

AMENDED IN ASSEMBLY AUGUST 18, 2016

AMENDED IN ASSEMBLY JUNE 20, 2016

AMENDED IN SENATE APRIL 6, 2016

AMENDED IN SENATE MARCH 28, 2016

**SENATE BILL**

**No. 1160**

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**Introduced by Senator Mendoza**  
*(Principal coauthor: Senator Pan)*

February 18, 2016

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An act to amend Sections ~~138.6, 4604.5, and 4610~~ of 138.4, 138.6, 4610.5, 4610.6, 4903.05, 4903.8, 5307.27, 5710, 5811, and 6409 of, to amend, repeal, and add Section 4610 of, and to add Section 4615 to, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 1160, as amended, Mendoza. ~~Workers' compensation: utilization review: compensation.~~

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

*Existing law requires the administrative director to develop and make available informational material written in plain language that describes the overall workers' compensation claims process, as specified.*

*This bill would require the administrative director to adopt regulations to provide employees with notice regarding access to medical treatment following the denial of a claim under the workers' compensation system.*

Existing law requires the Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations to develop a workers' compensation information system in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, with certain data to be collected electronically and to be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. Existing law requires the administrative director to assess an administrative penalty of not more than \$5,000 in a single year against a claims administrator for a violation of those data reporting requirements.

This bill would increase that penalty assessment to not more than \$10,000. The bill would require the administrative director to post on the Division of Workers' Compensation Internet Web site a list of claims administrators who are in violation of the data reporting requirements. ~~The bill would require penalty assessments, commencing January 1, 2019, of not less than \$15,000 and not more than \$45,000 for those violators if certain criteria are met.~~

~~Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury. Under existing law, an employee may be treated by a physician of his or her own choice at a facility of his or her choice. Existing law requires the administrative director to adopt guidelines that govern the extent and scope of that medical treatment. Under existing law, an employee is entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. Existing law makes these restrictions on visits inapplicable to postsurgical physical medicine and postsurgical rehabilitation services.~~

~~This bill would instead make those restrictions on the numbers of visits inapplicable to physical medicine and rehabilitation services. The bill would require the administrative director to adopt regulations for these purposes, as specified.~~

Existing law requires every employer to establish a utilization review process, and defines "utilization review" as utilization review or 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 and relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with providing medical treatment services. Existing law also provides

for an independent medical review process to resolve disputes over utilization review decisions, as defined.

*This bill would revise and recast provisions relating to utilization review, as specified, with regard to injuries occurring on or after January 1, 2018. Among other things, the bill would set forth the medical treatment services that would be subject to prospective utilization review under these provisions, as provided. The bill would authorize retrospective utilization review for treatment provided under these provisions under limited circumstances, as specified. The bill would establish procedures for prospective and retrospective utilization reviews and set forth provisions for removal of a physician or provider under designated circumstances. On and after January 1, 2018, the bill would establish new procedures for reviewing determinations regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted by the administrative director, as provided. The bill would make conforming changes to related provisions to implement these changes.*

~~This~~

*The bill would, commencing July 1, 2018, require each utilization review process to be accredited by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The bill would require the administrative director to adopt rules to implement the selection of an independent, nonprofit organization for ~~those certification purposes:~~ *accreditation purposes, and as specified.* The bill would authorize the administrative director to adopt rules to require additional specific criteria for measuring the quality of a utilization review process for purposes of ~~certification:~~ *accreditation and provide for certain exemptions. The bill would require the administrative director to develop a system for electronic reporting of documents related to utilization review performed by each employer, to be administered by the division.**

*Existing law requires every lien claimant to file its lien with the appeals board in writing upon a form approved by the appeals board. Existing law requires a lien to be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement, as specified.*

*This bill would require certain lien claimants that file a lien under these provisions to do so by filing a declaration, under penalty of perjury, that includes specified information. The bill would require current lien claimants to also file the declaration by a specified date. The bill would make a failure to file a declaration under these provisions grounds for dismissal of a lien. Because the bill would expand the crime of perjury, the bill would impose a state-mandated local program.*

*The bill would also automatically stay any physician or provider lien upon the filing of criminal charges against that person or entity for specified offenses involving medical fraud, as provided. The bill would authorize the administrative director to adopt regulations to implement that provision.*

*Existing law prohibits the assignment of a lien under these provisions, except under limited circumstances, as specified.*

*This bill would, for liens filed after January 1, 2017, invalidate any assignment of a lien made in violation of these provisions, by operation of law.*

*Existing law requires the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, to adopt, after public hearings, a medical treatment utilization schedule, to incorporate evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission, as specified.*

*This bill would authorize the administrative director to make updates to the utilization schedule by order, which would not be subject to the Administrative Procedure Act, as specified. The bill would require any order adopted pursuant to these provisions to be published on the Internet Web site of the division.*

*Existing law requires a deponent to receive certain expenses and reimbursements if an employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits as a dependent of an injured employee. Existing law authorizes the deponent to a reasonable allowance for attorney's fees, if represented by an attorney licensed in this state.*

*This bill would authorize the administrative director to determine the range of reasonable fees to be paid to a deponent.*

*Existing law provides that it is the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter. Existing law sets forth the qualifications of a qualified interpreter for these purposes, and provides for the settings under which a qualified interpreter may render services.*

*This bill would require the administrative director to promulgate regulations establishing criteria to verify the identity and credentials of individuals that provide interpreter services under these provisions.*

*Existing law requires physicians, as defined, who attend to injured or ill employees to file reports with specific information prescribed by law.*

*This bill would revise those reporting requirements, as prescribed.*

*Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.*

*This bill would make legislative findings to that effect.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: ~~no~~-yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 138.4 of the Labor Code is amended to  
2 read:

3 138.4. (a) For the purpose of this section, “claims  
4 administrator” means a self-administered workers’ compensation  
5 insurer; or a self-administered self-insured employer; or a  
6 self-administered legally uninsured employer; or a  
7 self-administered joint powers authority; or a third-party claims  
8 administrator for an insurer, a self-insured employer, a legally  
9 uninsured employer, or a joint powers authority.

10 (b) With respect to injuries resulting in lost time beyond the  
11 employee’s work shift at the time of injury or medical treatment  
12 beyond first aid:

13 (1) If the claims administrator obtains knowledge that the  
14 employer has not provided a claim form or a notice of potential  
15 eligibility for benefits to the employee, it shall provide the form

1 and notice to the employee within three working days of its  
2 knowledge that the form or notice was not provided.

3 (2) If the claims administrator cannot determine if the employer  
4 has provided a claim form and notice of potential eligibility for  
5 benefits to the employee, the claims administrator shall provide  
6 the form and notice to the employee within 30 days of the  
7 administrator's date of knowledge of the claim.

8 (c) The administrative director, in consultation with the  
9 Commission on Health and Safety and Workers' Compensation,  
10 shall prescribe reasonable rules and regulations, including notice  
11 of the right to consult with an attorney, where appropriate, for  
12 serving on the employee (or employee's dependents, in the case  
13 of death), the following:

14 (1) Notices dealing with the payment, nonpayment, or delay in  
15 payment of temporary disability, permanent disability,  
16 supplemental job displacement, and death benefits.

17 (2) Notices of any change in the amount or type of benefits  
18 being provided, the termination of benefits, the rejection of any  
19 liability for compensation, and an accounting of benefits paid.

20 (3) Notices of rights to select the primary treating physician,  
21 written continuity of care policies, requests for a comprehensive  
22 medical evaluation, and offers of regular, modified, or alternative  
23 work.

24 (d) The administrative director, in consultation with the  
25 Commission on Health and Safety and Workers' Compensation,  
26 shall develop, make fully accessible on the department's Internet  
27 Web site, and make available at district offices informational  
28 material written in plain language that describes the overall  
29 workers' compensation claims process, including the rights and  
30 obligations of employees and employers at every stage of a claim  
31 when a notice is required.

32 (e) Each notice prescribed by the administrative director shall  
33 be written in plain language, shall reference the informational  
34 material described in subdivision (d) to enable employees to  
35 understand the context of the notices, and shall clearly state the  
36 Internet Web site address and contact information that an employee  
37 may use to access the informational material.

38 (f) *On or before January 1, 2018, the administrative director*  
39 *shall adopt regulations to provide employees with notice that they*

1 *may access medical treatment outside of the workers' compensation*  
2 *system following the denial of their claim.*

3 **SECTION 1.**

4 *SEC. 2.* Section 138.6 of the Labor Code is amended to read:

5 138.6. (a) The administrative director, in consultation with  
6 the Insurance Commissioner and the Workers' Compensation  
7 Insurance Rating Bureau, shall develop a cost-efficient workers'  
8 compensation information system, which shall be administered by  
9 the division. The administrative director shall adopt regulations  
10 specifying the data elements to be collected by electronic data  
11 interchange.

12 (b) The information system shall do the following:

13 (1) Assist the department to manage the workers' compensation  
14 system in an effective and efficient manner.

15 (2) Facilitate the evaluation of the efficiency and effectiveness  
16 of the delivery system.

17 (3) Assist in measuring how adequately the system indemnifies  
18 injured workers and their dependents.

19 (4) Provide statistical data for research into specific aspects of  
20 the workers' compensation program.

21 (c) The data collected electronically shall be compatible with  
22 the Electronic Data Interchange System of the International  
23 Association of Industrial Accident Boards and Commissions. The  
24 administrative director may adopt regulations authorizing the use  
25 of other nationally recognized data transmission formats in addition  
26 to those set forth in the Electronic Data Interchange System for  
27 the transmission of data required pursuant to this section. The  
28 administrative director shall accept data transmissions in any  
29 authorized format. If the administrative director determines that  
30 any authorized data transmission format is not in general use by  
31 claims administrators, conflicts with the requirements of state or  
32 federal law, or is obsolete, the administrative director may adopt  
33 regulations eliminating that data transmission format from those  
34 authorized pursuant to this subdivision.

35 (d) (1) The administrative director shall assess an administrative  
36 penalty against a claims administrator for a violation of data  
37 reporting requirements adopted pursuant to this section. The  
38 administrative director shall promulgate a schedule of penalties  
39 providing for an assessment of no more than ten thousand dollars

1 (\$10,000) against a claims administrator in any single year,  
2 calculated as follows:

3 (A) No more than one hundred dollars (\$100) multiplied by the  
4 number of violations in that year that resulted in a required data  
5 report not being submitted or not being accepted.

6 (B) No more than fifty dollars (\$50) multiplied by the number  
7 of violations in that year that resulted in a required report being  
8 late or accepted with an error.

9 (C) Multiple errors in a single report shall be counted as a single  
10 violation.

11 (D) No penalty shall be assessed pursuant to Section 129.5 for  
12 any violation of data reporting requirements for which a penalty  
13 has been or may be assessed pursuant to this section.

14 (2) The schedule promulgated by the administrative director  
15 pursuant to paragraph (1) shall establish threshold rates of  
16 violations that shall be excluded from the calculation of the  
17 assessment, as follows:

18 (A) The threshold rate for reports that are not submitted or are  
19 submitted but not accepted shall not be less than 3 percent of the  
20 number of reports that are required to be filed by or on behalf of  
21 the claims administrator.

22 (B) The threshold rate for reports that are accepted with an error  
23 shall not be less than 3 percent of the number of reports that are  
24 accepted with an error.

25 (C) The administrative director shall set higher threshold rates  
26 as appropriate in recognition of the fact that the data necessary for  
27 timely and accurate reporting may not be always available to a  
28 claims administrator or the claims administrator's agents.

29 (D) The administrative director may establish higher thresholds  
30 for particular data elements that commonly are not reasonably  
31 available.

32 (3) The administrative director may estimate the number of  
33 required data reports that are not submitted by comparing a  
34 statistically valid sample of data available to the administrative  
35 director from other sources with the data reported pursuant to this  
36 section.

37 (4) All penalties assessed pursuant to this section shall be  
38 deposited in the Workers' Compensation Administration Revolving  
39 Fund.



1 (5) The administrative director shall publish an annual report  
2 disclosing the compliance rates of claims administrators and post  
3 the report and a list of claims administrators who are in violation  
4 of the data reporting requirements on the Internet Web site of the  
5 Division of Workers' Compensation.

