

AMENDED IN ASSEMBLY APRIL 6, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

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, *and to amend Section 2708 of the Unemployment Insurance Code*, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 584, as amended, 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.

Existing law authorizes the Employment Development Department to administer the disability compensation program. Existing law requires a claim for disability benefits to be supported by a certification of a treating physician or practitioner. Existing law defines physician by reference to the above provision and defines a practitioner as a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, or nurse practitioner, as specified, or, as to normal pregnancy or childbirth, a midwife, nurse midwife, or a nurse practitioner.

This bill would provide that claim for disability benefits may also be supported by a health professional as defined, and as specified.

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" means physicians and surgeons holding
4 an M.D. or D.O. degree, psychologists, acupuncturists,
5 optometrists, dentists, podiatrists, and chiropractic practitioners
6 licensed by California state law and within the scope of their
7 practice as defined by California state law.
8 (b) "Psychologist" means a psychologist licensed by California
9 state law with a doctoral degree in psychology, or a doctoral degree
10 deemed equivalent for licensure by the Board of Psychology
11 pursuant to Section 2914 of the Business and Professions Code,
12 and who either has at least two years of clinical experience in a
13 recognized health setting or has met the standards of the National
14 Register of the Health Service Providers in Psychology.

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

4 (d) “Acupuncturist” means a person who holds an
5 acupuncturist’s certificate issued pursuant to Chapter 12
6 (commencing with Section 4925) of Division 2 of the Business
7 and Professions Code.

8 (e) Nothing in this section shall be construed to authorize
9 acupuncturists to determine disability for the purposes of Article
10 3 (commencing with Section 4650) of Chapter 2 of Part 2, ~~or under~~
11 ~~Section 2708 of the Unemployment Insurance Code.~~

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

13 4610. (a) For purposes of this section, “utilization review”
14 means utilization review or utilization management functions that
15 prospectively, retrospectively, or concurrently review and approve,
16 modify, delay, or deny, based in whole or in part on medical
17 necessity to cure and relieve, treatment recommendations by
18 physicians, as defined in Section 3209.3, prior to, retrospectively,
19 or concurrent with the provision of medical treatment services
20 pursuant to Section 4600.

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

25 (c) Each utilization review process shall be governed by written
26 policies and procedures. These policies and procedures shall ensure
27 that decisions based on the medical necessity to cure and relieve
28 of proposed medical treatment services are consistent with the
29 schedule for medical treatment utilization adopted pursuant to
30 Section 5307.27. Prior to adoption of the schedule, these policies
31 and procedures shall be consistent with the recommended standards
32 set forth in the American College of Occupational and
33 Environmental Medicine Occupational Medical Practice
34 Guidelines. These policies and procedures, and a description of
35 the utilization process, shall be filed with the administrative director
36 and shall be disclosed by the employer to employees, physicians,
37 and the public upon request.

38 (d) If an employer, insurer, or other entity subject to this section
39 requests medical information from a physician in order to
40 determine whether to approve, modify, delay, or deny requests for

1 authorization, the employer shall request only the information
2 reasonably necessary to make the determination. The employer,
3 insurer, or other entity shall employ or designate a medical director
4 who holds an unrestricted license to practice medicine in this state
5 issued pursuant to Section 2050 or Section 2450 of the Business
6 and Professions Code. The medical director shall ensure that the
7 process by which the employer or other entity reviews and
8 approves, modifies, delays, or denies requests by physicians prior
9 to, retrospectively, or concurrent with the provision of medical
10 treatment services, complies with the requirements of this section.
11 Nothing in this section shall be construed as restricting the existing
12 authority of the Medical Board of California.

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

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

23 (1) Developed with involvement from actively practicing
24 physicians.

25 (2) Consistent with the schedule for medical treatment utilization
26 adopted pursuant to Section 5307.27. Prior to adoption of the
27 schedule, these policies and procedures shall be consistent with
28 the recommended standards set forth in the American College of
29 Occupational and Environmental Medicine Occupational Medical
30 Practice Guidelines.

