

Utilization Review and Independent Medical Review Regulations

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

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

§9785. Reporting Duties of the Primary Treating Physician.

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

(1) The “primary treating physician” is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616.

(2) A “secondary physician” is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

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

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

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

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

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

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

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

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

(A) continuing medical treatment; or

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

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4061 and 4062. If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.

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

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

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

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the

treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

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

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

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

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

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

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

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

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

(5) The employee is released from care;

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

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

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in

paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the “Primary Treating Physician's Progress Report” form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled “Primary Treating Physician's Progress Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: “I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3.”

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the “Request for Authorization of Medical Treatment,” DWC Form RFA, contained in section 9785.5. A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment.

(h) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the “Primary Treating Physician's Permanent and Stationary Report” form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

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

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

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

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

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

§9785.5. Request for Authorization Form, DWC Form RFA.

Request for Authorization, DWC Form RFA

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

Reference: Sections 4061, 4061.5, 4062, 4600, 4604.5, 4610, 4610.5, and 4610.6, Labor Code.

Article 5.5.1 Utilization Review Standards

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

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

- (a) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.
- (b) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician's Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.
- (c) “Claims Administrator” is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.
- (d) “Concurrent review” means utilization review conducted during an inpatient stay.
- (e) “Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician's Progress Report,” DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.
- (f) “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.
- (g) “Expedited review” means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's

life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

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

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

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

(k) “Material modification” is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

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

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

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

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

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

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

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

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

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

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

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, ~~and~~ 4610, and 4610.5, Labor Code.

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

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

(a) “Approval” means a decision that the requested treatment or service is medically appropriate to cure or relieve.

(b) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on a completed “Request for Authorization for Medical Treatment,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the “Request for Authorization for Medical Treatment,” DWC Form RFA.

(c) (1) "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). “Claims Administrator” includes any utilization review organization under contract to provide or conduct the claims administrator’s utilization review responsibilities. Unless otherwise indicated by context, “claims administrator” also means the employer.

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

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

(f) “Delay” means a decision by a reviewer that no determination based on medical necessity may be made within the 14-day time limit for the reasons listed in 9792.9.1(f).

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

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

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

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

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

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

(m) "Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified, in subdivision (c) and (f)(1) of section 9792.9.1

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

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

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

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

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

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

(t) "Request for authorization" means a written request for a specific course of proposed medical treatment. A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. "Completed," for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting treating physician for all fields indicated on the DWC Form RFA. The form must be signed by the physician and may be mailed, faxed or e-mailed.

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

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

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

(y) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed. The utilization review process begins when the completed DWC Form RFA is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

(z) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties.

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

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

This page is intentionally left blank.

§9792.9. Utilization Review Standards--Timeframe, Procedures and Notice Content – For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

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

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

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

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

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

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

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

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

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

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

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

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

and

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

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

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

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

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

(A) If the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

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

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

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

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

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

(f) Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting

physician must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The clinical reasons regarding medical necessity.

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

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

Either

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

or

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

and

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

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

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

and

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

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

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

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

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

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

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

(3) A list of all medical records reviewed.

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

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

(6) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator. The application, set forth at section 9792.10.1, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.

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

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

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

and

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

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

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

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

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

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013.

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

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

(1) For purposes of this section, the DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator’s utilization review organization. A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display either the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA.

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

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

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

(3) Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from

health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

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

(1) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall only contain the following information specific to the request:

(A) The date on which the DWC Form RFA was first received.

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

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

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

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

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

and

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

(2) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

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

(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

(2) If the DWC Form RFA is not completed as defined in section 9792.6.1(t), a non-physician reviewer or reviewer may either treat the form as complete and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete" no later than five (5) business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

(3) Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA, but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA.

(A) Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify the need for an expedited review upon submission of the request.

(B) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the DWC Form RFA to make the proper determination.

(C) If the reasonable information requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the completed DWC Form RFA is not received within 14 days from receipt of the completed DWC Form RFA, the reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested, or the reviewer may issue a decision to delay as provided in subdivision (f)(1)(A).

(4) Retrospective decisions to approve, modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the medical information that is reasonably necessary to make this determination.

(d) Decisions to approve a request for authorization.

(1) All decisions to approve a request for authorization set forth in a DWC Form RFA shall specify the specific medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

(2) For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

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

(B) Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth in subdivision (c)(4), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

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

(1) 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.

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

(3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician.

within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

(4) For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of information that is reasonably necessary to make this determination.

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

(A) The date on which the DWC Form RFA was first received.

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

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

(D) A list of all medical records reviewed.

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

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

(G) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator. The application, set forth at section 9792.10.1, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.

