

AMENDED IN SENATE APRIL 18, 2013

SENATE BILL

No. 626

Introduced by Senator Beall

February 22, 2013

An act to amend Sections 75, 4600, 4604.5, 4610, 4610.6, 4616, and 4660.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 626, as amended, Beall. Workers' compensation.

Existing law establishes a worker's compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law creates the Commission on Health and Safety and Workers' Compensation consisting of 8 voting members, that includes 4 voting members representing organized labor and 4 voting members representing employers.

This bill would increase the number of commission voting members to 10 by adding one voting member representing injured workers and one additional voting member representing employers, appointed by the Governor.

~~Existing law establishes a worker's compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury. Existing law authorizes, with some exceptions, the employee to be treated by a physician of his or her own choice or at a facility of his or her own choice after 30 days from the date the injury is reported. Existing law~~

prohibits a chiropractor from being the treating physician after the employee has received the maximum number of chiropractic visits.

~~This bill would delete that provision and would instead provide that a physician, as defined, may remain the patient's primary treating physician even if additional treatment has been denied as long as the physician complies with specified reporting requirements prohibition.~~

Existing law requires that the recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director be presumptively correct on the issue of extent and scope of medical treatment. Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an employee is entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

This bill would delete the limitation on chiropractic, occupational therapy, and physical therapy visits per industrial injury.

Existing law requires an employer to establish a medical treatment utilization review process and, in this regard, prohibits any person other than a licensed physician from modifying, delaying, or denying requests for authorization of medical treatment for reasons of medical necessity to cure and relieve. Existing law also provides for an independent medical review process to resolve disputes over a utilization review decision for injuries occurring on or after January 1, 2013, and for any decision that is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

This bill would revise these provisions to require that medical treatment utilization reviews and independent medical reviews be conducted by physicians or medical professionals, as applicable, who hold the same California license as the requesting physician. The bill would delete the requirement that *an* independent medical review organization keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization.

Existing law prohibits a workers' compensation administrative law judge, the appeals board, or any higher court from making a determination of medical necessity contrary to the determination of the independent medical review organization.

This bill would delete that provision.

Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of permanent partial disability and permanent total disability

for injuries occurring on or after January 1, 2013. Existing law requires that the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of injury be taken into account in determining the percentages of permanent partial disability or permanent total disability. Existing law, with some exceptions, prohibits increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, as specified.

This bill would delete the prohibition on increases in impairment ratings for psychiatric disorder and would make related changes.

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 75 of the Labor Code is amended to read:

2 75. (a) There is in the department the Commission on Health

3 and Safety and Workers' Compensation. The commission shall be

4 composed of ~~eight~~ 10 voting members. Four voting members shall

5 represent organized labor, *one voting member shall represent*

6 *injured workers*, and ~~four~~ five voting members shall represent

7 employers. Not more than one employer member shall represent

8 public agencies. ~~Two~~ Three of the employer ~~and members~~, two of

9 the labor members, *and the member representing injured workers*

10 shall be appointed by the Governor. The Senate Committee on

11 Rules and the Speaker of the Assembly shall each appoint one

12 employer and one labor representative. The public employer

13 representative shall be appointed by the Governor. No action of

14 the commission shall be valid unless agreed to by a majority of

15 the membership and by not less than two members representing

16 organized labor and two members representing employers.

17 (b) The commission shall select one of the members representing

18 organized labor to chair the commission during the 1994 calendar

19 year, and thereafter the commission shall alternatively select an

20 employer and organized labor representative to chair the

21 commission for one-year terms.

22 (c) The initial terms of the members of the commission shall

23 be four years, and they shall hold office until the appointment of

24 a successor. However, the initial terms of one employer and one

25 labor member appointed by the Governor shall expire on December

1 31, 1995; the initial terms of the members appointed by the Senate
2 Committee on Rules shall expire December 31, 1996; the initial
3 terms of the members appointed by the Speaker of the Assembly
4 shall expire on December 31, 1997; and the initial term of one
5 employer and one labor member appointed by the Governor shall
6 expire on December 31, 1998. Any vacancy shall be filled by
7 appointment to the unexpired term.

