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:

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

138.4. (a) For the purpose of this section, "claims administrator" means a self-administered workers' compensation insurer; or a self-administered self-insured employer; or a self-administered legally uninsured employer; or a self-administered joint powers authority; or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer, or a joint powers authority.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The information system shall do the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve,

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

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

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

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

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

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

(1) Developed with involvement from actively practicing physicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Developed with involvement from actively practicing physicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(2)~~

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

~~(3) Non-emergency~~

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

~~(4)~~

(3) Psychological treatment services.

~~(5)~~

(4) Home health care services.

~~(6)~~

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

~~(7)~~

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

~~(8)~~

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

~~(9)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) The entity conducting the utilization review services.

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

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

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, 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, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

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

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

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

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

(1) Developed with involvement from actively practicing physicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) The reason for the decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(q)~~

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

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

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

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

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

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

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

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

(3) Psychological treatment services.

(4) Home health care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) The entity conducting the utilization review services.

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

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

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, 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, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

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

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

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

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

(1) Developed with involvement from actively practicing physicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) The reason for the decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

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

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

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

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

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

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

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

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

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

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

(A) The employee's current medical condition.

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

(C) The request for authorization and utilization review decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If the 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, the deponent is entitled to receive in addition to all other benefits:

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

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

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

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

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

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

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

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

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

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

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

A qualified interpreter may render services during the following:

(A) A deposition.

(B) An appeals board hearing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 16.~~

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

O