

AMENDED IN ASSEMBLY AUGUST 29, 2016

AMENDED IN ASSEMBLY AUGUST 18, 2016

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
(Principal coauthor: Senator Pan)**

February 18, 2016

An act to amend Sections 138.4, 138.6, 4610.5, 4610.6, 4903.05, 4903.8, 5307.27, 5710, 5811, and 6409 of, to amend, repeal, and add Section 4610 of, and to add Section 4615 to, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 1160, as amended, Mendoza. Workers' compensation.

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 to develop and make available informational material written in plain language that describes the overall workers' compensation claims process, as specified.

This bill would require the administrative director to adopt regulations to provide employees with notice regarding access to medical treatment following the denial of a claim under the workers' compensation system.

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.

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 revise and recast provisions relating to utilization review, as specified, with regard to injuries occurring on or after January 1, 2018. Among other things, the bill would set forth the medical treatment services that would be subject to prospective utilization review under these provisions, as provided. The bill would authorize retrospective utilization review for treatment provided under these provisions under limited circumstances, as specified. The bill would establish procedures for prospective and retrospective utilization reviews and set forth provisions for removal of a physician or provider under designated circumstances. On and after January 1, 2018, the bill would establish new procedures for reviewing determinations regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted by the administrative director, as provided. The bill would make conforming changes to related provisions to implement these changes.

The 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 accreditation purposes, and as specified. 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 accreditation and provide for certain exemptions. The bill would require the administrative director to develop a system for electronic reporting of documents related to utilization review performed by each employer, to be administered by the division. *The bill would require the administrative director, on or after March 1, 2019, to contract with an outside independent research organization to evaluate and report on the impact of provision of medical treatment within the first 30 days after a claim is filed, for claims filed on or after January 1, 2017, to January 1, 2019. The bill would require the report to be completed before January 1, 2020, and to be distributed to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance.*

Existing law requires every lien claimant to file its lien with the appeals board in writing upon a form approved by the appeals board. Existing law requires a lien to be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement, as specified.

This bill would require certain lien claimants that file a lien under these provisions to do so by filing a declaration, under penalty of perjury, that includes specified information. The bill would require current lien claimants to also file the declaration by a specified date. The bill would make a failure to file a declaration under these provisions grounds for dismissal of a lien. Because the bill would expand the crime of perjury, the bill would impose a state-mandated local program.

The bill would also automatically stay any physician or provider lien upon the filing of criminal charges against that person or entity for specified offenses involving medical fraud, as provided. The bill would authorize the administrative director to adopt regulations to implement

that provision. *The bill would state findings and declarations of the Legislature in connection with these provisions.*

Existing law prohibits the assignment of a lien under these provisions, except under limited circumstances, as specified.

This bill would, for liens filed after January 1, 2017, invalidate any assignment of a lien made in violation of these provisions, by operation of law.

Existing law requires the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, to adopt, after public hearings, a medical treatment utilization ~~schedule,~~ *schedule* to incorporate evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission, as specified.

This bill would authorize the administrative director to make updates to the utilization schedule by order, which would not be subject to the Administrative Procedure Act, as specified. The bill would require any order adopted pursuant to these provisions to be published on the Internet Web site of the division.

Existing law requires a deponent to receive certain expenses and reimbursements if an employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits as a dependent of an injured employee. Existing law authorizes the deponent to *receive* a reasonable allowance for attorney's fees, if represented by an attorney licensed in this state.

This bill would authorize the administrative director to determine the range of reasonable fees to be paid to a deponent.

Existing law provides that it is the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter. Existing law sets forth the qualifications of a qualified interpreter for these purposes, and provides for the settings under which a qualified interpreter may render services.

This bill would require the administrative director to promulgate regulations establishing criteria to verify the identity and credentials of individuals that provide interpreter services under these provisions.

Existing law requires physicians, as defined, who attend to injured or ill employees to file reports with specific information prescribed by law.

This bill would revise those reporting requirements, as prescribed.

This bill would incorporate changes to Section 4610 of the Labor Code proposed by AB 2503, to be operative as specified if both bills are enacted.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

1 SECTION 1. Section 138.4 of the Labor Code is amended to
2 read:

3 138.4. (a) For the purpose of this section, “claims
4 administrator” means a self-administered workers’ compensation
5 insurer; or a self-administered self-insured employer; or a
6 self-administered legally uninsured employer; or a
7 self-administered joint powers authority; or a third-party claims
8 administrator for an insurer, a self-insured employer, a legally
9 uninsured employer, or a joint powers authority.

10 (b) With respect to injuries resulting in lost time beyond the
11 employee’s work shift at the time of injury or medical treatment
12 beyond first aid:

13 (1) If the claims administrator obtains knowledge that the
14 employer has not provided a claim form or a notice of potential
15 eligibility for benefits to the employee, it shall provide the form
16 and notice to the employee within three working days of its
17 knowledge that the form or notice was not provided.

18 (2) If the claims administrator cannot determine if the employer
19 has provided a claim form and notice of potential eligibility for
20 benefits to the employee, the claims administrator shall provide

1 the form and notice to the employee within 30 days of the
2 administrator’s date of knowledge of the claim.

3 (c) The administrative director, in consultation with the
4 Commission on Health and Safety and Workers’ Compensation,
5 shall prescribe reasonable rules and regulations, including notice
6 of the right to consult with an attorney, where appropriate, for
7 serving on the employee (or employee’s dependents, in the case
8 of death), the following:

9 (1) Notices dealing with the payment, nonpayment, or delay in
10 payment of temporary disability, permanent disability,
11 supplemental job displacement, and death benefits.

12 (2) Notices of any change in the amount or type of benefits
13 being provided, the termination of benefits, the rejection of any
14 liability for compensation, and an accounting of benefits paid.

15 (3) Notices of rights to select the primary treating physician,
16 written continuity of care policies, requests for a comprehensive
17 medical evaluation, and offers of regular, modified, or alternative
18 work.

19 (d) The administrative director, in consultation with the
20 Commission on Health and Safety and Workers’ Compensation,
21 shall develop, make fully accessible on the department’s Internet
22 Web site, and make available at district offices informational
23 material written in plain language that describes the overall
24 workers’ compensation claims process, including the rights and
25 obligations of employees and employers at every stage of a claim
26 when a notice is required.

27 (e) Each notice prescribed by the administrative director shall
28 be written in plain language, shall reference the informational
29 material described in subdivision (d) to enable employees to
30 understand the context of the notices, and shall clearly state the
31 Internet Web site address and contact information that an employee
32 may use to access the informational material.

33 (f) On or before January 1, 2018, the administrative director
34 shall adopt regulations to provide employees with notice that they
35 may access medical treatment outside of the workers’ compensation
36 system following the denial of their claim.

37 SEC. 2. Section 138.6 of the Labor Code is amended to read:

38 138.6. (a) The administrative director, in consultation with
39 the Insurance Commissioner and the Workers’ Compensation
40 Insurance Rating Bureau, shall develop a cost-efficient workers’

1 compensation information system, which shall be administered by
2 the division. The administrative director shall adopt regulations
3 specifying the data elements to be collected by electronic data
4 interchange.

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

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

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

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

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

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

28 (d) (1) The administrative director shall assess an administrative
29 penalty against a claims administrator for a violation of data
30 reporting requirements adopted pursuant to this section. The
31 administrative director shall promulgate a schedule of penalties
32 providing for an assessment of no more than ten thousand dollars
33 (\$10,000) against a claims administrator in any single year,
34 calculated as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

38 4610. (a) For purposes of this section, “utilization review”
39 means utilization review or utilization management functions that
40 prospectively, retrospectively, or concurrently review and approve,

1 modify, or deny, based in whole or in part on medical necessity
2 to cure and relieve, treatment recommendations by physicians, as
3 defined in Section 3209.3, prior to, retrospectively, or concurrent
4 with the provision of medical treatment services pursuant to Section
5 4600.

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

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

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

34 (e) No person other than a licensed physician who is competent
35 to evaluate the specific clinical issues involved in the medical
36 treatment services, and where these services are within the scope
37 of the physician's practice, requested by the physician may modify
38 or deny requests for authorization of medical treatment for reasons
39 of medical necessity to cure and relieve.

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

4 (1) Developed with involvement from actively practicing
5 physicians.

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

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

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

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

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

25 (1) Prospective or concurrent decisions shall be made in a timely
26 fashion that is appropriate for the nature of the employee's
27 condition, not to exceed five working days from the receipt of the
28 information reasonably necessary to make the determination, but
29 in no event more than 14 days from the date of the medical
30 treatment recommendation by the physician. In cases where the
31 review is retrospective, a decision resulting in denial of all or part
32 of the medical treatment service shall be communicated to the
33 individual who received services, or to the individual's designee,
34 within 30 days of receipt of information that is reasonably
35 necessary to make this determination. If payment for a medical
36 treatment service is made within the time prescribed by Section
37 4603.2, a retrospective decision to approve the service need not
38 otherwise be communicated.

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (j) This section shall remain in effect only until January 1, 2018,
33 and as of that date is repealed, unless a later enacted statute, that
34 is enacted before January 1, 2018, deletes or extends that date.

35 *SEC. 3.5. Section 4610 of the Labor Code is amended to read:*

36 4610. (a) For purposes of this section, "utilization review"
37 means utilization review or utilization management functions that
38 prospectively, retrospectively, or concurrently review and approve,
39 modify, ~~delay~~, or deny, based in whole or in part on medical
40 necessity to cure and relieve, treatment recommendations by

1 physicians, as defined in Section 3209.3, prior to, retrospectively,
2 or concurrent with the provision of medical treatment services
3 pursuant to Section 4600.