6 ~~(e) Commencing January 1, 2019, the administrative director~~  
7 ~~shall assess an additional administrative penalty against a claims~~  
8 ~~administrator for a violation of data reporting requirements adopted~~  
9 ~~pursuant to this section of not less than fifteen thousand dollars~~  
10 ~~(\$15,000) and not more than forty-five thousand dollars (\$45,000)~~  
11 ~~in any single year if both of the following are applicable:~~

12 ~~(1) In the immediate previous year, the claims adjuster was~~  
13 ~~assessed a penalty of eight thousand dollars (\$8,000) or more.~~

14 ~~(2) In the current year, the claims adjuster will be assessed a~~  
15 ~~penalty of eight thousand dollars (\$8,000) or more.~~

16 SEC. 2. Section 4604.5 of the Labor Code is amended to read:

17 4604.5. (a) ~~The recommended guidelines set forth in the~~  
18 ~~medical treatment utilization schedule adopted by the~~  
19 ~~administrative director pursuant to Section 5307.27 shall be~~  
20 ~~presumptively correct on the issue of extent and scope of medical~~  
21 ~~treatment. The presumption is rebuttable and may be controverted~~  
22 ~~by a preponderance of the scientific medical evidence establishing~~  
23 ~~that a variance from the guidelines reasonably is required to cure~~  
24 ~~or relieve the injured worker from the effects of his or her injury.~~  
25 ~~The presumption created is one affecting the burden of proof.~~

26 ~~(b) The recommended guidelines set forth in the schedule~~  
27 ~~adopted pursuant to subdivision (a) shall reflect practices that are~~  
28 ~~evidence and scientifically based, nationally recognized, and peer~~  
29 ~~reviewed. The guidelines shall be designed to assist providers by~~  
30 ~~offering an analytical framework for the evaluation and treatment~~  
31 ~~of injured workers, and shall constitute care in accordance with~~  
32 ~~Section 4600 for all injured workers diagnosed with industrial~~  
33 ~~conditions.~~

34 ~~(c) (1) Notwithstanding the medical treatment utilization~~  
35 ~~schedule, for injuries occurring on and after January 1, 2004, an~~  
36 ~~employee shall be entitled to no more than 24 chiropractic, 24~~  
37 ~~occupational therapy, and 24 physical therapy visits per industrial~~  
38 ~~injury.~~

39 ~~(2) (A) Paragraph (1) shall not apply when an employer~~  
40 ~~authorizes, in writing, additional visits to a health care practitioner~~

1 for physical medicine services. Payment or authorization for  
2 treatment beyond the limits set forth in paragraph (1) shall not be  
3 deemed a waiver of the limits set forth by paragraph (1) with  
4 respect to future requests for authorization.

5 (B) The Legislature finds and declares that the amendments  
6 made to subparagraph (A) by the act adding this subparagraph are  
7 declaratory of existing law.

8 (3) Paragraph (1) shall not apply to visits for physical medicine  
9 and rehabilitation services provided in compliance with a  
10 rehabilitation treatment utilization schedule established by the  
11 administrative director pursuant to Section 5307.27. The  
12 administrative director shall adopt regulations to effectuate this  
13 paragraph on or before January 1, 2018.

14 (d) For all injuries not covered by the official utilization schedule  
15 adopted pursuant to Section 5307.27, authorized treatment shall  
16 be in accordance with other evidence-based medical treatment  
17 guidelines that are recognized generally by the national medical  
18 community and scientifically based.

19 SEC. 3. Section 4610 of the Labor Code is amended to read:

20 4610. (a) For purposes of this section, “utilization review”  
21 means utilization review or utilization management functions that  
22 prospectively, retrospectively, or concurrently review and approve,  
23 modify, delay, or deny, based in whole or in part on medical  
24 necessity to cure and relieve, treatment recommendations by  
25 physicians, as defined in Section 3209.3, prior to, retrospectively,  
26 or concurrent with the provision of medical treatment services  
27 pursuant to Section 4600.

28 (b) Every employer shall establish a utilization review process  
29 in compliance with this section, either directly or through its insurer  
30 or an entity with which an employer or insurer contracts for these  
31 services.

32 (c) Each utilization review process shall be governed by written  
33 policies and procedures. These policies and procedures shall ensure  
34 that decisions based on the medical necessity to cure and relieve  
35 or proposed medical treatment services are consistent with the  
36 schedule for medical treatment utilization adopted pursuant to  
37 Section 5307.27. These policies and procedures, and a description  
38 of the utilization process, shall be filed with the administrative  
39 director and shall be disclosed by the employer to employees,  
40 physicians, and the public upon request.

1     ~~(d) If an employer, insurer, or other entity subject to this section~~  
2 ~~requests medical information from a physician in order to~~  
3 ~~determine whether to approve, modify, delay, or deny requests for~~  
4 ~~authorization, the employer shall request only the information~~  
5 ~~reasonably necessary to make the determination. The employer,~~  
6 ~~insurer, or other entity shall employ or designate a medical director~~  
7 ~~who holds an unrestricted license to practice medicine in this state~~  
8 ~~issued pursuant to Section 2050 or 2450 of the Business and~~  
9 ~~Professions Code. The medical director shall ensure that the process~~  
10 ~~by which the employer or other entity reviews and approves,~~  
11 ~~modifies, delays, or denies requests by physicians prior to,~~  
12 ~~retrospectively, or concurrent with the provision of medical~~  
13 ~~treatment services, complies with the requirements of this section.~~  
14 ~~Nothing in this section shall be construed as restricting the existing~~  
15 ~~authority of the Medical Board of California.~~

16     ~~(e) A person other than a licensed physician who is competent~~  
17 ~~to evaluate the specific clinical issues involved in the medical~~  
18 ~~treatment services, and where these services are within the scope~~  
19 ~~of the physician's practice, requested by the physician shall not~~  
20 ~~modify, delay, or deny requests for authorization of medical~~  
21 ~~treatment for reasons of medical necessity to cure and relieve.~~

22     ~~(f) The criteria or guidelines used in the utilization review~~  
23 ~~process to determine whether to approve, modify, delay, or deny~~  
24 ~~medical treatment services shall be all of the following:~~

25         ~~(1) Developed with involvement from actively practicing~~  
26 ~~physicians.~~

27         ~~(2) Consistent with the schedule for medical treatment utilization~~  
28 ~~adopted pursuant to Section 5307.27.~~

29         ~~(3) Evaluated at least annually, and updated if necessary.~~

30         ~~(4) Disclosed to the physician and the employee, if used as the~~  
31 ~~basis of a decision to modify, delay, or deny services in a specified~~  
32 ~~case under review.~~

33         ~~(5) Available to the public upon request. An employer shall~~  
34 ~~only be required to disclose the criteria or guidelines for the~~  
35 ~~specific procedures or conditions requested. An employer may~~  
36 ~~charge members of the public reasonable copying and postage~~  
37 ~~expenses related to disclosing criteria or guidelines pursuant to~~  
38 ~~this paragraph. Criteria or guidelines may also be made available~~  
39 ~~through electronic means. No charge shall be required for an~~

1 employee whose physician's request for medical treatment services  
2 is under review.

3 (g) In determining whether to approve, modify, delay, or deny  
4 requests by physicians prior to, retrospectively, or concurrent with  
5 the provisions of medical treatment services to employees all of  
6 the following requirements shall be met:

7 (1) Prospective or concurrent decisions shall be made in a timely  
8 fashion that is appropriate for the nature of the employee's  
9 condition, not to exceed five working days from the receipt of the  
10 information reasonably necessary to make the determination, but  
11 in no event more than 14 days from the date of the medical  
12 treatment recommendation by the physician. In cases where the  
13 review is retrospective, a decision resulting in denial of all or part  
14 of the medical treatment service shall be communicated to the  
15 individual who received services, or to the individual's designee,  
16 within 30 days of receipt of information that is reasonably  
17 necessary to make this determination. If payment for a medical  
18 treatment service is made within the time prescribed by Section  
19 4603.2, a retrospective decision to approve the service need not  
20 otherwise be communicated.

21 (2) When the employee's condition is such that the employee  
22 faces an imminent and serious threat to his or her health, including,  
23 but not limited to, the potential loss of life, limb, or other major  
24 bodily function, or the normal timeframe for the decisionmaking  
25 process, as described in paragraph (1), would be detrimental to the  
26 employee's life or health or could jeopardize the employee's ability  
27 to regain maximum function, decisions to approve, modify, delay,  
28 or deny requests by physicians prior to, or concurrent with, the  
29 provision of medical treatment services to employees shall be made  
30 in a timely fashion that is appropriate for the nature of the  
31 employee's condition, but not to exceed 72 hours after the receipt  
32 of the information reasonably necessary to make the determination.

33 (3) (A) Decisions to approve, modify, delay, or deny requests  
34 by physicians for authorization prior to, or concurrent with, the  
35 provision of medical treatment services to employees shall be  
36 communicated to the requesting physician within 24 hours of the  
37 decision. Decisions resulting in modification, delay, or denial of  
38 all or part of the requested health care service shall be  
39 communicated to physicians initially by telephone or facsimile,  
40 and to the physician and employee in writing within 24 hours for

1 concurrent review, or within two business days of the decision for  
2 prospective review, as prescribed by the administrative director.  
3 If the request is not approved in full, disputes shall be resolved in  
4 accordance with Section 4610.5, if applicable, or otherwise in  
5 accordance with Section 4062.

6 (B) ~~In the case of concurrent review, medical care shall not be~~  
7 ~~discontinued until the employee's physician has been notified of~~  
8 ~~the decision and a care plan has been agreed upon by the physician~~  
9 ~~that is appropriate for the medical needs of the employee. Medical~~  
10 ~~care provided during a concurrent review shall be care that is~~  
11 ~~medically necessary to cure and relieve, and an insurer or~~  
12 ~~self-insured employer shall only be liable for those services~~  
13 ~~determined medically necessary to cure and relieve. If the insurer~~  
14 ~~or self-insured employer disputes whether or not one or more~~  
15 ~~services offered concurrently with a utilization review were~~  
16 ~~medically necessary to cure and relieve, the dispute shall be~~  
17 ~~resolved pursuant to Section 4610.5, if applicable, or otherwise~~  
18 ~~pursuant to Section 4062. Any compromise between the parties~~  
19 ~~that an insurer or self-insured employer believes may result in~~  
20 ~~payment for services that were not medically necessary to cure~~  
21 ~~and relieve shall be reported by the insurer or the self-insured~~  
22 ~~employer to the licensing board of the provider or providers who~~  
23 ~~received the payments, in a manner set forth by the respective~~  
24 ~~board and in such a way as to minimize reporting costs both to the~~  
25 ~~board and to the insurer or self-insured employer, for evaluation~~  
26 ~~as to possible violations of the statutes governing appropriate~~  
27 ~~professional practices. No fees shall be levied upon insurers or~~  
28 ~~self-insured employers making reports required by this section.~~

29 (4) ~~Communications regarding decisions to approve requests~~  
30 ~~by physicians shall specify the specific medical treatment service~~  
31 ~~approved. Responses regarding decisions to modify, delay, or deny~~  
32 ~~medical treatment services requested by physicians shall include~~  
33 ~~a clear and concise explanation of the reasons for the employer's~~  
34 ~~decision, a description of the criteria or guidelines used, and the~~  
35 ~~clinical reasons for the decisions regarding medical necessity. If~~  
36 ~~a utilization review decision to deny or delay a medical service is~~  
37 ~~due to incomplete or insufficient information, the decision shall~~  
38 ~~specify the reason for the decision and specify the information that~~  
39 ~~is needed.~~

