

AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 13, 2015

**SENATE BILL**

**No. 563**

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**Introduced by Senator Pan**

February 26, 2015

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An act to amend Section 4610 of, *and to add Section 4610.2 to*, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 563, as amended, Pan. Workers' compensation: utilization review.

Existing law requires every employer, for purposes of workers' compensation, to establish a utilization review process to prospectively, retrospectively, or concurrently review requests by physicians for authorization to provide recommended medical treatment to injured employees. Existing law establishes timeframes for an employer to make a determination regarding a physician's request. Existing law requires the utilization review process to be governed by written policies and procedures, and requires that these policies and procedures be filed with the Administrative Director of the Division of Workers' Compensation and disclosed by the employer to employees, physicians, and the public upon request.

~~This bill would prohibit the use of the utilization review process for any treatment recommendations made by a physician if specified conditions are met, including that the treatment recommendation is solely for the purpose of maintaining an injured employee's current health care regimen for a preexisting injury and there is no evidence of a change in the employee's circumstances or condition showing that the services are no longer reasonably required to cure or relieve the injured worker from the effects of the industrial injury. The bill would~~

~~require the written policies and procedures governing utilization review to conform to these requirements:~~

~~The~~

~~This bill would also specifically require that the method of compensation compensation, and any incentive payments contingent upon the approval, modification, or denial of a claim claim, for an individual or entity providing services pursuant to the utilization review process, as specified, be filed with the administrative director and disclosed by the employer to employees, physicians, and the public upon request. The bill would exempt a request for medical treatment by a physician to cure or relieve an injured worker from the effect of an industrial injury from these requirements if the request meets specified conditions, including that a final award of permanent disability made by the appeals board specifies the provision of future medical treatment and that the request for medical treatment is for medical treatment that is specified by the award. The bill would also include a statement of legislative intent.~~

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) ~~(1)~~ Every 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 ~~(2) The utilization review process shall not be used for any~~  
16 ~~treatment recommendations made by a physician if all of the~~  
17 ~~following conditions are met:~~

1     ~~(A) The treatment recommendation is solely for the purpose of~~  
2     ~~maintaining an injured employee's current health care regimen for~~  
3     ~~a preexisting injury.~~

4     ~~(B) A prior treatment recommendation for the injured employee~~  
5     ~~was either prospectively, retrospectively, or concurrently reviewed~~  
6     ~~and approved, or modified, based in whole or in part on medical~~  
7     ~~necessity and the injured employee's current health care regimen~~  
8     ~~is a result of that decision.~~

9     ~~(C) There is no evidence of a change in the employee's~~  
10    ~~circumstances or condition showing that the services are no longer~~  
11    ~~reasonably required to cure or relieve the injured worker from the~~  
12    ~~effects of the industrial injury.~~

13    (c) ~~(1)~~ Each utilization review process shall be governed by  
14    written policies and procedures. These policies and procedures  
15    shall ensure that decisions based on the medical necessity to cure  
16    and relieve of proposed medical treatment services are consistent  
17    with the schedule for medical treatment utilization adopted pursuant  
18    to Section 5307.27. These policies and procedures, and a  
19    description of the utilization *review* process, including, but not  
20    limited to, the method of ~~compensation~~ *compensation*, and any  
21    incentive payments contingent upon the approval, modification,  
22    or denial of a ~~claim~~ *claim*, for an individual or entity providing  
23    services under this section, shall be filed with the administrative  
24    director and shall be disclosed by the employer to employees,  
25    physicians, and the public upon request.

26    ~~(2) The written policies and procedures shall conform to the~~  
27    ~~requirements of paragraph (2) of subdivision (b).~~

28    (d) If an employer, insurer, or other entity subject to this section  
29    requests medical information from a physician in order to  
30    determine whether to approve, modify, delay, or deny requests for  
31    authorization, the employer shall request only the information  
32    reasonably necessary to make the determination. The employer,  
33    insurer, or other entity shall employ or designate a medical director  
34    who holds an unrestricted license to practice medicine in this state  
35    issued pursuant to Section 2050 or Section 2450 of the Business  
36    and Professions Code. The medical director shall ensure that the  
37    process by which the employer or other entity reviews and  
38    approves, modifies, delays, or denies requests by physicians prior  
39    to, retrospectively, or concurrent with the provision of medical  
40    treatment services, complies with the requirements of this section.

1 Nothing in this section shall be construed as restricting the existing  
2 authority of the Medical Board of California.

