Regulations: Medical Provider Network, Physician Reporting, Utilization Review and Independent Medical Review

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

Article 3.5. Medical Provider Network

§9767.6. Treatment and Change of Physicians Within MPN

(a) When the injured covered employee notifies the employer or insured employer of the injury or files a claim for workers' compensation with the employer or insured employer, the employer or insurer or entity that provides physician network services shall arrange an initial medical evaluation with a MPN physician in compliance with the access standards set forth in section 9767.5.

(b) Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall provide for all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 and as set forth in title 8, California Code of Regulations, section 9792.20 et seq.

(c) The employer or insurer shall provide for the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars ($10,000).

(d) The insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

(e) At any point in time after the initial medical evaluation with an MPN physician, the covered employee may select a physician of his or her choice from within the MPN. Selection by the covered employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question. If a chiropractor is selected as a treating physician, the chiropractor may act as a treating physician only until the 24-visit cap is met unless otherwise authorized by the employer or insurer, after which the covered employee must select another treating physician in the MPN who is not a chiropractor, and if the employee fails to do so, then the insurer or employer may assign another treating physician who is not a chiropractor.

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee, within twenty (20) days of notice of selected physician, all

relevant medical records relating to the claim, if any, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall provide~~advise~~ any subsequently selected MPN physician ~~that~~ with any medical record or diagnostic and laboratory test result deemed relevant by that provider ~~will be delivered~~ upon request. The insurer or employer shall also provide ~~advise~~ all selected MPN physicians of the relevant MPN identification number, name, telephone number, fax number, email address, and mailing address of the person or entity to whom a request for authorization and bills should be sent.

(g) ~~(f)~~ A Petition for Change of Primary Treating Physician, as set forth at section 9786, cannot be utilized to seek a change of physician for a covered employee who is treating with a physician within the MPN, except as allowed under subdivision (b)(6) of section 9786. If the employer petitions to change the Primary Treating Physician pursuant to Labor Code section 4603, the panel of physicians shall be from the current MPN provider listing and shall meet the applicable MPN Access Standards.

Note: Authority cited: Sections 133, 4616(h) and 5307.3, Labor Code.
Reference: Sections 4604.5, 4616, 4616.3, 5307.27 and 5401, Labor Code.

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

§9781. Employee's Request for Change of Physician.

(a) This section shall not apply to self-insured and insured employers who offer a Medical Provider Network pursuant to section 4616 of the Labor Code.

(b) Pursuant to section 4601 of the Labor Code, and notwithstanding the 30 day time period specified in subdivision (c), the employee may request a one time change of physician at any time.

(1) An employee's request for change of physician pursuant to this subdivision need not be in writing. The claims administrator shall respond to the employee in the manner best calculated to inform the employee, and in no event later than 5 working days from receipt of said request, the claims administrator shall provide the employee an alternative physician, or if the employee so requests, a chiropractor or acupuncturist.

(2) Notwithstanding subdivision (a) of section 9780.1, if an employee requesting a change of physician pursuant to this subdivision has notified his or her employer in writing prior to the date of injury that he or she has either a personal chiropractor or a personal acupuncturist, and where the employee so requests, the alternative physician tendered by the claims administrator to the employee shall be the employee's personal chiropractor or personal acupuncturist as defined in subdivisions (b) and (c), respectively, of Labor Code section 4601. The notification to the employer must include the name and business address of the chiropractor or acupuncturist. The employer shall notify its employees of the requirements of this subdivision and provide its employees with an optional form for notification of a personal chiropractor or acupuncturist, in accordance with section 9880. DWC Form 9783.1 in section 9783.1 may be used for this purpose.

(3) Except where the employee is permitted to select a personal chiropractor or acupuncturist as defined in subdivisions (b) and (c), respectively, of Labor Code section 4601, the claims administrator shall advise the employee of the name and address of the alternative physician, or chiropractor or acupuncturist if requested, the date and time of an initial scheduled appointment, and any other pertinent information.

(c) Pursuant to section 4600, after 30 days from the date the injury is reported, the employee shall have the right to be treated by a physician or at a facility of his or her own choice within a reasonable geographic area.

(1) The employee shall notify the claims administrator of the name and address of the physician or facility selected pursuant to this subdivision. However, this notice requirement will be deemed to be satisfied if the selected physician or facility gives

notice to the claims administrator of the commencement of treatment or if the claims administrator receives this information promptly from any source.

(2) If so requested by the selected physician or facility, the employee shall sign a release permitting the selected physician or facility to report to the claims administrator as required by section 9785.

(d) When the claims administrator is notified of the name and address of an employee-selected physician or facility pursuant to subdivision (c), or of a personal chiropractor or acupuncturist pursuant to paragraph (2) of subdivision (b), the claims administrator shall, in writing, within twenty (20) days of receipt of notice of selected physician:

(1) Aauthorize such physician or facility or personal chiropractor or acupuncturist to provide all medical treatment reasonably required pursuant to section 4600 of the Labor Code.;

(2) Ffurnish the name and address contact information of the person or entity to whom billing for treatment should be sent.;

(3) arrange for the delivery Deliver to the initially selected physician or facility or personal chiropractor or acupuncturist of all relevant medical records information relating to the claim, including the results of diagnostic and laboratory testing all X-rays and the results of all laboratory studies done in relation to the injured employee's treatment.; and

(4) Advise any subsequently selected physician or facility or personal chiropractor or acupuncturist that any medical record or diagnostic test result deemed relevant to that provider will be delivered upon request.

(5) Provide the physician or facility with the name, telephone number, fax number, mailing address, and, if applicable, email address of the person or entity to whom a request for authorization should be sent.;

(6) If applicable, provide the physician or facility with a list of medical treatment services that can be rendered without the submission of a request for authorization.

(4) (7) provide the physician or facility with (1) the fax number, if available to be used to request authorization of treatment plans; (2) the complete requirements of section 9785; and (2) (3) the forms set forth in section 9785.2 and 9785.4 required reporting forms under that section. In lieu of providing the materials required in (1) and (2) and (3) immediately above, the claims administrator may shall may refer the physician or facility to the Division of Workers' Compensation's website where the applicable information and forms can be found at http://www.dir.ca.gov/DWC/dwc_home_ page.htm.

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

Reference: Sections 3551, 4600 and 4601, Labor Code.

§9785. Reporting Duties of the Primary Treating Physician.

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

(1) The “primary treating physician” is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616. For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

(2) A “secondary physician” is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

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

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

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

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

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

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

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

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

(A) continuing medical treatment; or

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

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

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

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

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

(e)(1) Within 5 working days following initial examination, ~~the initial~~ ~~a~~ a primary treating physician, including physicians rendering first aid treatment as defined in Labor Code section 5401(a), shall submit a written report to the claims administrator on the form entitled “Doctor's First Report of Occupational Injury or Illness,” Form 5021, set forth in section 14006.1. Emergency and urgent care physicians shall also submit a Form 5021 to the claims administrator following the initial visit to the treatment facility. ~~On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture). For dates of service prior to October 1, 2015, use Form 5021 (Rev. 4 1992). For dates of service on or after October 1, 2015, use Form 5021 (Rev. 5 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.~~

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

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

~~(3)~~ ~~(2)~~ (3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

~~(4)~~ ~~(3)~~ (4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

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

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

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

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

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

(5) The employee is released from care;

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

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

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

(g) (1) On or after ~~Prior to~~ (~~SIX MONTHS AFTER~~ EFFECTIVE DATE OF REGULATION), except ~~Except~~ for a response to a request for information made pursuant to subdivision (f)(7), reports required under ~~this~~ subdivision (f) ~~shall may~~ shall

be submitted on the “Primary Treating Physician's Progress Report” form (Form PR-2) contained in ~~S~~section 9785.2.1; the "Treating Physician's Report" form (DWC Form PR-1) contained in section 9785.6; or in the form of a narrative report. If a narrative report is used in lieu of a Form PR-2, it must be entitled, “Primary Treating Physician's Progress Report,” or, if a narrative report is used in lieu of a Form PR-1, It must be entitled, “Treating Physician’s Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2 or Form PR-1. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2~~:~~ (“I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3~~.~~”) or the Form PR-1 (“I declare under penalty of perjury that I am the physician who examined the patient, this report is true and correct to the best of my knowledge, and I have not violated Labor Code § 139.3”).

~~For dates of service prior to October 1, 2015, use Form PR-2 (Rev. 06-05). For dates of service on or after October 1, 2015, use Form PR-2 (Rev. 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form~~.

~~(2) On or after (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION), except for a response to a request for information made pursuant to subdivision (f)(7), reports required under subdivision (f) shall be submitted on the "Treating Physician's Report" form (DWC Form PR-1) contained in Section 9785.6, or in the form of a narrative report. If a narrative report is used, it must be entitled “Treating Physician's Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as the DWC Form PR-1. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-1: “I declare under penalty of perjury that I am the physician who examined the patient, this report is true and correct to the best of my knowledge, and I have not violated Labor Code §139.3.”~~

~~(3)~~(2) By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(h) ~~(g)~~ As applicable in section 9792.9.1 et seq., 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 made in a request for authorization in accordance with subdivision (g) and as set forth in section 9792.6.1(u).~~set forth on the "Request for Authorization," DWC Form RFA, contained in section 9785.5.~~ A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. ~~The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment.~~ A request for authorization can be made by the primary treating physician or a secondary physician.

(i)~~(h)~~ When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3.1 or section 9785.4.1, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section ~~10606~~ 10682. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

~~For dates of service prior to October 1, 2015, use Form PR-3 (Rev. 06-05) or PR-4 (Rev. 06-05), as applicable. For dates of service on or after October 1, 2015, use Form PR-3 (Rev. 2015) or PR-4 (Rev. 2015), as applicable. Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.~~

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

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

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

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4061, 4061.5, 4062, 4600, 4600.3, 4603.2, 4604.5, 4610.5, 4658.7, 4660, 4662, 4663 and 4664, Labor Code.

§ 9785.6. DWC Form PR-1: "Treating Physician's Report" – ~~Mandatory~~ Optional for Services On or After (EFFECTIVE DATE OF REGULATION)~~July 1, 2021~~.

Treating Physician's Report (DWC Form PR-1).

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4061.5, 4600, 4603.2, 4610, 4660, 4662, 4663 and 4664, Labor Code.

§9786. Petition for Change of Primary Treating Physician.

(a) A claims administrator desiring a change of primary treating physician pursuant to Labor Code Section 4603 shall file with the Administrative Director a petition, verified under penalty of perjury, on the "Petition for Change of Primary Treating Physician" form (DWC-Form 280 (Part A)) contained in Section 9786.1.

