

ASSEMBLY BILL

No. 584

Introduced by Assembly Member Fong

February 16, 2011

An act to amend Sections 3209.3 and 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 584, as introduced, Fong. Workers' compensation: utilization review.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that 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, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require the physician to be licensed by California state law.

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

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

1 SECTION 1. Section 3209.3 of the Labor Code is amended to
2 read:

3 3209.3. (a) "Physician"—~~includes~~ *means* physicians and
4 surgeons holding an M.D. or D.O. degree, psychologists,
5 acupuncturists, optometrists, dentists, podiatrists, and chiropractic
6 practitioners licensed by California state law and within the scope
7 of their practice as defined by California state law.

8 (b) "Psychologist" means a *psychologist* licensed ~~psychologist~~
9 *by California state law* with a doctoral degree in psychology, or
10 a doctoral degree deemed equivalent for licensure by the Board
11 of Psychology pursuant to Section 2914 of the Business and
12 Professions Code, and who either has at least two years of clinical
13 experience in a recognized health setting or has met the standards
14 of the National Register of the Health Service Providers in
15 Psychology.

16 (c) When treatment or evaluation for an injury is provided by
17 a psychologist, provision shall be made for appropriate medical
18 collaboration when requested by the employer or the insurer.

19 (d) "Acupuncturist" means a person who holds an
20 acupuncturist's certificate issued pursuant to Chapter 12
21 (commencing with Section 4925) of Division 2 of the Business
22 and Professions Code.

23 (e) Nothing in this section shall be construed to authorize
24 acupuncturists to determine disability for the purposes of Article
25 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under
26 Section 2708 of the Unemployment Insurance Code.

27 SEC. 2. Section 4610 of the Labor Code is amended to read:

28 4610. (a) For purposes of this section, "utilization review"
29 means utilization review or utilization management functions that

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

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

11 (c) Each utilization review process shall be governed by written
 12 policies and procedures. These policies and procedures shall ensure
 13 that decisions based on the medical necessity to cure and relieve
 14 of proposed medical treatment services are consistent with the
 15 schedule for medical treatment utilization adopted pursuant to
 16 Section 5307.27. Prior to adoption of the schedule, these policies
 17 and procedures shall be consistent with the recommended standards
 18 set forth in the American College of Occupational and
 19 Environmental Medicine Occupational Medical Practice
 20 Guidelines. These policies and procedures, and a description of
 21 the utilization process, shall be filed with the administrative director
 22 and shall be disclosed by the employer to employees, physicians,
 23 and the public upon request.

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

39 (e) No person other than a *physician* licensed—~~physician~~ by
 40 *California state law* who is competent to evaluate the specific

1 clinical issues involved in the medical treatment services, and
2 where these services are within the scope of the physician's
3 practice, requested by the physician may modify, delay, or deny
4 requests for authorization of medical treatment for reasons of
5 medical necessity to cure and relieve.

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

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

11 (2) Consistent with the schedule for medical treatment utilization
12 adopted pursuant to Section 5307.27. Prior to adoption of the
13 schedule, these policies and procedures shall be consistent with
14 the recommended standards set forth in the American College of
15 Occupational and Environmental Medicine Occupational Medical
16 Practice Guidelines.

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

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

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

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

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

1 individual who received services, or to the individual's designee,
2 within 30 days of receipt of information that is reasonably
3 necessary to make this determination.

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

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

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

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

15 (4) Communications regarding decisions to approve requests
16 by physicians shall specify the specific medical treatment service
17 approved. Responses regarding decisions to modify, delay, or deny
18 medical treatment services requested by physicians shall include
19 a clear and concise explanation of the reasons for the employer's
20 decision, a description of the criteria or guidelines used, and the
21 clinical reasons for the decisions regarding medical necessity.

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

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

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