8 (d) The commission shall meet every other month and upon the
9 call of the chair. Meetings shall be open to the public. Members
10 of the commission shall receive one hundred dollars (\$100) for
11 each day of their actual attendance at meetings of the commission
12 and other official business of the commission and shall also receive
13 their actual and necessary traveling expenses incurred in the
14 performance of their duty as a member. Payment of per diem and
15 traveling expenses shall be made from the Workers' Compensation
16 Administration Revolving Fund, when appropriated by the
17 Legislature.

18 **SECTION 1.**

19 *SEC. 2.* Section 4600 of the Labor Code is amended to read:

20 4600. (a) Medical, surgical, chiropractic, acupuncture, and
21 hospital treatment, including nursing, medicines, medical and
22 surgical supplies, crutches, and apparatuses, including orthotic and
23 prosthetic devices and services, that is reasonably required to cure
24 or relieve the injured worker from the effects of his or her injury
25 shall be provided by the employer. In the case of his or her neglect
26 or refusal reasonably to do so, the employer is liable for the
27 reasonable expense incurred by or on behalf of the employee in
28 providing treatment.

29 (b) As used in this division and notwithstanding any other
30 provision of law, medical treatment that is reasonably required to
31 cure or relieve the injured worker from the effects of his or her
32 injury means treatment that is based upon the guidelines adopted
33 by the administrative director pursuant to Section 5307.27.

34 (c) Unless the employer or the employer's insurer has
35 established or contracted with a medical provider network as
36 provided for in Section 4616, after 30 days from the date the injury
37 is reported, the employee may be treated by a physician of his or
38 her own choice or at a facility of his or her own choice within a
39 reasonable geographic area. ~~A physician, as defined in Section~~
40 ~~3209.3, may remain the employee's primary treating physician~~

1 ~~even if additional medical treatment, as specified in the medical~~
2 ~~treatment utilization schedule adopted under Section 5307.27, has~~
3 ~~been denied, as long as the physician complies with the reporting~~
4 ~~requirements set forth by the administrative director.~~

5 (d) (1) If an employee has notified his or her employer in
6 writing prior to the date of injury that he or she has a personal
7 physician, the employee shall have the right to be treated by that
8 physician from the date of injury if the employee has health care
9 coverage for nonoccupational injuries or illnesses on the date of
10 injury in a plan, policy, or fund as described in subdivisions (b),
11 (c), and (d) of Section 4616.7.

12 (2) For purposes of paragraph (1), a personal physician shall
13 meet all of the following conditions:

14 (A) Be the employee's regular physician and surgeon, licensed
15 pursuant to Chapter 5 (commencing with Section 2000) of Division
16 2 of the Business and Professions Code.

17 (B) Be the employee's primary care physician and has
18 previously directed the medical treatment of the employee, and
19 who retains the employee's medical records, including his or her
20 medical history. "Personal physician" includes a medical group,
21 if the medical group is a single corporation or partnership
22 composed of licensed doctors of medicine or osteopathy, which
23 operates an integrated multispecialty medical group providing
24 comprehensive medical services predominantly for
25 nonoccupational illnesses and injuries.

26 (C) The physician agrees to be predesignated.

27 (3) If the employee has health care coverage for nonoccupational
28 injuries or illnesses on the date of injury in a health care service
29 plan licensed pursuant to Chapter 2.2 (commencing with Section
30 1340) of Division 2 of the Health and Safety Code, and the
31 employer is notified pursuant to paragraph (1), all medical
32 treatment, utilization review of medical treatment, access to
33 medical treatment, and other medical treatment issues shall be
34 governed by Chapter 2.2 (commencing with Section 1340) of
35 Division 2 of the Health and Safety Code. Disputes regarding the
36 provision of medical treatment shall be resolved pursuant to Article
37 5.55 (commencing with Section 1374.30) of Chapter 2.2 of
38 Division 2 of the Health and Safety Code.

