

AMENDED IN SENATE AUGUST 2, 2010

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, 3762, 4610, and 4616 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 933, as amended, Fong. Workers' compensation: 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~~ *and* 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 *written* statement ~~signed under penalty of perjury attesting to the effect~~ 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: yes.

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

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

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

3 3209.3. (a) "Physician" means physicians and surgeons holding
4 an M.D. or D.O. degree, psychologists, acupuncturists,
5 optometrists, dentists, podiatrists, and chiropractic practitioners
6 licensed by California state law and within the scope of their
7 practice as defined by California state law.

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

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

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

22 (e) Nothing in this section shall be construed to authorize
23 acupuncturists to determine disability for the purposes of Article
24 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under
25 Section 2708 of the Unemployment Insurance Code.

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

27 3762. (a) Except as provided in subdivisions (b) and (c), the
28 insurer shall discuss all elements of the claim file that affect the
29 employer's premium with the employer, and shall supply copies
30 of the documents that affect the premium at the employer's expense

1 during reasonable business hours. Elements of the claim file that
2 affect the employer's premium include, but are not limited to, a
3 loss adjustment expense paid as a result of medical cost
4 containment services ordered by the insurer, if the medical cost
5 containment services ordered by the insurer were provided by a
6 third party, the name of the third party, and whether a portion of
7 the loss adjustment expense was retained, rebated, or reimbursed
8 to the insurer or an entity in which the insurer has a financial
9 interest.

10 (b) The right provided by this section shall not extend to any
11 document that the insurer is prohibited from disclosing to the
12 employer under the attorney-client privilege, any other applicable
13 privilege, or statutory prohibition upon disclosure, or under Section
14 1877.4 of the Insurance Code.

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

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

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

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. Prior to adoption of the schedule, these policies
9 and procedures shall be consistent with the recommended standards
10 set forth in the American College of Occupational and
11 Environmental Medicine Occupational Medical Practice
12 Guidelines. These policies and procedures, and a description of
13 the utilization process, shall be filed with the administrative director
14 and shall be disclosed by the employer to employees, physicians,
15 and the public upon request.

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

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

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

1 (1) Developed with involvement from actively practicing
2 physicians.

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

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

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

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

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

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

36 (2) When the employee's condition is such that the employee
37 faces an imminent and serious threat to his or her health, including,
38 but not limited to, the potential loss of life, limb, or other major
39 bodily function, or the normal timeframe for the decisionmaking
40 process, as described in paragraph (1), would be detrimental to the

1 employee's life or health or could jeopardize the employee's ability
2 to regain maximum function, decisions to approve, modify, delay,
3 or deny requests by physicians prior to, or concurrent with, the
4 provision of medical treatment services to employees shall be made
5 in a timely fashion that is appropriate for the nature of the
6 employee's condition, but not to exceed 72 hours after the receipt
7 of the information reasonably necessary to make the determination.

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

22 (B) In the case of concurrent review, medical care shall not be
23 discontinued until the employee's physician has been notified of
24 the decision and a care plan has been agreed upon by the physician
25 that is appropriate for the medical needs of the employee. Medical
26 care provided during a concurrent review shall be care that is
27 medically necessary to cure and relieve, and an insurer or
28 self-insured employer shall only be liable for those services
29 determined medically necessary to cure and relieve. If the insurer
30 or self-insured employer disputes whether or not one or more
31 services offered concurrently with a utilization review were
32 medically necessary to cure and relieve, the dispute shall be
33 resolved pursuant to Section 4062, except in cases involving
34 recommendations for the performance of spinal surgery, which
35 shall be governed by the provisions of subdivision (b) of Section
36 4062. Any compromise between the parties that an insurer or
37 self-insured employer believes may result in payment for services
38 that were not medically necessary to cure and relieve shall be
39 reported by the insurer or the self-insured employer to the licensing
40 board of the provider or providers who received the payments, in

1 a manner set forth by the respective board and in such a way as to
2 minimize reporting costs both to the board and to the insurer or
3 self-insured employer, for evaluation as to possible violations of
4 the statutes governing appropriate professional practices. No fees
5 shall be levied upon insurers or self-insured employers making
6 reports required by this section.

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

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

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

35 (i) If the administrative director determines that the employer,
36 insurer, or other entity subject to this section has failed to meet
37 any of the timeframes in this section, or has failed to meet any
38 other requirement of this section, the administrative director may
39 assess, by order, administrative penalties for each failure. A
40 proceeding for the issuance of an order assessing administrative

1 penalties shall be subject to appropriate notice to, and an
2 opportunity for a hearing with regard to, the person affected. The
3 administrative penalties shall not be deemed to be an exclusive
4 remedy for the administrative director. These penalties shall be
5 deposited in the Workers' Compensation Administration Revolving
6 Fund.

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

8 4616. (a) (1) On or after January 1, 2005, an insurer or
9 employer may establish or modify a medical provider network for
10 the provision of medical treatment to injured employees. The
11 network shall include physicians primarily engaged in the treatment
12 of occupational injuries and physicians primarily engaged in the
13 treatment of nonoccupational injuries. The goal shall be at least
14 25 percent of physicians primarily engaged in the treatment of
15 nonoccupational injuries. The administrative director shall
16 encourage the integration of occupational and nonoccupational
17 providers. The number and the office locations of physicians in
18 the medical provider network shall be sufficient to enable treatment
19 for injuries or conditions to be provided in a timely manner. The
20 provider network shall include an adequate number and type of
21 physicians, as described in Section 3209.3, or other providers, as
22 described in Section 3209.5, to treat common injuries experienced
23 by injured employees based on the type of occupation or industry
24 in which the employee is engaged, and the geographic area where
25 the employee is employed and resides.

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

32 (b) (1) The employer or insurer shall submit a plan for the
33 medical provider network to the administrative director for
34 approval.

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

37 (3) (A) An employer or insurer seeking renewal of its medical
38 provider network plan shall resubmit its plan at least 60 days prior
39 to the anniversary of the plan's three-year approval term. The
40 employer or insurer shall include information as may be required

1 by the administrative director at the time of resubmission so that
2 the administrative director may determine that the plan meets the
3 requirements of this section.

4 (B) If there have been no changes to the plan since it was last
5 approved by the administrative director, the employer or insurer
6 may submit a ~~statement signed under penalty of perjury attesting~~
7 *written statement to the effect* that there have been no changes,
8 and the administrative director shall approve the resubmitted plan
9 for a new three-year term of approval. *The statement shall read,*
10 *“I, the undersigned officer or employee of the medical provider*
11 *network seeking renewal of its medical provider network plan,*
12 *have read and know the contents of the most recent medical*
13 *provider network plan successfully approved by the administrative*
14 *director and, to the best of my knowledge and belief, the*
15 *information within that plan remains true and correct.”*

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

18 (A) A plan that was approved before January 1, 2009, shall be
19 resubmitted to the administrative director for approval by April 1,
20 2012.

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

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

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

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

38 (e) All treatment provided shall be provided in accordance with
39 the medical treatment utilization schedule established pursuant to
40 Section 5307.27.

1 (f) No person other than a physician licensed by California state
2 law who is competent to evaluate the specific clinical issues
3 involved in the medical treatment services, when these services
4 are within the scope of the physician's practice, may modify, delay,
5 or deny requests for authorization of medical treatment.

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

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

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