3 (e) No person other than a licensed physician who is competent  
4 to evaluate the specific clinical issues involved in the medical  
5 treatment services, and where these services are within the scope  
6 of the physician's practice, requested by the physician may modify,  
7 delay, or deny requests for authorization of medical treatment for  
8 reasons of medical necessity to cure and relieve.

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

12 (1) Developed with involvement from actively practicing  
13 physicians.

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

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

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

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

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

33 (1) Prospective or concurrent decisions shall be made in a timely  
34 fashion that is appropriate for the nature of the employee's  
35 condition, not to exceed five working days from the receipt of the  
36 information reasonably necessary to make the determination, but  
37 in no event more than 14 days from the date of the medical  
38 treatment recommendation by the physician. In cases where the  
39 review is retrospective, a decision resulting in denial of all or part  
40 of the medical treatment service shall be communicated to the

1 individual who received services, or to the individual's designee,  
2 within 30 days of receipt of information that is reasonably  
3 necessary to make this determination. If payment for a medical  
4 treatment service is made within the time prescribed by Section  
5 4603.2, a retrospective decision to approve the service need not  
6 otherwise be communicated.

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

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

32 (B) In the case of concurrent review, medical care shall not be  
33 discontinued until the employee's physician has been notified of  
34 the decision and a care plan has been agreed upon by the physician  
35 that is appropriate for the medical needs of the employee. Medical  
36 care provided during a concurrent review shall be care that is  
37 medically necessary to cure and relieve, and an insurer or  
38 self-insured employer shall only be liable for those services  
39 determined medically necessary to cure and relieve. If the insurer  
40 or self-insured employer disputes whether or not one or more

1 services offered concurrently with a utilization review were  
2 medically necessary to cure and relieve, the dispute shall be  
3 resolved pursuant to Section 4610.5, if applicable, or otherwise  
4 pursuant to Section 4062. Any compromise between the parties  
5 that an insurer or self-insured employer believes may result in  
6 payment for services that were not medically necessary to cure  
7 and relieve shall be reported by the insurer or the self-insured  
8 employer to the licensing board of the provider or providers who  
9 received the payments, in a manner set forth by the respective  
10 board and in such a way as to minimize reporting costs both to the  
11 board and to the insurer or self-insured employer, for evaluation  
12 as to possible violations of the statutes governing appropriate  
13 professional practices. No fees shall be levied upon insurers or  
14 self-insured employers making reports required by this section.

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

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

1 employer, the employer shall approve, modify, or deny the request  
2 for authorization within the timeframes specified in paragraph (1)  
3 or (2).

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

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

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

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

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

40 *SEC. 2. Section 4610.2 is added to the Labor Code, to read:*

1     4610.2. (a) A request for medical treatment by a physician to  
2     cure or relieve an injured worker from the effect of an industrial  
3     injury is not subject to Section 4610 if all of the following  
4     conditions are met:

5     (1) A final award of permanent disability made by the appeals  
6     board specifies the provision of future medical treatment.

7     (2) The request is for medical treatment that is specified by the  
8     final award described in paragraph (1).

9     (3) The request is for medical treatment that is evidence based.

10    (b) (1) If an employer believes that a request for medical  
11    treatment is not evidence based, the employer may conduct an  
12    expedited review as provided in paragraph (1) of subdivision (g)  
13    of Section 4610 and subdivision (d) of Section 4610.6. The  
14    employer shall not modify, delay, or deny the request for medical  
15    treatment during the review.

16    (2) If, after conducting the review specified in paragraph (1),  
17    the utilization review decision to modify, delay or deny is upheld  
18    by independent medical review, the employer may request a  
19    medical evaluation under Section 4062.1 to stipulate to the need  
20    for a different or additional treatment. The treatment shall only  
21    be stipulated to if it is evidence based and at least as efficacious  
22    as the prior stipulated medical treatment. The employer shall not  
23    modify, delay, or deny the request for medical treatment prior to  
24    stipulation on the new medical treatment.

25    (3) For purposes of this subdivision, the term “evidence based”  
26    has the same meaning as the term “evidence-based” as used in  
27    Section 5307.27 with respect to the medical treatment utilization  
28    schedule.

29    SEC. 3. It is the intent of the Legislature that the changes made  
30    to law by this act shall not have an impact on or alter in any way  
31    the decision of the court in *Patterson v. Oaks Farm* (2014) WL  
32    3952788.