SB-537 Workers' compensation: treatment and disability. (2019-2020)

Date Published: 10/09/2019 09:00 PM

Senate Bill No. 537

CHAPTER 647

An act to amend Sections 138.7, 4600.4, 4603.2, 4610, 4616, and 4616.5 of, and to add Sections 127.1, 138.8, and 5307.12 to, the Labor Code, relating to workers' compensation.

[Approved by Governor October 08, 2019. Filed with Secretary of State October 08, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

SB 537, Hill. Workers' compensation: treatment and disability.

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 employment. Existing law requires the employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury. Existing law requires the administrative director to adopt and revise periodically an official medical fee schedule establishing reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods.

Existing law defines a "physician" for purposes of the workers' compensation laws to include physicians and surgeons, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by state law and within the scope of their practice.

Existing law also requires the administrative director to post certain information on the division's internet website.

This bill would require the administrative director to issue a report to the Legislature, on or before January 1, 2023, comparing potential payment alternatives for providers to the official medical fee schedule. The bill would also require, on or before January 1, 2024, and annually thereafter, the administrative director to publish on the division's internet website provider utilization data for physicians, as defined above, who treated 10 or more injured workers during the 12 months before July 1 of the previous year, including the number of injured workers treated by the physician and the number of utilization review decisions that resulted in a modification or denial of a request for authorization of medical treatment based upon a determination of medical necessity. The bill would authorize the administrative director to withhold data if deemed necessary to protect patient privacy.

Existing law prohibits a person or public or private entity not a party to a claim for workers' compensation benefits from obtaining individually identifiable information obtained or maintained by the division regarding that claim, except as provided. Existing law requires the administrative director to develop a cost-efficient workers' compensation information system and authorizes the administrative director to use individually identifiable information for purposes of creating and maintaining that system.

This bill would require the administrative director to use individually identifiable information for purposes of creating provider medical utilization data as described above.

Existing law requires a workers' compensation insurer, third-party administrator, or other entity that requires, or pursuant to regulation requires, a treating physician to obtain either utilization review or prior authorization in order to diagnose or treat injuries or diseases compensable pursuant to specified law, to ensure the availability of those services from 9 a.m. to 5:30 p.m. Pacific standard time of each normal business day. Existing law defines a normal business day for these purposes to exclude Saturdays, under specified circumstances, Sundays, and certain holidays, as described.

This bill would revise the definition of a normal business day for these purposes to specifically exclude every Saturday, Sunday, and specified other holidays. The bill would also make technical changes.

Existing law authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for providing medical treatment to injured employees and imposes various duties upon the insurer, employer, or entity in connection with the network. Existing law requires every medical provider network to post on its internet website a roster of all treating physicians in the medical provider network and requires every network to provide to the administrative director the internet website address of the network and of its roster of treating physicians.

Existing law requires the administrative director to adopt a medical treatment utilization schedule. Existing law authorizes the administrative director to investigate complaints and to conduct random reviews of approved medical provider networks.

This bill would, commencing July 1, 2021, require every medical provider network to post on its internet website a roster of participating providers and to provide to the administrative director the internet website address of the network and of its roster of participating providers. The bill would revise the authority of the administrative director by giving the administrative director authority and discretion to investigate complaints, conduct random reviews, and take enforcement action against medical provider networks, an entity that provides ancillary services, as defined, or an entity providing services for or on behalf of the medical provider network or its providers, regarding noncompliance with, among others, the internet address and roster requirements imposed on those networks.

Existing law requires a physician providing treatment to send a request for authorization for medical treatment to the claims administrator. Existing law requires a provider's itemized request for payment to be submitted to an employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services for services provided on or after January 1, 2017.

This bill would prohibit an entity other than the requesting physician or provider from altering or amending a request for authorization for medical treatment prior to the submission of the request to the claims administrator, and would state that this provision is declaratory of existing law. The bill would require an itemized request for payment for services to be submitted to an employer with the physician's or provider's national provider identifier number.

Existing law requires the administrative director to adopt a schedule for payment of home health care services that are not covered by a Medicare fee schedule and are not otherwise covered by the official medical fee schedule described above. Existing law authorizes a health care provider or licensed health facility and a contracting agent, employer, or carrier to contract for reimbursement rates different from those in the fee schedule.