1 ~~(5) If the employer, insurer, or other entity cannot make a~~  
2 ~~decision within the timeframes specified in paragraph (1) or (2)~~  
3 ~~because the employer or other entity is not in receipt of all of the~~  
4 ~~information reasonably necessary and requested, because the~~  
5 ~~employer requires consultation by an expert reviewer, or because~~  
6 ~~the employer has asked that an additional examination or test be~~  
7 ~~performed upon the employee that is reasonable and consistent~~  
8 ~~with good medical practice, the employer shall immediately notify~~  
9 ~~the physician and the employee, in writing, that the employer~~  
10 ~~cannot make a decision within the required timeframe, and specify~~  
11 ~~the information requested but not received, the expert reviewer to~~  
12 ~~be consulted, or the additional examinations or tests required. The~~  
13 ~~employer shall also notify the physician and employee of the~~  
14 ~~anticipated date on which a decision may be rendered. Upon receipt~~  
15 ~~of all information reasonably necessary and requested by the~~  
16 ~~employer, the employer shall approve, modify, or deny the request~~  
17 ~~for authorization within the timeframes specified in paragraph (1)~~  
18 ~~or (2).~~

19 ~~(6) A utilization review decision to modify, delay, or deny a~~  
20 ~~treatment recommendation shall remain effective for 12 months~~  
21 ~~from the date of the decision without further action by the employer~~  
22 ~~with regard to any further recommendation by the same physician~~  
23 ~~for the same treatment unless the further recommendation is~~  
24 ~~supported by a documented change in the facts material to the~~  
25 ~~basis of the utilization review decision.~~

26 ~~(7) Utilization review of a treatment recommendation shall not~~  
27 ~~be required while the employer is disputing liability for injury or~~  
28 ~~treatment of the condition for which treatment is recommended~~  
29 ~~pursuant to Section 4062.~~

30 ~~(8) If utilization review is deferred pursuant to paragraph (7),~~  
31 ~~and it is finally determined that the employer is liable for treatment~~  
32 ~~of the condition for which treatment is recommended, the time for~~  
33 ~~the employer to conduct retrospective utilization review in~~  
34 ~~accordance with paragraph (1) shall begin on the date the~~  
35 ~~determination of the employer's liability becomes final, and the~~  
36 ~~time for the employer to conduct prospective utilization review~~  
37 ~~shall commence from the date of the employer's receipt of a~~  
38 ~~treatment recommendation after the determination of the~~  
39 ~~employer's liability.~~

1 ~~(h) Every employer, insurer, or other entity subject to this section~~  
2 ~~shall maintain telephone access for physicians to request~~  
3 ~~authorization for health care services.~~

4 ~~(i) If the administrative director determines that the employer,~~  
5 ~~insurer, or other entity subject to this section has failed to meet~~  
6 ~~any of the timeframes in this section, or has failed to meet any~~  
7 ~~other requirement of this section, the administrative director may~~  
8 ~~assess, by order, administrative penalties for each failure. A~~  
9 ~~proceeding for the issuance of an order assessing administrative~~  
10 ~~penalties shall be subject to appropriate notice to, and an~~  
11 ~~opportunity for a hearing with regard to, the person affected. The~~  
12 ~~administrative penalties shall not be deemed to be an exclusive~~  
13 ~~remedy for the administrative director. These penalties shall be~~  
14 ~~deposited in the Workers' Compensation Administration Revolving~~  
15 ~~Fund.~~

16 ~~(j) A utilization review process shall be accredited on or before~~  
17 ~~July 1, 2018, and every three years thereafter, or more frequently~~  
18 ~~if deemed necessary by the administrative director, by an~~  
19 ~~independent, nonprofit organization to certify that the utilization~~  
20 ~~review process meets specified criteria, including, but not limited~~  
21 ~~to, timeliness in issuing a utilization review decision, the scope of~~  
22 ~~medical material used in issuing a utilization review decision, and~~  
23 ~~requiring a policy preventing financial incentives to doctors and~~  
24 ~~other providers based on the utilization review decision. The~~  
25 ~~administrative director shall adopt rules to implement the selection~~  
26 ~~of an independent, nonprofit organization for those certification~~  
27 ~~purposes. The administrative director may adopt rules to require~~  
28 ~~additional specific criteria for measuring the quality of a utilization~~  
29 ~~review process for purposes of certification.~~

30 *SEC. 3. Section 4610 of the Labor Code is amended to read:*

31 4610. (a) For purposes of this section, "utilization review"  
32 means utilization review or utilization management functions that  
33 prospectively, retrospectively, or concurrently review and approve,  
34 modify, ~~delay,~~ or deny, based in whole or in part on medical  
35 necessity to cure and relieve, treatment recommendations by  
36 physicians, as defined in Section 3209.3, prior to, retrospectively,  
37 or concurrent with the provision of medical treatment services  
38 pursuant to Section 4600.

39 (b) Every employer shall establish a utilization review process  
40 in compliance with this section, either directly or through its insurer

1 or an entity with which an employer or insurer contracts for these  
2 services.

3 (c) Each utilization review process shall be governed by written  
4 policies and procedures. These policies and procedures shall ensure  
5 that decisions based on the medical necessity to cure and relieve  
6 of proposed medical treatment services are consistent with the  
7 schedule for medical treatment utilization adopted pursuant to  
8 Section 5307.27. These policies and procedures, and a description  
9 of the utilization process, shall be filed with the administrative  
10 director and shall be disclosed by the employer to employees,  
11 physicians, and the public upon request.

12 (d) If an employer, insurer, or other entity subject to this section  
13 requests medical information from a physician in order to  
14 determine whether to approve, modify, ~~delay~~, or deny requests for  
15 authorization, the employer shall request only the information  
16 reasonably necessary to make the determination. The employer,  
17 insurer, or other entity shall employ or designate a medical director  
18 who holds an unrestricted license to practice medicine in this state  
19 issued pursuant to Section 2050 or ~~Section~~ 2450 of the Business  
20 and Professions Code. The medical director shall ensure that the  
21 process by which the employer or other entity reviews and  
22 approves, modifies, ~~delays~~, or denies requests by physicians prior  
23 to, retrospectively, or concurrent with the provision of medical  
24 treatment services, complies with the requirements of this section.  
25 Nothing in this section shall be construed as restricting the existing  
26 authority of the Medical Board of California.

27 (e) No person other than a licensed physician who is competent  
28 to evaluate the specific clinical issues involved in the medical  
29 treatment services, and where these services are within the scope  
30 of the physician's practice, requested by the physician may ~~modify,~~  
31 ~~delay,~~ *modify* or deny requests for authorization of medical  
32 treatment for reasons of medical necessity to cure and relieve.

33 (f) The criteria or guidelines used in the utilization review  
34 process to determine whether to approve, modify, ~~delay~~, or deny  
35 medical treatment services shall be all of the following:

36 (1) Developed with involvement from actively practicing  
37 physicians.

38 (2) Consistent with the schedule for medical treatment utilization  
39 adopted pursuant to Section 5307.27.

40 (3) Evaluated at least annually, and updated if necessary.



1 (4) Disclosed to the physician and the employee, if used as the  
2 basis of a decision to ~~modify, delay,~~ *modify* or deny services in a  
3 specified case under review.

4 (5) Available to the public upon request. An employer shall  
5 only be required to disclose the criteria or guidelines for the  
6 specific procedures or conditions requested. An employer may  
7 charge members of the public reasonable copying and postage  
8 expenses related to disclosing criteria or guidelines pursuant to  
9 this paragraph. Criteria or guidelines may also be made available  
10 through electronic means. No charge shall be required for an  
11 employee whose physician's request for medical treatment services  
12 is under review.

13 (g) In determining whether to approve, ~~modify, delay,~~ *modify*,  
14 or deny requests by physicians prior to, retrospectively, or  
15 concurrent with the provisions of medical treatment services to  
16 employees all of the following requirements shall be met:

17 (1) Prospective or concurrent decisions shall be made in a timely  
18 fashion that is appropriate for the nature of the employee's  
19 condition, not to exceed five working days from the receipt of the  
20 information reasonably necessary to make the determination, but  
21 in no event more than 14 days from the date of the medical  
22 treatment recommendation by the physician. In cases where the  
23 review is retrospective, a decision resulting in denial of all or part  
24 of the medical treatment service shall be communicated to the  
25 individual who received services, or to the individual's designee,  
26 within 30 days of receipt of information that is reasonably  
27 necessary to make this determination. If payment for a medical  
28 treatment service is made within the time prescribed by Section  
29 4603.2, a retrospective decision to approve the service need not  
30 otherwise be communicated.

31 (2) When the employee's condition is such that the employee  
32 faces an imminent and serious threat to his or her health, including,  
33 but not limited to, the potential loss of life, limb, or other major  
34 bodily function, or the normal timeframe for the decisionmaking  
35 process, as described in paragraph (1), would be detrimental to the  
36 employee's life or health or could jeopardize the employee's ability  
37 to regain maximum function, decisions to approve, ~~modify, delay,~~  
38 or deny requests by physicians prior to, or concurrent with, the  
39 provision of medical treatment services to employees shall be made  
40 in a timely fashion that is appropriate for the nature of the

1 employee’s condition, but not to exceed 72 hours after the receipt  
2 of the information reasonably necessary to make the determination.  
3 (3) (A) Decisions to approve, modify, ~~delay~~, or deny requests  
4 by physicians for authorization prior to, or concurrent with, the  
5 provision of medical treatment services to employees shall be  
6 communicated to the requesting physician within 24 hours of the  
7 decision. Decisions resulting in ~~modification, delay~~, *modification*  
8 or denial of all or part of the requested health care service shall be  
9 communicated to physicians initially by telephone or facsimile,  
10 and to the physician and employee in writing within 24 hours for  
11 concurrent review, or within two business days of the decision for  
12 prospective review, as prescribed by the administrative director.  
13 If the request is not approved in full, disputes shall be resolved in  
14 accordance with Section 4610.5, if applicable, or otherwise in  
15 accordance with Section 4062.  
16 (B) In the case of concurrent review, medical care shall not be  
17 discontinued until the employee’s physician has been notified of  
18 the decision and a care plan has been agreed upon by the physician  
19 that is appropriate for the medical needs of the employee. Medical  
20 care provided during a concurrent review shall be care that is  
21 medically necessary to cure and relieve, and an insurer or  
22 self-insured employer shall only be liable for those services  
23 determined medically necessary to cure and relieve. If the insurer  
24 or self-insured employer disputes whether or not one or more  
25 services offered concurrently with a utilization review were  
26 medically necessary to cure and relieve, the dispute shall be  
27 resolved pursuant to Section 4610.5, if applicable, or otherwise  
28 pursuant to Section 4062. Any compromise between the parties  
29 that an insurer or self-insured employer believes may result in  
30 payment for services that were not medically necessary to cure  
31 and relieve shall be reported by the insurer or the self-insured  
32 employer to the licensing board of the provider or providers who  
33 received the payments, in a manner set forth by the respective  
34 board and in such a way as to minimize reporting costs both to the  
35 board and to the insurer or self-insured employer, for evaluation  
36 as to possible violations of the statutes governing appropriate  
37 professional practices. No fees shall be levied upon insurers or  
38 self-insured employers making reports required by this section.  
39 (4) Communications regarding decisions to approve requests  
40 by physicians shall specify the specific medical treatment service

1 approved. Responses regarding decisions to ~~modify, delay, modify~~  
2 or deny medical treatment services requested by physicians shall  
3 include a clear and concise explanation of the reasons for the  
4 employer's decision, a description of the criteria or guidelines  
5 used, and the clinical reasons for the decisions regarding medical  
6 necessity. If a utilization review decision to ~~deny or delay~~ a medical  
7 service is due to incomplete or insufficient information, the  
8 decision shall specify the reason for the decision and specify the  
9 information that is needed.

10 (5) If the employer, insurer, or other entity cannot make a  
11 decision within the timeframes specified in paragraph (1) or (2)  
12 because the employer or other entity is not in receipt of all of the  
13 information reasonably necessary and requested, because the  
14 employer requires consultation by an expert reviewer, or because  
15 the employer has asked that an additional examination or test be  
16 performed upon the employee that is reasonable and consistent  
17 with good medical practice, the employer shall immediately notify  
18 the physician and the employee, in writing, that the employer  
19 cannot make a decision within the required timeframe, and specify  
20 the information requested but not received, the expert reviewer to  
21 be consulted, or the additional examinations or tests required. The  
22 employer shall also notify the physician and employee of the  
23 anticipated date on which a decision may be rendered. Upon receipt  
24 of all information reasonably necessary and requested by the  
25 employer, the employer shall approve, modify, or deny the request  
26 for authorization within the timeframes specified in paragraph (1)  
27 or (2).