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

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

17 (d) *Unless otherwise indicated in this section, a physician*
18 *providing treatment under Section 4600 shall send any request for*
19 *authorization for medical treatment, with supporting*
20 *documentation, to the claims administrator for the employer,*
21 *insurer, or other entity according to rules adopted by the*
22 *administrative director.* If an employer, insurer, or other entity
23 subject to this section requests medical information from a
24 physician in order to determine whether to approve, modify, ~~delay,~~
25 or deny requests for authorization, ~~the employer that employer,~~
26 *insurer, or other entity* shall request only the information
27 reasonably necessary to make the determination. The employer,
28 insurer, or other entity shall employ or designate a medical director
29 who holds an unrestricted license to practice medicine in this state
30 issued pursuant to Section 2050 or ~~Section~~ 2450 of the Business
31 and Professions Code. The medical director shall ensure that the
32 process by which the employer or other entity reviews and
33 approves, modifies, ~~delays,~~ or denies requests by physicians prior
34 to, retrospectively, or concurrent with the provision of medical
35 treatment services, complies with the requirements of this section.
36 Nothing in this section shall be construed as restricting the existing
37 authority of the Medical Board of California.

38 (e) ~~No~~*A* person other than a licensed physician who is
39 competent to evaluate the specific clinical issues involved in the
40 medical treatment services, ~~and where if~~ these services are within

1 the scope of the physician's practice, requested by the ~~physician~~
2 ~~may modify, delay,~~ *physician, shall not modify* or deny requests
3 for authorization of medical treatment for reasons of medical
4 necessity to cure and relieve.

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

8 (1) Developed with involvement from actively practicing
9 physicians.

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

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

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

16 (5) Available to the public upon request. An employer shall
17 only be required to disclose the criteria or guidelines for the
18 specific procedures or conditions requested. An employer may
19 charge members of the public reasonable copying and postage
20 expenses related to disclosing criteria or guidelines pursuant to
21 this paragraph. Criteria or guidelines may also be made available
22 through electronic means. ~~No~~ A charge shall *not* be required for
23 an employee whose physician's request for medical treatment
24 services is under review.

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

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

1 4603.2, a retrospective decision to approve the service need not
2 otherwise be communicated.

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

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

29 (B) In the case of concurrent review, medical care shall not be
30 discontinued until the employee's physician has been notified of
31 the decision and a care plan has been agreed upon by the physician
32 that is appropriate for the medical needs of the employee. Medical
33 care provided during a concurrent review shall be care that is
34 medically necessary to cure and relieve, and an insurer or
35 self-insured employer shall only be liable for those services
36 determined medically necessary to cure and relieve. If the insurer
37 or self-insured employer disputes whether or not one or more
38 services offered concurrently with a utilization review were
39 medically necessary to cure and relieve, the dispute shall be
40 resolved pursuant to Section 4610.5, if applicable, or otherwise

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

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

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

1 for authorization within the timeframes specified in paragraph (1)
2 or (2).

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

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

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

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

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

1 (j) *This section shall remain in effect only until January 1, 2018,*
2 *and as of that date is repealed, unless a later enacted statute, that*
3 *is enacted before January 1, 2018, deletes or extends that date.*

4 SEC. 4. Section 4610 is added to the Labor Code, to read:

5 4610. (a) For purposes of this section, “utilization review”
6 means utilization review or utilization management functions that
7 prospectively, retrospectively, or concurrently review and approve,
8 modify, or deny, based in whole or in part on medical necessity
9 to cure and relieve, treatment recommendations by physicians, as
10 defined in Section 3209.3, prior to, retrospectively, or concurrent
11 with the provision of medical treatment services pursuant to Section
12 4600.

13 (b) For all dates of injury occurring on or after January 1, 2018,
14 emergency treatment services and medical treatment rendered for
15 a body part or condition *that is* accepted as compensable by the
16 ~~employer~~, *employer and is addressed by the medical treatment*
17 *utilization schedule adopted pursuant to Section 5307.7,* by a
18 member of the medical provider network or health care
19 organization, or by a physician predesignated pursuant to
20 subdivision (d) of Section 4600, within the 30 days following the
21 initial date of injury, shall be authorized without prospective
22 utilization review, except as provided in subdivision (c). *The*
23 *services rendered under this subdivision shall be consistent with*
24 *the medical treatment utilization schedule.* In the event that the
25 employee is not subject to treatment with a medical provider
26 network, health care organization, or predesignated physician
27 pursuant to subdivision (d) of Section 4600, the employee shall
28 be eligible for treatment under this section within 30 days following
29 the initial date of injury if the treatment is rendered by a physician
30 or facility selected by the employer. For treatment rendered by a
31 medical provider network physician, health care organization
32 physician, a physician predesignated pursuant to subdivision (d)
33 of Section 4600, or an employer-selected physician, the report
34 required under Section 6409 and a complete request for
35 authorization shall be submitted by the physician within five days
36 following the employee’s initial visit and evaluation.

37 (c) Unless authorized by the employer or rendered as emergency
38 medical treatment, the following medical treatment services, as
39 defined in rules adopted by the administrative director, that are
40 rendered through a member of the medical provider network or

1 health care organization, a predesignated physician, an
2 employer-selected physician, or an employer-selected facility,
3 within the 30 days following the initial date of injury, shall be
4 subject to prospective utilization review under this section:

5 ~~(1) Services provided for a condition or occupational injury or~~
6 ~~illness that is not addressed or allowed for in the medical treatment~~
7 ~~utilization schedule guidelines adopted pursuant to Section~~
8 ~~5307.27.~~

9 ~~(2)~~

10 (1) Pharmaceuticals, to the extent they are neither expressly
11 exempted from prospective review nor authorized by the drug
12 formulary adopted pursuant to Section 5307.27.

13 ~~(3) Non-emergency~~

14 (2) *Nonemergency* inpatient and outpatient surgery, including
15 all presurgical and postsurgical services.

16 ~~(4)~~

17 (3) Psychological treatment services.

18 ~~(5)~~

19 (4) Home health care services.

20 ~~(6)~~

21 (5) Imaging and radiology services, excluding X-rays.

22 ~~(7)~~

23 (6) All durable medical equipment, whose combined total value
24 exceeds two hundred fifty dollars (\$250), as determined by the
25 official medical fee schedule.

26 ~~(8)~~

27 (7) Electrodiagnostic medicine, including, but not limited to,
28 electromyography and nerve conduction studies.

29 ~~(9)~~

30 (8) Any other service designated and defined through rules
31 adopted by the administrative director.

32 (d) Any request for payment for treatment provided under
33 subdivision (b) shall comply with Section 4603.2 and be submitted
34 to the employer, or its insurer or claims administrator, within 30
35 days of the date the service was provided.

36 (e) If a physician fails to submit the report required under
37 Section 6409 and a complete request for authorization, as described
38 in subdivision (b), an employer may remove the physician's ability
39 under this subdivision to provide further medical treatment to the
40 employee that is exempt from prospective utilization review.

1 (f) An employer may perform retrospective utilization review
2 for any treatment provided pursuant to subdivision (b) solely for
3 the purpose of determining if the physician is prescribing treatment
4 consistent with the schedule for medical treatment utilization,
5 including, but not limited to, the drug formulary adopted pursuant
6 to Section 5307.27.

7 (1) If it is found after retrospective utilization reviews that there
8 is a pattern and practice of the physician or provider failing to
9 render treatment consistent with the schedule for medical treatment
10 utilization, including the drug formulary, the employer may remove
11 the ability of the predesignated physician, employer-selected
12 physician, or the member of the medical provider network or health
13 care organization under this subdivision to provide further medical
14 treatment to any employee that is exempt from prospective
15 utilization review. The employer shall notify the physician or
16 provider of the results of the retrospective utilization review and
17 the requirement for prospective utilization review for all subsequent
18 medical treatment.

19 (2) The results of retrospective utilization review may constitute
20 a showing of good cause for an employer's petition requesting a
21 change of physician or provider pursuant to Section 4603 and may
22 serve as grounds for termination of the physician or provider from
23 the medical provider network or health care organization.

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

28 (1) Each utilization review process that modifies or denies
29 requests for authorization of medical treatment shall be governed
30 by written policies and procedures. These policies and procedures
31 shall ensure that decisions based on the medical necessity to cure
32 and relieve of proposed medical treatment services are consistent
33 with the schedule for medical treatment utilization, including the
34 drug formulary, adopted pursuant to Section 5307.27.

35 (2) The employer, insurer, or other entity shall employ or
36 designate a medical director who holds an unrestricted license to
37 practice medicine in this state issued pursuant to Section 2050 or
38 Section 2450 of the Business and Professions Code. The medical
39 director shall ensure that the process by which the employer or
40 other entity reviews and approves, modifies, or denies requests by

1 physicians prior to, retrospectively, or concurrent with the provision
2 of medical treatment services complies with the requirements of
3 this section. Nothing in this section shall be construed as restricting
4 the existing authority of the Medical Board of California.

5 (3) (A) No person other than a licensed physician who is
6 competent to evaluate the specific clinical issues involved in the
7 medical treatment services, and where these services are within
8 the scope of the physician's practice, requested by the physician
9 may modify or deny requests for authorization of medical treatment
10 for reasons of medical necessity to cure and relieve or due to
11 incomplete or insufficient information under subdivisions (i) and
12 (j).

13 (B) (i) The employer, or any entity conducting utilization review
14 on behalf of the employer, shall neither offer nor provide any
15 financial incentive or consideration to a physician based on the
16 number of ~~modifications, delays,~~ *modifications* or denials made
17 by the physician under this section.

18 (ii) An insurer or third-party administrator shall not refer
19 utilization review services conducted on behalf of an employer
20 under this section to an entity in which the insurer or third-party
21 administrator has a financial interest as defined under Section
22 139.32. This prohibition does not apply if the insurer or third-party
23 administrator provides the employer and the administrative director
24 with prior written disclosure of both of the following:

25 (I) The entity conducting the utilization review services.

26 (II) The insurer or third-party administrator's financial interest
27 in the entity.

