**STATE OF CALIFORNIA**

**DEPARTMENT OF INDUSTRIAL RELATIONS**

**DIVISION OF WORKERS’ COMPENSATION**

**INITIAL STATEMENT OF REASONS**

**Subject Matter of Regulations: Utilization Review**

**California Code of Regulations, Title 8, Article 3.5 (§ 9767.6), Article 5 (§§ 9781, 9785, 9785.6, & 9786), Article 5.5.1 (§§ 9792.6, 9792.6.1, 9792.7, 9792.7.1, 9792.8, 9792.9, 9792.9.1, 9792.9.2, 9792.9.3, 9792.9.4, 9792.9.5, 9792.9.6, 9792.9.7, 9792.9.8, 9792.9.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.8, 9792.11, 9792.12, 9792.13, & 9792.15), and Article 5.5.2 (§§ 9792.27.1, & 9792.27.17)**

1. **INTRODUCTION / SUMMARY OF PROPOSAL**

The Division of Workers’ Compensation proposes to add, amend, or repeal regulations primarily pertaining to Article 5.5.1 of Title 8 of the California Code of Regulations to conform to legislative changes enacted under Senate Bill 1160 (Mendoza). [Stats 2016, ch. 868.] Accordingly, regulations impacted by these changes are also added, amended, or repealed. They include regulations in Article 3.5 (Medical Provider Network), 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); and Article 5.5.2 (Medical Treatment Utilization Schedule).

The following table reflects every regulation which is added, amended, or deleted, as specified, in this rulemaking (article titles are included to show relative positioning of the regulations):

| **Article and Section** | **Name of Article and/or Section** |
| --- | --- |
| Article 3.5 | Medical Provider Network |
| Amend section 9767.6 | Treatment and Change of Physicians within MPN |
| 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 |
| Amend section 9781 | Employees Request for Change of Physician |
| Amend section 9785 | Reporting Duties of the Primary Treating Physician |
| Adopt section 9785.6 | DWC Form PR-1: “Treating Physician’s Report” Mandatory for Services On or After 1/1/19 |
| Amend section 9786 | Petition for Change of Primary Treating Physician |
| Article 5.5.1 | Utilization Review Standards |
| Delete section 9792.6 | Utilization Review Standards—Definitions – For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013. |
| Amend section 9792.6.1 | Utilization Review Standards—Definitions – On or After January 1, 2013. |
| Amend section 9792.7 | Utilization Review Standards—Applicability. |
| Adopt section 9792.7.1 | DWC Form UR-01: “Application for Approval as Utilization Review Plan.” |
| Amend section 9792.8 | Utilization Review Standards – Medically-Based Criteria |
| Delete section 9792.9 | Utilization Review Standards-Timeframe, Procedures and Notice Content - For Injuries Occurring Prior to January 1, 2013, Where the Request for Authorization is Received Prior to July 1, 2013. |
| Amend section 9792.9.1 | Utilization Review Standards - Timeframe, Procedures and Notice – On or After July 1, 2013. |
| Adopt section 9792.9.2 | Utilization Review — Dispute of Liability; Deferral. |
| Adopt section 9792.9.3 | Utilization Review — Timeframes. |
| Adopt section 9792.9.4 | Utilization Review — Decisions to Approve a Request for Authorization. |
| Adopt section 9792.9.5 | Utilization Review — Decisions to Modify or Deny a Request for Authorization. |
| Adopt section 9792.9.6 | Utilization Review — Extension of Timeframe for Decision. |
| Adopt section 9792.9.7 | Utilization Review – Medical Treatment – First 30 Days of the Date of Injury. |
| Adopt section 9792.9.8 | Utilization Review — MTUS Drug Formulary. |
| Amend section 9792.10.1 | Utilization Review -- Dispute Resolution -- On or After January 1, 2013. |
| Amend section 9792.10.2 | Application for Independent Medical Review, DWC Form IMR. |
| Amend section 9792.10.3 | Independent Medical Review – Initial Review of Application. |
| Amend section 9792.10.4 | 9792.10.4. Independent Medical Review – Assignment and Notification. |
| Amend section 9792.10.5 | Independent Medical Review – Medical Records. |
| Amend section 9792.10.6 | Independent Medical Review – Standards and Timeframes. |
| Amend section 9792.10.8 | Independent Medical Review – Payment for Review. |
| Amend section 9792.11 | Investigation Procedures: Labor Code § 4610 Utilization Review Violations. |
| Amend section 9792.12 | Administrative Penalty Schedule for Utilization Review and Independent Medical Review Violations. |
| Amend section 9792.13 | Assessment of Administrative Penalties - Penalty Adjustment Factors. |
| Amend section 9792.15 | Administrative Penalties Pursuant to Labor Code §§4610, 4610.5, and 4610.6 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure. |
| Article 5.5.2 | Medical Treatment Utilization Schedule |
| Amend 9792.27.1 | Medical Treatment Utilization Schedule (MTUS) Drug Formulary – Definitions. |
| Amend section 9792.27.17 | Formulary – Dispute Resolution. |

1. **BACKGROUND, PROBLEM, AND GOALS**

In the California workers’ compensation system, employers must provide medical treatment for injuries sustained by its employees while on the job. When an employer receives a request for medical treatment of a workers’ compensation injury, it must either approve the request or, if the request is believed to be harmful or medically unnecessary, the employer can send the request to utilization review. Utilization review (“UR”) is the process of reviewing medical treatment recommendations (prospectively, concurrently, or retrospectively) to ensure that the requested treatment is medically necessary.

Utilization review in workers’ compensation was created in 2003 when the legislature passed Senate Bill (“SB”) 228 [Statutes 2003, Chapter 639] and, with it, changed the scope of reasonable medical care. It included the requirement that every employer have and use a utilization review process in conformity with outlined standards, specified timeframes, and other criteria whenever a request for authorization of medical treatment in a workers’ compensation claim was delayed, modified or denied.

Other key changes to the provision of medical treatment also occurred at the time or in years immediately following. Under SB 228, the legislature also implemented the use of an objective standard of care in determining medical necessity of treatment as determined by evidence-based medicine guidelines, which resulted in the creation of the medical treatment utilization schedule (“MTUS”). A year later in 2004, under Senate Bill 899 [Statutes 2004, Chapter 34], a system of Medical Provider Networks was introduced which allowed employers to provide medical treatment for workers’ compensation injuries via a network of physicians approved by the Administrative Director of the Division of Workers’ Compensation (“DWC”). (SB 899 also changed the landscape of resolving medical treatment disputes from one of dueling doctors to one in which a single doctor would resolve such disputes.)

Lengthy delays under this process, were, unfortunately, still common and expensive which set off another round of reforms in late 2012 culminating in the passage of Senate Bill 863 [Statutes 2012, Chapter 363]. Under SB 863, beginning on January 1, 2014, medical treatment disputes were to be resolved via Independent Medical Review (IMR) where an independent, unbiased physician reviewer would issue a final determination on the dispute after review of the record and application of the MTUS.

In the fall of 2015, Assembly Bill (“AB”) 1124 [Statutes 2015, Chapter 525] was enacted in response to the escalating cost of pharmaceuticals and the soaring use of opioids and other addictive medications. AB 1124 mandated the establishment of a drug formulary component to the existing medical treatment utilization schedule (“MTUS”) for medications commonly prescribed in workers’ compensation. Under this legislation, the DWC promulgated an MTUS Drug Formulary (“Drug Formulary”), effective January 1, 2018, which included a list of medications to be exempt or non-exempt from prospective (i.e., forward-looking) utilization review, and accompanying rules.

In the fall of 2016, the legislature passed Senate Bill 1160 [Statutes 2016, Chapter 868], which underpins this rulemaking action. SB 1160 made significant amendments to Labor Code section 4610 in response to complaints of excessive UR delays and denials. These amendments included an exemption from prospective UR, where certain conditions were met, for some medical treatment rendered to an injured worker within thirty days from the date of injury, effective January 1, 2018. (Employers may still conduct retrospective UR from which could flow specified consequences, for example, removal of the physician or provider from the employer’s medical provider network, if the provider is found to be abusing the exemption.) It also established expedited timelines for review of medications prescribed under the Drug Formulary adopted by the Administrative Director under AB 1124; empowered the Administrative Director with approval authority over UR plans; and required specified UR entities, effective July 1, 2018, to obtain accreditation by an independent, non-profit organization to ensure industry best practices regarding timeliness in treatment review, application of appropriate guidelines, and other critical measures. (Other changes under SB 1160 not captured or expanded under this rulemaking included reporting requirements for UR entities and the establishment of a UR database; and stricter rules around medical liens.)

To implement SB 1160 changes, improve the process of the delivery of medical treatment within workers’ compensation as identified by the DWC, and to enforce these changes, the DWC proposes to make amendments to the regulations listed and outlined above.

1. **TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS RELIED UPON IN PROPOSING THE ADOPTION, AMENDMENT, OR REPEAL OF A REGULATION**

The DWC did not rely on any technical, theoretical, or empirical studies, reports, or documents in creating this ISOR.

1. **SPECIFIC TECHNOLOGIES OR EQUIPMENT REQUIRED**

No specific, new technologies or equipment are required by these proposed regulations. The proposed changes add to or amend existing regulations which already require the use of general technologies (e.g., voicemail system, facsimile system, etc.) that are presumably in current use. While the amendment of an existing form (the IMR application form), the addition of a new physician form (the PR-1, which is a consolidation of a few existing forms), and the addition of a new UR plan application form (the UR-01) may cause some industry organizations or businesses to have to tweak or adapt existing technologies to maintain or improve system efficiency, such changes are discretionary.

Businesses that decide to tweak or adapt their existing systems (such as those which employ an electronic health records program) to better align their programs with the new/amended forms may, at first, experience an increase in cost. In the long term, however, since the PR-1 centralizes a claimant’s basic information and functions not only as a form to request authorization for treatment but also as the required form for multiple report-triggering events, the implementation and use of the PR-1 should inevitably result in an overall savings to the system in both time and cost.

1. **REASONABLE ALTERNATIVE(S) TO THE PROPOSED REGULATIONS AND REASONS FOR REJECTING THOSE ALTERNATIVE(S)**

The Administrative Director has not identified any effective alternative, or any equally effective and less burdensome alternative to the regulations at this time. Specifically, with respect to the requirement that some entities obtain Workers Compensation Utilization Management accreditation through URAC, an alternative accreditation organization was considered but discussions were halted when queries were unanswered by the accrediting organization. The public nevertheless is invited to submit viable alternatives during the public comment process.

1. **FACTS, EVIDENCE, DOCUMENTS, TESTIMONY, OR OTHER EVIDENCE ON WHICH THE AGENCY RELIES TO SUPPORT AN INITIAL DETERMINATION THAT THE ACTION WILL NOT HAVE A SIGNIFICANT ADVERSE ECONOMIC IMPACT ON BUSINESS. (Gov. Code Section 11346.2(5)(a)).**

The Administrative Director has determined that the proposed regulations will not have a significant adverse economic impact on business. Unique to this rulemaking is the fact that the statute upon which these draft regulations are based is already in effect. This has allowed access to some information reflective of the initial effects of the statute.

In one such example, according to DWC records, the URAC WCUM accreditation requirement, which initially costs $36,000 for 3 years of accreditation, has resulted in the closure of 2 and merger of 4 UR companies. Considering that there are 59 total UR companies currently on file with the DWC, the impact of the accreditation requirement under SB 1160 has been and will likely continue to be minimal.

Likewise, there appears to be support for the fact that the exemption from prospective UR for certain medical treatment rendered within 30-days from the date of injury (the “30-day exemption”) will have minimal impact on businesses. One study published in 2019 reported that, based on a comparison of 2017 and 2018 data, there was no appreciable change in the volume or timing of services subject to the 30-day exemption from prospective UR save for a small uptick in physical medicine services (which, in the study, included physical therapy, acupuncture, and chiropractic care). (CWCI, *Post-Reform Medical Service Approval Rates in California Worker’s Compensation*; David, Bullis, Jones, & Young (October 2019).) This is unsurprising since the 30-day exemption impacts a relatively small population of medical treatment. Moreover, it is predicted that any increase in cost due to the payment for services that fall under the 30-day exemption will be offset by savings in the reduction of frictional costs (such as those incurred in the appeals process, including litigation).

The mandate to accelerate the dispute resolution process for pharmaceutical treatments falling under the Drug Formulary is, like the 30-day exemption, a small change to an existing system, and is unlikely to cause any significant impact on business operations or expenditures. This position is supported by the lack of complaints received by the DWC since the statute has taken effect on January 1, 2018.

SB 1160 also made changes to the oversight of UR entities by allowing the DWC to approve of (or disapprove of) a UR plan. Regulatory changes under this rulemaking include significant alterations to the penalty scheme and penalty amounts attached to violations uncovered in a UR investigation. Under the new regulations, the old system of attaching a performance score to a UR investigation subject which, if equal to or above 85%, would waive penalties imposed for less serious violations, is being replaced in favor of a penalty schedule attached to violations uncovered in an investigation with no performance score and no waiver possibility (though mitigation will still be an option). This approach is favored by the Division as allowing for greater transparency to the public and for being more straight-forward and understandable. While these changes may initially result in an increase in penalties for UR investigation subjects, because most of the violations themselves have been in place since the beginning of UR in 2004 along with the DWC’s authority to impose them, they should come as no surprise and the subjects most affected will be UR entities who truly require remediation.

Under this rulemaking, the Administrative Director has also created a new physician report form, the PR-1, which is a consolidation of multiple existing forms. This new form will allow the centralization of medical information pertaining to the claimant, encourage the use of accessible medical guidelines critical to the approval of requested treatment, and streamline the medical reporting process. The first page of the new PR-1 form will act as a landing page to input and store basic information pertaining to the claimant and claim after which the physician can choose to fill out only the pages relevant to the purpose of the report. This may initially require treating physicians, claims administrators, and UR companies to have to adjust their existing electronic health records systems to accommodate the new form, but the anticipated long-term benefits and savings from utilizing one central report which directs consideration of treatment guidelines should eventually offset those costs.

Because the impacts to businesses overall will be small, an assessment of any impact on small businesses (as defined under California Government Code section 11346.3 subdivision (b)(4)(B) as being independently owned and operated, not dominant in their field of operation, and having fewer than 100 employees) is essentially moot.

1. **ECONOMIC IMPACT ASSESSMENT (Govt. Code section 11346.3(b))**

**The Creation or Elimination of Jobs within the State of California**

The Administrative Director estimates that this rulemaking will have a minimal impact on job creation or elimination within the state.

The regulatory changes regarding the exemption to prospective UR of some medical treatment rendered within 30-days of the date of injury (“the 30-day exemption”) and the acceleration of the resolution of formulary disputes are alterations of existing UR processes, the impacts of which are unlikely to result in either the creation or elimination of jobs.

The 30-day exemption requires less scrutiny of certain types of treatment recommendations, the appropriateness of which may be assessed retrospectively, after the treatment has been rendered, and for which other remedies have been assigned. This allows an insurer or UR entity to determine, based on business needs, whether to streamline or automate (and thereby expend less resources on) processes related to treatment authorization or instead to shift them to a different checkpoint. But, regardless, because the 30-day exemption only affects a relatively small proportion of medical treatment (i.e., treatment rendered within the first 30 days of the date of injury), an insurer or UR entity who determines to withdraw entirely from its right to conduct retrospective UR on these treatment requests is unlikely to enjoy a level of savings that justifies an elimination of jobs.

The accelerated timeframe for UR and IMR of formulary drugs under SB 1160 is arguably even less impactful to jobs since this change affects only the timing of a process that is already in place within the industry. It is possible that a UR entity who is unable to meet the accelerated timeframe demands may have to consider hiring additional personnel but would likely weigh that cost against the cost of authorizing a drug without sending it through UR. This change would, if anything, result in the creation of, rather than the elimination of, jobs.

Greater oversight of UR entities, by way of an accreditation requirement and the granting of approval authority to the AD over UR plans, was another key change under SB 1160.

The accreditation requirement, due to the additional expense charged by the named accreditation organization, has caused some UR entities to shut down or be acquired by larger UR organizations. Some jobs, therefore, may have been eliminated as a result of the accreditation requirement, but, because these entities were very small in scale, the elimination of any jobs is likely to have been minimal.

