AMENDED IN SENATE JUNE 14, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 933

Introduced by Assembly Member Fong

February 26, 2009

An act to amend Sections 3209.3 ~~and 4610~~*, 3762, 4610, and 4616* of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 933, as amended, Fong. Workers' compensation: ~~utilization review.~~ *medical treatment.*

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that 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.

This bill would require the physician to be licensed by California state law.

Existing law authorizes an employer or insurer to establish or modify a medical provider network for the provision of medical treatment to injured employees, and to submit a medical provider network plan to the administrative director for approval.

This bill would require reapproval of a medical provider network plan every 3 years. This bill would also require a medical provider network plan approved before January 1, 2011, to be resubmitted to the administrative director for approval, as specified. This bill would permit an employer or insurer to submit a statement signed under penalty of perjury attesting that there have been no changes to a plan since it was last approved by the administrative director. By expanding the scope of a crime, this bill would impose a state-mandated local program.

This bill would also require by April 1, 2011, the administrative director to require that procedures be established to ensure that a list of the medical providers made available for selection to provide treatment to an injured employee is accurate and updated semiannually.

Existing law requires every employer except the state to secure the payment of workers' compensation either by being insured against liability by one or more insurers duly authorized to write compensation insurance in this state or by securing a certificate of consent to self-insure from the Director of Industrial Relations. Existing law requires an insurer, with certain exceptions, to discuss all elements of a workers' compensation claim file that affect the employer's premium with the employer, and to supply copies of the documents that affect the premium at the employer's expense during reasonable business hours.

This bill would expressly provide that specified items are elements of a claim file that affect the employer's premium.

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: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 3209.3 of the Labor Code is amended to read:

3209.3. (a) "Physician" means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(b) "Psychologist" means a psychologist licensed by California state law with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under Section 2708 of the Unemployment Insurance Code.

SEC. 2. Section 3762 of the Labor Code is amended to read:

3762. (a) Except as provided in subdivisions (b) and (c), the insurer shall discuss all elements of the claim file that affect the employer's premium with the employer, and shall supply copies of the documents that affect the premium at the employer's expense during reasonable business hours. *Elements of the claim file that affect the employer's premium include, but are not limited to, a loss adjustment expense paid as a result of medical cost*

containment services ordered by the insurer, if the medical cost containment services ordered by the insurer were provided by a third party, the name of the third party, and whether a portion of the loss adjustment expense was retained, rebated, or reimbursed to the insurer or an entity in which the insurer has a financial interest.

(b) The right provided by this section shall not extend to any document that the insurer is prohibited from disclosing to the employer under the attorney-client privilege, any other applicable privilege, or statutory prohibition upon disclosure, or under Section 1877.4 of the Insurance Code.

(c) An insurer, third-party administrator retained by a self-insured employer pursuant to Section 3702.1 to administer the employer's workers' compensation claims, and those employees and agents specified by a self-insured employer to administer the employer's workers' compensation claims, are prohibited from disclosing or causing to be disclosed to an employer, any medical information, as defined in subdivision (b) of Section 56.05 of the Civil Code, about an employee who has filed a workers' compensation claim, except as follows:

(1) Medical information limited to the diagnosis of the mental or physical condition for which workers' compensation is claimed and the treatment provided for this condition.

(2) Medical information regarding the injury for which workers' compensation is claimed that is necessary for the employer to have in order for the employer to modify the employee's work duties.

~~SEC. 2.~~

SEC. 3. 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 based on the medical necessity to cure and relieve of 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 by California state law 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.

SEC. 4. Section 4616 of the Labor Code is amended to read:

4616. (a) (1) On or after January 1, 2005, an insurer or employer may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of nonoccupational injuries. The goal shall be at least 25 percent of physicians primarily engaged in the treatment of nonoccupational injuries. The administrative director shall encourage the integration of occupational and nonoccupational providers. The number *and the office locations* of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the ~~employees are employed~~ *employee is employed and resides*.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. ~~To the extent feasible, all~~ *All* medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart.

(b) *(1)* The employer or insurer shall submit a plan for the medical provider network to the administrative director for approval. ~~The administrative director shall approve the plan if he or she determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved.~~

(2) A medical provider network plan submitted pursuant to this subdivision shall have a three-year approval term.

(3) An employer or insurer seeking renewal of its medical provider network plan shall resubmit its plan at least 60 days prior

to the anniversary of the plan's three-year approval term. The employer or insurer shall include information as may be required by the administrative director at the time of resubmission so that the administrative director may determine that the plan meets the requirements of this section. If there have been no changes to the plan since it was last approved by the administrative director, the employer or insurer may submit a statement signed under penalty of perjury attesting that there have been no changes, and the administrative director shall approve the resubmitted plan for a new three-year term of approval.

(4) A plan that was approved before January 1, 2011, shall be resubmitted to the administrative director for approval as follows:

(A) A plan that was approved before January 1, 2009, shall be resubmitted to the administrative director for approval by April 1, 2012.

(B) A plan that was approved on or after January 1, 2009, shall be resubmitted to the administrative director at least 60 days prior to the three-year anniversary of the plan's approval.

(5) The administrative director shall approve the plan submitted by an employer or insurer if the administrative director determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submission, it shall be deemed approved.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27~~ or the American College of Occupational Medicine's Occupational Medicine Practice Guidelines, as appropriate~~.

(f) No person other than a~~ licensed~~ physician *licensed by California state law* who is competent to evaluate the specific clinical issues involved in the medical treatment services, when

these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) By April 1, 2011, the administrative director shall require that procedures be established to ensure that a list of the medical providers made available for selection to provide treatment to an injured employee pursuant to this section is accurate and updated semiannually.

~~(g)~~

(h) On or before November 1, 2004, the administrative director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

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

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