28 (C) The administrative director has authority pursuant to this
29 section to review any compensation agreement, payment schedule,
30 or contract between the employer, or any entity conducting
31 utilization review on behalf of the employer, and the utilization
32 review physician. Any information disclosed to the administrative
33 director pursuant to this paragraph shall be considered confidential
34 information and not subject to disclosure pursuant to the California
35 Public Records Act (Chapter 3.5 (commencing with Section 6250)
36 of Division 7 of Title 1 of the Government Code). Disclosure of
37 the information to the administrative director pursuant to this
38 subdivision shall not waive the provisions of the Evidence Code
39 relating to privilege.

1 (4) A utilization review process that modifies or denies requests
2 for authorization of medical treatment shall be accredited on or
3 before July 1, 2018, and shall retain active accreditation while
4 providing utilization review services, by an independent, nonprofit
5 organization to certify that the utilization review process meets
6 specified criteria, including, but not limited to, timeliness in issuing
7 a utilization review decision, the scope of medical material used
8 in issuing a utilization review decision, peer-to-peer consultation,
9 internal appeal procedure, and requiring a policy preventing
10 financial incentives to doctors and other providers based on the
11 utilization review decision. The administrative director shall adopt
12 rules to implement the selection of an independent, nonprofit
13 organization for those accreditation purposes. Until those rules are
14 adopted, the administrative director shall designate URAC as the
15 accrediting organization. The administrative director may adopt
16 rules to do any of the following:

17 (A) Require additional specific criteria for measuring the quality
18 of a utilization review process for purposes of accreditation.

19 (B) Exempt nonprofit, public sector internal utilization review
20 programs from the accreditation requirement pursuant to this
21 section, if the administrative director has adopted minimum
22 standards applicable to nonprofit, public sector internal utilization
23 review programs that meet or exceed the accreditation standards
24 developed pursuant to this section.

25 (5) On or before July 1, 2018, each employer, either directly or
26 through its insurer or an entity with which an employer or insurer
27 contracts for utilization review services, shall submit a description
28 of the utilization review process that modifies or denies requests
29 for authorization of medical treatment and the written policies and
30 procedures to the administrative director for approval. Approved
31 utilization review process descriptions and the accompanying
32 written policies and procedures shall be disclosed by the employer
33 to employees and physicians and made available to the public by
34 posting on the employer's, claims administrator's, or utilization
35 review organization's Internet Web site.

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

39 (1) Developed with involvement from actively practicing
40 physicians.

1 (2) Consistent with the schedule for medical treatment
2 utilization, including the drug formulary, adopted pursuant to
3 Section 5307.27.

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

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

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

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

21 (1) Except for treatment requests made pursuant to the
22 formulary, prospective or concurrent decisions shall be made in a
23 timely fashion that is appropriate for the nature of the employee's
24 condition, not to exceed five working days from the receipt of a
25 request for authorization for medical treatment and supporting
26 information reasonably necessary to make the determination, but
27 in no event more than 14 days from the date of the medical
28 treatment recommendation by the physician. Prospective decisions
29 regarding requests for treatment covered by the formulary shall
30 be made no more than five *working* days from the date of ~~the~~
31 ~~medical treatment request.~~ *receipt of the request for authorization*
32 *for medical treatment.* The request for authorization and supporting
33 documentation may be submitted electronically under rules adopted
34 by the administrative director.

35 (2) In cases where the review is retrospective, a decision
36 resulting in denial of all or part of the medical treatment service
37 shall be communicated to the individual who received services,
38 or to the individual's designee, within 30 days of receipt of
39 information that is reasonably necessary to make this
40 determination. If payment for a medical treatment service is made

1 within the time prescribed by Section 4603.2, a retrospective
2 decision to approve the service need not otherwise be
3 communicated.

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

16 (4) (A) Final decisions to approve, modify, or deny requests
17 by physicians for authorization prior to, or concurrent with, the
18 provision of medical treatment services to employees shall be
19 communicated to the requesting physician within 24 hours of the
20 decision by telephone, facsimile, or, if agreed to by the parties,
21 secure email.

22 (B) Decisions resulting in modification or denial of all or part
23 of the requested health care service shall be communicated in
24 writing to the employee, and to the physician if the initial
25 communication under subparagraph (A) was by telephone, within
26 24 hours for concurrent review, or within two business days of the
27 decision for prospective review, as prescribed by the administrative
28 director. If the request is modified or denied, disputes shall be
29 resolved in accordance with Section 4610.5, if applicable, or
30 otherwise in accordance with Section 4062.

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

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

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

24 (A) The reason for the decision.

25 (B) A specific description of the information that is needed.

26 (C) The date(s) and time(s) of attempts made to contact the
27 physician to obtain the necessary information.

28 (D) A description of the manner in which the request was
29 communicated.

30 (j) (1) If an employer, insurer, or other entity subject to this
31 section requests medical information from a physician in order to
32 determine whether to approve, modify, or deny requests for
33 authorization, the employer shall request only the information
34 reasonably necessary to make the determination.

35 (2) If the employer, insurer, or other entity cannot make a
36 decision within the timeframes specified in paragraph (1), (2), or
37 (3) of subdivision (i) because the employer or other entity is not
38 in receipt of, or in possession of, all of the information reasonably
39 necessary to make a determination, the employer shall immediately
40 notify the physician and the employee, in writing, that the employer

1 cannot make a decision within the required timeframe, and specify
2 the information that must be provided by the physician for a
3 determination to be made. Upon receipt of all information
4 reasonably necessary and requested by the employer, the employer
5 shall approve, modify, or deny the request for authorization within
6 the timeframes specified in paragraph (1), (2), or (3) of subdivision
7 (i).

8 (k) A utilization review decision to modify, ~~delay~~, or deny a
9 treatment recommendation shall remain effective for 12 months
10 from the date of the decision without further action by the employer
11 with regard to any further recommendation by the same physician,
12 or another physician within the requesting physician's practice
13 group, for the same treatment unless the further recommendation
14 is supported by a documented change in the facts material to the
15 basis of the utilization review decision.

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

20 (m) If utilization review is deferred pursuant to subdivision (l),
21 and it is finally determined that the employer is liable for treatment
22 of the condition for which treatment is recommended, the time for
23 the employer to conduct retrospective utilization review in
24 accordance with paragraph (2) of subdivision (i) shall begin on
25 the date the determination of the employer's liability becomes
26 final, and the time for the employer to conduct prospective
27 utilization review shall commence from the date of the employer's
28 receipt of a treatment recommendation after the determination of
29 the employer's liability.

30 (n) Every employer, insurer, or other entity subject to this section
31 shall maintain telephone access during California business hours
32 for physicians to request authorization for health care services and
33 to conduct peer-to-peer discussions regarding issues, including the
34 appropriateness of a requested treatment, modification of a
35 treatment request, or obtaining additional information needed to
36 make a medical necessity decision.

37 (o) The administrative director shall develop a system for the
38 mandatory electronic reporting of documents related to every
39 utilization review performed by each employer, which shall be
40 administered by the Division of Workers' Compensation. The

1 administrative director shall adopt regulations specifying the
2 documents to be submitted by the employer and the authorized
3 transmission format and timeframe for their submission. For
4 purposes of this subdivision, “employer” means the employer, the
5 insurer of an insured employer, a claims administrator, or a
6 utilization review organization, or other entity acting on behalf of
7 any of them.

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

20 (q) *The administrative director shall contract with an outside,*
21 *independent research organization on or after March 1, 2019, to*
22 *evaluate the impact of the provision of medical treatment within*
23 *the first 30 days after a claim is filed, for a claim filed on or after*
24 *January 1, 2017, and before January 1, 2019. The report shall be*
25 *provided to the administrative director, the Senate Committee on*
26 *Labor and Industrial Relations, and the Assembly Committee on*
27 *Insurance before January 1, 2020.*

28 ~~(q)~~

29 (r) This section shall become operative on January 1, 2018.

30 SEC. 4.5. Section 4610 is added to the Labor Code, to read:

31 4610. (a) For purposes of this section, “utilization review”
32 means utilization review or utilization management functions that
33 prospectively, retrospectively, or concurrently review and approve,
34 modify, or deny, based in whole or in part on medical necessity to
35 cure and relieve, treatment recommendations by physicians, as
36 defined in Section 3209.3, prior to, retrospectively, or concurrent
37 with the provision of medical treatment services pursuant to Section
38 4600.

39 (b) For all dates of injury occurring on or after January 1, 2018,
40 emergency treatment services and medical treatment rendered for

1 a body part or condition that is accepted as compensable by the
2 employer and is addressed by the medical treatment utilization
3 schedule adopted pursuant to Section 5307.7, by a member of the
4 medical provider network or health care organization, or by a
5 physician predesignated pursuant to subdivision (d) of Section
6 4600, within the 30 days following the initial date of injury, shall
7 be authorized without prospective utilization review, except as
8 provided in subdivision (c). The services rendered under this
9 subdivision shall be consistent with the medical treatment
10 utilization schedule. In the event that the employee is not subject
11 to treatment with a medical provider network, health care
12 organization, or predesignated physician pursuant to subdivision
13 (d) of Section 4600, the employee shall be eligible for treatment
14 under this section within 30 days following the initial date of injury
15 if the treatment is rendered by a physician or facility selected by
16 the employer. For treatment rendered by a medical provider
17 network physician, health care organization physician, a physician
18 predesignated pursuant to subdivision (d) of Section 4600, or an
19 employer-selected physician, the report required under Section
20 6409 and a complete request for authorization shall be submitted
21 by the physician within five days following the employee's initial
22 visit and evaluation.

23 (c) Unless authorized by the employer or rendered as emergency
24 medical treatment, the following medical treatment services, as
25 defined in rules adopted by the administrative director, that are
26 rendered through a member of the medical provider network or
27 health care organization, a predesignated physician, an
28 employer-selected physician, or an employer-selected facility,
29 within the 30 days following the initial date of injury, shall be
30 subject to prospective utilization review under this section:

31 (1) Pharmaceuticals, to the extent they are neither expressly
32 exempted from prospective review nor authorized by the drug
33 formulary adopted pursuant to Section 5307.27.

