

ASSEMBLY BILL

No. 2503

Introduced by Assembly Member Obernolte

February 19, 2016

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2503, as introduced, Obernolte. Workers' compensation: utilization review.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires every employer, for purposes of workers' compensation, to establish a utilization review process to prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, as provided. Existing law requires prospective or concurrent decisions to be made in a timely fashion that are appropriate for the nature of the employee's condition. Existing law also requires that decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees be communicated to the requesting physician within 24 hours of the decision.

This bill would clarify that the requirement that prospective or concurrent decisions be made in a timely fashion is in addition to the requirement that decisions to approve, modify, delay, or deny requests

by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees be communicated to the requesting physician within 24 hours of the decision. The bill would also make technical changes.

Vote: majority. Appropriation: no. Fiscal committee: no.
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~~ *Each* employer shall establish a utilization review
12 process in compliance with this section, either directly or through
13 its insurer or an entity with which an employer or insurer contracts
14 for these 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. These policies and procedures, and a description
21 of the utilization process, shall be filed with the administrative
22 director and shall be disclosed by the employer to employees,
23 physicians, and the public upon request.

24 (d) If an employer, insurer, or other entity subject to this section
25 requests medical information from a physician in order to
26 determine whether to approve, modify, delay, or deny requests for
27 authorization, the employer shall request only the information
28 reasonably necessary to make the determination. The employer,
29 insurer, or other entity shall employ or designate a medical director
30 who holds an unrestricted license to practice medicine in this state
31 issued pursuant to Section 2050 or Section 2450 of the Business

1 and Professions Code. The medical director shall ensure that the
2 process by which the employer or other entity reviews and
3 approves, modifies, delays, or denies requests by physicians prior
4 to, retrospectively, or concurrent with the provision of medical
5 treatment services, complies with the requirements of this section.
6 Nothing in this section shall be construed as restricting the existing
7 authority of the Medical Board of California.

8 (e) ~~No person~~ *A person* other than a licensed physician who is
9 competent to evaluate the specific clinical issues involved in the
10 medical treatment services, and where these services are within
11 the scope of the physician's practice, requested by the physician
12 ~~may shall not~~ modify, delay, or deny requests for authorization of
13 medical treatment for reasons of medical necessity to cure and
14 relieve.

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

18 (1) Developed with involvement from actively practicing
19 physicians.

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

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

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

26 (5) Available to the public upon request. An employer shall
27 only be required to disclose the criteria or guidelines for the
28 specific procedures or conditions requested. An employer may
29 charge members of the public reasonable copying and postage
30 expenses related to disclosing criteria or guidelines pursuant to
31 this paragraph. Criteria or guidelines may also be made available
32 through electronic means. ~~No~~ A charge shall *not* be required for
33 an employee whose physician's request for medical treatment
34 services is under review.

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

39 (1) Prospective or concurrent decisions shall be made in a timely
40 fashion that ~~is~~ *are* appropriate for the nature of the employee's

1 condition, not to exceed five working days from the receipt of the
2 information reasonably necessary to make the determination, but
3 in no event more than 14 days from the date of the medical
4 treatment recommendation by the physician. In cases where the
5 review is retrospective, a decision resulting in denial of all or part
6 of the medical treatment service shall be communicated to the
7 individual who received services, or to the individual's designee,
8 within 30 days of receipt of *the* information that is reasonably
9 necessary to make this determination. If payment for a medical
10 treatment service is made within the time prescribed by Section
11 4603.2, a retrospective decision to approve the service need not
12 otherwise be communicated.

