

UTILIZATION REVIEW STANDARDS	RULEMAKING COMMENTS THIRD 15-DAY PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.6(h)	<p>Commenter states that this section still allows for professionals outside the State of California to do UR and objects to this for the following reasons: (1) It undermines the statutory ability of the Medical Board of California and the other licensing boards in the State to license and supervise medical professionals; (2) It allows unlicensed out-of-state professionals to practice medicine in California; (3) It is not true “peer-review.” Professionals from outside California often have different- and lower- standards of medical care; (4) There are plenty of physicians in the State that are available for peer-review; (5) It takes business out of the State and into out-of-state insurance companies and UR companies; (6) The regulation is an insult to professionals in California. It essentially says that we can’t do our own peer-review; (7) Out-of-state licensing agencies cannot be expected to be interested in enforcing medical practice laws against physicians and other professionals who are essentially practicing in California. In other words, this regulation creates a regulatory black hole where no oversight will occur, no matter how egregious the error made by the out-of-state reviewer.</p> <p>Commenter recommends that the UR process and expert reviewers be restricted to professionals licensed in California.</p>	<p>James E. Lessenger, MD FACOEM Written Comment July 22, 2005</p>	<p>Disagree. Labor Code section 4610 requires the medical director of the utilization review program to have a California license. Section 4610(d) states, in relevant part, “[t]he employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code.” The section further provides that the medical director “shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section.” Further Labor Code section 4610(d) provides that “[n]othing in this section shall be construed as restricting the existing authority of the Medical Board of California.” Thus, it is clear from the statute that the medical director must have a California license, is responsible for compliance with the requirements of the statute, and these responsibilities are not construed to restrict the existing authority of the Medical Board of California.</p>	None.

		<p>On the other hand, if a UR reviewer is going to make decisions “for reasons of medical necessity to cure or relieve” the UR reviewer must be 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 scope of the physician’s practice.” This physician may then “approve, modify, delay, or deny requests for authorization of medical treatment” and as indicated above, for “reasons of medical necessity to cure and relieve.” (Labor Code, §4610(e).)</p> <p>The same analysis applies to the “expert reviewer” pursuant to Labor Code section 4610(g)(5).</p> <p>This is consistent with business practices allowing UR to be conducted by physicians throughout the nation.</p> <p>Thus, it is clear from the statute that while the medical director is required to have a California license, the reviewing physician is not required to have a California license, and in order to require compliance with the “existing authority of the Medical Board of California,” the medical director is responsible to ensure compliance with the requirements of the statute.</p>	
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Section 9792.10(a)(1)	<p>Commenter believes that some requesting physicians are unwilling to work within the framework of an evidence based practice and that the time for a qualified medical exam to be set has grown to be quite lengthy for all disputes in which a treatment plan cannot be agreed upon. Commenter believes that the primary treating physician should be on the hook for treatment rendered past the UR decision should the qualified medical examiner agree that the request was not medically necessary. Commenter opines that this would help by forcing the primary treating physician to really look at what is medically necessary as he may be on the hook for treatment that falls outside an evidence based practice.</p>	<p>John J. Roza Jr., DC Atlas Utilization Review Written Comment July 22, 2005</p>	<p>Disagree. The comment does not address the proposed changes made to the regulations subject the third 15-day notice. Moreover. The comment goes beyond the scope of the statute.</p>	None.
Section 9792.6(h)	<p>Commenter objects to this section as it allows for professionals outside the State of California to do UR and offers the following reasons: (1) It undermines the statutory ability of the Medical Board of California and the other licensing boards in the State to license and supervise medical professionals involved in the care of California patients; (2) It allows out-of-state professionals, most without a California license to practice medicine in California; (3) It is not true “peer-review.” Professionals from outside California often have different standards of medical care.</p> <p>Commenter states that he is frequently reviewed by Drs. practicing in the state of Texas. Very often they lack the local knowledge necessary to facilitate the return to work process. This results in case prolongation and the associated NEEDLESS</p>	<p>Steven A. Gest, MD Medical Director Emeryville Occupational Medical Center Written Comment July 23, 2005</p>	<p>Disagree. See response to comment submitted by James E. Lessenger, MD, FACOEM, dated July 22, 2005, above.</p>	None.

	<p>disability that comes from extended delay. Commenter recommends that the UR process and the associated expert reviewers be restricted to professionals licensed and residing in California. Commenter does not see the need to send our business to another state when there are competent medical doctors willing and able to do this work ethically and efficiently.</p>			
Section 9792.6(l)	<p>Commenter opposes the definition of medical director being limited to a physician or surgeon licensed by the Medical Board of California or the Osteopathic Board of California. Commenter states that since chiropractors and acupuncturists are included in the definition of physician in Labor Code section 3909.3 it would be logical to allow those licensed providers to be responsible for all decisions made in the utilization review process rather than limit the responsibility to a physician and surgeon. Commenter states that URAC accredited networks or managed care organizations that do not contract with physicians and surgeons, but with employer groups to manage their chiropractic and acupuncture claims would be penalized due to their medical director being a licensed chiropractor or acupuncturist.</p>	<p>R. Lloyd Friesen, DC Director – Professional & Governmental Affairs American Specialty Health Written Comment July 22, 2005</p>	<p>Disagree. The comment does not address the proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
Section 9792.6(h)	<p>Commenter continues to object to allowing professionals from out of state to perform utilization review on California patients. Commenter states that if this language does not change that he hopes that this section is challenged in court.</p>	<p>Richard F. Thompson, MD – Medical Director EK Health Written Comment July 27, 2005</p>	<p>Disagree. See response to comment submitted by James E. Lessenger, MD, FACOEM, dated July 22, 2005, above.</p>	<p>None.</p>

<p>General Comment</p>	<p>Commenter states that there are problems in the UR process consisting of delays of treatment requests; piecemeal denials; re-denials even in the face of the requesting doctor's well-reasoned appeal; denials expressly based upon ACOEM guidelines when ACOEM is silent concerning treatment requests; insistence upon evidence-based guidelines even when no such guideline can be found and ACOEM is silent, and despite prior effectiveness of the treatment for the particular patient, prolonged lack of treatment while the parties wait for supplemental exams or reports from busy AMEs.</p> <p>Commenter suggests that the following factors be considered where the ACOEM guidelines are silent and where the nationally recognized standards also do not address medical treatment: (1) The diagnosis of the condition; (2) The clinical findings of the treating doctor; (3) The nature of the treatment recommended; (4) The purpose for the treatment in light of the diagnosis and clinical findings; (5) The likelihood that the recommended treatment will improve the patient's activities of daily living or relieve them from the affects of the industrial injury.</p> <p>Commenter requests that the Division consider a regulation that provides any treatment request that costs less than a certain amount, perhaps \$250.00 that will be approved without going through the UR process, on a one-time basis, as long as it is not prohibited by law or regulation.</p>	<p>Benjamin K. Helfman Cheryl Forbes Skip Tescher Margueritte Sweeny Members of the Shasta Chapter of the California Applicants' Attorneys Association Written Comment July 22, 2005 Sent on July 28, 2005</p>	<p>Disagree. The comment does not address the proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
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	<p>Commenter further restates that there is no consensus regarding the meaning of the language in Labor Code section 4610(g)(B) which states: “In the case of concurrent review, medical care shall not be discontinued until the employee’s physician 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 employee...”</p>			
<p>Section 9792.9(b)(2)</p>	<p>Commenter notes that changes have been made which would prohibit a non-physician reviewer from seeking additional information necessary to assist the physician reviewer in rendering timely authorization and that this could result in unintended delays. Commenter believes that the UR process is more timely and efficient when utilization review nurses are able to secure additional information and seek clarification from health care providers.</p> <p>Commenter requests that non-physician reviewers, as discussed in Section 9792.7(b)(3) be allowed to seek appropriate information necessary to render a decision.</p>	<p>Kathleen Bissell Assistant Vice President Regional Director – Public Affairs Liberty Mutual Group Written Comment July 29, 2005</p>	<p>Agree. This is a clerical error. The intent of the modification was to prohibit pursuant to the statute the non-physician reviewer to modify, delay or deny the request for authorization. (See modification to 9792.9(b)(2)(A).) It was not the intention of the modification to disallow the non-physician reviewer from gathering the information to assist the reviewer. Section 9792.9(b)(2) will be modified for clerical error to restore the language “or a non-physician reviewer.” This is consistent with section 9792.7(b)(3) as indicated by the commenter.</p>	<p>Section 9792.9(b)(2) has been modified for clerical error. The deleted language “or non-physician reviewer” has been restored to the section.</p>
<p>Section 9792.6(h) Section 9792.6(l) Section 9792.6(q)</p>	<p>Commenter states that there is no requirement to get prior authorization for any treatment, as the code says, any medical treatment identified by a physician necessary to cure or relieve. Commenter wonders if there is an intention that these new regulations are adding this requirement, or simply providing requirements that once authorized, they will be paid for.</p>	<p>Patricia L. Sinnott, PT, PhD, MPH Health Economist Health Economics Resource Center (HERC) Written Comment August 2, 2005</p>	<p>Disagree. The comment does not address the proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