39 (4) If the employee has health care coverage for nonoccupational
40 injuries or illnesses on the date of injury in a group health insurance

1 policy as described in Section 4616.7, all medical treatment,
2 utilization review of medical treatment, access to medical
3 treatment, and other medical treatment issues shall be governed
4 by the applicable provisions of the Insurance Code.

5 (5) The insurer may require prior authorization of any
6 nonemergency treatment or diagnostic service and may conduct
7 reasonably necessary utilization review pursuant to Section 4610.

8 (6) An employee shall be entitled to all medically appropriate
9 referrals by the personal physician to other physicians or medical
10 providers within the nonoccupational health care plan. An
11 employee shall be entitled to treatment by physicians or other
12 medical providers outside of the nonoccupational health care plan
13 pursuant to standards established in Article 5 (commencing with
14 Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety
15 Code.

16 (e) (1) When at the request of the employer, the employer's
17 insurer, the administrative director, the appeals board, or a workers'
18 compensation administrative law judge, the employee submits to
19 examination by a physician, he or she shall be entitled to receive,
20 in addition to all other benefits herein provided, all reasonable
21 expenses of transportation, meals, and lodging incident to reporting
22 for the examination, together with one day of temporary disability
23 indemnity for each day of wages lost in submitting to the
24 examination.

25 (2) Regardless of the date of injury, "reasonable expenses of
26 transportation" includes mileage fees from the employee's home
27 to the place of the examination and back at the rate of twenty-one
28 cents (\$0.21) a mile or the mileage rate adopted by the Director
29 of Human Resources pursuant to Section 19820 of the Government
30 Code, whichever is higher, plus any bridge tolls. The mileage and
31 tolls shall be paid to the employee at the time he or she is given
32 notification of the time and place of the examination.

33 (f) When at the request of the employer, the employer's insurer,
34 the administrative director, the appeals board, or a workers'
35 compensation administrative law judge, an employee submits to
36 examination by a physician and the employee does not proficiently
37 speak or understand the English language, he or she shall be
38 entitled to the services of a qualified interpreter in accordance with
39 conditions and a fee schedule prescribed by the administrative
40 director. These services shall be provided by the employer. For

1 purposes of this section, “qualified interpreter” means a language
2 interpreter certified, or deemed certified, pursuant to Article 8
3 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of
4 Division 3 of Title 2 of, or Section 68566 of, the Government
5 Code.

6 (g) If the injured employee cannot effectively communicate
7 with his or her treating physician because he or she cannot
8 proficiently speak or understand the English language, the injured
9 employee is entitled to the services of a qualified interpreter during
10 medical treatment appointments. To be a qualified interpreter for
11 purposes of medical treatment appointments, an interpreter is not
12 required to meet the requirements of subdivision (f), but shall meet
13 any requirements established by rule by the administrative director
14 that are substantially similar to the requirements set forth in Section
15 1367.04 of the Health and Safety Code. The administrative director
16 shall adopt a fee schedule for qualified interpreter fees in
17 accordance with this section. Upon request of the injured employee,
18 the employer or insurance carrier shall pay for interpreter services.
19 An employer shall not be required to pay for the services of an
20 interpreter who is not certified or is provisionally certified by the
21 person conducting the medical treatment or examination unless
22 either the employer consents in advance to the selection of the
23 individual who provides the interpreting service or the injured
24 worker requires interpreting service in a language other than the
25 languages designated pursuant to Section 11435.40 of the
26 Government Code.

27 (h) Home health care services shall be provided as medical
28 treatment only if reasonably required to cure or relieve the injured
29 employee from the effects of his or her injury and prescribed by
30 a physician and surgeon licensed pursuant to Chapter 5
31 (commencing with Section 2000) of Division 2 of the Business
32 and Professions Code, and subject to Section 5307.1 or 5703.8.
33 The employer shall not be liable for home health care services that
34 are provided more than 14 days prior to the date of the employer’s
35 receipt of the physician’s prescription.

