

AMENDED IN SENATE APRIL 6, 2016

AMENDED IN SENATE MARCH 28, 2016

**SENATE BILL**

**No. 1160**

---

---

**Introduced by Senator Mendoza**

February 18, 2016

---

---

An act to amend ~~Section 4610~~ Sections 138.6, 3710.1, 4604.5, 4610, and 4610.5 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 1160, as amended, Mendoza. 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~~

*Existing law requires the Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations to develop a workers' compensation information system in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, with certain data to be collected electronically and to be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. Existing law requires the administrative director to assess an administrative penalty of not more than \$5,000 in a single year against a claims administrator for a violation of those data reporting requirements.*

*This bill would increase that penalty assessment to not more than \$10,000. The bill would require the administrative director to post on the Division of Workers' Compensation Web site a list of claims*

*administrators who are in violation of the data reporting requirements. The bill would require penalty assessments, commencing January 1, 2019, of not less than \$15,000 and not more than \$45,000 for those violators if certain criteria are met, and commencing January 1, 2020, would authorize penalty assessments of not less than \$100,000 for violators who engage in a pattern or practice of failing to comply with the data reporting requirements.*

*Existing law requires employers to secure the payment of compensation for injured employees in one or more specified ways. When an employer has failed to secure the payment of compensation as required, existing law requires the administrative director to issue and serve on the employer a stop order, prohibiting the use of employee labor by the employer until the employer's compliance.*

*This bill would similarly authorize a stop order until the employer complies if the administrative director finds that an employer or claims administrator engages in a pattern or practice of failing to comply with specified data reporting requirements.*

*Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury. Under existing law, an employee may be treated by a physician of his or her own choice at a facility of his or her choice. Existing law requires the administrative director to adopt guidelines that govern the extent and scope of that medical treatment. Under existing law, an employee is entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. Existing law makes these restrictions on visits inapplicable to postsurgical physical medicine and postsurgical rehabilitation services.*

*This bill would instead make those restrictions on the numbers of visits inapplicable to physical medicine and rehabilitation services. The bill would provide that for injuries covered by the official utilization schedule, if the specific clinical topic of an injury covered by the official utilization schedule has not been updated in 5 or more years, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based if the guideline is 5 or less years old.*

*Existing law requires every employer to establish a utilization review process, and defines "utilization review" as utilization review or utilization management functions that 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 providing medical treatment services. Existing law also provides for an independent medical review process to resolve disputes over utilization review decisions, as defined.

This bill would, commencing July 1, 2018, require each utilization review process to be accredited by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The bill would require the administrative director to adopt rules to implement the selection of an independent, nonprofit organization for those certification purposes. The bill would authorize the administrative director to adopt rules to require additional specific criteria for measuring the quality of a utilization review process for purposes of certification.

*Existing law provides as part of the utilization review process, that the definition of medical treatment provided to employees is that treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on specified standards, including, among others, guidelines adopted by the administrative director, as specified.*

*This bill would require the guidelines adopted by the administrative director to be evidence-based medical treatment guidelines that are scientifically based and recognized generally by the national medical community.*

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

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

1 SECTION 1. Section 138.6 of the Labor Code is amended to  
2 read:

3 138.6. (a) The administrative director, in consultation with  
4 the Insurance Commissioner and the Workers' Compensation  
5 Insurance Rating Bureau, shall develop a cost-efficient workers'  
6 compensation information system, which shall be administered by  
7 the division. The administrative director shall adopt regulations

1 *specifying the data elements to be collected by electronic data*  
2 *interchange.*

3 (b) The information system shall do the following:

4 (1) Assist the department to manage the workers' compensation  
5 system in an effective and efficient manner.

6 (2) Facilitate the evaluation of the efficiency and effectiveness  
7 of the delivery system.

8 (3) Assist in measuring how adequately the system indemnifies  
9 injured workers and their dependents.

10 (4) Provide statistical data for research into specific aspects of  
11 the workers' compensation program.