The authority granted to the AD to approve or disapprove of UR plans was an expansion of the AD’s existing authority (since 2004) to impose penalties for UR-related violations. Regulatory changes to enforce these oversight provisions include an updated investigation process, amendments to the penalty scheme, and increases to penalty amounts. These changes will likely require more attention from the UR entity during an investigation (which must occur at least once every 5 years), but will likely be absorbable by existing personnel already assigned to handle these functions.

**Creation of New Businesses or the Elimination of Existing Businesses within the State of California**

The Administrative Director (AD) has determined that the proposed regulations will have an overall minimum impact on the creation of new or elimination of existing businesses within the State of California.

The 30-day exemption and accelerated timeframe for the resolution of formulary disputes are adjustments to an existing system and, therefore, additional costs as a result of these changes will be absorbable by existing entities who are already engaged in UR functions.

The proposed PR-1 form may initially cause an increase in costs, particularly for a larger medical practice if it already utilizes an electronic health records and/or data processing system to generate reports. However, because the new form would mostly affect larger practices that are better equipped to weather increases in costs, such increases should not be so prohibitive as to cause business closures. Moreover, efficiencies gained in the long term from the centralization of a claimant’s information and the consolidation of various types of reports should eventually offset costs in favor of overall efficiency and savings.

The accreditation mandate for UR entities who engage in the modification or denial of a treatment request was effective starting July 1, 2018. The chosen accreditation organization, URAC, charges $36,000 for WCUM accreditation for the first three years. DWC records reflect that the accreditation requirement has caused 2 UR organizations to dissolve whilst 4 have been acquired by other, larger organizations. All 6 affected organizations conducted minimal UR activity at the time of their closures or acquisitions. The total number of active UR organizations at the time of this proposal is 59. Therefore, the elimination of these 6 organizations, given their marginal scale of business, represents a relatively small impact on existing businesses.

The regulations also implement SB 1160’s grant of additional authority to the AD to approve of UR plans; and propose modifications to the DWC’s UR investigation processes, scheme, and penalty amounts. Because the AD had already had the authority to impose penalties for UR violations since 2004 and the investigation processes and schemes are being amended to be administratively simpler, the AD has determined that these changes will be absorbable by existing UR organizations. Additionally, because of the many compliance rules surrounding workers’ compensation and rigorous accreditation requirements, the proposed regulations on the topic are unlikely to encourage or cause new ventures.

**The Expansion of Businesses Currently Doing Business within the State of California**

The Administrative Director has determined that the proposed regulations will not result in a major expansion of businesses currently existing within the state of California.

Both the 30-day exemption to prospective UR and the accelerated timeline for the resolution of formulary drug disputes are changes to an existing UR framework and should therefore be absorbable by existing UR businesses.

Oversight proposals (i.e., the URAC accreditation requirement and the authority of the DWC to approve UR plans), given the nature of the changes, are also unlikely to cause significant expansion of existing business.

As a result of the URAC accreditation requirement, DWC records reflect there to have been four UR organizations that have merged with other UR organizations as a result. However, because those four organizations had minimal operations to start, the impact of such acquisitions to the expanded organizations have been insignificant.

**Benefits of the Regulations to the Health and Welfare of California Residents, Worker Safety, and the State’s Environment**

The proposed regulations will benefit injured workers by eliminating delays and denials of necessary medical treatment and ensuring that utilization review (“UR”) systems are operating in accordance with the best practices of the industry.

Injured workers will benefit from regulations allowing reasonable medical treatment to be delivered expeditiously without administrative delay when it is most necessary, in the first month following an injury; and by hastening the delivery of necessary medications. Additionally, a new physician reporting form, which centralizes all of a claimant’s information, will aid in the efficient reporting of an injured worker’s medical status and the requesting of medical treatment necessary to reduce administrative confusion or delays in treatment.

Regulatory oversight provisions requiring accreditation with a nationally recognized accreditation company and the grant of authority to the Administrative Director to approve of UR plans will further ensure that UR operations are in accordance with the recommended best practices of the industry.

1. **DETAILED DISCUSSION OF EACH REGULATION – PURPOSE AND NECESSITY**

In addition to implementing the changes under SB 1160 discussed above, these proposed regulatory changes will also reflect the deletion of the word “delay” in many of the listed regulation sections to align with the deletion of that word in Labor Code section 4610, which was effective November 22, 2016. (This change was based on the view that a delay in treatment is still, in essence, a denial of treatment.) As this change and rationale is being identified here, occurrences of this change within the specific regulation sections below will simply refer to this paragraph.

# ARTICLE 3.5 Medical Provider Network

## Section 9767.6. Treatment and Change of Physicians within MPN

Section 9767.6 sets forth the requirements for medical treatment and change of physician within an MPN.

Subdivision (f) is added to ensure that insurers, upon notice of the employer-selected MPN physician, supply the MPN physician with relevant medical records. It also requires the insurer to provide billing information to the selected MPN physician.

Subdivision (f) is necessary to allow for better continuity of care (via the transition of relevant medical records) to an injured employee who oftentimes obtains initial treatment from a provider outside of the employer’s MPN but who is eventually required to treat with a primary treating provider within the employer’s MPN. It also aims to reduce delays and friction that can arise from ineffective billing information or procedures.

Subdivision (g), as proposed, is a renumbering of current subdivision (f) and is amended to allow an employer to petition for a change of primary treating physician under Labor Code section 4603 even where the PTP is within the employer’s MPN (because, usually, an employer is prohibited from petitioning for a change in treating physician for “good cause” under regulation 9786(b) where the treating physician is within the employer’s MPN). This change is necessary to conform with and implement one of several consequences under Labor Code section 4610 for an MPN physician who renders treatment exempt from prospective UR where the rendering of the exempt treatment is later found to be a part of a pattern and practice of providing treatment that is inconsistent with the MTUS.

Where an employer has requested a change of treating physician because of such circumstances, subdivision (g) also requires an employer to provide the panel of physicians (required on the Petition for Change of Treating Physician form) from the employer’s current MPN listing who also meet the MPN access standards. This instruction anticipates the natural question flowing from this rule about which alternate physicians are qualified to serve in place of the current treating physician where treatment is being provided within an MPN.

# 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

## Section 9781. Employee’s Request for Change of Physician.

Section 9781 sets forth the parameters for when an employee requests a change of physician as allowed under Labor Code section 4601 (i.e., when outside of an MPN system).

Subdivision (d) outlines the obligations of a claims administrator when an employee exercises his/her right to request a change of physician. It includes requirements pertaining to the delivery of relevant medical records to the selected medical provider and communication of information relevant to billing, submission of requests for authorization, and required reporting forms within the workers’ compensation system.

Specific amendments to subdivision (d) include the addition of an express timeframe of 20 days from receipt of notice of selected physician for the claims administrator to take measures to ensure continuity of care. Subdivision (d)(4) was added to require the claims administrator to advise subsequent physicians or providers that records relevant to that physician or provider’s care will be delivered if requested. Subdivision (d)(5) was added to require the claims administrator to provide contact information as to where a request for authorization should be sent. Subdivision (d)(6) was added to require the claims administrator, if applicable, to provide a list to providers of medical services for which no request for authorization is required. Subdivision (d)(7) was amended to require a claims administrator, when a physician is selected, to either provide required reporting forms or to refer the physician to the DWC website where the forms are accessible.

Amendments to subdivision (d) are imperative for continuity of care and to align with the obligations that attach to a claims administrator under regulatory section 9767.6 where an employee obtaining care within an MPN seeks to change his/her treating physician.

## Section 9785. Reporting Duties of the Primary Treating Physician.

Section 9785 sets forth the reporting duties of a primary treating physician (“PTP”). This section includes applicable definitions, scope of review of a PTP, PTPs’ reporting requirements; and makes reference to applicable sections for resolving disputes.

Subdivision (b)(3) deleted the word “delay.” (See above for explanation.)

Subdivision (d) was amended to align with other changes in the section and to include “secure” as a descriptor for when an exchange of information is allowed via electronic transmission. This amendment is necessary to balance the interest of information security with the expediency of information transmission through electronic means.

Subdivision (e) was amended to clarify that the obligation of a medical provider to submit a Doctor’s First Report of Occupational Injury or Illness (“DFR”) applies only to the initial treating physician, which includes physicians rendering first aid treatment. This amendment is necessary to cut out duplicative reports and to capture the full scope of information relating to work place injuries and their origins. Subdivision (e) also deleted instructions that are no longer relevant to the current version of the DFR.

Subdivision (f)(2) was amended for better syntax and the latter end of the text of old subdivision (f)(8) was incorporated into new subdivision (g). It was necessary to reorganize some of the text from subdivision (f)(8) to appear under subdivision (g) because of the newly proposed PR-1 form. Having a dedicated subdivision to address the transition regarding the use of the PR-2 form to the newly proposed PR-1 form is necessary to reduce confusion and for better organization.

Subdivision (g), as aforementioned in the discussion about subdivision (f)(8), is a new subdivision which includes language from the latter end of subdivision (f)(8), and additional text to require the use of a new physician reporting form, the PR-1, which is one of three forms included in this rulemaking. (For necessity of the PR-1 form, refer to section 9785.6, below.) Subdivision (g) has two subsections to allow providers to transition to using the new PR-1 form in place of the form PR-2. When read together, it gives providers 6 months-time to make the transition. The 6-month time period was chosen because it seemed like a reasonable yet adequate amount of time to allow providers to familiarize themselves with the new form and make the transition.

Subdivision (h) is a renumbering of current subdivision (g) and is necessary for proper sequence. Other changes are as follows: “et seq.” was added after the reference to section 9792.9.1 as that section, under this rulemaking, has been broken up into many sections beginning with 9792.9.1; amendments were made to continue the requirement that a request for authorization follow requirements as outlined in other pertinent sections and subdivisions, which is necessary for consistency; and text was added to clarify that a request for authorization may be made by both a PTP and a secondary physician. This is necessary to clear-up the misunderstanding that an RFA can only be made by the primary treating physician, which is not true since a secondary physician sometimes requires additional treatment (such as tests or examinations) in order to progress with appropriate medical care.

Subdivision (i) is a renumbering of current subdivision (h), and updates references to regulation numbers which are changing under this rulemaking and recent Workers’ Compensation Appeals Board rulemaking. This is necessary for accuracy.

Subdivision (j), (k), and (l) were renumbered due to the addition of subdivision (g)

## Section 9785.6. DWC Form PR-1: "Treating Physician's Report" – Mandatory for Services On or After January 1, 2019

Section 9785.6 is the section number assigned to the new DWC Form PR-1. It combines the DWC Form RFA (request for authorization of medical treatment); DWC PR-2 form (primary treating physician’s progress report); and specified reporting requirements of treating physicians.

The PR-1 allows the user to check a box correlating to options at the top of the first page to indicate the purpose of the form and then directs the user to the pertinent sections in the form which are germane to the purpose. The remainder of the first page contains basic information specific to the employee such as patient information, physician information, and claims administrator information. The necessity of the remaining pages will be subject to the purpose indicated by the checkboxes at the top of the first page. Attached to the PR-1 form is an instructional page to guide users through the use of the form.

The DWC Form PR-1 is imperative for improving the efficiency of the process of requesting medical treatment for an injured employee as it requires a request for treatment to be accompanied by substantiating documentation, and directs and encourages a requesting provider to reference the relevant treatment guideline applicable to the request. This form highlights the use of treatment guidelines, which are required and essential to rendering medically necessary treatment to injured employees and to limit delays resulting from appeals of utilization review denials or modifications. The PR-1 form also provides for all basic, identifying information pertaining to an injured worker’s claim for workers’ compensation benefits to be centralized in one location that will facilitate expedient and appropriate care.

## Section 9786. Petition for Change of Primary Treating Physician.

Section 9786 outlines the rules relevant for when a claims administrator petitions for a change in primary treating physician.

Subdivision (b)(1) and (4) were amended to align with the renumbering of other sections or subdivisions which changed as a result of this rulemaking.

Subdivision (b)(6) was added to implement the legislative creation of another “good cause” reason per Labor Code section 4610(f)(2) that warrants an employer’s petition for a change in primary treating physician (“PTP”). It allows a claims administrator to petition for a change in PTP under “good cause” when a PTP has been found via retrospective utilization review to have a pattern and practice of rendering treatment inconsistent with the MTUS during the 30-day exemption period, i.e., 30-days from the date of injury. This remedy balances the legislative directive under SB 1160 prohibiting prospective UR for certain treatment within 30 days of the date of injury.

Subdivision (c)(2) was amended to delete language directing a claims administrator who opposes the appropriateness or need of medical treatment to the WCAB. This language is no longer applicable and necessary since, in 2014, the legislature created the Independent Medical Review (IMR) process for dealing with disputes over the necessity and/or appropriateness of medical treatment.

Subdivision (c)(3) was amended to account for renumbering of other cited sections and to clarify that the 90-day time requirement for which a claims administrator has to file a petition for a change in PTP due to the PTP’s failure to timely file Form 5021 runs 90 days from when the claims administrator *had knowledge* of the initial examination, and not simply from the date of the initial examination. This is necessary to allow for fairness as there are many scenarios under which a claims administrator would not come to know of an initial examination until much later.

Subdivision (c)(4) was amended to reflect renumbering of other sections to which this section cites.

Subdivision (f) was amended to reflect more accurately that a PTP may serve as a PTP until an order granting the claims administrator’s petition for a change in PTP is issued. To say that a claims administrator must continue to pay for medical treatment rendered by the PTP until a petition for change in PTP is granted is inaccurate since treatment must still be medically necessary. To focus on the ability of a physician to serve as an injured worker’s primary treating physician (as opposed to the requirement of a claims administrator to pay) until the petition is granted more accurately expresses the meaning of this subdivision.

Subdivision (g) was amended for naming accuracy (i.e., of a subdivision which was originally referred to inaccurately as a subsection).

# 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.

This section is being deleted in its entirety as no longer applicable since it only applied to utilization review decision issued prior to July 1, 2013.

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

Specific Purpose & Necessity:

Section 9792.6.1 contains the definitions applicable to requests for authorization of medical treatment and the processes that are triggered from such requests. As originally enacted, the title included a date (January 1, 2013) after which this section was effective, but as that date is long past and is therefore moot, the title deletes the date reference.

Subdivision (a) amends the text to remove reference to the current Request for Authorization (“RFA”) form and deletes language pertaining to the RFA that is unnecessary. These changes align with updates to the proposed RFA form and to omit language that was considered redundant. A reference to section 9792.9.1 was also corrected as “9792.9.1 et seq” as that section, under this rulemaking, has been broken up into many sections.

Subdivision (d) amendments would update references to old or erroneous section numbers and reporting forms. It also deletes reference to the PR-2 and instead makes a general reference to section 9785 which outlines the various reporting requirements and forms.

The text of subdivision (e) was struck in its entirety since it defined the word “delay” and this word has been deleted from the statute (Labor Code section 4610). (See explanation above.) Subdivision (e) now reads, “reserved” to minimize the need to renumber subdivisions and other sections which may cross reference this section.

Subdivision (k) has been amended to clarify the definition of “expert reviewer.” This clarification is necessary to distinguish the meaning of “expert reviewer” from “reviewer” or “physician reviewer” which are also defined in this subdivision. (See below.) Originally, there was no definition for “physician reviewer” (even though the term is used throughout the regulations), and the definition of “expert reviewer” and “reviewer” were very similar. This amendment, along with the added definition of “physician reviewer” to the definition of “reviewer” (see below), clarifies that an expert reviewer, while similar to “physician reviewer,” serves a different purpose in the context of utilization review.

Subdivision (n) was amended to include a change in a UR plan’s medical director, address, company name or corporate structure as being a “material modification” in addition to changes in UR plan standards. Some UR organizations (“UROs”) are quite complex in structure and identifying a change in medical director, address, company name or corporate structure as being a material change triggers obligations on UROs to notify the DWC in a timely manner which allows the Division of Workers’ Compensation (“DWC”) to appropriately track them. This change aligns with the legislative grant of authority to the DWC to approve (or disapprove) of UROs who operate in the California workers’ compensation system.

Subdivision (o) made grammatical changes to the text.