36 *SEC. 3. Section 4604.5 of the Labor Code is amended to read:*
37 4604.5. (a) The recommended guidelines set forth in the
38 medical treatment utilization schedule adopted by the
39 administrative director pursuant to Section 5307.27 shall be
40 presumptively correct on the issue of extent and scope of medical

1 treatment. The presumption is rebuttable and may be controverted
2 by a preponderance of the scientific medical evidence establishing
3 that a variance from the guidelines reasonably is required to cure
4 or relieve the injured worker from the effects of his or her injury.
5 The presumption created is one affecting the burden of proof.

6 (b) The recommended guidelines set forth in the schedule
7 adopted pursuant to subdivision (a) shall reflect practices that are
8 evidence and scientifically based, nationally recognized, and peer
9 reviewed. The guidelines shall be designed to assist providers by
10 offering an analytical framework for the evaluation and treatment
11 of injured workers, and shall constitute care in accordance with
12 Section 4600 for all injured workers diagnosed with industrial
13 conditions.

14 ~~(e) (1) Notwithstanding the medical treatment utilization~~
15 ~~schedule, for injuries occurring on and after January 1, 2004, an~~
16 ~~employee shall be entitled to no more than 24 chiropractic, 24~~
17 ~~occupational therapy, and 24 physical therapy visits per industrial~~
18 ~~injury.~~

19 ~~(2) (A) Paragraph (1) shall not apply when an employer~~
20 ~~authorizes, in writing, additional visits to a health care practitioner~~
21 ~~for physical medicine services. Payment or authorization for~~
22 ~~treatment beyond the limits set forth in paragraph (1) shall not be~~
23 ~~deemed a waiver of the limits set forth by paragraph (1) with~~
24 ~~respect to future requests for authorization.~~

25 ~~(B) The Legislature finds and declares that the amendments~~
26 ~~made to subparagraph (A) by the act adding this subparagraph are~~
27 ~~declaratory of existing law.~~

28 ~~(3) Paragraph (1) shall not apply to visits for postsurgical~~
29 ~~physical medicine and postsurgical rehabilitation services provided~~
30 ~~in compliance with a postsurgical treatment utilization schedule~~
31 ~~established by the administrative director pursuant to Section~~
32 ~~5307.27.~~

33 ~~(d)~~

34 (c) For all injuries not covered by the official utilization schedule
35 adopted pursuant to Section 5307.27, authorized treatment shall
36 be in accordance with other evidence-based medical treatment
37 guidelines that are recognized generally by the national medical
38 community and scientifically based.

39 ~~SEC. 2.~~

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

1 4610. (a) For purposes of this section, “utilization review”
2 means utilization review or utilization management functions that
3 prospectively, retrospectively, or concurrently review and approve,
4 modify, delay, or deny, based in whole or in part on medical
5 necessity to cure and relieve, treatment recommendations by
6 physicians, as defined in Section 3209.3, prior to, retrospectively,
7 or concurrent with the provision of medical treatment services
8 pursuant to Section 4600.

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

13 (c) Each utilization review process shall be governed by written
14 policies and procedures. These policies and procedures shall ensure
15 that decisions based on the medical necessity to cure and relieve
16 of proposed medical treatment services are consistent with the
17 schedule for medical treatment utilization adopted pursuant to
18 Section 5307.27. These policies and procedures, and a description
19 of the utilization process, shall be filed with the administrative
20 director and shall be disclosed by the employer to employees,
21 physicians, and the public upon request.

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

37 (e) No person other than a physician who holds the same
38 California license as that held by the requesting physician who is
39 competent to evaluate the specific clinical issues involved in the
40 medical treatment services, and where these services are within

1 the scope of the physician's practice, requested by the physician
2 may modify, delay, or deny requests for authorization of medical
3 treatment for reasons of medical necessity to cure and relieve.

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

7 (1) Developed with involvement from actively practicing
8 physicians.

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

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

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

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

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

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

1 4603.2, a retrospective decision to approve the service need not
2 otherwise be communicated.