12 (c) The data collected electronically shall be compatible with  
13 the Electronic Data Interchange System of the International  
14 Association of Industrial Accident Boards and Commissions. The  
15 administrative director may adopt regulations authorizing the use  
16 of other nationally recognized data transmission formats in addition  
17 to those set forth in the Electronic Data Interchange System for  
18 the transmission of data required pursuant to this section. The  
19 administrative director shall accept data transmissions in any  
20 authorized format. If the administrative director determines that  
21 any authorized data transmission format is not in general use by  
22 claims administrators, conflicts with the requirements of state or  
23 federal law, or is obsolete, the administrative director may adopt  
24 regulations eliminating that data transmission format from those  
25 authorized pursuant to this subdivision.

26 (d) (1) The administrative director shall assess an administrative  
27 penalty against a claims administrator for a violation of data  
28 reporting requirements adopted pursuant to this section. The  
29 administrative director shall promulgate a schedule of penalties  
30 providing for an assessment of no more than ~~five thousand dollars~~  
31 ~~(\$5,000)~~ *ten thousand dollars (\$10,000)* against a claims  
32 administrator in any single year, calculated as follows:

33 (A) No more than one hundred dollars (\$100) multiplied by the  
34 number of violations in that year that resulted in a required data  
35 report not being submitted or not being accepted.

36 (B) No more than fifty dollars (\$50) multiplied by the number  
37 of violations in that year that resulted in a required report being  
38 late or accepted with an error.

39 (C) Multiple errors in a single report shall be counted as a single  
40 violation.

1 (D) No penalty shall be assessed pursuant to Section 129.5 for  
2 any violation of data reporting requirements for which a penalty  
3 has been or may be assessed pursuant to this section.

4 (2) The schedule promulgated by the administrative director  
5 pursuant to paragraph (1) shall establish threshold rates of  
6 violations that shall be excluded from the calculation of the  
7 assessment, as follows:

8 (A) The threshold rate for reports that are not submitted or are  
9 submitted but not accepted shall not be less than 3 percent of the  
10 number of reports that are required to be filed by or on behalf of  
11 the claims administrator.

12 (B) The threshold rate for reports that are accepted with an error  
13 shall not be less than 3 percent of the number of reports that are  
14 accepted with an error.

15 (C) The administrative director shall set higher threshold rates  
16 as appropriate in recognition of the fact that the data necessary for  
17 timely and accurate reporting may not be always available to a  
18 claims administrator or the claims administrator's agents.

19 (D) The administrative director may establish higher thresholds  
20 for particular data elements that commonly are not reasonably  
21 available.

22 (3) The administrative director may estimate the number of  
23 required data reports that are not submitted by comparing a  
24 statistically valid sample of data available to the administrative  
25 director from other sources with the data reported pursuant to this  
26 section.

27 (4) All penalties assessed pursuant to this section shall be  
28 deposited in the Workers' Compensation Administration Revolving  
29 Fund.

30 (5) The administrative director shall publish an annual report  
31 disclosing the compliance rates of claims—~~administrators.~~  
32 *administrators and post the report and a list of claims*  
33 *administrators who are in violation of the data reporting*  
34 *requirements on the Web site of the Division of Workers'*  
35 *Compensation.*

36 *(e) (1) Commencing January 1, 2019, the administrative*  
37 *director shall assess an additional administrative penalty against*  
38 *a claims administrator for a violation of data reporting*  
39 *requirements adopted pursuant to this section of not less than*  
40 *fifteen thousand dollars (\$15,000) and not more than forty-five*

1 thousand dollars (\$45,000) in any single year if both of the  
 2 following are applicable:

3 (A) In the immediate previous year, the claims adjuster was  
 4 assessed a penalty of eight thousand dollars (\$8,000) or more.

5 (B) In the current year, the claims adjuster will be assessed a  
 6 penalty of eight thousand dollars (\$8,000) or more.

7 (2) Commencing January 1, 2020, the administrative director  
 8 may assess an additional administrative penalty against a claims  
 9 administrator for a pattern or practice of failing to comply with  
 10 the data reporting requirements adopted pursuant to this section  
 11 of not less than one hundred thousand (\$100,000) in any single  
 12 year.