34 (2) Nonemergency inpatient and outpatient surgery, including
35 all presurgical and postsurgical services.

36 (3) Psychological treatment services.

37 (4) Home health care services.

38 (5) Imaging and radiology services, excluding X-rays.

1 (6) All durable medical equipment, whose combined total value
2 exceeds two hundred fifty dollars (\$250), as determined by the
3 official medical fee schedule.

4 (7) Electrodiagnostic medicine, including, but not limited to,
5 electromyography and nerve conduction studies.

6 (8) Any other service designated and defined through rules
7 adopted by the administrative director.

8 (d) Any request for payment for treatment provided under
9 subdivision (b) shall comply with Section 4603.2 and be submitted
10 to the employer, or its insurer or claims administrator, within 30
11 days of the date the service was provided.

12 (e) If a physician fails to submit the report required under
13 Section 6409 and a complete request for authorization, as
14 described in subdivision (b), an employer may remove the
15 physician's ability under this subdivision to provide further medical
16 treatment to the employee that is exempt from prospective
17 utilization review.

18 (f) An employer may perform retrospective utilization review
19 for any treatment provided pursuant to subdivision (b) solely for
20 the purpose of determining if the physician is prescribing treatment
21 consistent with the schedule for medical treatment utilization,
22 including, but not limited to, the drug formulary adopted pursuant
23 to Section 5307.27.

24 (1) If it is found after retrospective utilization reviews that there
25 is a pattern and practice of the physician or provider failing to
26 render treatment consistent with the schedule for medical treatment
27 utilization, including the drug formulary, the employer may remove
28 the ability of the predesignated physician, employer-selected
29 physician, or the member of the medical provider network or health
30 care organization under this subdivision to provide further medical
31 treatment to any employee that is exempt from prospective
32 utilization review. The employer shall notify the physician or
33 provider of the results of the retrospective utilization review and
34 the requirement for prospective utilization review for all subsequent
35 medical treatment.

36 (2) The results of retrospective utilization review may constitute
37 a showing of good cause for an employer's petition requesting a
38 change of physician or provider pursuant to Section 4603 and may
39 serve as grounds for termination of the physician or provider from
40 the medical provider network or health care organization.

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

5 (1) Each utilization review process that modifies or denies
6 requests for authorization of medical treatment shall be governed
7 by written policies and procedures. These policies and procedures
8 shall ensure that decisions based on the medical necessity to cure
9 and relieve of proposed medical treatment services are consistent
10 with the schedule for medical treatment utilization, including the
11 drug formulary, adopted pursuant to Section 5307.27.

12 (2) Unless otherwise indicated in this section, a physician
13 providing treatment under Section 4600 shall send any request for
14 authorization for medical treatment, with supporting
15 documentation, to the claims administrator for the employer,
16 insurer, or other entity according to rules adopted by the
17 administrative director. The employer, insurer, or other entity
18 shall employ or designate a medical director who holds an
19 unrestricted license to practice medicine in this state issued
20 pursuant to Section 2050 or 2450 of the Business and Professions
21 Code. The medical director shall ensure that the process by which
22 the employer or other entity reviews and approves, modifies, or
23 denies requests by physicians prior to, retrospectively, or
24 concurrent with the provision of medical treatment services
25 complies with the requirements of this section. Nothing in this
26 section shall be construed as restricting the existing authority of
27 the Medical Board of California.

28 (3) (A) A person other than a licensed physician who is
29 competent to evaluate the specific clinical issues involved in the
30 medical treatment services, if these services are within the scope
31 of the physician's practice, requested by the physician, shall not
32 modify or deny requests for authorization of medical treatment for
33 reasons of medical necessity to cure and relieve or due to
34 incomplete or insufficient information under subdivisions (i) and
35 (j).

36 (B) (i) The employer, or any entity conducting utilization review
37 on behalf of the employer, shall neither offer nor provide any
38 financial incentive or consideration to a physician based on the
39 number of modifications or denials made by the physician under
40 this section.

1 (ii) An insurer or third-party administrator shall not refer
2 utilization review services conducted on behalf of an employer
3 under this section to an entity in which the insurer or third-party
4 administrator has a financial interest as defined under Section
5 139.32. This prohibition does not apply if the insurer or third-party
6 administrator provides the employer and the administrative
7 director with prior written disclosure of both of the following:

8 (I) The entity conducting the utilization review services.
9 (II) The insurer or third-party administrator's financial interest
10 in the entity.

11 (C) The administrative director has authority pursuant to this
12 section to review any compensation agreement, payment schedule,
13 or contract between the employer, or any entity conducting
14 utilization review on behalf of the employer, and the utilization
15 review physician. Any information disclosed to the administrative
16 director pursuant to this paragraph shall be considered
17 confidential information and not subject to disclosure pursuant to
18 the California Public Records Act (Chapter 3.5 (commencing with
19 Section 6250) of Division 7 of Title 1 of the Government Code).
20 Disclosure of the information to the administrative director
21 pursuant to this subdivision shall not waive the provisions of the
22 Evidence Code relating to privilege.

23 (4) A utilization review process that modifies or denies requests
24 for authorization of medical treatment shall be accredited on or
25 before July 1, 2018, and shall retain active accreditation while
26 providing utilization review services, by an independent, nonprofit
27 organization to certify that the utilization review process meets
28 specified criteria, including, but not limited to, timeliness in issuing
29 a utilization review decision, the scope of medical material used
30 in issuing a utilization review decision, peer-to-peer consultation,
31 internal appeal procedure, and requiring a policy preventing
32 financial incentives to doctors and other providers based on the
33 utilization review decision. The administrative director shall adopt
34 rules to implement the selection of an independent, nonprofit
35 organization for those accreditation purposes. Until those rules
36 are adopted, the administrative director shall designate URAC as
37 the accrediting organization. The administrative director may
38 adopt rules to do any of the following:

39 (A) Require additional specific criteria for measuring the quality
40 of a utilization review process for purposes of accreditation.

1 (B) *Exempt nonprofit, public sector internal utilization review*
2 *programs from the accreditation requirement pursuant to this*
3 *section, if the administrative director has adopted minimum*
4 *standards applicable to nonprofit, public sector internal utilization*
5 *review programs that meet or exceed the accreditation standards*
6 *developed pursuant to this section.*

7 (5) *On or before July 1, 2018, each employer, either directly*
8 *or through its insurer or an entity with which an employer or*
9 *insurer contracts for utilization review services, shall submit a*
10 *description of the utilization review process that modifies or denies*
11 *requests for authorization of medical treatment and the written*
12 *policies and procedures to the administrative director for approval.*
13 *Approved utilization review process descriptions and the*
14 *accompanying written policies and procedures shall be disclosed*
15 *by the employer to employees and physicians and made available*
16 *to the public by posting on the employer's, claims administrator's,*
17 *or utilization review organization's Internet Web site.*

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

21 (1) *Developed with involvement from actively practicing*
22 *physicians.*

23 (2) *Consistent with the schedule for medical treatment*
24 *utilization, including the drug formulary, adopted pursuant to*
25 *Section 5307.27.*

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

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

30 (5) *Available to the public upon request. An employer shall only*
31 *be required to disclose the criteria or guidelines for the specific*
32 *procedures or conditions requested. An employer may charge*
33 *members of the public reasonable copying and postage expenses*
34 *related to disclosing criteria or guidelines pursuant to this*
35 *paragraph. Criteria or guidelines may also be made available*
36 *through electronic means. A charge shall not be required for an*
37 *employee whose physician's request for medical treatment services*
38 *is under review.*

39 (i) *In determining whether to approve, modify, or deny requests*
40 *by physicians prior to, retrospectively, or concurrent with the*

1 provisions of medical treatment services to employees, all of the
2 following requirements shall be met:

3 (1) Except for treatment requests made pursuant to the
4 formulary, prospective or concurrent decisions shall be made in
5 a timely fashion that is appropriate for the nature of the employee's
6 condition, not to exceed five working days from the receipt of a
7 request for authorization for medical treatment and supporting
8 information reasonably necessary to make the determination, but
9 in no event more than 14 days from the date of the medical
10 treatment recommendation by the physician. Prospective decisions
11 regarding requests for treatment covered by the formulary shall
12 be made no more than five working days from the date of receipt
13 of the medical treatment request. The request for authorization
14 and supporting documentation may be submitted electronically
15 under rules adopted by the administrative director.

16 (2) In cases where the review is retrospective, a decision
17 resulting in denial of all or part of the medical treatment service
18 shall be communicated to the individual who received services, or
19 to the individual's designee, within 30 days of the receipt of the
20 information that is reasonably necessary to make this
21 determination. If payment for a medical treatment service is made
22 within the time prescribed by Section 4603.2, a retrospective
23 decision to approve the service need not otherwise be
24 communicated.

