Assembly Bill No. 2081

Passed the Assembly August 29, 2008

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Chief Clerk of the Assembly

Passed the Senate August 25, 2008

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2008, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 3351, 3702.1, and 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 2081, Coto. Workers' 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, and requires an employer to provide, or pay for all reasonable costs of, medical services necessary to care for, or relieve, work-related injuries. Existing law defines an "employee" for purposes of those provisions to include, among other persons, all officers and members of boards of directors of quasi-public or private corporations while rendering actual service for the corporations for pay, except that when the officers and directors of the private corporation are the sole shareholders of the corporation, the corporation and the officers and directors shall come under the workers' compensation laws only by election, as provided.

This bill would provide that it is the burden of the private corporation to establish that the employee was properly excluded, as specified. It would also require a corporation with excluded employees who are not substantial shareholders to file an annual report with the Department of Industrial Relations that lists specified information.

Existing law prohibits a person, firm, or corporation, other than an insurer admitted to transact workers' compensation insurance in this state, to contract to administer claims of self-insured employers as a 3rd-party administrator without a certificate of consent.

This bill would require the 3rd-party administrator, in every contract made on or after January 1, 2009, to administer claims of a self-insured employer, to make specified financial interest disclosures. It would also authorize the Director of Industrial Relations to adopt regulations necessary to carry out these provisions.

Existing law requires every employer to establish a medical treatment utilization review process in compliance with specified requirements, either directly or through the insurer or an entity with which the employer or insurer contracts for these services. Existing law authorizes the administrative director to assess certain administrative penalties if he or she determines that the employer, insurer, or other entity subject to those requirements has failed to meet any of those requirements related to the establishment of the review process.

This bill would prohibit a claims adjuster, as defined, from paying or receiving compensation for utilization review services, based on the number of denials or the amount of savings generated by the person's or entity's utilization review services.

This bill would incorporate additional changes in Section 4610 of the Labor Code proposed by AB 2969, that would become operative only if SB 2969 and this bill are both chaptered and become effective on or before January 1, 2009, and this bill is chaptered last.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Workers' compensation fraud that is perpetrated by unscrupulous employers, claims adjusters, and medical bill review services puts legitimate employers at a competitive disadvantage, and causes unnecessary increases in workers' compensation insurance premiums.

(b) The Attorney General currently is prosecuting certain companies for promoting the practice of labeling or appointing rank-and-file employees as sham officers and shareholders in order to circumvent workers' compensation laws.

(c) The Fraud Assessment Commission within the Department of Insurance has documented instances of claims adjusters entering into agreements to refer all medical treatment requests to utilization review services to generate fees.

(d) This type of fraudulent conduct causes the workers' compensation system to incur costs estimated to be in the millions of dollars, and may equal or exceed the more highly publicized cases involving claimant fraud.

(e) In enacting the amendments to subdivision (c) of Section 3351 of the Labor Code made by Assembly Bill 2081 of the 2007–08 Regular Session, it is the intent of the Legislature to clarify that the exclusion, under existing law, of employees who are corporate officers or directors and shareholders applies only to bona fide officers or directors and shareholders.

SEC. 2. Section 3351 of the Labor Code is amended to read:

3351. "Employee" means every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes:

(a) Aliens and minors.

(b) All elected and appointed paid public officers.

(c) (1) All officers and members of boards of directors of quasi-public or private corporations while rendering actual service for the corporations for pay. However, when the officers and directors of the private corporation are the sole shareholders of the corporation, the corporation and the officers and directors shall come under the compensation provisions of this division only by election as provided in subdivision (a) of Section 4151.

(2) In any proceeding when the question arises of whether an employee was properly excluded from the compensation provisions of this division pursuant to this subdivision, it is the burden of the private corporation to establish by clear and convincing evidence that the employee was properly excluded, including establishing that the employee performs legitimate and substantial administrative or managerial functions as an officer or director of the corporation.

(3) A corporation with employees that are excluded from the compensation provisions of this division pursuant to this subdivision and who are not substantial shareholders as defined in subdivision (b) of Section 3717, shall file an annual report with the Department of Industrial Relations listing the name, job title, job duties, pay, and percentage of company shares owned by the excluded employees, the total number of employees of the corporation, and other information specified by the department. The report shall be made available by the Department of Industrial Relations to other government agencies with authority to enforce laws relating to workers' compensation.

(d) Except as provided in subdivision (h) of Section 3352, any person employed by the owner or occupant of a residential dwelling whose duties are incidental to the ownership, maintenance, or use of the dwelling, including the care and supervision of children, or whose duties are personal and not in the course of the trade, business, profession, or occupation of the owner or occupant.

(e) All persons incarcerated in a state penal or correctional institution while engaged in assigned work or employment as defined in paragraph (1) of subdivision (a) of Section 10021 of Title 8 of the California Code of Regulations, or engaged in work performed under contract.