13 SEC. 2. Section 3710.1 of the Labor Code is amended to read:

14 3710.1. (a) ~~Where~~ If an employer has failed to secure the  
 15 payment of compensation as required by Section 3700, the director  
 16 shall issue and serve on ~~such the~~ employer a stop order prohibiting  
 17 the use of employee labor by ~~such the~~ employer until the  
 18 employer's compliance with the provisions of Section 3700. ~~Such~~  
 19 The stop order shall become effective immediately upon service.  
 20 ~~Any~~ An employee so affected by ~~such the~~ work stoppage shall be  
 21 paid by the employer for ~~such~~ time lost, not exceeding 10 days,  
 22 pending compliance by the employer. ~~Such~~ An employer may  
 23 protest the stop order by making and filing with the director a  
 24 written request for a hearing within 20 days after service of ~~such~~  
 25 the stop order. ~~Such~~ The hearing shall be held within ~~5~~ five days  
 26 from the date of filing ~~such the~~ request. The director shall notify  
 27 the employer of the time and place of the hearing by mail. At the  
 28 conclusion of the hearing the stop order shall be immediately  
 29 affirmed or dismissed, and within 24 hours thereafter the director  
 30 shall issue and serve on all parties to the hearing by registered or  
 31 certified mail a written notice of findings and findings. A writ of  
 32 mandate may be taken from the findings to the appropriate superior  
 33 court. ~~Such~~ A writ ~~must~~ shall be taken within 45 days after the  
 34 mailing of the notice of findings and findings.

35 (b) If the administrative director finds that an employer or  
 36 claims administrator engages in a pattern or practice of failing  
 37 to comply with the data reporting requirements required by Section  
 38 138.6, the director may issue and serve a stop order on that  
 39 employer prohibiting the use of employee labor by the employer  
 40 until the employer's compliance with the provisions of Section

1 138.6. *The stop order shall become effective immediately upon*  
2 *service. An employee affected by the work stoppage shall be paid*  
3 *by the employer for time lost, not exceeding 10 days, pending*  
4 *compliance by the employer. The employer may protest the stop*  
5 *order by making and filing with the director a written request for*  
6 *a hearing within 20 days after service of the stop order. The*  
7 *hearing shall be held within five days from the date of filing the*  
8 *request. The director shall notify the employer of the time and*  
9 *place of the hearing by mail. At the conclusion of the hearing the*  
10 *stop order shall be immediately affirmed or dismissed, and within*  
11 *24 hours thereafter the director shall issue and serve on all parties*  
12 *to the hearing by registered or certified mail a written notice of*  
13 *findings and findings. A writ of mandate may be taken from the*  
14 *findings to the appropriate superior court. A writ shall be taken*  
15 *within 45 days after the mailing of the notice of findings and*  
16 *findings.*

17 SEC. 3. *Section 4604.5 of the Labor Code is amended to read:*

18 4604.5. (a) The recommended guidelines set forth in the  
19 medical treatment utilization schedule adopted by the  
20 administrative director pursuant to Section 5307.27 shall be  
21 presumptively correct on the issue of extent and scope of medical  
22 treatment. The presumption is rebuttable and may be controverted  
23 by a preponderance of the scientific medical evidence establishing  
24 that a variance from the guidelines reasonably is required to cure  
25 or relieve the injured worker from the effects of his or her injury.  
26 The presumption created is one affecting the burden of proof.

27 (b) The recommended guidelines set forth in the schedule  
28 adopted pursuant to subdivision (a) shall reflect practices that are  
29 evidence and scientifically based, nationally recognized, and peer  
30 reviewed. The guidelines shall be designed to assist providers by  
31 offering an analytical framework for the evaluation and treatment  
32 of injured workers, and shall constitute care in accordance with  
33 Section 4600 for all injured workers diagnosed with industrial  
34 conditions.

35 (c) (1) Notwithstanding the medical treatment utilization  
36 schedule, for injuries occurring on and after January 1, 2004, an  
37 employee shall be entitled to no more than 24 chiropractic, 24  
38 occupational therapy, and 24 physical therapy visits per industrial  
39 injury.