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

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

35 (5) Available to the public upon request. An employer shall
36 only be required to disclose the criteria or guidelines for the
37 specific procedures or conditions requested. An employer may
38 charge members of the public reasonable copying and postage
39 expenses related to disclosing criteria or guidelines pursuant to
40 this paragraph. Criteria or guidelines may also be made available

1 through electronic means. No charge shall be required for an
2 employee whose physician's request for medical treatment services
3 is under review.

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

8 (1) Prospective or concurrent decisions shall be made in a timely
9 fashion that is appropriate for the nature of the employee's
10 condition, not to exceed five working days from the receipt of the
11 information reasonably necessary to make the determination, but
12 in no event more than 14 days from the date of the medical
13 treatment recommendation by the physician. In cases where the
14 review is retrospective, the decision shall be communicated to the
15 individual who received services, or to the individual's designee,
16 within 30 days of receipt of information that is reasonably
17 necessary to make this determination.

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

30 (3) (A) Decisions to approve, modify, delay, or deny requests
31 by physicians for authorization prior to, or concurrent with, the
32 provision of medical treatment services to employees shall be
33 communicated to the requesting physician within 24 hours of the
34 decision. Decisions resulting in modification, delay, or denial of
35 all or part of the requested health care service shall be
36 communicated to physicians initially by telephone or facsimile,
37 and to the physician and employee in writing within 24 hours for
38 concurrent review, or within two business days of the decision for
39 prospective review, as prescribed by the administrative director.
40 If the request is not approved in full, disputes shall be resolved in

1 accordance with Section 4062. If a request to perform spinal
2 surgery is denied, disputes shall be resolved in accordance with
3 subdivision (b) of Section 4062.

4 (B) In the case of concurrent review, medical care shall not be
5 discontinued until the employee's physician has been notified of
6 the decision and a care plan has been agreed upon by the physician
7 that is appropriate for the medical needs of the employee. Medical
8 care provided during a concurrent review shall be care that is
9 medically necessary to cure and relieve, and an insurer or
10 self-insured employer shall only be liable for those services
11 determined medically necessary to cure and relieve. If the insurer
12 or self-insured employer disputes whether or not one or more
13 services offered concurrently with a utilization review were
14 medically necessary to cure and relieve, the dispute shall be
15 resolved pursuant to Section 4062, except in cases involving
16 recommendations for the performance of spinal surgery, which
17 shall be governed by the provisions of subdivision (b) of Section
18 4062. Any compromise between the parties that an insurer or
19 self-insured employer believes may result in payment for services
20 that were not medically necessary to cure and relieve shall be
21 reported by the insurer or the self-insured employer to the licensing
22 board of the provider or providers who received the payments, in
23 a manner set forth by the respective board and in such a way as to
24 minimize reporting costs both to the board and to the insurer or
25 self-insured employer, for evaluation as to possible violations of
26 the statutes governing appropriate professional practices. No fees
27 shall be levied upon insurers or self-insured employers making
28 reports required by this section.

29 (4) Communications regarding decisions to approve requests
30 by physicians shall specify the specific medical treatment service
31 approved. Responses regarding decisions to modify, delay, or deny
32 medical treatment services requested by physicians shall include
33 a clear and concise explanation of the reasons for the employer's
34 decision, a description of the criteria or guidelines used, and the
35 clinical reasons for the decisions regarding medical necessity.

36 (5) If the employer, insurer, or other entity cannot make a
37 decision within the timeframes specified in paragraph (1) or (2)
38 because the employer or other entity is not in receipt of all of the
39 information reasonably necessary and requested, because the
40 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).

(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.

SEC. 3. Section 2708 of the Unemployment Insurance Code is amended to read:

2708. (a) (1) In accordance with the director's authorized regulations, and except as provided in subdivision (c) and Sections 2708.1 and 2709, a claimant shall establish medical eligibility for each uninterrupted period of disability by filing a first claim for disability benefits supported by the certificate of a treating physician, *health professional*, or practitioner that establishes the sickness, injury, or pregnancy of the employee, or the condition of the family member that warrants the care of the employee. For subsequent periods of uninterrupted disability after the period covered by the initial certificate or any preceding continued claim,

1 a claimant shall file a continued claim for those benefits supported
2 by the certificate of a treating physician, *health professional*, or
3 practitioner. A certificate filed to establish medical eligibility for
4 the employee's own sickness, injury, or pregnancy shall contain
5 a diagnosis and diagnostic code prescribed in the International
6 Classification of Diseases, or, where no diagnosis has yet been
7 obtained, a detailed statement of symptoms.

8 (2) A certificate filed to establish medical eligibility of the
9 employee's own sickness, injury, or pregnancy shall also contain
10 a statement of medical facts including secondary diagnoses when
11 applicable, within the physician's, *health professional's*, or
12 practitioner's knowledge, based on a physical examination and a
13 documented medical history of the claimant by the physician,
14 *health professional*, or practitioner, indicating the physician's or
15 practitioner's conclusion as to the claimant's disability, and a
16 statement of the physician's, *health professional's*, or practitioner's
17 opinion as to the expected duration of the disability.

18 (b) An employee shall be required to file a certificate to establish
19 eligibility when taking leave to care for a family member with a
20 serious health condition. The certificate shall be developed by the
21 department. In order to establish medical eligibility of the serious
22 health condition of the family member that warrants the care of
23 the employee, the information shall be within the physician's,
24 *health professional's*, or practitioner's knowledge and shall be
25 based on a physical examination and documented medical history
26 of the family member and shall contain all of the following:

27 (1) A diagnosis and diagnostic code prescribed in the
28 International Classification of Diseases, or, where no diagnosis
29 has yet been obtained, a detailed statement of symptoms.

30 (2) The date, if known, on which the condition commenced.

31 (3) The probable duration of the condition.

32 (4) An estimate of the amount of time that the physician, *health*
33 *professional*, or practitioner believes the employee is needed to
34 care for the child, parent, spouse, or domestic partner.

35 (5) (A) A statement that the serious health condition warrants
36 the participation of the employee to provide care for his or her
37 child, parent, spouse, or domestic partner.

38 (B) "Warrants the participation of the employee" includes, but
39 is not limited to, providing psychological comfort, and arranging

1 “third party” care for the child, parent, spouse, or domestic partner,
2 as well as directly providing, or participating in, the medical care.

3 (c) The department shall develop a certification form for bonding
4 that is separate and distinct from the certificate required in
5 subdivision (a) for an employee taking leave to bond with a minor
6 child within the first year of the child’s birth or placement in
7 connection with foster care or adoption.

8 (d) The first and any continuing claim of an individual who
9 obtains care and treatment outside this state shall be supported by
10 a certificate of a treating physician, *health professional*, or
11 practitioner duly licensed or certified by the state or foreign country
12 in which the claimant is receiving the care and treatment. If a
13 physician, *health professional*, or practitioner licensed by and
14 practicing in a foreign country is under investigation by the
15 department for filing false claims and the department does not
16 have legal remedies to conduct a criminal investigation or
17 prosecution in that country, the department may suspend the
18 processing of all further certifications until the physician, *health*
19 *professional*, or practitioner fully cooperates, and continues to
20 cooperate with the investigation. A physician, *health professional*’s,
21 or practitioner licensed by and practicing in a foreign country who
22 has been convicted of filing false claims with the department may
23 not file a certificate in support of a claim for disability benefits for
24 a period of five years.