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

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

1 *decision by telephone, facsimile, or, if agreed to by the parties,*
2 *secure email.*

3 *(B) Decisions resulting in modification or denial of all or part*
4 *of the requested health care service shall be communicated in*
5 *writing to the employee, and to the physician if the initial*
6 *communication under subparagraph (A) was by telephone, within*
7 *24 hours for concurrent review, or within two business days of the*
8 *decision for prospective review, as prescribed by the administrative*
9 *director. If the request is modified or denied, disputes shall be*
10 *resolved in accordance with Section 4610.5, if applicable, or*
11 *otherwise in accordance with Section 4062.*

12 *(C) In the case of concurrent review, medical care shall not be*
13 *discontinued until the employee's physician has been notified of*
14 *the decision and a care plan has been agreed upon by the physician*
15 *that is appropriate for the medical needs of the employee. Medical*
16 *care provided during a concurrent review shall be care that is*
17 *medically necessary to cure and relieve, and an insurer or*
18 *self-insured employer shall only be liable for those services*
19 *determined medically necessary to cure and relieve. If the insurer*
20 *or self-insured employer disputes whether or not one or more*
21 *services offered concurrently with a utilization review were*
22 *medically necessary to cure and relieve, the dispute shall be*
23 *resolved pursuant to Section 4610.5, if applicable, or otherwise*
24 *pursuant to Section 4062. A compromise between the parties that*
25 *an insurer or self-insured employer believes may result in payment*
26 *for services that were not medically necessary to cure and relieve*
27 *shall be reported by the insurer or the self-insured employer to*
28 *the licensing board of the provider or providers who received the*
29 *payments, in a manner set forth by the respective board and in a*
30 *way that minimizes reporting costs both to the board and to the*
31 *insurer or self-insured employer, for evaluation as to possible*
32 *violations of the statutes governing appropriate professional*
33 *practices. Fees shall not be levied upon insurers or self-insured*
34 *employers making reports required by this section.*

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

1 *clinical reasons for the decisions regarding medical necessity. If*
2 *a utilization review decision to deny a medical service is due to*
3 *incomplete or insufficient information, the decision shall specify*
4 *all of the following:*

5 *(A) The reason for the decision.*

6 *(B) A specific description of the information that is needed.*

7 *(C) The date(s) and time(s) of attempts made to contact the*
8 *physician to obtain the necessary information.*

9 *(D) A description of the manner in which the request was*
10 *communicated.*

11 *(j) (1) Unless otherwise indicated in this section, a physician*
12 *providing treatment under Section 4600 shall send any request for*
13 *authorization for medical treatment, with supporting*
14 *documentation, to the claims administrator for the employer,*
15 *insurer, or other entity according to rules adopted by the*
16 *administrative director. If an employer, insurer, or other entity*
17 *subject to this section requests medical information from a*
18 *physician in order to determine whether to approve, modify, or*
19 *deny requests for authorization, that employer, insurer, or other*
20 *entity shall request only the information reasonably necessary to*
21 *make the determination.*

22 *(2) If the employer, insurer, or other entity cannot make a*
23 *decision within the timeframes specified in paragraph (1), (2), or*
24 *(3) of subdivision (i) because the employer or other entity is not*
25 *in receipt of, or in possession of, all of the information reasonably*
26 *necessary to make a determination, the employer shall immediately*
27 *notify the physician and the employee, in writing, that the employer*
28 *cannot make a decision within the required timeframe, and specify*
29 *the information that must be provided by the physician for a*
30 *determination to be made. Upon receipt of all information*
31 *reasonably necessary and requested by the employer, the employer*
32 *shall approve, modify, or deny the request for authorization within*
33 *the timeframes specified in paragraph (1), (2), or (3) of subdivision*
34 *(i).*

35 *(k) A utilization review decision to modify or deny a treatment*
36 *recommendation shall remain effective for 12 months from the*
37 *date of the decision without further action by the employer with*
38 *regard to a further recommendation by the same physician, or*
39 *another physician within the requesting physician's practice group,*
40 *for the same treatment unless the further recommendation is*

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

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

7 (m) If utilization review is deferred pursuant to subdivision (l),
8 and it is finally determined that the employer is liable for treatment
9 of the condition for which treatment is recommended, the time for
10 the employer to conduct retrospective utilization review in
11 accordance with paragraph (2) of subdivision (i) shall begin on
12 the date the determination of the employer's liability becomes
13 final, and the time for the employer to conduct prospective
14 utilization review shall commence from the date of the employer's
15 receipt of a treatment recommendation after the determination of
16 the employer's liability.

17 (n) Each employer, insurer, or other entity subject to this section
18 shall maintain telephone access during California business hours
19 for physicians to request authorization for health care services
20 and to conduct peer-to-peer discussions regarding issues, including
21 the appropriateness of a requested treatment, modification of a
22 treatment request, or obtaining additional information needed to
23 make a medical necessity decision.

24 (o) The administrative director shall develop a system for the
25 mandatory electronic reporting of documents related to every
26 utilization review performed by each employer, which shall be
27 administered by the Division of Workers' Compensation. The
28 administrative director shall adopt regulations specifying the
29 documents to be submitted by the employer and the authorized
30 transmission format and timeframe for their submission. For
31 purposes of this subdivision, "employer" means the employer, the
32 insurer of an insured employer, a claims administrator, or a
33 utilization review organization, or other entity acting on behalf of
34 any of them.

35 (p) If the administrative director determines that the employer,
36 insurer, or other entity subject to this section has failed to meet
37 any of the timeframes in this section, or has failed to meet any
38 other requirement of this section, the administrative director may
39 assess, by order, administrative penalties for each failure. A
40 proceeding for the issuance of an order assessing administrative

1 *penalties shall be subject to appropriate notice to, and an*
2 *opportunity for a hearing with regard to, the person affected. The*
3 *administrative penalties shall not be deemed to be an exclusive*
4 *remedy for the administrative director. These penalties shall be*
5 *deposited in the Workers' Compensation Administration Revolving*
6 *Fund.*

7 *(q) The administrative director shall contract with an outside,*
8 *independent research organization on or after March 1, 2019, to*
9 *evaluate the impact of the provision of medical treatment within*
10 *the first 30 days after a claim is filed, for a claim filed on or after*
11 *January 1, 2017, and before January 1, 2019. The report shall be*
12 *provided to the administrative director, the Senate Committee on*
13 *Labor and Industrial Relations, and the Assembly Committee on*
14 *Insurance before January 1, 2020.*

15 *(r) This section shall become operative on January 1, 2018.*

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

17 4610.5. (a) This section applies to the following disputes:

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

20 (2) Any dispute over a utilization review decision if the decision
21 is communicated to the requesting physician on or after July 1,
22 2013, regardless of the date of injury.

23 (3) Any dispute occurring on or after January 1, 2018, over
24 medication prescribed pursuant to the drug formulary adopted
25 pursuant to Section 5307.27.

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

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

30 (1) "Disputed medical treatment" means medical treatment that
31 has been modified or denied by a utilization review decision on
32 the basis of medical necessity.

33 (2) "Medically necessary" and "medical necessity" mean
34 medical treatment that is reasonably required to cure or relieve the
35 injured employee of the effects of his or her injury and based on
36 the following standards, which shall be applied as set forth in the
37 medical treatment utilization schedule, including the drug
38 formulary, adopted by the administrative director pursuant to
39 Section 5307.27:

1 (A) The guidelines, including the drug formulary, adopted by
2 the administrative director pursuant to Section 5307.27.

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

5 (C) Nationally recognized professional standards.

6 (D) Expert opinion.

7 (E) Generally accepted standards of medical practice.

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

11 (3) “Utilization review decision” means a decision pursuant to
12 Section 4610 to modify or deny, based in whole or in part on
13 medical necessity to cure or relieve, a treatment recommendation
14 or recommendations by a physician prior to, retrospectively, or
15 concurrent with, the provision of medical treatment services
16 pursuant to Section 4600 or subdivision (c) of Section 5402.
17 “Utilization review decision” may also mean a determination,
18 occurring on or after January 1, 2018, by a physician regarding
19 the medical necessity of medication prescribed pursuant to the
20 drug formulary adopted pursuant to Section 5307.27.

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

25 (d) If a utilization review decision denies or modifies a treatment
26 recommendation based on medical necessity, the employee may
27 request an independent medical review as provided by this section.

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

35 (f) As part of its notification to the employee regarding an initial
36 utilization review decision based on medical necessity that denies
37 or modifies a treatment recommendation, the employer shall
38 provide the employee with a one-page form prescribed by the
39 administrative director, and an addressed envelope, which the
40 employee may return to the administrative director or the

1 administrative director's designee to initiate an independent
2 medical review. The employee may also request independent
3 medical review electronically under rules adopted by the
4 administrative director. The employer shall include on the form
5 any information required by the administrative director to facilitate
6 the completion of the independent medical review. The form shall
7 also include all of the following:

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

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

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

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

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

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

31 (g) The independent medical review process may be terminated
32 at any time upon the employer's written authorization of the
33 disputed medical treatment. Notice of the authorization, any
34 settlement or award that may resolve the medical treatment dispute,
35 or the requesting physician withdrawing the request for treatment,
36 shall be communicated to the independent medical review
37 organization by the employer within five days.

38 (h) (1) The employee may submit a request for independent
39 medical review to the division. The request may be made

1 electronically under rules adopted by the administrative director.

2 The request shall be made no later than as follows:

3 (A) For formulary disputes, 10 days after the service of the
4 utilization review decision to the employee.

5 (B) For all other medical treatment disputes, 30 days after the
6 service of the utilization review decision to the employee.

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

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

19 (4) A provider of emergency medical treatment when the
20 employee faced an imminent and serious threat to his or her health,
21 including, but not limited to, the potential loss of life, limb, or
22 other major bodily function, may submit a request for independent
23 medical review on its own behalf. A request submitted by a
24 provider pursuant to this paragraph shall be submitted to the
25 administrative director or administrative director's designee within
26 the time limitations applicable for an employee to submit a request
27 for independent medical review.

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

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

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

20 (l) Upon notice from the administrative director that an
21 independent review organization has been assigned, the employer
22 shall electronically provide to the independent medical review
23 organization under rules adopted by the administrative director a
24 copy and list of all of the following documents within 10 days of
25 notice of assignment:

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

- 29 (A) The employee's current medical condition.
- 30 (B) The medical treatment being provided by the employer.
- 31 (C) The request for authorization and utilization review decision.

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

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

38 (4) A copy of any other relevant documents or information used
39 by the employer or its utilization review organization in
40 determining whether the disputed treatment should have been

1 provided, and any statements by the employer or its utilization
2 review organization explaining the reasons for the decision to deny
3 or modify the recommended treatment on the basis of medical
4 necessity. The employer shall concurrently provide a copy of the
5 documents required by this paragraph to the employee and the
6 requesting physician, except that documents previously provided
7 to the employee or physician need not be provided again if a list
8 of those documents is provided.