28 (6) A utilization review decision to ~~modify, delay, modify~~ or  
29 deny a treatment recommendation shall remain effective for 12  
30 months from the date of the decision without further action by the  
31 employer with regard to any further recommendation by the same  
32 physician for the same treatment unless the further recommendation  
33 is supported by a documented change in the facts material to the  
34 basis of the utilization review decision.

35 (7) Utilization review of a treatment recommendation shall not  
36 be required while the employer is disputing liability for injury or  
37 treatment of the condition for which treatment is recommended  
38 pursuant to Section 4062.

39 (8) If utilization review is deferred pursuant to paragraph (7),  
40 and it is finally determined that the employer is liable for treatment

1 of the condition for which treatment is recommended, the time for  
2 the employer to conduct retrospective utilization review in  
3 accordance with paragraph (1) shall begin on the date the  
4 determination of the employer's liability becomes final, and the  
5 time for the employer to conduct prospective utilization review  
6 shall commence from the date of the employer's receipt of a  
7 treatment recommendation after the determination of the  
8 employer's liability.

9 (h) Every employer, insurer, or other entity subject to this section  
10 shall maintain telephone access for physicians to request  
11 authorization for health care services.

12 (i) If the administrative director determines that the employer,  
13 insurer, or other entity subject to this section has failed to meet  
14 any of the timeframes in this section, or has failed to meet any  
15 other requirement of this section, the administrative director may  
16 assess, by order, administrative penalties for each failure. A  
17 proceeding for the issuance of an order assessing administrative  
18 penalties shall be subject to appropriate notice to, and an  
19 opportunity for a hearing with regard to, the person affected. The  
20 administrative penalties shall not be deemed to be an exclusive  
21 remedy for the administrative director. These penalties shall be  
22 deposited in the Workers' Compensation Administration Revolving  
23 Fund.

24 (j) *This section shall remain in effect only until January 1, 2018,*  
25 *and as of that date is repealed, unless a later enacted statute, that*  
26 *is enacted before January 1, 2018, deletes or extends that date.*

27 *SEC. 4. Section 4610 is added to the Labor Code, to read:*

28 *4610. (a) For purposes of this section, "utilization review"*  
29 *means utilization review or utilization management functions that*  
30 *prospectively, retrospectively, or concurrently review and approve,*  
31 *modify, or deny, based in whole or in part on medical necessity to*  
32 *cure and relieve, treatment recommendations by physicians, as*  
33 *defined in Section 3209.3, prior to, retrospectively, or concurrent*  
34 *with the provision of medical treatment services pursuant to Section*  
35 *4600.*

36 *(b) For all dates of injury occurring on or after January 1, 2018,*  
37 *emergency treatment services and medical treatment rendered for*  
38 *a body part or condition accepted as compensable by the employer,*  
39 *by a member of the medical provider network or health care*  
40 *organization, or by a physician predesignated pursuant to*

1 *subdivision (d) of Section 4600, within the 30 days following the*  
2 *initial date of injury, shall be authorized without prospective*  
3 *utilization review, except as provided in subdivision (c). In the*  
4 *event that the employee is not subject to treatment with a medical*  
5 *provider network, health care organization, or predesignated*  
6 *physician pursuant to subdivision (d) of Section 4600, the employee*  
7 *shall be eligible for treatment under this section within 30 days*  
8 *following the initial date of injury if the treatment is rendered by*  
9 *a physician or facility selected by the employer. For treatment*  
10 *rendered by a medical provider network physician, health care*  
11 *organization physician, a physician predesignated pursuant to*  
12 *subdivision (d) of Section 4600, or an employer-selected physician,*  
13 *the report required under Section 6409 and a complete request*  
14 *for authorization shall be submitted by the physician within five*  
15 *days following the employee's initial visit and evaluation.*

16 *(c) Unless authorized by the employer or rendered as emergency*  
17 *medical treatment, the following medical treatment services, as*  
18 *defined in rules adopted by the administrative director, that are*  
19 *rendered through a member of the medical provider network or*  
20 *health care organization, a predesignated physician, an*  
21 *employer-selected physician, or an employer-selected facility,*  
22 *within the 30 days following the initial date of injury, shall be*  
23 *subject to prospective utilization review under this section:*

24 *(1) Services provided for a condition or occupational injury or*  
25 *illness that is not addressed or allowed for in the medical treatment*  
26 *utilization schedule guidelines adopted pursuant to Section*  
27 *5307.27.*

28 *(2) Pharmaceuticals, to the extent they are neither expressly*  
29 *exempted from prospective review nor authorized by the drug*  
30 *formulary adopted pursuant to Section 5307.27.*

31 *(3) Non-emergency inpatient and outpatient surgery, including*  
32 *all presurgical and postsurgical services.*

33 *(4) Psychological treatment services.*

34 *(5) Home health care services.*

35 *(6) Imaging and radiology services, excluding X-rays.*

36 *(7) All durable medical equipment, whose combined total value*  
37 *exceeds two hundred fifty dollars (\$250), as determined by the*  
38 *official medical fee schedule.*

39 *(8) Electrodiagnostic medicine, including, but not limited to,*  
40 *electromyography and nerve conduction studies.*

1 (9) Any other service designated and defined through rules  
2 adopted by the administrative director.

3 (d) Any request for payment for treatment provided under  
4 subdivision (b) shall comply with Section 4603.2 and be submitted  
5 to the employer, or its insurer or claims administrator, within 30  
6 days of the date the service was provided.

7 (e) If a physician fails to submit the report required under  
8 Section 6409 and a complete request for authorization, as  
9 described in subdivision (b), an employer may remove the  
10 physician's ability under this subdivision to provide further medical  
11 treatment to the employee that is exempt from prospective  
12 utilization review.

13 (f) An employer may perform retrospective utilization review  
14 for any treatment provided pursuant to subdivision (b) solely for  
15 the purpose of determining if the physician is prescribing treatment  
16 consistent with the schedule for medical treatment utilization,  
17 including, but not limited to, the drug formulary adopted pursuant  
18 to Section 5307.27.

19 (1) If it is found after retrospective utilization reviews that there  
20 is a pattern and practice of the physician or provider failing to  
21 render treatment consistent with the schedule for medical treatment  
22 utilization, including the drug formulary, the employer may remove  
23 the ability of the predesignated physician, employer-selected  
24 physician, or the member of the medical provider network or health  
25 care organization under this subdivision to provide further medical  
26 treatment to any employee that is exempt from prospective  
27 utilization review. The employer shall notify the physician or  
28 provider of the results of the retrospective utilization review and  
29 the requirement for prospective utilization review for all subsequent  
30 medical treatment.

31 (2) The results of retrospective utilization review may constitute  
32 a showing of good cause for an employer's petition requesting a  
33 change of physician or provider pursuant to Section 4603 and may  
34 serve as grounds for termination of the physician or provider from  
35 the medical provider network or health care organization.

36 (g) Every employer shall establish a utilization review process  
37 in compliance with this section, either directly or through its  
38 insurer or an entity with which an employer or insurer contracts  
39 for these services.

1 (1) Each utilization review process that modifies or denies  
2 requests for authorization of medical treatment shall be governed  
3 by written policies and procedures. These policies and procedures  
4 shall ensure that decisions based on the medical necessity to cure  
5 and relieve of proposed medical treatment services are consistent  
6 with the schedule for medical treatment utilization, including the  
7 drug formulary, adopted pursuant to Section 5307.27.

8 (2) The employer, insurer, or other entity shall employ or  
9 designate a medical director who holds an unrestricted license to  
10 practice medicine in this state issued pursuant to Section 2050 or  
11 Section 2450 of the Business and Professions Code. The medical  
12 director shall ensure that the process by which the employer or  
13 other entity reviews and approves, modifies, or denies requests by  
14 physicians prior to, retrospectively, or concurrent with the  
15 provision of medical treatment services complies with the  
16 requirements of this section. Nothing in this section shall be  
17 construed as restricting the existing authority of the Medical Board  
18 of California.

19 (3) (A) No person other than a licensed physician who is  
20 competent to evaluate the specific clinical issues involved in the  
21 medical treatment services, and where these services are within  
22 the scope of the physician's practice, requested by the physician  
23 may modify or deny requests for authorization of medical treatment  
24 for reasons of medical necessity to cure and relieve or due to  
25 incomplete or insufficient information under subdivisions (i) and  
26 (j).

27 (B) (i) The employer, or any entity conducting utilization review  
28 on behalf of the employer, shall neither offer nor provide any  
29 financial incentive or consideration to a physician based on the  
30 number of modifications, delays, or denials made by the physician  
31 under this section.

32 (ii) An insurer or third-party administrator shall not refer  
33 utilization review services conducted on behalf of an employer  
34 under this section to an entity in which the insurer or third-party  
35 administrator has a financial interest as defined under Section  
36 139.32. This prohibition does not apply if the insurer or third-party  
37 administrator provides the employer and the administrative  
38 director with prior written disclosure of both of the following:

39 (I) The entity conducting the utilization review services.

1     (ii) *The insurer or third-party administrator's financial interest*  
2 *in the entity.*

3     (C) *The administrative director has authority pursuant to this*  
4 *section to review any compensation agreement, payment schedule,*  
5 *or contract between the employer, or any entity conducting*  
6 *utilization review on behalf of the employer, and the utilization*  
7 *review physician. Any information disclosed to the administrative*  
8 *director pursuant to this paragraph shall be considered*  
9 *confidential information and not subject to disclosure pursuant to*  
10 *the California Public Records Act (Chapter 3.5 (commencing with*  
11 *Section 6250) of Division 7 of Title 1 of the Government Code).*  
12 *Disclosure of the information to the administrative director*  
13 *pursuant to this subdivision shall not waive the provisions of the*  
14 *Evidence Code relating to privilege.*

15     (4) *A utilization review process that modifies or denies requests*  
16 *for authorization of medical treatment shall be accredited on or*  
17 *before July 1, 2018, and shall retain active accreditation while*  
18 *providing utilization review services, by an independent, nonprofit*  
19 *organization to certify that the utilization review process meets*  
20 *specified criteria, including, but not limited to, timeliness in issuing*  
21 *a utilization review decision, the scope of medical material used*  
22 *in issuing a utilization review decision, peer-to-peer consultation,*  
23 *internal appeal procedure, and requiring a policy preventing*  
24 *financial incentives to doctors and other providers based on the*  
25 *utilization review decision. The administrative director shall adopt*  
26 *rules to implement the selection of an independent, nonprofit*  
27 *organization for those accreditation purposes. Until those rules*  
28 *are adopted, the administrative director shall designate URAC as*  
29 *the accrediting organization. The administrative director may*  
30 *adopt rules to do any of the following:*

31     (A) *Require additional specific criteria for measuring the quality*  
32 *of a utilization review process for purposes of accreditation.*

33     (B) *Exempt nonprofit, public sector internal utilization review*  
34 *programs from the accreditation requirement pursuant to this*  
35 *section, if the administrative director has adopted minimum*  
36 *standards applicable to nonprofit, public sector internal utilization*  
37 *review programs that meet or exceed the accreditation standards*  
38 *developed pursuant to this section.*

39     (5) *On or before July 1, 2018, each employer, either directly*  
40 *or through its insurer or an entity with which an employer or*



1 insurer contracts for utilization review services, shall submit a  
2 description of the utilization review process that modifies or denies  
3 requests for authorization of medical treatment and the written  
4 policies and procedures to the administrative director for approval.  
5 Approved utilization review process descriptions and the  
6 accompanying written policies and procedures shall be disclosed  
7 by the employer to employees and physicians and made available  
8 to the public by posting on the employer's, claims administrator's,  
9 or utilization review organization's Internet Web site.

10 (h) The criteria or guidelines used in the utilization review  
11 process to determine whether to approve, modify, or deny medical  
12 treatment services shall be all of the following:

13 (1) Developed with involvement from actively practicing  
14 physicians.