The petition shall be accompanied by supportive documentary evidence relevant to the specific allegations raised. A proof of service by mail declaration shall be attached to the petition indicating that (1) the completed petition (Part A), (2) the supportive documentary evidence and (3) a blank copy of the "Response to Petition for Change of Primary Treating Physician", (DWC-Form 280 (Part B)), were served on the employee or, the employee's attorney, and the employee's current primary treating physician.

(b) Good cause to grant the petition shall be clearly shown by verified statement of facts, and, where appropriate, supportive documentary evidence. Good cause includes, but is not limited to any of the following:

(1) The primary treating physician has failed to comply with Section 9785, subdivisions (e), (f)(1-7), or ~~(g)~~ (i) by not timely submitting a required report or submitting a report which is inadequate due to material omissions or deficiencies;

(2) The primary treating physician has failed to comply with subdivision (f)(8) of Section 9785 by failing to submit timely or complete progress reports on two or more occasions within the 12-month period immediately preceding the filing of the petition;

(3) A clear showing that the current treatment is not consistent with the treatment plan submitted pursuant to Section 9785, subdivisions (e) or (f);

(4) A clear showing that the primary treating physician or facility is not within a reasonable geographic area as determined by ~~Section 9780(e).~~ section 9780(g).

(5) A clear showing that the primary treating physician has a possible conflict of interest, including but not limited to a familial, financial or employment relationship with the employee, which has a significant potential for interfering with the physician's ability to engage in objective and impartial medical decision making.

(6) A clear showing that the primary treating physician, providing medical treatment to the employee within the first 30 days following the date of injury under Labor Code section 4610, subdivision (b), has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule adopted pursuant to Labor Code section 5307.27.

(c)(1) Where good cause is based on inadequate reporting under subdivisions (b)(1) or (b)(2), the petition must show, by documentation and verified statement, that the claims administrator notified the primary treating physician or facility in writing of the complete requirements of Section 9785 prior to the physician's failure to properly report.

(2) Good cause shall not include a showing that current treatment is inappropriate or that there is no present need for medical treatment to cure or relieve from the effects of the injury or illness. ~~The claims administrator's contention that current treatment is inappropriate, or that the employee is no longer in need of medical treatment to cure or relieve from the effects of the injury or illness should be directed to the Workers' Compensation Appeals Board, not the Administrative Director, in support of a Petition for Change of Primary Treating Physician.~~

(3) Where an allegation of good cause is based upon failure to timely issue the “Doctor's First Report of Occupational Injury or Illness,” Form ~~DLSR~~ 5021, within 5 working days of the initial examination pursuant to Section 9785, subdivision (e)(1) ~~or (e)(2)~~, the petition setting forth such allegation shall be filed within 90 days of the claims administrator’s knowledge of the initial examination.

(4) The failure to verify a letter response to a request for information made pursuant to Section 9785(f)(7), failure to verify a narrative report submitted pursuant to Section 9785~~(f)(8)~~(g), or failure of the narrative report to conform to the format requirements of Section 9785~~(f)(8)~~(g) shall not constitute good cause to grant the petition unless the claims administrator submits documentation showing that the physician was notified of the deficiency in the verification or reporting format and allowed a reasonable time to correct the deficiency.

(d) The employee, his or her attorney, and/or the primary treating physician may file with the Administrative Director a response to said petition, provided the response is verified under penalty of perjury and is filed and served on the claims administrator and all other parties no later than 20 days after service of the petition. The response may be accompanied by supportive documentary evidence relevant to the specific allegations raised in the petition. The response may be filed using the “Response to Petition for Change of Primary Treating Physician” form (DWC-Form 280 (Part B)) contained in

Section 9786.1. Where the petition was served by mail, the time for filing a response shall be extended pursuant to the provisions of Code of Civil Procedure Section 1013. Unless good cause is shown, no other document will be considered by the Administrative Director except for the petition, the response, and supportive documentary evidence.

(e) The Administrative Director shall, within 45 days of the receipt of the petition, either:

(1) Dismiss the petition, without prejudice, for failure to meet the procedural requirements of this Section;

(2) Deny the petition pursuant to a finding that there is no good cause to require the employee to select a primary treating physician from the panel of physicians provided in the petition;

(3) Grant the petition and issue an order requiring the employee to select a physician from the panel of physicians provided in the petition, pursuant to a finding that good cause exists therefor;

(4) Refer the matter to the Workers' Compensation Appeals Board for hearing and determination by a Workers' Compensation Administrative Law Judge of such factual determinations as may be requested by the Administrative Director; or

(5) Issue a Notice of Intention to Grant the petition and an order requiring the submission of additional documents or information.

(f) ~~The claims administrator's liability to pay for medical treatment by the primary treating physician shall continue until an order of the Administrative Director issues granting the petition.~~ The physician may continue to serve as primary treating physician until an order of the Administrative Director issues granting the petition.

(g) The Administrative Director may extend the time specified in ~~Subsection~~ subdivision (e) within which to act upon the claims administrator's petition for a period of 30 days and may order a party to submit additional documents or information.

Authority cited: Sections 133, 139.5, 4603, 4603.2, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4603, ~~and~~ 4603.2, and 4610, Labor Code.

Article 5.5.1 Utilization Review Standards

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

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

~~(a) "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.~~

~~(b) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.~~

~~(c) "Claims Administrator" is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.~~

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

~~(e) "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.~~

~~(f) "Dispute liability" means an assertion by the claims administrator that a factual, medical, or legal basis exists that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.~~

~~(g) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the~~

~~absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.~~

~~(h) "Expedited review" means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.~~

~~(i) "Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.~~

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

~~(k) "Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) and (g)(1) of section 9792.9.~~

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

~~(m) "Medical Director" is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.~~

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

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

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

~~(q) “Request for authorization” means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.~~

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

~~(s) “Reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.~~

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

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

~~(v) “Written” includes a facsimile as well as communications in paper form.~~

~~Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.~~
~~Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610 and 4610.5, Labor Code.~~

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

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

(a) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, ~~based~~ set forth on ~~either~~ a completed “Request for Authorization,” as defined in this section ~~DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2)~~, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1 et seq. ~~and may be provided by utilizing the indicated response section of the “Request for Authorization,” DWC Form RFA if that form was initially submitted by the treating physician~~.

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

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

(d) "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," DIR Form ~~DLSR~~ 5021, found at California Code of Regulations, title 8, section ~~14006 or~~ 14006.1, or on the applicable physician reporting forms authorized by section 9785. ~~"Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.~~

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

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

(g) “Dispute liability” means an assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

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

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

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

(k) "Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice,~~who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information~~ whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, prior to the determination of medical necessity.

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

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

(n) "Material modification" is when the claims administrator changes utilization review vendor(s);~~,~~ ~~or~~ makes a change to the utilization review standards as specified in section 9792.7;~~,~~ or changes its medical director, address, company name or corporate structure.

(o) "Medical ~~D~~director" is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The ~~M~~medical ~~D~~director is responsible for all decisions made in the utilization review process.

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

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

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

(s) "MTUS Drug Formulary" means the drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15.

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

~~(t)~~ (u) "Request for authorization" means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

(1) Unless accepted by a claims administrator under section 9792.9.1(b) ~~(c)(2)~~, a request for authorization must be ~~set forth on a “Request for Authorization (DWC Form RFA),”~~ completed by a treating physician as outlined in this subdivision and in the manner authorized by section 9785(h) ~~as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment~~.

(2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization ~~must identify~~ identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; ~~identify with specificity a recommended treatment or treatments,~~ and ~~be~~ is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates ~~substantiating~~ the need for the requested treatment. A request for

authorization may be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6.

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or ~~e-mailed~~ sent electronically through the use of a secure, encrypted email system to~~, if designated,~~ the address, fax number, or e-mail address designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature or via electronic data interchange.

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

~~(v)~~ (w)(1) "Reviewer" or "physician reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's or physician reviewer's practice.

(2) "Non-physician reviewer" means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.

(x) "URAC" is the non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, D.C., 20005, or as indicated online at www.urac.org, that provides accreditation for workers' compensation utilization review programs.

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

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

~~(y)~~ (aa) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, ~~delay,~~ or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed request for authorization ~~the completed DWC Form RFA~~, or a request for authorization

accepted as complete under section 9792.9.1(b) ~~(c)(2),~~ is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

~~(z)~~ (bb) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail, unless sent through the use of a secure, encrypted email system.

(cc) "Normal business day" or "business day" does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

(dd) "Working day" as used in this article is the same as "business day" or "normal business day."

Authority cited: Sections 133, 4603.5, and 5307.3, Labor Code.
Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.7. Utilization Review Standards--Applicability

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

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

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

(3) A description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. The treatment protocols or standards governing the utilization review process shall be consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27.

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

(5) A description of the claims administrator's practice, if applicable, of any prior authorization process, including but not limited to, where authorization is provided without the submission of the request for authorization.

(6)(A) For utilization review plans that modify or deny treatment requests, proof of accreditation through the Workers' Compensation Utilization Management Accreditation program administered by URAC.

(B) A public sector internal utilization review plan that modifies or denies treatment requests need not obtain URAC accreditation under subdivision (a)(6) if it provides in its plan submission to the Administrative Director a statement under penalty of perjury by the plan's medical director that the plan meets or exceeds the standards established by URAC's Workers' Compensation Utilization Management Accreditation program.

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

(2) A reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice, may, except as indicated below, ~~delay,~~ modify or deny~~,~~ requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in ~~section 9792.9 (c)(1), (c)(2), or (d), or~~ section 9792.9.3 and 9792.9.4 ~~9792.9.1(c) and (d)~~. Any time beyond the time specified in these sections is subject to the provisions of section ~~9792.9(h) or section 9792.9.1(f)~~ 9792.9.6.

(c) (1) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims

administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has an approved ~~filed a complete~~ utilization review plan on file with the Administrative Director~~.~~, which also identifies the claims administrator client(s) on whose behalf it performs any utilization review functions. ~~A modified utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan.~~

(2) Utilization review plans that modify or deny treatment requests shall submit with their plan a completed DWC Form UR-01, "Application for Approval as Utilization Review Plan," set forth in section 9792.7.1, with an original signature by the applicant's medical director. The utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word-searchable PDF format. The hard copy of the completed, signed original shall be maintained by the applicant and made available for review by the Administrative Director upon request. Electronic signatures in compliance with California Labor ~~Government~~ Code section 110.5 or 3206.5 ~~16.5~~ are acceptable.

(3) A utilization review plan that submits an application for approval thereby releases URAC from any obligation it may have, contractual or other, regarding nondisclosure of any of its files relating to the utilization review plan's accreditation or audits with URAC. Accordingly, the Division of Workers' Compensation may obtain such documents from URAC for the purpose of ensuring or enforcing compliance with the rules governing utilization review at sections 9792.6.1 et seq.