Subdivision (s) added a definition for “MTUS Drug Formulary.” Because drugs are also medical treatment to which an injured worker is entitled and to which a claims administrator may conduct UR, MTUS Drug Formulary rules, which also contain exemptions to prospective UR, must also be accounted for in the UR regulations. It is therefore necessary to define “MTUS Drug Formulary” in the definitions section pertaining to UR rules.

Proposed subdivision (t) is a renumbering of current subdivision (s), and is necessary for proper sequence.

Proposed subdivision (u) is a renumbering of current subdivision (t), and is necessary for proper sequence. Its purpose is to clearly and accurately define a “request for authorization” as used in this section and for purposes of investigations and penalties. Amendments include updates to cross-references of other sections whose numbers or subdivisions have changed as a result of this rulemaking, which is necessary for accuracy, and deletion of information that is no longer pertinent (see specifically subdivision (u)(1)), which is also necessary for accuracy and to avoid confusion.

Amendments were also made to clarify the parameters of a “completed” RFA under subsection (2):

* The proposal requires the provider to not only specifically identify the recommended treatment(s), but also to identify the specific treatments in the designated place, whether it be on an appropriate form or in a narrative report, as allowed. This is necessary to make the process of reviewing treatment requests more efficient given the tight timeframe for UR and the relatively light burden on the treating provider.
* The proposal also requires documentation substantiating an RFA to have been created no earlier than 30 days before the date of the submission of the RFA. This is necessary to ensure RFAs are germane to an employee’s current medical condition, which are subject to change with the passage of time.

Subsection (3) of subdivision (u) was also amended to update the use of a secure email system where an RFA is transmitted through electronic means; and includes a cross-reference to the section pertinent to the claims administrator designation for receipt of RFAs. This is necessary to comply with standards pertaining to protected health information.

Subdivision (v) is a renumbering of current subdivision (u) and is necessary for proper sequence.

Subdivision (w) is a renumbering of current subdivision (v) and is necessary for proper sequence. Amendments were further made to clarify that “reviewer” and “physician reviewer” mean the same thing since “physician reviewer,” though used frequently throughout the regulations, is not defined. Further, two subsections were added to differentiate “reviewer” and “physician reviewer” from “non-physician reviewer” to distinguish the different roles allowable for someone who assists in the UR process (i.e., “non-physician reviewer”) versus someone who can ultimately modify or deny requested treatment (i.e., “reviewer” or “physician reviewer”). Accordingly, text throughout the proposal has been amended as needed.

Subdivision (x) was added to define “URAC” based on its physical location or else as indicated on its website. This is necessary for consistency with the statute at Labor Code section 4610(g)(4), which designates URAC (absent other designation by the Administrative Director) as the organization from which UR companies who modify or deny requests for medical treatment must obtain accreditation.

Subdivision (y) is a renumbering of current subdivision (w) and is necessary for proper sequence. The word “delay” is also struck. See explanation above.

Subdivision (z) is a renumbering of current subdivision (x) and is necessary for proper sequence.

Subdivision (aa) is a renumbering of current subdivision (y) and is necessary for proper sequence. This subdivision was also amended to strike the word “delay.” See explanation above. Other minor changes were made to align with the creation of the new form PR-1 and to align with renumbering changes, which is necessary for accuracy.

Subdivision (bb) is a renumbering of current subdivision (z) and is necessary for proper sequence. The proposal adds text to allow for the electronic submission of health records via a secure, encrypted email system. This amendment balances the interest of information security with the expediency of information transmission through secure, electronic means.

Subdivision (cc) is added to define “normal business day” or “business day” as UR processes are often required to be completed in a specified number of business days. This is necessary to clarify confusion over whether Saturdays and the day after Thanksgiving are business days for the purpose of calculating timeliness obligations required of entities who perform UR. This change also aligns with the statutory clarification of this term under AB 539 reflected in Labor Code section 4600.4. [Statutes 2019, Chapter 647.]

Subdivision (dd) is added to define “working day,” which is necessary since the term is often used interchangeably (both in the statutes and regulations) with “business day” as applicable to UR processes.

## § 9792.7.  Utilization Review Standards – Applicability

Specific Purpose & Necessity

Section 9792.7 sets forth the standards for a utilization review (UR) plan and its processes.

Subdivision (a) outlines the elements of what must be contained in a UR plan. Its introductory text is amended to delete words that are no longer relevant and for better syntax. This is necessary to reduce any confusion that may result from the existence of words that have no application.

Subdivision (a)(6)(A) proposes to require utilization review organizations (UROs) who engage in modifying or denying treatment requests to include proof of URAC accreditation in its UR plans. It further clarifies the specific type of accreditation (Workers’ Compensation Utilization Management Accreditation) that is acceptable under this requirement. This subdivision is necessary to carry out the legislative mandate requiring accreditation of specified UR companies under SB 1160.

Subdivision (a)(6)(B) proposes to exempt public sector entities conducting internal UR from the URAC accreditation requirement if the entity submits a statement with its UR plan, under penalty of perjury, confirming that its plan meets or exceeds the requisite URAC accreditation standards. This method was chosen as the most efficient means of implementing the legislation expressly allowing for such an exemption.

In subdivision (b)(1) & (2), the word “delay” was struck from the text. See explanation above.

Subdivision (b)(3) updates references to section numbers which changed due to reorganizing and renumbering, and is necessary for accuracy.

Subdivision (c) sets forth the requirements related to the filing of a UR plan with the Administrative Director. Subsections have been added to subdivision (c) to set forth additional criteria required for UR plan approval pursuant to the AD’s authority under SB 1160 to approve specified UR plans. This is necessary to ensure that plans approved by the AD are operating in compliance with the law and for better organization and grouping of the filing requirements. Text requiring modification of a plan to be filed with the AD within 30 days after execution of a material modification, which appears deleted, has been reorganized to appear in subsection (4). This is necessary for better organization of regulations pertaining to the UR plan approval process.

Subdivision (c)(1) clarifies that when a claims administrator submits a letter identifying its external UR organization in lieu of filing its own plan, the identified UR entity must have an *approved* UR plan on file with the Administrative Director that also identifies the claims administrator(s) on whose behalf it performs UR. This is necessary to implement and be consistent with the legislative mandate that all UR plans performing UR modifications or denials be approved (as opposed to simply filed) by the DWC. Additionally, given the myriad ways that claims administrators and UR plans are or can be affiliated, this will also help the Division to keep track of the varying relationships. The regulation also deletes the portion of the text relating to the filing of a modified UR plan, which is addressed in new subdivision (c)(4).

Subdivision (c)(2) adds a requirement that UR plans that modify or deny treatment requests must submit with its plan a completed DWC Form UR-01, one of three new forms that are part of this rulemaking. The form acts as a cover page for the submission of a UR plan and centralizes all essential information pertaining to the plan, including a list of its clients and vendors, on the form. The subdivision further expounds on criteria surrounding this requirement such as format of a UR plan submission and retention. This form is a tool the DWC has chosen to create and use under its newly granted authority to approve of a UR plan that modifies or denies treatment requests. Requiring the use of this form is necessary to allow the DWC to organize, record, and monitor UR entities and track the various relationships between insurers, UR entities, and their vendors, which is essential for enforcing the laws concerning UR.

Subdivision (c)(3) was added to allow the DWC the ability to obtain records from URAC pertaining to a URO’s accreditation as well as audits of the URO performed by URAC. This is essential to the DWC’s authority to monitor UR entities, their processes, and potential problem areas; and is especially necessary because URAC’s contract with these UROs does not allow it to disclose such records unless required by law.

Subdivision (c)(4) requires a UR plan to file a material modification of its plan with the DWC within 30 calendar days of the modification. This requirement is necessary to allow the DWC to have continual oversight over plans which often undergo changes that are material to their operations. (The 30-day timeframe is a carry-over from the prior, existing regulation on this subject (at section 9792.7(c)).) This subdivision also requires any material modification to be accompanied by a statement certifying that the modified plan continues to be in compliance with the law. This requirement is necessary to encourage the applicant to fully and seriously consider the impact of its plan modification before submission.

Subdivision (d) was added to inform UR plan applicants of the first step in the process of filing a UR plan for approval, where applicable, with the Administrative Director. It allows the DWC 30 days to consider whether a UR plan submitted for approval has submitted a complete application. This is necessary to establish a transparent process for the acceptance of a UR plan for approval by the DWC. The 30-day time frame was chosen as a reasonable amount of time for considering the completeness of a UR plan given the existing DWC staff and other, rotating duties. A lesser amount of time would have been unrealistic and a greater amount of time seemed excessive.

Subdivision (e) was added to expound on the approval process begun in subdivision (d) for UR plans that modify or deny treatment requests.

Subsection (e)(1) sets forth the time line for the approval process. Upon receipt of a complete plan application, the AD would approve or deny the plan within 60 days. Where specific deficiencies are identified but the plan has substantially complied with the law, the AD may grant a conditional approval for up to 6 months to allow an opportunity for the plan to correct its deficiencies. The conditional approval may be extended for another 6 months if there is a showing of a good faith effort and ability by the plan to correct its deficiencies. Under the proposal, a UR plan operating under a conditional approval would be deemed denied at the end of its conditional approval term unless deficiencies are remediated prior to expiration.

Subsection (e)(2) sets forth the process for when a UR plan submitted for approval is denied. It would require the AD’s denial of a UR plan applicant to be executed in writing and include the reasons for non-approval. It would require the denial to be transmitted by certified mail and for the denial to be effective for a period of 12 months unless a lesser timeframe is agreed upon by the AD for good cause.

These rules are necessary to account for the often common situation where deficiencies in a UR plan are identified but not timely resolved by the applicant. Under the DWC’s new authority to approve plans, the rules outlined in subdivision (e) provide notice and set expectations for UR organizations who are required by law to obtain DWC approval of their plans. The initial 60-day allowance for the Division to approve or deny a UR plan was based on an estimation of the DWC’s ability to complete the task given the DWC-UR unit’s resources, other duties, and the number of existing UR plans. A total of 1 year of conditional approval time (in two, 6-month conditional approval periods) was created in acknowledgment of the fact that process adjustments required by changes in the law may take time to implement, but also that 1-year should be a sufficient period of notice for a plan to implement such changes. The DWC wanted to make sure that a UR plan had fair opportunity to make required changes to their system given that plan rejection by the DWC, unless a lesser timeframe is agreed upon for good cause, would result in a 12-month prohibition on a repeat application for UR plan approval.

Subdivision (f) was added to allow UR organizations whose UR plans are rejected by the DWC to appeal the rejection to the Workers’ Compensation Appeals Board by filing a petition within 20 days of the issuance of the rejection. Due to the impact such a rejection may have on a UR entity, an appeals process is necessary for due process.

Subdivision (g) was added to require an organization to update an approved plan if necessary to bring the plan into legal compliance. It would allow an organization 30 days from receipt of a notice requiring a plan update to bring its plan into compliance. It would inform that a UR organization’s failure to update its plan could result in probation or suspension of its plan, or a revocation of its plan approval. This requirement is necessary to account for changes that inevitably occur and that may affect compliance in such regulated entities.

Subdivision (h) was added to outline the reasons for and process by which probation, suspension or revocation of an approved UR plan may occur.

Subsection (h)(1) allows the AD to place a UR plan on probation, suspension or revocation of approval if a UR program operates out of compliance with the terms of its approved plan or the law; if it fails to timely adopt and implement updates to its UR plan as specified by the Administrative Director; if it knowingly makes false statements or representations to the Administrative Director or fails to submit plan modifications or updates as required; or if it fails to respond to at least two or more repeated requests or inquiries by the Administrative Director concerning plan compliance. This graduated system of checks allows the Administrative Director flexibility in enforcing legal compliance while minimizing unnecessary disruption to the provision of medical treatment in the workers’ compensation system.

Subsection (h)(2) would require the Administrative Director to issue a written notice of the violations substantiating the probation, suspension, or revocation; and allow for 14 days after receipt of such notice to correct the violation or propose a plan for timely correction. This timeframe considers the need for swift remediation of a practice or process that violates the law balanced against due process and a reasonable opportunity for the regulated entity to make corrections.

Where violations have not been remediated in a timely manner, subsection (h)(3)(A) requires the Administrative Director to issue a Findings and Notice of Action specifying the time period for which probation, suspension, or revocation would take effect; and bars a UR plan whose approval has been revoked from applying again for UR approval for a period of 12 months following revocation unless a lesser timeframe is agreed upon for good cause. These rules are required to allow for due process and to impart the seriousness of noncompliance.

Subsection (h)(3)(B) further requires the UR organization to provide notice of its suspension or revocation by issuing a copy of the Findings and Notice of Action to all entities for whom it performs UR. This notice requirement is necessary so that clients of the subject entity can make other arrangements as needed to minimize interruptions in business operations involving utilization review.

Subdivision (i) would allow a UR organization that received a Findings and Notice of Action (for probation, suspension, or revocation) to request re-evaluation of such Findings by submitting, under penalty of perjury, a written explanation accompanied by supportive, documentary evidence within 14 days of the issuance of the Findings and Notice of Action. It would further require the Administrative Director to respond to the request for re-evaluation within 45 days (which may be extended for 30 days) of the request, and request additional documentation or information at any time during this process. The Division of Workers’ Compensation acknowledges the potential severity of these consequences on business operations, and, therefore, these provisions are necessary to allow a means of appeal for UR organizations who are faced with such action and who choose not to appeal via the Workers’ Compensation Appeals Board, which is another alternative under subdivision (j), below.

Subdivision (j) allows a UR organization that received a Findings and Notice of Action (for probation, suspension, or revocation) to appeal such notice to the Workers’ Compensation Appeals Board as an alternative to requesting re-evaluation. A UR organization who chooses to do so must file its petition within 20 days of the issuance of such notice and would concurrently serve its petition with the Administrative Director. This is necessary to allow an alternative means of appeal of a Findings and Notice of Action for UR organizations who may feel more comfortable appealing to a court than to the DWC.

Subdivision (k) clarifies that the violations established via the probation, suspension, and revocation process as outlined in this section would not bar penalties that result from an investigation of a utilization review entity. This is necessary for coordination between the investigation process and the process of probation, suspension, and revocation outlined in this section.

Subdivision (l) requires the Administrative Director to post on the Division’s website a list of all UR organizations that have filed a plan with the DWC and to indicate their statuses such as approved, denied, inactive, probation, suspended, or revoked. The proposal authorizes the AD to mark as inactive any UR entity who has not performed UR activity under its own name for 12 consecutive months following the last UR activity performed under its own name. These rules are necessary for transparency and to provide a resource from which the public can check on the legitimacy of a UR entity.

Subdivision (m) is a renumbering of the current subdivision (d), which has otherwise remained unchanged, and is necessary for accuracy.

The “Authorities cited” section is amended to include Labor Code section 4610, which is the primary statute pertaining to utilization review.

## § 9792.7.1.  DWC Form UR-01: “Application for Approval as Utilization Review Plan.”

Section 9792.7.1 is the regulation associated with the new DWC Form UR-01, which is one of three forms created under this rulemaking. This form constitutes the cover page of a UR plan when a UR plan is submitted for approval by the DWC, which, pursuant to SB 1160, has been granted approval authority over UR plans that modify or deny treatment requests. This form is essential to managing basic, relevant information applicable to a UR plan and will allow the DWC to better monitor and track UR plans which often undergo changes in an array of areas.

## § 9792.8.  Utilization Review Standards – Medically-based Criteria.

Section 9792.8 sets forth the medical treatment utilization schedule (MTUS) as the criteria to be applied at UR for determining whether requested treatment is medical necessary.

Subdivision (a) was amended for better syntax and to highlight the fact that the MTUS includes the methodology for evaluating medical evidence as set forth at section 5307.27 of the Labor Code. Text that included instruction on what guideline to apply prior to adoption of the MTUS was deleted as this is no longer relevant since the establishment of the MTUS. Also deleted was text regarding disclosure of the applied MTUS criteria in a UR decision that modified, delayed, or denied treatment. This text is being deleted because it is misplaced and redundant since such obligations are later required under proposed section 9792.9.5, below (Decisions to Modify or Deny a Request for Authorization). Deleted text based on the above included part of subdivision (a)(1) and all of (a)(2) & (3). Deletion of (a)(4) is addressed below in the discussion of subdivision (b).

