

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

ADDENDUM TO FINAL STATEMENT OF REASONS

Subject Matter:

Workers' Compensation – Utilization Review Standards

Title 8, California Code of Regulations, sections 9792.6 through 9792.11

In addition to the statements set forth in the Initial Statement of Reasons the regulations are necessary for the following reasons:

Section 9792.6 Utilization Review Standards—Definitions

Necessity:

Section 9792.6(a)—Definition of the term “ACOEM Practice Guidelines.”

Labor Code section 4610(b) requires every employer establish a utilization review process in compliance with the statute. Labor Code section 4610(c) provides that the utilization review process shall ensure that the decisions based on medical necessity to cure or relieve the effects of the industrial injury must be consistent with the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27, and that prior to the adoption of the schedule, the proposed medical treatment must be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The term “ACOEM Practice Guidelines” is the term used throughout the regulations to refer to the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.

Section 9792.6(b)—Definition of the term “authorization.”

Labor Code section 4610 employs the phrase request for authorization. It is necessary to define the term authorization in the context of these regulations when a physician submits a request for authorization of medical treatment. This definition makes reference to the issue of appropriate reimbursement for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury. The definition also makes reference to Labor Code section 4600 which sets forth the type of treatment the injured worker is entitled to receive under workers' compensation, and further makes reference to the fact that this treatment is subject to the provisions of Labor Code section 5402. The definition also points the reader to the workers' compensation forms which are used to set forth the treatment plan and request for authorization, and the appropriate Labor Code sections where these forms are contained.

Section 9792.6(c)—Definition of the term “claims administrator.”

Labor Code section 4610 states that every employer shall establish a utilization review process “either directly or through its insurer or an entity with which an employer or insurer contracts for these services.” Labor Code section 4610 further enumerates many acts which must be conducted by the employer, insurer or entity contracted to conduct utilization review. The claims administrator definition has been crafted by using the common definition used throughout workers’ compensation regulations and by adding two additional elements. First, the definition includes the term “an insured employer” because throughout the regulatory process it was determined that some insured employers were conducting some of the utilization review on their own. By including the “insured employer” in the definition of claims administrator it has been assured that if they choose to conduct utilization review on their own, they would be required to comply with the requirements of the regulations, and be subject to penalties for failure to comply with the requirements of the regulations. Second, the definition adds the new term “other entity subject to Labor Code section 4610.” This term will also include utilization review organizations conducting utilization review for purposes of compliance and penalties. After public comments it was necessary to include the sentence: “The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities,” to allow the utilization review organizations to perform all acts required by the statute and the regulations which are required to be performed by the claims administrator in the context of utilization review.

Section 9792.6(d)—Definition of the term “concurrent review.”

Labor Code section 4610, and general principles of utilization review provide for “concurrent review.” It is necessary to define the term “concurrent review” as “utilization review conducted during an inpatient stay, to differentiate from review of treatment which may be conducted in an office setting which would require prior authorization (prospective review), and from review of treatment that has already been completed in an office setting (retrospective review).

Section 9792.6(e)—Definition of the term “course of treatment.”

It is necessary to define the term “course of treatment” in the context of utilization review in workers’ compensation. As a matter of practice in workers’ compensation, the physician is required to set forth the treatment plan in the form entitled: “Doctor’s First Report of Occupational Injury or Illness,” or the form entitled: “Primary Treating Physician’s Progress Report.” However, to facilitate communication between the requesting physicians and the claims administrators, the course of treatment is also defined to include a “narrative form” (i.e., a written report) containing the same information required in the Primary Treating Physician’s Progress Report, as many physicians use narrative reports when more detailed information is needed.

Section 9792.6(f)—Definition of the term “emergency health care services.”

It is necessary to define the term “emergency health care services,” to differentiate these services from services provided on an expedited basis. Treatment provided on emergency basis does not require prior authorization, and are not subject to expedited review, but may be subject to retrospective review. Physicians should not be required to withhold treatment in an emergency in order to request authorization.

Section 9792.6(g)—Definition of the term “expedited review.”

Labor Code section 4610, and general principles of utilization review, provide for expedited review of requests for authorization of proposed medical treatment. It is necessary to define the term “expedited review” as it is defined by the statute in Labor Code section 4610(g)(2), which states this is “when the injured worker’s condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker’s life or health or could jeopardize the injured worker’s permanent ability to regain maximum function.”

Section 9792.6(h)—Definition of the term “expert reviewer.”

Labor Code section 4610 allows for the claims administrator to extend the statutory timeframes if the claims administrator needs to consult with an “expert reviewer.” Labor Code section 4610(e) provides that “no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, ... may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve.” Labor Code section 3209.3 defines the term “physician” as “include[ing] physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law, and within the scope of their practice as defined by California state law.” Labor Code section 3204—“Chapter’s definitions govern construction,” states that “[u]nless the context otherwise requires, the definitions hereinafter set forth in this chapter shall govern the construction and meaning of the terms and phrases used in this division.”

The term “expert reviewer” has been defined to include the definition of physician as set forth in Labor Code section 3209.3, with the exception that it does not require the physician to be licensed in the state of California. This is required within the context of Labor Code section 4610, which requires that every employer establish a utilization review process. The general business practices of utilization review is to allow utilization review to be conducted by licensed physicians, regardless of licensing state, who are competent to evaluate the specific clinical issues presented. Thus, the term “expert reviewer” has been defined to mean “a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual’s scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.” (For more explanation, see statement of necessity for definition of term “reviewer” set forth below.)

Section 9792.6(i)—Definition of the term “health care provider.”

It is necessary to define the term “health care provider” in the context of utilization review standards regulations. During the provision of medical treatment there will not be only physicians involved in the process but there will also be other providers of medical services. Thus, the term is defined to include “a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization.” The definition further

includes a medical provider network as provided in Labor Code section 4616 as a health care provider.

Section 9792.6(j)—Definition of the term “immediately.”