(4) All utilization review plan entities shall file a material modification of its utilization review plan with the Administrative Director within 30 calendar days of the material modification. The material modification shall include a DWC Form UR-01 set forth in section 9792.7.1, completed as applicable with an original signature by the applicant's medical director, and an attached statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 et seq. The modified utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word searchable PDF format. Electronic signatures in compliance with California Labor Code section 110.5 or 3206.5 are acceptable.

(d) Within 30 days after receipt of the utilization review plan or plan modification submitted under subdivision (c), the Administrative Director shall notify the organization in writing that the plan is complete and has been accepted for filing or that the plan is not complete. If the plan is not complete, the Administrative Director shall specify in the notice what additional information or documents are needed from the organization in order for the plan to be deemed complete. Notice that a utilization review plan submission is complete does not preclude the Administrative Director from later

requesting additional documentation or records necessary for determining a utilization review plan's compliance with the law.

(e) (1) For utilization review plans that deny or modify treatment requests, the Administrative Director shall approve or deny the plan or plan modification within 60 days following the issuance of the Administrative Director's notice that a utilization review plan filing or filing of plan modification is complete. ~~receipt of the complete DWC Form UR-01 and accompanying plan.~~ If specific deficiencies are identified but the applicant substantially complies with the requirements of Labor Code section 4610 and this Article, a conditional approval may be granted for a period not to exceed six (6) months to permit the applicant the opportunity to correct those deficiencies. If the deficiencies are not corrected after the first period of conditional approval, or the condition upon which an approval may be granted is not satisfied, the conditional authorization to operate may be extended for a period not to exceed six (6) months if the applicant demonstrates a good faith effort and ability to correct the deficiencies. A conditional authorization to operate shall expire at the end of its stated period and the application shall be deemed denied, unless the deficiencies are removed prior to its expiration and an approval has been granted before that date.

(2) The Administrative Director shall notify a utilization review plan applicant of a denial under subdivision (e) in writing and shall state the reasons for non-approval. The denial shall be transmitted to the plan by certified mail and shall be in effect for 12 months unless a lesser timeframe is agreed upon for good cause by the Administrative Director.

(f) A utilization review plan applicant may appeal the Administrative Director's denial under subdivision (e) by filing, within twenty (20) days of the issuance of the denial, a petition with the Workers' Compensation Appeals Board pursuant to California Code of Regulations, title 8, section 10560. A copy of the petition shall be concurrently served on the Administrative Director.

(g) The Administrative Director may require an organization to update its approved plan if it is determined that a change in the plan is required in order to bring the plan into compliance with the law. An organization that receives a Notice of Required Update shall have 30 days from the receipt of the notice to bring its plan into compliance. Failure to adopt and implement required changes may result in the probation or suspension of a plan or revocation of plan approval.

(h) (1) The Administrative Director may place on probation, suspend, or revoke approval of a utilization review plan for any one or more of the following reasons:

(A) The UR program is operating out of compliance with the terms of its approved plan or the law;

(B) The plan fails to timely adopt and implement updates to its UR plan as specified by the Administrative Director;

(C) The plan knowingly makes false statements or representations to the Administrative Director or fails to submit plan modifications or updates as required by this Article;
(D) The plan fails to respond to at least two or more repeated requests or inquires by the Administrative Director concerning plan compliance.

(2) If the Administrative Director determines that one or more of the circumstances in subdivision (g)(1) applies, the Administrative Director shall issue written notice of the violation(s). Upon receipt of such notice, the organization shall have 14 days to correct the violation, or respond with a plan of action to timely correct the violation.

(3)(A) If the Administrative Director determines that the violations have not been remediated in a timely manner, a Findings and Notice of Action shall issue to the organization specifying the time period for which probation, suspension, or revocation will take effect. A plan whose approval has been revoked shall be barred from applying again for approval for 12 months following the date of revocation, unless a lesser timeframe is agreed upon for good cause by the Administrative Director.

(B) Where the Findings and Notice of Action are for the suspension or revocation of a UR plan, the UR plan shall issue a copy of the Findings and Notice of Action to all organizations for which it performs utilization review.

(i)(1) Within 14 days of the issuance of the Findings and Notice of Action, a UR plan may request a re-evaluation of the probation, suspension or revocation by submitting to the Administrative Director, under penalty of perjury, a written explanation accompanied by documentary evidence supportive of the request for re-evaluation.

(2) Within 45 days of the request for re-evaluation, the Administrative Director shall issue a Decision and Order affirming, modifying, or rescinding the Notice of Action, which shall include an explanation for the decision. The Administrative Director may extend the time for issuing a Decision and Order for a period of 30 days. At any time during re-evaluation, the Administrative Director may order a plan to submit additional documentation or information.

(j) A utilization review plan entity may, as an alternative to requesting re-evaluation under subdivision (i), appeal a Notice of Action to the Workers' Compensation Appeals Board by filing a petition within 20 days of the issuance of such notice under California Code of Regulations, title 8, section 10560. A copy of the petition shall be concurrently served on the Administrative Director.

(k) Nothing in this section shall prevent the Administrative Director from imposing penalties as applicable under section 9792.12.

(l) The Administrative Director shall post on the Division's website a list of all entities who have filed a complete utilization review plan under this section, indicating the plans'

statuses as they evolve including, but not limited to, approved, denied, inactive, probation, suspended, or revoked. Utilization review plan entities who cease to perform utilization review under its own name for a period of 12 consecutive months following the last UR activity performed under its own name may be marked as inactive.

~~(d)~~ (m) (1) 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)~~ (2) The claims administrator may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means. If a member of the public requests a hard copy of the utilization review plan, the claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

Authority cited: Sections 133, 4603.5, 4610 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

§ 9792.7.1. DWC Form UR-01: "~~Application for Approval as~~ Utilization Review Plan Application or Modification."

~~Application for Approval as~~ Utilization Review Plan Application or Modification (DWC Form UR-01).

Authority cited: Sections 133, 4603.5, 4610, and 5307.3, Labor Code. Reference: Sections 4600 and 4610, Labor Code.

§ 9792.8. Utilization Review Standards – Medically-Based Criteria.

(a)~~(1)~~ The criteria for a physician reviewer to determine the medical necessity of requested treatment shall be consistent with the ~~schedule for~~ medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27, including the methodology for evaluating medical evidence under section 9792.25.1. ~~Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, Second Edition. 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 scientific medical 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) 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. Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5307.27. After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, treatment may not be denied on the sole basis that the treatment is not addressed by that schedule.~~

(b) Nothing in this section precludes authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with section 9792.21.1(e).

~~(3) The relevant portion of the criteria or guidelines used shall be disclosed in written form to the requesting physician, 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 requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify, delay or deny the treatment request.~~

~~(4) Nothing in this section precludes authorization of medical treatment not included in the specific criteria under section 9792.8(a)(3).~~

Authority cited: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

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

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

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

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

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

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

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

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

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

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

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

~~(E) The following mandatory language advising the injured employee:~~
~~"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.~~
~~and~~
~~"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."~~

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

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

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

~~(2) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.~~

~~(A) If the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a~~

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

~~(3) Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve a request shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review.~~

~~(4) Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~

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

~~(d) When review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~

~~(e) Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services, however, may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.~~

~~(f) Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours~~

~~after the receipt of the written information reasonably necessary to make the determination. The requesting physician must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:~~

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

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

~~(g) The review and decision to deny, delay or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.~~

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

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

~~(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.~~

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

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

~~information has been included, shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with this subdivision. The written notification shall not include the rationale, criteria or guidelines used for the decision.~~

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

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

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

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

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

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

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

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

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

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

~~(6) The clinical reasons regarding medical necessity.~~

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

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

~~Either~~

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

~~or~~

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

~~and~~

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

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

~~"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in~~

~~parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.~~

~~and~~

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

~~In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~

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

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

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

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

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

~~(3) A list of all medical records reviewed.~~

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

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

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

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

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

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

and

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

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

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

~~decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.~~

~~(n) Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail.~~

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

~~Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610 and 4610.5, Labor Code.~~

§9792.9.1. Utilization Review ~~Standards—~~Receipt of Request for Authorization; Acceptance of Defective ~~Incomplete~~ Request ~~Timeframe, Procedures and Notice – On or After January 1, 2013~~.

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

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

(a) (1) ~~For purposes of this section,~~ A request for authorization ~~the DWC Form RFA~~ shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization. A request for authorization ~~the DWC Form RFA~~ transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The copy of the request for authorization ~~DWC Form RFA~~ or the cover sheet accompanying

the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the request for authorization ~~DWC Form RFA~~.

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

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

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

(3) Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

(b)(1) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it “not complete” and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

(2) Upon receipt of a request for authorization submitted via a non-designated address, e-mail address, or fax number; a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as if it had been submitted via a designated point of contact, or, within five (5) business days from receipt, mark it as "Resubmission Required" and return it to the requesting physician with an attached letter or notice specifying the reason for the return of the request and the designated facsimile, email, or postal address to where the request should be re-sent. A request for authorization accepted as if it were submitted via a designated point of contact shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

§9792.9.2. Utilization Review —Dispute of Liability; Deferral.

(a)(1) ~~(b)~~ Utilization review of a request for authorization of medical treatment ~~request made on the DWC Form RFA~~ may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

(2)(A) A claims administrator who determines that Labor Code section 4610(k) precludes the need for utilization review must comply with the requirements under this section.

(B) A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment. This includes, but is not limited to, when a physician marks the checkbox at the top of either the DWC Form RFA or the DWC Form PR-1 indicating that the report is a "Resubmission – Change in Material Fact," or, if the request is made in a narrative report, includes such express and unequivocal indication on the first page of the report. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.

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

counsel, the injured worker's attorney. The written decision shall contain the following information specific to the request:

(1) ~~(A)~~ The date on which the request for authorization ~~DWC Form RFA~~ was first received.

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

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

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

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

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

and

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

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

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

§9792.9.3. Utilization Review — Timeframes.

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

(a) ~~(1)~~ The first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed or accepted as complete request for authorization ~~DWC Form RFA~~, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization ~~DWC Form RFA~~.

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

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

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

(c) ~~(4)~~ Prospective or concurrent decisions to approve, modify, ~~delay,~~ or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (b) ~~(c)(3)~~ would be detrimental to the injured worker's condition, shall be

reviewed by the claims administrator under the timeframe set forth in subdivision (b) ~~(c)(3)~~.