This bill, on and after July 1, 2021, would require an entity that provides physician or ancillary network service to provide a payor with a written disclosure of the reimbursement amount paid to the provider with a rate sheet if a contracted reimbursement rate is more than 20% below the official medical fee schedule, as specified. The bill would authorize an entity that provides physician or ancillary network services to require a payor to sign a nondisclosure agreement before providing that disclosure.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 127.1 is added to the Labor Code, to read:

127.1. (a) The administrative director, with input from the Commission on Health and Safety and Workers' Compensation, shall issue a report to the Legislature, on or before January 1, 2023, comparing potential payment alternatives for providers to the official medical fee schedule, including, but not limited to, capitation, bundled payments, quality incentives, and value-based payment systems.

(b) The report shall address advantages and disadvantages of each alternative payment system to the official medical fee schedule and make recommendations to the Legislature on alternative payment pilot programs.

(c) The report shall be submitted in compliance with Section 9795 of the Government Code. The requirement for submitting a report imposed by this section shall be inoperative on January 1, 2024, pursuant to Section 10231.5 of the Government Code.

SEC. 2. Section 138.7 of the Labor Code is amended to read:

138.7. (a) Except as expressly permitted in subdivision (b), a person or public or private entity not a party to a claim for workers' compensation benefits shall not obtain individually identifiable information obtained or maintained by the division regarding that claim. For purposes of this section, "individually identifiable information" means any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

(b) (1) (A) The administrative director, or a statistical agent designated by the administrative director, may use individually identifiable information for purposes of creating and maintaining the workers' compensation information system as specified in Section 138.6.

(B) The administrative director may publish the identity of claims administrators in the annual report disclosing the compliance rates of claims administrators pursuant to subdivision (d) of Section 138.6.

(C) The administrative director shall use individually identifiable information for purposes of creating provider medical utilization data as specified in Section 138.8.

(2) (A) The State Department of Public Health may use individually identifiable information for purposes of establishing and maintaining a program on occupational health and occupational disease prevention as specified in Section 105175 of the Health and Safety Code.

(B) (i) The State Department of Health Care Services may use individually identifiable information for purposes of seeking recovery of Medi-Cal costs incurred by the state for treatment provided to injured workers that should have been incurred by employers and insurance carriers pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(ii) The Department of Industrial Relations shall furnish individually identifiable information to the State Department of Health Care Services, and the State Department of Health Care Services may furnish the information to its designated agent, provided that the individually identifiable information shall not be disclosed for use other than the purposes described in clause (i). The administrative director may adopt regulations solely for the purpose of governing access by the State Department of Health Care Services or its designated agents to the individually identifiable information as defined in subdivision (a).

(3) (A) Individually identifiable information may be used by the Division of Workers' Compensation and the Division of Occupational Safety and Health as necessary to carry out their duties. The administrative director shall adopt regulations governing the access to the information described in this subdivision by these divisions. Any regulations adopted pursuant to this subdivision shall set forth the specific uses for which this information may be obtained.

(B) Individually identifiable information maintained in the workers' compensation information system and the Division of Workers' Compensation may be used by researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation as necessary to carry out the commission's research. The administrative director shall adopt regulations governing the access to the information described in this subdivision by commission researchers. These regulations shall set forth the specific uses for which this information may be obtained and include provisions guaranteeing the confidentiality of individually identifiable information. Individually identifiable information obtained under this subdivision shall not be disclosed to commission members. Individually identifiable information obtained by researchers under contract to the commission pursuant to this subparagraph may not be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(C) Individually identifiable information may be used by the Office of Self-Insurance Plans of the Department of Industrial Relations as necessary to carry out its duties, including evaluating the costs of administration, workers' compensation benefit expenditures, and solvency and performance of the public self-insured employers' workers' compensation programs.

(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other persons or public or private entities for the purpose of bona fide statistical research. This research shall not divulge individually identifiable information concerning a particular employee, employer, claims administrator, or any other person or entity. The regulations adopted pursuant to this paragraph shall include provisions guaranteeing the confidentiality of individually identifiable information. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(5) (A) This section shall not operate to exempt from disclosure any information that is considered to be a public record pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) contained in an individual's file once an application for adjudication has been filed pursuant to Section 5501.5.

(B) Individually identifiable information shall not be provided to any person or public or private entity who is not a party to the claim unless that person self-identifies or that public or private entity identifies itself and states the reason for making the request. The administrative director may require the person or public or private entity making the request to produce information to verify that the name and address of the requester is valid and correct. If the purpose of the request is related to preemployment screening, the administrative director shall notify the person about whom the information is requested that the information was provided and shall include the following in 12-point type:

"IT MAY BE A VIOLATION OF FEDERAL AND STATE LAW TO DISCRIMINATE AGAINST A JOB APPLICANT BECAUSE THE APPLICANT HAS FILED A CLAIM FOR WORKERS' COMPENSATION BENEFITS."

