

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

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

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

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

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

**PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS**

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

Written comments should be addressed to:

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

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than **5:00 p.m. on Thursday, July 14, 2005**. Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (415) 703-4720. Written comments may also be sent electronically (via e-mail), using the following e-mail address: [dwcrules@hq.dir.ca.gov](mailto:dwcrules@hq.dir.ca.gov).

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

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

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

## DOCUMENTS SUPPORTING THE RULEMAKING FILE

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

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

## FORMAT OF PROPOSED MODIFICATIONS

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

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

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

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

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

Deletions from the codified emergency regulatory text after the 1<sup>st</sup> 15-day period comment are indicated by single strike-through italic text, thus: ~~*single strike-through italic text*~~.

Additions to the codified emergency regulatory text after the 1<sup>st</sup> 15-day period comment are indicated by single underlined italic text, thus: *single underlined italic text*.

## SUMMARY OF PROPOSED CHANGES

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

This section provides definitions for key terms in the regulations.

**Section 9792.6(b)** The definition of “authorization” was amended to clarify that the term 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, 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 on a narrative form containing the same information required in the DWC Form PR-2.

**Section 9792.6(c)** The definition of “Claims Administrator” was amended for clarification purposes to delete the phrase “for an insurer, a self-insured employer, a legally uninsured employer, a joint powers authority” following the phrase “a third-party claims administrator” as superfluous, and to clarify the last sentence of the definition to state that the claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

**Section 9792.6(h)** The term “expert physician reviewer” was amended to change the term to “expert reviewer.” The definition was further amended to clarify that an expert reviewer is a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and 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 scope of practice, as defined by the licensing board, who has been consulted by the physician reviewer, the health care reviewer or the utilization review medical director to provide specialized review of medical information.

**Section 9792.6(j)** A new definition has been added in subdivision 9792.6(j). The term “health care reviewer” has been defined to mean a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, and chiropractic practitioner licensed by any state or the District of Columbia except California, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the individual’s practice.

**Section 9792.6(k)** The term “immediately” was defined in subdivision 9792.6(j). The subdivision has been re-lettered 9792.6(k).

**Section 9792.6(l)** A new term has been added in subdivision 9792.6(l). The term “material modification” has been defined to mean when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

**Section 9792.6(m)** A new term has been added to subdivision 9792.6(m). The term “Medical Director” has been defined to mean the physician and surgeon licensed by the Medical Board of the State of California or the Board of Osteopathic Examiners of the State 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.

**Section 9792.6(n)** The term “medical services” was defined in subdivision 9792.6(k). The subdivision has been re-lettered 9792.6(n).

**Section 9792.6(o)** The term “physician reviewer” was defined in subdivision 9792.6(l). The subdivision has been re-lettered 9792.6(o). The term has been amended for clarification purposes to mean a physician as defined in section 3209.3 of the Labor Code holding an active California license, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the physician’s practice as defined by the licensing board.

**Section 9792.6(p)** The term “prospective review” was defined in subdivision 9792.6(m). The subdivision has been re-lettered 9792.6(p).

**Section 9792.6(q)** The term “request for authorization” was defined in subdivision 9792.6(n). The subdivision has been re-lettered 9792.6(q). The term has been amended for clarification to add the name of Form DLSR 5021, “Doctor’s First Report of Occupational Injury or Illness.”

**Section 9792.6(r)** The term “retrospective review” was defined in subdivision 9792.6(o). The subdivision has been re-lettered 9792.6(r).

**Section 9792.6(s)** The term “utilization review plan” was defined in subdivision 9792.6(p). The subdivision has been re-lettered 9792.6(s). The word “review” has been inserted to clarify the last phrase of the sentence as “utilization review process.”

**Section 9792.6(t)** The term “utilization review process” was defined in subdivision 9792.6(q). The subdivision has been re-lettered 9792.6(t).

**Section 9792.6(u)** The term “written” was defined in subdivision 9792.6(r). The subdivision has been re-lettered 9792.6(u).

The Reference under this section was amended to insert section 3209.3 of the Labor Code as a reference.

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

**Section 9792.7(a)(1)** This subdivision was amended for clarification purposes to delete the phrase “area(s) of practice.”

**Section 9792.7(a)(3)** The second sentence of the subdivision was amended for clarification purposes. The sentence now states: “A description of the process used to review authorization for treatment requests which are not addressed in the treatment protocols or standards routinely used.”