<p>General comment</p>	<p>Commenter has made substantial proposed changes to the text of the regulations requiring that reviewers be licensed in California and to provide the services they are reviewing and experienced in the care of injured workers. In support of her numerous modifications, commenter states that she has heard anecdotes about pediatricians doing review, and there is long standing practice of nurses and chiropractors reviewing physical therapy although they are not licensed to provide physical therapy services. Additionally, commenter states that when she heard that research from Lewin specified that the California workers' compensation system adds 25 - 35% more work to the care of injured workers, above that which is required for non workers' compensation care, commenter opines that it is imperative that reviewers be familiar both with the kinds of injuries and with the regulatory environment under which these providers practice. Commenter believes that reviewers from outside the state are not adequately qualified to do this work, and also believes that the HMO world requires physicians to be licensed in the states in which they provide medical review.</p> <p>Commenter requests that the Division include physical therapists in the reviewer and expert reviewer categories because she believes that they are far more qualified to judge the appropriateness of physical therapy care (and deny it when inappropriate) than any other provider.</p>		<p>Disagree. The comments are not consistent with the requirements of Labor Code section 4610. Regarding the comment that all reviewers should be licensed in California, see response to comment submitted by James E. Lessenger, MD, FACOEM, dated July 22, 2005, above. Moreover, the comments do not address the specific proposed changes made to the regulations subject the third 15-day notice, and the comments also go beyond the scope of the statute and the regulations.</p> <p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice. Also, pursuant to Labor Code section 3209.3, a physical therapist is not a physician.</p>	<p>None.</p> <p>None.</p>
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General comment	<p>Commenter proposes that the division adopt a system like Medicare, where the physician makes the referral, and then the treating provider (physical therapist, chiropractor, DME) is responsible for documenting progress, and value for the continuation of the service. Commenter states that if these providers cannot validate (both with physician agreement and documented improvement) then the physical therapist is left to manage his or her own financial liability, not depending on the physician to do his or her work.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice. The comment also goes beyond the scope of the statute.</p>	None.
General comment	<p>Commenter states that the definition for the claims adjustor needs to be consistent with the non-physician reviewer.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
9792.6(j)	<p>Commenter proposes that the term “health care provider” be changed to the term “provider” with the following definition: “means a licensed health care provider of medical and health care services, including but not limited to an individual provider or facility, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
General comment	<p>Commenter requests that the division add the following definition: “Medical treatment utilization schedule” means a guide to be used in utilization review programs which addresses, at a minimum, the frequency, duration, intensity and appropriateness of treatment procedures and modalities provided in the medical care of individuals with</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.

9792.6(n)	<p>common work-related conditions, illnesses and injuries.”</p> <p>Commenter suggests the following modifications to the term prospective review: “Prospective review means any utilization review conducted prior to the delivery of the requested medical services, except for utilization review conducted during an inpatient stay.”</p>		<p>Agree. The definition of prospective review was amended to include the suggested modifications after the 45-day comment period. Due to clerical error, this modification was not included in the final text of the regulations.</p>	<p>Section 9792.6(m) is corrected for clerical error to reflect the definition noticed after the 45-day comment period which is consistent with this comment.</p>
9792.6(o)	<p>Commenter suggests the following modifications to the term request for authorization: "Request for authorization" means a request for written confirmation of an oral or written request for approval and commitment to pay for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h). An oral request for authorization must be followed by a written request for authorization within seventy-two (72) hours. The written confirmation of an oral or written request for authorization 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 Reports, 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>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
General Comment	<p>Commenter suggests that a new definition for the term “utilization review be added to the regulations as follows: “Utilization Review”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations</p>	<p>None.</p>

	<p>means claims administrative functions that prospectively, retrospectively, or concurrently review and approve, modify, delay or deny, payment for medical treatment recommended by physicians, as defined in Labor Code section 3209.3 and based in whole or in part on medical necessity to cure or relieve. Utilization review may be performed by a “reviewer” as defined in 9792.6 (q), an “expert reviewer” as defined in 9792.6(h) or a claims adjuster (needs definition). 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.</p>		<p>subject the third 15-day notice.</p>	
Section 9792.6(r)	<p>Commenter suggests the suggests that the term utilization review plan be amended as follows: “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 program of utilization review adopted by the claims administrator.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
Section 9792.6(s)	<p>Commenter requests that the division delete the definition of the term “utilization review process.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
Section 9792.7(a)	<p>Commenter suggests the text of section 9792.7(a) be re-written as follows: “(a) Effective January 1, 2004, in compliance with Labor Code section 4610, every claims administrator shall establish and maintain a program for utilization review for treatment rendered on or after January 1, 2004,</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

	<p>regardless of date of injury. Each utilization review program shall designate a Medical Director as defined in 9792.6(m) who shall oversee and be held responsible for all decisions made in the utilization review program. The utilization review program shall be set forth in a utilization review plan which shall contain:"</p>			
Section 9792.7(a)(1)	<p>Commenter suggests the text of section 9792.7(a)(1) be re-written as follows: "The name address, phone number, and medical license number of the employed or designated Medical Director as defined in 9792.6 (m), 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."</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
Section 9792.7(a)(3)	<p>Commenter suggests the text of section 9792.7(a)(3) be re-written as follows: "The name, address, phone number, and medical license number of the employed or designated Medical Director as defined in 9792.6 (m), 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."</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
Section 9792.7(a)(4)	<p>Commenter offers two alternatives to the text of section 9792.7(a)(4) as follows: "A description of the personnel and their qualifications and the resources used in the development and review of the criteria used in the utilization review program, including the methods utilized for updating the criteria;" or "A description of the qualifications and</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

<p>Section 9792.7(a)(5)</p>	<p>functions of the personnel involved in decision-making and implementation of the utilization review program.”</p> <p>Commenter suggests the text of section 9792.7(a)(5) be re-written as follows: “If applicable, a description of the claims administrator’s process for prior authorization of treatment, including but not limited to where authorization is provided without the submission of the request for authorization.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.7(b)(1)</p>	<p>Commenter suggests the text of section 9792.7(a)(5) be re-written as follows: “The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, delays, or denies requests for authorization for treatment authorized by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.7(b)(2)</p>	<p>Commenter suggests the text of section 9792.7(a)(5) be re-written as follows: “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 <i>practice as defined by the licensing board</i> may, except as indicated below, approve, 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.”</p>		<p>Disagree. The commenter appears to propose that language which was deleted from the last draft of the regulations be re-instated. The language was previously deleted based on comments from the public that it was incorrectly limiting the review of the physicians.</p>	<p>None.</p>

