AMENDED IN ASSEMBLY JUNE 23, 2015

AMENDED IN ASSEMBLY JUNE 4, 2015

AMENDED IN SENATE APRIL 6, 2015

SENATE BILL No. 542

Introduced by Senator Mendoza

February 26, 2015

An act to amend ~~Section~~ *Sections 4616, 4616.2, 4616.4, 4616.5, and* 5307.8 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 542, as amended, Mendoza. Workers' compensation: ~~home health care services:~~ *medical provider networks* fee schedules.

(1) 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 authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for the provision of medical treatment to injured employees, and requires the administrative director to contract with individual physicians or an independent medical review organization to perform independent medical reviews.

This bill would clarify that those independent medical reviews are medical provider network independent medical reviews. The bill would make conforming changes.

(2) Existing law requires every medical provider network to post, and update quarterly, a roster of treating physicians in the medical provider network on its Internet Web site.

This bill would require every medical provider network to post on its Internet Web site information about how to contact the medical provider network contact and medical access assistants, and also information about how to obtain a copy of the complete employee notification, as defined.

(3) Existing law requires an insurer, employer, or entity that provides physician network services to submit a plan for the medical provider network to the administrative director to be approved for a period of 4 years. Commencing January 1, 2014, existing approved plans are deemed approved for a period of 4 years from their most recent application or modification approval date.

This bill would provide that, commencing January 1, 2016, a modification that updates an entire medical provider network plan to bring the plan into full compliance with applicable laws would be deemed approved for a period of 4 years from the modification approval date. The bill would provide that the expiration of the medical provider network's current 4-year approval period will not change if a modification does not update a medical provider network plan to bring the plan into full compliance with applicable laws.

(4) Existing law requires an insurer, employer, or entity that provides physician network services to file continuity of care policies. Existing law requires an insurer, employer, or entity that provides physician network services to provide completion of treatment by a terminated provider if at the time of the employer-employee contract's termination, the injured employee was receiving services from that provider for various conditions, as specified.

This bill would instead require medical provider networks to file continuity of care policies. The bill would require an employer or its claims administrator to provide for the completion of treatment by a terminated provider under specified circumstances.

The bill would also define an "entity that provides physician network services" for the purposes described above to mean a medical network licensed by a designated government department or a legal entity that offers medical management and physician network services within California.

~~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~~

(5) Existing law requires the administrative director to adopt an official medical fee schedule that establishes reasonable maximum fees paid for specified medical services related to workers' compensation. Existing law also requires the administrative director to adopt a schedule for payment of home health care services that are not covered by a Medicare fee schedule and are not otherwise covered by the official medical fee schedule. Existing law requires this fee schedule to be based on the maximum service hours and fees set forth in provisions of law governing in-home supportive services.

This bill would authorize, rather than require, the fee schedule to be based on either the maximum service hours and fees set forth in provisions of state law governing in-home supportive services or other state or federal home health care services fee schedules, as specified.

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

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

SECTION 1. Section 4616 of the Labor Code is amended to read:

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

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of

rural areas, specifically those in which health facilities are located at least 30 miles apart and areas in which there is a health care shortage.

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

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

(B) Commencing January 1, 2016, every medical provider network shall post on its Internet Web site information about how to contact the medical provider network contact and medical access assistants, and information about how to obtain a copy of the complete employee notification.

(C) For purposes of this paragraph, an "complete employee notification" shall have the same meaning as provided in Section 9767.12 of Title 8 of the California Code of Regulations.

(5) Commencing January 1, 2014, every medical provider network shall provide one or more persons within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, and subsequent physicians if necessary, under Section 4616.3. Medical access assistants shall have a toll-free telephone number that injured employees may use and shall be available at least from 7 a.m. to 8 p.m. Pacific Standard Time, Monday through Saturday, inclusive, to respond to injured employees, contact physicians' offices during regular business hours, and schedule appointments.

The administrative director shall promulgate regulations on or before July 1, 2013, governing the provision of medical access assistants.