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

15 (3) (A) Decisions to approve, modify, delay, or deny requests
16 by physicians for authorization prior to, or concurrent with, the
17 provision of medical treatment services to employees shall be
18 communicated to the requesting physician within 24 hours of the
19 decision. Decisions resulting in modification, delay, or denial of
20 all or part of the requested health care service shall be
21 communicated to physicians initially by telephone or facsimile,
22 and to the physician and employee in writing within 24 hours for
23 concurrent review, or within two business days of the decision for
24 prospective review, as prescribed by the administrative director.
25 If the request is not approved in full, disputes shall be resolved in
26 accordance with Section 4610.5, if applicable, or otherwise in
27 accordance with Section 4062.

28 (B) In the case of concurrent review, medical care shall not be
29 discontinued until the employee's physician has been notified of
30 the decision and a care plan has been agreed upon by the physician
31 that is appropriate for the medical needs of the employee. Medical
32 care provided during a concurrent review shall be care that is
33 medically necessary to cure and relieve, and an insurer or
34 self-insured employer shall only be liable for those services
35 determined medically necessary to cure and relieve. If the insurer
36 or self-insured employer disputes whether or not one or more
37 services offered concurrently with a utilization review were
38 medically necessary to cure and relieve, the dispute shall be
39 resolved pursuant to Section 4610.5, if applicable, or otherwise
40 pursuant to Section 4062. Any compromise between the parties

1 that an insurer or self-insured employer believes may result in
2 payment for services that were not medically necessary to cure
3 and relieve shall be reported by the insurer or the self-insured
4 employer to the licensing board of the provider or providers who
5 received the payments, in a manner set forth by the respective
6 board and in such a way as to minimize reporting costs both to the
7 board and to the insurer or self-insured employer, for evaluation
8 as to possible violations of the statutes governing appropriate
9 professional practices. No fees shall be levied upon insurers or
10 self-insured employers making reports required by this section.

11 (4) Communications regarding decisions to approve requests
12 by physicians shall specify the specific medical treatment service
13 approved. Responses regarding decisions to modify, delay, or deny
14 medical treatment services requested by physicians shall include
15 a clear and concise explanation of the reasons for the employer's
16 decision, a description of the criteria or guidelines used, and the
17 clinical reasons for the decisions regarding medical necessity. If
18 a utilization review decision to deny or delay a medical service is
19 due to incomplete or insufficient information, the decision shall
20 specify the reason for the decision and specify the information that
21 is needed.

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

1 (6) A utilization review decision to modify, delay, or deny a
2 treatment recommendation shall remain effective for 12 months
3 from the date of the decision without further action by the employer
4 with regard to any further recommendation by the same physician
5 for the same treatment unless the further recommendation is
6 supported by a documented change in the facts material to the
7 basis of the utilization review decision.

8 (7) Utilization review of a treatment recommendation shall not
9 be required while the employer is disputing liability for injury or
10 treatment of the condition for which treatment is recommended
11 pursuant to Section 4062.

12 (8) If utilization review is deferred pursuant to paragraph (7),
13 and it is finally determined that the employer is liable for treatment
14 of the condition for which treatment is recommended, the time for
15 the employer to conduct retrospective utilization review in
16 accordance with paragraph (1) shall begin on the date the
17 determination of the employer's liability becomes final, and the
18 time for the employer to conduct prospective utilization review
19 shall commence from the date of the employer's receipt of a
20 treatment recommendation after the determination of the
21 employer's liability.

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

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

37 ~~SEC. 3.~~

38 *SEC. 5.* Section 4610.6 of the Labor Code is amended to read:

39 4610.6. (a) Upon receipt of a case pursuant to Section 4610.5,
40 an independent medical review organization shall conduct the

1 review in accordance with this article and any regulations or orders
2 of the administrative director. The organization's review shall be
3 limited to an examination of the medical necessity of the disputed
4 medical treatment.

5 (b) Upon receipt of information and documents related to a case,
6 the medical reviewer or reviewers selected to conduct the review
7 by the independent medical review organization shall promptly
8 review all pertinent medical records of the employee, provider
9 reports, and any other information submitted to the organization
10 or requested from any of the parties to the dispute by the reviewers.
11 If the reviewers request information from any of the parties, a copy
12 of the request and the response shall be provided to all of the
13 parties. The reviewer or reviewers shall also review relevant
14 information related to the criteria set forth in subdivision (c).

