§ 9792.6. Utilization Review Standards--Definitions

As used in this Article:

(a) ″ACOEM Practice Guidelines″ means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.

(b) ″Authorization″ means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to *section 4600 of the Labor Code*, subject to the provisions of *section 5402 of the Labor Code*, based on the Doctor's First Report of Occupational Injury or Illness,″ Form DLSR 5021, or on the ″Primary Treating Physician's Progress Report,″ DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.

(c) ″Claims Administrator″ is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to *Labor Code section 4610*. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory Authority

AUTHORITY:

Note: Authority cited:*Sections 133, 4603.5 and 5307.3, Labor Code*. Reference:*Sections 3209.3, 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code*.

History

HISTORY:

1. New section filed 7-20-95; operative 7-20-95. Submitted to OAL for printing only pursuant to *Government Code section 11351* (Register 95, No. 29).

2. Amendment of subsections (a)(4), (c)(1), (c)(3)(iii)-(iv) and (c)(4)(i)-(iii) filed 11-9-98; operative 1-1-99 (Register 98, No. 46).
3. New article 5.5.1 (sections 9792.6-9792.11) and repealer and new section filed 12-9-2004 as an emergency; operative 12-13-2004 (Register 2004, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-2005 or emergency language will be repealed by operation of law on the following day.
4. New article 5.5.1 (sections 9792.6-9792.11) and repealer and new section refiled 4-6-2005 as an emergency; operative 4-12-2005 (Register 2005, No. 14). A Certificate of Compliance must be transmitted to OAL by 8-10-2005 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 4-6-2005 order, including amendment of section and Note, transmitted to OAL 8-10-2005 and filed 9-22-2005 (Register 2005, No. 38).

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