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013.

- This section was added to apply to either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where a treatment request is made on or after July 1, 2013, regardless of the date of injury.

- This section sets forth UR timeframes and procedures in light of the changes mandated by SB 863. Significant changes include the required use of the “Request for Authorization for Medical Treatment (DWC Form RFA),” as contained in California Code of Regulations, title 8, section 9785.5. This form will assist in defining treatment requests so that disputes regarding ambiguous requests, or those that are not compliant with the MTUS, can be resolved prior to the initiation of the IMR process.

- Subdivision (b) conforms to amended Labor Code section 4610(g)(7) and (8), which allows UR to be deferred if there is a dispute regarding liability. The subdivision sets forth the procedure by which to defer UR and, upon a determination regarding liability, when the UR procedure recommences.

- The timeframes in the proposed regulation match those of existing section 9792.9.

However, they are restructured in a more logical order to match the type of UR decision that is being rendered by the claims administrator.

- Written decisions to delay, deny, or modify a UR request, the requirements of which are set forth in subdivision (e), include the postage-paid Application for Independent Medical Review, DWC Form IMR-1.

- Subdivision (f) clarifies the procedure to follow when a claims administrator notifies the provider of an allowed extension of the UR timeframes (based on the lack of information submitted with the request or the need for an additional test or specialized consultation.

- Subdivision (h) is included to comply with Labor Code section 4610(g)(6), which mandates that, absent a change in material facts, a UR decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator.

Item 7 – Section 9792.10. Utilization Review Standards--Dispute Resolution– For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

- This section is amended to clarify its application to UR decisions issued prior to July 1, 2013 for occupational injuries occurring prior to January 1, 2013. References to obsolete forms are deleted in subdivision (a)(4).

Item 8 – Section 9792.10.1. Utilization Review Standards--Dispute Resolution – On or After January 1, 2013.

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

- Definitions of “claims administrator,” “disputed medical treatment,” “expedited review,” “medically necessary,” and “utilization review decision” are added to ensure that their meaning, as used in the regulations, will be clear to the regulated public.

- Definition of “medically necessary” in subdivision (a)(4) includes the hierarchy of objective, evidence-based medical treatment guidelines, starting with the MTUS, that will be applied by IMR reviewers.

- Subdivision (b) reaffirms Labor Code section 4610.5’s mandate that all treatment disputes must be resolved by the IMR procedure. The subdivision sets forth the timeframe in which to request IMR, the requirement that the Application for Independent Medical Review, DWC Form IMR-1, be used, the parties who are eligible to seek review of a treating physician’s treatment recommendation, and requirement for a physician certification if an expedited review is sought.

- Subdivision (c) sets forth the timeframes for sending an IMR request if liability is disputed or if the claims administrator fails to provide the form with its adverse decision letter.

- Subdivision (d) provides that the employee may utilize the claims administrator’s internal

appeal process to resolve treatment disputes. Any such internal appeal must be completed within 15 days of the UR decision.

- Subdivision (e) requires that medical care should not be discontinued in the case of concurrent (in-patient) review until a plan has been agreed upon.

Item 9 – Section 9792.10.2. Application for Independent Medical Review, DWC Form IMR-1.

- This section is the form to be used by the employee to apply for IMR. The contents of the form are mandated by Labor Code section 4610.5(f). The form will be completed by the claims administrator and will accompany the adverse UR decision letter.

Item 10 – Section 9792.10.3. Independent Medical Review – Initial Review of Application.

- This section sets forth the process by which the Administrative Director determines, based on an initial review of the IMR application, whether the medical treatment dispute is eligible for IMR.

- Subdivision (a) sets forth several reasons why an application may be deemed ineligible, including an untimely filing, a duplicate filing, or one in which a liability determination must be made prior to the initiation of IMR.

- Subdivision (b) and (c) allow the Administrative Director to request, and the parties to submit, additional documentation addressing the issue of eligibility.