Labor Code section 4610(g)(5) provides that if the employer, insurer, or utilization review entity cannot make a decision with regard to the request for authorization within the statutory timeframes because lack of information, need to consult with an expert, or need for additional examinations or tests, the employer insurer or utilization review entity shall “immediately notify the physician and the employee in writing.” Thus, it is necessary to define the term “immediately” to avoid confusion and to prevent different extensions of timeframes for compliance with the statutory requirements. These specific requirements of the statute have been set forth in the regulations at subdivisions (b)(1), (b)(2) or (c) and (g)(1) of section 9792.9, and the term has been defined as “within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions” specified in these subdivisions.

Section 9792.6(k)—Definition of the term “material modification.”

Labor Code section 4610(c) requires that the utilization review plan, consisting of the policies, procedures, and description of the utilization review process, be filed with the Administrative Director. Labor Code section 4610(f) sets forth, in relevant part, the requirements for the utilization review plan. These requirements have been set forth in section 9792.7. Section 9792.7(c) requires that a modified utilization review plan be filed with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan. It is necessary to define the term “material modification” to clarify that when the claims administrator changes vendors a material modification has occurred requiring the filing of a modified plan. Further, it is necessary to clarify that any changes to the utilization review plan as described in Section 9792.7 consist a “material modification” requiring the filing of a modified plan.

Section 9792.6(l)—Definition of the term “Medical Director.”

Labor Code section 4610(d) requires that the employer, insurer or utilization review entity, employ a medical director who holds an unrestricted license to practice medicine in the State of California pursuant to Section 2050 or 2450 of the Business and Professions Code. Business and Professions Code section 2050 provides that the Division of Licensing shall issue one form of certificate to all physicians and surgeons licensed by the board which shall be designated as a "physician's and surgeon's certificate." Business and Professions Code section 2450 provide for the creation of the Osteopathic Medical Board of California which has authority over persons holding or applying for physician's and surgeon's certificates. Pursuant to these requirements as set forth in Labor Code section 4610(d), it is necessary to define the term “medical director” as the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. Labor Code section 4610(d) further provides that the medical director “shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays or denies requests for authorization ... complies with the requirements this section.” In order to implement, interpret and make specific this requirement it is necessary to make sure that the medical director is ultimately responsible for all decisions made in the utilization review process.

Thus, the term “medical director” has been further defined to state that the medical director is responsible for all decisions made in the utilization review process.

Section 9792.6(m)—Definition of the term “medical services.”

It is necessary to define the term “medical services” within the context of workers’ compensation because these regulations directly address the provision of medical services.

Section 9792.6(n)—Definition of the term “prospective review.”

Labor Code section 4610, and general principles of utilization review provide for “prospective review.” It is necessary to define the term to refer to utilization review conducted prior to the delivery of the requested medical services. The term is differentiated from “concurrent review” by indicating that this review does not apply to utilization review conducted during an inpatient stay.

Section 9792.6(o)—Definition of the term “request for authorization.”

Labor Code section 4610 employs the term “request for authorization” on numerous occasions. The term refers to a request for a specific course of proposed medical treatment. The term is associated with very strict timelines set forth by the statute. It is necessary to clearly define this term to protect these timelines and to insure that the public understands when the timelines are triggered. The definition of the term request for authorization allows for both written and oral requests for authorization as provided by the statute (see Labor Code section 4610(h)) in order to expedite the process. However, in order to protect the timelines in the event of disputes, the definition states that an oral request for authorization must be followed by a written confirmation of the request within 72 hours. Furthermore, the definition specifies that the request for authorization, must be submitted in the “Doctor’s First Report of Occupational Injury or Illness,” or the form entitled: “Primary Treating Physician’s Progress Report.” However, to facilitate expedited communication between the requesting physicians and the claims administrators, the request for authorization may also be submitted in a “narrative form” (i.e., a written report) containing the same information required in the Primary Treating Physician’s Progress Report. The definition further states that if a narrative format is used, the document must be clearly marked at the top that it is a request for authorization. This is necessary to alert the claims administrator of the request in light of the strict timelines of the statute and the regulations.

Section 9792.6(p)—Definition of the term “retrospective review.”

Labor Code section 4610, and general principles of utilization review, provide for retrospective review of requests for authorization of proposed medical treatment. It is necessary to define the term to mean utilization review conducted after medical services have been provided and for which approval has not already been given.

Section 9792.6(q)—Definition of the term “reviewer.”

I. Introduction

Labor Code section 4610(e) provides that “no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve.” Labor Code section 3209.3 defines the term “physician” as “includ[ing] physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law, and within the scope of their practice as defined by California state law.” Labor Code section 3204 - “Chapter’s definitions govern construction,” states that “[u]nless the context otherwise requires, the definitions hereinafter set forth in this chapter shall govern the construction and meaning of the terms and phrases used in this division.”

The definition of the term “reviewer” has been crafted to include the definition of physician as set forth in Labor Code section 3209.3, based upon the interpretation that it does not require the physician to be licensed in the state of California. This is required within the context of Labor Code section 4610, which requires that every employer establish a utilization review process. The general business practices of utilization review is to allow utilization review to be conducted at a national level by licensed physicians, regardless of licensing state, who are competent to evaluate the specific clinical issues presented. Thus, the definition of “reviewer” has been defined to mean “a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer’s practice.”

In this regard, it is relevant to note the fundamental rule of statutory construction. It is also relevant to note that the statutes governing utilization review in the Health and Safety Code, and the Insurance Code, also allow for physicians licensed outside of California to perform utilization review functions.