Subdivision (b) was added to make clear that the requirements regarding use of the MTUS does not preclude authorization of treatment which may not be supported or addressed in the MTUS where medical circumstances warrant departure. This addition is necessary to clarify that claims administrators are not required to deny requests for treatment merely because a treatment is not squarely consistent with the MTUS, a position which had been causing confusion among some insurers. The addition of subdivision (b) also subsumes old subdivision (a)(4); as such, (a)(4) was deleted.

## § 9792.9.  Utilization Review ****Standards-Timeframe, Procedures and Notice Content - For Injuries Occurring Prior to January 1, 2013, Where the Request for Authorization is Received Prior to July 1, 2013.****

This section is being deleted in its entirety as no longer applicable since it only applied to requests for authorization of treatment received prior to July 1, 2013.

## § 9792.9.1.  Utilization Review– Receipt of Request for Authorization; Acceptance of Incomplete Request.

Section 9792.9.1 sets forth the parameters regarding if and when a request for authorization by a claims administrator has been received. Originally, section 9792.9.1 included all rules pertaining to the process of utilization review from receipt to various responses, which made it long and unwieldy. Therefore, it is being parsed out in this rulemaking to allow for ease of use, especially since the addition of rules concerning the 30-day and formulary exemptions to prospective UR would make it even longer.

Section 9792.9.1’s introductory text discussing the scope of application of these rules, and introductory language in subdivision (a) requiring a request for authorization to be on DWC Form RFA, will no longer be applicable under this rulemaking and is, therefore, being deleted.

Subdivision (a) now begins with subsection (1) as a needed renumbering. The words, “for purposes of this section” have been struck since to leave them would limit the following text to this section alone, which is incorrect given the parsing out of section 9792.9.1. Other amendments to subdivision (a)(1) and (a)(2) delete specific references to the DWC Form RFA, and replace it with a general reference to a “request for authorization” to accommodate the change in form (as well as the transition time between the two forms).

Subdivision (b) (which is a reorganization and amended version of current section 9792.9.1(c)(2)(A)) addresses the situation in which an incomplete Request for Authorization (“RFA”) is received, with completeness being defined at section 9792.6.1(u). The proposal would simplify the current, complicated rules that have caused confusion.

Specifically, in the current version, upon receipt of a DWC Form RFA that does not include certain information (i.e., identification of the employee and provider, identification of recommended treatment, substantiating documentation, and signature of requesting physician), or, in the case of a request for authorization that does not utilize the DWC Form RFA, does not clearly indicate “Request for Authorization” at the top of the first page of the document, does not list all requested medical services, goods, or items on the first page, or is not accompanied by substantiating documentation; a (UR) reviewer must either regard the request as complete and comply with UR timeframes or mark it as “not complete,” specify the reason for the finding, and return the request to the requesting physician no later than 5 business days from receipt. The UR timeframe would begin anew upon receipt of a completed RFA.

In the proposed version, the requirements for completeness are dealt with by cross-reference to the regulation that defines “completeness” for a request for authorization, and the instructions otherwise remain the same except for the indication that any request accepted as complete will subject the UR entity to penalties if such request is selected or otherwise included in an investigation. This change was necessary to ensure not only timely processing of treatment requests but to promote quality review as well, since a faster review of treatment requests that are incomplete does not typically yield better results as the treatment will usually be denied. This triggers an appeals path premised upon a treatment request that is incomplete, which ultimately ends up being ineffective, inefficient, and costly.

## § 9792.9.2. Utilization Review – Dispute of Liability; Deferral.

Section 9792.9.2 (currently section 9792.9.1(b)) addresses the situation when, at the time of receipt of an RFA, there is still a dispute over claim liability or the recommended treatment for reasons other than medical necessity. The text in proposed subdivision (a)(1) was amended to accommodate the change in the form of the request for authorization of treatment. Additionally, subsection (2)(A) was added to subdivision (a) to clarify that a claims administrator must comply with the requirements pertaining to a deferral decision when it is determined that Labor Code section 4610(k) precludes the claims administrator from having to conduct UR on the request. This ensures that such decisions are communicated in a timely and complete way. Subsection (2)(B) further clarifies that deferral, however, does not apply when such request unequivocally contains an opinion or statement by the requesting physician that there has been a change in facts material to the basis of the prior denial of such same treatment in which case the requirements for a denial or modification decision (at proposal 9792.9.5) applies. This is necessary to allow practical application of Labor Code section 4610(k) while balancing injured workers’ rights to medical treatment.

Because this is now a new section, the authority and reference sections are being added here (as well as to each subsequent new section that is part of current section 9792.9.1).

## § 9792.9.3. Utilization Review – Timeframes.

Section 9792.9.3 (currently section 9792.9.1(c)) addresses the timeframe in which a CA/URO must make a decision after receipt of a complete RFA. Introductory language was deleted as unnecessary since the title of the regulation indicates the subject matter.

Subdivision (a) is a renumbering of current section 9792.9.1(c)(1). References to the DWC RFA form were struck and replaced with a general reference to accommodate the change in form. Language was inserted to clarify that the first day in counting any timeframe requirement is the first normal business or working day after receipt of a completed RFA as opposed to just “the day after receipt” of an RFA.

Amendments to proposed subdivision (a) (i.e., current subdivisions 9792.9.1(c)(2)(A) & (B)) also include deletion of language instructing on what a CA/URO should do upon receipt of an incomplete RFA. This text is no longer necessary as this process has been simplified and addressed in section 9792.9.1(b).

Text from current subdivision 9792.9.1(c)(2)(A) & (B), which instructed on what a CA/URO should do upon receipt of an incomplete RFA, was deleted. This text is no longer necessary as this process has been simplified and addressed in section 9792.9.1(b).

Proposed subdivision (b) is a renumbering of current subdivision 9792.9.1(c)(3) and was amended to strike “delay” (see explanation above) and to update an old reference to the DWC Form RFA to accommodate the change in form (as well as the transition time between the two forms).

Proposed subdivision (c) is a renumbering of current subdivision 9792.9.1(c)(4). The word “delay” is being struck (see explanation above) and cross references to other subdivisions, which are changing as a result of this rulemaking, are corrected.

Proposed subdivision (d) is a renumbering of current subdivision 9792.9.1(c)(5). It strikes the word “delay” (see explanation above); and clarifies that the timeframe for making a decision on a retrospective RFA is triggered both by receipt of a retro RFA as well as receipt of information regarding rendered medical treatment. This change is necessary to address the reality that a bill issued subsequent to the rendering of treatment often includes some level of information for which a medical necessity decision can be rendered.

Subdivision (e) proposes an exception to these timeframe requirements for treatment that is exempt under the MTUS formulary. This is necessary to accommodate the separate timeframe rules that apply to exempt formulary drugs which are explained at proposed section 9792.9.8.

## § 9792.9.4. Utilization Review – Decisions to Approve a Request for Authorization.

Proposed section 9792.9.4 is a renumbering of current section 9792.9.1(d) and sets forth rules pertaining to UR decisions to approve a request for authorization of medical treatment.

Proposed subdivision (a) is a renumbering of current section 9792.9.1(d)(1). The proposal makes minor clarifications to the text and also includes as a requirement in a written decision to approve treatment, if applicable, an indication of the date the additional information, exam, or consultation was requested and received. This is necessary to better track and analyze timely processing of UR approvals where the history of the review included the need for additional information.

Subdivision (a)(2) proposes to require UR approvals of requested treatment, where applicable, to indicate that it applied to the generic version of a requested drug. This is necessary to provide accurate information and set expectations as to what is being approved to the requesting provider and patient where the request was for a brand name drug but did not indicate the need to dispense the drug as written. This will also help with determining eligibility for Independent Medical Review, a dispute resolution program offered whenever UR modifies or denies a treatment request.

Subdivision (a)(3) proposes to require UR approvals to indicate that, if applicable, the authorization of a drug is due to its exempt status on the MTUS Drug Formulary. This is necessary to encourage the use of the Drug Formulary, to educate physicians about it, and for potential tracking purposes.

Proposed subdivision (b) is a renumbering of current section 9792.9.1(d)(2). It makes syntactical changes and amends the possibility of communication by electronic mail to be secure and agreed-to by the parties. This amendment is necessary to conform to the statutory allowance for this form of communication. (See Labor Code section 4610(i)(4)(A).)

Proposed subdivision (c)(1) is a renumbering of current section 9792.9.1(d)(3)(A), and is necessary for proper organization.

Proposed subdivision (c)(2) is a renumbering of current section 9792.9.1(d)(3)(B). It deletes citations that are no longer relevant and generalizes the reference to a request for authorization due to the change in the RFA form. Text requiring that payment for a medical bill be submitted (on an RFA) within the 30 day timeframe as indicated in current section 9792.9.1(c)(5) in order to be considered a retrospective approval was deleted as being redundant of proposed regulation section 9792.9.3(d).

## § 9792.9.5. Utilization Review –Decisions to Modify or Deny a Request for Authorization.

Proposed section 9792.9.5 is a renumbering of current section 9792.9.1(e). It sets forth rules pertaining to utilization decisions to modify or deny a request for authorization of medical treatment.

Introductory text, appearing at current section 9792.9.1(e), was deleted since the topic of the section appears in the title and would otherwise be redundant. Renumbering of subdivisions was also necessary throughout this section.

Proposed subdivision (a) is a renumbering of current section 9792.9.1(e)(1) and deleted the word “delay.” See explanation above.

Proposed subdivision (c) is a renumbering of current section 9792.9.1(e)(3) and was amended to condition electronic mail communication if agreed to by the parties. This change is necessary to align with the statute (Labor Code section 4610(i)(4)(A)). The word “delay” was also struck to conform with a statutory change. (See explanation above.) Other changes represent a rewriting of the subdivision to clarify that written notice need only issue to the requesting physician if the initial communication to the physician was via telephone. Additionally, the rewritten version clarifies that written notice must issue to the injured worker and, if applicable the injured worker’s representative, regardless of the way the initial communication was made to the requesting physician. The prior version had been causing confusion as it was sometimes being read to mean that initial communication to the physician via facsimile or email did not require subsequent written communication to the injured worker or the injured worker’s representative.

Proposed subdivision (d) is a renumbering of current section 9792.9.1(e)(4), and is amended to clarify that the scope of this subdivision applies to retrospective denials based on medical necessity (as opposed to a lack of information); and also loosened the triggering event that requires communication of a written decision to deny or modify a retrospective request for authorization of treatment to include either the receipt of an RFA or receipt of information reasonably necessary to make a determination. This widening of the triggering event is necessary to account for the reality that, for retrospective requests, a claims administrator often first becomes aware of the retrospective request from the receipt of a bill or invoice for treatment already rendered.

Proposed subdivision (e) is a renumbering of current section 9792.9.1(e)(5) and sets forth the requirements pertaining to a UR decision to modify or deny a treatment request. It covers requirements relating to service of the decision letter, requisite signatures (which has been clarified to require the physician reviewer’s signature), and, lastly, content requirements, for which further elaboration is provided in the following subsections. The changes in the introductory language of this subdivision are minor and were made for better syntax.

Proposed subdivision (e)(1) is a renumbering of current section 9792.9.1(e)(5)(A)) was amended to omit reference to the current RFA form and instead refer to it generally to account for the fact that an RFA will be contained in the new PR-1 and may also take a narrative form.

Subdivision (e)(2) proposes to require a UR decision modifying or denying treatment request(s) to include, if additional information or tests or consultations had been requested, identification of the missing information (or requirement for a test or consultation), the details of the attempts made in obtaining the information, the manner in which such attempts were made, and, if applicable, the date on which the missing information (or result of a test or consultation) was first received. This information is necessary in a UR denial letter since, without it, denial of treatment based on a lack of information, which extends the timeframe requirement for a UR decision letter, is susceptible to abuse. Requiring a UR entity to set forth these details is necessary to curtail abuse and allows for transparency and a more efficient investigation process should such a case be captured in an investigation.

Proposed subdivision (e)(3) is a renumbering of current section 9792.9.1(e)(5)(B).

Proposed subdivision (e)(4) is a renumbering of current section 9792.9.1(e)(5)(C)) and specifies that the description of the specific course of proposed treatment is that which is set forth on the request for authorization (RFA). This specification is necessary to clarify where the treatment request ought to be and to emphasize the importance of the RFA.

Proposed subdivision (e)(5) is a renumbering of current section 9792.9.1(e)(5)(D).

Proposed subdivision (e)(6) is a renumbering of current section 9792.9.1(e)(5)(E).

Proposed subdivisions (e)(7) and (e)(8) splits up current section 9792.9.1(e)(5)(F) for better organization.

Subdivision (e)(7) takes the first portion of current section 9792.9.1(e)(5)(F) and adds language to require, when applicable, an explanation to account for a denial that is due to the need for further information, or an additional test, exam, or consultation (as opposed to medical necessity); and that the request will be reconsidered after receipt of the missing information. It also proposes to require a UR reviewing physician to directly address any contention made by the requesting physician indicating that prerequisite treatment should be overlooked or is irrelevant to the treatment request. These requirements were added to encourage meaningful consideration of the treatment and substantive discourse between the requesting and reviewing physician so as to reduce treatment delays and allow for better management of an injured worker’s industrial injury.

Proposed subdivision (e)(8) carries over the part of current section 9792.9.1(e)(5)(F) that was cut off from proposed subdivision (e)(7) and makes it its own requirement. The stricken portion was added to proposed subdivision (e)(7). These changes are helpful for better organization of the content requirements of a UR modification or denial letter.

Subdivision (e)(9) proposes to require a UR modification or denial letter to identify the URAC accredited entity who performed the UR and that is approved by the DWC. This requirement is necessary for proper oversight of UR entities whose structures are often complicated by affiliations with subsidiaries, parent corporations, and vendors. This requirement will allow the DWC (and the injured worker or his/her representative) to easily identify the entity responsible for the UR decision so that corrections can be addressed with the appropriate entity.

Proposed subdivision (e)(10) is a renumbering of current section 9792.9.1(e)(5)(G). The proposal strikes the last sentence (instructing about which IMR form to use prior to March 1, 2014) since, given the passage of time, it is now moot.

Proposed subdivision (e)(11) is a renumbering of current section 9792.9.1(e)(5)(H), which has been amended to indicate that the notification to the injured employee regarding the timeframe for submitting an IMR application is indicated on the second page of the application rather than being due 30 calendar days after service of the UR decision (this language was struck). This amendment is necessary to align with statutory changes to the UR and IMR timeframes with respect to formulary disputes.

Proposed subdivision (e)(12) is a renumbering of current subdivision 9792.9.1(e)(5)(I). The mandatory language has been amended to add the inclusion of Independent Medical Review as an option for appealing a UR denial or modification. The express inclusion of IMR as a way to dispute the outcome of a UR decision in the required mandatory language eliminates any ambiguity as to the fact that IMR is the mechanism of appeal of a UR decision.

Proposed subdivision (e)(13) is a renumbering of current subdivision 9792.9.1(e)(5)(J), and is required for proper organization.

Proposed subdivision (e)(14) is a renumbering of current subdivision 9792.9.1(e)(5)(K). The only changes include the deletion of the word “delay” (see explanation above); insertion of the word “physician” before “reviewer” where necessary for clarification; and the insertion of a comma to clarify the list of “reviewer, expert reviewer, or the medical director….”

Proposed subdivision (f) is a renumbering of current section 9792.9.1(e)(6) and its subsections.

Proposed subdivision (g) appears to be newly added, but is actually a reorganization of current subdivision 9792.9.1(h), which now appears as striked-through text under proposed section 9792.9.6. The only change in the proposal is the addition of the language, “…or another physician within the requesting physician’s practice group….” The addition of this language is necessary to comport with changes in the statute (at Labor Code section 4610(k)), which were added to close a loop hole whereby a physician whose request was denied or modified at UR would then ask another physician in his or her practice group to make the same request in order to circumvent the rule barring an RFA of the same treatment for 12 months where no documented, material change in facts underlying the UR decision has occurred.

## § 9792.9.6. Utilization Review – Extension of Timeframe for Decision.

Proposed section 9792.9.6 is a renumbering of current section 9792.9.1(f) and addresses the situation in which the claims administrator, due to a materially incomplete record, is unable to make a determination regarding medical necessity within the required timeframe. By statute, if the missing information falls into one of three types, the timeframe allotted for responding to a request for authorization of treatment may be extended.

