AMENDED IN SENATE JUNE 6, 2012

AMENDED IN ASSEMBLY MARCH 12, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1687

Introduced by Assembly Member Fong

February 14, 2012

An act to amend Section ~~4610~~ *138.4* of, and to add Section 4610.2 to, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1687, as amended, Fong. Workers' ~~compensation: utilization review.~~ *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 every employer to establish a utilization review process, either directly or through its insurer or an entity with which an employer contracts for these services, for the purpose of reviewing and approving, modifying, delaying, or denying treatment recommendations made by physicians with respect to injured workers. Existing law requires that ~~communications regarding decisions to approve requests by physicians specify the specific medical treatment service approved, and that responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians 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~~ *the administrative director, in consultation with the Commission on*

Health and Safety and Workers' Compensation, prescribed rules and regulations for serving notices that contain specified information on employees.

~~This bill would additionally require that communications or responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians also include a clear and concise explanation of the available options for objecting to the modification, delay, or denial of those medical services, to appear on the first page of the communication in no less than 12-point bold type so as to be prominently visible to the employee.~~

This bill would add information regarding objections to decisions based on utilization reviews to those notices for which rules and regulations are required to be prescribed.

Under existing law, when a party to a proceeding institutes proceedings to terminate an award made by the Workers' Compensation Appeals Board for continuing medical treatment and is unsuccessful in these proceedings, the appeals board is authorized to award reasonable attorney's fees to an applicant resisting these proceedings.

This bill would authorize the appeals board to award attorney's fees reasonably incurred by an applicant *who prevails in a proceeding* in connection with the enforcement of a medical award following a dispute that arises in the course of the utilization review process *if the applicant employs an attorney to enforce the award.*

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

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

~~SECTION 1. Section 4610 of the Labor Code is amended to read:~~

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

~~(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer~~

~~or an entity with which an employer or insurer contracts for these services.~~

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

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

~~(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. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.~~

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

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

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

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

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

~~(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the~~

~~employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.~~

~~(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of 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 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of 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. 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, 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. Communications or responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians also shall include a clear and concise explanation of the available options for objecting to the modification, delay, or denial of those medical services, which shall appear on the first page of the communication in no less than 12-point bold type so as to be prominently visible to the employee.~~

~~(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).~~

~~(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.~~

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, *explanations of the options available to object to a decision made pursuant to the utilization review process, as described in Section 4610, to modify, delay, or deny medical treatment,* 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.

SEC. 2. Section 4610.2 is added to the Labor Code, to read:

4610.2. If an award made by the appeals board specifies the provision of future medical treatment and a dispute arises in the course of a utilization review conducted pursuant to Section 4610 in connection with the enforcement of this award, and the applicant employs an attorney for purposes of enforcing the award *and prevails*, the appeals board may award attorney's fees reasonably incurred by the applicant in connection with enforcement of the award.

CORRECTIONS:

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