II. Statutory Construction

The fundamental rule of statutory construction is that the court should ascertain the legislative intent so as to effectuate the purpose of the law. To achieve this, the statute should be construed with reference to the whole system of law of which it is a part, so that all may be harmonized and have effect. The legislative intent will be determined to the extent possible by looking at the language of the statute read as a whole. If the words of the statute, given their ordinary and commonsense meaning are clear and unambiguous on its face, then the court will not look further to ascertain the legislative intent. But language that appears unambiguous on its face may be shown to have a latent ambiguity. If so, a court may turn to customary rules of statutory construction or legislative history for guidance. Statutory language which seems clear when considered in isolation may in fact be ambiguous or uncertain when considered in context. The statute needs to be construed with reference to the whole system of law of which it is a part, so that all may be harmonized and have effect. (See *Anne Muller v. Automobile Club of Southern California* (1998) 61 CA4th 431,440-441; *County of Yolo v. Los Rios Community College District* (1992) 5 CA4th 1242, 1248-1249).

Finally, although the ultimate interpretation of a statute rests with the courts, unless unreasonable, or clearly contrary to the statutory language or purpose, the consistent construction of a statute by an agency charged with responsibility for putting the statutory

machinery into effect and enforcing it, is entitled to great weight and deference. (See *Dyna-Med, Inc. v. Fair Employment and Housing Commission* (1985) 193 CA3d 38; *Dix v. Superior Court* (1991) 53 Cal.3d 442, 460; 85 Op. Cal. Atty. Gen. 157).

Meaning of “including” as used in Labor Code §3209.3

Labor Code §3209.3(a) states the following: “‘Physician’ *includes* physicians and surgeons holding an M.D. or O.D. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.” (Emphasis added.) At issue is whether licensed physicians outside of the state of California fall within this definition. The use of the word “includes” creates an ambiguity as to whether the list following the word “includes” is exhaustive or partial. The *Dictionary of Modern Legal Usage*, 2nd Edition, Bryan A. Garner, states the word including [includes] “should not be used to introduce an exhaustive list, for it implies that the list is only partial. In the words of one federal court, ‘It is hornbook law that the use of the word *including* indicates that the specified list...is illustrative, not exclusive.’ *Puerto Rico Maritime Shipping Auth. v. I.C.C.* (D.C. Cir. 1981) 645 F.2d 1102, 1112 n. 26.”

Although some courts have found that the word “includes” may be used as a word of limitation, courts have also held that the “[t]erm ‘includes’ is ‘ordinarily a word of enlargement and not of limitation. [Citation.] The statutory definition of [a] thing as “including” certain things does not necessarily place thereon a meaning limited to the inclusions.’ [Citations.]” (*Associated Indemnity Corporation v. Pacific Southwest Airlines* (1982) 128 CA3d 898, 905).

The ambiguity of the word “includes” in Labor Code § 3209.3 was addressed by the court in *State Compensation Insurance Fund v. Workers’ Compensation Appeals Board and Juan Pablo Arroyo* (1977) 69 CA3d 884, 893. In *State Compensation Insurance Fund*, the appellant contended Labor Code §4600 did not provide for reimbursement of medical costs for services of respondent employee’s physicians because they were not licensed by California state law as provided for by Labor Code §3209.3. The court held that the definition of “physician” contained in Labor Code §3209.3 *did not* exclude a physician licensed to practice in another country or another state. Therefore, the term “includes” as used in Labor Code §3209.3 is expansive, and therefore, includes physicians licensed to practice in other states or countries as well as physicians licensed to practice in California. At the time of this opinion, “physician” as defined in §3209.3 is, in pertinent part, the same as in the current statute. (In 1977, the statute read as follows, “Physician includes physicians and surgeons, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.”)

The court in *State Compensation Insurance Fund*, p. 890-891, interpreted the legislative intent of Labor Code §3209.3 to be as follows, “It appears section 3209.3 was designed merely to codify the rule developed by these cases that compensation is not allowed for treatment by nonphysicians. It is doubtful the Legislature ever considered the application of the section to treatment by out-of-state physicians.” The court further reasoned that the appeals board has jurisdiction over all controversies arising out of injuries suffered *without* the territorial limits of this state in those cases where the contract of hire was made in this state (p. 891; Labor Code §5305). Therefore, it would be unreasonable to require an employee out-of-state to either return to California for treatment or bear the cost of treatment. Labor Code §4600.6(i) further

exemplifies the legislature’s clear intent to provide for out-of-state medical care to injured workers in that this statute sets forth the requirements to qualify as a health care organization for facilities not located in California. Labor Code §4600.6(i) states in pertinent part, “[f]acilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.”

Based on the holding of *State Compensation Insurance Fund*, the term “physician” as defined in Labor Code §3209.3 includes licensed out-of-state physicians, and therefore, the proposed regulation is in conformance with the relevant statutes. Furthermore, the court in *Dyna-Med, Inc.* held that “[w]here the Legislature has failed to modify that statute so as to require an interpretation contrary to the regulation, that fact may be considered to be an indication that the ruling was consistent with the Legislature’s intent.” By analogy, since the Legislature has failed to modify Labor Code §3209.3 so as to require an interpretation contrary to case law interpretation, this fact should be considered as an indication that the Legislature’s intent was correctly interpreted in 1977 by the court in *State Compensation Insurance Fund*.

Labor Code §4610 – Use of the word “physician”

Labor Code §3204 – “Chapter’s definitions to govern construction” states the following, “[u]nless the context otherwise requires, the definitions hereinafter set forth in this chapter shall govern the construction and meaning of the terms and phrases used in this division.”

As determined in *State Compensation Insurance Fund*, the list included in Labor Code §3209.3 is illustrative and not exhaustive, therefore, Labor Code §4610(d) must necessarily clearly indicate that the medical director is required to be licensed to practice medicine in the state of California. Thus, Labor Code §4610(d) states in pertinent part, “[t]he employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code”.

Labor Code §4610 distinguishes the requirements of the medical director in subsection (d) from the physician reviewer in subsection (e) by stating the physician reviewer can be “[n]o person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician’s practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.”

