APPENDIX

4610 Pre-1/1/2018

(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) 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.

(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. 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) 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. 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. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) 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.

(f) 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 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.

(g) 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) 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, 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 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.

(2) If the employee's condition is one in which 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 decision making 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.

(3) (A) 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. Decisions resulting in modification 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 4610.5, if applicable, or otherwise in accordance with 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 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.

(4) 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 the reason for the decision and specify the information that is needed.

(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).

(6) 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 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.

(7) 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.

(8) If utilization review is deferred pursuant to paragraph (7), 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 (1) 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.

(h) Each 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.

(j) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

4610 Post-1/1/2018

(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) 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.

(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) 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. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(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 Web site.

(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 working 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 working 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 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, 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 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(s) and time(s) 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.

(r) This section shall become operative on January 1, 2018.