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

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

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

30 (p) The claims administrator who issued the utilization review
31 decision in dispute shall notify the independent medical review
32 organization if there is a change in the claims administrator
33 responsible for the claim. Notice shall be given to the independent
34 medical review organization within five working days of the
35 change in administrator taking effect.

36 SEC. 6. Section 4610.6 of the Labor Code is amended to read:

37 4610.6. (a) Upon receipt of a case pursuant to Section 4610.5,
38 an independent medical review organization shall conduct the
39 review in accordance with this article and any regulations or orders
40 of the administrative director. The organization's review shall be

1 limited to an examination of the medical necessity of the disputed
2 medical treatment.

3 (b) Upon receipt of information and documents related to a case,
4 the medical reviewer or reviewers selected to conduct the review
5 by the independent medical review organization shall promptly
6 review all pertinent medical records of the employee, provider
7 reports, and any other information submitted to the organization
8 or requested from any of the parties to the dispute by the reviewers.
9 If the reviewers request information from any of the parties, a copy
10 of the request and the response shall be provided to all of the
11 parties. The reviewer or reviewers shall also review relevant
12 information related to the criteria set forth in subdivision (c).

13 (c) Following its review, the reviewer or reviewers shall
14 determine whether the disputed health care service was medically
15 necessary based on the specific medical needs of the employee
16 and the standards of medical necessity as defined in subdivision
17 (c) of Section 4610.5.

18 (d) (1) The organization shall complete its review and make
19 its determination in writing, and in layperson's terms to the
20 maximum extent practicable, and the determination shall be issued,
21 as follows:

22 (A) For a dispute over medication prescribed pursuant to the
23 drug formulary submitted under subdivision (h) of Section 4610.5,
24 within five working days from the date of receipt of the request
25 for review and supporting documentation, or within less time as
26 prescribed by the administrative director.

27 (B) For all other medical treatment disputes submitted for review
28 under subdivision (h) of Section 4610.5, within 30 days of receipt
29 of the request for review and supporting documentation, or within
30 less time as prescribed by the administrative director.

31 (C) If the disputed medical treatment has not been provided and
32 the employee's provider or the administrative director certifies in
33 writing that an imminent and serious threat to the health of the
34 employee may exist, including, but not limited to, serious pain,
35 the potential loss of life, limb, or major bodily function, or the
36 immediate and serious deterioration of the health of the employee,
37 the analyses and determinations of the reviewers shall be expedited
38 and rendered within three days of the receipt of the information.

39 (2) Subject to the approval of the administrative director, the
40 deadlines for analyses and determinations involving both regular

1 and expedited reviews may be extended for up to three days in
2 extraordinary circumstances or for good cause.

3 (e) The medical professionals' analyses and determinations shall
4 state whether the disputed health care service is medically
5 necessary. Each analysis shall cite the employee's medical
6 condition, the relevant documents in the record, and the relevant
7 findings associated with the provisions of subdivision (c) to support
8 the determination. If more than one medical professional reviews
9 the case, the recommendation of the majority shall prevail. If the
10 medical professionals reviewing the case are evenly split as to
11 whether the disputed health care service should be provided, the
12 decision shall be in favor of providing the service.

13 (f) The independent medical review organization shall provide
14 the administrative director, the employer, the employee, and the
15 employee's provider with the analyses and determinations of the
16 medical professionals reviewing the case, and a description of the
17 qualifications of the medical professionals. The independent
18 medical review organization shall keep the names of the reviewers
19 confidential in all communications with entities or individuals
20 outside the independent medical review organization. If more than
21 one medical professional reviewed the case and the result was
22 differing determinations, the independent medical review
23 organization shall provide each of the separate reviewer's analyses
24 and determinations.

25 (g) The determination of the independent medical review
26 organization shall be deemed to be the determination of the
27 administrative director and shall be binding on all parties.

28 (h) A determination of the administrative director pursuant to
29 this section may be reviewed only by a verified appeal from the
30 medical review determination of the administrative director, filed
31 with the appeals board for hearing pursuant to Chapter 3
32 (commencing with Section 5500) of Part 4 and served on all
33 interested parties within 30 days of the date of mailing of the
34 determination to the aggrieved employee or the aggrieved
35 employer. The determination of the administrative director shall
36 be presumed to be correct and shall be set aside only upon proof
37 by clear and convincing evidence of one or more of the following
38 grounds for appeal:

39 (1) The administrative director acted without or in excess of the
40 administrative director's powers.

1 (2) The determination of the administrative director was
2 procured by fraud.

3 (3) The independent medical reviewer was subject to a material
4 conflict of interest that is in violation of Section 139.5.

5 (4) The determination was the result of bias on the basis of race,
6 national origin, ethnic group identification, religion, age, sex,
7 sexual orientation, color, or disability.

8 (5) The determination was the result of a plainly erroneous
9 express or implied finding of fact, provided that the mistake of
10 fact is a matter of ordinary knowledge based on the information
11 submitted for review pursuant to Section 4610.5 and not a matter
12 that is subject to expert opinion.

13 (i) If the determination of the administrative director is reversed,
14 the dispute shall be remanded to the administrative director to
15 submit the dispute to independent medical review by a different
16 independent review organization. In the event that a different
17 independent medical review organization is not available after
18 remand, the administrative director shall submit the dispute to the
19 original medical review organization for review by a different
20 reviewer in the organization. In no event shall a workers'
21 compensation administrative law judge, the appeals board, or any
22 higher court make a determination of medical necessity contrary
23 to the determination of the independent medical review
24 organization.

25 (j) Upon receiving the determination of the administrative
26 director that a disputed health care service is medically necessary,
27 the employer shall promptly implement the decision as provided
28 by this section unless the employer has also disputed liability for
29 any reason besides medical necessity. In the case of reimbursement
30 for services already rendered, the employer shall reimburse the
31 provider or employee, whichever applies, within 20 days, subject
32 to resolution of any remaining issue of the amount of payment
33 pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of
34 services not yet rendered, the employer shall authorize the services
35 within five working days of receipt of the written determination
36 from the independent medical review organization, or sooner if
37 appropriate for the nature of the employee's medical condition,
38 and shall inform the employee and provider of the authorization.

39 (k) Failure to pay for services already provided or to authorize
40 services not yet rendered within the time prescribed by subdivision

1 (l) is a violation of this section and, in addition to any other fines,
2 penalties, and other remedies available to the administrative
3 director, the employer shall be subject to an administrative penalty
4 in an amount determined pursuant to regulations to be adopted by
5 the administrative director, not to exceed five thousand dollars
6 (\$5,000) for each day the decision is not implemented. The
7 administrative penalties shall be paid to the Workers'
8 Compensation Administration Revolving Fund.

9 (l) The costs of independent medical review and the
10 administration of the independent medical review system shall be
11 borne by employers through a fee system established by the
12 administrative director. After considering any relevant information
13 on program costs, the administrative director shall establish a
14 reasonable, per-case reimbursement schedule to pay the costs of
15 independent medical review organization reviews and the cost of
16 administering the independent medical review system, which may
17 vary depending on the type of medical condition under review and
18 on other relevant factors.

19 (m) The administrative director may publish the results of
20 independent medical review determinations after removing
21 individually identifiable information.

22 (n) If any provision of this section, or the application thereof to
23 any person or circumstances, is held invalid, the remainder of the
24 section, and the application of its provisions to other persons or
25 circumstances, shall not be affected thereby.

26 SEC. 7. Section 4615 is added to the Labor Code, to read:

27 4615. (a) Any lien filed by or on behalf of a physician or
28 provider of medical treatment services under Section 4600 or
29 medical-legal services under Section ~~4060~~, 4621, and any accrual
30 of interest related to the lien, shall be automatically stayed upon
31 the filing of criminal charges against that physician or provider
32 for an offense involving fraud against the workers' compensation
33 system, medical billing fraud, insurance fraud, or fraud against the
34 Medicare or Medi-Cal programs. The stay shall be in effect from
35 the time of the filing of the charges until the disposition of the
36 criminal proceedings. The administrative director may promulgate
37 rules for the implementation of this section.

38 (b) *The administrative director shall promptly post on the*
39 *division's Internet Web site the names of any physician or provider*

1 *of medical treatment services whose liens were stayed pursuant*
2 *to this section.*

3 SEC. 8. Section 4903.05 of the Labor Code is amended to read:

4 4903.05. (a) Every lien claimant shall file its lien with the
5 appeals board in writing upon a form approved by the appeals
6 board. The lien shall be accompanied by a full statement or
7 itemized voucher supporting the lien and justifying the right to
8 reimbursement and proof of service upon the injured worker or,
9 if deceased, upon the worker's dependents, the employer, the
10 insurer, and the respective attorneys or other agents of record. *For*
11 *liens filed on or after January 1, 2017, the lien shall also be*
12 *accompanied by an original bill in addition to either the full*
13 *statement or itemized voucher supporting the lien.* Medical records
14 shall be filed only if they are relevant to the issues being raised by
15 the lien.

16 (b) Any lien claim for expenses under subdivision (b) of Section
17 4903 or for claims of costs shall be filed with the appeals board
18 electronically using the form approved by the appeals board. The
19 lien shall be accompanied by a proof of service and any other
20 documents that may be required by the appeals board. The service
21 requirements for Section 4603.2 are not modified by this section.

22 (c) (1) For liens filed on or after January 1, 2017, any lien claim
23 for expenses under subdivision (b) of Section 4903 that is subject
24 to a filing fee under this section shall be accompanied at the time
25 of filing by a declaration stating, under penalty of perjury, that the
26 dispute is not subject to an independent bill review *and independent*
27 *medical review* under ~~Section~~ *Sections* 4603.6 and 4610.5,
28 *respectively*, that the lien claimant satisfies one of the following:

29 (A) Is the employee's treating physician providing care through
30 a medical provider network.

31 (B) Is the agreed medical evaluator or qualified medical
32 evaluator.

33 (C) Has provided treatment authorized by the employer or claims
34 administrator under Section 4610.