1 (2) (A) Paragraph (1) shall not apply when an employer  
2 authorizes, in writing, additional visits to a health care practitioner  
3 for physical medicine services. Payment or authorization for  
4 treatment beyond the limits set forth in paragraph (1) shall not be  
5 deemed a waiver of the limits set forth by paragraph (1) with  
6 respect to future requests for authorization.

7 (B) The Legislature finds and declares that the amendments  
8 made to subparagraph (A) by the act adding this subparagraph are  
9 declaratory of existing law.

10 (3) Paragraph (1) shall not apply to visits for ~~postsurgical~~  
11 physical medicine and ~~postsurgical~~ rehabilitation services provided  
12 in compliance with a ~~postsurgical~~ *rehabilitation* treatment  
13 utilization schedule established by the administrative director  
14 pursuant to Section 5307.27. *The administrative director shall*  
15 *adopt regulations to effectuate this paragraph on or before January*  
16 *1, 2018.*

17 (d) (1) For all injuries not covered by the official utilization  
18 schedule adopted pursuant to Section 5307.27, authorized treatment  
19 shall be in accordance with other evidence-based medical treatment  
20 guidelines that are recognized generally by the national medical  
21 community and scientifically based.

22 (2) *For injuries covered by the official utilization schedule*  
23 *adopted pursuant to Section 5307.27, if the specific clinical topic*  
24 *of an injury covered by the official utilization schedule has not*  
25 *been updated in five or more years, authorized treatment shall be*  
26 *in accordance with other evidence-based medical treatment*  
27 *guidelines that are recognized generally by the national medical*  
28 *community and scientifically based if the guideline is five or less*  
29 *years old.*

30 **SECTION 1.**

31 *SEC. 4.* Section 4610 of the Labor Code is amended to read:

32 4610. (a) For purposes of this section, “utilization review”  
33 means utilization review or utilization management functions that  
34 prospectively, retrospectively, or concurrently review and approve,  
35 modify, delay, or deny, based in whole or in part on medical  
36 necessity to cure and relieve, treatment recommendations by  
37 physicians, as defined in Section 3209.3, prior to, retrospectively,  
38 or concurrent with the provision of medical treatment services  
39 pursuant to Section 4600.

1 (b) Every employer shall establish a utilization review process  
2 in compliance with this section, either directly or through its insurer  
3 or an entity with which an employer or insurer contracts for these  
4 services.

5 (c) Each utilization review process shall be governed by written  
6 policies and procedures. These policies and procedures shall ensure  
7 that decisions based on the medical necessity to cure and relieve  
8 of proposed medical treatment services are consistent with the  
9 schedule for medical treatment utilization adopted pursuant to  
10 Section 5307.27. These policies and procedures, and a description  
11 of the utilization process, shall be filed with the administrative  
12 director and shall be disclosed by the employer to employees,  
13 physicians, and the public upon request.

14 (d) If an employer, insurer, or other entity subject to this section  
15 requests medical information from a physician in order to  
16 determine whether to approve, modify, delay, or deny requests for  
17 authorization, the employer shall request only the information  
18 reasonably necessary to make the ~~determination~~. *determination,*  
19 *and shall provide a physician at least 72 hours to respond to any*  
20 *request for medical information.* The employer, insurer, or other  
21 entity shall employ or designate a medical director who holds an  
22 unrestricted license to practice medicine in this state issued  
23 pursuant to Section 2050 or Section 2450 of the Business and  
24 Professions Code. The medical director shall ensure that the process  
25 by which the employer or other entity reviews and approves,  
26 modifies, delays, or denies requests by physicians prior to,  
27 retrospectively, or concurrent with the provision of medical  
28 treatment services, complies with the requirements of this section.  
29 Nothing in this section shall be construed as restricting the existing  
30 authority of the Medical Board of California.