(f) All working members of a partnership or limited liability company receiving wages irrespective of profits from the partnership or limited liability company; provided that where the working members of the partnership or limited liability company are general partners or managers, the partnership or limited liability company and the partners or managers shall come under the compensation provisions of this division only by election as provided in subdivision (a) of Section 4151. If a private corporation is a general partner or manager, "working members of a partnership or limited liability company" shall include the corporation and the officers and directors of the corporation, provided that the officers and directors are the sole shareholders of the corporation. If a limited liability company is a partner or member, "working members of the partnership or limited liability company" shall include the managers of the limited liability company.

(g) For the purposes of subdivisions (c) and (f), the persons holding the power to revoke a trust as to shares of a private corporation or as to general partnership or limited liability company interests held in the trust, shall be deemed to be the shareholders of the private corporation, or the general partners of the partnership, or the managers of the limited liability company.

SEC. 3. Section 3702.1 of the Labor Code is amended to read:

3702.1. (a) No person, firm, or corporation, other than an insurer admitted to transact workers' compensation insurance in this state, shall contract to administer claims of self-insured employers as a third-party administrator unless in possession of a certificate of consent to administer self-insured employers workers' compensation claims.

(b) As a condition of receiving a certificate of consent, all persons given discretion by a third-party administrator to deny, accept, or negotiate a workers' compensation claim shall demonstrate their competency to the director by written examination, or other methods approved by the director.

(c) A separate certificate shall be required for each adjusting location operated by a third-party administrator. A third-party administrator holding a certificate of consent shall be subject to regulation only under this division with respect to the adjustment, administration, and management of workers' compensation claims for any self-insured employer.

(d) A third-party administrator retained by a self-insured employer to administer the employer's workers' compensation claims shall estimate the total accrued liability of the employer for the payment of compensation for the employer's annual report to the director and shall make the estimate both in good faith and with the exercise of a reasonable degree of care. The use of a third-party administrator shall not, however, discharge or alter the employer's responsibilities with respect to the report.

(e) (1) In every contract to administer claims of a self-insured employer, the third-party administrator shall disclose to the employer any financial interest of the third-party administrator in any provider of goods or services expected to be utilized in the administration of the claims. If a financial interest arises after the date of the contract, the interest shall be disclosed in writing no later than the date that any bill for those services, or any accounting of expenditure on behalf of the employer for those services, is presented to the employer. This subdivision shall apply to contracts made or renewed on or after January 1, 2009.

(2) For purposes of this section, a provider of goods or services includes any provider of a product or service for which the employer is required to pay, whether as a loss cost or as an adjusting expense apart from the contracted fees of the third-party administrator for adjusting services. Goods and services utilized in the administration of the claims may include, but are not limited to, bill reviewing, utilization reviewing, bookkeeping, accounting, data processing, case management, medical and ancillary goods and services, pharmaceutical products and services, and legal services.

(3) For purposes of this subdivision, a "financial interest of the third-party administrator" includes a financial interest of any of the third-party administrator's owners, officers, directors, or claims-adjusting employees, or a spouse, registered domestic partner, parent, or child of any of those persons, but an "owner" does not include a person owning less than 5 percent of the stock of a publicly traded corporation.

(4) For purposes of this subdivision, "financial interest" includes any rebate, discount, consulting fee, referral fee, fee-sharing, or benefit received or expected from the revenues of the provider of goods or services.

(5) The director may adopt regulations necessary to carry out the intent of this subdivision to prevent hidden conflicts of interest and ensure full disclosure to self-insured employers of the costs associated with claims adjustment.

SEC. 4. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means 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, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

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

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions are based on the medical necessity to cure and relieve, and require that proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the

administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

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

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

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

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

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

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

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the

specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

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

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

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

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

and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

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

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

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

(j) (1) A claims administrator, as defined in Section 138.4, shall not pay or receive compensation for utilization review services based on the number of denials or the amount of savings generated by the person's or entity's utilization review services.

(2) Nothing in this subdivision shall be construed to prohibit compensation of the utilization review services a person or entity provides if the compensation does not violate paragraph (1).

SEC. 4.5. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means 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, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

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

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions are based on the medical necessity to cure and relieve, and require that proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section.

Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

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

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

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

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

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

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

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

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but

in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

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

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer

or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

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

for authorization within the timeframes specified in paragraph (1) or (2).

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

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

(j) (1) A claims administrator, as defined in Section 138.4, shall not pay or receive compensation for utilization review services, based on the number of denials or the amount of savings generated by the person's or entity's utilization review services.

(2) Nothing in this subdivision shall be construed to prohibit compensation of the utilization review services a person or entity provides if the compensation does not violate paragraph (1).

SEC. 5. Section 4.5 of this bill incorporates amendments to Section 4610 of the Labor Code proposed by both this bill and AB 2969. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2009, (2) each bill amends Section 4610 of the Labor Code, and (3) this bill is enacted after AB 2969, in which case Section 4 of this bill shall not become operative.

Approved _____, 2008

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Governor