Therefore, the word “physician” as used within the context of Labor Code §4610, allows a physician reviewer described in Labor Code §4610(e) to be a licensed out-of-state physician. The use of the word “includes” in Labor Code §3209.3 to define the word “physician” must be used as a word of “enlargement”, when applied to the context of this utilization review statute. This is necessary (and in accordance with Labor Code §3204) because the general business practices of utilization review is to allow utilization review to be conducted at a national level by licensed physicians, regardless of licensing state, who are competent to evaluate the specific clinical issues presented. Furthermore, Labor Code section 4610 provides for very restrictive timeframes to be used in the utilization review process. (See, Lab. Code, §§ 4610(g)(1)-4610(g)(3).) It is the standard across the country to have a national pool of physicians to conduct utilization review. This ensures that there are a sufficient number of physicians available to

conduct utilization review without disrupting provision of medical services, and functions as a cost control measure.

III. Other Statutes Allow for Physicians Licensed Outside California to Perform Utilization Review Functions

Knox-Keene Act

Health and Safety Code §§ 1340 et seq., known as the Knox-Keene Act, governs Health Care Service Plans. Health & Safety Code section 1367.01 of the Knox-Keene Act sets forth standards for the process of review by health care service plans for requests made by providers for services for enrollees. Section 1367.01 (c) specifically states that “A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state....” Section 1367.01(e) states “No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.”

This language mirrors the language in the proposed utilization review regulations at sections 9792.6(l) and (q) which requires the medical director to be licensed in California, yet provides that the physician who denies or modifies requests for authorization, apart from the medical director, need only be a licensed physician.

The definition of “physician” in the Knox-Keene Act is also noteworthy. Section 1358.5(8) states the following: “Physician” shall not be defined more restrictively than as defined in the Medicare program.

The Medicare Program definition of “physician” as found in 42 USCS §1395x is as follows: (r) Physician. The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7) [42 USCS § 1301(a)(7)]),...” The word “physician” as defined by this statute is also composed of a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who are legally authorized to perform as such by the State in which he or she performs them.

With respect to the Knox-Keene definition of “physician,” the Utilization Review Standards definition of “Reviewer” is in keeping with the Knox-Keene requirement. The definition of “Reviewer” is compatible because it is not more restrictive than the definition of “physician” found in the Medicare program. Rather than being more restrictive, the definition is more expansive in that it includes psychologists and acupuncturists and allows for licensure by any state or the District of Columbia.

The California Legislative Committee Analysis of Pending Bills in the context of the Knox-Keene Act is also applicable to the question of whether a reviewer must be licensed in California. Assembly Floor Bill No. AB 58 was a bill requiring an employee of a health care service plan (health plan), who is responsible for the final decision, or for the process in which a final decision is made, regarding the medical necessity or medical appropriateness of any

diagnosis, treatment, operation, or prescription to be a physician *licensed by the Medical Board of California*. (Emphasis added.)(California Committee Analysis, Assembly Floor Bill No. AB 58, Date of Hearing: June 2, 1999.) This Bill was vetoed by the Governor. In the Governor's Veto Message he stated in pertinent part (California Committee Analysis, Senate Floor Bill No. AB 58, January 6, 2000):

"AB 58 would preclude out-of-state experts from making determinations regarding medical necessity which will, in some cases, inhibit the best input on critical clinical questions. ... This effectively prohibits plans from employing top experts to make the decisions in very specialized cases. Out-of-state expertise provides significant benefits to patients, especially when dealing with rare diseases. While I believe very strongly that physicians should be making medical necessity decisions, the requisite expertise to make these decisions sometimes lies beyond our borders."

California Insurance Code

The California Insurance Code governs disability insurers. Section 10123.135(c) specifically states that "the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state...." While 10123.135(e) in pertinent part states "An individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may not deny or modify requests for authorization of health care services for an insured for reasons of medical necessity."

Here is yet another example of a statute which recognizes that in terms of requiring California licensure, the license requirements of a medical director may differ from the requirements of the physician who works under the medical director.

As with the definition of "physician" in the Knox-Keen Act, the definition of "physician" in the Insurance code provides at section 10192.5(h) that "Physician" shall not be defined more restrictively than as defined in the Medicare program. The Utilization Review Standards definition of "Reviewer" is compatible because it is not more restrictive than the definition of "physician" found in the Medicare program.

Medi-Cal Program

In California, the federal Medicaid Program is administered by the state as the California Medical Assistance Program (Medi-Cal). This program provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled).

Title 22, California Code of Regulations, section 51053, which governs the California Medical Assistance Program, defines "Physician" as a doctor of medicine or osteopathy. Section 51228 also provides that in order to participate in the Medi-Cal Program "A physician shall be licensed as a physician and surgeon by the California Board of Medical Quality Assurance or the California Board of Osteopathic Examiners *or similarly licensed by a comparable agency of the state in which he practices.*" (Emphasis added.) The Medi-Cal system, therefore, allows for participation by physicians licensed outside of California. *Cabbage v. Parker Community*

Hospital (1984) 744 F.2d 665; *County of Sacramento v. Lackner* (1979) 97 Cal.App.3d 576 (A Medi-Cal number permits a health care provider to receive reimbursement from the state for services rendered to eligible California residents.)

In addition, Title 22, section CCR 51006 of the California Medical Assistance Program also enumerates instances when out of state coverage is appropriate as follows:

“(a) Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:

- (1) When an emergency arises from accident, injury or illness; or
- (2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or
- (3) Where the health of the individual would be endangered if he undertook travel to return to California; or
- (4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or
- (5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the State.”

This reference, although not specifically related to utilization review, shows that in other contexts, a physician who is licensed in a state other than California may practice medicine in a program administered by the State of California. The references to the Knox-Keene Act and the California Insurance Code demonstrate that there are pre-existing models which allow for a physician who is licensed in a state other than California to practice California utilization review functions.

Section 9792.6(r)—Definition of the term “utilization review plan.”

Labor Code section 4610 requires every employer to “establish a utilization review process” (Lab. Code, §4610(b)) which shall “be filed with the Administrative Director” (Lab. Code, §4610(c)). The utilization review process is contained in the “utilization review plan.” It is necessary to define the term utilization review plan to mean the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

Section 9792.6(s)—Definition of the term “utilization review process.”