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

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

- 1 (1) Developed with involvement from actively practicing  
2 physicians.
- 3 (2) Consistent with the schedule for medical treatment utilization  
4 adopted pursuant to Section 5307.27.
- 5 (3) Evaluated at least annually, and updated if necessary.
- 6 (4) Disclosed to the physician and the employee, if used as the  
7 basis of a decision to modify, delay, or deny services in a specified  
8 case under review.
- 9 (5) Available to the public upon request. An employer shall  
10 only be required to disclose the criteria or guidelines for the  
11 specific procedures or conditions requested. An employer may  
12 charge members of the public reasonable copying and postage  
13 expenses related to disclosing criteria or guidelines pursuant to  
14 this paragraph. Criteria or guidelines may also be made available  
15 through electronic means. No charge shall be required for an  
16 employee whose physician’s request for medical treatment services  
17 is under review.
- 18 (g) In determining whether to approve, modify, delay, or deny  
19 requests by physicians prior to, retrospectively, or concurrent with  
20 the provisions of medical treatment services to employees all of  
21 the following requirements shall be met:
  - 22 (1) Prospective or concurrent decisions shall be made in a timely  
23 fashion that is appropriate for the nature of the employee’s  
24 condition, not to exceed five working days from the receipt of the  
25 information reasonably necessary to make the determination, but  
26 in no event more than 14 days from the date of the medical  
27 treatment recommendation by the physician. In cases where the  
28 review is retrospective, a decision resulting in denial of all or part  
29 of the medical treatment service shall be communicated to the  
30 individual who received services, or to the individual’s designee,  
31 within 30 days of receipt of information that is reasonably  
32 necessary to make this determination. If payment for a medical  
33 treatment service is made within the time prescribed by Section  
34 4603.2, a retrospective decision to approve the service need not  
35 otherwise be communicated.
  - 36 (2) When the employee’s condition is such that the employee  
37 faces an imminent and serious threat to his or her health, including,  
38 but not limited to, the potential loss of life, limb, or other major  
39 bodily function, or the normal timeframe for the decisionmaking  
40 process, as described in paragraph (1), would be detrimental to the

1 employee's life or health or could jeopardize the employee's ability  
2 to regain maximum function, decisions to approve, modify, delay,  
3 or deny requests by physicians prior to, or concurrent with, the  
4 provision of medical treatment services to employees shall be made  
5 in a timely fashion that is appropriate for the nature of the  
6 employee's condition, but not to exceed 72 hours after the receipt  
7 of the information reasonably necessary to make the determination.

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

21 (B) In the case of concurrent review, medical care shall not be  
22 discontinued until the employee's physician has been notified of  
23 the decision and a care plan has been agreed upon by the physician  
24 that is appropriate for the medical needs of the employee. Medical  
25 care provided during a concurrent review shall be care that is  
26 medically necessary to cure and relieve, and an insurer or  
27 self-insured employer shall only be liable for those services  
28 determined medically necessary to cure and relieve. If the insurer  
29 or self-insured employer disputes whether or not one or more  
30 services offered concurrently with a utilization review were  
31 medically necessary to cure and relieve, the dispute shall be  
32 resolved pursuant to Section 4610.5, if applicable, or otherwise  
33 pursuant to Section 4062. Any compromise between the parties  
34 that an insurer or self-insured employer believes may result in  
35 payment for services that were not medically necessary to cure  
36 and relieve shall be reported by the insurer or the self-insured  
37 employer to the licensing board of the provider or providers who  
38 received the payments, in a manner set forth by the respective  
39 board and in such a way as to minimize reporting costs both to the  
40 board and to the insurer or self-insured employer, for evaluation

1 as to possible violations of the statutes governing appropriate  
2 professional practices. No fees shall be levied upon insurers or  
3 self-insured employers making reports required by this section.

4 (4) Communications regarding decisions to approve requests  
5 by physicians shall specify the specific medical treatment service  
6 approved. Responses regarding decisions to modify, delay, or deny  
7 medical treatment services requested by physicians shall include  
8 a clear and concise explanation of the reasons for the employer's  
9 decision, a description of the criteria or guidelines used, and the  
10 clinical reasons for the decisions regarding medical necessity. If  
11 a utilization review decision to deny or delay a medical service is  
12 due to incomplete or insufficient information, the decision shall  
13 specify the reason for the decision and specify the information that  
14 is needed.