15 (2) Consistent with the schedule for medical treatment  
16 utilization, including the drug formulary, adopted pursuant to  
17 Section 5307.27.

18 (3) Evaluated at least annually, and updated if necessary.

19 (4) Disclosed to the physician and the employee, if used as the  
20 basis of a decision to modify or deny services in a specified case  
21 under review.

22 (5) Available to the public upon request. An employer shall only  
23 be required to disclose the criteria or guidelines for the specific  
24 procedures or conditions requested. An employer may charge  
25 members of the public reasonable copying and postage expenses  
26 related to disclosing criteria or guidelines pursuant to this  
27 paragraph. Criteria or guidelines may also be made available  
28 through electronic means. No charge shall be required for an  
29 employee whose physician's request for medical treatment services  
30 is under review.

31 (i) In determining whether to approve, modify, or deny requests  
32 by physicians prior to, retrospectively, or concurrent with the  
33 provisions of medical treatment services to employees, all of the  
34 following requirements shall be met:

35 (1) Except for treatment requests made pursuant to the  
36 formulary, prospective or concurrent decisions shall be made in  
37 a timely fashion that is appropriate for the nature of the employee's  
38 condition, not to exceed five working days from the receipt of a  
39 request for authorization for medical treatment and supporting  
40 information reasonably necessary to make the determination, but

1 *in no event more than 14 days from the date of the medical*  
2 *treatment recommendation by the physician. Prospective decisions*  
3 *regarding requests for treatment covered by the formulary shall*  
4 *be made no more than five days from the date of the medical*  
5 *treatment request. The request for authorization and supporting*  
6 *documentation may be submitted electronically under rules adopted*  
7 *by the administrative director.*

8 (2) *In cases where the review is retrospective, a decision*  
9 *resulting in denial of all or part of the medical treatment service*  
10 *shall be communicated to the individual who received services, or*  
11 *to the individual's designee, within 30 days of receipt of*  
12 *information that is reasonably necessary to make this*  
13 *determination. If payment for a medical treatment service is made*  
14 *within the time prescribed by Section 4603.2, a retrospective*  
15 *decision to approve the service need not otherwise be*  
16 *communicated.*

17 (3) *When the employee's condition is such that the employee*  
18 *faces an imminent and serious threat to his or her health, including,*  
19 *but not limited to, the potential loss of life, limb, or other major*  
20 *bodily function, or the normal timeframe for the decisionmaking*  
21 *process, as described in paragraph (1), would be detrimental to*  
22 *the employee's life or health or could jeopardize the employee's*  
23 *ability to regain maximum function, decisions to approve, modify,*  
24 *or deny requests by physicians prior to, or concurrent with, the*  
25 *provision of medical treatment services to employees shall be made*  
26 *in a timely fashion that is appropriate for the nature of the*  
27 *employee's condition, but not to exceed 72 hours after the receipt*  
28 *of the information reasonably necessary to make the determination.*

29 (4) (A) *Final decisions to approve, modify, or deny requests*  
30 *by physicians for authorization prior to, or concurrent with, the*  
31 *provision of medical treatment services to employees shall be*  
32 *communicated to the requesting physician within 24 hours of the*  
33 *decision by telephone, facsimile, or, if agreed to by the parties,*  
34 *secure email.*

35 (B) *Decisions resulting in modification or denial of all or part*  
36 *of the requested health care service shall be communicated in*  
37 *writing to the employee, and to the physician if the initial*  
38 *communication under subparagraph (A) was by telephone, within*  
39 *24 hours for concurrent review, or within two business days of the*  
40 *decision for prospective review, as prescribed by the administrative*

1 *director. If the request is modified or denied, disputes shall be*  
2 *resolved in accordance with Section 4610.5, if applicable, or*  
3 *otherwise in accordance with Section 4062.*

4 *(C) In the case of concurrent review, medical care shall not be*  
5 *discontinued until the employee's physician has been notified of*  
6 *the decision and a care plan has been agreed upon by the physician*  
7 *that is appropriate for the medical needs of the employee. Medical*  
8 *care provided during a concurrent review shall be care that is*  
9 *medically necessary to cure and relieve, and an insurer or*  
10 *self-insured employer shall only be liable for those services*  
11 *determined medically necessary to cure and relieve. If the insurer*  
12 *or self-insured employer disputes whether or not one or more*  
13 *services offered concurrently with a utilization review were*  
14 *medically necessary to cure and relieve, the dispute shall be*  
15 *resolved pursuant to Section 4610.5, if applicable, or otherwise*  
16 *pursuant to Section 4062. Any compromise between the parties*  
17 *that an insurer or self-insured employer believes may result in*  
18 *payment for services that were not medically necessary to cure*  
19 *and relieve shall be reported by the insurer or the self-insured*  
20 *employer to the licensing board of the provider or providers who*  
21 *received the payments, in a manner set forth by the respective*  
22 *board and in such a way as to minimize reporting costs both to*  
23 *the board and to the insurer or self-insured employer, for*  
24 *evaluation as to possible violations of the statutes governing*  
25 *appropriate professional practices. No fees shall be levied upon*  
26 *insurers or self-insured employers making reports required by this*  
27 *section.*

28 *(5) Communications regarding decisions to approve requests*  
29 *by physicians shall specify the specific medical treatment service*  
30 *approved. Responses regarding decisions to modify or deny*  
31 *medical treatment services requested by physicians shall include*  
32 *a clear and concise explanation of the reasons for the employer's*  
33 *decision, a description of the criteria or guidelines used, and the*  
34 *clinical reasons for the decisions regarding medical necessity. If*  
35 *a utilization review decision to deny a medical service is due to*  
36 *incomplete or insufficient information, the decision shall specify*  
37 *all of the following:*

38 *(A) The reason for the decision.*

39 *(B) A specific description of the information that is needed.*

1 (C) The date(s) and time(s) of attempts made to contact the  
2 physician to obtain the necessary information.

3 (D) A description of the manner in which the request was  
4 communicated.

5 (j) (1) If an employer, insurer, or other entity subject to this  
6 section requests medical information from a physician in order to  
7 determine whether to approve, modify, or deny requests for  
8 authorization, the employer shall request only the information  
9 reasonably necessary to make the determination.

10 (2) If the employer, insurer, or other entity cannot make a  
11 decision within the timeframes specified in paragraph (1), (2), or  
12 (3) of subdivision (i) because the employer or other entity is not  
13 in receipt of, or in possession of, all of the information reasonably  
14 necessary to make a determination, the employer shall immediately  
15 notify the physician and the employee, in writing, that the employer  
16 cannot make a decision within the required timeframe, and specify  
17 the information that must be provided by the physician for a  
18 determination to be made. Upon receipt of all information  
19 reasonably necessary and requested by the employer, the employer  
20 shall approve, modify, or deny the request for authorization within  
21 the timeframes specified in paragraph (1), (2), or (3) of subdivision  
22 (i).

23 (k) A utilization review decision to modify, delay, or deny a  
24 treatment recommendation shall remain effective for 12 months  
25 from the date of the decision without further action by the employer  
26 with regard to any further recommendation by the same physician,  
27 or another physician within the requesting physician's practice  
28 group, for the same treatment unless the further recommendation  
29 is supported by a documented change in the facts material to the  
30 basis of the utilization review decision.

31 (l) Utilization review of a treatment recommendation shall not  
32 be required while the employer is disputing liability for injury or  
33 treatment of the condition for which treatment is recommended  
34 pursuant to Section 4062.

35 (m) If utilization review is deferred pursuant to subdivision (l),  
36 and it is finally determined that the employer is liable for treatment  
37 of the condition for which treatment is recommended, the time for  
38 the employer to conduct retrospective utilization review in  
39 accordance with paragraph (2) of subdivision (i) shall begin on  
40 the date the determination of the employer's liability becomes

1 *final, and the time for the employer to conduct prospective*  
2 *utilization review shall commence from the date of the employer's*  
3 *receipt of a treatment recommendation after the determination of*  
4 *the employer's liability.*

5 *(n) Every employer, insurer, or other entity subject to this*  
6 *section shall maintain telephone access during California business*  
7 *hours for physicians to request authorization for health care*  
8 *services and to conduct peer-to-peer discussions regarding issues,*  
9 *including the appropriateness of a requested treatment,*  
10 *modification of a treatment request, or obtaining additional*  
11 *information needed to make a medical necessity decision.*

12 *(o) The administrative director shall develop a system for the*  
13 *mandatory electronic reporting of documents related to every*  
14 *utilization review performed by each employer, which shall be*  
15 *administered by the Division of Workers' Compensation. The*  
16 *administrative director shall adopt regulations specifying the*  
17 *documents to be submitted by the employer and the authorized*  
18 *transmission format and timeframe for their submission. For*  
19 *purposes of this subdivision, "employer" means the employer, the*  
20 *insurer of an insured employer, a claims administrator, or a*  
21 *utilization review organization, or other entity acting on behalf of*  
22 *any of them.*

23 *(p) If the administrative director determines that the employer,*  
24 *insurer, or other entity subject to this section has failed to meet*  
25 *any of the timeframes in this section, or has failed to meet any*  
26 *other requirement of this section, the administrative director may*  
27 *assess, by order, administrative penalties for each failure. A*  
28 *proceeding for the issuance of an order assessing administrative*  
29 *penalties shall be subject to appropriate notice to, and an*  
30 *opportunity for a hearing with regard to, the person affected. The*  
31 *administrative penalties shall not be deemed to be an exclusive*  
32 *remedy for the administrative director. These penalties shall be*  
33 *deposited in the Workers' Compensation Administration Revolving*  
34 *Fund.*

35 *(q) This section shall become operative on January 1, 2018.*

36 *SEC. 5. Section 4610.5 of the Labor Code is amended to read:*

37 *4610.5. (a) This section applies to the following disputes:*

38 *(1) Any dispute over a utilization review decision regarding*  
39 *treatment for an injury occurring on or after January 1, 2013.*

1 (2) Any dispute over a utilization review decision if the decision  
2 is communicated to the requesting physician on or after July 1,  
3 2013, regardless of the date of injury.

4 (3) *Any dispute occurring on or after January 1, 2018, over*  
5 *medication prescribed pursuant to the drug formulary adopted*  
6 *pursuant to Section 5307.27.*

7 (b) A dispute described in subdivision (a) shall be resolved only  
8 in accordance with this section.

9 (c) For purposes of this section and Section 4610.6, the  
10 following definitions apply:

11 (1) “Disputed medical treatment” means medical treatment that  
12 has been ~~modified, delayed,~~ *modified* or denied by a utilization  
13 review ~~decision.~~ *decision on the basis of medical necessity.*

14 (2) “Medically necessary” and “medical necessity” mean  
15 medical treatment that is reasonably required to cure or relieve the  
16 injured employee of the effects of his or her injury and based on  
17 the following standards, which shall be applied ~~in the order listed,~~  
18 ~~allowing reliance on a lower ranked standard only if every higher~~  
19 ~~ranked standard is inapplicable to the employee’s medical~~  
20 ~~condition.~~ *as set forth in the medical treatment utilization schedule,*  
21 *including the drug formulary, adopted by the administrative*  
22 *director pursuant to Section 5307.27:*

23 (A) ~~The guidelines~~ *guidelines, including the drug formulary,*  
24 *adopted by the administrative director pursuant to Section 5307.27.*

25 (B) Peer-reviewed scientific and medical evidence regarding  
26 the effectiveness of the disputed service.

27 (C) Nationally recognized professional standards.

28 (D) Expert opinion.

29 (E) Generally accepted standards of medical practice.

30 (F) Treatments that are likely to provide a benefit to a patient  
31 for conditions for which other treatments are not clinically  
32 efficacious.