Labor Code section 4610(b) requires the employer to establish a “utilization review process.” It is necessary to define this term in context with utilization review and workers’ compensation in the State of California. This process means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. It also necessary to clarify that utilization review does not include determinations of the work-relatedness of injury or

disease, or bill review for the purpose of determining whether the medical services were accurately billed. Utilization review is limited to a review on the basis of medical necessity.

Section 9792.6(t)—Definition of the term “written.”

The regulations require that the request for authorization be submitted either in oral form or in written form. If the request for authorization is submitted in oral form, a confirmation of the oral request must be submitted in written form. It is necessary to define the term "written" to include a facsimile as well as communications in paper form.

Section 9792.7 Utilization Review Standards—Applicability

Necessity:

The total annual cost of the California workers’ compensation system more than doubled from 1995 to 2002, growing from about \$9.5 billion to about \$25 billion. During the same time, workers’ compensation medical expenditures increased from \$2.6 billion to \$5.3 billion per year. It is estimated that in 2004, medical payments will account for two-thirds of all workers’ compensation costs. (Commission on Health and Safety and Workers’ Compensation, Workers’ Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf.)

The rise in medical care expenditures has adversely affected the entire workers’ compensation system. Employers in California experience higher costs for workers’ compensation medical care than employers in most other states. California ranks highest in workers’ compensation premiums. Studies indicate that the high utilization of specific kinds of medical services in California workers’ compensation system is one of the major reasons for the difference. Pursuant to the Workers’ Compensation Research Institute, the median number of medical visits per workers’ compensation claim in California is more than 70 percent greater than other states. The higher utilization is mostly due to higher rates of specific kinds of services including, physical medicine, psychological therapy, and chiropractic care. Further, the evidence for higher medical costs in workers’ compensation relative to group health is consistently strong. Studies indicate a substantial positive differential for workers’ compensation medical care. The studies find that workers’ compensation pays 33%-300% more than group health to treat the same conditions. Over-utilization of medical treatment not only affects the costs of the California workers’ compensation system but it also can be injurious to the injured worker. Over-utilization of medical treatment exposes the injured worker to unnecessary risk of harm. Many medical procedures have a risk attached to them and each time they are performed, the risk of a problem increases. When injured workers are over-treated they often suffer injuries as a result of the treatment. The over-utilization of medical treatment can lead to the injured worker not returning to work and losing his or her job. Utilization review protects the injured worker by not allowing treatment that could be injurious to them. (Commission on Health and Safety and Workers’ Compensation, Workers’ Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf; Outline: Estimating the Range of Savings from Introduction of Guidelines Including ACOEM (Revised), Frank Neuhauser, UC DATA/Survey Research Center, University of California, Berkeley, October 20, 2003, <http://www.dir.ca.gov/chswc/EstimatingRangeSavingsGuidelinesACOEM.doc>.)

In response to the State's widely-acknowledged workers' compensation crisis, the Legislature passed Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004) which adopted several provisions designated to control workers' compensation costs. Among these provisions, Senate Bill 228 adopted Labor Code section 4610, requiring employers to establish and maintain a utilization review process. Pursuant to the statute, the Administrative Director sets forth the requirement in section 9792.7(a) that every claims administrator must establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury. The utilization review process must be set forth in a utilization review plan. To assist the public in setting forth the utilization review plan, the Administrative Director enumerates the information which needs to be included in the plan in section 9792.7, subdivisions (a)(1) through (a)(5). This information is necessary to assist the Division of Workers' Compensation in evaluating the utilization review plans to ensure that the plans comply with the requirements of the statute which are listed in Labor Code section 4610(f).

It is necessary to set forth the responsibility of the medical director of the utilization review process as provided in section 9792.7(b)(1). Labor Code section 4610(d) requires that the employer, insurer or utilization review entity employ or designate a medical director to ensure that the process by which the claims administrator reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with the requirements of the statute. Further, the Labor Code section 4610(e) requires that when a request is being evaluated for reasons of medical necessity to cure or relieve the effects of the industrial injury, if the reviewer is going to delay, modify or deny the request, that reviewer must be a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice. It is necessary to set forth this requirement in section 9792.7(b)(2). (Further, see statement of necessity above regarding the definition of reviewer.)

It is necessary to differentiate those situations under utilization review where the request for authorization of proposed medical treatment is approved as opposed to denied, modified or delayed. As stated above, the statute (Labor Code section 4610(e)) requires a licensed physician to be involved in the utilization review when the request for authorization of proposed medical treatment is being denied, modified or delayed "for reasons of medical necessity." Thus, the statute does not prohibit a non-physician from evaluating the request for authorization and communicating with the requesting physician regarding the request and approving such request. The statute envisions that many requests for authorization of medical treatment would be resolved at the non-physician level for purposes of providing expedited services to the injured worker. Section 9792.7(b)(3) sets forth the proper procedure in this regard, delineating the limitations of the review pursuant to the statute (see, Labor Code section 4610(g)).

It is necessary to set forth the requirement pursuant to Labor Code section 4610(c) that the utilization review plan must be filed with the Administrative Director in section 9792.7(c), and to facilitate the filing of the plans. If different claims administrators are using the same utilization review company and the utilization review company has already filed the plan with the Administrative Director, the regulations allow the claims administrator to submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions. Further, in order to have complete updated plans it is necessary to require the filing of a modified utilization review plan when material modifications to the plan

have occurred. (See explanation of necessity regarding the definition of “material modification” above.

Labor Code section 4610(d)(5) requires that the complete utilization review plan be made available to the public upon request. It is necessary to set forth this requirement in section 9792.7(d). In order to provide the exchange of information the regulations allow the claims administrator to make available the complete utilization review plan through electronic means, and to avoid excessive costs to companies the regulations allow the claims administrator to charge reasonable copying and postage expenses related to disclosing the complete utilization review plan when the request is of a hard copy of the plan.