- Determinations of ineligibility are issued by the Administrative Director; such determinations are subject to appeal before Workers' Compensation Appeals Board within 30 days of receipt of the determination.

Item 11 – Section 9792.10.4. Independent Medical Review – Assignment and Notification.

- This section implements Labor Code section 4610.5(k) by setting forth the procedure by which the independent medical review organization (IMRO) notifies the parties that the IMR application is eligible for IMR review. The IMRO will advise the parties of: the IMRO contact information; the disputed medical treatment subject to review, with pertinent information such as provider name and UR decision date; whether the review is expedited; and the documents that must be provided by the parties to conduct a review.

- The claims administrator is advised that the failure to comply with the document production section – section 9792.10.5 - could result in the assessment of administrative penalties up to $5,000.00 per day.

- Subdivision (g) provides that a regular IMR review could be converted into an expedited review if, subsequent to the receipt of the IMR application, the IMRO receives from the employee's treating physician a certification that the employee faces an imminent and serious threat to his or her health.

Item 12 – Section 9792.10.5. Independent Medical Review – Medical Records.

- This section sets forth the documents that must be provided by the claims administrator, and may be provide by the injured worker, in order to conduct IMR. The documents to

be provided by the claims administrator are mandated by Labor Code section 4610.5(*l*) and (m). The documents to be provided by the employee is set forth at Labor Code section 4610.5(f)(3). The parties may also submit any newly developed or discovered relevant medical records.

- The parties are to submit the documents concurrently, within fifteen (15) days following receipt of the IMRO assignment notification, or, for expedited review, within (24) hours following receipt of the notification.

- Subdivision (c) allows the IMRO to request additional documents or information necessary to make a determination that the requested treatment is medically necessary.

Item 13 – Section 9792.10.6. Independent Medical Review – Standards and Timeframes.

- This section sets forth the process by which a medical reviewer assigned by the IMRO reviews all necessary evidence and issues an IMR determination as to whether the disputed medical treatment is medically necessary based on the specific medical needs of the employee and the medical treatment guidelines. Subdivision (b) allows the IMRO, upon written approval of the Administrative Director, to use more than one reviewer if it is found that the employee's condition and the disputed medical treatment is sufficiently complex such that a single reviewer could not reasonably address all disputed issues.

- Subdivision (d) sets forth the required elements of an IMR determination.

- Subdivision (e) provides that the IMRO shall provide the Administrative Director and the parties with a final IMR determination. The final IMR determination shall include a description of the qualifications of the medical reviewer, the determination issued by the medical reviewer. The IMRO must, in compliance with Labor Code section 4610.6(f), keep the names of the reviewer confidential. Under subdivision (h) the final IMR determination is deemed to be the determination of the Administrative Director and is binding on all parties.

- Subdivision (g) sets forth the timeframes for the IMRO to issue an final IMR determination. For a regular review, the deadline is within thirty (30) days of the receipt of the IMR application and all supporting documents. For expedited review, the deadline is within three (3) days of the receipt of the IMR application and supporting documentation. The deadlines may be extended for up to three days in extraordinary circumstances or for good cause.

Item 14 – Section 9792.10.7. Independent Medical Review – Implementation of Determination and Appeal.

- This section applies Labor Code section 4610.6(j)'s mandate as to how and when final IMR determinations are implemented, and provides that a claims administrator is subject to administrative penalties for a failure to timely implement a decision.

- Subdivision (c) and (d) provide and clarify the time and manner by which a claims administrator can appeal a final IMR determination to the Workers' Compensation Appeals Board (WCAB), as allowed by Labor Code section 4610(h).

- Subdivision (h) implements Labor Code section 4610.6(i) by providing the procedure for

reassigning an IMR review should the WCAB reverse and remand the final IMR determination.