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

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

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

and

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

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

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

(f)(1) The timeframe for decisions specified in subdivision (c) may only be extended with a written notice of delay by the reviewer under one or more of the following circumstances:

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

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

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

(2) If subdivisions (f)(1)(A), (B) or (C) above apply, the reviewer shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations

or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered

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

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

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

(g) Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

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

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§9792.10. Utilization Review Standards--Dispute Resolution– For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

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

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

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

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

(4) Additionally, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim, Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10252.1, and request an expedited hearing and decision on his or her entitlement to medical treatment if the request for medical treatment is not authorized within the time limitations set forth in section 9792.9, or when there exists a bona fide dispute as to entitlement to medical treatment.

(b) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

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

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

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

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

(a) For the purpose of independent medical review under sections 9792.10.1 through 9792.10.9 of this Article, the following definitions apply:

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

(2) "Disputed medical treatment" means medical treatment that has been modified, delayed, or denied by a utilization review decision.

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

(4) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the employee of the effects of their injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(A) The Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(5) “Utilization review decision” means a decision pursuant to Labor Code section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

(b)(1) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers’ Compensation Appeals Board under this Article.

(2) A request for independent medical review must be communicated by the employee, the employee’s representative, or the employee’s attorney by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director’s designee, within 30 days of service of the utilization review decision. The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment.

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

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

(C) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review under subdivision (b)(2) on its own behalf within 30 days of receipt of the utilization review decision that either delays, denies, or modifies the provider’s retrospective request for authorization of the emergency medical treatment.

(3) If expedited review is requested for a decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, a certification from the employee's treating physician indicating that the employee faces an imminent and serious threat to his or her health as described in section 9792.10.1(a)(3).

(c)(1) If at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit an application for independent medical review under subdivision (b)(2) is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(2) If the claims administrator fails to comply with any provision of section 9792.9(1) or section 9792.9.1(e) at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review under subdivision (b)(2) shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

(d) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the 30-day time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6. Any internal utilization review appeal process conducted under this subdivision must be completed within 15 days of the date of utilization review decision.

(e) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

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

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

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

[Placeholder for Form]

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

Reference: Sections 4600, 4610, and 4610.5, Labor Code.

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

(a) Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. For the purpose of this Article, “disputed medical treatment” means recommended medical treatment that has been modified, delayed, or denied by a utilization review decision issued pursuant to section 9792.9 or section 9792.9.1. In making this determination, the Administrative Director shall consider:

- (1) The timeliness and completeness of the Application;
- (2) Any previous application or request for independent medical review of the disputed medical treatment;
- (3) Any assertion by the claims administrator that a factual or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.
- (4) Other reasons, if any, that the application may be ineligible for independent medical review.

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

(c) The parties shall respond to any reasonable request made pursuant to subdivision (b) within fifteen (15) days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review under section 9792.10.4.

(d) If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the claims administrator agrees that the case is eligible for independent medical review, a request for independent medical review shall be

deferred if at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

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

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

Reference: Sections 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.4. Independent Medical Review – Assignment and Notification.

Within one business day following a finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 shall notify the parties in writing that the dispute has been assigned to that organization for review. The notification shall contain:

- (a) The name and address of the independent review organization;
- (b) Identification of the disputed medical treatment, including the date of the request for authorization, the name of the requesting physician, and the date of the claims administrator's utilization review decision.
- (c) The date the Application for Independent Medical Review, DWC Form IMR, was received by the Independent Review Organization.
- (d) A statement whether the independent medical review will be conducted on a regular or expedited basis.
- (e) For regular review, a statement that within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically, the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to \$5,000.00.
- (f) For expedited review, a statement that within twenty-four (24) hours following receipt of the notification the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to \$5,000.00.
- (g) Review conducted on a regular basis shall be converted into an expedited review if, subsequent to the receipt of the Application for Independent Medical Review, DWC Form IMR, the independent review organization receives from the employee's treating physician a certification that the employee faces an imminent and serious threat to his or her health as described in section 9792.10.1(a)(3). The independent review organization shall immediately notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review.

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.5. Independent Medical Review – Medical Records.

(a) (1) Within fifteen (15) days following receipt of the mailed notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for expedited review within twenty-four (24) hours following receipt of the notification, the claims administrator shall provide to the independent medical review organization all of the following documents:

(A) A copy of all reports of the employee's treating physician relevant to the employee's current medical condition produced within one year prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination.

(B) A copy of the adverse determination by the claims administrator notifying the employee and the employee's treating physician that the disputed medical treatment was denied, delayed or modified.

(C) A copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.

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

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

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

(2) The claims administrator shall, concurrent with the provision of documents under subdivision (a), serve on the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). The claims administrator shall provide with the notification a copy of all documents that was not previously provided to the employee or the employee's representative.