Section 9792.7(b)(3)	<p>Commenter suggests the text of section 9792.7(a)(5) be re-written as follows: “A claims adjustor, as defined in 9792.6, may be perform the initial utilization review by applying specified criteria to requests for authorization for medical services. A claims adjustor may approve requests for authorization of medical services. A claims adjustor may discuss applicable criteria with the requesting provider should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting provider may voluntarily withdraw the request for authorization for a portion or all of the treatment in question and submit an amended request for treatment authorization, and the claims adjustor may approve the amended request for treatment authorization. Additionally, a claims adjustor 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.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice. The commenter introduces a new term to the regulation which was never part of the text of the noticed versions of the regulations. The term used by the Division is claims administrator which is properly defined in the regulations.</p>	None.
Section 9792.7(c)	<p>Commenter suggests that the word “process” be substituted with the word “program” pursuant to her previous changes.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
Section 9792.7(d)	<p>Commenter suggests that the word “process” be substituted with the word “program” pursuant to her previous changes.</p>		<p>Disagree. The comment does not address the specific proposed</p>	None.

<p>Section 9792.8</p>	<p>Commenter suggests deleting “Medically-Based Criteria” from the title of the section.</p>		<p>changes made to the regulations subject the third 15-day notice.</p> <p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>9792.8(a)</p>	<p>Commenter suggests the text of section 9792.8(a) be re-written as follows: “(a) Pursuant to Labor Code section 5307.27, the administrative director shall adopt a medical treatment utilization schedule, which shall be presumptively correct on the extent and scope of medical treatment and shall make the medical treatment utilization schedule available to the public.</p> <p>“(1) Prior to adoption of the schedule, the guidelines provided in the American College of Occupational and Environmental Medicine’s (ACOEM) Practice Guidelines, Second Edition shall be presumptively correct on the issue of the extent and scope of medical treatment until the Medical Treatment Utilization Schedule is adopted.</p> <p>“(2) For any condition, illness or injury not included in the official medical treatment utilization schedule, including the ACOEM Practice Guidelines treatment shall be authorized if the proposed treatment is in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

<p>Section 9792.9(a)</p> <p>Section 9792.9(a)(1)</p>	<p>“(i). Treatment may not be denied on the sole basis that the treatment is not addressed by the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.2 or the ACOEM Guidelines.</p> <p>“(ii). The presumption of correctness shall be rebuttable and may be controverted by a preponderance of 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.</p> <p>“(iii) Upon request, the provider, injured worker, or injured worker’s attorney shall be provided a written copy of the relevant portion of the criteria or guidelines used to guide the decision to modify, delay, or deny services in a specific case under review.</p> <p>“(iv).The claims administrator may not charge a provider, an injured worker, or the injured worker’s attorney for this copy of the relevant portion of the criteria or guidelines used to modify, delay or deny the treatment request.”</p> <p>Commenter suggests the substitution of the word “any” for the word “the” in the beginning of the sentence of this section.</p> <p>Commenter suggests that the last sentence in this section be modified as follows: “The requesting provider must indicate the need for an expedited review, if so requested upon submission of the request.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p> <p>Agree in part. It is noted that modifications have been made throughout the regulations to substitute the term “provider” with the term “requesting physician”. This section will be amended for clerical</p>	<p>None.</p> <p>Section 9792.9(a)(1) has been amended to substitute the word “provider” with the term “requesting physician.”</p>
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Section 9792.9(b)(2)	<p>Commenter suggests the text of section 9792.9(b)(2) be re-written as follows: “The reviewer may request additional information reasonably necessary to render a decision within five (5) working days from the date of receipt of the written request for authorization. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization.”</p>		<p>error to substitute the appropriate term pursuant to commenter’s suggestion.</p> <p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
Section 9792.9(b)(2)(A)	<p>Commenter suggests the text of section 9792.9(b)(2) be re-written as follows: “If the reasonable additional information is not received by the claims administrator within 14 days of the date of the original written request for authorization, a reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
Section 9792.9(b)(3)	<p>Commenter suggests the entire text of section 9792.9(b)(3) be re-written as follows: “The claims administrator shall communicate the results of Decisions to approve requests for prior or concurrent authorization for medical services to the requesting provider within 24 hours of the decision.</p> <p>(i) Any decision to approve a <i>request</i> shall be communicated to the requesting provider initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.

<p>Section 9792.9(c)</p>	<p>provider within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review.</p> <p>(ii) Any decision to modify, delay or deny a provider’s request for authorization 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 provider 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.”</p> <p>Commenter substitutes the term “requesting physician” with the term “requesting provider.”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(e)</p>	<p>Commenter suggests the introductory text of section 9792.9(e) be re-written as follows: “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 provider must indicate the need for an expedited review upon submission of the request. Expedited review may be requested when one of the following conditions exists:”</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

Section 9792.9(f)	Commenter states that the text of this section should be part of the definition of a reviewer		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.9(g)	Commenter suggests the introduction of the text of section 9792.9(g) be re-written as follows: “The timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may only be extended by the agreement between the provider (attorney) and claims administrator under the following circumstances:”		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.9(g)(2) Section 9792.9(j)(8)	Commenter substitutes the term “requesting physician” with the term “requesting provider.” Further, commenter suggests deleting the paragraphs of these sections relating to notifying the provider of goods or services of the UR decision.		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.9(h) Section 9792.9(j) Section 9792.9(l) Section 9792.10(a)(2)	Commenter substitutes the term “requesting physician” with the term “requesting provider” in all of these sections.		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.9(k)	Commenter suggests the text of section 9792.9(k) be re-written as follows: “The written decision modifying, delaying or denying treatment authorization provided to the requesting provider 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 for the treating provider to discuss the decision with		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.

<p>Section 9792.10 (a)</p>	<p>either the reviewer, the expert reviewer or the medical director.. The hours of availability shall be at a minimum, four (4) hours a per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time,or an agreed upon alternate scheduled time to discuss the decision with the requesting provider. In the event the reviewer is unavailable, the requesting provider may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.”</p> <p>Commenter suggests the text of section 9792.10(a) be re-written as follows: “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, and include the following requirements:</p> <p>(1) An objection to a decision which disapproves in whole or in part a request for authorization of medical treatment, must be communicated in writing by the injured worker or the injured worker’s attorney to the claims administrator 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.” Commenter further re-numbers the subdivisions.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
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9792.9(b)(4)	<p>Commenter objects to the requirement in the regulations requiring the claims administrator to attach a list of all Information & Assistance offices. Commenter states that only providing a single central phone number should be adequate.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
9792.8(a)(3)	<p>Commenter objects to the requirement to disclose in written form the relevant portion of the UR guidelines, especially when all providers are expected to be following these guidelines already. Commenter states that this should be provided only upon written request. Commenter opines that these requirements will make a UR determination letter several pages long in addition to having to send to multiple parties resulting in significant added expense to the UR process with limited added value.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
9792.9(g)(2)	<p>Additionally, commenter objects to the last sentence of Section 9792.9(g) (C) (2), requires the UR Agent to have to produce a different version of the UR notification letter (i.e. one which includes the rationale for the provider, injured worker, and attorney) and a separate notice for the non-physician provider which does not include the rationale.</p>		<p>Disagree. The modifications are intended to protect the medical privacy of the injured worker.</p>	None.
Section 9792.8(a)(3)(B)	<p>Commenter believe that deleting this section is good as this step as this would have been extraordinarily burdensome for UR Agents to have to provide hard copies of the criteria on every review, especially when providers are supposed to be practicing in accordance with these guidelines and should already have them available. Commenter believes that hey should</p>		<p>Disagree. This section was deleted as duplicative of section 9792.8(a)(3) above. Commenter is still required to provide a copy of the relevant portion of the criteria or guidelines used with the written UR determination.</p>	None.

