

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
455 Golden Gate Avenue, 9th Floor
San Francisco, CA 94102

NOTICE OF EMERGENCY REGULATORY ADOPTION

Finding of Emergency and Informative Digest

Subject Matter of Regulations: Workers' Compensation – Utilization Review Standards

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, proposes to adopt Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with section 9792.6. This action is necessary in order to implement, on an emergency basis, the provisions of Labor Code section 4610 and Labor Code section 4604.5, as amended by Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004), and Labor Code section 4062 as amended by Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). The former section 9792.6 of the California Code of Regulations is repealed effective January 1, 2004, by Senate Bill 228 (Chapter 639, Stats. of 2003, section 49).

Finding of Emergency

The Administrative Director of the Division of Workers' Compensation finds that the proposed regulations attached hereto are necessary for the immediate preservation of the public peace, health and safety or general welfare.

Statement of Emergency

The containment of medical costs in the workers' compensation system is critical for the future of California. The total annual costs of the California workers' compensation system more than doubled from 1995 to 2002, growing from about \$9.5 billion to about \$25 billion. During the same time, workers' compensation medical expenditures increased from \$2.6 billion to \$5.3 billion per year. It is estimated that in 2004, medical payments will account for two-thirds of all workers' compensation costs. (Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf.)

The rise in medical care expenditures has adversely affected the entire workers' compensation system. Employers in California experience higher costs for workers' compensation medical care than employers in most other states. California ranks highest in workers' compensation premiums. Studies indicate that the high utilization of specific kinds of medical services in California workers' compensation system is one of the major reasons for the difference. Pursuant to the Workers' Compensation Research Institute, the median number of medical visits per workers' compensation claim in California is more than 70 percent greater than other states. The

higher utilization is mostly due to higher rates of specific kinds of services including, physical medicine, psychological therapy, and chiropractic care. Further, the evidence for higher medical costs in workers' compensation relative to group health is consistently strong. Studies indicate a substantial positive differential for workers' compensation medical care. The studies find that workers' compensation pays 33%-300% more than group health to treat the same conditions. (Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf; Outline: Estimating the Range of Savings from Introduction of Guidelines Including ACOEM (Revised), Frank Neuhauser, UC DATA/Survey Research Center, University of California, Berkeley, October 20, 2003, <http://www.dir.ca.gov/chswc/EstimatingRangeSavingsGuidelinesACOEM.doc>.)

In response to the State's widely-acknowledged workers' compensation crisis, the Legislature passed Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004) which adopted several provisions designated to control workers' compensation costs: section 5307.27, requiring the Administrative Director to adopt a medical treatment utilization schedule on or before December 1, 2004, section 4604.5, providing that the medical treatment utilization schedule pursuant to Labor Code section 5307.27 is presumptively correct on the issue of extent and scope of medical treatment, and that until such schedule is adopted the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines), is presumptively correct on the issue of extent and scope of medical treatment, and section 4610, requiring employers to establish and maintain a utilization review process.

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

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

Labor Code section 4604.5 provides that upon adoption by the Administrative Director of a medical treatment utilization schedule, pursuant to section 5307.27, the recommended guidelines set forth in that schedule shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to section 5307.27. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Labor Code section 4604.5 further provides that prior to the adoption of a utilization schedule by the Administrative Director, and three months after the publication date of the ACOEM Practice

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

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

The estimated total savings from introduction of utilization guidelines to the California workers' compensation system, including ACOEM Practice Guidelines, ranges from \$1.4 billion to \$4.5 billion.¹

The utilization review statute is not self-executing. Regulatory interpretation is needed so employers will be able to determine the standards and criteria for creating and implementing the utilization review plan. This mandatory program which is intended to generate substantial savings will not be effective without regulatory interpretation. Further, lack of guidance and defined structure of the utilization review process will result in confusion over the legal requirements, likely resulting in increased litigation and costs. The regulations clarify the timeframes involved in the utilization review process pursuant to the statute, and set forth the procedures and notice content requirements necessary to facilitate expedited communication between the treating physicians and providers, thus resulting in timely access to medical care. Further, the regulations provide clarification and guidance with respect to the dispute resolution process, and the penalties which will be imposed for failure to comply with the requirements of the statute. Without interpretation from the Division of Workers' Compensation, medical treatment authorization disputes have increased and authorization and payment of otherwise necessary medical treatment has been unduly denied or delayed. Without these regulations, there will continue to be an upsurge of litigation before the Workers' Compensation Appeals Board over the extent and scope of medical treatment due to an increase in the number of denials and delays of medical treatment in the utilization review process.

