AMENDED IN ASSEMBLY JUNE 20, 2016

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 Sections 138.6, ~~3710.1, 4604.5, 4610, and 4610.5~~ *4604.5, and 4610* 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 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 *Internet* 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.~~ *met.*

~~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.~~ *The bill would require the administrative director to adopt regulations for these purposes, as specified.*

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:

138.6. (a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a cost-efficient workers' compensation information system, which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.

(b) The information system shall do the following:

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

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

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

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

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format is not in general use by claims administrators, conflicts with the requirements of state or federal law, or is obsolete, the administrative director may adopt regulations eliminating that data transmission format from those authorized pursuant to this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) ~~(1)~~ Commencing January 1, 2019, the administrative director shall assess an additional administrative penalty against a claims administrator for a violation of data reporting requirements adopted pursuant to this section of not less than fifteen thousand dollars ($15,000) and not more than forty-five thousand dollars ($45,000) in any single year if both of the following are applicable:

~~(A)~~

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

~~(B)~~

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

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

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

~~3710.1. (a) If an employer has failed to secure the payment of compensation as required by Section 3700, the director shall issue and serve on the employer a stop order prohibiting the use of employee labor by the employer until the employer's compliance with the provisions of Section 3700. The stop order shall become effective immediately upon service. An employee affected by the work stoppage shall be paid by the employer for time lost, not exceeding 10 days, pending compliance by the employer. An employer may protest the stop order by making and filing with the director a written request for a hearing within 20 days after service of the stop order. The hearing shall be held within five days from the date of filing the request. The director shall notify the employer of the time and place of the hearing by mail. At the conclusion of the hearing the stop order shall be immediately affirmed or dismissed, and within 24 hours thereafter the director shall issue and serve on all parties to the hearing by registered or certified mail a written notice of findings and findings. A writ of mandate may be taken from the findings to the appropriate superior court. A writ shall be taken within 45 days after the mailing of the notice of findings and findings.~~

~~(b) If the administrative director finds that an employer or claims administrator engages in a pattern or practice of failing to comply with the data reporting requirements required by Section 138.6, the director may issue and serve a stop order on that employer prohibiting the use of employee labor by the employer until the employer's compliance with the provisions of Section 138.6. The stop order shall become effective immediately upon service. An employee affected by the work stoppage shall be paid by the employer for time lost, not exceeding 10 days, pending compliance by the employer. The employer may protest the stop order by making and filing with the director a written request for a hearing within 20 days after service of the stop order. The hearing shall be held within five days from the date of filing the request. The director shall notify the employer of the time and place of the hearing by mail. At the conclusion of the hearing the stop order shall be immediately affirmed or dismissed, and within 24 hours thereafter the director shall issue and serve on all parties to the hearing by registered or certified mail a written notice of findings and findings. A writ of mandate may be taken from the findings to the appropriate superior court. A writ shall be taken within 45 days after the mailing of the notice of findings and findings.~~

~~SEC. 3.~~

SEC. 2. Section 4604.5 of the Labor Code is amended to read:

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

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

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

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

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

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

(d) ~~(1)~~ For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, 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.

~~(2) For injuries covered by the official utilization schedule adopted pursuant to Section 5307.27, if the specific clinical topic of an injury covered by the official utilization schedule has not been updated in five 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 five or less years old.~~

~~SEC. 4.~~

SEC. 3. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means 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, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

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

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

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

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

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

(1) Developed with involvement from actively practicing physicians.

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

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

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

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

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

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

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including,

but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

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

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who

received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

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

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

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is

supported by a documented change in the facts material to the basis of the utilization review decision.

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

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

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

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

(j) A utilization review process shall be accredited on or before July 1, 2018, and every three years thereafter, or more frequently if deemed necessary by the administrative director, 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

administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those certification purposes. The administrative director may adopt rules to require additional specific criteria for measuring the quality of a utilization review process for purposes of certification.

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

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

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

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

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

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

~~(1) "Disputed medical treatment" means medical treatment that has been modified, delayed, or denied by a utilization review decision.~~

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

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

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

~~(C) Nationally recognized professional standards.~~

~~(D) Expert opinion.~~

~~(E) Generally accepted standards of medical practice.~~

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

~~(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402.~~

~~(4) Unless otherwise indicated by context, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.~~

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

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

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

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

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

~~(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:~~

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

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

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

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

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

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

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

~~(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a~~

~~provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.~~

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

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

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

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

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

~~(A) The employee's current medical condition.~~

~~(B) The medical treatment being provided by the employer.~~

~~(C) The disputed medical treatment requested by the employee.~~

~~(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.~~

~~(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.~~

~~(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.~~

~~(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.~~

~~(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (*l*) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.~~

~~(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.~~

O