

TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
ARTICLE 5.5.1 UTILIZATION REVIEW STANDARDS

§ 9792.6. Utilization Review Standards—Definitions

As used in this Article:

(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) “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.

(g) “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.

(h) "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.

(i) "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.

(j) "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.

(k) "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.

(l) "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.

(m) "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.

(n) "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.

(o) "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.

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

(q) “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.

(r) “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.

(s) "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.

(t) "Written" includes a facsimile as well as communications in paper form.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.7. Utilization Review Standards—Applicability

(a) 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. 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. A description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria. 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 American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), Second Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com). After 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 that schedule.

(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.

(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 subdivisions (b)(1), (b)(2) or (c). 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.

(c) 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 filed a complete utilization review plan with the Administrative Director. 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.

(d) 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) 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: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.8. Utilization Review Standards—Medically-Based Criteria

(a)(1) 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 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.

(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: Sections 133, 4603.5, 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

(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) 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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.

(g)(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 and Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408. 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.

(h) 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.

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

(j) A written decision modifying, delaying or denying treatment authorization under this section 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 and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408.

(8) 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.”

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.”

(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 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 or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event 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.

(l) 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.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.10. Utilization Review Standards—Dispute Resolution

(a)(1) 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) 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) 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 the injured worker is 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) Additionally, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim, and a Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408, 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) The following requirements shall 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 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 injured worker. 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.

(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.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.