**Section 9792.7(a)(5)** This subdivision was amended for after public comments requesting clarification. The subdivision now requires that the utilization review plan contain 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.

**Section 9792.7(b)(2)** This subdivision was amended to state that a “health care reviewer” in addition to a physician reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, may delay, modify or deny requests for authorization. Further, the subdivision was amended to clarify that the services of the “physician reviewer” or the “health care reviewer” must be within the scope of practice as defined by the licensing board.

**Section 9792.7(b)(3)** This subdivision was amended for clerical error. The last sentence of the subdivision now states: “Any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (g)(1)(A) through (g)(1)(C) of section 9792.9.

**Section 9792.7(c)** This subdivision was amended to clarify the new requirement that a new utilization review plan shall be filed with the Administrative Director. The last sentence of the subdivision now states: “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.

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

**Section 9792.8(a)(3)** This subdivision was amended to delete two references to the phrase “the provider of goods or services that are identified in the request for authorization.”

**Section 9792.8(a)(3)(B)** This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” The subdivision was further amended for clerical error to correct the reference to section 9792.9, subdivision (j).

**Section 9792.8(a)(4)** This subdivision was amended for clerical error to delete the word “disclosed” and to correct the reference of section 9792.7(a)(3) to 9792.8(a)(3).

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

**Section 9792.9(b)(2)** This subdivision was amended to clarify that a “health care reviewer” in addition to the physician reviewer or a non-physician reviewer may request appropriate information necessary to render a decision within the applicable timeframe.

**Section 9792.9(b)(2)(A)** This subdivision was amended to clarify that the “health care reviewer” in addition to the physician reviewer may deny the request for authorization when the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request.

**Section 9792.9(b)(3)** This subdivision was amended for clerical error to insert the phrase “a request” which was mistakenly deleted from the previous text.

**Section 9792.9(b)(4)** This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” Further, the subdivision was amended to add the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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.”

**Section 9792.9(c)** This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” Further, the subdivision was amended to add the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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.”

**Section 9792.9(d)** This subdivision has been amended for clarification purposes. The subdivision now states that “[p]reauthorization shall not be required prior to provision of emergency health care services. Emergency health care services, however, may be subjected to retrospective review.”

**Section 9792.9(f)** This subdivision was amended to clarify that the review and decision to deny, delay or modify a request for medical treatment may be conducted by a health care reviewer in addition to a physician reviewer.

**Section 9792.9(g)(1)(B)** This subdivision was amended to clarify that the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may be extended when a health care reviewer, in addition to 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.

**Section 9792.9(g)(1)(C)** This subdivision was amended to delete the word “physician” from the term “expert physician reviewer,” as the term was changed to “expert reviewer.”

**Section 9792.9(g)(2)** This subdivision was amended to delete two references to the phrase “the provider of goods or services that are identified in the request for authorization.” The subdivision was further amended to delete the word “physician” and properly refer to the new term “expert reviewer.” Moreover, the subdivision was further amended to insert the following new language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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.”

**Section 9792.9(g)(3)** This subdivision was amended for clerical error to clarify that the decision shall be communicated pursuant to subdivisions (b)(3) or (b)(4).

**Section 9792.9(j)** This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.”

**Section 9792.9(j)(7)** This subdivision was amended for clerical error to insert the word “that” in the last sentence.

**Section 9792.9(j)(8)** This subdivision was amended to add the following language at the end of the subdivision: “In addition, the non-physician provider of goods or services identified in the request for authorization 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.”

**Section 9792.9(k)** This subdivision was amended to require that the written decision modifying, delaying or denying treatment authorization provided to the physician contain the name and specialty of the health care reviewer and expert reviewer in addition to the physician reviewer. Further, the subdivision was amended to require that the written decision disclose the hours of availability of the health care reviewer or expert reviewer in addition of the physician reviewer or the medical director for the treating physician to discuss the decision. The language describing the hours of availability has been clarified to state that the time “shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time” or that the parties can reach “an agreed upon scheduled time to discuss the decision with the requesting physician.”

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

**Section 9792.10(a)(3)** This subdivision was amended for clerical error to insert a coma between the words “and” and “if” in the sentence.

**Section 9792.10(b)(1)** This subdivision was amended to delete the phrase “the provider of goods or services that are identified in the request for authorization.” The subdivision was further amended to include the following language: “In addition, the non-physician provider of goods or services identified in the request for authorization 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.”