(d) ~~(5)~~ Retrospective decisions to approve, modify, ~~delay,~~ or deny a request for authorization shall be made within 30 days of receipt of the request for authorization or receipt of ~~and medical~~ information regarding rendered medical treatment that is sufficient for a reviewer ~~reasonably necessary~~ to make a determination as to whether the treatment was medically necessary.

(e) The calculation of time as outlined in this section applies to all utilization review decisions insofar as they do not contravene the timeframes relating to MTUS formulary disputes, which are subject to the requirements of section 9792.9.8.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

§9792.9.4. Utilization Review — Decisions to Approve a Request for Authorization.

~~(d) Decisions to approve a request for authorization.~~

(a) (1) All written decisions to approve a request for authorization shall specify the ~~specific the~~ date the complete, or accepted as complete, request for authorization was first received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision. If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

(2) For approvals of a request for authorization of a drug where the request for authorization did not indicate “Do Not Substitute” or “Dispense as Written,” the written decision approving the request in generic form shall indicate, “generic substitute authorized” or words to that effect and meaning.

(3) For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, “Exempt per MTUS Drug Formulary” or words to that effect and meaning.

(4) For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, “30-day exemption” or words to that effect and meaning.

(b) ~~(2)~~ For prospective, concurrent, or expedited review, a decision to approve ~~approvals~~ a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision~~, and shall be communicated to the requesting physician initially~~ by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. If the initial ~~The~~ communication is by telephone, written communication shall issue ~~be followed by written notice~~ to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

(c) (1) ~~(3)(A)~~ For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

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

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

§9792.9.5. Utilization Review — Decisions to Modify or Deny a Request for Authorization.

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

(a) ~~(1)~~ The review and decision to deny~~, delay,~~ or modify a request for medical treatment must be conducted by a physician reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

(b) ~~(2)~~ Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

(c) (3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney Written communication of the decision shall issue to the injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review, and within two (2) business days for prospective review, and, for expedited review, within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.

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

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

(1) (A) The date on which the completed or accepted request for authorization DWC Form RFA was first received.

(2) If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.

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

(4) (C) A description of the specific course of proposed medical treatment set forth on the request for authorization for which authorization was requested.

(5) ~~(D)~~ A list of all medical records reviewed.

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

(7) ~~(F)~~ A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation. Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

(8) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision ~~pursuant to section 9792.8. If a utilization review decision to modify, or deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.~~

(9) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.

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

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

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

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

and

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

(13) ~~(J)~~ Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(14) ~~(K)~~ The written decision modifying~~, delaying~~ or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or, if applicable, expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

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

(1) ~~(A)~~ Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.

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

(g) A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from

the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

§9792.9.6. Utilization Review — Extension of Timeframe for Decision.

(a) ~~(f)~~(1) The timeframes for decisions specified in section 9792.9.3 ~~subdivision (c)~~ may only be extended under one or more of the following circumstances:

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

(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

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

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

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

(c) (1) ~~(3) (A)~~ If the information reasonably necessary to make a determination under subdivision (a) ~~(f)~~ (1)(A) that is requested by the reviewer or non-physician reviewer is

not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, ~~the~~ a physician reviewer shall deny the request in accordance with applicable rules in section 9792.9.5(e). ~~with the stated condition that the request will be reconsidered upon receipt of the information~~

(2) ~~(B)~~ If the results of the additional examination or test required under subdivision (a) ~~(f)~~(1)(B), or the specialized consultation under subdivision (a) ~~(f)~~(1)(C), that is requested by the physician reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request in accordance with the applicable requirements under section 9792.9.5(e) ~~with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation~~.

(d)(1) ~~(4)~~ Upon receipt of the information requested pursuant to subdivisions (a) ~~(f)~~ (1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5. ~~The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in 9792.9.1(d) or (e), whichever is applicable.~~

(2) ~~(5)~~ Upon receipt of the information requested pursuant to subdivisions (a) ~~(f)~~ (1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5. ~~The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received and be communicated pursuant to subdivisions (d)(2) or (e)(3), whichever is applicable.~~

(3) ~~(6)~~ Upon receipt of the information requested pursuant to subdivisions (a) ~~(f)~~ (1)(A), (B), or (C), the claims administrator or reviewer, for retrospective review, shall make the decision to approve, modify~~, delay,~~ or deny the request for authorization within thirty (30) calendar days of receipt of the information requested in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5. ~~The decision shall include the date the requested information was received it was made and be communicated pursuant to subdivisions (d)(3) or (e)(4), whichever is applicable~~.

~~(g) Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims~~

~~administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.~~

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

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.9.7. Utilization Review – Medical Treatment – First 30 Days of the Date of Injury.

(a) Notwithstanding the requirements of sections 9792.9.1 through 9792.9.6, a treating physician specified in Labor Code section 4610(b), may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury, provided that:

(1) The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator.

(2) The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.

(3) The initial treating physician timely submits the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator as required by section 9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.

(4) All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.

(5) The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted to the claims administrator within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.

(b) The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and shall require prospective utilization review under section 9792.9.1 or 9792.9.3:

(1) Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.

(2) Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association's *Current Procedural Terminology (CPT®)* pursuant to the physician and non-physician practitioner fee schedule at section 9789.12 et seq., and 2) any Healthcare Common Procedure Coding System (HCPCS) procedure code defined as "surgery" in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule at section 9789.30 et seq.

(3) Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.

(4) Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than $250.00.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's *Current Procedural Terminology (CPT®)* Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis.

(8) Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

(c) (1) If the claims administrator determines, after retrospective review, that a physician providing treatment under subdivision (a) of this section has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may:

(A) Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator. The claims administrator must provide written notice to the physician that: (1) documents, based on retrospective review, the physician's pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary; (2) advises that based on the documented failure the physician can no longer render exempt treatment to any injured worker whose claims are adjusted or administered by the claims administrator; and (3) advises of the requirement of prospective utilization review for all subsequent medical treatment.

(B) Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician under section 9786.

(C) Terminate the physician from the claims administrator's or employer's medical provider network or health care organization.

(2) For the purpose of this section, "pattern and practice" means when treatment has been rendered inconsistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, for twenty (20) separate and unrelated recommended medical services or goods with ten (10) or more injured workers over the course of three (3) months; or for eight (8) separate and unrelated medical services or goods with two (2) or less injured workers within a month.

(d) If a physician renders treatment under this section without timely submitting the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator as required by section 9785(e), or without timely submitting a complete

request for authorization as required by section 9792.6.1(u), the claims administrator may remove the physician's ability to provide further medical treatment that is exempt from prospective review to the employee for the remainder of the thirty-day time period referenced at subdivision (a) by issuing written notice to the physician. The written notice must identify that the physician either failed to timely submit the DIR Form 5021 or failed to timely submit a complete request for authorization, advise that the physician can no longer render exempt treatment to the injured worker for the remainder of the thirty days, and advise that any such treatment is subject to prospective utilization review.

(e) Any dispute between the treating physician and the claims administrator regarding application of the provisions as allowed under subdivision (c) or (d) shall be resolved by the Workers' Compensation Appeals Board.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

§9792.9.8. Utilization Review — MTUS Drug Formulary.

(a)This subdivision governs review of Exempt Drugs listed on the MTUS Drug List.

(1) Notwithstanding sections 9792.9.1 through 9792.9.7, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review:

(A) Drugs identified on the MTUS Drug List as exempt under section 9792.27.1;

(B) Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12; and

(C) Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13.

(2) Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

(b) This subdivision governs review of Non-Exempt Drugs that are listed on the MTUS Drug List. For a drug not covered under subdivision (a) of this section, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

(1) Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under subdivision (a) of this section shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request for treatment. The reviewer or non-physician reviewer may request the treating physician to provide additional information reasonably necessary to make a determination as follows:

(A) The reviewer or physician reviewer shall request the information from the treating physician within no less than four (4) ~~two (2)~~ business days from the date of receipt of the request for authorization.

(B) If the information is not received within five (5) business days from the date of the request for authorization of treatment, a physician reviewer may deny the request in accordance with section 9792.9.5, subdivision (e).

(2) The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

(3) The extension of time as set forth in section 9792.9.6 is not applicable to a request for authorization of a drug covered under this subdivision.

(c) This subdivision governs review of drugs that are not listed on the MTUS Drug List. A treating physician must request authorization through prospective review for a drug not listed on the MTUS Drug List by submitting a request for authorization in the manner set forth in section 9792.6.1(u) or in a manner agreed upon by the treating physician and the claims administrator, regardless of whether a drug is prescribed or dispensed within 30 days from the date of injury. Prospective decisions to approve, modify, or deny a request for authorization of a drug not listed on the MTUS Drug List shall be made in a timely fashion in accordance with section 9792.9.3 and section 9792.9.6. The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

(d) Notwithstanding subdivision (b), a request for authorization that requests both drugs and non-pharmaceutical treatment related to the same injury or illness ~~condition~~ shall be reviewed under the timeframes set forth in section 9792.9.3 and section 9792.9.6 and the requirements of sections 9792.9.4 and 9792.9.5.

(e) Except for drugs that fall under 9792.9.7(a), a utilization review decision to deny a request for authorization of a drug which falls under subdivision (a) of this section based on the failure of the treating physician to prescribe or dispense the medication consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule, can be grounds for the denial of payment for the medication.

(f) (1) A decision to modify or deny a request for authorization under this section based on medical necessity shall be reviewed only through the claims administrator's voluntary

internal utilization review appeals process, or the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

(2) A dispute regarding a decision to modify or deny a request for authorization under this section based on a reason other than medical necessity shall be resolved only through the claims administrator's voluntary internal utilization review appeals process or by the Workers' Compensation Appeals Board.

(3) If a decision is made to modify or deny a request for authorization under this section based on both medical necessity and a reason other than medical necessity, the non-medical necessity dispute shall be resolved first.

(g) The following rules apply when a treating physician prescribes or dispenses a drug to treat an injured worker under the provisions of section 9792.9.7(a).

(1) The injured worker's initial treating physician shall describe in the treatment plan on the “Doctor's First Report of Occupational Injury or Illness,” DIR Form 5021, all drugs that are being prescribed or dispensed to treat the injured worker, and list on the request for authorization required under section 9792.9.7(a)(4), all drugs that are being prescribed or dispensed. Subsequent primary treating physicians shall submit a request for authorization following their first visit with the injured worker indicating all drugs that are being prescribed or dispensed for treatment.

(2) The treating physician may prescribe or dispense a drug identified under subdivision (a) of this section without the need to obtain authorization through prospective utilization review.

(3) For a drug not covered under subdivision (a) of this section, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.9.1, or in a manner agreed upon by the treating physician and the claims administrator.