35 (D) Has made a diligent search and determined that the employer
36 does not have a medical provider network in place.

37 (E) Has documentation that medical treatment has been
38 neglected or unreasonably refused to the ~~employee~~. *employee as*
39 *provided by Section 4600.*

1 (F) Can show that the expense was incurred for an emergency
2 medical condition, as defined by subdivision (b) of Section 1317.1
3 of the Health and Safety Code.

4 (G) *Is a certified interpreter rendering services during a*
5 *medical-legal examination, a copy service providing medical-legal*
6 *services, or has an expense allowed as a lien under rules adopted*
7 *by the administrative director.*

8 ~~(2) For all liens filed prior to January 1, 2017, lien claimants~~
9 ~~shall have until July 1, 2017, to file the declaration provided under~~
10 ~~paragraph (1).~~

11 (2) *Lien claimants shall have until July 1, 2017, to file a*
12 *declaration pursuant to paragraph (1) for any lien claim filed*
13 *before January 1, 2017, for expenses pursuant to subdivision (b)*
14 *of Section 4903 that is subject to a filing fee under this section.*

15 (3) The failure to file a signed declaration under this subdivision
16 shall result in the dismissal of the lien with prejudice by operation
17 of law. Filing of a false declaration shall be grounds for dismissal
18 with prejudice after notice.

19 (d) All liens filed on or after January 1, 2013, for expenses under
20 subdivision (b) of Section 4903 or for claims of costs shall be
21 subject to a filing fee as provided by this subdivision.

22 (1) The lien claimant shall pay a filing fee of one hundred fifty
23 dollars (\$150) to the Division of Workers' Compensation prior to
24 filing a lien and shall include proof that the filing fee has been
25 paid. The fee shall be collected through an electronic payment
26 system that accepts major credit cards and any additional forms
27 of electronic payment selected by the administrative director. If
28 the administrative director contracts with a service provider for
29 the processing of electronic payments, any processing fee shall be
30 absorbed by the division and not added to the fee charged to the
31 lien filer.

32 (2) On or after January 1, 2013, a lien submitted for filing that
33 does not comply with paragraph (1) shall be invalid, even if lodged
34 with the appeals board, and shall not operate to preserve or extend
35 any time limit for filing of the lien.

36 (3) The claims of two or more providers of goods or services
37 shall not be merged into a single lien.

38 (4) The filing fee shall be collected by the administrative
39 director. All fees shall be deposited in the Workers' Compensation

1 Administration Revolving Fund and applied for the purposes of
2 that fund.

3 (5) The administrative director shall adopt reasonable rules and
4 regulations governing the procedure for the collection of the filing
5 fee, including emergency regulations as necessary to implement
6 this section.

7 (6) Any lien filed for goods or services that are not the proper
8 subject of a lien may be dismissed upon request of a party by
9 verified petition or on the appeals board's own motion. If the lien
10 is dismissed, the lien claimant will not be entitled to reimbursement
11 of the filing fee.

12 (7) No filing fee shall be required for a lien filed by a health
13 care service plan licensed pursuant to Section 1349 of the Health
14 and Safety Code, a group disability insurer under a policy issued
15 in this state pursuant to the provisions of Section 10270.5 of the
16 Insurance Code, a self-insured employee welfare benefit plan, as
17 defined in Section 10121 of the Insurance Code, that is issued in
18 this state, a Taft-Hartley health and welfare fund, or a publicly
19 funded program providing medical benefits on a nonindustrial
20 basis.

21 SEC. 9. Section 4903.8 of the Labor Code is amended to read:

22 4903.8. (a) (1) Any order or award for payment of a lien filed
23 pursuant to subdivision (b) of Section 4903 shall be made for
24 payment only to the person who was entitled to payment for the
25 expenses as provided in subdivision (b) of Section 4903 at the time
26 the expenses were incurred, who is the lien owner, and not to an
27 assignee unless the person has ceased doing business in the capacity
28 held at the time the expenses were incurred and has assigned all
29 right, title, and interest in the remaining accounts receivable to the
30 assignee.

31 (2) All liens filed pursuant to subdivision (b) of Section 4903
32 shall be filed in the name of the lien owner only, and no payment
33 shall be made to any lien claimant without evidence that he or she
34 is the owner of that lien.

35 (3) Paragraph (1) does not apply to an assignment that was
36 completed prior to January 1, 2013, or that was required by a
37 contract that became enforceable and irrevocable prior to January
38 1, 2013. This paragraph is declarative of existing law.

39 (4) For liens filed after January 1, 2017, the lien shall not be
40 assigned unless the person has ceased doing business in the

1 capacity held at the time the expenses were incurred and has
2 assigned all right, title, and interest in the remaining accounts
3 receivable to the assignee. The assignment of a lien, in violation
4 of this paragraph is invalid by operation of law.

5 (b) If there has been an assignment of a lien, either as an
6 assignment of all right, title, and interest in the accounts receivable
7 or as an assignment for collection, a true and correct copy of the
8 assignment shall be filed and served.

9 (1) If the lien is filed on or after January 1, 2013, and the
10 assignment occurs before the filing of the lien, the copy of the
11 assignment shall be served at the time the lien is filed.

12 (2) If the lien is filed on or after January 1, 2013, and the
13 assignment occurs after the filing of the lien, the copy of the
14 assignment shall be served within 20 days of the date of the
15 assignment.

16 (3) If the lien is filed before January 1, 2013, the copy of the
17 assignment shall be served by January 1, 2014, or with the filing
18 of a declaration of readiness or at the time of a lien hearing,
19 whichever is earliest.

20 (c) If there has been more than one assignment of the same
21 receivable or bill, the appeals board may set the matter for hearing
22 on whether the multiple assignments constitute bad-faith actions
23 or tactics that are frivolous, harassing, or intended to cause
24 unnecessary delay or expense. If so found by the appeals board,
25 appropriate sanctions, including costs and attorney's fees, may be
26 awarded against the assignor, assignee, and their respective
27 attorneys.

28 (d) At the time of filing of a lien on or after January 1, 2013, or
29 in the case of a lien filed before January 1, 2013, at the earliest of
30 the filing of a declaration of readiness, a lien hearing, or January
31 1, 2014, supporting documentation shall be filed including one or
32 more declarations under penalty of perjury by a natural person or
33 persons competent to testify to the facts stated, declaring both of
34 the following:

35 (1) The services or products described in the bill for services
36 or products were actually provided to the injured employee.

37 (2) The billing statement attached to the lien truly and accurately
38 describes the services or products that were provided to the injured
39 employee.

1 (e) A lien submitted for filing on or after January 1, 2013, for
2 expenses provided in subdivision (b) of Section 4903, that does
3 not comply with the requirements of this section shall be deemed
4 to be invalid, whether or not accepted for filing by the appeals
5 board, and shall not operate to preserve or extend any time limit
6 for filing of the lien.

7 (f) This section shall take effect without regulatory action. The
8 appeals board and the administrative director may promulgate
9 regulations and forms for the implementation of this section.

10 SEC. 10. Section 5307.27 of the Labor Code is amended to
11 read:

12 5307.27. (a) The administrative director, in consultation with
13 the Commission on Health and Safety and Workers' Compensation,
14 shall adopt, after public hearings, a medical treatment utilization
15 schedule, that shall incorporate the evidence-based, peer-reviewed,
16 nationally recognized standards of care recommended by the
17 commission pursuant to Section 77.5, and that shall address, at a
18 minimum, the frequency, duration, intensity, and appropriateness
19 of all treatment procedures and modalities commonly performed
20 in workers' compensation cases. Evidence-based updates to the
21 utilization schedule shall be made through an order exempt from
22 Sections 5307.3 and 5307.4, and the rulemaking provisions of the
23 Administrative Procedure Act (Chapter 3.5 (commencing with
24 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
25 Code), but the administrative director shall allow at least a 30-day
26 period for public comment and a public hearing. The administrative
27 director shall provide responses to submitted comments prior to
28 the effective date of the updates. All orders issued pursuant to this
29 subdivision shall be published on the Internet Web site of the
30 Division of Workers' Compensation.

31 (b) On or before July 1, 2017, the medical treatment utilization
32 schedule adopted by the administrative director shall include a
33 drug formulary using evidence-based medicine. Nothing in this
34 section shall prohibit the authorization of medications that are not
35 in the formulary when the variance is demonstrated, consistent
36 with subdivision (a) of Section 4604.5.

37 (c) The drug formulary shall include a phased implementation
38 for workers injured prior to July 1, 2017, in order to ensure injured
39 workers safely transition to medications pursuant to the formulary.

1 (d) This section shall apply to all prescribers and dispensers of
2 medications serving injured workers under the workers'
3 compensation system.

4 SEC. 11. Section 5710 of the Labor Code is amended to read:

5 5710. (a) The appeals board, a workers' compensation judge,
6 or any party to the action or proceeding, may, in any investigation
7 or hearing before the appeals board, cause the deposition of
8 witnesses residing within or without the state to be taken in the
9 manner prescribed by law for like depositions in civil actions in
10 the superior courts of this state under Title 4 (commencing with
11 Section 2016.010) of Part 4 of the Code of Civil Procedure. To
12 that end the attendance of witnesses and the production of records
13 may be required. Depositions may be taken outside the state before
14 any officer authorized to administer oaths. The appeals board or
15 a workers' compensation judge in any proceeding before the
16 appeals board may cause evidence to be taken in other jurisdictions
17 before the agency authorized to hear workers' compensation
18 matters in those other jurisdictions.

19 (b) If the employer or insurance carrier requests a deposition to
20 be taken of an injured employee, or any person claiming benefits
21 as a dependent of an injured employee, the deponent is entitled to
22 receive in addition to all other benefits:

23 (1) All reasonable expenses of transportation, meals, and lodging
24 incident to the deposition.

25 (2) Reimbursement for any loss of wages incurred during
26 attendance at the deposition.