15 (c) Following its review, the reviewer or reviewers shall
16 determine whether the disputed health care service was medically
17 necessary based on the specific medical needs of the employee
18 and the standards of medical necessity as defined in subdivision
19 (c) of Section 4610.5.

20 (d) The organization shall complete its review and make its
21 determination in writing, and in layperson's terms to the maximum
22 extent practicable, within 30 days of the receipt of the request for
23 review and supporting documentation, or within less time as
24 prescribed by the administrative director. If the disputed medical
25 treatment has not been provided and the employee's provider or
26 the administrative director certifies in writing that an imminent
27 and serious threat to the health of the employee may exist,
28 including, but not limited to, serious pain, the potential loss of life,
29 limb, or major bodily function, or the immediate and serious
30 deterioration of the health of the employee, the analyses and
31 determinations of the reviewers shall be expedited and rendered
32 within three days of the receipt of the information. Subject to the
33 approval of the administrative director, the deadlines for analyses
34 and determinations involving both regular and expedited reviews
35 may be extended for up to three days in extraordinary
36 circumstances or for good cause.

37 (e) The medical professionals' analyses and determinations shall
38 state whether the disputed health care service is medically
39 necessary. Each analysis shall cite the employee's medical
40 condition, the relevant documents in the record, and the relevant

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

7 (f) The independent medical review organization shall provide
8 the administrative director, the employer, the employee, and the
9 employee's provider with the analyses and determinations of the
10 medical professionals reviewing the case, and a description of the
11 qualifications of the medical professionals. Independent medical
12 reviews shall be conducted by medical professionals who hold the
13 same California license as the requesting physician. If more than
14 one medical professional reviewed the case and the result was
15 differing determinations, the independent medical review
16 organization shall provide each of the separate reviewer's analyses
17 and determinations.

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

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

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

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

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

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

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

6 (i) If the determination of the administrative director is reversed,
7 the dispute shall be remanded to the administrative director to
8 submit the dispute to independent medical review by a different
9 independent review organization. In the event that a different
10 independent medical review organization is not available after
11 remand, the administrative director shall submit the dispute to the
12 original medical review organization for review by a different
13 reviewer in the organization.

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

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

38 (l) The costs of independent medical review and the
39 administration of the independent medical review system shall be
40 borne by employers through a fee system established by the

1 administrative director. After considering any relevant information
2 on program costs, the administrative director shall establish a
3 reasonable, per-case reimbursement schedule to pay the costs of
4 independent medical review organization reviews and the cost of
5 administering the independent medical review system, which may
6 vary depending on the type of medical condition under review and
7 on other relevant factors.

8 (m) The administrative director may publish the results of
9 independent medical review determinations after removing
10 individually identifiable information.

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

15 ~~SEC. 4.~~

16 *SEC. 6.* Section 4616 of the Labor Code is amended to read:

17 4616. (a) (1) On or after January 1, 2005, an insurer, employer,
18 or entity that provides physician network services may establish
19 or modify a medical provider network for the provision of medical
20 treatment to injured employees. The network shall include
21 physicians primarily engaged in the treatment of occupational
22 injuries. The administrative director shall encourage the integration
23 of occupational and nonoccupational providers. The number of
24 physicians in the medical provider network shall be sufficient to
25 enable treatment for injuries or conditions to be provided in a
26 timely manner. The provider network shall include an adequate
27 number and type of physicians, as described in Section 3209.3, or
28 other providers, as described in Section 3209.5, to treat common
29 injuries experienced by injured employees based on the type of
30 occupation or industry in which the employee is engaged, and the
31 geographic area where the employees are employed.

32 (2) Medical treatment for injuries shall be readily available at
33 reasonable times to all employees. To the extent feasible, all
34 medical treatment for injuries shall be readily accessible to all
35 employees. With respect to availability and accessibility of
36 treatment, the administrative director shall consider the needs of
37 rural areas, specifically those in which health facilities are located
38 at least 30 miles apart and areas in which there is a health care
39 shortage.

