Workers' Comp

California Utilization Review Regulation Updates Effective April 1, 2026

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10 MIN READ

The California Office of Administrative Law has adopted the California Division of Workers' Compensation (CA DWC) rules, 8 CCR §§ 9767.6, 9781, 9785, 9785.6, 9786, 9792.6 et seq and 8 CCR §§ 9792.27.1 and 9792.27.17 relating to requirements for Medical Provider Network (MPN) physicians, change of treating physicians, utilization review (UR) standards, and the drug formulary.

This regulatory alert outlines key updates impacting utilization review, along with related changes tied to MPN physicians, change of treating physicians, and the MTUS drug formulary. These rules go into effect on April 1, 2026.

Utilization Review Standards [§9792.6.1]

Key changes include:

- Deletes definition for "Delay";
- **Authorization**: Removes reference to DWC Form RFA
- **Course of Treatment**: Definition updated
- **Expert Reviewer**: Adds clarification that consultation must be "requested by claims administrator or utilization review organization, necessitating an extension of time, prior to the determination of medical necessity"
- **Material Modification**: Expanded to include "changes in medical director, address, company name or corporate structure"
- **Request for Authorization**: Definition updated
- **Reviewer**: Expanded to include both physician and non-physician reviewers
- **Utilization Review Plan**: Adds definitions for "Normal business day"/"business day" and "Working day"
- Adds definition of "non-physician reviewer" means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment;
    - Specifies that a non-physician reviewer may **not** modify or deny a treatment request;
- Adds definitions for "MTUS Drug Formulary" and "URAC"

Utilization Review Applicability [§9792.7]

UR Plan Timeline Extensions and Approvals

- Adds a 60-day extension after the initial 60-day review period for UR plans; provisional approval if no action after 120 days
- Increases the UR plan appeal timeframe from rejection/denial to 25 days
- Removes January 1, 2004 date restriction; adds "medically necessary" requirement for treatment

New UR Plan Requirements

- UR plans that modify/deny treatment must provide proof of URAC Workers' Compensation Utilization Management Accreditation
- Claims administrators may submit a letter identifying the contracted URO instead of filing a plan if URO has an approved plan on file
- When an employer petitions to change Primary Treating Physician, the panel must be from the current MPN provider listing meeting Access Standards

UR Plan Documentation Requirements

- UR plans modifying/denying treatment must submit DWC Form UR-01 with medical director's signature
- Plans must be submitted on CDs/flash drives in searchable PDF format; electronic signatures accepted
- Submitting the application releases URAC from confidentiality obligations; DWC may obtain URAC documents for compliance verification
- Material modifications must be filed within 30 days with compliance certification

UR Plan Administrative Process

- The Administrative Director must notify organizations within 30 days if the plan is complete or specify missing information
- For plans that deny/modify treatments, an approval/denial decision is required within 60 days of complete submission
- Conditional approvals possible for up to 6 months, with a possible 6-month extension if a good-faith effort is shown
- Denial notifications must state reasons and are effective for 12 months unless a shorter period is agreed upon

UR Plan Appeals and Compliance

- Denied applicants may appeal to the Workers' Compensation Appeals Board within 20 days
- Administrative Director may require plan updates for compliance; organizations have 30 days to implement
- Non-compliance may result in probation, suspension, or revocation

Enforcement Provisions

- Grounds for disciplinary action include operating out of compliance, failure to implement updates, false statements, or non-responsiveness
- Written notice of violations issued with 14-day correction period
- Revoked plans barred from reapplying for 12 months unless shorter period approved
- Suspended/revoked plans must notify all organizations for which they perform UR

DWC Form UR-01: "Utilization Review Plan Application or Modification" [§9792.7.1]

- Adds new section to incorporate DWC Form UR-01 (New 03/2025)

Utilization Review – Medically-Based Criteria [§9792.8]

- Physician reviewers must use criteria consistent with the medical treatment utilization schedule (Labor Code §5307.27), including the methodology for evaluating medical evidence under §9792.25.1
- Treatment beyond utilization schedule coverage may be authorized when medical circumstances warrant an exception (per §9792.21.1(e)), if supported by best available medical evidence

Utilization Review – Receipt of Request for Authorization; Acceptance of Incomplete Request [§9792.9.1]

- Deletes "the DWC Form RFA" and replaces it with "request for authorization";
- Adds a provision that, upon receipt of a request for authorization that does not meet the definition of a complete request for authorization, a claims administrator, non-physician reviewer as allowed, or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five business days from receipt. A request for authorization accepted as complete will be subject to investigation and assessment of administrative penalties;