Amendments to account for renumbering and corrected citations (for accuracy) as a result of this rulemaking are littered throughout this section and include the following: subdivisions (a)(1), (b)(1) & (2), (c)(1) & (2), and (d)(1), (2), & (3).

Proposed subdivision (a) is a renumbering of current section 9792.9.1(f)(1), and includes a citation change for accuracy.

Proposed subdivision (b)(1) is a renumbering of current section 9792.9.1(f)(2)(A) and includes a citation correction.

Proposed subdivision (b)(2) is a renumbering of current section 9792.9.1(f)(2)(B). The proposal corrects a citation, deletes a reference to the “DWC Form RFA” as that form will be phased out, and makes a few syntactic changes. The last sentence has also been struck since the anticipated date of a decision that depends on receipt of information which is not yet a part of the record is meaningless and unnecessarily complicated.

Proposed subdivision (c)(1) is a renumbering of current section 9792.9.1(f)(3)(A) and includes a citation correction. Additionally, the word “accepted” has been inserted as another way to describe a request for authorization (“RFA”) to conform to the design of the regulations allowing for acceptance of an incomplete RFA. Lastly, citation to another applicable regulation section has been inserted for completeness.

Proposed subdivision (c)(2) is a renumbering of current section 9792.9.1(f)(3)(B) and reflects citation corrections for accuracy. It also adds “physician” as a qualifier to “reviewer” to reduce the need to refer back to the definitions section. Additionally, text requiring communication that a request will be reconsidered when additional information is received was struck because it is redundant of language which was added to another proposed section (9792.9.5(e)(7)) covering this requirement.

Proposed subdivision (d)(1), which is a renumbering of current section 9792.9.1(f)(4), applicable to non-expedited prospective or concurrent utilization review, was amended to correct a citation. Additionally, descriptive text was deleted and replaced with reference to applicable regulations (referring to rules about approving, modifying, or denying requests), which was done for accuracy.

Proposed subdivision (d)(2), which is a renumbering of current section 9792.9.1(f)(5), applicable to expedited utilization review, was amended in the same way and for the same reason as indicated in proposed subdivision (d)(1), above.

Proposed subdivision (d)(3), which is a renumbering of current section 9792.9.1(f)(6), applicable to retrospective utilization review, was amended in the same way and for the same reason as in proposed subdivisions (d)(1) and (d)(2), above.

Subdivision (g) was deleted as it is redundant of requirements outlined at proposed section 9792.9.5(e)(2).

Subdivision (h) appears to have been deleted, but has actually been reorganized. It now appears at proposed section 9792.9.5(g).

## § 9792.9.7. Utilization Review – Medical Treatment – First 30 Days of the Date of Injury.

Section 9792.9.7 sets forth rules applicable to the exemption from prospective UR for certain treatment rendered within thirty days of the date of injury under SB 1160 (“30-day exemption”) which has been written into Labor Code section 4610. This exemption is relatively new to the utilization review system in workers’ compensation which, prior to this change, required all treatment (other than emergency services) for which a guarantee of payment was sought (i.e., preauthorization) to undergo prospective utilization review if required by the claims administrator.

Subdivision (a) proposes an outline to the conditions necessary for the 30-day exemption to apply. The first four subsections are conditions as stated in the statute at Labor Code section 4610(b), but have been broken down into subsections. Subsection (5) is a restatement of Labor Code section 4610(d).

Subdivision (b) proposes a list of treatments which are not subject to the 30-day exemption. All of the listed treatments in subsections (1) through (7) follow the listed exceptions in the statute at Labor Code section 4610(c).

* Subsection (1), essentially, restates Labor Code section 4610(c)(1) and would be substantively the same.
* Subsection (2) proposes to expound on the inpatient and outpatient nonemergency surgery exception (to the 30-day exemption to prospective UR) to include nonemergency surgery and surgical services in any setting, including, a hospital, clinic, ambulatory surgical center, and physician’s office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. Subsection (2) further proposes to define "surgery" for the purpose of this section to mean 1) any procedure set forth in the Surgery section of the American Medical Association’s Current Procedural Terminology (CPT®) pursuant to the physician and non-physician practitioner fee schedule at section 9789.12 et seq., and 2) any Healthcare Common Procedure Coding System (HCPCS) procedure code defined as “surgery” in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule at section 9789.30 et seq. Because nonemergency inpatient and outpatient surgery includes a broad scope of services, it is necessary to be as specific as possible to curtail abuse and prevent loopholes.
* Subsection (3) proposes to expound on the psychological treatment services exception (to the 30-day exemption to prospective UR) to also include psychiatric treatment as an equivalent, and to set forth that such services includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective UR under the MTUS Drug Formulary. Because “psychological services” can include a range of services, it is necessary to be as specific as possible to curtail abuse and prevent loopholes.
* Subsection (4) proposes to clarify that the home health care services exception (to the 30-day exemption to prospective UR) includes health care and other medically necessary services provided to an injured worker in the residential setting. This specificity is necessary in order to curtail abuse as much as possible and prevent loopholes.
* Subsection (5) proposes to exclude imaging and radiology services, except for X-rays, from the 30-day exemption to prospective UR. This exemption is lifted from the statute as-is. It is necessary to include it here for the sake of providing a complete list of services or treatments that are excluded from the 30-day exemption to prospective UR.
* Subsection (6) proposes to expound on the statutory exemption for durable medical equipment (DME) that has a total combined value of more than $250, as determined by the official medical fee schedule (OMFS). The regulation would add prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for an expected course of treatment is greater than $250 per the OMFS. The regulation would further clarify that this exception applies to unlisted items that fall under this category where the billed amount is greater than $250.
* Subsection (7) proposes to expound on the statutory exception (to the 30-day exemption to prospective UR) pertaining to electrodiagnostic medicine, including, but not limited to electromyography and nerve conduction studies. The regulation would define electrodiagnostic medicine as a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. The regulation would state that this includes, but is not limited to, procedures set forth in the American Medical Association’s Current Procedural Terminology (CPT®) Medicine section, under the subheading “Neurology and Neuromuscular Procedures,” and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis. It is necessary to specify and define the treatments which fall under this exception (to the 30-day exemption to prospective UR) to curtail abuse and to close loopholes where possible.
* Subsection (8) of subdivision (b) proposes to include spinal injections to the list of treatments that are not subject to the 30-day exemption to prospective UR. Because spinal injections would not typically be rendered within 30 days of injury (unless on an emergency basis for which other rules would apply), any recommendation for such treatment carries the probability that it is not medically necessary and is, therefore, added to the list of treatments not subject to the 30-day exemption.

Subdivision (c) proposes remedies available to the claims administrator who finds, upon retrospective review, that the provider has a pattern and practice of rendering exempt treatment in a manner inconsistent with the guidelines. This is necessary to carry out the statutory design of the 30-day exemption and the checks on that exemption built in by the legislature. (See Labor Code section 4610(f).)

Subdivision (c)(1)(A) proposes to establish the first remedy available to a claims administrator who determines that a physician has a pattern and practice of rendering exempt treatment inconsistent with the guidelines, which is the removal of the physician’s ability to render treatment exempt from prospective UR to any injured worker whose claim is adjusted by the claims administrator. This part is lifted from the statute and is repeated here as it is necessary to provide logical and comprehensive coverage of the rules pertaining to this topic. Subdivision (c)(1)(A) further proposes to set forth the process by which a claims administrator may exercise this remedy, essentially requiring written notice and content requirements. This is necessary for consistent application of this remedy and to ensure an orderly process.

Subdivisions (c)(1)(B) & (C) list the other statutory remedies available to a claims administrator who determines that a physician has a pattern and practice of rendering exempt treatment inconsistent with the guidelines. These remedies are not different from what is already in the statute but it is necessary to include them here to allow for comprehensive coverage of the rules on this topic.

Subdivision (c)(2) proposes to set forth the definition of “pattern and practice” in the context of a provider who renders treatment under the 30-day exemption in a way that is inconsistent with the guidelines. It is defined under the proposal as being when a provider fails to render treatment consistent with the MTUS for 20 separate and unrelated medical services or goods with 10 or more injured workers over the course of 3 months; or for eight separate and unrelated medical services or goods with 2 or less injured workers within a month. This standard is based on internal data tallying the number of unique claims (with each unique claim representing an injured worker) handled by a workers compensation provider in the year 2018. Due to the great disparity in number of unique claims handled by providers in the comp system, two criteria were designed in an attempt to capture a pattern and practice for providers who manage a large caseload versus providers who have a more concentrated, lower-volume practice. The use of the words “separate and unrelated” were used to signify that the count should consider treatment that is unique in time, but not necessarily unique in treatment (such as where the need for pain medication is repeated), and that is also not a treatment or service that is conditioned on the necessity of a related service or treatment (as in, for example, where standard medical care would require the need for antibacterial ointment to prevent an infection after suturing). Setting forth such a definition is necessary to provide meaning to the words “pattern and practice” in the context of a provider who renders treatment under subdivision (a).

Subdivision (d) proposes to set forth the remedy available to a claims administrator when a physician fails to render exempt treatment without timely submitting the “Doctor’s First Report of Occupational Injury or Illness” or when a physician fails to timely submit a complete request for authorization. This part of the regulation is lifted from the statute and is necessary to repeat here to provide logical and comprehensive coverage of the rules pertaining to this topic. Subdivision (d) further sets forth the notice and content requirements a claims administrator must follow in order to exercise this option. These rules are necessary for consistent application of and process for this remedy.

Subdivision (e) proposes that disputes over the remedies a claims administrator exercises under subdivisions (c) and (d) are to be resolved at the Workers’ Compensation Appeals Board. This is necessary to allow for a process of appeal and due process.

## § 9792.9.8. Utilization Review – MTUS Drug Formulary.

This section proposes rules applicable to utilization review of medications on the MTUS Drug Formulary, which contain its own set of exemptions to prospective UR with respect to medication and, additionally, are required to be processed on a shortened timeframe as required by Labor Code section 4610. Because of the particular set of rules which apply to each exemption, it is critical to have carefully drafted rules to instruct stakeholders on the handling of these matters.

Subdivision (a) proposes rules pertaining to drugs on the MTUS Drug List that are exempt from prospective review. Subsection (1) identifies the different categories of exempt drugs by cross-referencing the applicable provisions in the formulary regulations. They are included to provide context and a logical layout of UR rules pertaining to this particular subject matter, i.e., the formulary exemption to prospective UR. Subsection (2) clarifies that, despite its exempt status, an exempt drug as identified in subsection (1), must still be listed in a request for authorization submitted to the claims administrator. This is necessary because, without the identification of an Exempt Drug on a request for authorization, a claims administrator would not be able to determine whether to exercise its right to conduct retrospective review of the exempt drug as allowed by law.

Subdivision (b) proposes requirements for prospective UR of non-exempt drugs, i.e., drugs listed on the MTUS Drug List (see 8 CCR section 9792.27.15) that are not identified as exempt in subdivision (a). It sets forth the timeframe and standards applicable for UR of non-exempt drugs. It instructs that prospective UR is required for requests of these types of drugs regardless of whether the request fell within the 30-day exemption time period. This is a reiteration of the statute and is necessary for context and to provide comprehensive coverage of this complicated area of law.

Subsection (1) of subdivision (b) further proposes a 5-day timeframe for UR of these types of requests and instructs on how a UR physician reviewer may go about requesting for more information, if necessary (in (1)(A) and (1)(B)), for these types of requests. It proposes (in (1)(A)) that a request for additional information must be made within 2 business days of receipt of the request and, (in (1)(B)) if not received within 5 business days of the request for information, must be denied in accordance with other applicable sections pertaining to the denial (or modification) of a request. It is necessary to set forth the time period pertaining to this process because the statute is silent regarding the claims administrator’s ability to request additional information for these types of treatment requests. The 2-business-day timeframe is reasonable given the strict 5-business-day timeframe for the issuance of a UR decision on these types of requests.

Subsection (2) proposes that the outcome or decision for such requests follow the procedures set forth at the regulation sections pertaining to approvals or modifications and denials. This express instruction is necessary for completeness and clarity in this complicated area of law.

Subsection (3) proposes to expressly set forth the fact that the extension of time for UR that ordinarily applies to treatment requests (at section 9792.9.6) does not apply to treatment requests under this section (i.e., non-exempt drugs listed on the MTUS Drug Formulary). This express instruction is necessary for completeness and clarity in this complicated area of law.

Subdivision (c) proposes requirements for prospective UR of drugs not listed on the MTUS Drug List (i.e., an unlisted drug). The statute (Labor Code section 4610(i) is ambiguous as to whether the strict 5-business-day timeframe for “treatment covered by the formulary” applies to drugs that are not listed on the Drug Formulary (8 CCR section 9792.27.15). The DWC has determined to exempt drugs not expressly listed on the Drug Formulary from the strict 5-business-day timeframe due to the rationale that drugs not listed on the formulary may be those that are less frequently prescribed for work place injuries and, therefore, may require more time to determine medical necessity. As such, subdivision (c) is necessary to make this distinction and instruct accordingly.

Subdivision (d) proposes that when a request for authorization of treatment includes both a listed formulary drug and non-drug treatment, which have differing review timeframes, the request should be handled according to processes that apply to the non-drug treatment. This instruction is necessary to account for the practical reality that a treating physician will often request both non-drug and drug treatments in a single request for authorization of treatment.

Subdivision (e) proposes a remedy of non-payment where a formulary-exempt drug was found to be not medically necessary insofar as it is not included in an RFA that falls within thirty days of the date of injury. This is necessary because, while the legislature expressly laid out the remedies available for treatment exempt under the 30-day exemption, which does not include denial of payment, it did not do so with respect to exempt formulary drugs (that do not fall within the 30-day exemption) which are later found to be inconsistent with treatment guidelines. Typically, where treatment is found to be not medically necessary, payment is withheld. Therefore, this rule is necessary to clarify and reconcile the disparate remedies.

Subdivision (f) proposes rules pertaining to dispute resolution and the appeals process for modifications or denials of formulary drugs. Subsection (1) states that a decision to modify or deny an RFA under this section based on medical necessity shall be reviewed only through either the claims administrator’s voluntary internal appeals process or via independent medical review. Subsection (2) states that a dispute based on anything other than medical necessity shall only be resolved through either the claims administrator’s voluntary internal appeals process or by the Workers’ Compensation Appeals Board. Subsection (3) states that if a modification or denial of an RFA is based on both medical necessity and a non-medical necessity reason, then the non-medical necessity dispute shall be resolved first. These rules are declaratory of existing law but are necessary to repeat here for clarity and completeness given the legislative changes in the utilization review process to this particular set of treatment.

Subdivision (g) proposes rules applicable to when a formulary drug is included in a request for authorization within thirty days from the date of injury (i.e., during the 30-day exemption period). This situation is particularly complex because there are many rules specific to both the 30-day exemption and the formulary.

Subdivision (g)(1) reiterates the need for the treating physician prescribing a drug within the 30-day exemption timeframe to complete a “Doctor’s First Report,” and subdivision (g)(2) expressly instructs that prospective UR is not necessary for a drug that is exempt on the formulary when prescribed or dispensed within the 30-day exemption timeframe. Although this proposal is a restatement of existing law, they are necessary to provide comprehensive coverage of what is required when a drug is prescribed within the 30-day exemption timeframe.

Subdivision (g)(3) proposes to make clear that for a drug that is not exempt on the MTUS Drug List, prior authorization via utilization review (if required by the claims administrator) is required. This is necessary to provide complete and comprehensive instruction on the rules pertaining to utilization review of drugs that are prescribed or dispensed within the 30-day exemption timeframe.

Subdivision (g)(4) reiterates the rule consistent with statutory changes under SB 1160 that treatment rendered within thirty days of the date of injury are exempt from prospective UR, including drugs which are exempt on the formulary. For such exempt treatment, retrospective UR can only be conducted for the purpose of determining whether the treatment was consistent with the MTUS guidelines. Subdivision (g)(4)(A) further instructs that a finding that the drug was dispensed inconsistently with the MTUS cannot be a basis for the denial of payment, and instead, under subdivision (g)(4)(B), may be used to establish a pattern and practice of rendering treatment that is not medically necessary under the guidelines. These rules are necessary to provide a complete picture of all the rules pertaining to the particularly complicated area of utilization review of formulary drugs that are prescribed within the 30-day exemption timeframe.