<p>Section 9792.8(a)(3)</p>	<p>only be provided upon request.</p> <p>Commenter notes that his section was revised to require that the relevant portion of the criteria used to be disclosed in written form. Commenter questions what this means and how is it different from the intent of what was in (B). Commenter questions if the intent of this revision makes it acceptable to cite the name of the ACOEM (or other scientifically evidence based criteria if ACOEM not available) without having to provide the entire content of the criteria. Commenter states that it appears this is the intent in Sections 9792.9 (j)(4) and 9792.9(j)(5).</p>		<p>Disagree. See response to comment above.</p>	<p>None.</p>
<p>Section 9792.9(b)(4) Section 9792.9 (c) Section 9792.9(f)(2) Section 9792.9(j)(8) Section 9792.10(b)(1)</p> <p>Section 9792.9(k)</p>	<p>Commenter requests that the division reinstate the requirement that when sending notification of a utilization review decision, the notice to the non-physician provider "...not include the rationale, criteria, or guidelines used for the decision". Commenter opines that to create a separate letter for a non-physician reviewer does not serve the interests of the parties involved because all providers need to understand the recommendation outcome and determine alternative treatment based on the support for the recommendation. Further, commenter states that since all providers of treatment are held to the same standards within the regulations to provide treatment and services in accordance with ACOEM and other evidence-based guidelines, all providers should receive the same letter.</p> <p>Commenter requests that the division revise Section 9792.9 (k) to limit the timeframe for discussion between the treating provider and</p>	<p>Kelly M. Weigand, Esq. Workers' Compensation and Rental Division First Health Written Comment August 3, 2005</p>	<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p> <p>Disagree. The comment does not address the specific proposed changes made to the regulations</p>	<p>None.</p> <p>None.</p>

	<p>the health care reviewer. Commenter believes the timeframe for this discussion should be restricted to within the 20-day limit allowed for disputing the utilization review decision. Commenter represents a utilization review entity performing functions on behalf of claims administrators and welcomes discussions with treating providers but believes that these discussions need to take place in a timely manner.</p>		<p>subject the third 15-day notice.</p>	
<p>Section 9792.6(c)</p>	<p>Commenter recommends deleting “an insured employer” from the definition of the term “claims administrator.” Commenter states that she has previously submitted this comment, but wishes to underscore her concern.</p>	<p>Brenda Ramirez Medical and Rehabilitation Director California Workers’ Compensation Institute (CWCI) August 5, 2005 Written Comment</p>	<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(b)(2)</p>	<p>Commenter suggests adding the language that information may be requested by a “non-physician reviewer.” Commenter believes that a non-physician reviewer should be permitted to request necessary appropriate information that was not provided with the original request for authorization. Commenter believes that this information may then result in approval by the non-physician reviewer or referral to a reviewer for further consideration. Commenter states that permitting only a physician to request missing information is unnecessary and not an efficient use of the physician’s time.</p>		<p>Agree. See response to comment submitted by Kathleen Bissell, Liberty Mutual Group, dated July 29, 2005, above.</p>	<p>See action taken in connection with comment submitted by Kathleen Bissell, Liberty Mutual Group, dated July 29, 2005, above.</p>
<p>Section 9792.9(k)</p>	<p>Commenter recommends revising this section to request the specialty of the expert reviewer but not the specialty of the reviewer. Commenter believes that it is appropriate to disclosed the specialty of an expert reviewer</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

	but that there is no necessity to disclose the first level reviewer's specialty.			
General Comment	<p>Commenter states that no additional comments are warranted. However, commenter suggests that the division give consideration to the additional observations submitted by the California Workers' Compensation Institute (CWCI).</p> <p>Commenter thanks the division for the excellent work that has been done toward the implementation of AB 277, SB 288 and SB 899.</p>	<p>Mark Webb Assistant General Counsel American International Companies Written Comment August 5, 2005</p>	Agree in part. See responses to comments submitted by Brenda Ramirez, California Workers' Compensation Institute (CWCI), dated August 5, 2005, above.	None.
Section 9792.8(a)(2)	<p>Commenter states that the sentence "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." is incorrect. Commenter states that this paragraph might be misinterpreted to mean that a denial of treatment on the sole basis that the treatment is not addressed by the ACOEM Guidelines is permitted after adoption of the § 5307.27 Guidelines. Commenter believes that what this rule should say is that both before and after the § 5307.27 Guidelines have been adopted, a treatment request cannot be denied on the sole basis that it is not addressed in ACOEM.</p>	<p>Mark Gerlach Consultant California Applicants' Attorneys Association Written Comment August 5, 2005</p>	Disagree. Sentence is clear and accurate. The suggested revisions change the meaning of the sentence and it is inconsistent with the statute. (See, Labor Code section 5307.27.)	None.
Section 9792.8(a)(3)	<p>Commenter states that this paragraph was amended to delete subparagraphs (A) and (B) as "duplicative." Commenter does not see where the protections offered by these subparagraphs are duplicated. Specifically, subparagraph (B) requires that a written copy</p>		Disagree. The paragraphs were duplicative. Specifically paragraph (3) states that the relevant portion of the criteria or guidelines used shall be disclosed in written form to the listed parties if used as the basis of a	None.

Section 9792.9(b)(3)	<p>of the relevant portion of the criteria or guideline used to modify, delay or deny a treatment request must be included with the written notice of the modification, delay or denial.</p> <p>Commenter states that although this comment does not deal with changes in this 15 day notice, he repeats the statement from his previous letter that this section does not conform to statute.</p>		<p>decision to modify, delay, or deny services in a specific case under review, and that these parties may not be charged for a copy.</p> <p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	None.
Section 9792.9(b)(4)	<p>Commenter points out that this paragraph has been amended to provide that any non-physician provider of goods or services must include contact information in a request for authorization and that he has no objection to this requirement. However, with regard to the last sentence of this paragraph commenter notes that there is no reason to prohibit a notification to this provider from including "the rationale, criteria or guidelines used for the decision." Commenter agrees that for a non-physician provider, the statute does not require that the criteria or guideline be disclosed unless the provider requests disclosure as a member of the public, but he sees no reason to prohibit the voluntary disclosure.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice. However, it is noted that if there is a voluntary disclosure, the agreement should be between the requesting physician and the provider of goods or services as authorized by the patient on a case by case basis, thus there is no need to include the language in the regulations.</p>	None.
Section 9792.9(k)	<p>Commenter notes that this subdivision has been amended to allow the requesting physician to discuss a written denial or modification "with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services." Commenter appreciates that the intent of this change is to "facilitate</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice. Further, With regard to the issue of alleged violations in the UR process</p>	None.