Utilization Review – Dispute of Liability; Deferral [§9792.9.2]

- Specifies that a claims administrator who determines that Labor Code section 4610(k) precludes the need for utilization review must comply with the requirements under this section;
- Provides that a request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. **Such a request must be reviewed by a physician reviewer, and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5**;

Utilization Review – Timelines [§9792.9.3]

- Clarifies that the first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed or accepted as complete request for authorization;

Utilization Review — Decisions to Approve a Request for Authorization [§9792.9.4]

- Adds language pertaining to drug authorization;
    - For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form must indicate, "generic substitute authorized" or words to that effect and meaning;
    - For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request must indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning;

- For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request must identify the exempt treatment as, “30-day exemption” or words to that effect and meaning;

Utilization Review — Decisions to Modify or Deny a Request for Authorization [§9792.9.5]

- Amends criteria for a written decision modifying, or denying treatment authorization;
  - Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician must provide an explanation for why the requesting physician’s explanation is insufficient;
- Specifies that a utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity must remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician’s practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision;

Utilization Review — Extension of Timeframe for Decision [§9792.9.6]

- Adds language clarifying that if a consultation by an expert reviewer is needed, the specialty of the expert reviewer to be consulted must be identified;

Utilization Review – Medical Treatment – First 30 Days of the Date of Injury [§9792.9.7]

- Allows a treating physician to render medically necessary treatment or services to an injured worker without prospective utilization review for the first 30 days after the date of injury, provided that:
  - The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator;
  - The treatment or service is consistent with the recommendations set forth in the applicable guideline of the adopted medical treatment utilization schedule;
  - The initial treating physician timely submits the “Doctor's First Report of Occupational Injury or Illness,” DIR Form 5021, to the claims administrator, setting forth in detail the anticipated treatment plan for the injured worker;
  - All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator;
    - The form must be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness;
    - Subsequent treating physicians during the 30-day period must submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.
  - The treating physician's medical treatment bill for the non-emergency treatment is submitted to the claims administrator within 30 days of the date the service was provided;
    - Medical treatment bills for emergency treatment services must be submitted within 180 days of the date that the treatment was provided;

- Excludes the following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, from this section:
  - Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary;
  - Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office;
  - Psychological or psychiatric treatment services;
  - Home health care services;
  - Imaging and radiology services, excluding X-rays;
  - All DMEPOS where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than $250.00;
  - Electrodiagnostic medicine;
  - Spinal injections;
- Specifies that if the claims administrator determines, after retrospective review, that a physician providing treatment has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may:
  - Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator;
  - Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician;
  - Terminate the physician from the claims administrator's or employer's medical provider network or health care organization;

Utilization Review — MTUS Drug Formulary [§9792.9.8]

- Provides for the review of Exempt Drugs listed on the MTUS Drug List;
- Provides the types of drugs that can be dispensed to an injured worker without obtaining authorization through prospective review;
- Specifies that for a drug not covered under this section, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator;
- Requires prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under this section to be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed 5 business days from the date of receipt of the request for treatment;

Utilization Review– Dispute Resolution [§9792.10.1]

- Requires a request for independent medical review of a utilization review decision that denies or modifies a medical treatment request to be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator;
- Specifies if the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision;

Investigation Procedures: Labor Code § 4610 Utilization Review Violations [§9792.11]

- Revises investigations practices and penalties for persons in violation of Utilization Review rules.

Administrative Penalty Schedule for Utilization Review and Independent Medical Review Violations [§9792.12]

- Monetary Penalties Established for Failure to:
  - Obtain Administrative Director approval for utilization review plan before operation
  - Obtain/maintain URAC accreditation before starting or continuing UR functions
  - Ensure only physician reviewers modify or deny treatment requests based on medical necessity
  - Ensure only physician reviewers deny authorization requests when necessary information/tests/consultation is missing
  - Prevent non-physician reviewers from denying/modifying treatment requests
  - Follow deferral requirements when medical necessity cannot be determined after applying treatment utilization schedule
  - Discuss and document attempts to discuss care plan options with requesting physician before denying/discontinuing care during concurrent review
  - Respond to complete/accepted authorization requests
  - Make timely decisions for non-expedited reviews within 5 working days of receiving authorization request or requested information
  - Make/issue written decisions within 72 hours for expedited review requests
  - Disclose or make available approved utilization review process descriptions and accompanying written policies/procedures

Formulary – Dispute Resolution [§9792.27.17]

- Provides that formulary disputes may be resolved through the procedure for expedited hearings.

If you have any questions or if we can be of service, please contact our Utilization Review Client Services team at urclientservices@genexservices.com

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