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

26 (3) (A) ~~Decisions~~*In addition to the requirement that*
27 *prospective or concurrent decisions be made in a timely fashion,*
28 *as set forth in paragraph (1), decisions to approve, modify, delay,*
29 *or deny requests by physicians for authorization prior to, or*
30 *concurrent with, the provision of medical treatment services to*
31 *employees shall be communicated to the requesting physician*
32 *within 24 hours of the decision. Decisions resulting in modification,*
33 *delay, or denial of all or part of the requested health care service*
34 *shall be communicated to physicians initially by telephone or*
35 *facsimile, and to the physician and employee in writing within 24*
36 *hours for concurrent review, or within two business days of the*
37 *decision for prospective review, as prescribed by the administrative*
38 *director. If the request is not approved in full, disputes shall be*
39 *resolved in accordance with Section 4610.5, if applicable, or*
40 *otherwise in accordance with Section 4062.*

1 (B) In the case of concurrent review, medical care shall not be
2 discontinued until the employee's physician has been notified of
3 the decision and a care plan has been agreed upon by the physician
4 that is appropriate for the medical needs of the employee. Medical
5 care provided during a concurrent review shall be care that is
6 medically necessary to cure and relieve, and an insurer or
7 self-insured employer shall only be liable for those services
8 determined medically necessary to cure and relieve. If the insurer
9 or self-insured employer disputes whether or not one or more
10 services offered concurrently with a utilization review were
11 medically necessary to cure and relieve, the dispute shall be
12 resolved pursuant to Section 4610.5, if applicable, or otherwise
13 pursuant to Section 4062. ~~Any~~ A compromise between the parties
14 that an insurer or self-insured employer believes may result in
15 payment for services that were not medically necessary to cure
16 and relieve shall be reported by the insurer or the self-insured
17 employer to the licensing board of the provider or providers who
18 received the payments, in a manner set forth by the respective
19 board and ~~in such a way as to minimize~~ *that minimizes* reporting
20 costs both to the board and to the insurer or self-insured employer,
21 for evaluation as to possible violations of the statutes governing
22 appropriate professional practices. ~~No fees~~ *Fees* shall *not* be levied
23 upon insurers or self-insured employers making reports required
24 by this section.

25 (4) Communications regarding decisions to approve requests
26 by physicians shall specify the specific medical treatment service
27 approved. Responses regarding decisions to modify, delay, or deny
28 medical treatment services requested by physicians shall include
29 a clear and concise explanation of the reasons for the employer's
30 decision, a description of the criteria or guidelines used, and the
31 clinical reasons for the decisions regarding medical necessity. If
32 a utilization review decision to deny or delay a medical service is
33 due to incomplete or insufficient information, the decision shall
34 specify the reason for the decision and specify the information that
35 is needed.

36 (5) If the employer, insurer, or other entity cannot make a
37 decision within the timeframes specified in paragraph (1) or (2)
38 because the employer or other entity is not in receipt of all of the
39 information reasonably necessary and requested, because the
40 employer requires consultation by an expert reviewer, or because

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

14 (6) A utilization review decision to modify, delay, or deny a
15 treatment recommendation shall remain effective for 12 months
16 from the date of the decision without further action by the employer
17 with regard to ~~any~~ a further recommendation by the same physician
18 for the same treatment unless the further recommendation is
19 supported by a documented change in the facts material to the
20 basis of the utilization review decision.

21 (7) Utilization review of a treatment recommendation shall not
22 be required while the employer is disputing liability for injury or
23 treatment of the condition for which treatment is recommended
24 pursuant to Section 4062.

25 (8) If utilization review is deferred pursuant to paragraph (7),
26 and it is finally determined that the employer is liable for treatment
27 of the condition for which treatment is recommended, the time for
28 the employer to conduct retrospective utilization review in
29 accordance with paragraph (1) shall begin on the date the
30 determination of the employer's liability becomes final, and the
31 time for the employer to conduct prospective utilization review
32 shall commence from the date of the employer's receipt of a
33 treatment recommendation after the determination of the
34 employer's liability.

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

38 (i) If the administrative director determines that the employer,
39 insurer, or other entity subject to this section has failed to meet
40 any of the timeframes in this section, or has failed to meet any

1 other requirement of this section, the administrative director may
2 assess, by order, administrative penalties for each failure. A
3 proceeding for the issuance of an order assessing administrative
4 penalties shall be subject to appropriate notice to, and an
5 opportunity for a hearing with regard to, the person affected. The
6 administrative penalties shall not be deemed to be an exclusive
7 remedy for the administrative director. These penalties shall be
8 deposited in the Workers' Compensation Administration Revolving
9 Fund.

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