	<p>communication" in those situations where the original reviewer is not available, this change will actually make no practical difference in most situations. Commenter states that the only effect of this language is to give permission to the requesting physician to talk to a substitute reviewer. Commenter points out those requesting physicians do not need permission to discuss a treatment request with a substitute reviewer; in most cases they would be happy to talk to any live person about the request. Commenter offers excerpts from a physician's letter to illustrate his point.</p> <p>Commenter is both surprised and disappointed that the division did not take note of his previous comments and expand the 4 hour window for contacting the reviewing physician. Commenter states that one of the goals of these regulations should be to speed up the provision of medical services and minimize the need for formal legal proceedings.</p>		<p>raised by the commenter, this will be addressed in the presently undergoing UR violation penalty regulations rulemaking.</p>	
Section 9792.6(c)	<p>Commenter recommends deleting the term "insured employer" from the definition of "claims administrator."</p>	<p>Jose Ruiz Assistant Claims Rehabilitation Manager State Compensation Insurance Fund (SCIF) August 5, 2005 Written Comment</p>	<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
Section 9792.6(l)	<p>Commenter objects to the definition of the term "medical director" as inconsistent with Labor Code 4610(d). Commenter states that under the statute the medical director is not responsible for all UR decisions.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

Section 9792.9(b)(2)	Commenter states that this subsection is contradictory to §9792.7(b)(3) which provides the ability for non-physician reviewers to request additional information that is reasonably necessary. Commenter recommends the deleted language “or non-physician reviewer” be restored to the section.		Agree. See response to comment submitted by Kathleen Bissell, Liberty Mutual Group, dated July 29, 2005, above.	See action taken in connection with comment submitted by Kathleen Bissell, Liberty Mutual Group, dated July 29, 2005, above.
Section 9792.9(b)(4)	Commenter states that this subsection contains language which requires that the claims administrator notify a non-physician provider of goods or services in writing of a decision to modify, delay or deny a request. Commenter points out that this phraseology also appears in §§ 9792.9(c), 9792.9(g)(2), 9792.9(j)(8), and 9792.10(b)(1):Commenter recommends deleting the proposed subsection as not required by the statute.		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.6(q)	While Commenter prefers the structure proposed in the original proposed regulations, he praises the newly-proposed subsection (q) of this section and considers it an improvement over prior changes to the original proposed regulations. Most importantly, commenter recognizes that in this latest (3 rd) version, the former subsections (j) and (l) entitled “Health Care Reviewer” and “Physician reviewer” are collapsed into the newly-proposed subsection (q), and praises the Department for clarifying that under the newly proposed subsection (q), a “reviewer” may be licensed by “any state or the District of Columbia.”	David Farber American Association of Independent Claims Professionals (AAICP) Written Comment August 5, 2005	Agree in part.	None.

Section 9792.9(b)(2)(A)	Commenter objects to this section wherein a non-physician reviewer is not allowed to deny a request for authorization for lack of information. Commenter further states that because of the deadline, a peer advisor (a reviewer) may issue utilization review denials without adequate information to finalize a decision in accordance with Labor Code 4610.		Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.6(b)	Commenter states that the addition of new language “pursuant to section 4600 of the Labor Code” does not address how “authorization” is defined to include “appropriate reimbursement will be made for a specific course of proposed medical treatment” which is discordant with the generally accepted definition of “utilization review” which does not include reimbursement. Commenter believes that including reimbursement in “utilization review” blurs the line between utilization review, claims management, and bill review.		Disagree. The revision clarifies that the course of proposed medical treatment should be consistent with medical treatment to cure or relieve the effects of the injury pursuant to Labor Code section 4600. The remaining portion of the comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.6(l)	Commenter provides the following reasons that he feels that it is inappropriate to include the last sentence of this subsection: First, this is a definitional section and the last sentence is not part of a definition, but rather adds an operational function and an obligation on the part of the Medical Director. Secondly, it simply is not feasible (or even physically possible) for a single Medical Director to be responsible for every decision made in the utilization review process, given the volume of reviews many UR firms are dealing with. The Medical Director should be responsible for ensuring an appropriate UR process is	Steven W. Rosen, MD President and Chief Medical Officer CompPartners Written Comment August 5, 2005	Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.

<p>Section 9792.6(q) Section 9792.6(h) Section 9792.7(b)(2) Section 9792.9(f)</p>	<p>established and for taking appropriate steps to see that it is followed.</p> <p>Commenter proposes that the following definition should be added elsewhere (not in the definitions section) the following duties on the part of the Medical Director: “The Medical Director shall review and approve all UR standards and protocols, shall review the qualifications of all Reviewers, and shall participate in the Quality Assurance activities and the responses to formal grievances.”</p> <p>Alternatively, the commenter suggests that proposed final sentence could be clarified by making the Medical Director responsible for <i>oversight</i> of decisions made in the utilization review process, as follows: “... The Medical Director is responsible for oversight of all decisions made in the utilization review process.”</p> <p>Commenter states that the phrase “where these services are within the scope of practice” is too limiting and needs to be expanded. Commenter believes that the “scope of practice” limitation also is vague and might allow unqualified reviewers to comment in areas where they are not competent. Commenter opines that at a minimum, the following language should be added to clarify the Regulations: “... where these services are within the scope of the reviewer’s practice or are services with which the reviewer is familiar by training or experience.”</p>		<p>Disagree. The phrase “within the scope of practice” derives directly from the statute. See Labor Code section 4610(e).</p>	<p>None.</p>
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Section 9792.6(h)	<p>Commenter suggests that the definition of expert reviewer be modified as follows: “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 <i>or are services with which the reviewer is familiar by board certification, training or experience</i>, who has been consulted by the reviewer or the utilization review medical director to provide specialized review or medical information.”</p>		<p>Disagree. The phrase “within the scope of practice” derives directly from the statute. See Labor Code section 4610(e). Furthermore, the previously used language, “as defined by the licensing board,” caused great confusion and it was interpreted as limiting and restricting by the public.</p>	None.
Section 9792.6(h) (Continued)	<p>Commenter also suggests adding board certification in order to distinguish the “expert reviewer” from the “reviewer”.</p>		<p>Disagree. It is not appropriate to add board certification to distinguish the two types of reviewers as all physicians groups do not have board certification. Using the suggested language would preclude certain types of physicians from acting as expert reviewers such as acupuncturists.</p>	None.
Section 9792.7(b)(2)	<p>Commenter suggests that the following italic language be added to this section: “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 practice <i>or are services with which the reviewer is familiar by training or experience</i>, may, except as indicated below, delay, modify or deny requests for authorization of medical treatment for reasons</p>		<p>Disagree. The phrase “within the scope of practice” derives directly from the statute. See Labor Code section 4610(e).</p>	None.

<p>Section 9792.9(f)</p>	<p>of medical necessity to cure or relieve the effects of the industrial injury.”</p> <p>Commenter suggest that the following italic language be added to this section: “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 or are services with which the individual is familiar by training or experience.</p> <p>Alternatively, commenter suggests that the Regulations could leave, as proposed, the above four sections in which the term “scope of practice” is used, and instead use the Definitions section (§ 9792.6) to clarify the defined term, “scope of practice”, along the following lines: “(r) ‘Scope of practice’ means (i) activities and interventions consistent with training or clinical practice for the individual’s specialty or (ii) special knowledge or expertise derived from experience or specialized courses of study in medical utilization review for physicians not primarily engaged in clinical practice.”</p>		<p>Disagree. The phrase “within the scope of practice” derives directly from the statute. See Labor Code section 4610(e).</p>	<p>None.</p>
<p>Section 9792.8(a)(2)</p>	<p>Commenter states that this section needs clarification. The first sentence addresses those situations when the <i>condition or illness</i> is not addressed by ACOEM guidelines (or, after its adoption, by the new §5307.27 Schedule). By contrast, the second and third sentences then appear to address the situation</p>		<p>Disagree. ACOEM recommended treatment is based on a specific condition or illness (diagnosis), therefore sentence is accurate as written.</p>	<p>None.</p>