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

33 (6) A utilization review decision to modify, delay, or deny a  
34 treatment recommendation shall remain effective for 12 months  
35 from the date of the decision without further action by the employer  
36 with regard to any further recommendation by the same physician  
37 for the same treatment unless the further recommendation is  
38 supported by a documented change in the facts material to the  
39 basis of the utilization review decision.

1 (7) Utilization review of a treatment recommendation shall not  
2 be required while the employer is disputing liability for injury or  
3 treatment of the condition for which treatment is recommended  
4 pursuant to Section 4062.

5 (8) If utilization review is deferred pursuant to paragraph (7),  
6 and it is finally determined that the employer is liable for treatment  
7 of the condition for which treatment is recommended, the time for  
8 the employer to conduct retrospective utilization review in  
9 accordance with paragraph (1) shall begin on the date the  
10 determination of the employer's liability becomes final, and the  
11 time for the employer to conduct prospective utilization review  
12 shall commence from the date of the employer's receipt of a  
13 treatment recommendation after the determination of the  
14 employer's liability.

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

18 (i) If the administrative director determines that the employer,  
19 insurer, or other entity subject to this section has failed to meet  
20 any of the timeframes in this section, or has failed to meet any  
21 other requirement of this section, the administrative director may  
22 assess, by order, administrative penalties for each failure. A  
23 proceeding for the issuance of an order assessing administrative  
24 penalties shall be subject to appropriate notice to, and an  
25 opportunity for a hearing with regard to, the person affected. The  
26 administrative penalties shall not be deemed to be an exclusive  
27 remedy for the administrative director. These penalties shall be  
28 deposited in the Workers' Compensation Administration Revolving  
29 Fund.

30 (j) A utilization review process shall be accredited on or before  
31 July 1, 2018, and every ~~five~~ *three* years thereafter, *or more*  
32 *frequently if deemed necessary by the administrative director*, by  
33 an independent, nonprofit organization to certify that the utilization  
34 review process meets specified criteria, including, but not limited  
35 to, timeliness in issuing a utilization review decision, the scope of  
36 medical material used in issuing a utilization review decision, and  
37 requiring a policy preventing financial incentives to doctors and  
38 other providers based on the utilization review decision. The  
39 administrative director shall adopt rules to implement the selection  
40 of an independent, nonprofit organization for those certification

1 purposes. The administrative director may adopt rules to require  
2 additional specific criteria for measuring the quality of a utilization  
3 review process for purposes of certification.

4 *SEC. 5. Section 4610.5 of the Labor Code is amended to read:*

5 4610.5. (a) This section applies to the following disputes:

6 (1) Any dispute over a utilization review decision regarding  
7 treatment for an injury occurring on or after January 1, 2013.

8 (2) Any dispute over a utilization review decision if the decision  
9 is communicated to the requesting physician on or after July 1,  
10 2013, regardless of the date of injury.

11 (b) A dispute described in subdivision (a) shall be resolved only  
12 in accordance with this section.

13 (c) For purposes of this section and Section 4610.6, the  
14 following definitions apply:

15 (1) “Disputed medical treatment” means medical treatment that  
16 has been modified, delayed, or denied by a utilization review  
17 decision.

18 (2) “Medically necessary” and “medical necessity” mean  
19 medical treatment that is reasonably required to cure or relieve the  
20 injured employee of the effects of his or her injury and based on  
21 the following standards, which shall be applied in the order listed,  
22 allowing reliance on a lower ranked standard only if every higher  
23 ranked standard is inapplicable to the employee’s medical  
24 condition:

25 (A) The guidelines adopted by the administrative director  
26 pursuant to ~~Section 5307.27~~. *5307.27 or, pursuant to subdivision*  
27 *(d) of Section 4604.5, evidence-based medical treatment guidelines*  
28 *that are scientifically based and recognized generally by the*  
29 *national medical community.*

30 (B) Peer-reviewed scientific and medical evidence regarding  
31 the effectiveness of the disputed service.

32 (C) Nationally recognized professional standards.

33 (D) Expert opinion.

34 (E) Generally accepted standards of medical practice.