(b) (1) An insurer, employer, or entity that provides physician network services shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan for a period of four years if he or she determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved. Commencing January 1, 2014, existing approved plans shall be deemed approved for a period of four years from the *approval date of the* most recent application or modification ~~approval date.~~ *submitted prior to 2014.* Plans for reapproval for medical provider networks shall be submitted at least six months before the expiration of the four-year approval period. *Commencing January 1, 2016, a modification that updates an entire medical provider network plan to bring the plan into full compliance with all current statutes and regulations shall be deemed approved for a period of four years from the modification approval date. An approved modification that does not update an entire medical provider network plan to bring the plan into full compliance with all current statutes and regulations shall not alter the expiration of the medical provider network's four-year approval period.* Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed.

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

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

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

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

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

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

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

(f) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

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

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

SEC. 2. Section 4616.2 of the Labor Code is amended to read:

4616.2. (a) ~~An insurer, employer, or entity that provides physician network services that arranges for care for injured employees through a~~ *A* medical provider network shall file a written continuity of care policy with the administrative director.

(b) If approved by the administrative director, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. ~~The insurer, employer, or entity that provides physician~~ *A medical provider* network ~~services~~ shall file a revision of the continuity of care policy with the administrative director if it makes a material change to the policy.

(c) ~~The insurer, employer, or entity that provides physician network services shall provide to all~~ *All* employees entering the workers' compensation system *shall be provided* notice of ~~its~~ *the medical provider network's* written continuity of care policy and information regarding the process for an employee to request a review under the policy ~~and shall provide~~, *and,* upon request, a copy of the *medical provider network's* written ~~policy to an employee.~~ *continuity of care policy.*

(d) (1) ~~An insurer, employer, or entity that provides physician network services that offers a medical provider network shall, at~~ *At* the request of an injured employee, ~~provide the~~ completion of

treatment *shall be provided by a terminated provider* as set forth in this ~~section by a terminated provider.~~ *section.*

(2) The completion of treatment shall be provided by a terminated provider to an injured employee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in paragraph (3).

(3) The ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* shall provide for the completion of treatment for the following conditions subject to coverage through the workers' compensation system:

(A) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of treatment shall be provided for the duration of the acute condition.

(B) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services,~~ *its claims administrator* in consultation with the injured employee and the terminated provider and consistent with good professional practice. Completion of treatment under this paragraph shall not exceed 12 months from the contract termination date.

(C) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(D) Performance of a surgery or other procedure that is authorized by the ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

(4) (A) The ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* is not required to continue the provider's services beyond the contract termination date.

(B) Unless otherwise agreed by the terminated provider and the ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services,~~ *its claims administrator,* the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the ~~insurer, employer, or entity that provides physician~~ *medical provider* network ~~services~~ for currently contracting providers providing similar services who are practicing in the same or a similar geographic area as the terminated provider. The ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* is not required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(5) An ~~insurer~~ *employer* or ~~employer~~ *its claims administrator* shall ensure that the requirements of this section are met.

(6) This section shall not require an ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* to provide for completion of treatment by a provider whose contract with the ~~insurer, employer, or entity that provides physician~~ *medical provider* network ~~services~~ has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(7) Nothing in this section shall preclude an ~~insurer, employer,~~ *employer* or ~~entity that provides physician network services~~ *its claims administrator* from providing continuity of care beyond the requirements of this section.

~~(e) The insurer, employer, or entity that provides physician network services may require the terminated provider whose~~

~~services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer, employer, or entity that provides physician network services is not required to continue the provider's services beyond the contract termination date.~~

SEC. 3. Section 4616.4 of the Labor Code is amended to read:

4616.4. (a) (1) The administrative director shall contract with individual physicians, as described in paragraph (2), or an independent medical review organization to perform *medical provider network (MPN)* independent medical reviews pursuant to this section.

(2) Only physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of the Business and Professions Code may be independent medical reviewers.

(3) The administrative director shall ensure that the independent medical reviewers or those within the review organization shall do all of the following:

(A) Be appropriately credentialed and privileged.

(B) Ensure that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensure that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions consistent with the medical utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

(D) Ensure that confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensure the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensure adequate screening for conflicts of interest.

(4) Medical professionals selected by the administrative director or the independent medical review organizations to review medical

treatment decisions shall be physicians, as specified in paragraph (2) of subdivision (a), who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions taken or pending by any hospital, government, or regulatory body.