1 (3) Commencing January 1, 2014, a treating physician shall be
2 included in the network only if, at the time of entering into or
3 renewing an agreement by which the physician would be in the
4 network, the physician, or an authorized employee of the physician
5 or the physician's office, provides a separate written
6 acknowledgment in which the physician affirmatively elects to be
7 a member of the network. Copies of the written acknowledgment
8 shall be provided to the administrative director upon the
9 administrative director's request. This paragraph shall not apply
10 to a physician who is a shareholder, partner, or employee of a
11 medical group that elects to be part of the network.

12 (4) Commencing January 1, 2014, every medical provider
13 network shall post on its Internet Web site a roster of all treating
14 physicians in the medical provider network and shall update the
15 roster at least quarterly. Every network shall provide to the
16 administrative director the Internet Web site address of the network
17 and of its roster of treating physicians. The administrative director
18 shall post, on the division's Internet Web site, the Internet Web
19 site address of every approved medical provider network.

20 (5) Commencing January 1, 2014, every medical provider
21 network shall provide one or more persons within the United States
22 to serve as medical access assistants to help an injured employee
23 find an available physician of the employee's choice, and
24 subsequent physicians if necessary, under Section 4616.3. Medical
25 access assistants shall have a toll-free telephone number that
26 injured employees may use and shall be available at least from 7
27 a.m. to 8 p.m. Pacific Standard Time, Monday through Saturday,
28 inclusive, to respond to injured employees, contact physicians'
29 offices during regular business hours, and schedule appointments.
30 The administrative director shall promulgate regulations on or
31 before July 1, 2013, governing the provision of medical access
32 assistants.

33 (b) (1) An insurer, employer, or entity that provides physician
34 network services shall submit a plan for the medical provider
35 network to the administrative director for approval. The
36 administrative director shall approve the plan for a period of four
37 years if he or she determines that the plan meets the requirements
38 of this section. If the administrative director does not act on the
39 plan within 60 days of submitting the plan, it shall be deemed
40 approved. Commencing January 1, 2014, existing approved plans

1 shall be deemed approved for a period of four years from the most
2 recent application or modification approval date. Plans for
3 reapproval for medical provider networks shall be submitted at
4 least six months before the expiration of the four-year approval
5 period. Upon a showing that the medical provider network was
6 approved or deemed approved by the administrative director, there
7 shall be a conclusive presumption on the part of the appeals board
8 that the medical provider network was validly formed.

9 (2) Every medical provider network shall establish and follow
10 procedures to continuously review the quality of care, performance
11 of medical personnel, utilization of services and facilities, and
12 costs.

13 (3) Every medical provider network shall submit geocoding of
14 its network for reapproval to establish that the number and
15 geographic location of physicians in the network meets the required
16 access standards.

17 (4) The administrative director shall at any time have the
18 discretion to investigate complaints and to conduct random reviews
19 of approved medical provider networks.

20 (5) Approval of a plan may be denied, revoked, or suspended
21 if the medical provider network fails to meet the requirements of
22 this article. Any person contending that a medical provider network
23 is not validly constituted may petition the administrative director
24 to suspend or revoke the approval of the medical provider network.
25 The administrative director may adopt regulations establishing a
26 schedule of administrative penalties not to exceed five thousand
27 dollars (\$5,000) per violation, or probation, or both, in lieu of
28 revocation or suspension for less severe violations of the
29 requirements of this article. Penalties, probation, suspension, or
30 revocation shall be ordered by the administrative director only
31 after notice and opportunity to be heard. Unless suspended or
32 revoked by the administrative director, the administrative director's
33 approval of a medical provider network shall be binding on all
34 persons and all courts. A determination of the administrative
35 director may be reviewed only by an appeal of the determination
36 of the administrative director filed as an original proceeding before
37 the reconsideration unit of the workers' compensation appeals
38 board on the same grounds and within the same time limits after
39 issuance of the determination as would be applicable to a petition

1 for reconsideration of a decision of a workers' compensation
2 administrative law judge.