35 (F) Treatments that are likely to provide a benefit to a patient  
36 for conditions for which other treatments are not clinically  
37 efficacious.

38 (3) “Utilization review decision” means a decision pursuant to  
39 Section 4610 to modify, delay, or deny, based in whole or in part  
40 on medical necessity to cure or relieve, a treatment

1 recommendation or recommendations by a physician prior to,  
2 retrospectively, or concurrent with, the provision of medical  
3 treatment services pursuant to Section 4600 or subdivision (c) of  
4 Section 5402.

5 (4) Unless otherwise indicated by context, “employer” means  
6 the employer, the insurer of an insured employer, a claims  
7 administrator, or a utilization review organization, or other entity  
8 acting on behalf of any of them.

9 (d) If a utilization review decision denies, modifies, or delays  
10 a treatment recommendation, the employee may request an  
11 independent medical review as provided by this section.

12 (e) A utilization review decision may be reviewed or appealed  
13 only by independent medical review pursuant to this section.  
14 Neither the employee nor the employer shall have any liability for  
15 medical treatment furnished without the authorization of the  
16 employer if the treatment is delayed, modified, or denied by a  
17 utilization review decision unless the utilization review decision  
18 is overturned by independent medical review in accordance with  
19 this section.

20 (f) As part of its notification to the employee regarding an initial  
21 utilization review decision that denies, modifies, or delays a  
22 treatment recommendation, the employer shall provide the  
23 employee with a form not to exceed two pages, prescribed by the  
24 administrative director, and an addressed envelope, which the  
25 employee may return to the administrative director or the  
26 administrative director’s designee to initiate an independent  
27 medical review. The employer shall include on the form any  
28 information required by the administrative director to facilitate the  
29 completion of the independent medical review. The form shall  
30 also include all of the following:

31 (1) Notice that the utilization review decision is final unless the  
32 employee requests independent medical review.

33 (2) A statement indicating the employee’s consent to obtain any  
34 necessary medical records from the employer or insurer and from  
35 any medical provider the employee may have consulted on the  
36 matter, to be signed by the employee.

37 (3) Notice of the employee’s right to provide information or  
38 documentation, either directly or through the employee’s physician,  
39 regarding the following:

1 (A) The treating physician's recommendation indicating that  
2 the disputed medical treatment is medically necessary for the  
3 employee's medical condition.

4 (B) Medical information or justification that a disputed medical  
5 treatment, on an urgent care or emergency basis, was medically  
6 necessary for the employee's medical condition.

7 (C) Reasonable information supporting the employee's position  
8 that the disputed medical treatment is or was medically necessary  
9 for the employee's medical condition, including all information  
10 provided to the employee by the employer or by the treating  
11 physician, still in the employee's possession, concerning the  
12 employer's or the physician's decision regarding the disputed  
13 medical treatment, as well as any additional material that the  
14 employee believes is relevant.

15 (g) The independent medical review process may be terminated  
16 at any time upon the employer's written authorization of the  
17 disputed medical treatment.

18 (h) (1) The employee may submit a request for independent  
19 medical review to the division no later than 30 days after the  
20 service of the utilization review decision to the employee.

21 (2) If at the time of a utilization review decision the employer  
22 is also disputing liability for the treatment for any reason besides  
23 medical necessity, the time for the employee to submit a request  
24 for independent medical review to the administrative director or  
25 administrative director's designee is extended to 30 days after  
26 service of a notice to the employee showing that the other dispute  
27 of liability has been resolved.

28 (3) If the employer fails to comply with subdivision (f) at the  
29 time of notification of its utilization review decision, the time  
30 limitations for the employee to submit a request for independent  
31 medical review shall not begin to run until the employer provides  
32 the required notice to the employee.

33 (4) A provider of emergency medical treatment when the  
34 employee faced an imminent and serious threat to his or her health,  
35 including, but not limited to, the potential loss of life, limb, or  
36 other major bodily function, may submit a request for independent  
37 medical review on its own behalf. A request submitted by a  
38 provider pursuant to this paragraph shall be submitted to the  
39 administrative director or administrative director's designee within

1 the time limitations applicable for an employee to submit a request  
2 for independent medical review.

