

AMENDED IN ASSEMBLY MARCH 12, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 1687

Introduced by Assembly Member Fong

February 14, 2012

An act to amend Section 4610 of, *and to add Section 4610.2 to*, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1687, as amended, Fong. Workers' compensation: utilization review.

Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires every employer to establish a utilization review process, either directly or through its insurer or an entity with which an employer contracts for these services, for the purpose of reviewing and approving, modifying, delaying, or denying treatment recommendations made by physicians with respect to injured workers. Existing law requires that communications regarding decisions to approve requests by physicians specify the specific medical treatment service approved, and that responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians 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.

This bill would additionally require that communications or responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians also include a clear and concise explanation of the available options for objecting to the modification, delay, or

denial of those medical services, *to appear on the first page of the communication in no less than 12-point bold type so as to be prominently visible to the employee.*

Under existing law, when a party to a proceeding institutes proceedings to terminate an award made by the Workers' Compensation Appeals Board for continuing medical treatment and is unsuccessful in these proceedings, the appeals board is authorized to award reasonable attorney's fees to an applicant resisting these proceedings.

This bill would authorize the appeals board to award attorney's fees reasonably incurred by an applicant in connection with the enforcement of a medical award following a dispute that arises in the course of the utilization review process.

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

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

1 SECTION 1. Section 4610 of the Labor Code is amended to
2 read:

3 4610. (a) For purposes of this section, "utilization review"
4 means utilization review or utilization management functions that
5 prospectively, retrospectively, or concurrently review and approve,
6 modify, delay, or deny, based in whole or in part on medical
7 necessity to cure and relieve, treatment recommendations by
8 physicians, as defined in Section 3209.3, prior to, retrospectively,
9 or concurrent with the provision of medical treatment services
10 pursuant to Section 4600.

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

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

1 Guidelines. These policies and procedures, and a description of
2 the utilization process, shall be filed with the administrative director
3 and shall be disclosed by the employer to employees, physicians,
4 and the public upon request.

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

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

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

29 (1) Developed with involvement from actively practicing
30 physicians.

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

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

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

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

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

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

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

36 (3) (A) Decisions to approve, modify, delay, or deny requests
37 by physicians for authorization prior to, or concurrent with, the
38 provision of medical treatment services to employees shall be
39 communicated to the requesting physician within 24 hours of the
40 decision. Decisions resulting in modification, delay, or denial of

1 all or part of the requested health care service shall be
2 communicated to physicians initially by telephone or facsimile,
3 and to the physician and employee in writing within 24 hours for
4 concurrent review, or within two business days of the decision for
5 prospective review, as prescribed by the administrative director.
6 If the request is not approved in full, disputes shall be resolved in
7 accordance with Section 4062. If a request to perform spinal
8 surgery is denied, disputes shall be resolved in accordance with
9 subdivision (b) of Section 4062.

10 (B) In the case of concurrent review, medical care shall not be
11 discontinued until the employee's physician has been notified of
12 the decision and a care plan has been agreed upon by the physician
13 that is appropriate for the medical needs of the employee. Medical
14 care provided during a concurrent review shall be care that is
15 medically necessary to cure and relieve, and an insurer or
16 self-insured employer shall only be liable for those services
17 determined medically necessary to cure and relieve. If the insurer
18 or self-insured employer disputes whether or not one or more
19 services offered concurrently with a utilization review were
20 medically necessary to cure and relieve, the dispute shall be
21 resolved pursuant to Section 4062, except in cases involving
22 recommendations for the performance of spinal surgery, which
23 shall be governed by the provisions of subdivision (b) of Section
24 4062. Any compromise between the parties that an insurer or
25 self-insured employer believes may result in payment for services
26 that were not medically necessary to cure and relieve shall be
27 reported by the insurer or the self-insured employer to the licensing
28 board of the provider or providers who received the payments, in
29 a manner set forth by the respective board and in such a way as to
30 minimize reporting costs both to the board and to the insurer or
31 self-insured employer, for evaluation as to possible violations of
32 the statutes governing appropriate professional practices. Fees
33 shall not be levied upon insurers or self-insured employers making
34 reports required by this section.

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

1 clinical reasons for the decisions regarding medical necessity.
2 Communications or responses regarding decisions to modify, delay,
3 or deny medical treatment services requested by physicians also
4 shall include a clear and concise explanation of the available
5 options for objecting to the modification, delay, or denial of those
6 medical services, *which shall appear on the first page of the*
7 *communication in no less than 12-point bold type so as to be*
8 *prominently visible to the employee.*

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

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

30 (i) If the administrative director determines that the employer,
31 insurer, or other entity subject to this section has failed to meet
32 any of the timeframes in this section, or has failed to meet any
33 other requirement of this section, the administrative director may
34 assess, by order, administrative penalties for each failure. A
35 proceeding for the issuance of an order assessing administrative
36 penalties shall be subject to appropriate notice to, and an
37 opportunity for a hearing with regard to, the person affected. The
38 administrative penalties shall not be deemed to be an exclusive
39 remedy for the administrative director. These penalties shall be

1 deposited in the Workers' Compensation Administration Revolving
2 Fund.

3 *SEC. 2. Section 4610.2 is added to the Labor Code, to read:*

4 *4610.2. If an award made by the appeals board specifies the*
5 *provision of future medical treatment and a dispute arises in the*
6 *course of a utilization review conducted pursuant to Section 4610*
7 *in connection with the enforcement of this award, and the applicant*
8 *employs an attorney for purposes of enforcing the award, the*
9 *appeals board may award attorney's fees reasonably incurred by*
10 *the applicant in connection with enforcement of the award.*

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