(4) The claims administrator may conduct retrospective review of a drug prescribed or dispensed to the injured worker under subdivision (a) of this section only for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.

(A) Payment for an exempt drug dispensed under the provisions of section 9792.9.7(a) shall not be denied based on a determination that use of the drug was not consistent with the applicable guideline.

(B) Use of an exempt drug that is not consistent with the applicable guideline may be used as a basis to find that the physician, under section 9792.9.7(d), has a pattern and

practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule.

Authority: Sections 133, 4610, 5307.3, and 5307.27, Labor Code.
Reference: Sections 4600, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

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

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

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

(a)(1) A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.5(e).

(2) If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision.

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

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

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

(A) ~~(i) An unrepresented employee may designate a~~ A parent, guardian, conservator, relative, or other designee of the employee pursuant to Labor Code section 4610.5(j) ~~as an agent to act on his or her behalf in filing an application for independent medical review under this subdivision. A designation of an agent executed prior to the utilization review decision shall not be valid~~.

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

(2) ~~(B)~~ A provider of emergency medical treatment pursuant to Labor Code section 4610.5(h)(4). ~~when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review under this section on its own behalf within 30 days after the service of the utilization review decision that either delays, denies, or modifies the provider's retrospective request for authorization of the emergency medical treatment.~~

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

(e) ~~(c)~~(1) If, at the time of a utilization review decision, the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time limitation for the employee to submit an application for independent medical review under subdivision (a) shall not begin to run until the claims administrator serves ~~for the employee to submit an application for independent medical review under subdivision (b)(1) is extended to 30 days after service of~~ a notice to the employee stating that the ~~showing that the other~~ dispute of liability has been resolved.

(2) If the claims administrator provides the employee with a written utilization review determination modifying~~, delaying,~~ or denying a treatment request that does not contain the required elements set forth in section 9792.9.5(e) ~~9792.9(l) or section 9792.9.1(e)~~ at

the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review under subdivision (a) ~~(b)(1)~~ shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

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

(2) A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (f~~d~~)(1). If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued, by the claims administrator within ten (10) days after receipt of the request under subdivision (f~~d~~)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

(3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.5(e) ~~9792.9.1(e)~~. The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7) ~~9792.9.1(e)(5)(G),~~ must indicate that the decision is a modification after appeal.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.
Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

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

[DWC Form IMR (Rev. ~~07/2018~~ ~~06/2024~~ DATE ADOPTED BY OAL)]

Authority: Sections 133, 4603.5, 4610.5, and 5307.3, Labor Code.
Reference: Sections 4600, 4610, and 4610.5, Labor Code.

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

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

(1) The timeliness and completeness of the Application;

(2) Any previous application or request for independent medical review of the disputed medical treatment;

(3) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.

(4) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician.

(5) The employee's date of injury.

(6) The failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.6 ~~9792.9.1(f)~~ for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation.

(b) The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, if the employee is represented by counsel, the employee's attorney, and the requesting physician, as appropriate, by the most efficient means available.

(c) The parties shall respond to any reasonable request made pursuant to subdivision (b) within five (5) business days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review under section 9792.10.4.

(d) If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the claims administrator

agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

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

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

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

9792.10.4. Independent Medical Review – Assignment and Notification.

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

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

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

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

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

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

(5) ~~For regular review, a~~A statement that the independent review organization must receive the documents indicated in section 9792.10.5 within ten (10) calendar days of the date designated on the notification for review of a dispute involving only a drug or drugs listed on the MTUS Drug Formulary; or fifteen (15) calendar days for any other type of dispute (or, if the notification was provided electronically, ~~of the date designated on the notification, if the notification was provided by mail, or~~ within twelve (12) calendar days). ~~of the date designated on the notification if the notification was provided electronically, the independent review organization must receive the documents indicated in section 9792.10.5.~~ For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties ~~up to $5,000.00~~.

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

(c) Review conducted on a regular basis shall be converted into an expedited review if, subsequent to the receipt of the Application for Independent Medical Review, DWC Form IMR, the independent review organization receives from the employee's treating physician written certification with supporting documentation verifying that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j). The independent review organization shall immediately notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review.

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610 and 4610.5, Labor Code.

§ 9792.10.5. Independent Medical Review – Medical Records.

(a) (1) ~~Within fifteen (15) days f~~Following the mailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, the claims administrator shall electronically submit, within 10 days for disputes regarding only a drug or drugs listed on the MTUS Drug Formulary, or within 15 days (or 12 days if the notification was sent electronically) for all

other types of disputes, or within twenty-four (24) hours for expedited review, ~~or within twelve (12) days if the notification was sent electronically, or for expedited review within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the claims administrator~~ all of the following documents:

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

(B) A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.5(e)(7) ~~9792.9.1(e)(5)~~, which notified the employee that the disputed medical treatment was denied~~, delayed~~ or modified. Neither the written determination nor the application's instructions should be included.

(C) Other than the written determination by the claims administrator issued under section 9792.9.5(e) ~~9792.9.1(e)(5)~~ , a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.

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

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

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

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

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

(b) (1) ~~Within fifteen (15) days f~~Following the mailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, the employee or the employee's representative, or any party identified in section 9792.10.1(c), shall electronically submit, within 10 days for disputes regarding only a drug or drugs listed on the MTUS Drug Formulary; within 15 days (or, if the notice was sent electronically, 12 days) for all other types of disputes; or within twenty-four (24) hours for expedited review, ~~or within twelve (12) days if the notification was sent electronically, or for expedited review within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the employee, if represented the employee's attorney, or any party identified in section 9792.10.1(b)(2)~~ any of the following documents:

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

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

(iii) Reasonable information supporting the position that the disputed medical treatment is or was medically necessary, including all information provided by the employee's treating physician, or any additional material that the employee believes is relevant.

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

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

administrator, unless the offer of medical records is declined or otherwise prohibited by law.

(c) At any time following the submission of documents under subdivision (a) and (b), the independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases, two (2) business days after the request is received in cases involving only a dispute regarding a drug listed on the MTUS Drug Formulary, or one (1) calendar day after the request is received in concurrent or expedited cases.

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

Authority: Sections 133, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.6. Independent Medical Review – Standards and Timeframes.

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

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

(2) If a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may~~,~~ issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.5(e)(4) ~~9792.9.1(e)(5)~~, and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review determination shall issue based solely on the information provided by a utilization review determination.

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

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

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

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

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

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

(g) Timeframes for final determinations:

(1) For regular review <u>of a medical treatment dispute, other than a dispute that only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List</u>, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

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

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

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

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

(4) For review of a dispute that only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the independent review organization shall complete its review and make its final determination within five (5) business days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

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

(i) Upon receipt of credible information that the claims administrator has failed to comply with its obligations under the independent medical review requirements set forth in Labor Code sections 4610.5 or in sections 9792.6 through 9792.10.8 of this Article, the Administrative Director shall, concurrent or subsequent to the issuance of the final determination issued by the independent review organization, issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c).

Authority: Sections 133, 4603.5 4610.5, and 5307.3, Labor Code.
Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.8. Independent Medical Review – Payment for Review.

(a) The costs of independent medical review and the administration of the independent medical review system shall be borne by claims administrators. For each Application

for Independent Medical Review, DWC Form IMR, assigned to an independent review organization for an independent medical review of a disputed medical treatment, the fee for the claims administrator shall be:

(1) $ 345.00 for each application where a determination is issued under section 9792.10.6(b):

(2) For withdrawn reviews:

(A) $ 115.00 for each application where review is terminated by the independent review organization prior to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer.

~~(1) For calendar year 2013:~~

~~(A) For regular review:~~

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

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

~~(B) For expedited review:~~

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

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

~~(C) For withdrawn reviews:~~

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

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

~~(3) Re-reviews: If it is determined that a re-review is required under Labor Code section 4610.6(h), the re-review shall be completed without any additional cost. Each subsequent order for re-review on a single IMR case beyond the first re-review shall incur a fee of $295.00 to be paid by the claims administrator.~~

~~(2) For calendar year 2014:~~

~~(A) For regular review:~~

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

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

~~(B) For expedited review:~~

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

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

~~(C) For withdrawn reviews:~~

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

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

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

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

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

Authority: Sections 133, 4603.5, 5307.3, and 4610.6, Labor Code.
Reference: Sections 4610, 4610.5, and 4610.6, Labor Code.

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

(a) To carry out the responsibilities mandated by Labor Code Section 4610(i), notwithstanding Labor Code section 129(a) through (d) and section 129.5 subdivisions (a) through (d), the Administrative Director, or his or her designee, shall investigate the utilization review process of any employer, insurer or other entity subject to the provisions of section 4610. The investigation shall include, but not be limited to, review and inspection of the practices, files, documents and other records, whether electronic

or paper, of the claims administrator, and any other person responsible for utilization review processes, whether in full or in part, for an employer. As used in sections 9792.11 through 9792.15, the phrase 'utilization review organization' includes any person or entity with which the employer, ~~or~~ an insurer, or third party administrator~~,~~ contracts to fulfill part or all of the employer's utilization review responsibilities under Labor Code section 4610 and Title 8 of the California Code of Regulations, sections 9792.6 through 9792.15.

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

(b) Administrative penalties, where applicable, may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations.

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

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

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

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

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

Complaints should be mailed to DWC Medical Unit-UR, P.O. Box 71010, Oakland, CA 94612, attention UR Complaints or emailed to DWCUR@dir.ca.gov. Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6.1 through 9792.12.

(gc) The Administrative Director, or his or her designee, may conduct a utilization review investigation, including but not limited to an on-site investigation at any location where Labor Code Section 4610 utilization review processes occur, as follows:

(1) For utilization review organizations:

(1A) A Routine Investigation shall be initiated forat each known claims administrator or utilization review organization at least, but not limited to, once every five (5) years and, where applicable, shall run concurrently with the profile audit review executed pursuant to Labor Code sections 129 and 129.5. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(q) or section 9792.6.1(u)(t), received by the utilization review organization during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation or may include or combine the results of a Target Investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(2B) Target Investigations:

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

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

(B)3. The Return Target Investigation and the Special Target Investigation may include: (i) a review of the requests for authorization previously investigated which contained

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

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

~~(2) For a claims administrator:~~

~~(A) A Routine Investigation shall be initiated at each claims adjusting location at least once every five (5) years concurrent with the profile audit review done pursuant to Labor Code sections 129 and 129.5. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(q) or section 9792.6.1(u)(t), received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.~~

~~(B) Target Investigations:~~

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

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

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

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

Population of requests for authorization received during a three month calendar period	**Sample Size**
5 or less	all
6-10	1 less than total
11-13	2 less than total
14-16	3 less than total
17-18	4 less than total
19-20	5 less than total
21-23	6 less than total
24	17
25-26	18
27-29	19
30-31	20
32-33	21
34-36	22
37-39	23
40-41	24
42-44	25
45-48	26
49-51	27

52-55	28
56-58	29
59-62	30
63-67	31
68-72	32
73-77	33
78-82	34
83-88	35
89-95	36
96-102	37
103-110	38
111-119	39
120-128	40
129-139	41
140-151	42
152-164	43
165-179	44
180-197	45
198-217	46
218-241	47
242-269	504~~8~~
270-304	554~~9~~
305-346	55~~50~~
347-399	55~~51~~
400-468	55~~52~~
469-562	60~~53~~
563-696	60~~54~~
697-905	60~~55~~
906-1,272	65~~56~~
1,273-2,091	65~~57~~
2,092-5,530	70~~58~~
5,531~~+~~ or more	70~~59~~

(j) The Administrative Director may request additional files where the files initially selected are incomplete or otherwise invalid.

