

AMENDED IN ASSEMBLY MARCH 29, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

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 amended, 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. require, when an employee is referred to a physician, an employer, insurer, or other entity that is subject to the provisions governing utilization review to inform the physician treating the employee of the name, address, telephone number, fax number, and email address of the claims administrator or utilization review organization to which the request for authorization for medical treatment shall be sent.~~ 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) Each 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. 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.

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

22 (e) A person other than a licensed physician who is competent
23 to evaluate the specific clinical issues involved in the medical
24 treatment services, and where these services are within the scope
25 of the physician's practice, requested by the physician shall not
26 modify, delay, or deny requests for authorization of medical
27 treatment for reasons of medical necessity to cure and relieve.

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

31 (1) Developed with involvement from actively practicing
32 physicians.

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

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

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

39 (5) Available to the public upon request. An employer shall
40 only be required to disclose the criteria or guidelines for the

1 specific procedures or conditions requested. An employer may
2 charge members of the public reasonable copying and postage
3 expenses related to disclosing criteria or guidelines pursuant to
4 this paragraph. Criteria or guidelines may also be made available
5 through electronic means. A charge shall not be required for an
6 employee whose physician's request for medical treatment services
7 is under review.

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

12 (1) Prospective or concurrent decisions shall be made in a timely
13 fashion that are appropriate for the nature of the employee's
14 condition, not to exceed five working days from the receipt of the
15 information reasonably necessary to make the determination, but
16 in no event more than 14 days from the date of the medical
17 treatment recommendation by the physician. In cases where the
18 review is retrospective, a decision resulting in denial of all or part
19 of the medical treatment service shall be communicated to the
20 individual who received services, or to the individual's designee,
21 within 30 days of receipt of the information that is reasonably
22 necessary to make this determination. If payment for a medical
23 treatment service is made within the time prescribed by Section
24 4603.2, a retrospective decision to approve the service need not
25 otherwise be communicated.

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

38 (3) (A) ~~In addition to the requirement that prospective or~~
39 ~~concurrent decisions be made in a timely fashion, as set forth in~~
40 ~~paragraph (1), decisions~~ *Decisions* to approve, modify, delay, or

1 deny requests by physicians for authorization prior to, or concurrent
2 with, the provision of medical treatment services to employees
3 shall be communicated to the requesting physician within 24 hours
4 of the decision. Decisions resulting in modification, delay, or denial
5 of all or part of the requested health care service shall be
6 communicated to physicians initially by telephone or facsimile,
7 and to the physician and employee in writing within 24 hours for
8 concurrent review, or within two business days of the decision for
9 prospective review, as prescribed by the administrative director.
10 If the request is not approved in full, disputes shall be resolved in
11 accordance with Section 4610.5, if applicable, or otherwise in
12 accordance with Section 4062.

13 (B) In the case of concurrent review, medical care shall not be
14 discontinued until the employee's physician has been notified of
15 the decision and a care plan has been agreed upon by the physician
16 that is appropriate for the medical needs of the employee. Medical
17 care provided during a concurrent review shall be care that is
18 medically necessary to cure and relieve, and an insurer or
19 self-insured employer shall only be liable for those services
20 determined medically necessary to cure and relieve. If the insurer
21 or self-insured employer disputes whether or not one or more
22 services offered concurrently with a utilization review were
23 medically necessary to cure and relieve, the dispute shall be
24 resolved pursuant to Section 4610.5, if applicable, or otherwise
25 pursuant to Section 4062. A compromise between the parties that
26 an insurer or self-insured employer believes may result in payment
27 for services that were not medically necessary to cure and relieve
28 shall be reported by the insurer or the self-insured employer to the
29 licensing board of the provider or providers who received the
30 payments, in a manner set forth by the respective board and in a
31 way that minimizes reporting costs both to the board and to the
32 insurer or self-insured employer, for evaluation as to possible
33 violations of the statutes governing appropriate professional
34 practices. Fees shall not be levied upon insurers or self-insured
35 employers making reports required by this section.

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

1 decision, a description of the criteria or guidelines used, and the
2 clinical reasons for the decisions regarding medical necessity. If
3 a utilization review decision to deny or delay a medical service is
4 due to incomplete or insufficient information, the decision shall
5 specify the reason for the decision and specify the information that
6 is needed.

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

25 (6) A utilization review decision to modify, delay, or deny a
26 treatment recommendation shall remain effective for 12 months
27 from the date of the decision without further action by the employer
28 with regard to a further recommendation by the same physician
29 for the same treatment unless the further recommendation is
30 supported by a documented change in the facts material to the
31 basis of the utilization review decision.

32 (7) Utilization review of a treatment recommendation shall not
33 be required while the employer is disputing liability for injury or
34 treatment of the condition for which treatment is recommended
35 pursuant to Section 4062.

36 (8) If utilization review is deferred pursuant to paragraph (7),
37 and it is finally determined that the employer is liable for treatment
38 of the condition for which treatment is recommended, the time for
39 the employer to conduct retrospective utilization review in
40 accordance with paragraph (1) shall begin on the date the

1 determination of the employer's liability becomes final, and the
2 time for the employer to conduct prospective utilization review
3 shall commence from the date of the employer's receipt of a
4 treatment recommendation after the determination of the
5 employer's liability.

6 (h) Each employer, insurer, or other entity subject to this section
7 shall maintain telephone access for physicians to request
8 authorization for health care services.

9 (i) If the administrative director determines that the employer,
10 insurer, or other entity subject to this section has failed to meet
11 any of the timeframes in this section, or has failed to meet any
12 other requirement of this section, the administrative director may
13 assess, by order, administrative penalties for each failure. A
14 proceeding for the issuance of an order assessing administrative
15 penalties shall be subject to appropriate notice to, and an
16 opportunity for a hearing with regard to, the person affected. The
17 administrative penalties shall not be deemed to be an exclusive
18 remedy for the administrative director. These penalties shall be
19 deposited in the Workers' Compensation Administration Revolving
20 Fund.