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

Section 9792.10.1 currently identifies and sets forth rules pertaining to the process of appealing a UR decision that modifies or denies a treatment request.

Current subdivision (a) was deleted as unnecessarily redundant of existing statutory law.

Subdivision (a)(1) proposes the timeframe and method by which an eligible party may file an IMR application. The 30-day timeframe is from existing law and is applicable to all treatment requests subject to prospective UR (except for formulary disputes, addressed in the next proposed subsection, which have been fast-tracked by the legislature). This is lifted from the statute and is included for the purpose of presenting a complete IMR application process.

Subdivision (a)(2) proposes that where a UR decision only modifies or denies a formulary drug, a shortened timeframe (10 days) for appealing the decision to IMR applies. This is necessary to implement the faster timeframe established by the legislature pertaining to formulary drugs and to offer a solution to the scenario in which a UR decision addresses both a drug and non-drug treatment in one decision letter.

In subdivision (b), text that was rendered redundant upon the proposal of subdivision (a)(1) was deleted. This is necessary to be as concise as possible and for better organization.

Subdivision (c) is a renumbering of current subdivision (b)(2) and sets forth rules pertaining to who can apply for IMR. This subdivision’s subsections were renumbered where applicable.

Additionally, proposed subdivision (c)(1)(A) was rewritten to reference the statutory section applicable to designation of an agent and delete language that would be redundant of the cited statute. This is a non-substantive change and is included for comprehensive coverage of these rules.

Additionally, the word “delay” in proposed subdivision (c)(1)(B) was struck. (See explanation above.)

Additionally, proposed subdivision (c)(2) (which is current section (b)(2)(B)), allowing for a provider of emergency medical treatment to be eligible for filing an IMR application, was amended to reference the applicable statutory section and delete language that would be redundant with the cited statute. This is a non-substantive change and is included for comprehensive coverage of these rules.

Proposed subdivision (d) is a renumbering of current subdivision (b)(3) and is necessary for proper order.

Proposed subdivision (e)(1) renumbers current subdivision (c)(1) and amends the text for better syntax. It is substantively unchanged. In subsection (2) of this subdivision, the word, “delaying” is struck (see explanation above), and citations which changed as a result of renumbering were corrected. These changes are necessary for clarity and accuracy.

Proposed subdivision (f)(1) renumbers current subdivision (d)(1), and makes a correction to a reference to the time limit a claimant has for filing an IMR application. This change is necessary for consistency.

Additionally, proposed subdivision (f)(2), which renumbers current subdivision (d)(2), makes edits to set forth a 10-day timeframe for completion and issuance of an internal UR appeals decision where such decision only pertains to a drug listed on the MTUS Drug List (i.e., formulary). This was added to align with the legislature’s decision to fast-track disputes covered by the formulary. Since the legislature assigned a shortened timeframe for the submission of an IMR application (10 days from issuance of an adverse UR decision letter) and for the time by which the IMR reviewer must issue a final determination for formulary disputes (5 days after receipt of a request for review and supporting documentation, which ends up being longer since the IMR organization must allow a claims administrator approximately 15 days to submit documentation), the 10-day timeframe assigned for the completion and issuance of an internal UR appeal decision seemed reasonable in that the internal UR appeals process would conclude prior to the completion of IMR (and would thereby allow the opportunity for withdrawal of the IMR in the event of a reversal of the original UR decision). (See Labor Code section 4610.5).

Additionally, proposed subdivision (f)(3), which renumbers current subdivision (d)(3), makes corrections to citations which would change under this proposal (due to renumbering and/or the addition of section numbers).

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

Section 9792.10.2 is the section number assigned to the DWC Form IMR. A new, updated version is proposed in this rulemaking. A new version is necessary to align with the acceleration of timeframes associated with utilization review and dispute resolution for formulary drugs; and for correcting non-substantive errors in the prior version. Due to formatting difficulties resulting from recently enforced accessibility requirements, a new version is replacing the old version despite the two being substantially similar. A breakdown of each change on the proposed form and the specific purpose of each change is as follows:

* Instructions at the top of the form are bulleted instead of listed numerically. This is necessary for better layout.
* The third bullet adds in capital letters that the deadline for filing this form is on page 2. This is necessary to convey critical information as well as to highlight the importance of the filing deadline.
* Three additional checkboxes (“Retrospective for Exempt Treatment (Non-Drug),” “Retrospective for Exempt Treatment (Drug),” and “Medication Only – MTUS Formulary Drug List”) were added as options for “Type of Utilization Review.” The options for “Retrospective for Exempt Treatment (Non-Drug)” and “Retrospective for Exempt Treatment (Drug)” were added to accompany the statutory allowance for claims administrators to conduct retrospective UR for treatment which are exempt from prospective UR and to which other remedies are available upon a finding, retrospectively, that the exempt treatment was not medically necessary. Differentiating between drug and non-drug exempt treatment is necessary because it determines the timeframe within which the IMR organization must issue a final decision. The option for “Medication Only – MTUS Formulary Drug List” was added to accompany the newly accelerated timeframes that are attached to dispute resolution of formulary drugs.
* All address boxes on the form (for employee, claims administrator, and requesting physician) are being separated into separate field boxes (such as address containing numerical portion, city, state, and zip code). This is necessary to assist with administrative functions as it will make electronic searches easier and more accurate.
* The field for “Employer Name,” which currently appears in the employee information section, is being moved into the section relating to the claims administrator. This will reduce any confusion that may have resulted from the address and telephone field for an employee being placed next to the employer field box. It also makes more sense for the “Employer Name” to be grouped with the claims administrator information since the claims administrator is associated with the employer.
* In the Disputed Medical Treatment section, “Date of UR Determination Letter” was changed to “\*Mailing Date of the Utilization Review Determination Letter.” This is necessary for proper calculation of the deadline for submission of the IMR application since the IMR application deadline runs from the date of mailing of the UR determination letter rather than the date printed on it. The addition of the asterisk is required because it is referenced in the last section of the form regarding the deadline for filing of the application.
* In the Disputed Medical Treatment section, the question relating to whether the claims administrator is disputing liability of the requested treatment has been slightly reworded for clarity.
* In the Disputed Medical Treatment section, the requested medical treatment in dispute must be listed. For clarity, a small grammatical change was implemented and the word “drug” was expressly included in the instruction preceding the list.
* At the end of the form, a section titled “Deadline for Filing IMR Application” was added. This is necessary to accommodate the accelerated timeframe for disputes over formulary drug treatment and to clearly inform applicants of their rights.

The IMR Application Instructions, which is attached to the IMR Application Form, has also been amended to align with statutory changes relating to the acceleration of the utilization review and dispute resolution timeframe for formulary drugs. Additional changes were implemented for better clarity and accuracy. The changes are as follows:

* In the first paragraph, an added descriptor was included in parenthesis to clarify that the written determination letter is sometimes referred to as a UR determination letter.
* In the second paragraph, the word “DELAY” was struck. (See explanation above.)
* In the third paragraph, wording was changed for clarity.
* The second bullet after the third paragraph includes changes to clarify instructions about the authorized representative designation form.
* The third bullet after the third paragraph includes minor, semantic changes for clarity.
* The fifth bullet after the third paragraph includes minor, semantic changes for clarity.
* The sixth bullet after the third paragraph includes minor, semantic changes for clarity.

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

Section 9792.10.3 currently sets forth the criteria involved in determining eligibility of an IMR application after it has been submitted by the claimant/employee. The only change proposed in this section is at subdivision (a)(6) where a citation was corrected to accommodate this rulemaking.

## § 9792.10.4. Independent Medical Review – Assignment and Notification.

Section 9792.10.4 currently sets forth the process for assignment of the IMR application, notification of assignment by the IMR organization to the employee and other relevant parties, and the process for the IMR organization (“IMRO”) to seek relevant medical records pertaining to the treatment dispute. After an IMR application has been delegated to an IMRO, it requires the IMRO to send out a notification to the relevant parties containing enumerated information as instructed, including the time limit allowed for the submission of records.

The proposal amends subsection (5) of subdivision (b) to specify that, for a dispute involving only a drug or drugs listed on the MTUS Drug Formulary, records be submitted within 10 calendar days of the date designated on the notification for review, or 15 calendar days (or 12 calendar days if the notification was provided electronically) for any other type of dispute. This is necessary to align with the legislative mandate that disputes covered under the MTUS Drug Formulary be resolved faster. Additionally, text specifying the maximum amount of penalties for the failure of a claims administrator to promptly provide records has been struck as unnecessary and redundant since the text already references the Labor Code section authorizing the penalty and repeats what is already included in the schedule of penalties within section 9792.12.

## § 9792.10.5. Independent Medical Review – Medical Records.

Section 9792.10.5 sets forth rules pertaining to the submission of medical records by a claims administrator once an application for IMR has been assigned to an IMR organization. The proposal suggests citation edits to accompany renumbering under this rulemaking and are necessary for accuracy. Discussion on the proposal’s other amendments follow below.

Subdivision (a) sets forth the time and substance requirements for what claims administrators’ must submit upon receipt of notification of assignment of an IMR application. Subsection (1) of subdivision (a) proposes to shorten the timeframe allowed for a claims administrator to submit documents after receipt of a notice by the IMR organization that a drug-only dispute has been assigned for IMR from 15 to 10 days. This change is necessary to align with the legislative mandate that disputes about the necessity of drug treatment be resolved faster. The proposal also requires electronic submission of the requisite documents by the claims administrator. This is necessary to expedite resolution of disputes regarding medical care to injured workers and is also reflective of current industry standards. Other changes were non substantive, syntactical edits.

Subdivision (a)(1)(A) proposes to require that, in addition to copies of relevant medical records, a list of the reports also accompany the records submitted by the claims administrator. Because the medical records relevant to a treatment dispute are often voluminous, and because the timeframe for review is very tight, requiring the claims administrator, who has already been collecting and organizing the records, to submit a list along with the records will help to expedite the IMR process.

Subdivision (b) sets forth the time and substance requirements for what an employee (or other qualified person) may submit upon receipt of a notice of assignment of an IMR application. Subsection (1) of subdivision (b) proposes to shorten the timeframe allowed for an employee (or other qualified person) to submit documents after receipt of a notice by the IMRO that a drug-only dispute has been assigned for IMR from 15 to 10 days. This change is necessary to align with the legislative mandate that disputes about the necessity of drug treatment be resolved faster.

Subdivision (c) states that the IMRO may reasonably request additional information or documentation necessary to make a determination regarding the medical necessity of treatment. It also sets forth the timeframe by which a party must respond to a request for additional information by the IMRO. The proposal amends this subdivision to require the submission of additional documentation identified and required by the IMR) from five to two business days where a dispute only involves a drug or drugs listed on the MTUS Drug Formulary. This is necessary to align with the legislative directive that disputes over drugs listed on the MTUS Drug Formulary be resolved faster.

## § 9792.10.6. Independent Medical Review – Standards and Timeframes.

Section 9792.10.6 currently sets forth the substantive and procedural requirements with respect to independent medical review.

Subdivision (b)(2) was amended to delete an unnecessary comma, a grammatical error, and to correct a reference to another section which would change under this rulemaking. This is necessary for accuracy.

Subdivision (g) instructs on the rules regarding timeframes in which a final (substantive) determination of medical necessity shall issue.

Subdivision (g)(1) amends the existing rule to carve out disputes concerning only drugs listed on the MTUS Drug List from the requirement that a final determination be issued within 30 days from receipt of the IMR application and supporting documentation. This is necessary to comport with the legislative mandate that such disputes be resolved on a shortened timeframe both while at UR and, if applicable, at IMR. Subdivision (g)(1)(B) would also be amended to add the word, “independent” as an adjective to “medical review” for clarity. This is a non-substantive change.

As a necessary counterpart to the changes in subdivision (g)(1), subdivision (g)(4) was added to instruct that IMR over disputes of drugs listed on the MTUS Drug List be completed and a final determination issue within five business days of receipt of the IMR application and supporting documentation.

## § 9792.10.8. Independent Medical Review – Payment for Review.

Section 9792.10.8 sets forth the payment requirements associated with independent medical review, which is borne by claims administrators.

The proposal would delete subsections in subdivision (a) as they reflected the cost of IMR in years past (2013 and 2014) and are, therefore, no longer relevant. In place of the deleted subsections are proposed subsections (1), (2), and (3) in subdivision (a). Subsection (a)(1) sets forth the cost of an IMR (regardless of type); subsection (a)(2) sets forth the cost of IMR when an application is withdrawn; and subsection (a)(3) sets forth the costs pertaining to re-reviews ordered under Labor Code section 4610.6(h).

Unlike the current regulation, proposed (a)(1) does not distinguish costs based on the credentials of the reviewer, whether a review is regular or expedited, or whether there was more than one reviewer on the case. These distinctions were removed based upon feedback from the independent review organization indicating that the costs are the same regardless of these factors. The proposal also reflects lower costs for IMR, which have been made possible by operational tweaks implemented for efficiency by the review organization.

For withdrawn reviews, the regulation at subdivision (a)(2)(B) was amended to clarify that termination of a case during, and not merely subsequent to, the records’ submission process would not qualify as a withdrawal that lowered the cost of the review. This amendment is necessary to align with costs incurred by the independent review organization.

For re-reviews, the proposal would state at subdivision (a)(3) that the first re-review is free of charge, but that subsequent re-reviews (on the same IMR case) would incur a fee of $295.00. This amount was provided by the independent review organization as the reasonable compensation required for conducting multiple re-reviews for a single case.

## § 9792.11. Investigation Procedures: Labor Code § 4610 Utilization Review Violations.

Section 9792.11 sets forth the procedures for utilization review investigations under the authority granted to the Administrative Director at Labor Code section 4610(p). Large organizational changes to this section have been made such that sections which appear to have been added are, rather, a rearrangement of existing regulations. These changes are included in the explanations below. Another significant change to this section is the removal of a performance rating assigned to an investigation subject at the conclusion of its investigation, which was thought to unnecessarily complicate the process. These proposed regulations reflect a more straight-forward penalty schedule (see section 9792.12), the summary of which would be posted on the Division’s website at the conclusion of an investigation.

Subdivision (a) was amended to include language from subdivision (b). Because subdivision (a) sets forth the purpose and scope of a UR investigation, inclusion of language from subdivision (b) accounting for the potential overlap of a UR investigation with a claims audit (and penalties) under Labor Code section 129 and 129.5 within subdivision (a) is more sensible. Text to indicate that an investigation can apply to an entity that performs only part of the UR process was also added. This is necessary to clarify the scope of a UR investigation and to close a loophole used by some UR entities, who, by contracting to perform only part of the UR process, attempt to evade an investigation.

Proposed subdivision (b) is a condensed version of current subdivision (f), which sets forth as a general matter the consequence of penalties for noncompliance as allowed under Labor Code section 4610(p). Because it has the nature of setting ground rules for utilization review investigations, its arrangement to appear near the top of the section is more appropriate.

Proposed subdivision (c), which is current subdivision (i), sets forth the applicable time period to which these investigation regulations attach. (Current subdivision (c) is now proposed subdivision (g).) Because this provision informs about the parameters of an investigation, it is more appropriately placed near the start of the section.

Proposed subdivision (d), which is current subdivision (h), informs that the Administrative Director may also use parts of the Government Code to determine whether violations have occurred. Because this provision is introductory in nature (in that it tells potential investigation subjects about other laws at the disposal of the Administrative Director), it is more appropriately placed at the start of the section.

Proposed subdivision (e), which is current subdivision (g), sets forth instruction for the potential situation in which a UR investigation overlaps with a profile audit review (i.e., claims audit). The only change in text is to the email address (from DWCManagedCare@dir.ca.gov to DWCUR@dir.ca.gov) for which UR complaints should be submitted as the DWC has its own mailbox specifically dedicated for UR issues. Because this provision is generally related to the scope of a utilization review investigation, it is more appropriately placed at the start of the section among other subdivisions with the same purpose.