<p>General Comment</p>	<p>where the <i>treatment</i> in question is not addressed by the ACOEM guidelines (or the Schedule). Commenter suggests that to be logically parallel with the first sentence, the second and third sentences should be limited to those situations when the condition or illness itself is not addressed by ACOEM guidelines (or the new Schedule).</p> <p>Commenter would like to point out that no set of guidelines can possibly list every single proposed treatment that would not be authorized for a particular condition or illness. Commenter opines that this would expect the guideline drafters to imagine every possible proposed treatment and specifically disapprove it. Commenter states that when a particular set of guidelines elects to address a condition or illness, but then does not specifically approve a particular treatment, it is fair to infer that such treatment is not affirmatively endorsed by those guidelines.</p> <p>Commenter further states that even as proposed, he understands the language to mean that a reviewer would be correct in denying the treatment under consideration as long as such treatment is not addressed by at least two sets of guidelines (ACOEM plus one other set of evidence-based guidelines that are generally recognized by the national medical community and are scientifically based). In such a situation, the fact that the ACOEM guidelines do not address such treatment would not be the sole reason for denial.</p>		<p>Disagree. Comment goes beyond scope of the UR regulations and it is more appropriately directed to the medical treatment utilization schedule regulations which will be submitted to OAL later this year.</p>	<p>None.</p>
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	<p>Commenter believes this section should address the situation when there simply are not in existence any evidence-based medical treatment guidelines recognized by the national medical community. Commenter proposes adding the following as a new second sentence: “When there are no other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based, authorized treatment shall be in accordance with what is reasonable and consistent with professionally recognized standards of medical practice.”</p>			
<p>Section 9792.8(a)(3)</p>	<p>Commenter states that the proposed changes to this section present several issues. First, Commenter feels there can be significant copyright problems when dealing with portions of criteria or guidelines that are not a part of ACOEM. Secondly, commenter states that portions of guidelines can be taken out of context and this can be abused. The unscrupulous use of quotation marks and ellipses may result in the reader being misled.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice. Moreover, the service of the portions of the guidelines used in the UR decision is required by statute. See Labor Code section 4610(f)(4).</p>	<p>None.</p>
<p>Section 9792.9(g)(3) Section 9792.9(g)(4)</p>	<p>Commenter states that this language appears to give the claims administrator the right to modify or deny a request without review by a physician. Although the claims administrator may approve a request, Commenter believes the decision to modify or deny should be reserved to the reviewer.</p>		<p>The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(k)</p>	<p>Commenter states that as revised, this section is problematic for two reasons. First, a process already exists to resolve disputes between the</p>		<p>Disagree. With regard to the requesting physician appeal process set forth in this section, the comment</p>	<p>None.</p>

<p>Section 9792.9(k) (Continued)</p>	<p>reviewer and the requesting physician. The requesting physician may request an appeal in which the areas of dispute are outlined. If an appeal process is not available, the provider may resolve the dispute via Labor Code section 4062.</p> <p>Commenter questions the language allowing the requesting physician to discuss the UR decision with another reviewer if the original reviewer is unavailable. Commenter states that in order to have any meaningful discussion the second reviewer must have access to the medical records supplied with the initial request. Most reviewers are not housed in the same location, so the second reviewer normally would not have access to this information. Even in the event the information is available, the second reviewer would be compelled to spend the time necessary to review the information, which could take hours, prior to being in a position to have a discussion of any value. Commenter feels that this is not feasible, and it would significantly increase the cost of reviews while not resulting in anything beneficial to the parties involved. Commenter opines that the proposed sentence upsets the carefully crafted regulatory scheme, by requiring that a second reviewer be continuously available to discuss the case. Commenter states that such a requirement is not consistent with the established regulations governing timeliness.</p>		<p>does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p> <p>Disagree. The language of the regulations is phrased in terms of “may” not “shall” to allow discussion with another reviewer. This modification was made after comments from UR reviewers requesting some flexibility in the regulations in the event the reviewer is unavailable. If another reviewer is used, then compliance with the UR process is required.</p>	<p>None.</p>
<p>Section 9792.9(b)(2)</p>	<p>Commenter states that this provision should be clarified to read that the information must be requested by a reviewer “or the reviewer’s</p>	<p>Harry Monroe, Jr. Director, Government Relations</p>	<p>Agree in part. See response to comment submitted by Kathleen Bissell, Liberty Mutual Group, dated</p>	<p>See action taken in connection with comment submitted by Kathleen</p>

<p>Section 9792.8(a)(3)</p>	<p>designee.” Commenter believes that this language will ensure that the reviewer is responsible for the decision making process while retaining clarity that the reviewer can delegate administrative functions to appropriate staff.</p> <p>Commenter states that this requirement, which is unique throughout the United States, creates an unreasonably time consuming and expensive mandate for utilization review agents and peer review doctors. Commenter states that the rule should instead adhere to the industry standard that an adverse determination letter must disclose the source of the criteria or guidelines that were used.</p>	<p>Concentra, Inc. Written Comment August 5, 2005</p>	<p>July 29, 2005, above.</p> <p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>Bissell, Liberty Mutual Group, dated July 29, 2005, above.</p> <p>None.</p>
<p>Section 9792.9(j)(8)</p>	<p>Commenter states that the new option presented as mandatory language for decisions modifying, delaying, or denying treatment requires enclosure of a complete list of Information and Assistance Offices. Commenter states that this information is available by calling the toll-free number also required by this mandatory language. As such, Commenter feels this provision is duplicative and unnecessary and should be omitted.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(k)</p>	<p>Commenter doesn’t believe that it is feasible for physician reviewers in active practice to be available 4 hours per week. Instead, commenter suggests that the regulation require a reviewer to schedule a time to discuss the decision upon the request of the treating doctor.</p>		<p>Disagree. This section already provides for this requirement when it states “or an agreed upon schedule time to discuss the decision with the requesting physician.”</p>	<p>None.</p>

Section 9792.6(1)	Commenter continues to be concerned with the approach of trying to make the Medical Director responsible for the utilization review determinations and not just responsible for the utilization review process	Peggy Hohertz Regulatory Compliance Analyst Fair Isaac Corporation Written Comment August 5, 2005	Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.8(a)(3)	Commenter agrees with the change include only the “relevant portion of the criteria or guidelines...”		Agree.	None.
Section 9792.9(d)	Commenter approves of the language.		Agree.	None.
General Comment	<p>Commenter is concerned that some reviewers that are knowingly applying ACOEM incorrectly to illegally in an attempt to deny medically necessary treatment. Commenter opines the following changes will help solve this problem and improve the utilization review process: (1) Reviewers should be required to sign the UR under penalty of perjury just as all physicians and QMEs must.</p> <p>(2) Specific penalties should be added to this regulation for reviewers who contentiously and callously deny care by using inappropriate references of ACOEM (or other practice guidelines) that do not fit the context of the specific case.</p>	Kassie Donoghue, DC President California Chiropractic Association Written Comment August 5, 2005	Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.	None.
Section 9792.7(b)(2)	Commenter recommends an amendment to section 9792.7 (b)(2) to specify that the reviewing physician must be of the same licensure as the treating physician.		Disagree. With regard to the issue of alleged violations in the UR process raised by the commenter, this will be addressed in the presently undergoing UR violation penalty regulations rulemaking.	None.
			Disagree. This is not required by the statute.	None.