Section 9792.8 Utilization Review Standards—Medically-Based Criteria

Necessity:

Labor Code section 5307.27 requires the Administrative Director to adopt a medical treatment utilization schedule that incorporates evidence-based, peer reviewed, and nationally recognized standards of care, which shall address, at a minimum, the frequency, duration, intensity and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation. Labor Code section 4604.4(a) provides that upon adoption by the administrative director of a medical treatment utilization schedule, the recommended guidelines set forth in the schedule are presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof. Labor Code section 4604.4(b) provides that the recommended guidelines set forth in the schedule shall reflect practices that are evidence and scientifically-based, nationally recognized, and peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

Using parallel language, Labor Code section 4604.4(c) provides that until the effective date of a medical treatment utilization schedule, the recommended guidelines set forth in the ACOEM Practice Guidelines are presumptively correct on the issue of extent and scope of medical treatment, regardless of date of injury; that the presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury, in accordance with Section 4600; and that the presumption created is one affecting the burden of proof. Labor Code section 4610(b) provides, in relevant part, that the “policies and procedures governing the utilization review process shall be consistent with” the ACOEM Practice Guidelines. Labor Code section 4610(f)(2), relating to the requirements of the criteria or guidelines used in the utilization review process as set forth in the utilization review plan requires that “prior to the adoption of the [utilization review] schedule, the policies and procedures [governing the utilization review process] shall be consistent with” the ACOEM Practice Guidelines.

It is necessary to set forth the medically-based criteria pursuant to the above referenced Labor Code sections in section 9792.8. Section 9792.8(a)(1) provides that the medical criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code section 5307.27, and that prior to adoption of the schedule, the medical criteria or medical guidelines used in the utilization review process shall be consistent with the ACOEM Practice Guidelines. Further, it is necessary to set forth the presumption of correctness pursuant to the above-referenced Labor Codes in the regulations. Thus, this section provides that the guidelines set forth in the ACOEM Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to Labor Code section 5307.27. The section further provides that the presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

In response to the over-utilization problem previously described, the legislature has adopted Labor Code section 4604.5(d)(1), stating “[n]otwithstanding the medical treatment utilization schedule or the guidelines set forth in the [ACOEM] Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. Section 4604(d)(2), however, provides for the exception that the “subdivision shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services.”

It is necessary to set forth the physical medicine limitations in this section setting forth the medically-based criteria in subdivision (d)(1) as required by the statute to inform the public that there are areas where the statute sets forth specific limitations in the medical treatment areas of chiropractic, occupational therapy and physical therapy treatment. The statute, however, provides an exception when the employer authorizes, in writing, additional treatment. It is necessary to set forth this exception in section 9792.8(d)(2) because there are many instances when further treatment is necessary, as for example, post-surgical situations.

Labor Code section 4604.5(b) provides that “[t]he recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer-reviewed.” It further provides that “[t]he guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.” In adopting Labor Code section 4604.5, the legislature indicated that the schedule and the ACOEM Practice Guidelines are intended to offer “an analytical framework for the evaluation and treatment” of injured workers. The legislature was aware that there would be treatment which would be addressed neither by the schedule nor by the ACOEM Practice Guidelines. Thus, Labor Code section 4604.5(e) was adopted to provide that “[f]or all injuries not covered by the [ACOEM] Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.”

It is necessary to set forth this element of the medically-based criteria in the utilization review standards regulations in section 9792.8(a)(2) to clarify that medical treatment not addressed by the ACOEM Guidelines is permitted as long as this treatment is “in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based. Further, during the rulemaking process it was learned that some claims administrators were denying medical treatment on the basis that the treatment was not addressed by the ACOEM Practice Guidelines. It is necessary to emphasize in the regulations treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5307.27. Further, it is necessary to clarify that after the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, treatment may not be denied on the sole basis that the treatment is not addressed by that schedule.

Labor Code section 4610(f)(4) provides that the criteria or guidelines used in the decision to approve, modify, delay or deny the request for authorization for proposed medical treatment shall be disclosed to the physician and employee, if used as the basis for the decision. It is necessary to set forth this requirement in section 9792.8(3) pursuant to the statute, and to clarify that only the relevant portion of the criteria or guideline must be disclosed. Further, as it is the practice in workers’ compensation laws, if the injured worker is represented by an attorney, service of decisions relating to the injured worker’s case must be served on the attorney of the injured worker. As required under Labor Code section 4610(f)(5), section 9792.8(3) provides that the claims administrator may not charge the requesting physician, the injured worker and/or his or her attorney for a copy of the relevant portion of the criteria or guidelines used to modify, delay or deny the treatment request.

It is necessary to provide in section 9792.8(a)(4) that “[n]othing in this section precludes authorization of medical treatment not included in the specific criteria under section 9792.8(a)(3). This subdivision is necessary to allow claims administrators to approve treatment which best addresses the medical needs of the injured worker.

Section 9792.9 Utilization Review Standards—Timeframe, Procedures and Notice Content

Necessity:

Labor Code section 4610 sets forth very restrictive timeframes to be used in the utilization review process. As it is common, when there are restrictive timeframes, disputes arise causing delay. In order to facilitate understanding of the requirements of the statute, section 9792.9 sets forth the timeframes provided by the statute, the procedures required by the statute, and the notices required by the statute to protect the rights of the parties.

It is necessary to provide in the regulations in section 9792.9(a) that “[t]he request for authorization for a course of treatment as defined in section 9792.6(e) must be in written form.” This documentation is necessary to avoid disputes relating to whether authorization was provided. To avoid further disputes, it is necessary to clarify in section 9792(a)(1) when the written request for authorization is deemed to have been received by the claims administrator by facsimile, and what type of information is required on the copy of the request. Labor Code

section 4610(g)(2) provides that prospective or concurrent decisions related to an expedited review must be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. Thus, it is necessary to require the requesting physician to indicate the need for an expedited review upon submission of a facsimile request to alert the claims administrator of the expedited nature of the request and avoid unnecessary and unjustified interruption of provision of medical treatment.