Proposed subdivision (f), which is current subdivision (e), informs as to the handling of UR complaints. Because a complaint can also substantiate an investigation and violation, it is more appropriately placed here among other subdivisions that inform about the scope of UR investigations. No changes have been made to the text.

Proposed subdivision (g) is a renumbering of current subdivision (c). The introductory text was amended to include the possibility of an on-site investigation at any location where utilization review processes occur. This is necessary to allow for full investigatory powers concomitant with approval authority newly granted to the Administrative Director by the legislature.

Further amendments include the consolidation of current subdivisions (c)(1) and (2) into proposed subdivision (g)(1) and (2). This subdivision is now organized so that the focus is on the type of investigation (i.e., routine or target) rather than on the type of organization that is being investigated, which contained a large amount of redundancy.

Subdivision (g)(1), as proposed, would focus on routine investigations. It has been amended to reflect text needed to account for differences that apply to the situation in which a claims administrator (instead of a stand-alone UR organization) is the subject of a UR investigation, which is currently reflected in subdivision (c)(2)(A).

Subdivision (g)(2), as proposed, would focus on target investigations. The section regarding Return Target Investigations has been deleted since it was triggered when an investigation subject did not at least receive an eighty-five percent performance rating, and the performance rating aspect of UR investigations is being removed under this rulemaking. Additionally, the trigger for a Target Investigation is defined broadly such that it can include the situation where a subject has been identified as having systemic problems with its UR program. As such, this subsection, as proposed, would focus only on Target Investigations and has been amended to reflect such.

Proposed subdivision (h) is a reorganization of current subdivision (q), and sets forth the process for beginning a Target Investigation (which includes what was known as a Special Target Investigation). Because it is procedural in nature and is being included under the umbrella of a Target Investigation, it is better placed here, prior to regulations that delve into the substantive aspects of an investigation.

Proposed subdivision (i) is a renumbering of current subdivision (d), and sets forth the table which will be used for the selection of files. This table was amended to allow for a slightly more robust investigation by increasing the number of files subject to investigation of entities that receive the greatest number of treatment requests. This is necessary to allow for a deeper look at the entities that conduct the greatest number of utilization review while balancing the resources available to the Division of Workers’ Compensation (“Division”).

Subdivision (j) proposes to allow for the selection of additional files where the first set are incomplete or otherwise invalid. This is necessary to allow for a complete and robust review which will allow the Division to have greater investigatory oversight of entities conducting utilization review.

Current subdivision (e), which appears struck, has instead been reorganized to appear at proposed subdivision (f). (See above.)

Current subdivision (f), which appears struck, has instead been reorganized to appear at proposed subdivision (b). (See above.)

Current subdivision (g), which appears struck, has instead been reorganized to appear at proposed subdivision (e). (See above.)

Current subdivision (h), which appears struck, has instead been reorganized to appear at proposed subdivision (d). (See above.)

Current subdivision (i), which appears struck, has instead been reorganized to appear at proposed subdivision (c). (See above.)

Subdivision (k), as proposed, is a renumbering of current subdivision (j), was amended to strike text that are no longer relevant and add text where needed based on changes made for the purpose of simplifying the investigation rules. These changes are required to maintain consistency throughout the investigation regulations.

Subdivision (k)(1), as proposed, is a renumbering of current subdivision (j)(1), and sets forth the specific information required at the outset of an investigation where the investigation subject utilizes an electronic system for intake of treatment request. An amendment was made to language circumscribing the treatment requests identified for investigation as those received at an investigation site as opposed to those received generally by the investigation subject (regardless of situs) to close any loophole that may have been exploited by a literal interpretation of such language. Clarification was added to the disposition information required of every file selected for investigation, and text was added to require the selected files to be produced in a complete and organized fashion. These changes are necessary to ensure robust enforcement of UR entities and to facilitate an orderly and expeditious investigation process.

References to the word “delay” (or forms of “delay”) were struck in proposed subdivisions (k)(1), (3), and (4). (See explanation above.)

Subdivision (k)(5) proposes to require documentation of accreditation during the investigation process. This is necessary as part of the Division’s oversight authority to ensure that all UR entities which modify or deny treatment requests have the requisite accreditation.

Subdivision (l) is a renumbering of current subdivision (j)(5) and was amended for better sentence structure and to allow the Division to obtain documents relevant to accreditation when such additional documentation is required during an investigation. This is necessary as part of the Division’s oversight authority to ensure compliance with UR rules.

Proposed subdivision (m) is a renumbering of current subdivision (k), and corrects a citation to a subdivision changing under this rulemaking. It also adds a timeframe for when additional documentation, if needed, shall be submitted to the Division. This is necessary to ensure that the Division is able to perform its oversight duties in a timely fashion.

Subdivision (n) is newly proposed in order to allow the Division to capture a minimum percentage of files (40%) in which a treatment request was modified or denied as part of its investigation. The rule would also allow the Division to increase the time span from which files are selected from 3 months to a period of up to 6 months prior to the notice of investigation. These rules are necessary to ensure a meaningful investigation of entities that are very active in UR while maintaining fairness.

Proposed subdivision (o) is a renumbering of the latter half of current subdivision (k), and is amended to align with changes to the UR investigation regulations, in particular, the decision to tailor the files selected for review to include a minimum percentage of modify or denial decisions. This change is necessary for consistency.

Subdivision (p) as proposed is a renumbering of current subdivision (l), and is amended to align with changes to the UR investigation regulations, in particular, the decision to generalize the requirements as applicable to an investigation subject rather than having particular requirements depending on the type of organization under investigation. This change is necessary for consistency.

Subdivision (q) as proposed is a renumbering of current subdivision (m), and is amended to allow for generalized regulations which do not depend on the type of organization under investigation, and also allows for an unannounced onsite investigation. This change is necessary for consistency and to allow the Division to have effective oversight over UR organizations.

Subdivision (r), which is current subdivision (n), was amended to generalize and simplify requirements for an investigation subject when additional records are required in the course of an investigation. These changes are necessary for ensuring consistency in the enforcement of UR regulations.

Subdivision (s) appears as though it is being newly added, but is the same as current subdivision (s). Due to the complete reorganization of this section, it was easier to strike the old subdivision and reposition it here. The fact that renumbering did not change subdivision (s) is mere coincidence.

Proposed subdivision (t) is a simplified version of current subdivision (o) regarding the method for calculating UR timelines when determining compliance. Instead of reiterating the time rules as current subdivision (o) did, proposed subdivision (t) instead cross references to the substantive regulation addressing this topic. This change is necessary for consistency and clarity.

Proposed subdivision (u) is a renumbering of current subdivision (p). Corrections to citations have been made for accuracy.

Proposed subdivision (v) is current subdivision (t), and was amended to implement changes allowing for simplification of the UR investigation regulations. In particular, amendments allow for a generalized rule applicable to any and all investigation subjects; strikes any reference to a performance rating (which will no longer apply); inserts the availability of a probationary period where an investigation has uncovered systemic problems within the investigation subject; and allows for a post preliminary report conference. These amendments are necessary to ensure consistency in the Division’s approach to UR investigations and for proper oversight.

Proposed subdivision (w) is a renumbering of current subdivision (u), which is necessary for proper order.

Proposed subdivision (x) is a renumbering of current subdivision (v), which is necessary for proper order.

Amendments in subdivision (x)(1)(A) (which is a renumbering of subdivision (v)(1)) were made to inform of procedures where an investigation does not result in probation or withdrawal of an approval of a UR plan. This is necessary to establish a clear process of investigation and to accommodate the changes in the proposal under the Division’s oversight authority. This subdivision was also amended to remove references to abatement or a performance rating, which will no longer be relevant based on the Division’s decision to simplify investigation regulations under this rulemaking.

Subdivision (x)(1)(B) proposes to add a rule instructing investigation subjects of requirements that are triggered when the Division places the subject on probation. This is necessary to establish a clear investigation process and to carry out the delegation of oversight given by the legislature to the Division of entities performing utilization review.

Subdivision (x)(1)(C) proposes to add a rule instructing investigation subjects of the requirements that are triggered when the Division withdraws its approval of the subject’s utilization review plan. This is necessary to establish a clear investigation process and to carry out the oversight delegation given by the legislature to the Division of entities performing utilization review.

Subdivision (y) is a repositioning of current section 9792.12(b)(6). It has been reorganized to appear under section 9792.11 as it concerns UR investigation procedures and is not part of the penalty schedule under 9792.12. The reference to “performance rating” was also struck from the original text as it will no longer be relevant under the new UR investigation and penalty rules for reasons mentioned above.

Subdivision (z) proposes to instruct that, for subjects placed on probation, the Division will conduct another investigation sooner than the required timeframe associated with a routine investigation, though it will be conducted in the same way. This is necessary to establish a clear investigation process and to carry out the authority delegated by the legislature to the Division for oversight of entities performing utilization review. A return investigation for entities placed on probation will allow the Division to ensure the subject has corrected deficiencies previously identified or uncovered during a routine investigation.

Subdivision (aa) proposes to limit the number of times an entity can be placed on probation following an investigation. This is necessary to render a probationary period meaningful and to carry out the authority delegated to the Division for oversight of entities performing utilization review.

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

Section 9792.12 sets forth a schedule of penalties relevant to utilization review (UR) and associated subjects. This rewritten version reflects a complete overhaul of the original structure of this section, which, generally, divided the penalties into subdivisions based on the importance attributed to a requirement by the Administrative Director; and also, as mentioned above, included a process for calculating and mitigating or appealing a performance rating. The proposal reorganizes existing penalties into categories (identified at the start of each subdivision) and adds other penalties to the categories which were either overlooked in an earlier rulemaking or are needed for the implementation of changes to UR under SB 1160. Restructuring this section into a straight-forward penalty schedule, and doing away with the performance rating and the additional option to have penalties waived if certain criteria were met, simplifies and clarifies what was once an overly elaborate process. Additionally, because utilization review has been a part of the workers’ compensation system for many years now (since 2004), an allowance for a waiver of penalties, originally offered to cushion the impact of the new UR regulations at the time, is no longer justified. For the same reason, a general increase in penalties, especially for those which were so insignificant as to render them ineffective in discouraging unlawful practices, have been implemented with larger increases attached to offenses considered to be more harmful or reflective of a brazen disregard of the law.

(Due to the enormity of the reorganization of this section, the below explanations are designed to address each change in the draft regulations in the order that they appear.)

Current subdivision (a) and its title have been struck to allow the introductory language of the regulation to stand alone.

Proposed subdivision (a) now lists penalties related to violations of UR plan requirements.

Subdivision (a)(4) proposes to add a $30,000 penalty for the failure of a UR plan that modifies or denies treatment requests to obtain approval of its UR plan from the Division. This enforcement mechanism and the $30,000 associated penalty is essential to give meaning to the authority delegated by the legislature to the Division for oversight of entities that modify or deny treatment requests.

Subdivision (a)(5), as proposed, is a renumbering of current subdivision (a)(4), and addresses the failure to file a material modification of a UR plan with the Administrative Director as required by law. It has been edited to be more succinct but has not otherwise changed and is substantively the same. The proposed version references the regulation that supports the penalty, which is structurally consistent with other similar penalties. The penalty associated with this violation has increased from $5,000 to $10,000 consistent with the general increase in penalties and relative to similar violations.

Subdivision (a)(6) proposes to impose a $10,000 penalty for the failure of a UR plan that modifies or denies treatment requests to obtain URAC accreditation. This enforcement mechanism is essential to provide meaning to the relatively new accreditation requirement enacted under SB 1160. The $10,000 penalty was determined as a fair sanction in light of other relative penalties and the schedule as a whole.

Proposed subdivision (a)(7) is a renumbering of current subdivision (a)(5), which is necessary for proper order. A reference to a regulation was also corrected for accuracy.

Subdivision (a)(8) proposes to impose a $25,000 penalty for the failure of a UR entity to comply with the laws prohibiting financial incentives to its reviewing physicians. This enforcement mechanism is essential to provide meaning to the prohibition of this practice and/or disclosure requirement enacted under SB 1160. The $25,000 penalty was determined as a fair sanction in light of other relative penalties and the schedule as a whole.

Subdivision (a)(9) proposes to impose a $20,000 penalty for the failure of a UR entity to retain records as required under the regulations. This enforcement mechanism is essential to provide meaning to the record retention requirement, which does not currently have an associated penalty. The $20,000 penalty was determined as a fair sanction in light of other relative penalties and the schedule as a whole. In particular, the fact that an investigation may be thwarted if records are inadequate makes a failure to keep records under the retention schedule particularly harmful and thereby justifies the relatively high penalty.

Subdivision (b) sets forth the schedule of penalties related to violations of UR plan operations.

Proposed subdivision (b)(1) sets forth violations and penalties attached to the requirement that specified decisions must be made by an appropriate physician reviewer.

Proposed subdivision (b)(1)(A) is a reorganization of current subdivision (a)(7) with a few changes. “Licensed physician” in the current (a)(7) was updated in proposed (b)(1) to reflect “physician reviewer” to comport with the updated definition in section 9792.6.1(w)(2). The word “delay” was also struck (see explanation above).

Proposed subdivision (b)(1)(B) adds a penalty to enforce the requirement that only a physician reviewer may deny requests for authorization of medical treatment when there has been a failure, under proposed section 9792.9.6, to obtain information, tests, or consultations needed to make a determination of medical necessity. The $25,000 penalty amount was determined to be fair since the current penalty assigned for when there has been an inappropriate reviewer is $25,000.

Proposed subdivision (b)(1)(C) adds a penalty to enforce the requirement that only a physician reviewer may review a request for treatment that would otherwise be exempt from utilization review but for the fact that the request expressly and unequivocally indicates or opines that there has been a change in facts material to the basis of the prior denial of such same treatment (as set forth at proposed section 9792.9.2(a)(2)(B).) The $25,000 penalty amount was determined to be fair since the current penalty assigned for when there has been an inappropriate reviewer is $25,000.

Proposed subdivision (b)(2) is a renumbering of current subdivision (a)(6).

Current subdivision (a)(7) has been struck and now appears at proposed subdivision (b)(1). (See above.)

Proposed subdivision (b)(3) is a replacement of current subdivision (a)(10). (See below for explanation of that subdivision’s deletion.) Proposed subdivision (b)(3) imposes a penalty for the failure to comply with deferral requirements as set forth at proposed section 9792.9.2 and is necessary to ensure that an appropriate and timely response is provided even for requests that do not require UR.

Proposed subdivision (b)(4) is a reorganization of current subdivision (a)(11) and updates the Labor Code citation for accuracy. There are no substantive changes.

Subdivision (b)(5) proposes to impose a $3,000 penalty to enforce the newly mandated prohibition against prospective UR for some medical treatment rendered within thirty days of the date of injury as outlined in proposed section 9792.9.7. This is essential to provide meaning and effect to the statute. The $3,000 penalty was determined as a fair sanction in light of other relative penalties and the schedule as a whole.

Subdivision (b)(6) is the reorganization and consolidation of penalties at current subdivisions (a)(12), (a)(13), and (a)(14) regarding a UR entity’s complete failure to respond to a request for authorization of treatment. These changes are necessary for better organization and to simplify the penalties. Penalty amounts were also increased from $2,000 to $3,000 in the case of a non-expedited concurrent review; from $1,000 to $2,500 in the case of a non-expedited prospective review; and from $500 to $750 in the case of retrospective review. These penalties were determined as fair sanctions in light of other relative penalties and the schedule as a whole.

Current subdivision (a)(8) has been struck as it was overly complicated and inconsistent with the Division’s goal of encouraging communication and expeditious and necessary medical treatment for injured workers. Additionally, in the event such violation is discovered, it can be sufficiently assessed under the catch-all penalty that is being proposed under this rulemaking.

Current subdivision (a)(9) has been struck and reorganized; it is now covered in proposed subdivisions (b)(8) and (b)(9), below.

Current subdivision (a)(10) has been struck and replaced with proposed subdivision (b)(3). (See above.) It has become apparent that some treatment requests are not amenable to medical necessity determination even after application of the MTUS because workers’ compensation medical benefits encompass more than what may be commonly considered as medical treatment. Therefore, it would be inequitable to impose a penalty for a review which, after good faith application of the MTUS, concludes that the requested treatment is not addressed by the MTUS. The Division believes that such questions should be addressed in court.

