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

Article 4. Certification Standards for Health Care Organizations

§ 9770. Definitions.

(a) "Administrative Director" means the administrative director of the Division of Workers' Compensation.

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

(c) "Division" means the Division of Workers' Compensation.

(d) "Employer" means an employer as defined in Section 3300 of the Labor Code.

(e) "HCO Enrollee" means a person who is eligible to receive services from an HCO.

(f) "Health care organization" ("HCO") means any entity certified as a health care organization by the administrative director pursuant to Section 4600.5 of the Labor Code and this article.

~~(g) "International Classification of Diseases- 9th Revision (ICD-9) code" means the 4 or 5 digit number which identifies the illness, injury, disease, cause of death, or other morbid state of an enrollee that corresponds to the numeric classifications and descriptions listed in International Classification of Diseases. Clinical Modification. 9th Revision (ICD-9CM) US Department of Health and Human Services, Health Care Financing Administration. Washington DC: Superintendent of Documents, and updated successor revised manuals.~~

(g ~~h~~) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(h ~~i~~) "Participating provider" means a provider who is employed by or under contract with an HCO for purposes of providing occupational medical or health services or services required by this article.

(i ~~j~~) "Patient" means an HCO enrollee who is currently obtaining treatment or services for a work-related injury or illness.

(j ~~k~~) "Primary treating physician" means the treating physician primarily responsible for managing the care of the injured worker in accordance with Section 9785.5.

(k ~~l~~) "Professionally recognized standards of care" means health care practice encompassing the learning, skill and clinical judgment ordinarily possessed and used by a provider of good standing in similar circumstances.

(*l* ~~m~~) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(m ~~n~~) "Revocation" means the termination of a health care organization's certification to provide services pursuant to Section 4600.5 of the Labor Code and this article.

(n ~~o~~) "Standard Industrial Classification code" means the 4 digit number which identifies the primary type of economic activity which the employer is engaged in that corresponds to the numeric classifications and descriptions listed in The Standard Industrial Classification Manual 1987, Office of Management and Budget, Washington DC: Superintendent of Documents, US Government Printing Office, 1989, and updated successor revised manuals.

(o ~~p~~) "Suspension" means the health care organization's authority to enter into new, renewed, or amended contracts with claims administrators has been suspended by the administrative director for a specific period of time.

(p ~~q~~) "Utilization review" or "Utilization Management" is the system used to manage, assess, improve, or review patient care and decision-making through case by case assessments of the medical reasonableness or medical necessity of the frequency, duration, level and appropriateness of medical care and services, based upon professionally recognized standards of care. Utilization review may include, but is not limited to, prospective, concurrent, and retrospective review of a request for authorization of medical treatment.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 3300, 4061.5, 4600.5, 5400, 5401 and 5402, Labor Code.

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

§9785 Reporting Duties of the Primary Treating Physician

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

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

procedures contained in the medical provider network pursuant to Labor Code section 4616. For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

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

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

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

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

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

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

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

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

(A) continuing medical treatment; or

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

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061 4062, 4600.5, 4616.3, or 4616.4. If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061, 4062, and 4610.

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

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

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written re~~-~~port to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form ~~DLSR~~ 5021. Emergency and urgent care physicians shall also submit a Form ~~DLSR~~ 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation,

acupuncture). For dates of service prior to October 1, 2015, use Form 5021 (Rev. 4 1992). For dates of service on or after October 1, 2015, use Form 5021 (Rev. 5 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.

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

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

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

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

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

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

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

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

(5) The employee is released from care;

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

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

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.
Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3."

<u>For dates of service prior to October 1, 2015, use Form PR-2 (Rev. 06-05). For dates of service on or after October 1, 2015, use Form PR-2 (Rev. 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.</u>

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

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

(h) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and

Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

For dates of service prior to October 1, 2015, use Form PR-3 (Rev. 06-05) or PR-4 (Rev. 06-05), as applicable. For dates of service on or after October 1, 2015, use Form PR-3 (Rev. 2015) or PR-4 (Rev. 2015), as applicable. Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.

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

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

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

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061, 4061.5, 4062, 4600, 4600.3, 4603.2, 4604.5, 4610.5, 4658.7, 4660, 4662, 4663 and 4664, Labor Code.

§9785.2.1. Form PR-2 "Primary Treating Physician Progress Report" – Services On or After October 1, 2015

[DWC Form PR-2 (Rev. 2015)]

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061.5, 4600, 4603.2, 4610, 4636, 4660, 4662, 4663 and 4664, Labor Code.

§9785.3.1. Form PR-3 "Primary Treating Physician's Permanent and Stationary Report" – Services On or After October 1, 2015

[DWC Form PR-3 (Rev. 2015)]

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061.5, 4600, 4603.2, 4636, 4660, 4662, 4663 and 4664, Labor Code.

§9785.4. Form PR-4 "Primary Treating Physician's Permanent and Stationary Report"

[DWC Form PR-4 (Rev. 06-05)]

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections ~~4600,~~ 4061.5, 4600, 4603.2, 4636, 4604.5, 4660, 4662, 4663 and 4664, Labor Code.

§9785.4.1. Form PR-4 "Primary Treating Physician's Permanent and Stationary Report" – Services On or After October 1, 2015

[DWC Form PR-3 (Rev. 2015)]

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4061.5, 4600, 4603.2, 4636, 4604.5, 4660, 4662, 4663 and 4664, Labor Code.

Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011

Section 9792.5.1 Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides.

(a) The *California Division of Workers' Compensation Medical Billing and Payment Guide*, versions listed below, which set forth billing, payment and coding rules for paper and electronic medical treatment bill submissions, are incorporated by reference. They may be downloaded from the Division of Workers' Compensation through the Department of Industrial Relations' website at www.dir.ca.gov or may be obtained by writing to:

DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
ATTN: MEDICAL BILLING AND PAYMENT GUIDE
P.O. BOX 71010
OAKLAND, CA 94612

(1) California Division of Workers' Compensation Medical Billing and Payment Guide 2011, for bills submitted on or after October 15, 2011.
(2) California Division of Workers' Compensation Medical Billing and Payment Guide, Version 1.1, for bills submitted on or after January 1, 2013.
(3) California Division of Workers' Compensation Medical Billing and Payment Guide, Version 1.2.1, for bills submitted on or after February 12, 2014.
(4) California Division of Workers' Compensation Medical Billing and Payment Guide, Version 1.2.2, for bills submitted on or after October 1, 2015.

(b) The *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide*, versions listed below, which sets forth billing, payment and coding rules and technical information for electronic medical treatment bill submissions, are incorporated by reference. They may be downloaded from the Division of Workers' Compensation website at www.dir.ca.gov or may be obtained by writing to:

DIVISION OF WORKERS' COMPENSATION

MEDICAL UNIT
ATTN: MEDICAL BILLING AND PAYMENT COMPANION GUIDE
P.O. BOX 71010
OAKLAND, CA 94612

(1) California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.0, dated 2012, for bills submitted on or after October 18, 2012.
(2) California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.1, for bills submitted on or after January 1, 2013.
(3) California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.2, for bills submitted on or after February 12, 2014.

Authority: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.
Reference: Section 4600, 4603.2 and 4603.4, Labor Code.