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

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

~~Complaints should be mailed to DWC Medical Unit-UR, P.O. Box 71010, Oakland, CA 94612, attention UR Complaints or emailed to DWCManagedCare@dir.ca.gov. Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.~~

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

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

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

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

(k)~~(j)~~ Unless the Administrative Director in his or her discretion determines that advance notice will render an investigation ~~Special Target or Return Target Investigation~~ less useful, the Administrative Director shall initiate an investigation under this section by issuing ~~claims administrator or utilization review organization shall be notified of its selection for an Investigation. Claims administrators and utilization review organizations~~

~~shall be sent~~ a Notice of Utilization Review Investigation to the investigation subject. The Notice of Utilization Review Investigation shall require the investigation subject to provide the following:

(1) A description of the system used to identify each request for authorization (if applicable). To the extent the system identifies any of the following information in an electronic format, the claims administrator or utilization review organization shall provide in an electronic format a list of each and every request for authorization received by~~at~~ the investigation subject~~site~~ during a three month calendar period specified by the Administrative Director, or his or her designee, and the following data elements: i) a unique identifying number for each request for authorization if one has been assigned; ii) the name of the injured worker; iii) the claim number used by the claims adjuster; iv) the initial date of receipt of the request for authorization; v) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal); vi) the disposition (approve;~~,~~ deny;~~, delay,~~ and if denial, whether the denial was based on medical necessity or was the result of requiring additional information, tests, or consultation as set forth at subdivision (a) of section 9792.9.6; modify;~~,~~ or withdrawal); and, vii) if applicable, the type of person who withdrew the request (requesting physician, claims adjuster, injured employee or his or her attorney, or other person). In the event the claims administrator or utilization review organization is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed requests for authorization are sorted in the following order: by type of utilization review, type of disposition, and date of receipt of the initial request.~~;~~ Files must be complete and orderly, to the extent possible, by reflecting all documents in the utilization review process that fall under a request for authorization in chronological order.

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

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

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

(5) If applicable, a copy of the most recent accreditation document issued by URAC or other accrediting organization as approved by the Administrative Director under Labor Code section 4610(g)(4) which verifies that the utilization review plan organization meets the Labor Code section 4610(g)(4) accreditation requirement.

(l5) The ~~following additional information, may be requested by the~~ Administrative Director, or his or her designee, as applicable to the type of entity investigated, at any time during the investigation process, may request additional information including but not limited to the following: i) whether utilization review services are provided externally; ii) the name(s) of the utilization review organization(s); iii) the name and address of the employer; ~~and~~ iv) the name and address of the insurer; and (v) documents relevant to the utilization review plan's accreditation including but not limited to copies of audit or investigation reports, files, or documents issued or generated by the plan or accrediting organization.

(mk) The utilization review organization or claims administrator shall provide the requested information listed in subdivision (jk) within fourteen (14) calendar days of receipt of the Notice of Utilization Review Investigation. Additional documentation as required under subdivision (l) shall be provided within 5 business days unless an extension is granted in writing.

(n) Where the investigation is of a utilization review plan organization that performs modifications and/or denials of requests for authorization, at least 40%, or as close to 40% as possible, of the files ultimately selected for review shall be comprised of files which modified or denied complete or accepted requests for authorization. In order to meet this requirement, the Administrative Director may expand the scope of files subject to review to go beyond the 3-month calendar period, as referenced at section 9792.11(~~e~~g), up to a total of 6 months.

(o) Based on the information provided, the Administrative Director, or his or her designee, shall provide the claims administrator or utilization review organization with a Notice of Investigation Commencement, which shall include a list of ~~randomly~~ the selected requests for authorization ~~from a three month calendar period~~ designated by the Administrative Director and complaint files (if applicable) for investigation.

(p~~l~~) ~~For utilization review organizations:~~ Within fourteen (14) calendar days of receipt from the Administrative Director, or his or her designee, of the Notice of Investigation Commencement, the ~~utilization review organization~~ investigation subject shall deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether electronic or paper, for each request for authorization listed. Copies of the records shall be delivered with a statement signed under penalty of perjury by the custodian of records of the investigation subject~~for the location at which the records are held~~, attesting that all of the records produced are true, correct, and complete copies of the originals~~,~~ in his or her possession. After reviewing the records, the Administrative Director, or his or her designee, shall determine if an onsite investigation is required. If an onsite investigation is required, fourteen (14) calendar days' notice shall be provided to the ~~utilization review organization~~investigation subject.

(q~~m~~) Where the Administrative Director has opted to conduct an onsite investigation, ~~For claims administrators:~~ ~~T~~the Notice of Investigation Commencement shall be

provided to the ~~claims administrator~~investigation subject at least fourteen (14) calendar days prior to the commencement of the onsite investigation unless the Administrative Director determines, in his or her discretion, that doing so would render the investigation less useful. The investigation subject ~~claims administrator~~ shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.

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

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

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

(t) For the purposes of assessing penalties, the requirement to perform any act related to utilization review practices shall be calculated based on timelines outlined under section 9792.9.3.

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

(1) where the request for authorization is made by mail through the U.S. postal service and no proof of service by mail exists, the request shall be deemed to have been received by the claims administrator, or utilization review organization on whichever date is earlier, either the receipt date stamped by the addressee, or within five (5) calendar days of the date stated in the request for authorization; or, where the addressee can show a delay in mailing by the postmark date on the mailing envelope, then: (A) within five (5) calendar days of the postmark date, if the place of mailing and place of address are both within California; (B) within ten (10) calendar days if the place of address is within the United States but outside of California; or (C) within twenty (20) calendar days if the place of address is outside of the United States; and

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

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

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

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

(v~~t~~) Following a review of the selected investigation files, a~~A~~ preliminary investigation report will be provided to the ~~claims administrator or utilization review organization~~investigation subject. The preliminary investigation report shall consist of the preliminary notice of utilization review penalty assessments, ~~the performance rating,~~ and may include one or more requests for additional documentation or compliance. If the Administrative Director has determined that the investigation has uncovered the existence of a systemic problem in the operations, procedures, or policies of an approved utilization review plan organization, notice of his/her intent to place the utilization review plan on probation or withdraw approval of the plan, and the underlying reasons shall also be included in the preliminary investigation report. The investigation subject may request a conference within twenty-one (21) calendar days of the issuance of the preliminary report. ~~A conference to discuss the preliminary investigation report shall be scheduled, if necessary, within twenty-one calendar days from the issuance of the preliminary findings.~~ Following the conference or, after twenty-one (21) calendar days in the case where no conference has been requested, ~~,~~ the Administrative Director or his or her designee shall issue an Order to Show Cause Re: Assessment of Administrative Penalty (which shall include the final investigation report and any applicable notices), as set forth in section 9792.15.

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

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

(1) (A) For investigation subjects whose investigations did not result in probation or withdrawal of approval of its UR plan, a~~A~~ notice, which shall include a copy of the final investigation report, the measures actually implemented to ~~abate~~ correct such conditions, and the website address for the Division where the ~~performance rating and~~ summary of violations is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report.

(B) For investigation subjects whose investigations resulted in the UR plan being placed on probation, a notice, which shall include a copy of the final investigation report, a statement indicating that the Division has placed the utilization review plan on probation, and the website address for the Division where the summary of violations and probationary status is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report.

(C) For investigation subjects whose investigations resulted in a withdrawal of approval of its utilization review plan, a notice, which shall include a copy of the final investigation report, a statement indicating that the Division's approval of its utilization review plan has been withdrawn, and the website address for the Division where the summary of violations and withdrawn status is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report.

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

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

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

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

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

(z) Where the Administrative Director has determined that an investigation subject is to be placed on probation, the Administrative Director shall commence a return investigation of the plan in 180 to 360 days from the date of the issuance of the final report or, if applicable, final determination. The return investigation shall follow the procedures set forth for a routine investigation under this section.

(aa) A probationary period following an investigation may only be granted once per investigation.

Authority: Sections 11180-11191, Government Code; and Sections 133, 4610 and 5307.3, Labor Code. Reference: Sections 60, 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

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

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

(a) For violations relating to utilization review plan requirements:

(1) For failure to establish a Labor Code section 4610 utilization review plan: $50,000;

(2) For failure to include all of the requirements of section 9792.7(a) in the utilization review plan: $5,000;

(3) For failure to file the utilization review plan or a letter in lieu of a utilization review plan with the Administrative Director as required by section 9792.7(c): $ 10,000;

(4) For utilization review plans that modify or deny treatment requests, failure to obtain approval of a utilization review plan with the Administrative Director prior to operation: $30,000;

~~(4)~~ (5) For failure to file a ~~modified~~ material modification of a utilization review plan with the Administrative Director ~~within 30 calendar days after the claims administrator makes a material modification to the plan~~ as required by section 9792.7(c): $10~~5~~,000;

(6) For failure to obtain or maintain URAC accreditation as required under Labor Code section 4610 (g)(4) prior to commencing or continuing to function as a utilization review plan: $10,000;

(7~~5~~) For failure to employ or designate a physician as a medical director, as defined in section 9792.6.1(o)(l), of the utilization review process, as required by section 9792.7(b): $50,000;

(8) As required by Labor Code section 4610(g), for failure to comply with the laws prohibiting financial incentives or consideration to physicians conducting utilization review: $25,000;

(9) For failure to retain records as required under section 9792.11(r): $20,000;

(b) For violations relating to utilization review plan operations:

(1) (A) For failure to comply with the requirement that only a physician reviewer may modify, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in Labor Code section 4604.5(c): $25,000;

(B) For failure to comply with the requirement that only a physician reviewer may deny requests for authorization of medical treatment where there has been a failure to obtain the necessary information, tests, or consultation under section 9792.9.6: $25,000;

(C) For failure to comply with the requirement as set forth in sections 9792.6.1(w) prohibiting a non-physician reviewer from ~~reviewing~~ denying or modifying a treatment request under section 9792.9.2(a)(2)(B) that would otherwise be subject to Labor Code section 4610(k): $25,000;

(2~~6~~) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): $25,000;

~~(7) For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in Labor Code section 4604.5(c): $25,000;~~

(3) For failure to comply with requirements at section 9792.9.2 (deferral) when the medical necessity of requested treatment cannot be determined after application of the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27: $5,000;

(4) For failure to discuss and/or document attempts to discuss reasonable options for a care plan with the requesting physician as required by Labor Code section 4610(i)(4)(C), prior to denying authorization of or discontinuing medical care, in the case of concurrent review: $10,000;

(5) For requiring prospective utilization review for each medical treatment that complies with the conditions set forth in section 9792.9.7(a): $3,000.