For the same reasons, it is necessary to clarify in section 9792(a)(2) when the written request for authorization is deemed to have been received by the claims administrator by mail.

As previously stated, Labor Code section 4610 provides very strict timeframes for the utilization review process. It is necessary to set forth in Section 9792.9(b) these timeframes in a clear and concise manner so as to enable proper compliance with the statute. Labor Code section 4610(g) provides that "[i]n determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees" certain requirements must be met.

One of these requirements is contained in Labor Code section 4610(g)(1), which states that "[p]rospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician."

Consistent with Labor Code section 4610(g)(1), it is necessary to set forth this timeframe in the section 9792.9(b)(1) to state that prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for authorization. Section 9792.9(b)(2) further clarifies Labor Code section 4610(g)(1) by providing that if appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. Consistent with Labor Code section 4610(g)(1), however, section 9792.9(b)(2) makes it clear that in no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider. Thus, section 9792.9, subdivisions (b)(1) and (b)(2) clearly state that the claims administrator has five days to make the decision on the request, but if further information is required that information may be requested and considered up to the 14th day. On the 14th day, however, a decision on the request must be issued when conducting prospective or concurrent review.

It is necessary to clarify in section 9792.9(b)(2)(A) that if the information requested under Labor Code section 4610(g)(1) is not received within the 14 days, the request must be denied by a reviewer (if so decided by the claims administrator) with the stated condition that the request will be considered upon receipt of the information requested. This is consistent with the requirement in Labor Code section 4610(e) that only a licensed physician may deny a request for authorization.

Labor Code section 4610 not only provides a timeframe for when decisions are made, but it also provides a different timeframe for when and how decisions are communicated to the requesting physician. Moreover, Labor Code section 4610 provides for different manners of communicating the decision depending on whether the decision is to “approve” or whether the decision is to “modify, delay or deny” the request for authorization. Labor Code section 4610(g)(3)(A) provides that “[d]ecisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees *shall be communicated to the requesting physician within 24 hours of the decision.*” The statute further provides that “[d]ecisions resulting in modification, delay, or denial of all or part of the requested health care service *shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review.*”

As provided by the statute, while the physician is entitled to communication of the utilization review decision by telephone within 24 hours for concurrent and prospective review, the employee is not entitled to this communication. However, when the decision is to modify, delay or deny the request, the decision must be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review. It is necessary to clarify section 4610 in section 9792.9, subdivisions (b)(3) and (b)(4). Subdivision (b)(3) provides that “[d]ecisions to approve a physician’s request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve a request shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review.” Subdivision (b)(4) provides, on the other hand, that “[d]ecisions to modify, delay or deny a physician’s request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review.” Further this section provides that “[i]n addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.” This requirement is to facilitate communication between the non-physician provider of goods or services and the requesting physician for purposes of having the requesting physician discuss the decision with the reviewer. A copy of the decision is not provided to the non-physician provider of goods or services to protect patient privacy rights.

Because of the strict timeframes in the statute, it is necessary to define a “normal business day in section 9792.9(b)(5) for clarification purposes to mean “a business day as defined in Labor Code section 4600.4 and Civil Code section 9.”

In addition to concurrent review and prospective review, Labor Code section 4610 provides for retrospective review. Subdivision (g)(1) provides that “[i]n cases where the review is

retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.”

It is necessary to set forth the timeframe for prospective review provided for in the statute in section 9792.9(c), which states “[w]hen review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination.” Further this section provides for communication of the decision to the non-physician provider of goods or services. A copy of the decision is not provided to the non-physician provider of goods or services to protect patient privacy rights.

Emergency health care services are not subject to concurrent or prospective review. It is necessary to clarify in Section 9792.9(d) that failure to obtain prior authorization for emergency health care services is not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. However, it is reasonable to provide that emergency health care services may be subjected to retrospective review, and that documentation for emergency health care services shall be made available to the claims administrator upon request.

Labor Code section 4610(g)(2) provides a specific timeframe for prospective or concurrent decisions related to an expedited review. This section provides that “[w]hen the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.”

It is necessary to set forth in section 9792.9(e) the timeframe for expedited review related to prospective or concurrent decisions, and the type of situations as set forth in the statute which require expedited review. The timeframe pursuant to the statute is set forth in this section as not to exceed 72 hours after receipt of the written information necessary to make the decision. Moreover, it is necessary to provide that the requesting physician must indicate the need for an expedited review upon submission of the request, to assure that the services are properly evaluated in a timely fashion, and that the strict timeframe under these circumstances is met. The section describes the two situations subject to expedited review in 9792.9(e)(1) and (2).

Labor Code section 4610(e) further qualifies the type of licensed physician which may modify, delay or deny a request for authorization of proposed medical treatment for reasons of medical necessity. The licensed physician must be “competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice.”

It is necessary to describe at 9792.9(f) the required qualifications of the licensed physician modifying, delaying or denying a request for authorization of proposed medical treatment for reasons of medical necessity. Section 9792.9(f) provides that “[t]he review and decision to deny, delay or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual’s practice.”

Labor Code section 4610(g)(5) provides that “[i]f the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered.”

It is necessary to clarify Labor Code section 4610 to reflect that there are situations where the timeframes specified in the statute at section 4610(g)(1) may be extended pursuant to section 4610(g)(5). Thus, section 9792.9(g)(1) provides that the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may only be extended by the claims administrator when the claims administrator is not in receipt of all of the necessary medical information reasonably requested (9792.9(g)(2)(A)), when the reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice (9792.9(g)(2)(B)), or when the claims administrator needs a specialized consultation and review of medical information by an expert reviewer (9792.9(g)(2)(C)).