Item 15 – Section 9792.10.8. Independent Medical Review – Payment for Review

- Labor Code section 4610.6 requires that the costs of IMR and the administration of the IMR system be borne by employers through a fee system established by the Administrative Director. The Administrative Director must establish a reasonable per-case reimbursement schedule to pay the costs of IMR reviews, which may vary based on the type of medical condition under review and on other relevant factors. This section sets forth the reasonable costs of the IMR process. The amounts were determined by the contracted IMRO, Maximus Federal Services, Inc., in consultation with DWC. Factors considered in the fees were: whether the physician reviewer was a M.D. or a D.O.; whether the review was performed on a regular basis or was expedited; and whether the review was withdrawn.

- Subdivision (c) provides that the aggregate total fee owed by the claims administrator for IMR reviews conducted during the prior calendar month shall be paid to the IMRO within thirty (30) days of the billing. A 10 percent increase will be applied if the invoice is not paid within ten (10) days after it becomes due.

- Subdivision (d) provides that the IMR fee is non-refundable and not subject to discount or rebate. Any discount involving the fee will be submitted to the Administrative Director for informal resolution.

Item 16 – Section 9792.10.9. Independent Medical Review – Publishing of Determination.

- This section implements Labor Code section 4610.6(m), providing that the Administrative Director may publish the results of independent medical review determinations after removing all individually identifiable information, including, but not limited to, the employee, all medical providers, the claims administrator, any of the claims administrator's employees or contractors, or any utilization review organization.

Item 17 – Section 9792.12. Administrative Penalty Schedule for Utilization Review and Independent Medical Review Violations.

- This section is amended to set forth the administrative penalties that may be assessed against claims administrators for violating their UR and IMR obligations. Mandatory penalties include:

- For the failure to timely communicate a written decision modifying, delaying, or denying a treatment authorization: $250 per day, up to a maximum of $5,000.

- For the failure to provide an IMR Application: $2,000.

- For the failure to include in a written decision modifying, delaying, or denying a treatment authorization notification of the IMR process: $2,000.

- For the failure to include in a written decision modifying, delaying, or denying a treatment authorization notification of the voluntary internal appeal process and that such a process is not a bar to pursuing IMR: $2,000.

- For the failure to timely provide IMR information requested by the Administrative Director: $100.00 for each day the response is untimely, up to a maximum of $5,000.00.
- For the failure to timely provide all mandatory IMR information: $250.00 for each day the response is untimely under section 9792.10.3(c), up to a maximum of $5,000.00.
- For the failure to timely implement a final IMR determination of the Administrative Director: $500.00 for each day up to a maximum of $5,000.00.
- For the failure to timely pay a fee invoice sent by the IMRO: $250.

Statewide Adverse Economic Impact on Business

The Department of Industrial Relations, Division of Workers' Compensation has determined that the proposed regulatory action will have no significant statewide adverse economic impact directly affecting business. The Division relies upon the costs savings estimates set forth in the WCIRB's Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012.

Policy Statement Overview

The objective of the proposed emergency regulations is to establish an independent medical review program, when medical treatment decisions are made by conflict-free medical experts applying recognized treatment guidelines, for injured workers with dates of injury occurring on or after January 1, 2013 as mandated by Labor Code section 4610.5 and 4610.6.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

NONE

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The Department of Industrial Relations, Division of Workers' Compensation has determined that this proposed regulatory action would not impose a mandate on local agencies or school districts.

FISCAL IMPACT STATEMENT (attached Form 399)

A. Cost or Savings to any state agency: **NONE**

B. Cost to any local agency required to be reimbursed under Part 7(commencing with Section 17500) of Division 4: **NONE**

C. Cost to any school district required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4: **NONE**

D. Other nondiscretionary cost or savings imposed on local agencies: **NONE**

E. Cost or savings in federal funding to the state: **NONE**

STATEMENT OF CONFIRMATION OF
MAILING OF FIVE-DAY EMERGENCY NOTICE
(Title 1, CCR section 50(a)(5)(A))

The Division of Workers' Compensation sent notice of the proposed emergency action to every person who has filed a request for notice of regulatory action at least five working days before submitting the emergency regulations to the Office of Administrative Law in accordance with the requirements of Government Code section 11346.1(a)(2).