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

(b) (1) Within fifteen (15) days following receipt of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or for expedited review, within twenty-four (24) hours following receipt of the notification, the employee, or any party identified in section 9792.10.1(b)(2), may provide to the independent medical review organization any of the following documents:

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

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

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

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

(3) Any newly developed or discovered relevant medical records in the possession of the employee, or any party identified in section 9792.10.1(b)(2), after the documents identified in subdivision (b) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The employee, or any party identified in section 9792.10.1(b)(2), shall concurrently provide a copy of medical records required by this subdivision to the claims administrator, unless the offer of medical records is declined or otherwise prohibited by law.

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

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

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.6. Independent Medical Review – Standards and Timeframes.

- (a) The independent medical review process may be terminated at any time upon the claims administrator's written authorization of all disputed medical treatment.
- (b) Upon assignment of the disputed medical treatment dispute for independent medical review, the independent review organization shall designate a medical reviewer to conduct an examination of the documents submitted pursuant to section 9792.10.5 and issue a determination, using plain language where possible, as to whether the disputed medical treatment is medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in section 9792.10.1(a)(4).
- (c) The independent review organization, upon written approval by the Administrative Director, may utilize more than one medical reviewer to reach a determination regarding the medical necessity of a disputed medical treatment if it is found that the employee's condition and the disputed medical treatment is sufficiently complex such that a single reviewer could not reasonably address all disputed issues.
- (d) The determination issued by the medical reviewer shall state whether the disputed medical treatment is medically necessary. The determination shall include the employee's medical condition, a statement of the disputed medical treatment, references to the specific medical and scientific evidence utilized pursuant to section 9792.10.1(a)(4), and the clinical reasons regarding medical necessity.
- (e) The independent review organization shall provide the Administrative Director, the claims administrator, the employee, and the employee's provider with a final determination regarding the medical necessity of the disputed medical treatment. With the final determination, the independent review organization shall provide a description of the qualifications of the medical reviewer or reviewers and the determination issued by the medical reviewer.
- (1) If more than one medical reviewer reviewed the case, the independent review organization shall provide each reviewer's determination.
- (2) The recommendation of the majority of medical reviewers shall prevail. If the reviewers are evenly split as to whether the disputed medical treatment should be provided, the decision shall be in favor of providing the treatment.
- (f) The independent review organization shall keep the names of the reviewer, or reviewers if applicable, confidential in all communications with entities or individuals outside the independent review organization.
- (g) Timeframes for final determinations:
- (1) For regular review, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent

Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

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

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

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

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.7. Independent Medical Review – Implementation of Determination and Appeal.

(a) Upon receiving the final determination of the Administrative Director that a disputed medical treatment is medically necessary, the claims administrator shall, unless an appeal is filed under subdivision (c), promptly implement the decision unless the claims administrator has also disputed liability for any reason besides medical necessity.

(1) In the case of reimbursement for services already rendered, the claims administrator shall reimburse the provider or employee, whichever applies, within twenty (20) days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive.

(2) In the case of services not yet rendered, the claims administrator shall authorize the services within five (5) working days of receipt of the final determination, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(b) The failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by this section is subject to, in addition to any other fines, penalties, and other remedies available to the Administrative Director, an administrative penalty as set forth in section 9792.12(a) for each day the decision is not implemented.

(c) The parties may appeal a final determination of the Administrative Director by filing a petition with the Workers' Compensation Appeals Board.

(d) If the final determination of the Administrative Director is reversed by the Workers' Compensation Appeals Board, the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

(1) Submit the dispute to independent medical review by a different independent review organization, if available;

(2) If a different independent medical review organization is not available after remand, the Administrative Director shall submit the dispute to the original independent review organization for review by a different reviewer in the organization.

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

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.10.8. Independent Medical Review – Payment for Review.

(a) The costs of independent medical review and the administration of the independent medical review system shall be borne by claims administrators. For each Application for Independent Medical Review, DWC Form IMR, assigned to an independent review organization for an independent medical review of a disputed medical treatment, the fee for the claims administrator shall be:

(1) For calendar year 2013:

(A) For regular review:

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

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

(B) For expedited review:

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

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

(C) For withdrawn reviews:

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

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

(2) For calendar year 2014:

(A) For regular review:

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

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

(B) For expedited review:

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

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

(C) For withdrawn reviews:

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

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

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

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

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

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

Reference: Sections 4610, 4610.5, and 4610.6, Labor Code.

§ 9792.10.9. Independent Medical Review – Publishing of Determinations.

The Administrative Director may publish the results of independent medical review determinations after removing all individually identifiable information as defined in Labor Code section 138.7, including, but not limited to, the employee, all medical providers, the claims administrator, any of the claims administrator's employees or contractors, or any utilization review organization.