33 (3) “Utilization review decision” means a decision pursuant to  
34 Section 4610 to ~~modify, delay,~~ *modify* or deny, based in whole or  
35 in part on medical necessity to cure or relieve, a treatment  
36 recommendation or recommendations by a physician prior to,  
37 retrospectively, or concurrent with, the provision of medical  
38 treatment services pursuant to Section 4600 or subdivision (c) of  
39 Section 5402. *“Utilization review decision” may also mean a*  
40 *determination, occurring on or after January 1, 2018, by a*

1 *physician regarding the medical necessity of medication prescribed*  
2 *pursuant to the drug formulary adopted pursuant to Section*  
3 *5307.27.*

4 (4) Unless otherwise indicated by context, “employer” means  
5 the employer, the insurer of an insured employer, a claims  
6 administrator, or a utilization review organization, or other entity  
7 acting on behalf of any of them.

8 (d) If a utilization review decision ~~denies, modifies, or delays~~  
9 *denies or modifies* a treatment ~~recommendation~~, *recommendation*  
10 *based on medical necessity*, the employee may request an  
11 independent medical review as provided by this section.

12 (e) A utilization review decision may be reviewed or appealed  
13 only by independent medical review pursuant to this section.  
14 Neither the employee nor the employer shall have any liability for  
15 medical treatment furnished without the authorization of the  
16 employer if the treatment is ~~delayed, modified, modified~~ or denied  
17 by a utilization review ~~decision~~ *decision*, unless the utilization  
18 review decision is overturned by independent medical review in  
19 accordance with this section.

20 (f) As part of its notification to the employee regarding an initial  
21 utilization review decision *based on medical necessity* that ~~denies,~~  
22 ~~modifies, or delays~~ *denies or modifies* a treatment recommendation,  
23 the employer shall provide the employee with a ~~form not to exceed~~  
24 ~~two pages; one-page form~~ prescribed by the administrative director,  
25 and an addressed envelope, which the employee may return to the  
26 administrative director or the administrative director’s designee  
27 to initiate an independent medical review. *The employee may also*  
28 *request independent medical review electronically under rules*  
29 *adopted by the administrative director.* The employer shall include  
30 on the form any information required by the administrative director  
31 to facilitate the completion of the independent medical review.  
32 The form shall also include all of the following:

33 (1) Notice that the utilization review decision is final unless the  
34 employee requests independent medical review.

35 (2) A statement indicating the employee’s consent to obtain any  
36 necessary medical records from the employer or insurer and from  
37 any medical provider the employee may have consulted on the  
38 matter, to be signed by the employee.

1 (3) Notice of the employee's right to provide information or  
2 documentation, either directly or through the employee's physician,  
3 regarding the following:

4 (A) The treating physician's recommendation indicating that  
5 the disputed medical treatment is medically necessary for the  
6 employee's medical condition.

7 (B) Medical information or justification that a disputed medical  
8 treatment, on an urgent care or emergency basis, was medically  
9 necessary for the employee's medical condition.

10 (C) Reasonable information supporting the employee's position  
11 that the disputed medical treatment is or was medically necessary  
12 for the employee's medical condition, including all information  
13 provided to the employee by the employer or by the treating  
14 physician, still in the employee's possession, concerning the  
15 employer's or the physician's decision regarding the disputed  
16 medical treatment, as well as any additional material that the  
17 employee believes is relevant.

18 (g) The independent medical review process may be terminated  
19 at any time upon the employer's written authorization of the  
20 disputed medical treatment. *Notice of the authorization, any*  
21 *settlement or award that may resolve the medical treatment dispute,*  
22 *or the requesting physician withdrawing the request for treatment,*  
23 *shall be communicated to the independent medical review*  
24 *organization by the employer within five days.*

25 (h) (1) The employee may submit a request for independent  
26 medical review to the ~~division no later than 30 days after the~~  
27 ~~service of the utilization review decision to the employee.~~ *division.*  
28 *The request may be made electronically under rules adopted by*  
29 *the administrative director. The request shall be made no later*  
30 *than as follows:*

31 (A) *For formulary disputes, 10 days after the service of the*  
32 *utilization review decision to the employee.*

33 (B) *For all other medical treatment disputes, 30 days after the*  
34 *service of the utilization review decision to the employee.*

35 (2) If at the time of a utilization review decision the employer  
36 is also disputing liability for the treatment for any reason besides  
37 medical necessity, the time for the employee to submit a request  
38 for independent medical review to the administrative director or  
39 administrative director's designee is extended to 30 days after



1 service of a notice to the employee showing that the other dispute  
2 of liability has been resolved.

3 (3) If the employer fails to comply with subdivision (f) at the  
4 time of notification of its utilization review decision, the time  
5 limitations for the employee to submit a request for independent  
6 medical review shall not begin to run until the employer provides  
7 the required notice to the employee.

8 (4) A provider of emergency medical treatment when the  
9 employee faced an imminent and serious threat to his or her health,  
10 including, but not limited to, the potential loss of life, limb, or  
11 other major bodily function, may submit a request for independent  
12 medical review on its own behalf. A request submitted by a  
13 provider pursuant to this paragraph shall be submitted to the  
14 administrative director or administrative director's designee within  
15 the time limitations applicable for an employee to submit a request  
16 for independent medical review.

17 (i) An employer shall not engage in any conduct that has the  
18 effect of delaying the independent review process. Engaging in  
19 that conduct or failure of the employer to promptly comply with  
20 this section is a violation of this section and, in addition to any  
21 other fines, penalties, and other remedies available to the  
22 administrative director, the employer shall be subject to an  
23 administrative penalty in an amount determined pursuant to  
24 regulations to be adopted by the administrative director, not to  
25 exceed five thousand dollars (\$5,000) for each day that proper  
26 notification to the employee is delayed. The administrative  
27 penalties shall be paid to the Workers' Compensation  
28 Administration Revolving Fund.

29 (j) For purposes of this section, an employee may designate a  
30 parent, guardian, conservator, relative, or other designee of the  
31 employee as an agent to act on his or her behalf. A designation of  
32 an agent executed prior to the utilization review decision shall not  
33 be valid. The requesting physician may join with or otherwise  
34 assist the employee in seeking an independent medical review,  
35 and may advocate on behalf of the employee.

36 (k) The administrative director or his or her designee shall  
37 expeditiously review requests and immediately notify the employee  
38 and the employer in writing as to whether the request for an  
39 independent medical review has been approved, in whole or in  
40 part, and, if not approved, the reasons therefor. If there appears to

1 be any medical necessity issue, the dispute shall be resolved  
2 pursuant to an independent medical review, except that, unless the  
3 employer agrees that the case is eligible for independent medical  
4 review, a request for independent medical review shall be deferred  
5 if at the time of a utilization review decision the employer is also  
6 disputing liability for the treatment for any reason besides medical  
7 necessity.

8 (l) Upon notice from the administrative director that an  
9 independent review organization has been assigned, the employer  
10 shall *electronically* provide to the independent medical review  
11 organization *under rules adopted by the administrative director a*  
12 *copy and list of* all of the following documents within 10 days of  
13 notice of assignment:

14 (1) A copy of all of the employee's medical records in the  
15 possession of the employer or under the control of the employer  
16 relevant to each of the following:

17 (A) The employee's current medical condition.

18 (B) The medical treatment being provided by the employer.

19 (C) ~~The disputed medical treatment requested by the employee.~~  
20 *request for authorization and utilization review decision.*

21 (2) A copy of all information provided to the employee by the  
22 employer concerning employer and provider decisions regarding  
23 the disputed treatment.

24 (3) A copy of any materials the employee or the employee's  
25 provider submitted to the employer in support of the employee's  
26 request for the disputed treatment.

27 (4) A copy of any other relevant documents or information used  
28 by the employer or its utilization review organization in  
29 determining whether the disputed treatment should have been  
30 provided, and any statements by the employer or its utilization  
31 review organization explaining the reasons for the decision to  
32 ~~deny, modify, or delay~~ *deny or modify* the recommended treatment  
33 on the basis of medical necessity. The employer shall concurrently  
34 provide a copy of the documents required by this paragraph to the  
35 employee and the requesting physician, except that documents  
36 previously provided to the employee or physician need not be  
37 provided again if a list of those documents is provided.

38 (m) Any newly developed or discovered relevant medical  
39 records in the possession of the employer after the initial documents  
40 are provided to the independent medical review organization shall

1 be forwarded immediately to the independent medical review  
2 organization. The employer shall concurrently provide a copy of  
3 medical records required by this subdivision to the employee or  
4 the employee's treating physician, unless the offer of medical  
5 records is declined or otherwise prohibited by law. The  
6 confidentiality of medical records shall be maintained pursuant to  
7 applicable state and federal laws.

8 (n) If there is an imminent and serious threat to the health of  
9 the employee, as specified in subdivision (c) of Section 1374.33  
10 of the Health and Safety Code, all necessary information and  
11 documents required by subdivision (l) shall be delivered to the  
12 independent medical review organization within 24 hours of  
13 approval of the request for review.

14 (o) The employer shall promptly issue a notification to the  
15 employee, after submitting all of the required material to the  
16 independent medical review organization, that lists documents  
17 submitted and includes copies of material not previously provided  
18 to the employee or the employee's designee.

19 (p) *The claims administrator who issued the utilization review*  
20 *decision in dispute shall notify the independent medical review*  
21 *organization if there is a change in the claims administrator*  
22 *responsible for the claim. Notice shall be given to the independent*  
23 *medical review organization within five working days of the change*  
24 *in administrator taking effect.*

25 *SEC. 6. Section 4610.6 of the Labor Code is amended to read:*

26 4610.6. (a) Upon receipt of a case pursuant to Section 4610.5,  
27 an independent medical review organization shall conduct the  
28 review in accordance with this article and any regulations or orders  
29 of the administrative director. The organization's review shall be  
30 limited to an examination of the medical necessity of the disputed  
31 medical treatment.

32 (b) Upon receipt of information and documents related to a case,  
33 the medical reviewer or reviewers selected to conduct the review  
34 by the independent medical review organization shall promptly  
35 review all pertinent medical records of the employee, provider  
36 reports, and any other information submitted to the organization  
37 or requested from any of the parties to the dispute by the reviewers.  
38 If the reviewers request information from any of the parties, a copy  
39 of the request and the response shall be provided to all of the

1 parties. The reviewer or reviewers shall also review relevant  
2 information related to the criteria set forth in subdivision (c).

3 (c) Following its review, the reviewer or reviewers shall  
4 determine whether the disputed health care service was medically  
5 necessary based on the specific medical needs of the employee  
6 and the standards of medical necessity as defined in subdivision  
7 (c) of Section 4610.5.

8 (d) (1) The organization shall complete its review and make  
9 its determination in writing, and in layperson's terms to the  
10 maximum extent practicable, ~~within 30 days of the receipt of the~~  
11 ~~request for review and supporting documentation, or within less~~  
12 ~~time as prescribed by the administrative director. If and the~~  
13 ~~determination shall be issued, as follows:~~

14 (A) *For a dispute over medication prescribed pursuant to the*  
15 *drug formulary submitted under subdivision (h) of Section 4610.5,*  
16 *within five working days from the date of receipt of the request for*  
17 *review and supporting documentation, or within less time as*  
18 *prescribed by the administrative director.*

19 (B) *For all other medical treatment disputes submitted for*  
20 *review under subdivision (h) of Section 4610.5, within 30 days of*  
21 *receipt of the request for review and supporting documentation,*  
22 *or within less time as prescribed by the administrative director.*

23 (C) *If the disputed medical treatment has not been provided and*  
24 *the employee's provider or the administrative director certifies in*  
25 *writing that an imminent and serious threat to the health of the*  
26 *employee may exist, including, but not limited to, serious pain,*  
27 *the potential loss of life, limb, or major bodily function, or the*  
28 *immediate and serious deterioration of the health of the employee,*  
29 *the analyses and determinations of the reviewers shall be expedited*  
30 *and rendered within three days of the receipt of the information.*

31 **Subject**

32 (2) *Subject to the approval of the administrative director, the*  
33 *deadlines for analyses and determinations involving both regular*  
34 *and expedited reviews may be extended for up to three days in*  
35 *extraordinary circumstances or for good cause.*

36 (e) The medical professionals' analyses and determinations shall  
37 state whether the disputed health care service is medically  
38 necessary. Each analysis shall cite the employee's medical  
39 condition, the relevant documents in the record, and the relevant  
40 findings associated with the provisions of subdivision (c) to support

1 the determination. If more than one medical professional reviews  
2 the case, the recommendation of the majority shall prevail. If the  
3 medical professionals reviewing the case are evenly split as to  
4 whether the disputed health care service should be provided, the  
5 decision shall be in favor of providing the service.