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

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

12 (e) All treatment provided shall be provided in accordance with
13 the medical treatment utilization schedule established pursuant to
14 Section 5307.27.

15 (f) No person other than a physician who holds the same
16 California license as the requesting physician who is competent
17 to evaluate the specific clinical issues involved in the medical
18 treatment services, when these services are within the scope of the
19 physician's practice, may modify, delay, or deny requests for
20 authorization of medical treatment.

21 (g) Commencing January 1, 2013, every contracting agent that
22 sells, leases, assigns, transfers, or conveys its medical provider
23 networks and their contracted reimbursement rates to an insurer,
24 employer, entity that provides physician network services, or
25 another contracting agent shall, upon entering or renewing a
26 provider contract, disclose to the provider whether the medical
27 provider network may be sold, leased, transferred, or conveyed to
28 other insurers, employers, entities that provide physician network
29 services, or another contracting agent, and specify whether those
30 insurers, employers, entities that provide physician network
31 services, or contracting agents include workers' compensation
32 insurers.

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

38 ~~SEC. 5.~~

39 *SEC. 7.* Section 4660.1 of the Labor Code is amended to read:

1 4660.1. This section shall apply to injuries occurring on or
2 after January 1, 2013.

3 (a) In determining the percentages of permanent partial or
4 permanent total disability, account shall be taken of the nature of
5 the physical injury or disfigurement, the occupation of the injured
6 employee, and his or her age at the time of injury.

7 (b) For purposes of this section, the “nature of the physical
8 injury or disfigurement” shall incorporate the descriptions and
9 measurements of physical impairments and the corresponding
10 percentages of impairments published in the American Medical
11 Association (AMA) Guides to the Evaluation of Permanent
12 Impairment (5th edition) with the employee’s whole person
13 impairment, as provided in the guides, multiplied by an adjustment
14 factor of 1.4.

15 (c) There shall be no increases in impairment ratings for sleep
16 dysfunction or sexual dysfunction, or both, arising out of a
17 compensable physical injury. Nothing in this section shall limit
18 the ability of an injured employee to obtain treatment for sleep
19 dysfunction or sexual dysfunction, if any, that are a consequence
20 of an industrial injury.

21 (d) The administrative director may formulate a schedule of age
22 and occupational modifiers and may amend the schedule for the
23 determination of the age and occupational modifiers in accordance
24 with this section. The Schedule for Rating Permanent Disabilities
25 pursuant to the American Medical Association (AMA) Guides to
26 the Evaluation of Permanent Impairment (5th edition) and the
27 schedule of age and occupational modifiers shall be available for
28 public inspection and, without formal introduction in evidence,
29 shall be prima facie evidence of the percentage of permanent
30 disability to be attributed to each injury covered by the schedule.
31 Until the schedule of age and occupational modifiers is amended,
32 for injuries occurring on or after January 1, 2013, permanent
33 disabilities shall be rated using the age and occupational modifiers
34 in the permanent disability rating schedule adopted as of January
35 1, 2005.

36 (e) The schedule of age and occupational modifiers shall
37 promote consistency, uniformity, and objectivity.

38 (f) The schedule of age and occupational modifiers and any
39 amendment thereto or revision thereof shall apply prospectively
40 and shall apply to and govern only those permanent disabilities

1 that result from compensable injuries received or occurring on and
2 after the effective date of the adoption of the schedule, amendment,
3 or revision, as the case may be.

4 (g) Nothing in this section shall preclude a finding of permanent
5 total disability in accordance with Section 4662.

6 (h) In enacting the act adding this section, it is not the intent of
7 the Legislature to overrule the holding in Milpitas Unified School
8 District v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187
9 Cal.App.4th 808.

10 (i) The Commission on Health and Safety and Workers'
11 Compensation shall conduct a study to compare average loss of
12 earnings for employees who sustained work-related injuries with
13 permanent disability ratings under the schedule, and shall report
14 the results of the study to the appropriate policy and fiscal
15 committees of the Legislature no later than January 1, 2016.

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