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

Reference: Sections 4610, 4610.5, and 4610.6, Labor Code.

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

(a) Mandatory Administrative Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty amount that shall be assessed for each failure to comply with the utilization review process required by Labor Code section 4610, the independent medical review process required by Labor Code sections 4610.5 and 4610.6, and sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, is:

- (1) For failure to establish a Labor Code section 4610 utilization review plan: \$ 50,000;
- (2) For failure to include all of the requirements of section 9792.7(a) in the utilization review plan: \$ 5,000;
- (3) For failure to file the utilization review plan or a letter in lieu of a utilization review plan with the Administrative Director as required by section 9792.7(c): \$ 10,000;
- (4) For failure to file a modified utilization review plan with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan as required by section 9792.7(c): \$ 5,000;
- (5) For failure to employ or designate a physician as a medical director, as defined in section 9792.6(l), of the utilization review process, as required by section 9792.7(b): \$ 50,000;
- (6) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): \$ 25,000;
- (7) For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in Labor Code section 4604.5(c): \$ 25,000;
- (8) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request to possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: \$ 1,000;
- (9) For failure to communicate the decision in response to a request for an expedited review, as defined in section 9792.6(g), in a timely fashion, as required by section 9792.9 and section 9792.9.1: \$ 15,000;
- (10) For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the medical treatment utilization schedule adopted pursuant to section 5307.27 of the Labor Code: \$ 5,000;

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

(12) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: \$ 2,000;

(13) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: \$ 1,000;

(14) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a retrospective review: \$ 500;

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

(16) For failure to timely serve the Administrative Director with documentation of compliance pursuant to section 9792.11(v)(5): \$ 500.

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

(18) For the failure to timely communicate a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1(e)(3): \$250 per day, up to a maximum of \$5,000.

(19) For the failure to provide an Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with all applicable fields completed by the claims administrator, with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1: \$2,000.

(20) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1 a clear statement that advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, within 30 calendar days of receipt of the decision: \$2,000.

(21) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1 a statement detailing the claims administrator's internal utilization review appeals process for the requesting physician, if any,

and a statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis: \$2,000.

(22) For the failure to timely provide information requested by the Administrative Director under section 9792.10.3(b): \$100.00 for each day the response is untimely under section 9792.10.3(c), up to a maximum of \$5,000.00.

(23) For the failure to timely provide all information required by section 9792.10.5(a) and (c): \$250.00 for each day the response is untimely under section 9792.10.3(c), up to a maximum of \$5,000.00.

(24) For the failure to timely implement a final determination of the Administrative Director under section 9792.10.7: \$500.00 for each day up to a maximum of \$5,000.00.

(25) For the failure to timely pay an invoice sent from the designated independent medical review organization under section 9792.10.8(c): \$250.

(b) Additional Penalties and Remediation.

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

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

(B) The factor for notice(s) with faulty content shall be determined by dividing the number of requests involving notice(s) with faulty content by the total number of randomly selected requests.

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

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

(E) If the investigation subject's performance rating meets or exceeds eighty-five percent, the Administrative Director, or his or her designee, shall assess no penalties for the violations listed

in this subdivision. If the performance rating is less than eighty-five percent, the violations shall be assessed as set forth below in (b)(2) through (b)(5):

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

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

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

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

(3) In the event the Administrative Director, or his or her designee, returns for a Return Target Investigation, after the initial violation has become final, and the subject fails to meet the performance standard of 85%, the amount of penalty shall be calculated as described below and in no event shall the penalty amount be waived:

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

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

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

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

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

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

(C) For failure to make a decision to approve ~~or modify or deny~~ the request for authorization, within five (5) working days of receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(h)(3) and section 9792.9.1(f)(3);

(D) For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of the information, as required by section 9792.9(h)(4) and section 9792.9.1(f)(5);

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

(F) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines, to the injured employee whose case is under review, as required by Labor Code section 4610(f)(5) and section 9792.8(a)(3) Title 8 of the California Code of Regulations.

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

(A) For failure by a non-physician or physician reviewer to timely notify the requesting physician, as required by section 9792.9(c)(2) or section 9792.9.1(c)(3)(B), that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9(c) or section 9792.9.1(c);

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

(C) For failure to send a written notice of the decision to modify, delay or deny to the requesting party, and to the injured employee and to his or her attorney if any, within twenty four (24) hours of making the decision for concurrent review, or within two business days for prospective review, as required by Labor Code section 4610(g)(3)(A) and section 9792.9(c)(4) of Title 8 of the California Code of Regulations;

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

(E) For failure to document that one of the following events occurred prior to the claims

administrator providing written notice for delay under Labor Code section 4610(g)(5):

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

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

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

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

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

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

Authority: Sections 133, 4610, and 5307.3, Labor Code.

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