3 (i) An employer shall not engage in any conduct that has the  
4 effect of delaying the independent review process. Engaging in  
5 that conduct or failure of the employer to promptly comply with  
6 this section is a violation of this section and, in addition to any  
7 other fines, penalties, and other remedies available to the  
8 administrative director, the employer shall be subject to an  
9 administrative penalty in an amount determined pursuant to  
10 regulations to be adopted by the administrative director, not to  
11 exceed five thousand dollars (\$5,000) for each day that proper  
12 notification to the employee is delayed. The administrative  
13 penalties shall be paid to the Workers' Compensation  
14 Administration Revolving Fund.

15 (j) For purposes of this section, an employee may designate a  
16 parent, guardian, conservator, relative, or other designee of the  
17 employee as an agent to act on his or her behalf. A designation of  
18 an agent executed prior to the utilization review decision shall not  
19 be valid. The requesting physician may join with or otherwise  
20 assist the employee in seeking an independent medical review,  
21 and may advocate on behalf of the employee.

22 (k) The administrative director or his or her designee shall  
23 expeditiously review requests and immediately notify the employee  
24 and the employer in writing as to whether the request for an  
25 independent medical review has been approved, in whole or in  
26 part, and, if not approved, the reasons therefor. If there appears to  
27 be any medical necessity issue, the dispute shall be resolved  
28 pursuant to an independent medical review, except that, unless the  
29 employer agrees that the case is eligible for independent medical  
30 review, a request for independent medical review shall be deferred  
31 if at the time of a utilization review decision the employer is also  
32 disputing liability for the treatment for any reason besides medical  
33 necessity.

34 (l) Upon notice from the administrative director that an  
35 independent review organization has been assigned, the employer  
36 shall provide to the independent medical review organization all  
37 of the following documents within 10 days of notice of assignment:

38 (1) A copy of all of the employee's medical records in the  
39 possession of the employer or under the control of the employer  
40 relevant to each of the following:

- 1 (A) The employee’s current medical condition.
- 2 (B) The medical treatment being provided by the employer.
- 3 (C) The disputed medical treatment requested by the employee.
- 4 (2) A copy of all information provided to the employee by the
- 5 employer concerning employer and provider decisions regarding
- 6 the disputed treatment.
- 7 (3) A copy of any materials the employee or the employee’s
- 8 provider submitted to the employer in support of the employee’s
- 9 request for the disputed treatment.
- 10 (4) A copy of any other relevant documents or information used
- 11 by the employer or its utilization review organization in
- 12 determining whether the disputed treatment should have been
- 13 provided, and any statements by the employer or its utilization
- 14 review organization explaining the reasons for the decision to
- 15 deny, modify, or delay the recommended treatment on the basis
- 16 of medical necessity. The employer shall concurrently provide a
- 17 copy of the documents required by this paragraph to the employee
- 18 and the requesting physician, except that documents previously
- 19 provided to the employee or physician need not be provided again
- 20 if a list of those documents is provided.
- 21 (m) Any newly developed or discovered relevant medical
- 22 records in the possession of the employer after the initial documents
- 23 are provided to the independent medical review organization shall
- 24 be forwarded immediately to the independent medical review
- 25 organization. The employer shall concurrently provide a copy of
- 26 medical records required by this subdivision to the employee or
- 27 the employee’s treating physician, unless the offer of medical
- 28 records is declined or otherwise prohibited by law. The
- 29 confidentiality of medical records shall be maintained pursuant to
- 30 applicable state and federal laws.
- 31 (n) If there is an imminent and serious threat to the health of
- 32 the employee, as specified in subdivision (c) of Section 1374.33
- 33 of the Health and Safety Code, all necessary information and
- 34 documents required by subdivision (l) shall be delivered to the
- 35 independent medical review organization within 24 hours of
- 36 approval of the request for review.
- 37 (o) The employer shall promptly issue a notification to the
- 38 employee, after submitting all of the required material to the
- 39 independent medical review organization, that lists documents

- 1 submitted and includes copies of material not previously provided
- 2 to the employee or the employee's designee.

O