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

¹ (Outline: Estimating the Range of Savings from Introduction of Guidelines Including ACOEM (Revised), Frank Neuhauser, UC DATA/Survey Research Center, University of California, Berkeley, October 20, 2003, <http://www.dir.ca.gov/chswc/EstimatingRangeSavingsGuidelinesACOEM.doc>.)

adopted. Section 9792.6 sets forth the definitions of terms used in this regulation. Section 9792.7 sets forth the applicability of the utilization review process. Section 9792.8 identifies the medically-based criteria required pursuant to the statute. Section 9792.9 sets forth the timeframes, procedures and notice contents required pursuant to the statute. Section 9792.10 sets forth the dispute resolution process. Section 9792.11 identifies the penalties which may be assessed for violations of the statute. The emergency adoption of the proposed regulations is necessary to implement the utilization review process which is a critical element of the workers' compensation reform legislation.

The Administrative Director has therefore determined that the emergency adoption of the proposed regulations is necessary for the immediate preservation of the public peace, health and safety or general welfare.

Authority and Reference

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

Reference is to Labor Code sections 129, 129.5, 4062, 4600, 4600.4, 4603.2, 4604.5, and 4610.

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These regulations are required by legislative enactment - Statutes of 2003, Chapter 639 (SB 228) and Statutes of 2004, Chapter 34 (SB 899).

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

Section 5307.27 of the Labor Code, as adopted by Senate Bill 228, requires the Administrative Director, in consultation with the Commission on Health and Safety and Workers' Compensation, to adopt on or before December 1, 2004, after public hearings, a medical treatment utilization schedule. The utilization schedule shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.

Section 4610 of the Labor Code, as adopted by Senate Bill 228, requires employers to establish and maintain a utilization review process, effective January 1, 2004, consistent with the utilization schedule developed by the Administrative Director pursuant to section 5307.27, and prior to adoption of that schedule, consistent with the ACOEM Practice Guidelines.

Section 4604.5 of the Labor Code, as adopted by Senate Bill 228, provides that upon adoption by the Administrative Director of a medical treatment utilization schedule pursuant to section 5307.27, the recommended guidelines set forth in that schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be

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

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

The Administrative Director now adopts administrative regulations governing the Utilization Review Process. These regulations implement, interpret, and make specific sections 4604.5 and 4610 of the Labor Code as follows:

1. Section 9792.6

This section provides definitions for key terms employed in these regulations to ensure that their meaning will be clear to the regulated public. The key terms include:

(a) “ACOEM Practice Guidelines” is defined to identify the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, Second Edition.

(b) “Claims Administrator” is defined to specify that the term refers to a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer or a joint powers authority.

(c) “Concurrent review” is defined as the utilization review conducted during an inpatient stay.

(d) “Course of treatment” is defined as the course of medical treatment set forth in the treatment plan contained in the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021 or in the “Primary Treating Physician’s Progress Report,” DWC Form PR-2.

(e) “Emergency health care services” is defined as 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.

(f) “Expedited review” is defined as 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.

(g) “Expert reviewer” is defined as the physician, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician’s practice, who has been consulted by the reviewing physician or utilization review medical director to provide specialized review of medical information.

(h) “Health care provider” is defined as 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.

(i) “Medical services” is defined as 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.

(j) “Prospective review” is defined as utilization review conducted prior to the delivery of the requested medical services.

(k) “Request for authorization” is defined as 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 in Form DLSR 5021, section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of section 9785.

(l) “Retrospective review” is defined as utilization review conducted after medical services have been provided and for which services approval has not already been given.

(m) “Utilization review plan” is defined to identify 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 process.

(n) “Utilization review process” is defined as 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.

(o) “Written” is defined to state that the term includes a facsimile as well as communications in paper form.

2. Section 9792.7

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

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

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

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

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

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

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

(2) This subdivision provides that no person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

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

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

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

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

3. Section 9792.8

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

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

(2) This subdivision provides that for all conditions or injuries not covered by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

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

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

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

4. Section 9792.9

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

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

(1) This subdivision provides that for purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on

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

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

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

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

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

(A) This subdivision provides that if the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the provider, the claims administrator may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

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

purposes of this section “normal business day” means a business day as defined in section 9 of the Civil Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The clinical reasons regarding medical necessity.

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

(8) Include the following mandatory language:

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

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

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

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

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

(k) This subdivision provides that authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods either by facsimile or mail.

5. Section 9792.10

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

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

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

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

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

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

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

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

6. Section 9792.11

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

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

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

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

There are no other matters prescribed by statute applicable to the Division of Workers' Compensation or to any specific regulation or class of regulations.

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed regulations do not apply to any local agency or school district.

FISCAL IMPACTS

Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with section 17500) of Division 4 of the Government Code:

None. The proposed regulations do not apply to any local agency or school district.

Other nondiscretionary costs/savings imposed upon local agencies:

None. The proposed regulations do not apply to any local agency.

Costs or savings to state agencies or costs/savings in federal funding to the State:

None.