(6) For failure to respond to a complete or accepted request for authorization:

(A) In the case of a non-expedited concurrent review: $3,000;

(B) In the case of a non-expedited prospective review: $2,500;

(C) In the case of a retrospective review: $750.

~~(8) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request without documenting the amended request as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: $1,000;~~

~~(9) For failure to communicate the decision in response to a request for an expedited review, as defined in section 9792.6(g), in a timely fashion, as required by section 9792.9 and section 9792.9.1: $15,000;~~

~~(10) For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the medical treatment utilization schedule adopted pursuant to section 5307.27 of the Labor Code: $5,000;~~

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

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

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

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

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

(7) For each failure to timely make a decision under section 9792.9.3(b) for non-expedited prospective or concurrent review within 5 working days of receipt of a request for authorization, or after receipt of requested information, tests or examinations, or consultations under section 9792.9.6(d); or to communicate, whether initially or in writing, a decision to approve, modify, or deny a non-expedited prospective or

concurrent request to the appropriate parties as required by sections 9792.9.4(b), 9792.9.5(c), and 9792.9.6(d): $250 for each day the failure is ongoing, up to a maximum of $5,000 at which point the violation may be deemed a failure to respond to a complete or accepted request for authorization as applicable under section 9792.12(b)(6) and the additional penalty for that failure attaches;

(8) Under sections 9792.9.3, 9792.9.4, or 9792.9.5, for the failure to timely make and/or issue written communication of a decision within 72 hours of receipt of a complete or accepted request for expedited review, as defined in section 9792.6.1(j), or upon receipt of the requested information under section 9792.9.6(d): $250 for each hour the response is untimely up to a maximum of $18,000;

(9) For each failure to timely make and/or communicate a retrospective review decision to approve, modify, or deny the request, within thirty (30) days of receipt of information that is reasonably necessary to make a determination, as required by sections 9792.9.4(c) or 9792.9.5(d), or upon receipt of the requested information under section 9792.9.6(d): $150 for each day that the failure is ongoing, up to a maximum of $3,000 at which point the violation may be deemed a failure to respond to a complete or accepted request for authorization as applicable under section 9792.12(b)(6) and the additional penalty for that failure attaches;

(10) For failure to timely communicate in writing the reason for extending the required timeframe for the issuance of a decision as required by section 9792.9.6(b): $250 for each day that passes without a response, up to a maximum of $5,000 at which point the violation may be deemed a failure to respond to a complete or accepted request for authorization as applicable under section 9792.12(b)(6) and the additional penalty for that failure attaches;

(11) For failure to document that one of the following events at section 9792.9.6(a) of Title 8 of the California Code of Regulations occurred prior to the claims administrator providing written notice for extending the timeframe for decision under section 9792.9.3: $200;

(12) For failure to comply with documentation requirements applicable to ~~document efforts to obtain information from the requesting party prior to issuing~~ a denial of a request for authorization on the basis of lack of reasonable and necessary information as required under section 9792.9.5(e)(2): $200.

(13) For failure to include in the written decision that modifies or denies authorization, when applicable, all of the items required under section 9792.9.5(e): $300 for each item;

(14) For each failure to operate the plan in accordance with the plan filed and/or approved by the Administrative Director other than a failure already identified in this penalty schedule: $5,000.

(15) Reserved.

(c) For violations related to investigation procedures and miscellaneous violations:

(1) For failure to timely provide a complete copy of any document, file, or record, whether electronic or paper, that was requested by the Administrative Director pursuant to section 9792.11: $500 for each day the failure is ongoing up to a maximum of $10,000 unless a greater penalty is warranted under subdivision (e) of this section.

(2) For providing a backdated, altered, or fraudulent document to the Administrative Director, or his or her designee, or intentionally withholding a document, which would have the effect of avoiding liability for an obligation under this Article or for the assessment of an administrative penalty under this section: $5,000 for each backdated, altered, or withheld document, unless a greater penalty is warranted under subdivision (e) of this section.

(3) For failure to timely comply with any and each compliance requirement listed in a Final Report, if no timely answer was filed, or any compliance requirement listed in the Determination and Order after any and all appeals have become final: $500 for each day the failure is ongoing up to a maximum of $20,000 unless a greater penalty is warranted under subdivision (e) of this section.

(4~~16~~) For failure to timely serve the Administrative Director with documentation of compliance pursuant to section 9792.11(x~~v~~)(5): $500 for each day the failure is ongoing up to a maximum of $20,000 unless a greater penalty is warranted under subdivision (e) of this section.

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

~~(b) Additional Utilization Review Penalties and Remediation.~~

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

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

~~(B) The factor for notice(s) with faulty content shall be determined by dividing the~~

~~number of requests involving notice(s) with faulty content by the total number of randomly selected requests.~~

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

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

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

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

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

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

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

~~(3) In the event the Administrative Director, or his or her designee, returns for a Return Target Investigation, after the initial violation has become final, and the subject fails to meet the performance standard of 85%, the amount of penalty shall be calculated as~~

~~described below and in no event shall the penalty amount be waived:~~

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

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

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

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

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

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

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

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

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

(5)~~(F)~~ For failure to disclose or otherwise ~~to~~ make available, if requested, the Utilization Review criteria or guidelines~~, to the injured employee whose case is under review,~~ as

required by Labor Code section 4610(~~f~~h)(5): $200. ~~and section 9792.8(a)(3) Title 8 of the California Code of Regulations.~~

(6) For failure to disclose or otherwise make available the approved utilization review process descriptions and the accompanying written policies and procedures as required by Labor Code section 4610, subdivision (g)(5) and section 9792.7(m) of Title 8 of the California Code of Regulations: $200.

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

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

~~(B) For failure to communicate the decision to approve to the requesting physician in the case of prospective or concurrent review, by phone or fax within 24 hours of the decision, as required by Labor Code section 4610(g)(3)(A) and in accordance with section 9792.9(c)(3) or section 9792.9.1(d)(2);~~

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

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

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

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

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

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

~~(F) Reserved.~~

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

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

(d~~c~~) Independent Medical Review Administrative Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty amount that shall be assessed for each failure to comply with the independent medical review process required by Labor Code sections 4610.5 and 4610.6, and sections 9792.6.1 through 9792.10.8 of this Article is:

(1) For the failure to provide the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with a written decision modifying~~, delaying,~~ or denying a treatment authorization under section 9792.9.5(e)~~sections 9792.9(l) or 9792.9.1~~: $2,000.

(2) For the failure to complete all applicable fields on the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, ~~that~~ which is provided with a written decision modifying~~, delaying,~~ or denying a treatment authorization under section 9792.9.5 ~~sections 9792.9(l) or 9792.9.1~~:

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

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

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

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

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

(3) For the failure to include in a written decision modifying~~, delaying,~~ or denying a treatment authorization under section 9792.9.5 ~~sections 9792.9(l) or 9792.9.1~~ a clear statement that advising the injured employee that any dispute shall be resolved in

accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, within 10 or 30 days of service of the utilization review decision in accordance with section 9792.10.1(a): $1,000.

(4) For the failure to include in a written decision modifying~~, delaying,~~ or denying a treatment authorization under section 9792.9.5 ~~sections 9792.9(l) or 9792.9.1~~ a statement detailing the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis: $1,000.

(5) For the failure to timely provide information requested by the Administrative Director under section 9792.10.3(b): $500.00 for each day the response is untimely under section 9792.10.3(c), up to a maximum of $7,500.00. ~~5,000.00.~~

(6) For the failure to timely provide all information required by section 9792.10.5(a) and (c): $500.00 for each day the response is untimely up to a maximum of $7,500.00. ~~$5,000.00.~~

(7) For the failure to authorize services found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within either five (5) business days of receipt of the determination, or sooner if appropriate for the employee’s medical condition, or five (5) business days from the date the determination is final, if an appeal of the determination has been filed under Labor Code section 4610.6(h): $1,000.00 for each day up to a maximum of $10,000~~5,000.00~~.

(8) For the failure to reimburse for services already rendered that has been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h), subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive: $500.00 for each day up to a maximum of $10,000.~~5,000.00~~

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

(e) (1) For any other act or failure pertaining to utilization review in violation of Labor Code section 4610 and sections 9792.6.1 through 9792.12 of Title 8 of the California Code of Regulations: a penalty of up to $50,000 and/or revocation of approval or suspension of the utilization review plan, depending on the gravity of the violation; the characteristics or similarity of the violation to other violations listed in this penalty schedule; the history of previous violations; the frequency of violations uncovered during the investigation; the good faith behavior of the investigation subject; and other cause as determined by the Administrative Director.

(2) Where a violation under this article results in the inability of the Administrative Director to conduct a full investigation of any complaint or issue, additional penalties may be imposed in accordance with the penalty provision of subsection (1) of this subdivision.

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

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

Authority: Sections 60, 133, 4610, 4610.5, 4610.6 and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4610.5, 4610.6, and 4614, Labor Code.

§9792.13. Assessment of Administrative Penalties - Penalty Adjustment Factors.

(a) In any investigation that the Administrative Director deems appropriate, prior to the issuance of the final investigation report, the Administrative Director, or his or her designee, may mitigate a penalty amount imposed under section 9792.12 after considering each of these factors:

(1) The medical consequences or gravity of the violation(s);

(2) The good faith of the claims administrator or utilization review organization. Mitigation for good faith shall be determined based on documentation of attempts to comply with the Labor Code and regulations and shall result in a reduction of 20% for each applicable penalty;

(3) The history of previous penalties;

(4) The frequency of violations found during the investigation giving rise to a penalty;

(5) Penalties may be mitigated outside the above mitigation guidelines in extraordinary circumstances, when strict application of the mitigation guidelines would be clearly inequitable; and

~~(6) In the event an objection or appeal is filed pursuant to subsection 9792.15 of these regulations, whether the claims administrator or utilization review organization abated the alleged violation within the time period specified by the Administrative Director or his or her designee.~~

(b) The Administrative Director, or his or her designee, may assess both an administrative penalty under Labor Code section 4610 and 4610.6 and a civil penalty under ~~subdivision (e) of~~ Labor Code section 129.5(e) based on the same violation(s).