6 (f) The independent medical review organization shall provide  
7 the administrative director, the employer, the employee, and the  
8 employee's provider with the analyses and determinations of the  
9 medical professionals reviewing the case, and a description of the  
10 qualifications of the medical professionals. The independent  
11 medical review organization shall keep the names of the reviewers  
12 confidential in all communications with entities or individuals  
13 outside the independent medical review organization. If more than  
14 one medical professional reviewed the case and the result was  
15 differing determinations, the independent medical review  
16 organization shall provide each of the separate reviewer's analyses  
17 and determinations.

18 (g) The determination of the independent medical review  
19 organization shall be deemed to be the determination of the  
20 administrative director and shall be binding on all parties.

21 (h) A determination of the administrative director pursuant to  
22 this section may be reviewed only by a verified appeal from the  
23 medical review determination of the administrative director, filed  
24 with the appeals board for hearing pursuant to Chapter 3  
25 (commencing with Section 5500) of Part 4 and served on all  
26 interested parties within 30 days of the date of mailing of the  
27 determination to the aggrieved employee or the aggrieved  
28 employer. The determination of the administrative director shall  
29 be presumed to be correct and shall be set aside only upon proof  
30 by clear and convincing evidence of one or more of the following  
31 grounds for appeal:

32 (1) The administrative director acted without or in excess of the  
33 administrative director's powers.

34 (2) The determination of the administrative director was  
35 procured by fraud.

36 (3) The independent medical reviewer was subject to a material  
37 conflict of interest that is in violation of Section 139.5.

38 (4) The determination was the result of bias on the basis of race,  
39 national origin, ethnic group identification, religion, age, sex,  
40 sexual orientation, color, or disability.

1 (5) The determination was the result of a plainly erroneous  
2 express or implied finding of fact, provided that the mistake of  
3 fact is a matter of ordinary knowledge based on the information  
4 submitted for review pursuant to Section 4610.5 and not a matter  
5 that is subject to expert opinion.

6 (i) If the determination of the administrative director is reversed,  
7 the dispute shall be remanded to the administrative director to  
8 submit the dispute to independent medical review by a different  
9 independent review organization. In the event that a different  
10 independent medical review organization is not available after  
11 remand, the administrative director shall submit the dispute to the  
12 original medical review organization for review by a different  
13 reviewer in the organization. In no event shall a workers'  
14 compensation administrative law judge, the appeals board, or any  
15 higher court make a determination of medical necessity contrary  
16 to the determination of the independent medical review  
17 organization.

18 (j) Upon receiving the determination of the administrative  
19 director that a disputed health care service is medically necessary,  
20 the employer shall promptly implement the decision as provided  
21 by this section unless the employer has also disputed liability for  
22 any reason besides medical necessity. In the case of reimbursement  
23 for services already rendered, the employer shall reimburse the  
24 provider or employee, whichever applies, within 20 days, subject  
25 to resolution of any remaining issue of the amount of payment  
26 pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of  
27 services not yet rendered, the employer shall authorize the services  
28 within five working days of receipt of the written determination  
29 from the independent medical review organization, or sooner if  
30 appropriate for the nature of the employee's medical condition,  
31 and shall inform the employee and provider of the authorization.

32 (k) Failure to pay for services already provided or to authorize  
33 services not yet rendered within the time prescribed by subdivision  
34 (l) is a violation of this section and, in addition to any other fines,  
35 penalties, and other remedies available to the administrative  
36 director, the employer shall be subject to an administrative penalty  
37 in an amount determined pursuant to regulations to be adopted by  
38 the administrative director, not to exceed five thousand dollars  
39 (\$5,000) for each day the decision is not implemented. The

1 administrative penalties shall be paid to the Workers’  
2 Compensation Administration Revolving Fund.

3 (l) The costs of independent medical review and the  
4 administration of the independent medical review system shall be  
5 borne by employers through a fee system established by the  
6 administrative director. After considering any relevant information  
7 on program costs, the administrative director shall establish a  
8 reasonable, per-case reimbursement schedule to pay the costs of  
9 independent medical review organization reviews and the cost of  
10 administering the independent medical review system, which may  
11 vary depending on the type of medical condition under review and  
12 on other relevant factors.

13 (m) The administrative director may publish the results of  
14 independent medical review determinations after removing  
15 individually identifiable information.

16 (n) If any provision of this section, or the application thereof to  
17 any person or circumstances, is held invalid, the remainder of the  
18 section, and the application of its provisions to other persons or  
19 circumstances, shall not be affected thereby.

20 *SEC. 7. Section 4615 is added to the Labor Code, to read:*

21 *4615. Any lien filed by or on behalf of a physician or provider*  
22 *of medical treatment services under Section 4600 or medical-legal*  
23 *services under Section 4060, and any accrual of interest related*  
24 *to the lien, shall be automatically stayed upon the filing of criminal*  
25 *charges against that physician or provider for an offense involving*  
26 *fraud against the workers’ compensation system, medical billing*  
27 *fraud, insurance fraud, or fraud against the Medicare or Medi-Cal*  
28 *programs. The stay shall be in effect from the time of the filing of*  
29 *the charges until the disposition of the criminal proceedings. The*  
30 *administrative director may promulgate rules for the*  
31 *implementation of this section.*

32 *SEC. 8. Section 4903.05 of the Labor Code is amended to read:*

33 4903.05. (a) Every lien claimant shall file its lien with the  
34 appeals board in writing upon a form approved by the appeals  
35 board. The lien shall be accompanied by a full statement or  
36 itemized voucher supporting the lien and justifying the right to  
37 reimbursement and proof of service upon the injured worker or,  
38 if deceased, upon the worker’s dependents, the employer, the  
39 insurer, and the respective attorneys or other agents of record.

1 Medical records shall be filed only if they are relevant to the issues  
2 being raised by the lien.

3 (b) Any lien claim for expenses under subdivision (b) of Section  
4 4903 or for claims of costs shall be filed with the appeals board  
5 electronically using the form approved by the appeals board. The  
6 lien shall be accompanied by a proof of service and any other  
7 documents that may be required by the appeals board. The service  
8 requirements for Section 4603.2 are not modified by this section.

9 (c) (1) *For liens filed on or after January 1, 2017, any lien*  
10 *claim for expenses under subdivision (b) of Section 4903 that is*  
11 *subject to a filing fee under this section shall be accompanied at*  
12 *the time of filing by a declaration stating, under penalty of perjury,*  
13 *that the dispute is not subject to an independent bill review under*  
14 *Section 4603.6 and that the lien claimant satisfies one of the*  
15 *following:*

16 (A) *Is the employee's treating physician providing care through*  
17 *a medical provider network.*

18 (B) *Is the agreed medical evaluator or qualified medical*  
19 *evaluator.*

20 (C) *Has provided treatment authorized by the employer or*  
21 *claims administrator under Section 4610.*

22 (D) *Has made a diligent search and determined that the*  
23 *employer does not have a medical provider network in place.*

24 (E) *Has documentation that medical treatment has been*  
25 *neglected or unreasonably refused to the employee.*

26 (F) *Can show that the expense was incurred for an emergency*  
27 *medical condition, as defined by subdivision (b) of Section 1317.1*  
28 *of the Health and Safety Code.*

29 (2) *For all liens filed prior to January 1, 2017, lien claimants*  
30 *shall have until July 1, 2017, to file the declaration provided under*  
31 *paragraph (1).*

32 (3) *The failure to file a signed declaration under this subdivision*  
33 *shall result in the dismissal of the lien with prejudice by operation*  
34 *of law. Filing of a false declaration shall be grounds for dismissal*  
35 *with prejudice after notice.*

36 (e)

37 (d) All liens filed on or after January 1, 2013, for expenses under  
38 subdivision (b) of Section 4903 or for claims of costs shall be  
39 subject to a filing fee as provided by this subdivision.



1 (1) The lien claimant shall pay a filing fee of one hundred fifty  
2 dollars (\$150) to the Division of Workers' Compensation prior to  
3 filing a lien and shall include proof that the filing fee has been  
4 paid. The fee shall be collected through an electronic payment  
5 system that accepts major credit cards and any additional forms  
6 of electronic payment selected by the administrative director. If  
7 the administrative director contracts with a service provider for  
8 the processing of electronic payments, any processing fee shall be  
9 absorbed by the division and not added to the fee charged to the  
10 lien filer.

11 (2) On or after January 1, 2013, a lien submitted for filing that  
12 does not comply with paragraph (1) shall be invalid, even if lodged  
13 with the appeals board, and shall not operate to preserve or extend  
14 any time limit for filing of the lien.

15 (3) The claims of two or more providers of goods or services  
16 shall not be merged into a single lien.

17 (4) The filing fee shall be collected by the administrative  
18 director. All fees shall be deposited in the Workers' Compensation  
19 Administration Revolving Fund and applied for the purposes of  
20 that fund.

21 (5) The administrative director shall adopt reasonable rules and  
22 regulations governing the procedure for the collection of the filing  
23 fee, including emergency regulations as necessary to implement  
24 this section.

25 (6) Any lien filed for goods or services that are not the proper  
26 subject of a lien may be dismissed upon request of a party by  
27 verified petition or on the appeals board's own motion. If the lien  
28 is dismissed, the lien claimant will not be entitled to reimbursement  
29 of the filing fee.

30 (7) No filing fee shall be required for a lien filed by a health  
31 care service plan licensed pursuant to Section 1349 of the Health  
32 and Safety Code, a group disability insurer under a policy issued  
33 in this state pursuant to the provisions of Section 10270.5 of the  
34 Insurance Code, a self-insured employee welfare benefit plan, as  
35 defined in Section 10121 of the Insurance Code, that is issued in  
36 this state, a Taft-Hartley health and welfare fund, or a publicly  
37 funded program providing medical benefits on a nonindustrial  
38 basis.

39 *SEC. 9. Section 4903.8 of the Labor Code is amended to read:*

1 4903.8. (a) (1) Any order or award for payment of a lien filed  
2 pursuant to subdivision (b) of Section 4903 shall be made for  
3 payment only to the person who was entitled to payment for the  
4 expenses as provided in subdivision (b) of Section 4903 at the time  
5 the expenses were incurred, ~~and not to an assignee~~ *incurred, who*  
6 *is the lien owner, and not to an assignee* unless the person has  
7 ceased doing business in the capacity held at the time the expenses  
8 were incurred and has assigned all right, title, and interest in the  
9 remaining accounts receivable to the assignee.

10 (2) *All liens filed pursuant to subdivision (b) of Section 4903*  
11 *shall be filed in the name of the lien owner only, and no payment*  
12 *shall be made to any lien claimant without evidence that he or she*  
13 *is the owner of that lien.*

14 (2)

15 (3) Paragraph (1) does not apply to an assignment that was  
16 completed prior to January 1, 2013, or that was required by a  
17 contract that became enforceable and irrevocable prior to January  
18 1, 2013. This paragraph is declarative of existing law.

19 (4) *For liens filed after January 1, 2017, the lien shall not be*  
20 *assigned unless the person has ceased doing business in the*  
21 *capacity held at the time the expenses were incurred and has*  
22 *assigned all right, title, and interest in the remaining accounts*  
23 *receivable to the assignee. The assignment of a lien, in violation*  
24 *of this paragraph is invalid by operation of law.*

25 (b) If there has been an assignment of a lien, either as an  
26 assignment of all right, title, and interest in the accounts receivable  
27 or as an assignment for collection, a true and correct copy of the  
28 assignment shall be filed and served.

29 (1) If the lien is filed on or after January 1, 2013, and the  
30 assignment occurs before the filing of the lien, the copy of the  
31 assignment shall be served at the time the lien is filed.

32 (2) If the lien is filed on or after January 1, 2013, and the  
33 assignment occurs after the filing of the lien, the copy of the  
34 assignment shall be served within 20 days of the date of the  
35 assignment.