As indicated above, Labor Code section 4610(g)(5) further provides that, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe. The statute further requires the employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered.

It is necessary to set forth in section 9792.9(g)(2) the requirement that the claims administrator must inform the requesting physician and the injured worker when the timeframe for making the utilization review decision is being extended and the reasons. The regulations further provide for further notice to the injured worker’s attorney as provided for in the regulations, and for limited notification to the provider of goods or services as previously explained above. Because utilization review directly impacts the injured worker’s need for medical treatment and insofar as the Workers’ Compensation Appeals Board Rules provide that an injured worker is entitled to an expedited hearing on the issue of entitlement to medical treatment (sections 10136(b)(1), 10400, and 10408), section 9792.9(g)(2) further provides that the notice extending the time to make a decision must include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker’s attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408.

Labor Code section 4610(g)(5) further provides that “[u]pon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) [of section 4610(g)].” It is necessary to clarify that after the requested information is received the timeframe reverts back to the original timeframe of 5 days as set forth in Labor Code section 4610, subdivision (g)(1). However, because only licensed physicians are permitted under the statute to make decisions to “delay, modify or deny” for purposes of medical necessity, section 9792.9, subdivisions (g)(3) and (g)(4) set forth in separate subdivisions the appropriate timeframes which are applicable under the statute. In connection with concurrent and prospective review, section 9792.9(g)(3) provides that “[u]pon receipt of information pursuant to subdivisions (A), (B), or (C) above, and (b)(2)(A), the claims administrator shall make the decision to approve, and the reviewer shall make a decision to modify or deny, the request for authorization within five (5) working days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivisions (b)(3) or (b)(4).” Moreover, in connection with retrospective review, section 9792.9(g)(4) provides that “[u]pon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, and the reviewer shall make a decision to modify or deny, the request for authorization within thirty (30) days of receipt of the information for retrospective review.”

Labor Code section 4610(h) provides that “[e]very employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.” It is necessary to set forth this requirement in section 9792.9(h). However, because utilization review is being conducted at a national level, it is important to require that the claims administrator maintain telephone access from 9:00 AM to 5:30 PM Pacific Time, on normal business days. It is also necessary to state in the regulation the reason for the requirement of the telephone access, which is for health care providers to request authorization for medical services. Moreover, it is pertinent to require the claims administrator to have a facsimile number available for physicians to request authorization for medical services, and to require that the claims administrator also maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. Reference is again made to the “normal business day” definition in Labor Code section 4600.4 and Civil Code section 9. Because many claims administrator’s office do not stay open 24 hours, it is necessary to facilitate after business hours communications. The regulations provide for this by stating that for purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number for after business hours requests.

As previously indicated, Labor Code section 4610(f)(4) provides that the criteria or guidelines used in the decision to approve, modify, delay or deny the request for authorization for proposed medical treatment shall be disclosed to the physician and employee, if used as the basis for the decision. It is necessary to provide guidance to the public by outlining the necessary information which must be contained in the written decision. Section 9792.9(i) provides a description of the necessary information to be included in a decision approving a request for authorization. A written decision approving a request for treatment authorization must specify the specific medical treatment service approved.

Section 9792.9(j), on the other hand, provides a very detailed description of the information which is required to be included in a written decision modifying, delaying or denying a request for authorization. It is necessary to outline the information which is required to be included in the written decision modifying, delaying or denying the request for medical treatment to protect the due process rights of the injured worker by providing sufficient information to inform the injured worker, and his or attorney, of the basis of the decision and the methods by which an appeal to the decision may be filed on a timely basis. If the injured worker is not represented by counsel, the notice must contain mandatory information regarding the information and assistance office of the Division of Workers' Compensation and contact information.

It is necessary to also provide in the letter modifying, delaying or denying the request for authorization of medical treatment information regarding the reviewer. This information is necessary to allow communication between the requesting physician and the reviewing physician to determine the best medical treatment approach for the specific case. In this regard, section 9792.9(k) provides that the written decision modifying, delaying or denying treatment authorization provided to the requesting physician shall contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. Further, to prevent communication problems, this section requires that the written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

It is necessary to encourage the reviewers conducting utilization review to discuss the requests with the requesting physicians. In this regard, Section 9792.9(l) provides that authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail.

Section 9767.10 Utilization Review Standards—Dispute Resolution

Necessity:

Labor Code section 4610(g)(3)(A) provides, in relevant part, that “[i]f the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062. Labor Code section 4610(g)(3)(B) further provides, in pertinent part, that “[i]f the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062.”

Labor Code section 4062(a) provides as follows: “If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the

other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.”

Pursuant to the statute it is necessary to provide in section 9792.10(a)(1) that if the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code section 4062. It is also necessary to assure that the public learns that the timeframe to file an objection is within 20 days from the utilization review decision as set forth in section 9792.10(a)(2). Because many utilization review organizations provide their own internal appeal programs, the regulations allow for the parties to participate in this program if they so choose, however, the regulations make it clear that when the injured worker or attorney is notified of the internal appeal process, they must also be notified of the appeal process under Labor Code section 4062 per the statute. Thus, the participation is voluntary, and this is reflected in Section 9792.10(a)(3). Moreover, it is necessary to alert the injured worker that he or she is also entitled to file an Application for Adjudication of Claim, and a Request for Expedited Hearing pursuant to sections 10136(b)(1), 10400, and 10408, and request an expedited hearing and decision on his or her entitlement to medical treatment, as stated in Section 9792.10(a)(4).

Labor Code section 4610(g)(3)(B) provides, in relevant part, that “[i]n the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee.” The statute further provides that “[m]edical care provided during a concurrent review shall be care that is medically necessary to cure and relieve” the effects of the industrial injury.

It is necessary to remind the reviewer that the statute sets forth requirements which must be met prior to a concurrent review decision to deny authorization for medical treatment. Section 9792.10(b)(1) and (2) provide pursuant to the statute that in the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. Moreover, the regulations specify that medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury.