

***AB 584 (Fong) – Worker's' Compensation: Utilization Review***

***Introduced February 16, 2001, Amended April 6, 2011***

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require the physician to be licensed by California state law.

Existing law authorizes the Employment Development Department to administer the disability compensation program. Existing law requires a claim for disability benefits to be supported by a certification of a treating physician or practitioner.

Existing law defines physician by reference to the above provision and defines a practitioner as a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, or nurse practitioner, as specified, or, as to normal pregnancy or childbirth, a midwife, nurse midwife, or a nurse practitioner.

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



AMENDED IN ASSEMBLY APRIL 6, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 584**

---

**Introduced by Assembly Member Fong**

February 16, 2011

---

An act to amend Sections 3209.3 and 4610 of the Labor Code, *and to amend Section 2708 of the Unemployment Insurance Code*, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 584, as amended, Fong. Workers' compensation: utilization review.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that no

person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require the physician to be licensed by California state law.

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

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

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

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

1 SECTION 1. Section 3209.3 of the Labor Code is amended to  
2 read:

3 3209.3. (a) "Physician" means physicians and surgeons holding  
4 an M.D. or D.O. degree, psychologists, acupuncturists,  
5 optometrists, dentists, podiatrists, and chiropractic practitioners  
6 licensed by California state law and within the scope of their  
7 practice as defined by California state law.

8 (b) "Psychologist" means a psychologist licensed by California  
9 state law with a doctoral degree in psychology, or a doctoral degree  
10 deemed equivalent for licensure by the Board of Psychology  
11 pursuant to Section 2914 of the Business and Professions Code,  
12 and who either has at least two years of clinical experience in a  
13 recognized health setting or has met the standards of the National  
14 Register of the Health Service Providers in Psychology.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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



1 the employer has asked that an additional examination or test be  
2 performed upon the employee that is reasonable and consistent  
3 with good medical practice, the employer shall immediately notify  
4 the physician and the employee, in writing, that the employer  
5 cannot make a decision within the required timeframe, and specify  
6 the information requested but not received, the expert reviewer to  
7 be consulted, or the additional examinations or tests required. The  
8 employer shall also notify the physician and employee of the  
9 anticipated date on which a decision may be rendered. Upon receipt  
10 of all information reasonably necessary and requested by the  
11 employer, the employer shall approve, modify, or deny the request  
12 for authorization within the timeframes specified in paragraph (1)  
13 or (2).

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

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

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

31 2708. (a) (1) In accordance with the director's authorized  
32 regulations, and except as provided in subdivision (c) and Sections  
33 2708.1 and 2709, a claimant shall establish medical eligibility for  
34 each uninterrupted period of disability by filing a first claim for  
35 disability benefits supported by the certificate of a treating  
36 physician, *health professional*, or practitioner that establishes the  
37 sickness, injury, or pregnancy of the employee, or the condition  
38 of the family member that warrants the care of the employee. For  
39 subsequent periods of uninterrupted disability after the period  
40 covered by the initial certificate or any preceding continued claim,

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

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

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

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

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

31 (3) The probable duration of the condition.

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

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

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

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

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

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

25 (e) For purposes of this part:

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

35 (1)

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

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

4 (2)

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

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

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

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

7 (1) Identification of diagnoses.

8 (2) Identification of symptoms.

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

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

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

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

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