36 (3) If the lien is filed before January 1, 2013, the copy of the  
37 assignment shall be served by January 1, 2014, or with the filing  
38 of a declaration of readiness or at the time of a lien hearing,  
39 whichever is earliest.

1 (c) If there has been more than one assignment of the same  
2 receivable or bill, the appeals board may set the matter for hearing  
3 on whether the multiple assignments constitute bad-faith actions  
4 or tactics that are frivolous, harassing, or intended to cause  
5 unnecessary delay or expense. If so found by the appeals board,  
6 appropriate sanctions, including costs and attorney's fees, may be  
7 awarded against the assignor, assignee, and their respective  
8 attorneys.

9 (d) At the time of filing of a lien on or after January 1, 2013, or  
10 in the case of a lien filed before January 1, 2013, at the earliest of  
11 the filing of a declaration of readiness, a lien hearing, or January  
12 1, 2014, supporting documentation shall be filed including one or  
13 more declarations under penalty of perjury by a natural person or  
14 persons competent to testify to the facts stated, declaring both of  
15 the following:

16 (1) The services or products described in the bill for services  
17 or products were actually provided to the injured employee.

18 (2) The billing statement attached to the lien truly and accurately  
19 describes the services or products that were provided to the injured  
20 employee.

21 (e) A lien submitted for filing on or after January 1, 2013, for  
22 expenses provided in subdivision (b) of Section 4903, that does  
23 not comply with the requirements of this section shall be deemed  
24 to be invalid, whether or not accepted for filing by the appeals  
25 board, and shall not operate to preserve or extend any time limit  
26 for filing of the lien.

27 (f) This section shall take effect without regulatory action. The  
28 appeals board and the administrative director may promulgate  
29 regulations and forms for the implementation of this section.

30 *SEC. 10. Section 5307.27 of the Labor Code is amended to*  
31 *read:*

32 5307.27. (a) The administrative director, in consultation with  
33 the Commission on Health and Safety and Workers' Compensation,  
34 shall adopt, after public hearings, a medical treatment utilization  
35 schedule, that shall incorporate the evidence-based, peer-reviewed,  
36 nationally recognized standards of care recommended by the  
37 commission pursuant to Section 77.5, and that shall address, at a  
38 minimum, the frequency, duration, intensity, and appropriateness  
39 of all treatment procedures and modalities commonly performed  
40 in workers' compensation cases. *Evidence-based updates to the*

1 utilization schedule shall be made through an order exempt from  
2 Sections 5307.3 and 5307.4, and the rulemaking provisions of the  
3 Administrative Procedure Act (Chapter 3.5 (commencing with  
4 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
5 Code), but the administrative director shall allow at least a 30-day  
6 period for public comment and a public hearing. The administrative  
7 director shall provide responses to submitted comments prior to  
8 the effective date of the updates. All orders issued pursuant to this  
9 subdivision shall be published on the Internet Web site of the  
10 Division of Workers' Compensation.

11 (b) On or before July 1, 2017, the medical treatment utilization  
12 schedule adopted by the administrative director shall include a  
13 drug formulary using evidence-based medicine. Nothing in this  
14 section shall prohibit the authorization of medications that are not  
15 in the formulary when the variance is demonstrated, consistent  
16 with subdivision (a) of Section 4604.5.

17 (c) The drug formulary shall include a phased implementation  
18 for workers injured prior to July 1, 2017, in order to ensure injured  
19 workers safely transition to medications pursuant to the formulary.

20 (d) This section shall apply to all prescribers and dispensers of  
21 medications serving injured workers under the workers'  
22 compensation system.

23 *SEC. 11. Section 5710 of the Labor Code is amended to read:*

24 5710. (a) The appeals board, a workers' compensation judge,  
25 or any party to the action or proceeding, may, in any investigation  
26 or hearing before the appeals board, cause the deposition of  
27 witnesses residing within or without the state to be taken in the  
28 manner prescribed by law for like depositions in civil actions in  
29 the superior courts of this state under Title 4 (commencing with  
30 Section 2016.010) of Part 4 of the Code of Civil Procedure. To  
31 that end the attendance of witnesses and the production of records  
32 may be required. Depositions may be taken outside the state before  
33 any officer authorized to administer oaths. The appeals board or  
34 a workers' compensation judge in any proceeding before the  
35 appeals board may cause evidence to be taken in other jurisdictions  
36 before the agency authorized to hear workers' compensation  
37 matters in those other jurisdictions.

38 (b) If the employer or insurance carrier requests a deposition to  
39 be taken of an injured employee, or any person claiming benefits

1 as a dependent of an injured employee, the deponent is entitled to  
2 receive in addition to all other benefits:

3 (1) All reasonable expenses of transportation, meals, and lodging  
4 incident to the deposition.

5 (2) Reimbursement for any loss of wages incurred during  
6 attendance at the deposition.

7 (3) One copy of the transcript of the deposition, without cost.

8 (4) A reasonable allowance for attorney's fees for the deponent,  
9 if represented by an attorney licensed by the State Bar of this state.  
10 The fee shall be discretionary with, and, if allowed, shall be set  
11 by, the appeals board, but shall be paid by the employer or his or  
12 her insurer. *The administrative director shall determine the range*  
13 *of reasonable fees to be paid.*

14 (5) If interpretation services are required because the injured  
15 employee or deponent does not proficiently speak or understand  
16 the English language, upon a request from either, the employer  
17 shall pay for the services of a language interpreter certified or  
18 deemed certified pursuant to Article 8 (commencing with Section  
19 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or  
20 Section 68566 of, the Government Code. The fee to be paid by the  
21 employer shall be in accordance with the fee schedule adopted by  
22 the administrative director and shall include any other  
23 deposition-related events as permitted by the administrative  
24 director.

25 *SEC. 12. Section 5811 of the Labor Code is amended to read:*

26 5811. (a) No fees shall be charged by the clerk of any court  
27 for the performance of any official service required by this division,  
28 except for the docketing of awards as judgments and for certified  
29 copies of transcripts thereof. In all proceedings under this division  
30 before the appeals board, costs as between the parties may be  
31 allowed by the appeals board.

32 (b) (1) It shall be the responsibility of any party producing a  
33 witness requiring an interpreter to arrange for the presence of a  
34 qualified interpreter.

35 (2) A qualified interpreter is a language interpreter who is  
36 certified, or deemed certified, pursuant to Article 8 (commencing  
37 with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of  
38 Title 2 of, or Section 68566 of, the Government Code. The duty  
39 of an interpreter is to accurately and impartially translate oral  
40 communications and transliterate written materials, and not to act

1 as an agent or advocate. An interpreter shall not disclose to any  
 2 person who is not an immediate participant in the communications  
 3 the content of the conversations or documents that the interpreter  
 4 has interpreted or transliterated unless the disclosure is compelled  
 5 by court order. An attempt by any party or attorney to obtain  
 6 disclosure is a bad faith tactic that is subject to Section 5813.

7 Interpreter fees that are reasonably, actually, and necessarily  
 8 incurred shall be paid by the employer under this section, provided  
 9 they are in accordance with the fee schedule adopted by the  
 10 administrative director.

11 A qualified interpreter may render services during the following:

12 (A) A deposition.

13 (B) An appeals board hearing.

14 (C) A medical treatment appointment or medical-legal  
 15 examination.

16 (D) During those settings which the administrative director  
 17 determines are reasonably necessary to ascertain the validity or  
 18 extent of injury to an employee who does not proficiently speak  
 19 or understand the English language.

20 *(c) The administrative director shall promulgate regulations*  
 21 *establishing criteria to verify the identity and credentials of*  
 22 *individuals who provide interpreter services in all necessary*  
 23 *settings and proceedings within the workers' compensation system.*  
 24 *Those regulations shall be adopted no later than January 1, 2018.*

25 *SEC. 13. Section 6409 of the Labor Code is amended to read:*

26 6409. (a) Every physician as defined in Section 3209.3 who  
 27 attends any injured employee shall file a complete report of ~~every~~  
 28 ~~that~~ occupational injury or occupational illness ~~to the employee~~  
 29 ~~in a manner prescribed by the administrative director of the~~  
 30 ~~Division of Workers' Compensation. The report shall include a~~  
 31 ~~diagnosis, the injured employee's description of how the injury or~~  
 32 ~~illness occurred, any treatment rendered at the time of the~~  
 33 ~~examination, any work restrictions resulting from the injury or~~  
 34 ~~illness, a treatment plan, and other content as prescribed by the~~  
 35 ~~administrative director. The form shall be filed electronically with~~  
 36 ~~the Division of Workers' Compensation and the employer, or if~~  
 37 ~~insured, with the employer's insurer, on forms prescribed for that~~  
 38 ~~purpose by the Department of Industrial Relations. A portion of~~  
 39 ~~the form shall be completed by the injured employee, if he or she~~  
 40 ~~is able to do so, describing how the injury or illness occurred. The~~

1 ~~form shall be filed~~ within five days of the initial examination.  
2 ~~Inability or failure of an injured employee to complete his or her~~  
3 ~~portion of the form shall not affect the employee's rights under~~  
4 ~~this code, and shall not excuse any delay in filing the form. The~~  
5 ~~employer or insurer, as the case may be, shall file the physician's~~  
6 ~~report with the department within five days of receipt. Each report~~  
7 ~~of occupational injury or occupational illness shall indicate the~~  
8 ~~social security number of the injured employee. If the treatment~~  
9 ~~is for pesticide poisoning or a condition suspected to be pesticide~~  
10 ~~poisoning, the physician shall also file a complete report, which~~  
11 ~~need not include the affidavit required pursuant to this section,~~  
12 ~~with the department, and also, within 24 hours of the initial~~  
13 ~~examination shall examination, file a complete report with the~~  
14 ~~local health officer by facsimile transmission or other means. If~~  
15 ~~the treatment is for pesticide poisoning or a condition suspected~~  
16 ~~to be pesticide poisoning, the physician shall not be compensated~~  
17 ~~for the initial diagnosis and treatment unless the report is filed with~~  
18 ~~the *Division of Workers' Compensation*, the employer, or if insured,~~  
19 ~~with the employer's insurer, and includes or is accompanied by a~~  
20 ~~signed affidavit which certifies that a copy of the report was filed~~  
21 ~~with the local health officer pursuant to this section.~~

22 (b) As used in this section, "occupational illness" means any  
23 abnormal condition or disorder caused by exposure to  
24 environmental factors associated with employment, including acute  
25 and chronic illnesses or diseases which may be caused by  
26 inhalation, absorption, ingestion, or direct contact.

27 *SEC. 14. The Legislature finds and declares that Section 4 of*  
28 *this act, which adds Section 4610 to the Labor Code, imposes a*  
29 *limitation on the public's right of access to the meetings of public*  
30 *bodies or the writings of public officials and agencies within the*  
31 *meaning of Section 3 of Article I of the California Constitution.*  
32 *Pursuant to that constitutional provision, the Legislature makes*  
33 *the following findings to demonstrate the interest protected by this*  
34 *limitation and the need for protecting that interest:*

35 *The limitations on the people's rights of access set forth in this*  
36 *act are necessary to protect the privacy and integrity of information*  
37 *submitted to the Administrative Director of the Division of*  
38 *Workers' Compensation pursuant to subparagraph (C) of*  
39 *paragraph (3) of subdivision (g) of Section 4610 of the Labor*  
40 *Code.*

1     *SEC. 15. The amendment of subdivision (a) of Section 4903.8*  
2     *of the Labor Code made by this act does not constitute a change*  
3     *in, but is declaratory of, existing law.*

4     *SEC. 16. No reimbursement is required by this act pursuant*  
5     *to Section 6 of Article XIII B of the California Constitution because*  
6     *the only costs that may be incurred by a local agency or school*  
7     *district will be incurred because this act creates a new crime or*  
8     *infraction, eliminates a crime or infraction, or changes the penalty*  
9     *for a crime or infraction, within the meaning of Section 17556 of*  
10    *the Government Code, or changes the definition of a crime within*  
11    *the meaning of Section 6 of Article XIII B of the California*  
12    *Constitution.*