<p>Section 9792.6(h); Section 9792.6(q); Section 9792.7(b)(2)</p>	<p>Commenter opposes these sections because they allow reviews to be conducted by physicians that are not licensed in California. ACOEM is not the only standard by which claims are denied. Commenter has received several complaints about claims being denied on the basis that a proposed treatment is outside the scope of practice of the doctor of chiropractic.</p>		<p>Disagree. See response to comment submitted by James E. Lessenger, MD, FACOEM, dated July 22, 2005, above.</p>	<p>None.</p>
<p>Section 9792.7(b)(3)</p>	<p>Commenter recommends deleting the third and fourth sentences in this section. Commenter finds it appropriate for non-physician reviewers to initially review requests for treatment and approve treatment plans and non-physicians should be able to call the physician to get additional information or clarification. However, commenter opines that non-physicians should not be able to negotiate treatment with the physician because they do not have the training necessary to engage in a debate on appropriate patient management protocols and standards.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>Section 9792.9(b)(2)</p>	<p>Commenter recommends an amendment that gives physicians the same amount of time to respond to requests for additional information as claims representatives (five days). Commenter is concerned that reviewers may use section 9792.9 (b)(2) to deny care inappropriately. The way it is written, commenter believes that if a claims representative does not have enough information to make a decision, the representative can wait until the 13th day to send it back to the physician which would leave the physician only one day to respond</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>

<p>Section 9792.9(e)(1)</p>	<p>before the claims representative can deny care.</p> <p>Commenter requests that this section be amended to allow for an expedited review for injured workers that are in severe pain. Commenter that feels patients with intense pain should qualify for an expedited review and fourteen days is too long to wait for authorization when the patient is in severe pain.</p>		<p>Disagree. The comment does not address the specific proposed changes made to the regulations subject the third 15-day notice.</p>	<p>None.</p>
<p>9792.6(q)</p>	<p>Supplemental response to objection to definition of the term “reviewer” as set forth in the first comment of this chart.</p>	<p>James E. Lessenger, MD FACOEM Written Comment July 22, 2005</p>	<p><u>I. Introduction</u></p> <p>Labor Code section 4610(e) provides that “no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve.” Labor Code section 3209.3 defines the term “physician” as “includ[ing] physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law, and within the scope of their practice as defined by California state law.” Labor Code section 3204 - “Chapter’s definitions govern construction,” states that “[u]nless the context otherwise requires, the definitions hereinafter set forth in this chapter shall govern</p>	<p>None.</p>