(C) Any residence address is confidential and shall not be disclosed to any person or public or private entity except to a party to the claim, a law enforcement agency, an office of a district attorney, any person for a journalistic purpose, or other governmental agency.

(D) This paragraph does not prohibit the use of individually identifiable information for purposes of identifying bona fide lien claimants.

(c) Except as provided in subdivision (b), individually identifiable information obtained by the division is privileged and is not subject to subpoena in a civil proceeding unless, after reasonable notice to the division and a hearing, a court determines that the public interest and the intent of this section will not be jeopardized by disclosure of the information. This section shall not operate to restrict access to information by any law enforcement agency or district attorney's office or to limit admissibility of that information in a criminal proceeding.

(d) It is unlawful for any person who has received individually identifiable information from the division pursuant to this section to provide that information to any person who is not entitled to it under this section.

SEC. 3. Section 138.8 is added to the Labor Code, to read:

138.8. (a) On or before January 1, 2024, and annually thereafter, the administrative director shall publish on the division's internet website provider utilization data, as reported to the Division of Workers' Compensation, for physicians who treated 10 or more injured workers during the 12 months before July 1 of the previous year. The provider utilization data shall include all of the following:

(1) The physician's first and last name.

(2) The physician's specialty.

(3) The physician's National Provider Identifier.

(4) The number of injured workers treated by the physician.

(5) The International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) codes by both diagnosis and procedure.

(6) A short description of the ICD-10 codes used by the physician.

(7) The number of utilization review decisions that resulted in a modification or denial of a request for authorization of medical treatment based upon a determination of medical necessity.

(8) The number of independent medical review decisions issued in response to an appeal of a utilization review decision that resulted in a modification or denial based upon medical necessity and the number of independent medical review decisions that resulted in the utilization review modification or denial being overturned.

(9) Any additional data as determined by the administrative director.

(b) For purposes of this section, "physician" has the same meaning as set forth in Section 3209.3.

(c) The administrative director may withhold data contained in subdivision (a) if deemed necessary to protect patient privacy.

SEC. 4. Section 4600.4 of the Labor Code is amended to read:

4600.4. (a) A workers' compensation insurer, third-party administrator, or other entity that requires, or pursuant to regulation requires, a treating physician to obtain either utilization review or prior authorization in order to diagnose or treat injuries or diseases compensable under this article, shall ensure the availability of those services from 9 a.m. to 5:30 p.m. Pacific standard time of each normal business day.

(b) For purposes of this article, "normal business day" does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

SEC. 5. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) (1) Upon selecting a physician pursuant to Section 4600, the employee or physician shall notify the employer of the name and address, including the name of the medical group, if applicable, of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination, as required by Section 6409, and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(2) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was entitled to select the physician pursuant to Section 4600, the employee shall be entitled to continue treatment with that physician at the employer's expense in accordance with this division, notwithstanding Section 4616.2. The employer shall be required to pay from the date of the initial examination if the physician's report was submitted within five working days of the initial examination. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee shall not be required to pay for any services prior to the date the physician's report was submitted.

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer is not liable for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) (A) A provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. This section does not prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(B) Effective for services provided on or after January 1, 2017, the request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The administrative director shall adopt rules to implement the 12-month limitation period. The rules shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. The request for payment is barred unless timely submitted.

(C) The request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer with the national provider identifier (NPI) number for the physician or provider who provided the service for which payment is sought in accordance with rules adopted by the administrative director pursuant to Section 4603.4. Failure to include the physician's or provider's NPI shall result in the request for payment being barred until the physician's or provider's NPI is submitted with the request for payment. This subparagraph does not preclude an employer, insurer, pharmacy benefit manager, or third-party claims administrator from requiring the physician's or provider's NPI at an earlier date. This subparagraph is declaratory of existing law.

(D) Notwithstanding the requirements of this paragraph, a copy of the prescription shall not be required with a request for payment for pharmacy services, unless the provider of services has entered into a written agreement, as provided in this paragraph, that requires a copy of a prescription for a pharmacy service.

(E) This section does not preclude an employer, insurer, pharmacy benefits manager, or third-party claims administrator from requesting a copy of the prescription during a review of any records of prescription drugs that were dispensed by a pharmacy.

