

AMENDED IN ASSEMBLY APRIL 19, 2016

AMENDED IN ASSEMBLY MARCH 29, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2503**

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**Introduced by Assembly Member Obernolte**

February 19, 2016

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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 require, when an employee is referred to a ~~physician,~~ *physician* by an employer, insurer, or other entity that is subject to the provisions governing utilization review ~~to inform~~ *review*, 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~~ *to send any* request for authorization for medical treatment ~~shall be sent.~~ *to the claims administrator for the employer, insurer, or other entity.* 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.

24 (d) When an employee is referred to a ~~physician,~~ *the physician*  
25 *by an* employer, insurer, or other entity subject to this section ~~shall~~  
26 ~~inform the physician treating the employee of the name, address,~~

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

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

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

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

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

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

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

38 (5) Available to the public upon request. An employer shall  
39 only be required to disclose the criteria or guidelines for the  
40 specific procedures or conditions requested. An employer may

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

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

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

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

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

1 decision. Decisions resulting in modification, delay, or denial of  
2 all or part of the requested health care service shall be  
3 communicated to physicians initially by telephone or facsimile,  
4 and to the physician and employee in writing within 24 hours for  
5 concurrent review, or within two business days of the decision for  
6 prospective review, as prescribed by the administrative director.  
7 If the request is not approved in full, disputes shall be resolved in  
8 accordance with Section 4610.5, if applicable, or otherwise in  
9 accordance with 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 4610.5, if applicable, or otherwise  
22 pursuant to Section 4062. A compromise between the parties that  
23 an insurer or self-insured employer believes may result in payment  
24 for services that were not medically necessary to cure and relieve  
25 shall be reported by the insurer or the self-insured employer to the  
26 licensing board of the provider or providers who received the  
27 payments, in a manner set forth by the respective board and in a  
28 way that minimizes reporting costs both to the board and to the  
29 insurer or self-insured employer, for evaluation as to possible  
30 violations of the statutes governing appropriate professional  
31 practices. Fees shall not be levied upon insurers or self-insured  
32 employers making reports required by this section.

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

1 due to incomplete or insufficient information, the decision shall  
2 specify the reason for the decision and specify the information that  
3 is needed.

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

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

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

33 (8) If utilization review is deferred pursuant to paragraph (7),  
34 and it is finally determined that the employer is liable for treatment  
35 of the condition for which treatment is recommended, the time for  
36 the employer to conduct retrospective utilization review in  
37 accordance with paragraph (1) shall begin on the date the  
38 determination of the employer's liability becomes final, and the  
39 time for the employer to conduct prospective utilization review  
40 shall commence from the date of the employer's receipt of a

1 treatment recommendation after the determination of the  
2 employer's liability.

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

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