Workers' Compensation Utilization Review Authorization Flow Chart

Under Labor Code Section 4610, services can be prospectively, retrospectively, or concurrently reviewed, approved, modified, expedited, delayed, or denied. A prospective review is any utilization review (UR) conducted prior to the delivery of requested medical services (8 CCR §9792.6 (n)) , where a concurrent review is UR conducted during an inpatient (hospital) stay (8 CCR §9792.6 (d)), and a retrospective review is UR conducted after medical services have been provided and for which approval has not already been given (8 CCR §9792.6 (p)). While all carriers must have a formal UR process, the Labor Code does not require that all requests for medical treatment be sent through the formal UR process, and some reviews may be approved through prior authorization. Emergency health care services, where an injured worker has acute symptoms severe enough that they need immediate medical attention, differ from other reviews in that they are not required to be reviewed at all, but may be reviewed retrospectively. "Prior authorization" is a description of the claims administrator's practice that allows certain specific treatments be provided without first asking for approval. For example, the claims administrator may inform a particular clinic that any treatment given within the first five days of an injury is automatically approved. Under the prior authorization process a physician does not need to ask for approval by submitting a request for authorization.

Under state regulations, AMEs and QMEs cannot treat the injured workers they are evaluating. Therefore, the AME and QME reports are not requests for authorization to provide treatment. If an AME or QME recommend treatment and that treatment did not already go through UR, the TP could subsequently request authorization to provide treatment, based on the recommendations of the AME or QME. The DWC is aware that some employers/insurers are sending some AME and QME reports to UR. It is expected that this area will be clarified in case law, as the statues do not specifically address the issue.

Decisions must be based in whole or in part on medical necessity to cure and relieve treatment recommended by the treating physician (TP). Non-physicians may approve services, but only physicians, as defined by Labor Code Section 3209.3, may deny, modify, or delay services (8 CCR §9792.7 (b) (3)). Treatment decisions must be consistent with standards set forth in the ACOEM Practice Guidelines or if the service is not included in ACOEM, consistent with other nationally-recognized treatment guidelines. An approved request for authorization means assurance that appropriate reimbursement for a specific treatment will be paid (8 CCF §9792.6 (b)).

To be a valid review, the physician reviewer must be competent to evaluate the specific clinical issues involved in the medical treatment and the service must be within their scope of practice. This does not mean that it must be an actual peer-to-peer review. Decisions must be communicated in by fax or phone to the TP within 24 hours and followed-up in writing. The UR decision must contain a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity. The California UR regulations and California scope of practice will be applied to both in state and out of state reviewers.

Disputes are resolved under Labor Code Section 4062 or if the request is for spine surgery, under Labor Code Section 4062 (b).
UR Complaints are filed with the Division of Workers' Compensation—see attached UR Complaint Form. Send a copy to COA.

Only written requests must meet deadlines specified in Section 4610. UR reviewers have no legal responsibility to respond to an oral request in any certain timeframe.