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. A properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:

(A) Pays the provider at the rates in effect within the 45-day period.

(B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if the physician or provider disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(3) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made within 60 days after receipt of each separate itemization, together with any required reports and any written authorization for services that may have been received by the physician.

(4) Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical provider and shall not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission. This paragraph applies only to duplicate submissions and does not apply to any other penalties or interest that may be applicable to the original submission.

(5) (A) An employer may defer objecting to or paying any bill submitted by, or on behalf of, a provider whose liens are stayed pursuant to Section 4615, and the time limits for taking any action prescribed by paragraphs (2) and (3) shall not commence until the stay is lifted pursuant to Section 4615.

(B) An employer may object to any bill submitted by, or on behalf of, a provider who has been suspended pursuant to Section 139.21.

(c) Interest or an increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of an itemization submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that itemization by the physician or medical provider. When an individual or entity conducting an itemization review determines that additional information or documentation is necessary to review the itemization, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) (A) An individual or entity reviewing an itemization of service submitted by a physician or medical provider, including a medical provider network, an entity that provides ancillary services, as defined in Section 4616.5, or an entity providing services for or on behalf of the medical provider network or its providers, shall not alter the procedure codes listed or recommend reduction of the amount of the payment unless the documentation submitted by the physician or medical provider with the itemization of service has been reviewed by that individual or entity. If the reviewer does not recommend payment for services as itemized by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or changed other parts of the itemization and the

specific deficiency in the itemization or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(B) The amendments to subparagraph (A) made by the act adding this subparagraph are declaratory of existing law.

(e) (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The item and amount in dispute.

(C) The additional payment requested and the reason therefor.

(D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

(2) If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(f) Except as provided in paragraph (4) of subdivision (e), the appeals board shall have jurisdiction over disputes arising out of this section pursuant to Section 5304.

SEC. 6. 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) 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) (1) Except for emergency treatment services, 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.

(2) (A) In the case of emergency treatment services, 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 180 days of the date the service was provided.

(B) For the purposes of this subdivision, “emergency treatment services” means treatment for an emergency medical condition defined in subdivision (b) of Section 1317.1 of the Health and Safety Code and provided in a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(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) (A) 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. This section does not limit the existing authority of the Medical Board of California.

(B) A request for authorization, including its supporting documentation, shall not be altered or amended by any entity other than the requesting physician or provider prior to the submission of the request to the claims administrator in accordance with subparagraph (A). This subparagraph is declaratory of existing law.

(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 website.

(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 normal business 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 normal business 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 the employee's 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 normal 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 and time 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.

SEC. 7. Section 4616 of the Labor Code is amended to read:

4616. (a) (1) An insurer, employer, or entity that provides physician network services may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries. The administrative director shall encourage the integration of occupational and nonoccupational providers. The number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries

experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart and areas in which there is a health care shortage.

(3) A treating physician shall be included in the network only if, at the time of entering into or renewing an agreement by which the physician would be in the network, the physician, or an authorized employee of the physician or the physician's office, provides a separate written acknowledgment in which the physician affirmatively elects to be a member of the network. Copies of the written acknowledgment shall be provided to the administrative director upon the administrative director's request. This paragraph shall not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to be part of the network.

(4) (A) (i) Commencing July 1, 2021, every medical provider network shall post on its internet website a roster of all participating providers, which includes all physicians and ancillary service providers in the medical provider network, and shall update the roster at least quarterly. Every network shall provide to the administrative director the internet website address of the network and of its roster of participating providers. The roster of participating providers shall include, at a minimum, the name of each individual provider and their office address and office telephone number. If the ancillary service is provided by an entity rather than an individual, then that entity's name, address, and telephone number shall be listed.

(ii) The administrative director shall post, on the division's internet website, the internet website address of every approved medical provider network.

(B) Every medical provider network shall post on its internet website information about how to contact the medical provider network contact and medical access assistants, and information about how to obtain a copy of any notification regarding the medical provider network that is required to be given to an employee by regulations adopted by the administrative director.

(5) Every medical provider network shall provide one or more persons within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, and subsequent physicians if necessary, under Section 4616.3. Medical access assistants shall have a toll-free telephone number that injured employees may use and shall be available at least from 7 a.m. to 8 p.m. Pacific standard time, Monday through Saturday, to respond to injured employees, contact physicians' offices during regular business hours, and schedule appointments. The administrative director shall promulgate regulations governing the provision of medical access assistants.