(c) The Administrative Director, or his or her designee, shall not collect payment for an administrative penalty under Labor Code section 4610 from both the utilization review organization and the claims administrator for an assessment based on the same violation(s).

(d) Where an injured worker's or a requesting provider's refusal to cooperate in the utilization review process has prevented the claims administrator or utilization review organization from determining whether there is a legal obligation to perform an act, the Administrative Director, or his or her designee, may forego a penalty assessment for any related act or omission. The claims administrator or utilization review organization shall have the burden of proof in establishing both the refusal to cooperate and that such refusal prevented compliance with the relevant applicable statute or regulation.

Note: Authority cited: Sections 60, 133, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

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

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

regulation adopted by the Administrative Director pursuant to the authority of sections 4610(i), 4610.5(i), and 4610.6(k),

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

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

(2) For administrative penalties assessed under section 4610~~(i)~~(p), the final investigation report, which shall consist of the notice of utilization review penalty assessment, ~~the performance rating,~~ and, if applicable,~~may include~~ one or more requests for documentation or compliance, and/or notice of the Administrative Director's intent to place the investigation subject on probation or to withdraw approval of the utilization review plan;

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

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

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

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

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

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

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

(4) Set forth any affirmative and other defenses;

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

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

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

an answer. The respondent may also file a written request for leave to assert additional defenses, which the Administrative Director may grant upon a showing of good cause.

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

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

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

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

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

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

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

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

(1) Exploration of settlement possibilities;

(2) Preparation of stipulations;

(3) Clarification of issues;

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

(5) Objections to proffers of evidence;

(6) Order of presentation of evidence and cross-examination;

(7) Rulings regarding issuance of subpoenas and protective orders;

(8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing;

(9) Any other matters as shall promote the orderly and prompt conduct of the hearing.

(n) The Administrative Director or the designated hearing officer shall issue a pre-hearing order incorporating the matters determined at the pre-hearing conference. The Administrative Director or the designated hearing officer may direct one or more of the parties to prepare the pre-hearing order.

(o) Not less than thirty (30) calendar days prior to the date of the evidentiary hearing, the respondent shall file and serve the original and one copy of a written statement with the Administrative Director or the designated hearing officer specifying the legal and factual bases for its answer and each defense, listing all witnesses the respondent intends to call to testify at the hearing, and appending copies of all documents and other evidence the respondent intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the written statement and supporting evidence are not timely filed and served, the Administrative Director or the designated hearing officer shall dismiss the answer and issue a written Determination based on the evidence provided by the investigating unit of the Division of Workers' Compensation. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence. The Administrative Director or the designated hearing officer may grant the request, upon a showing of good cause. If

leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.

(p) Oral testimony shall be taken only on oath or affirmation.

(q)(1) Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.

(2) In the absence of a contrary order by the Administrative Director or the designated hearing officer, the investigating unit of the Division of Workers' Compensation shall present evidence first.

(3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of the evidence improper over objection in civil actions.

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

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

introduced in evidence, but it shall be given only the same effect as other hearsay evidence.

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

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

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

(v) The Determination and Order Assessing Penalty, if any, shall become final on the day it is served, unless the aggrieved party files a timely Petition Appealing the Determination of the Administrative Director. All findings and assessments in the Determination and Order Assessing Penalty not contested in the Petition Appealing the Determination of the Administrative Director shall become final as though no petition were filed.

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

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

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

with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.

Note: Authority cited: Sections 133, 4610, 4610.5, 4610.6 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4610.5, 4610.6, 4614 and 5300, Labor Code.

Article 5.5.2 Medical Treatment Utilization Schedule

§9792.27.1 Medical Treatment Utilization Schedule (MTUS) Drug Formulary – Definitions.

For purposes of sections 9792.27.1 through 9792.27.23, the following definitions shall apply:

(a) "Administer" means the direct application of a drug or device to the body of the patient by injection, inhalation, ingestion, or other means.

(b) "Authorization through prospective review" means authorization for proposed treatment obtained through the utilization review process set forth in section 9792.6.1 et seq.

(c) "Brand name drug" means a drug that is produced or distributed under an FDA original New Drug Application (NDA) or Biologic License Application (BLA) approved by the FDA. It also includes a drug product marketed by any cross-licensed producers or distributors operating under the same NDA or BLA.

(d) "Combination drug" means a fixed dose combination of two or more active drug ingredients into a single dosage form that is FDA-approved for marketing.

(e) "Compounded drug" means any drug subject to:

(1) Article 4.5 (commencing with section 1735) or article 7 (commencing with section 1751) of division 17 of title 16 of the California Code of Regulations, or

(2) Other regulation adopted by the State Board of Pharmacy to govern the practice of compounding, or

(3) Federal law governing compounding, including title 21, United State Code, sections 353a, 353a-1, 353b.

(f) "Dispense" means: 1) the furnishing of a drug upon a prescription from a physician or other health care provider acting within the scope of his or her practice, or 2) the

furnishing of drugs directly to a patient by a physician acting within the scope of his or her practice.

(g) "Executive Medical Director" means the medical director of the Division of Workers' Compensation.

(h) "Exempt drug" means a drug on the MTUS Drug List which is designated as being a drug that does not require authorization through prospective review prior to dispensing the drug, provided that the drug is prescribed in accordance with the MTUS Treatment Guidelines. The Exempt status of a drug is designated in the column with the heading labeled "Exempt / "Exempt / Non-Exempt."

(i) "Expedited review" means the expedited utilization review conducted prior to the delivery of the requested medical services, in accordance with Labor Code section 4610 and title 8, California Code of Regulations section 9792.6.1 et seq.

(j) "FDA" means the United States Food and Drug Administration within the United States Department of Health & Human Services.

(k) "FDA-approved drug" means a prescription or nonprescription drug that has been approved by the FDA under the federal Food, Drug, and Cosmetic Act, title 21, United States Code, section 301 et seq.

(l) "Generic drug" means a drug that is produced or distributed under an FDA Abbreviated New Drug Application (ANDA) approved by the FDA. A generic drug may be substituted for a therapeutic equivalent brand name drug pursuant to applicable state and federal laws and regulations.

(m) "MTUS Drug Formulary" means the MTUS Drug List set forth in section 9792.27.15 and the formulary rules set forth in sections 9792.27.1 through 9792.27.23.

(n) "MTUS Drug List" means the drug list and related information in section 9792.27.15, which sets forth the Exempt or Non-Exempt status of drugs listed by active drug ingredient(s).

(o) "Non-Exempt drug" means a drug on the MTUS Drug List which is designated as requiring authorization through prospective review prior to dispensing the drug. The Non-Exempt Drug status of a drug is designated in the column labeled "Exempt / Non-Exempt."

(p) "Nonprescription drug" or "over-the-counter drug" (OTC drug) means a drug which may be sold without a prescription and which is labeled for use by the consumer without the supervision of a health care professional.

(q) "Off-label use" means use of a drug for a condition, or in a dosage or method of administration, not listed in the drug's FDA-approved labeling for approved use.

(r) “OTC Monograph,” where OTC stands for over-the-counter, means a monograph established by the FDA setting forth acceptable ingredients, doses, formulations, and labeling for a class of OTC drugs.

(s) “Perioperative Fill” means the policy set forth in section 9792.27.13 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed within the perioperative period and meets specified criteria.

(t) “P&T Committee” means the Pharmacy and Therapeutics Committee established by the Administrative Director pursuant to Labor Code section 5307.29 to review and consult with the administrative director on available evidence of the relative safety, efficacy, and effectiveness of drugs within a class of drugs in the updating of the evidence-based drug formulary.

(u) “Physician”: Notwithstanding the definition in Labor Code section 3209.3, for purposes of the MTUS Drug Formulary, “Physician” means a medical doctor, doctor of osteopathy, or other health care provider whose scope of practice includes the prescription of drugs. However, for purposes of membership on the P&T Committee, “physician” means a medical doctor or doctor of osteopathy licensed pursuant to the California Business and Professions Code.

(v) “Prescription drug” means any drug whose labeling states “Caution: Federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import.

(w) “Prospective review” means the utilization review conducted prior to the delivery of the requested medical services, in accordance with Labor Code section 4610 and title 8, California Code of Regulations section 9792.6.1 et seq.

(x) “Special Fill” means the policy set forth in section 9792.27.12 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed or dispensed in accordance with the criteria set forth in subdivision (b) of section 9792.27.12.

(y) A “therapeutic equivalent” is a drug designated by the FDA as equivalent to a Reference Listed Drug if the two drugs are pharmaceutical equivalents (contain the same active ingredient(s), dosage form, route of administration and strength), and are bioequivalent (comparable availability and rate of absorption of the active ingredient(s).) Drugs that the FDA considers to be therapeutically equivalent products are assigned a Therapeutic Equivalence Evaluation Code beginning with the letter “A” in the FDA publication "Orange Book: Approved Products with Therapeutic Equivalence Evaluations” which is available on the FDA website and accessible via a link provided on the department’s website.

(z) “Unlisted drug” means a drug that does not appear on the MTUS Drug List and which is one of the following: an FDA-approved or a nonprescription drug that is

marketed pursuant to an FDA OTC Monograph. An “unlisted drug” does not include a compounded drug but does include a combination drug.

Authority: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.
Reference: Sections 4600, 4604.5, 5307.27 and 5307.29, Labor Code.

§ 9792.27.17. Formulary – Dispute Resolution.

(a) Medical Necessity Disputes.
Disputes over the medical necessity of pharmaceutical treatment covered by the MTUS Drug Formulary are governed by the utilization review and independent medical review provisions of Labor Code sections 4610, 4610.5, and regulations at section 9792.6.1 et seq, and section 9792.10.1 et seq.

(b) Formulary Rule Medical Treatment Disputes Other than Medical Necessity Disputes.
Disputes over failure to follow formulary rules, other than medical necessity disputes covered by subdivision (a), shall be resolved through the procedure for expedited hearings ~~non-IMR/IBR disputes~~ set forth in WCAB rules, title 8, California Code of Regulations, section 10782 ~~10451.2, Determination of Medical Treatment Disputes~~.

Authority: Sections 133, 4603.5, 5307.3, 5307.1 and 5307.27, Labor Code.
Reference: Sections 4600, 4604.5, 5307.1, 5307.27 and 5307.29, Labor Code.