Current subdivision (a)(11), which appears struck, has been reorganized to appear at proposed subdivision (b)(4). (See above.)

Current subdivisions (a)(12), (13), and (14) were struck and consolidated. They are now captured at proposed subdivision (b)(6). (See above.)

Current subdivision (a)(15) has been struck and reorganized to appear at proposed subdivision (c)(6). (See below.)

Proposed subdivision (b)(7) is a rewritten version of current subdivision (b)(4)(C) (below) regarding the requirement to timely make a decision and/or issue a response to a request for authorization of non-expedited concurrent or prospective treatment. It has been updated with appropriate cross-references but has not substantively changed in the characterization of the violation. The proposal, however, would amend the penalty amount associated with the violation to reflect an increase from a flat penalty of $100 to $250 per day up to a maximum of $5,000, at which point the penalty for failing to respond to an RFA also attaches as indicated in the prior subsection ($5,000 in the case of a non-expedited concurrent or prospective review.) Based on this penalty structure, a UR plan that is up to 20 days late in responding to a complete or accepted request for authorization of treatment would accrue a penalty at a lesser rate after which the violation is viewed as a failure to respond at all and the associated penalty for that violation would also attach. This is necessary for meaningful enforcement of the requirement that UR plans make timely decisions and responses to treatment requests, and for consistency relative to the general increase in penalties.

Proposed subdivision (b)(8) is a rewritten version of current subdivision (a)(9) regarding the obligations to timely make and communicate a decision in response to a request for expedited review of requested treatment. Originally, the penalty, which read as a failure to merely communicate a decision in response to a request for expedited review, was sufficient because the regulations were organized in such a way that communicating the decision necessarily included making the decision. However, under this rulemaking, since the sections regarding making and communicating decisions in response to an expedited request have been separated, it made better sense to rewrite current (a)(9) to accommodate this restructuring, though not a substantive change. The proposal, however, would amend the penalty amount associated with the (timeliness) violation to reflect an increase from a flat penalty of $15,000 to $250 per hour up to a maximum of $18,000 (which would accrue in 72 hours), at which point the penalty for failing to respond to a request for treatment at an expedited level also attaches as indicated in the prior subsection ($10,000 in the case of an expedited review). Based on this penalty structure, a UR plan that is up to 72 hours late in responding to an expedited request for authorization of treatment would accrue a penalty amount at a lower rate after which the violation is viewed as a failure to respond at all and the associated penalty for that violation would also attach. This is necessary for meaningful enforcement of the requirement that UR plans respond timely to treatment requests, especially in expedited situations, and for consistency relative to the general increase in penalties.

Proposed subdivision (b)(9) is a consolidated version of current subdivisions (b)(4)(D), which addressed the failure to timely make and communicate an adverse UR decision in response to a retrospective request for treatment, and (b)(5)(D), which addressed the failure to make and communicate an approval of a retrospective treatment request. These sections were combined for better organization but remain substantively unchanged. The proposal, however, would amend the penalty amount associated with the violation to reflect an increase from a flat penalty of $100 (for a violation of old (b)(4)(D)) and a flat penalty of $50 (for a violation of old (b)(5)(D)) to $150 per day up to a maximum of $3,000, at which point the penalty for failing to respond to an RFA also attaches as indicated in the prior subsection ($3,000 in the case of a non-expedited concurrent or prospective review.) Based on this penalty structure, a UR plan that is up to 20 days late in deciding on and responding to a complete or accepted retrospective request for authorization of treatment would accrue a penalty at a lower rate after which the violation is viewed as a failure to respond at all and the associated penalty for that violation would also attach. This is necessary for meaningful enforcement of the requirement that UR plans respond timely to treatment requests, even where retrospective, and for consistency relative to the general increase in penalties.

Proposed subdivision (b)(10) is a rewritten version of current subdivisions (b)(4)(A), (b)(5)(A), and (b)(5)(G) pertaining to timely notice and manner requirements when medical necessity of requested treatment cannot be determined due to the need for additional information or tests or exam(s). They were consolidated due to redundancy and structural reorganization of this penalty section. The proposal further omits the word “delay” (see explanation above) and cites to the proposed section applicable to the failure to respond to a complete or accepted request for authorization to minimize redundancy. It is otherwise substantively unchanged.

Proposed subdivision (b)(11) is a rewritten version of current subdivision (b)(5)(E) regarding the failure to document the reason for denying treatment on the basis of lack of reasonable and necessary information. It retains the same substantive meaning but has been simplified by citing to the regulation that includes the applicable circumstances triggering the need for documentation (as opposed to repeating the circumstances that are already in the citation). The penalty amount, however, was increased from $50 to $200, which is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Subdivision (b)(12) is a reorganization of current subdivision (b)(4)(B) pertaining to the failure to document efforts to obtain information from the requesting party prior to denying treatment on the basis of a lack of reasonable and necessary information. It is substantively unchanged except for an increase in the penalty amount from $100 to $200, which is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Subdivision (b)(13) is a reorganization of current subdivision (b)(4)(E) pertaining to the content requirements of a UR decision that modifies or denies a treatment request, and includes minor non substantive changes. The word “delay” was also struck. (See explanation above.) The penalty amount, however, was increased from $100 to $300, which is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Subdivision (b)(14) proposes the requirement that UR entities operate in accordance with their respective plans filed and/or approved through the Administrative Director (AD). This is a new provision and is necessary to give meaning to the authority delegated by the legislature to the Division for oversight of entities that modify or deny treatment requests.

Subdivision (b)(15) has been reserved in case the need to add an additional penalty under this subdivision arises.

Subdivision (c) lists penalties related to violations of UR investigation procedures and miscellaneous provisions.

Subdivision (c)(1) proposes to enforce the process of obtaining records, files, or other documents necessary for a comprehensive and efficient investigation of a UR entity by imposing a penalty of $500 for each day a response is untimely up to a maximum of $10,000 unless a greater penalty is warranted. UR investigation subjects are sometimes less than timely in the production of documents or files needed for a complete and efficient investigation. This provision, therefore, is necessary to add meaning to the Division’s requests for documents in the course of an investigation.

Subdivision (c)(2) proposes to prohibit UR investigation subjects from misrepresenting documentation in order to avoid penalties by imposing a penalty of $5000 for each backdated, altered, or withheld document unless a greater penalty is warranted. Because a UR investigation is comprised largely of file review, this provision is necessary to ensure the integrity of the investigation documents.

Subdivision (c)(3) is a reorganization of current subdivision (a)(17) pertaining to the failure of an investigation subject 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 all appeals have become final. A couple of minor changes were made to this subsection. The first change is the addition of “and each” following “For failure to timely comply with any,” and is necessary to clarify that the penalty is not for the aggregate number of violations cited under this provision but for each violation. The second and last amendment to this provision is the addition of the words “for each day the failure is ongoing up to a maximum of $20,000 unless a greater penalty is warranted under subdivision (e) of this section” following the amount of the penalty of $500. This change represents a potentially significant increase in the penalty amount associated with this violation, but is necessary for meaningful enforcement of this important compliance requirement, and is consistent relative to the general increase in penalties.

Subdivision (c)(4) is current subdivision (a)(16), which is a violation for failure to timely serve the AD with documentation of compliance of the notice requirements that take place after the issuance of an Order to Show Cause (where no answer has been filed). Amendments include a citation correction to accommodate changes made under this rulemaking, and, following the penalty amount of $500, the addition of the words “for each day the failure is ongoing up to a maximum of $20,000 unless a greater penalty is warranted under subdivision (e) of this section.” This change represents a potentially significant increase in the penalty amount in the case of an investigation subject that delays the issuance of the specified notice, but is necessary for meaningful enforcement of this notice requirement, and is consistent relative to the general increase in penalties.

Current subdivision (a)(17) has been struck and reorganized. It now appears as subdivision (c)(3). (See above.)

Current subdivision (b)(1), (b)(2), and (b)(3) (pertaining to calculations for determining and/or waiver of the performance rating or outlining the consequences for failing a Return Target Investigation which is prompted by a performance rating below 85%) including all of its subsections, have been struck. Because the Division proposes to move away from an investigation built around a performance rating to a system that utilizes a penalty schedule without the need for a return target investigation triggered by a failing score, those subdivisions would be moot and no longer be relevant.

Current subdivision (b)(4)(A) has been struck and reorganized as proposed subdivision (b)(11). (See above.)

Current subdivision (b)(4)(B) has been struck and reorganized. The substance of this subdivision appears in this proposal at subdivision (b)(13). (See above.)

Current subdivision (b)(4)(C) has been struck and reorganized. The substance of this subdivision appears in this proposal at subdivision (b)(7). (See above.)

Current subdivision (b)(4)(D) has been struck and reorganized to appear in this proposal at subdivision (b)(10). (See above.)

Current subdivision (b)(4)(E) has been struck and reorganized to appear in this proposal at subdivision (b)(12). (See above.)

Proposed subdivision (c)(5) is a reorganization and rewording of current subdivision (b)(4)(F) pertaining to the obligation of an investigation subject to disclose criteria or guidelines for specified conditions or treatments if requested by a member of the public. Non-substantive changes include a correction to the Labor Code citation (which currently reflects the citation that was applicable pre SB 1160) and removal of the citation to the regulation since it would be removed as redundant under this rulemaking. The proposal would also increase the penalty from a flat $100 to $200 and would be necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Regarding proposed subdivision (c)(6), it is necessary to review current subdivision (b)(4)(F), which is proposed subdivision (c)(5), and current subdivision (a)(15), which is proposed subdivision (c)(6). They are separate violations but, when read together, appear to be the same. Review of the cross-citations in each of these subdivisions, however, reflects that current subdivision (a)(15) should have cited to Labor Code section 4610(c), which, at the time it was established, was the version that existed pre SB 1160 requiring a description of the UR process and its pertinent policies and procedures to be filed with the AD and disclosed to the public upon request. This aligns with the cited-to regulation counterpart, section 9792.7(d), which is also cited in current subdivision (a)(15). Therefore, proposed subdivision (c)(6) represents a correction and update to current subdivision (a)(15). These updates are necessary for accuracy and consistency but are not meant to be substantive changes. The proposal, however, would increase the penalty from a flat $100 to $200 and is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Current subdivision (b)(5) has been struck as it is part of the old penalty structure and is therefore not relevant.

Current subdivision (b)(5)(A) has been struck and reorganized to appear at proposed subdivision (b)(11). (See above.)

Current subdivision (b)(5)(B) has been struck and reorganized to appear at proposed subdivision (b)(9). (See above.)

Current subdivision (b)(5)(C) has been struck and reorganized to appear also at proposed subdivision (b)(9). (See above.)

Current subdivision (b)(5)(D) has been struck and reorganized to appear at proposed subdivision (b)(10). (See above.)

Current subdivision (b)(5)(E) and all of its subsections have been struck and reorganized to appear at proposed subdivision (b)(12). (See above.)

Current subdivision (b)(5)(F) has been struck as it was a reserved section that is no longer needed.

Current subdivision (b)(5)(G) has been struck and now appears at proposed subdivision (b)(11). (See above.)

Current subdivision (b)(6) has been struck and reorganized to appear at proposed section 9792.11(y) as it concerns UR investigation procedures whereas section 9792.12 is a penalty schedule.

Proposed subdivision (d) is a renumbering of current subdivision (c), which is necessary for proper order. It also includes an update to the cited regulations applicable to scope based on changes under the proposal, which is necessary for consistency.

Proposed subdivision (d)(1), which is current subdivision (c)(1), has been amended to strike the word “delaying” (see explanation above), and to correct citations that are changing under this rulemaking.

Proposed subdivision (d)(2), which is current subdivision (c)(2), has been amended to strike the word “delaying” (see explanation above), and to correct citations that are changing under this rulemaking. The word “that” has also been corrected to “which” for correct grammar.

Proposed subdivision (d)(3), which is current subdivision (c)(3), has been amended to reflect technical corrections based on statutory changes or citation changes under this rulemaking. Specifically, the word “delaying” has been struck (see explanation above); citations have been changed to align with changes under this rulemaking; and the time in which an injured worker has to submit an application for independent medical review has been amended to include 10 days to align with a statutory change on this subject. These changes are necessary for consistency.

Proposed subdivision (d)(4), which is current subdivision (c)(4), has been amended to strike the word “delaying” (see explanation above), and to correct citations that are changing under this rulemaking.

Proposed subdivision (d)(5), which is current subdivision (c)(5), pertaining to the failure to submit documents requested by the Administrative Director in order to determine IMR eligibility, has been amended to increase the cap on the penalty associated with this violation from $5,000 to $7,500. The penalty increase is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Proposed subdivision (d)(6), which is current subdivision (c)(6), pertaining to the failure to submit medical records or additional records requested by the Administrative Director in order to determine medical necessity, has been amended to increase the cap on the penalty associated with this violation from $5,000 to $7,500. The penalty increase is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Proposed subdivision (d)(7), which is current subdivision (c)(7) pertaining to the failure to timely authorize services found to be medically necessary by IMR, has been amended to increase the cap on the penalty associated with this violation from $5,000 to $10,000. The penalty increase is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Proposed subdivision (d)(8), which is current subdivision (c)(8) pertaining to the failure to timely reimburse for services already rendered that are found to be medically necessary by IMR, has been amended to increase the cap on the penalty associated with this violation from $5,000 to $10,000. The penalty increase is necessary for meaningful enforcement and consistency relative to the general increase in penalties.

Proposed subdivision (e)(1), which is entirely new, would add a catch-all penalty for any violations that have not been identified thus far. It would list the factors that would be considered when determining a proper penalty amount, up to a maximum of $50,000, if a violation were found using this subdivision and is necessary to provide a rational basis from which the DWC would formulate the penalty amount. The penalty would also include the possibility of revocation or suspension of the UR plan. Overall, this is necessary to ensure that the mission of the DWC to enforce the rules and requirements pertaining to utilization review are meaningful and not thwarted by the absence of an express violation in the penalty schedule.

Proposed subdivision (e)(2), which is entirely new, would close any loopholes that may arise during an investigation in the event that the finding of one violation inhibits the ability of the DWC to conduct a comprehensive investigation that may have led to the discovery of further violations. This is necessary to ensure that the ability of the Division to enforce the rules and requirements pertaining to utilization review are not thwarted by an absence or loophole in the rules, for example, where a UR plan entity knowingly violates a rule based on its calculation that payment for such violation would be less costly or preferable to full compliance.

Proposed subdivision (f) is a renumbering of current subdivision (d), which is necessary for proper order.

Proposed subdivision (g) is a renumbering of current subdivision (e), which is necessary for proper order. Text regarding abatement has also been struck as abatement will no longer be an option after this rulemaking for reasons mentioned above.

## § 9792.13. Assessment of Administrative Penalties – Penalty Adjustment Factors.

Subdivision (a) has been amended to specify when mitigation may occur, i.e., prior to the issuance of the final report. This is necessary to clarify the timing of the mitigation option in the investigation process.

Current subdivision (a)(6) has been struck as abatement will no longer be relevant after this rulemaking for reasons mentioned above.

## § 9792.15. Administrative Penalties Pursuant to Labor Code §§4610, 4610.5, and 4610.6 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure.

Section 9792.15 sets forth rules regarding the process of ending or appealing a UR investigation final report.

Subdivision (b), subsection (2), was amended to correct a Labor Code citation for accuracy (from section 4610(i) to 4610(p)), strike the reference to a performance rating as it will no longer exist after this rulemaking (for reasons mentioned above), and to include as an element of the Order to Show Cause, if applicable, the Division’s intent to place the subject on probation or to withdraw approval of the UR plan. This is necessary to give meaning to the Division’s authority to regulate specified UR organizations.

# ARTICLE 5.5.2 Medical Treatment Utilization Schedule

## §9792.27.1 Medical Treatment Utilization Schedule (MTUS) Drug Formulary – Definitions.

Section 9792.27.1 sets forth rules pertaining to the Medical Treatment Utilization Schedule (“MTUS”).

Subdivision (r) has been amended to spell-out the acronym, OTC. This is necessary for clarity.

## § 9792.27.17. Formulary – Dispute Resolution.

Subdivision (b) was amended to align with recent Workers Compensation Appeals Board (WCAB) rule changes, and are necessary for accuracy.