(b) (1) An insurer, employer, or entity that provides physician network services shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan for a period of four years if the administrative director determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved. Commencing January 1, 2014, existing approved plans shall be deemed approved for a period of four years from the approval date of the most recent application or modification submitted prior to 2014. Plans for reapproval for medical provider networks shall be submitted at least six months before the expiration of the four-year approval period. Commencing January 1, 2016, a modification that updates an entire medical provider network plan to bring the plan into full compliance with all current statutes and regulations shall be deemed approved for a period of four years from the modification approval date. An approved modification that does not update an entire medical provider network plan to bring the plan into full compliance with all current statutes and regulations shall not alter the expiration of the medical provider network's four-year approval period. Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed.

(2) Every medical provider network shall establish and follow procedures to continuously review the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

(3) Every medical provider network shall submit geocoding of its network for reapproval to establish that the number and geographic location of physicians in the network meets the required access standards.

(4) Approval of a plan may be denied, revoked, or suspended if the medical provider network fails to meet the requirements of this article. Any person contending that a medical provider network is not validly constituted may petition the administrative director to suspend or revoke the approval of the medical provider network. The administrative director may adopt regulations establishing a schedule of administrative penalties not to exceed five thousand dollars ($5,000) per violation, or probation, or both, in lieu of revocation or suspension for less severe violations of the requirements of this article. Penalties, probation, suspension, or revocation shall be ordered by the administrative director only after notice and opportunity to be heard. Unless

suspended or revoked by the administrative director, the administrative director's approval of a medical provider network shall be binding on all persons and all courts. A determination of the administrative director may be reviewed only by an appeal of the determination of the administrative director filed as an original proceeding before the reconsideration unit of the workers' compensation appeals board on the same grounds and within the same time limits after issuance of the determination as would be applicable to a petition for reconsideration of a decision of a workers' compensation administrative law judge.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27.

(f) Only a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) Every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer, entity that provides physician network services, or another contracting agent shall, upon entering or renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred, or conveyed to other insurers, employers, entities that provide physician network services, or another contracting agent, and specify whether those insurers, employers, entities that provide physician network services, or contracting agents include workers' compensation insurers.

(h) On or before November 1, 2004, the administrative director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

(i) The administrative director has the authority and discretion to investigate complaints, conduct random reviews, and take enforcement action against medical provider networks, an entity that provides ancillary services, or an entity providing services for or on behalf of the medical provider network or its providers regarding noncompliance with the requirements of this section or Section 4603.2 or 4610.

SEC. 8. Section 4616.5 of the Labor Code is amended to read:

4616.5. (a) For purposes of this article, "employer" means a self-insured employer, joint powers authority, or the state.

(b) For purposes of this article, "entity that provides physician network services" means a medical network licensed by the Department of Insurance or Department of Managed Health Care, or a third-party claims adjusting organization licensed by the Department of Insurance or certified by the Office of Self-Insurance Plans, or a legal entity that offers medical management or physician network services within California.

(c) For purposes of this article, "entity that provides ancillary services" means an entity that provides medical services or goods, as authorized by Section 4600, by a nonphysician, including, but not limited to, interpreter services, physical therapy, and pharmaceutical services.

SEC. 9. Section 5307.12 is added to the Labor Code, to read:

5307.12. (a) If a health care provider or health facility, licensed pursuant to Section 1250 of the Health and Safety Code, and an entity that provides physician network services, as defined in subdivision (b) of Section 4616.5, or an entity that provides ancillary network services, as defined in subdivision (c) of Section 4616.5, contract for a reimbursement rate that is more than 20 percent below the official medical fee schedule, excluding goods and pharmaceuticals, the entity that provides physician or ancillary network services shall provide the payor with a written disclosure, on a form promulgated by the administrative director, of the reimbursement amount paid to the provider.

(b) Before providing the disclosure required pursuant to subdivision (a), the entity that provides physician or ancillary network services may require the payor to sign a nondisclosure agreement with the entity that provides physician or ancillary network services agreeing to maintain the confidentiality of the disclosed information.

(c) A nondisclosure agreement signed pursuant to subdivision (b) shall not prohibit the division from obtaining the information disclosed pursuant to subdivision (a). This subdivision is declaratory of existing law.

(d) This section does not apply to an entity that provides physician or ancillary network services that discloses, or arranges for the disclosure of, the same pricing and payment information to both the health care provider or health facility and the person or entity paying for the services.

(e) This section shall become operative on July 1, 2021.