27 (3) One copy of the transcript of the deposition, without cost.

28 (4) A reasonable allowance for attorney's fees for the deponent,
29 if represented by an attorney licensed by the State Bar of this state.
30 The fee shall be discretionary with, and, if allowed, shall be set
31 by, the appeals board, but shall be paid by the employer or his or
32 her insurer. The administrative director ~~shall~~ *shall, on or before*
33 *July 1, 2018*, determine the range of reasonable fees to be paid.

34 (5) If interpretation services are required because the injured
35 employee or deponent does not proficiently speak or understand
36 the English language, upon a request from either, the employer
37 shall pay for the services of a language interpreter certified or
38 deemed certified pursuant to Article 8 (commencing with Section
39 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or
40 Section 68566 of, the Government Code. The fee to be paid by the

1 employer shall be in accordance with the fee schedule adopted by
2 the administrative director and shall include any other
3 deposition-related events as permitted by the administrative
4 director.

5 SEC. 12. Section 5811 of the Labor Code is amended to read:

6 5811. (a) No fees shall be charged by the clerk of any court
7 for the performance of any official service required by this division,
8 except for the docketing of awards as judgments and for certified
9 copies of transcripts thereof. In all proceedings under this division
10 before the appeals board, costs as between the parties may be
11 allowed by the appeals board.

12 (b) (1) It shall be the responsibility of any party producing a
13 witness requiring an interpreter to arrange for the presence of a
14 qualified interpreter.

15 (2) A qualified interpreter is a language interpreter who is
16 certified, or deemed certified, pursuant to Article 8 (commencing
17 with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of
18 Title 2 of, or Section 68566 of, the Government Code. The duty
19 of an interpreter is to accurately and impartially translate oral
20 communications and transliterate written materials, and not to act
21 as an agent or advocate. An interpreter shall not disclose to any
22 person who is not an immediate participant in the communications
23 the content of the conversations or documents that the interpreter
24 has interpreted or transliterated unless the disclosure is compelled
25 by court order. An attempt by any party or attorney to obtain
26 disclosure is a bad faith tactic that is subject to Section 5813.

27 Interpreter fees that are reasonably, actually, and necessarily
28 incurred shall be paid by the employer under this section, provided
29 they are in accordance with the fee schedule adopted by the
30 administrative director.

31 A qualified interpreter may render services during the following:

32 (A) A deposition.

33 (B) An appeals board hearing.

34 (C) A medical treatment appointment or medical-legal
35 examination.

36 (D) During those settings which the administrative director
37 determines are reasonably necessary to ascertain the validity or
38 extent of injury to an employee who does not proficiently speak
39 or understand the English language.

1 (c) The administrative director shall promulgate regulations
2 establishing criteria to verify the identity and credentials of
3 individuals who provide interpreter services in all necessary
4 settings and proceedings within the workers' compensation system.
5 Those regulations shall be adopted no later than January 1, 2018.

6 SEC. 13. Section 6409 of the Labor Code is amended to read:

7 6409. (a) Every physician as defined in Section 3209.3 who
8 attends any injured employee shall file a complete report of that
9 occupational injury or occupational illness in a manner prescribed
10 by the administrative director of the Division of Workers'
11 Compensation. The report shall include a diagnosis, the injured
12 employee's description of how the injury or illness occurred, any
13 treatment rendered at the time of the examination, any work
14 restrictions resulting from the injury or illness, a treatment plan,
15 and other content as prescribed by the administrative director. The
16 form shall be filed electronically with the Division of Workers'
17 Compensation and the employer, or if insured, with the employer's
18 insurer, within five days of the initial examination. If the treatment
19 is for pesticide poisoning or a condition suspected to be pesticide
20 poisoning, the physician shall also, within 24 hours of the initial
21 examination, file a complete report with the local health officer
22 by facsimile transmission or other means. If the treatment is for
23 pesticide poisoning or a condition suspected to be pesticide
24 poisoning, the physician shall not be compensated for the initial
25 diagnosis and treatment unless the report is filed with the Division
26 of Workers' Compensation, the employer, or if insured, with the
27 employer's insurer, and includes or is accompanied by a signed
28 affidavit which certifies that a copy of the report was filed with
29 the local health officer pursuant to this section.

30 (b) As used in this section, "occupational illness" means any
31 abnormal condition or disorder caused by exposure to
32 environmental factors associated with employment, including acute
33 and chronic illnesses or diseases which may be caused by
34 inhalation, absorption, ingestion, or direct contact.

35 SEC. 14. The Legislature finds and declares that ~~Section 4~~
36 ~~Sections 4 and 4.5~~ of this act, which ~~adds~~ *add* Section 4610 to the
37 Labor Code, ~~imposes~~ *impose* a limitation on the public's right of
38 access to the meetings of public bodies or the writings of public
39 officials and agencies within the meaning of Section 3 of Article
40 I of the California Constitution. Pursuant to that constitutional

1 provision, the Legislature makes the following findings to
2 demonstrate the interest protected by this limitation and the need
3 for protecting that interest:

4 The limitations on the people's rights of access set forth in this
5 act are necessary to protect the privacy and integrity of information
6 submitted to the Administrative Director of the Division of
7 Workers' Compensation pursuant to ~~subparagraph (C) of paragraph~~
8 ~~(3) of subdivision (g) of~~ Section 4610 of the Labor Code.

9 SEC. 15. The amendment of *paragraphs (1) and (2) of*
10 *subdivision (a) of Section 4903.8 of the Labor Code* made by this
11 act does not constitute a change in, but is declaratory of, existing
12 law.

13 *SEC. 16. The Legislature finds and declares the following:*

14 *(a) Section 4 of Article XIV of the California Constitution vests*
15 *the Legislature with plenary power to create and to enforce a*
16 *complete system of workers' compensation by appropriate*
17 *legislation, and that plenary power includes, without limitation,*
18 *the power and authority to make full provision for the manner and*
19 *means by which any lien for compensation for those services may*
20 *be filed or enforced within the workers' compensation system.*

21 *(b) Despite prior legislative action to reform the lien filing and*
22 *recovery process within the workers' compensation system,*
23 *including Senate Bill 863 in 2012, there continues to be abuse of*
24 *the lien process within the workers' compensation system by some*
25 *providers of medical treatment and other medical-legal services*
26 *who have engaged in fraud or other criminal conduct within the*
27 *workers' compensation system, or who have engaged in medical*
28 *billing fraud, insurance fraud, or fraud against the federal*
29 *Medicare or Medi-Cal systems.*

30 *(c) Notwithstanding fraudulent and criminal conduct by some*
31 *providers of medical treatment or other medical-legal services,*
32 *those providers have continued to file and to collect on liens within*
33 *the workers' compensation system while criminal charges alleging*
34 *fraud within the workers' compensation system, or medical billing*
35 *or insurance fraud, or fraud within the federal Medicare or*
36 *Medi-Cal systems, are pending against those providers.*

37 *(d) The ability of providers of medical treatment or other*
38 *medical-legal services to continue to file and to collect on liens,*
39 *while criminal charges are pending against the provider, including*
40 *through the use of lien or collection assignments, has created*

1 *excessive and unnecessary administrative burdens for the workers’*
2 *compensation system, has resulted in pressure on employers and*
3 *insurers to settle liens that may in fact have arisen from prior or*
4 *ongoing criminal conduct, has threatened the health and safety of*
5 *workers who may be referred for or receive medical treatment or*
6 *other medical-legal services that not reasonable and necessary,*
7 *has allowed continued funding of fraudulent practices through*
8 *ongoing lien collections during the pendency of criminal*
9 *proceedings, and has undermined public confidence in the workers’*
10 *compensation system.*

11 *(e) Therefore, in order to ensure the efficient, just, and orderly*
12 *administration of the workers’ compensation system, and to*
13 *accomplish substantial justice in all cases, the Legislature declares*
14 *that it is necessary to enact legislation to provide that any lien*
15 *filed by, or for recovery of compensation for services rendered by,*
16 *any provider of medical treatment or other medical-legal services*
17 *shall be automatically stayed upon the filing of criminal charges*
18 *against that provider for an offense involving fraud against the*
19 *workers’ compensation system, medical billing fraud, insurance*
20 *fraud, or fraud against the federal Medicare or Medi-Cal*
21 *programs, and that the stay shall remain in effect until the*
22 *resolution of the criminal proceedings.*

23 *SEC. 17. (a) Section 3.5 of this bill incorporates amendments*
24 *to Section 4610 of the Labor Code proposed by both this bill and*
25 *Assembly Bill 2503. It shall only become operative if (1) both bills*
26 *are enacted and become effective on or before January 1, 2017,*
27 *(2) each bill amends Section 4610 of the Labor Code, and (3) this*
28 *bill is enacted after Assembly Bill 2503, in which case Section 3*
29 *of this bill shall not become operative.*

30 *(b) Section 4.5 of this bill incorporates, in Section 4610 of the*
31 *Labor Code as proposed to be added by this bill, amendments to*
32 *Section 4610 of the Labor Code that are proposed by Assembly*
33 *Bill 2503. It shall only become operative if (1) both bills are*
34 *enacted on or before January 1, 2017, (2) Assembly Bill 2503*
35 *amends Section 4610 of the Labor Code, and (3) this bill adds*
36 *Section 4610 to the Labor Code, in which case, regardless of the*
37 *order in which this bill and Assembly Bill 2503 are enacted, Section*
38 *4 of this bill shall not become operative.*

1 ~~SEC. 16.~~
2 *SEC. 18.* No reimbursement is required by this act pursuant to
3 Section 6 of Article XIII B of the California Constitution because
4 the only costs that may be incurred by a local agency or school
5 district will be incurred because this act creates a new crime or
6 infraction, eliminates a crime or infraction, or changes the penalty
7 for a crime or infraction, within the meaning of Section 17556 of
8 the Government Code, or changes the definition of a crime within
9 the meaning of Section 6 of Article XIII B of the California
10 Constitution.

O