

AMENDED IN SENATE JANUARY 4, 2016

AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 13, 2015

**SENATE BILL**

**No. 563**

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**Introduced by Senator Pan**

February 26, 2015

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

LEGISLATIVE COUNSEL'S DIGEST

SB 563, as amended, Pan. Workers' compensation: utilization review.

Existing law requires every employer, for purposes of workers' compensation, to establish a utilization review process to prospectively, retrospectively, or concurrently review requests by physicians for authorization to provide recommended medical treatment to injured employees. Existing law establishes timeframes for an employer to make a determination regarding a physician's request. Existing law requires the utilization review process to be governed by written policies and procedures, and requires that these policies and procedures be filed with the Administrative Director of the Division of Workers' Compensation and disclosed by the employer to employees, physicians, and the public upon request.

~~This bill would require that the method of compensation, and any incentive payments contingent upon the approval, modification, or denial of a claim, for an individual or entity providing services pursuant to the utilization review process, as specified, be filed with the administrative director and disclosed by the employer to employees, physicians, and the public upon request. The bill would exempt a request~~

for medical treatment by a physician to cure or relieve an injured worker from the effect of an industrial injury from these requirements if the request meets specified conditions, including that a final award of permanent disability made by the appeals board specifies the provision of future medical treatment and that the request for medical treatment is for medical treatment that is specified by the award. The bill would also include a statement of legislative intent: *prohibit the employer, or any entity conducting utilization review on behalf of the employer, from offering or providing any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician. The bill would grant the administrative director authority pursuant to this provision 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.*

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

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

- 1     SECTION 1. Section 4610 of the Labor Code is amended to  
2     read:
- 3     4610. (a) For purposes of this section, “utilization review”  
4     means utilization review or utilization management functions that  
5     prospectively, retrospectively, or concurrently review and approve,  
6     modify, delay, or deny, based in whole or in part on medical  
7     necessity to cure and relieve, treatment recommendations by  
8     physicians, as defined in Section 3209.3, prior to, retrospectively,  
9     or concurrent with the provision of medical treatment services  
10    pursuant to Section 4600.
- 11    (b) Every employer shall establish a utilization review process  
12    in compliance with this section, either directly or through its insurer  
13    or an entity with which an employer or insurer contracts for these  
14    services.
- 15    (c) Each utilization review process shall be governed by written  
16    policies and procedures. These policies and procedures shall ensure  
17    that decisions based on the medical necessity to cure and relieve  
18    of proposed medical treatment services are consistent with the  
19    schedule for medical treatment utilization adopted pursuant to  
20    Section 5307.27. These policies and procedures, and a description

1 of the utilization process, shall be filed with the administrative  
2 director and shall be disclosed by the employer to employees,  
3 physicians, and the public upon request.

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

19 (e) No person other than a licensed physician who is competent  
20 to evaluate the specific clinical issues involved in the medical  
21 treatment services, and where these services are within the scope  
22 of the physician’s practice, requested by the physician may modify,  
23 delay, or deny requests for authorization of medical treatment for  
24 reasons of medical necessity to cure and relieve. *The employer, or*  
25 *any entity conducting utilization review on behalf of the employer,*  
26 *shall neither offer nor provide any financial incentive or*  
27 *consideration to a physician based on the number of modifications,*  
28 *delays, or denials made by the physician under this section. The*  
29 *administrative director has authority pursuant to this section to*  
30 *review any compensation agreement, payment schedule, or contract*  
31 *between the employer, or any entity conducting utilization review*  
32 *on behalf of the employer, and the utilization review physician.*

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

36 (1) Developed with involvement from actively practicing  
37 physicians.

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

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

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

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

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

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

31 (2) When the employee's condition is such that the employee  
32 faces an imminent and serious threat to his or her health, including,  
33 but not limited to, the potential loss of life, limb, or other major  
34 bodily function, or the normal timeframe for the decisionmaking  
35 process, as described in paragraph (1), would be detrimental to the  
36 employee's life or health or could jeopardize the employee's ability  
37 to regain maximum function, decisions to approve, modify, delay,  
38 or deny requests by physicians prior to, or concurrent with, the  
39 provision of medical treatment services to employees shall be made  
40 in a timely fashion that is appropriate for the nature of the

1 employee's condition, but not to exceed 72 hours after the receipt  
2 of the information reasonably necessary to make the determination.

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

16 (B) In the case of concurrent review, medical care shall not be  
17 discontinued until the employee's physician has been notified of  
18 the decision and a care plan has been agreed upon by the physician  
19 that is appropriate for the medical needs of the employee. Medical  
20 care provided during a concurrent review shall be care that is  
21 medically necessary to cure and relieve, and an insurer or  
22 self-insured employer shall only be liable for those services  
23 determined medically necessary to cure and relieve. If the insurer  
24 or self-insured employer disputes whether or not one or more  
25 services offered concurrently with a utilization review were  
26 medically necessary to cure and relieve, the dispute shall be  
27 resolved pursuant to Section 4610.5, if applicable, or otherwise  
28 pursuant to Section 4062. Any compromise between the parties  
29 that an insurer or self-insured employer believes may result in  
30 payment for services that were not medically necessary to cure  
31 and relieve shall be reported by the insurer or the self-insured  
32 employer to the licensing board of the provider or providers who  
33 received the payments, in a manner set forth by the respective  
34 board and in such a way as to minimize reporting costs both to the  
35 board and to the insurer or self-insured employer, for evaluation  
36 as to possible violations of the statutes governing appropriate  
37 professional practices. No fees shall be levied upon insurers or  
38 self-insured employers making reports required by this section.

39 (4) Communications regarding decisions to approve requests  
40 by physicians shall specify the specific medical treatment service

1 approved. Responses regarding decisions to modify, delay, or deny  
2 medical treatment services requested by physicians shall include  
3 a clear and concise explanation of the reasons for the employer’s  
4 decision, a description of the criteria or guidelines used, and the  
5 clinical reasons for the decisions regarding medical necessity. If  
6 a utilization review decision to deny or delay a medical service is  
7 due to incomplete or insufficient information, the decision shall  
8 specify the reason for the decision and specify the information that  
9 is needed.

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

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

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

39 (8) If utilization review is deferred pursuant to paragraph (7),  
40 and it is finally determined that the employer is liable for treatment

1 of the condition for which treatment is recommended, the time for  
2 the employer to conduct retrospective utilization review in  
3 accordance with paragraph (1) shall begin on the date the  
4 determination of the employer's liability becomes final, and the  
5 time for the employer to conduct prospective utilization review  
6 shall commence from the date of the employer's receipt of a  
7 treatment recommendation after the determination of the  
8 employer's liability.

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

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

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26 **All matter omitted in this version of the bill**  
27 **appears in the bill as amended in the**  
28 **Senate, April 30, 2015. (JR11)**  
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