(b) If, after the third physician's opinion, the treatment or diagnostic service remains disputed, the injured employee may request *MPN* independent medical review regarding the disputed treatment or diagnostic service still in dispute after the third physician's opinion in accordance with Section 4616.3. The standard to be utilized for *MPN* independent medical review is identical to that contained in the medical treatment utilization schedule established in Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate.

(c) Applications for *MPN* independent medical review shall be submitted to the administrative director on a one-page form provided by the administrative director entitled ~~"Independent~~ "*MPN Independent* Medical Review Application." The form shall contain a signed release from the injured employee, or a person authorized pursuant to law to act on behalf of the injured employee, authorizing the release of medical and treatment information. The injured employee may provide any relevant material or documentation with the application. The administrative director or the independent medical review organization shall assign the independent medical reviewer.

(d) Following receipt of the application for *MPN* independent medical review, the employer or insurer shall provide the independent medical reviewer, assigned pursuant to subdivision

(c), with all information that was considered in relation to the disputed treatment or diagnostic service, including both of the following:

(1) A copy of all correspondence from, and received by, any treating physician who provided a treatment or diagnostic service to the injured employee in connection with the injury.

(2) A complete and legible copy of all medical records and other information used by the physicians in making a decision regarding the disputed treatment or diagnostic service.

(e) Upon receipt of information and documents related to the application for *MPN* independent medical review, the independent medical reviewer shall conduct a physical examination of the injured employee at the employee's discretion. The reviewer may order any diagnostic tests necessary to make his or her determination regarding medical treatment. Utilizing the medical treatment utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate, and taking into account any reports and information provided, the reviewer shall determine whether the disputed health care service was consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines based on the specific medical needs of the injured employee.

(f) The independent medical reviewer shall issue a report to the administrative director, in writing, and in layperson's terms to the maximum extent practicable, containing his or her analysis and determination whether the disputed health care service was consistent with the medical treatment utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate, within 30 days of the examination of the injured employee, or within less time as prescribed by the administrative director. If the disputed health care service has not been provided and the independent medical reviewer certifies in writing that an imminent and serious threat to the health of the injured employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the

injured employee, the report shall be expedited and rendered within three days of the examination by the independent medical reviewer. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the administrative director for up to three days in extraordinary circumstances or for good cause.

(g) The independent medical reviewer's analysis shall cite the injured employee's medical condition, the relevant documents in the record, and the relevant findings associated with the documents or any other information submitted to the reviewer in order to support the determination.

(h) The administrative director shall immediately adopt the determination of the independent medical reviewer, and shall promptly issue a written decision to the parties.

(i) If the determination of the independent medical reviewer finds that the disputed treatment or diagnostic service is consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, the injured employee may seek the disputed treatment or diagnostic service from a physician of his or her choice from within or outside the medical provider network. Treatment outside the medical provider network shall be provided consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Practice Guidelines. The employer shall be liable for the cost of any approved medical treatment in accordance with Section 5307.1 or 5307.11.

SEC. 4. Section 4616.5 of the Labor Code is amended to read:

4616.5. *(a)* For purposes of this article, "employer" means a self-insured employer, joint powers authority, or the state.

(b) For purposes of this article, "entity that provides physician network services" means a medical network licensed by the Department of Insurance or Department of Managed Health Care, or a third-party claims adjusting organization licensed by the Department of Insurance or the certified by the Office of Self Insurance Plans, or a legal entity that offers medical management and physician network services within California.

~~SECTION 1.~~

SEC. 5. Section 5307.8 of the Labor Code is amended to read:

5307.8. (a) Notwithstanding Section 5307.1, the administrative director shall adopt, after public hearings, a schedule for payment of home health care services provided in accordance with Section 4600 that are not covered by a Medicare fee schedule and are not otherwise covered by the official medical fee schedule adopted pursuant to Section 5307.1. The schedule shall set forth fees and requirements for service providers, and may be based upon, but is not limited to, being based upon, either of the following:

(1) The maximum service hours and fees as set forth in regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A state or federal home health care services fee schedule other than the schedule described in paragraph (1), including a fee schedule authorized for purposes of the Medi-Cal program or a fee schedule administered by the federal Office of Workers' Compensation Programs.

(b) Fees shall not be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury. If appropriate, attorney's fees for recovery of home health care services fees under this section may be awarded in accordance with Section 4906 and any applicable rules or regulations.

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