25 (e) For purposes of this part:

26 (1) “*Health professional*” means a psychologist, optometrist,
27 dentist, podiatrist, or chiropractor, provided that he or she is duly
28 licensed on any state or foreign country, or in a territory or
29 possession of a country, in which care and treatment was provided
30 to the employee or the employee’s family member with a serious
31 health condition. The care and treatment shall be within the scope
32 of his or her practice, as defined by the laws of the licensing
33 jurisdiction. For purposes of this part, all references to a physician
34 shall be also deemed to apply to a health professional.

35 (1)

36 (2) “Physician” ~~has the same meaning as defined in Section~~
37 ~~3209.3 of the Labor Code~~ means a physician and surgeon holding
38 an M.D. or D.O. degree, provided that he or she is duly licensed
39 in any state or foreign country, or in a territory or possession of
40 any country, in which care and treatment was provided to the

1 *employee or the employee's family member with a serious health*
2 *condition. The care and treatment shall be within the scope of his*
3 *or her practice, as defined by the laws of the licensing jurisdiction.*

4 (2)

5 (3) (A) ~~"Practitioner" means a person duly licensed or certified~~
6 ~~in California acting within the scope of his or her license or~~
7 ~~certification who is a dentist, podiatrist, or a nurse practitioner,~~
8 ~~and in the case of a nurse practitioner, after performance of a~~
9 ~~physical examination by a nurse practitioner and collaboration~~
10 ~~with a physician and surgeon, or as to normal pregnancy or~~
11 ~~childbirth, a midwife or nurse midwife, or nurse practitioner nurse~~
12 ~~practitioner who is duly licensed or certified in any state or foreign~~
13 ~~country, or in a territory or possession of any country, in which~~
14 ~~he or she has provided care and treatment to the employee or the~~
15 ~~employee's family member with a serious health condition. The~~
16 ~~care and treatment shall be within the scope of his or her practice,~~
17 ~~as defined by the laws of the licensing or certifying jurisdiction~~
18 ~~and the nurse practitioner shall have performed a physical~~
19 ~~examination and collaborated with a physician and surgeon~~
20 ~~holding an M.D. or D.O. degree.~~

21 (B) *For purposes of normal pregnancy or childbirth,*
22 *"practitioner" means a midwife, nurse midwife, or a nurse*
23 *practitioner operating within the scope of his or her practice, as*
24 *determined by the laws of the licensing or certifying jurisdiction,*
25 *who is duly licensed or certified in any state or foreign country,*
26 *or a territory or possession of a country, in which he or she has*
27 *provided care to the employee or the employee's family member*
28 *with a serious health condition.*

29 (f) *For a claimant who is hospitalized in or under the authority*
30 *of a county hospital in this state, a certificate of initial and*
31 *continuing medical disability, if any, shall satisfy the requirements*
32 *of this section if the disability is shown by the claimant's hospital*
33 *chart, and the certificate is signed by the hospital's registrar. For*
34 *a claimant hospitalized in or under the care of a medical facility*
35 *of the United States government, a certificate of initial and*
36 *continuing medical disability, if any, shall satisfy the requirements*
37 *of this section if the disability is shown by the claimant's hospital*
38 *chart, and the certificate is signed by a medical officer of the*
39 *facility duly authorized to do so.*

1 (g) ~~Nothing in this~~ This section shall *not* be construed to
2 preclude the department from requesting additional medical
3 evidence to supplement the first or any continued claim if the
4 additional evidence can be procured without additional cost to the
5 claimant. The department may require that the additional evidence
6 include any or all of the following:

7 (1) Identification of diagnoses.

8 (2) Identification of symptoms.

9 (3) A statement setting forth the facts of the claimant's disability.

10 The statement shall be completed by any of the following
11 individuals:

12 (A) The physician, *health professional*, or practitioner treating
13 the claimant.

14 (B) The registrar, authorized medical officer, or other duly
15 authorized official of the hospital or health facility treating the
16 claimant.

17 (C) An examining physician or other representative of the
18 department.