		<p>the construction and meaning of the terms and phrases used in this division.”</p> <p>The definition of the term “reviewer” has been crafted to include the definition of physician as set forth in Labor Code section 3209.3, based upon the interpretation that it does not require the physician to be licensed in the state of California. This is required within the context of Labor Code section 4610, which requires that every employer establish a utilization review process. The general business practices of utilization review is to allow utilization review to be conducted at a national level by licensed physicians, regardless of licensing state, who are competent to evaluate the specific clinical issues presented. Thus, the definition of “reviewer” has been defined to mean “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.”</p> <p>In this regard, it is relevant to note the fundamental rule of statutory</p>	
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		<p>construction. It is also relevant to note that the statutes governing utilization review in the Health and Safety Code, and the Insurance Code, also allow for physicians licensed outside of California to perform utilization review functions.</p> <p><u>II. Statutory Construction</u></p> <p>The fundamental rule of statutory construction is that the court should ascertain the legislative intent so as to effectuate the purpose of the law. To achieve this, the statute should be construed with reference to the whole system of law of which it is a part, so that all may be harmonized and have effect. The legislative intent will be determined to the extent possible by looking at the language of the statute read as a whole. If the words of the statute, given their ordinary and commonsense meaning are clear and unambiguous on its face, then the court will not look further to ascertain the legislative intent. But language that appears unambiguous on its face may be shown to have a latent ambiguity. If so, a court may turn to customary rules of statutory construction or legislative history for guidance. Statutory language which seems clear when considered in isolation may in fact be ambiguous or uncertain when considered in context. The statute needs to be</p>	
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		<p>construed with reference to the whole system of law of which it is a part, so that all may be harmonized and have effect. (See <i>Anne Muller v. Automobile Club of Southern California</i> (1998) 61 CA4th 431,440-441; <i>County of Yolo v. Los Rios Community College District</i> (1992) 5 CA4th 1242, 1248-1249).</p> <p>Finally, although the ultimate interpretation of a statute rests with the courts, unless unreasonable, or clearly contrary to the statutory language or purpose, the consistent construction of a statute by an agency charged with responsibility for putting the statutory machinery into effect and enforcing it, is entitled to great weight and deference. (See <i>Dyna-Med, Inc. v. Fair Employment and Housing Commission</i> (1985) 193 CA3d 38; <i>Dix v. Superior Court</i> (1991) 53 Cal.3d 442, 460; 85 Op. Cal. Atty. Gen. 157).</p> <p><u>Meaning of “including” as used in Labor Code §3209.3</u></p> <p>Labor Code §3209.3(a) states the following: “‘Physician’ <i>includes</i> physicians and surgeons holding an M.D. or O.D. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of</p>	
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		<p>their practice as defined by California state law.” (Emphasis added.) At issue is whether licensed physicians outside of the state of California fall within this definition. The use of the word “includes” creates an ambiguity as to whether the list following the word “includes” is exhaustive or partial. The <i>Dictionary of Modern Legal Usage</i>, 2nd Edition, Bryan A. Garner, states the word including [includes] “should not be used to introduce an exhaustive list, for it implies that the list is only partial. In the words of one federal court, ‘It is hornbook law that the use of the word <i>including</i> indicates that the specified list...is illustrative, not exclusive.’ <i>Puerto Rico Maritime Shipping Auth. v. I.C.C.</i> (D.C. Cir. 1981) 645 F.2d 1102, 1112 n. 26.”</p> <p>Although some courts have found that the word “includes” may be used as a word of limitation, courts have also held that the “[t]erm ‘includes’ is ‘ordinarily a word of enlargement and not of limitation. [Citation.] The statutory definition of [a] thing as “including” certain things does not necessarily place thereon a meaning limited to the inclusions.’ [Citations.]” (<i>Associated Indemnity Corporation v. Pacific Southwest Airlines</i> (1982) 128 CA3d 898, 905).</p>	
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		<p>The ambiguity of the word “includes” in Labor Code § 3209.3 was addressed by the court in <i>State Compensation Insurance Fund v. Workers’ Compensation Appeals Board and Juan Pablo Arroyo</i> (1977) 69 CA3d 884, 893. In <i>State Compensation Insurance Fund</i>, the appellant contended Labor Code §4600 did not provide for reimbursement of medical costs for services of respondent employee’s physicians because they were not licensed by California state law as provided for by Labor Code §3209.3. The court held that the definition of “physician” contained in Labor Code §3209.3 <i>did not</i> exclude a physician licensed to practice in another country or another state. Therefore, the term “includes” as used in Labor Code §3209.3 is expansive, and therefore, includes physicians licensed to practice in other states or countries as well as physicians licensed to practice in California. At the time of this opinion, “physician” as defined in §3209.3 is, in pertinent part, the same as in the current statute. (In 1977, the statute read as follows, “Physician includes physicians and surgeons, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by</p>	
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		<p>California state law.”)</p> <p>The court in <i>State Compensation Insurance Fund</i>, p. 890-891, interpreted the legislative intent of Labor Code §3209.3 to be as follows, “It appears section 3209.3 was designed merely to codify the rule developed by these cases that compensation is not allowed for treatment by nonphysicians. It is doubtful the Legislature ever considered the application of the section to treatment by out-of-state physicians.” The court further reasoned that the appeals board has jurisdiction over all controversies arising out of injuries suffered <i>without</i> the territorial limits of this state in those cases where the contract of hire was made in this state (p. 891; Labor Code §5305). Therefore, it would be unreasonable to require an employee out-of-state to either return to California for treatment or bear the cost of treatment. Labor Code §4600.6(i) further exemplifies the legislature’s clear intent to provide for out-of-state medical care to injured workers in that this statute sets forth the requirements to qualify as a health care organization for facilities not located in California. Labor Code §4600.6(i) states in pertinent part, “[f]acilities not located in this state shall conform to all licensing and</p>	
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		<p>other requirements of the jurisdiction in which they are located.”</p> <p>Based on the holding of <i>State Compensation Insurance Fund</i>, the term “physician” as defined in Labor Code §3209.3 includes licensed out-of-state physicians, and therefore, the proposed regulation is in conformance with the relevant statutes. Furthermore, the court in <i>Dyna-Med, Inc.</i> held that “[w]here the Legislature has failed to modify that statute so as to require an interpretation contrary to the regulation, that fact may be considered to be an indication that the ruling was consistent with the Legislature’s intent.” By analogy, since the Legislature has failed to modify Labor Code §3209.3 so as to require an interpretation contrary to case law interpretation, this fact should be considered as an indication that the Legislature’s intent was correctly interpreted in 1977 by the court in <i>State Compensation Insurance Fund</i>.</p> <p><u>Labor Code §4610 – Use of the word “physician”</u></p> <p>Labor Code §3204 – “Chapter’s definitions to govern construction” states the following, “[u]nless the context otherwise requires, the definitions hereinafter set forth in</p>	
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		<p>this chapter shall govern the construction and meaning of the terms and phrases used in this division.”</p> <p>As determined in <i>State Compensation Insurance Fund</i>, the list included in Labor Code §3209.3 is illustrative and not exhaustive, therefore, Labor Code §4610(d) must necessarily clearly indicate that the medical director is required to be licensed to practice medicine in the state of California. Thus, Labor Code §4610(d) states in pertinent part, “[t]he employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code”.</p> <p>Labor Code §4610 distinguishes the requirements of the medical director in subsection (d) from the physician reviewer in subsection (e) by stating the physician reviewer can be “[n]o 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 scope of the physician’s practice, requested by the physician may modify, delay, or deny requests for authorization of medical</p>	
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		<p>treatment for reasons of medical necessity to cure and relieve.”</p> <p>Therefore, the word “physician” as used within the context of Labor Code §4610, allows a physician reviewer described in Labor Code §4610(e) to be a licensed out-of-state physician. The use of the word “includes” in Labor Code §3209.3 to define the word “physician” must be used as a word of “enlargement”, when applied to the context of this utilization review statute. This is necessary (and in accordance with Labor Code §3204) because the general business practices of utilization review is to allow utilization review to be conducted at a national level by licensed physicians, regardless of licensing state, who are competent to evaluate the specific clinical issues presented. Furthermore, Labor Code section 4610 provides for very restrictive timeframes to be used in the utilization review process. (See, Lab. Code, §§ 4610(g)(1)-4610(g)(3).) It is the standard across the country to have a national pool of physicians to conduct utilization review. This ensures that there are a sufficient number of physicians available to conduct utilization review without disrupting provision of medical services, and functions as a cost control measure.</p>	
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		<p><u>III. Other Statutes Allow for Physicians Licensed Outside California to Perform Utilization Review Functions</u></p> <p><u>Knox-Keene Act</u></p> <p>Health and Safety Code §§ 1340 et seq., known as the Knox-Keene Act, governs Health Care Service Plans. Health & Safety Code section 1367.01 of the Knox-Keene Act sets forth standards for the process of review by health care service plans for requests made by providers for services for enrollees. Section 1367.01 (c) specifically states that “A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state....” Section 1367.01(e) states “No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.”</p> <p>This language mirrors the language in the proposed utilization review</p>	
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		<p>regulations at sections 9792.6(l) and (q) which requires the medical director to be licensed in California, yet provides that the physician who denies or modifies requests for authorization, apart from the medical director, need only be a licensed physician.</p> <p>The definition of “physician” in the Knox-Keen Act is also noteworthy. Section 1358.5(8) states the following: “Physician” shall not be defined more restrictively than as defined in the Medicare program.</p> <p>The Medicare Program definition of “physician” as found in 42 USCS §1395x is as follows: (r) Physician. The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7) [42 USCS § 1301(a)(7)]),...</p> <p>The word “physician” as defined by this statute is also composed of a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who are legally authorized to perform as such by the State in which he or she performs</p>	
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		<p>them.</p> <p>With respect to the Knox-Keene definition of “physician,” the Utilization Review Standards definition of “Reviewer” is in keeping with the Knox-Keene requirement. The definition of “Reviewer” is compatible because it is not more restrictive than the definition of “physician” found in the Medicare program. Rather than being more restrictive, the definition is more expansive in that it includes psychologists and acupuncturists and allows for licensure by any state or the District of Columbia.</p> <p>The California Legislative Committee Analysis of Pending Bills in the context of the Knox-Keene Act is also applicable to the question of whether a reviewer must be licensed in California. Assembly Floor Bill No. AB 58 was a bill requiring an employee of a health care service plan (health plan), who is responsible for the final decision, or for the process in which a final decision is made, regarding the medical necessity or medical appropriateness of any diagnosis, treatment, operation, or prescription to be a physician <i>licensed by the Medical Board of California</i>. (Emphasis added.)(California Committee Analysis, Assembly Floor Bill No.</p>	
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		<p>AB 58, Date of Hearing: June 2, 1999.) This Bill was vetoed by the Governor. In the Governor's Veto Message he stated in pertinent part (California Committee Analysis, Senate Floor Bill No. AB 58, January 6, 2000):</p> <p>"AB 58 would preclude out-of-state experts from making determinations regarding medical necessity which will, in some cases, inhibit the best input on critical clinical questions. ... This effectively prohibits plans from employing top experts to make the decisions in very specialized cases. Out-of-state expertise provides significant benefits to patients, especially when dealing with rare diseases. While I believe very strongly that physicians should be making medical necessity decisions, the requisite expertise to make these decisions sometimes lies beyond our borders."</p> <p><u>California Insurance Code</u></p> <p>The California Insurance Code governs disability insurers. Section 10123.135(c) specifically states that "the insurer shall employ or designate a medical director who</p>	
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			<p>holds an unrestricted license to practice medicine in this state...” While 10123.135(e) in pertinent part states “An individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may not deny or modify requests for authorization of health care services for an insured for reasons of medical necessity.”</p> <p>Here is yet another example of a statute which recognizes that in terms of requiring California licensure, the license requirements of a medical director may differ from the requirements of the physician who works under the medical director.</p> <p>As with the definition of “physician” in the Knox-Keen Act, the definition of “physician” in the Insurance code provides at section 10192.5(h) that “Physician” shall not be defined more restrictively than as defined in the Medicare program. The Utilization Review Standards definition of “Reviewer” is compatible because it is not more restrictive than the definition of “physician” found in the Medicare program.</p>	
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		<p><u>Medi-Cal Program</u></p> <p>In California, the federal Medicaid Program is administered by the state as the California Medical Assistance Program (Medi-Cal). This program provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled).</p> <p>Title 22, California Code of Regulations, section 51053, which governs the California Medical Assistance Program, defines "Physician" as a doctor of medicine or osteopathy. Section 51228 also provides that in order to participate in the Medi-Cal Program "A physician shall be licensed as a physician and surgeon by the California Board of Medical Quality Assurance or the California Board of Osteopathic Examiners <i>or similarly licensed by a comparable agency of the state in which he practices.</i>" (Emphasis added.) The Medi-Cal system, therefore, allows for participation by physicians licensed outside of California. <i>Cabbage v. Parker Community Hospital</i> (1984) 744 F.2d 665; <i>County of Sacramento v. Lackner</i> (1979) 97 Cal.App.3d 576 (A Medi-Cal number permits a health care provider to receive reimbursement from the state for</p>	
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		<p>services rendered to eligible California residents.)</p> <p>In addition, Title 22, section CCR 51006 of the California Medical Assistance Program also enumerates instances when out of state coverage is appropriate as follows:</p> <p>“(a) Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:</p> <ol style="list-style-type: none"> (1) When an emergency arises from accident, injury or illness; or (2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or (3) Where the health of the individual would be endangered if he undertook travel to return to California; or (4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or (5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from 	
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			<p>resources and facilities within the State.”</p> <p>This reference, although not specifically related to utilization review, shows that in other contexts, a physician who is licensed in a state other than California may practice medicine in a program administered by the State of California. The references to the Knox-Keene Act and the California Insurance Code demonstrate that there are pre-existing models which allow for a physician who is licensed in a state other than California to practice California utilization review functions.</p>	
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