

**RESOLUTION 02-06-05**

**DIGEST**

Workers' Compensation: Utilization Review Notices

Amends Labor Code section 4610 to require a physician to provide a copy of the request for approval for treatment to counsel for the injured employee.

**RESOLUTIONS COMMITTEE RECOMMENDATION**

APPROVE IN PRINCIPLE

History:

No similar resolutions found.

Reasons:

This resolution amends Labor Code section 4610 to require a physician to provide a copy of the request for approval for treatment to counsel for the injured employee. This resolution should be approved in principle because it will ensure that treatment of injured employees is not delayed.

Enacted in 2004, SB 899 effected change to California's Workers' Compensation system. Many changes related to medical treatment of injured employees. Procedures were implemented providing for review by the workers' compensation insurance carriers of treatment authorization requests made by treating physicians. There were time-frames devised as to when a decision must be made regarding the treatment. If no decision regarding treatment is made within that time, the carrier must so notify the physician and employee, explaining why the decision cannot be made within that time.

SB 899 does not provide for notifying the employee about when that request was made. Without knowing when the request is made, the employee has no idea when he will be treated. The employee does not know if the carrier is complying with the time requirements to respond to the treatment authorization request.

The employee is entitled to know the status of the authorization request since his treatment is at issue. He may be ill or in pain, and is entitled to know when he will receive treatment. By requiring the authorization request to be served on the employee's counsel, it will ensure that the time requirements are known to the employee and his or her counsel.

**TEXT OF RESOLUTION**

RESOLVED that the Conference of Delegates of California Bar Associations recommends that legislation be sponsored to amend Labor Code section 4610 to read as follows:

- 1     §4610
- 2             (a) For purposes of this section, "utilization review" means utilization review or utilization
- 3 management functions that prospectively, retrospectively, or concurrently review and approve,
- 4 modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment
- 5 recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent
- 6 with the provision of medical treatment services pursuant to Section 4600.
- 7             (b) Every employer shall establish a utilization review process in compliance with this
- 8 section, either directly or through its insurer or an entity with which an employer or insurer contracts
- 9 for these services.
- 10            (c) Each utilization review process shall be governed by written policies and procedures.
- 11 These policies and procedures shall ensure that decisions based on the medical necessity to cure
- 12 and relieve of proposed medical treatment services are consistent with the schedule for medical
- 13 treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these
- 14 policies and procedures shall be consistent with the recommended standards set forth in the
- 15 American College of Occupational and Environmental Medicine Occupational Medical Practice
- 16 Guidelines. These policies and procedures, and a description of the utilization process, shall be filed

17 with the administrative director and shall be disclosed by the employer to employees, physicians,  
18 and the public upon request.

19 (d) If an employer, insurer, or other entity subject to this section requests medical information  
20 from a physician in order to determine whether to approve, modify, delay, or deny requests for  
21 authorization, the employer shall request only the information reasonably necessary to make the  
22 determination. The employer, insurer, or other entity shall employ or designate a medical director  
23 who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050  
24 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the  
25 process by which the employer or other entity reviews and approves, modifies, delays, or denies  
26 requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment  
27 services, complies with the requirements of this section. Nothing in this section shall be construed as  
28 restricting the existing authority of the Medical Board of California.

29 (e) No person other than a licensed physician who is competent to evaluate the specific  
30 clinical issues involved in the medical treatment services, and where these services are within the  
31 scope of the physician's practice, requested by the physician may modify, delay, or deny requests for  
32 authorization of medical treatment for reasons of medical necessity to cure and relieve.

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

35 (1) Developed with involvement from actively practicing physicians.

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

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

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

43 (5) Available to the public upon request. An employer shall only be required to disclose the  
44 criteria or guidelines for the specific procedures or conditions requested. An employer may charge  
45 members of the public reasonable copying and postage expenses related to disclosing criteria or  
46 guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through  
47 electronic means. No charge shall be required for an employee whose physician's request for  
48 medical treatment services is under review. The responding party shall further indicate where a free  
49 copy of his/her/their utilization review process may be viewed on the Internet, or shall serve a copy of  
50 his/her/their utilization review process upon the physician, applicant, and applicant's counsel free of  
51 charge each time he/she/they give a response to a request.

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

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

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

70 (3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization  
71 prior to, or concurrent with, the provision of medical treatment services to employees shall be  
72 communicated to the requesting physician within 24 hours of the decision. Decisions resulting in

73 modification, delay, or denial of all or part of the requested health care service shall be  
74 communicated to physicians initially by telephone or facsimile, and to the physician and employee in  
75 writing within 24 hours for concurrent review, or within two business days of the decision for  
76 prospective review, as prescribed by the administrative director. If the request is not approved in full,  
77 disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is  
78 denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

79 (B) In the case of concurrent review, medical care shall not be discontinued until the  
80 employee's physician has been notified of the decision and a care plan has been agreed upon by the  
81 physician that is appropriate for the medical needs of the employee. Medical care provided during a  
82 concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or  
83 self-insured employer shall only be liable for those services determined medically necessary to cure  
84 and relieve. If the insurer or self-insured employer disputes whether or not one or more services  
85 offered concurrently with a utilization review were medically necessary to cure and relieve, the  
86 dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for  
87 the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of  
88 Section 4062. Any compromise between the parties that an insurer or self-insured employer believes  
89 may result in payment for services that were not medically necessary to cure and relieve shall be  
90 reported by the insurer or the self-insured employer to the licensing board of the provider or  
91 providers who received the payments, in a manner set forth by the respective board and in such a  
92 way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for  
93 evaluation as to possible violations of the statutes governing appropriate professional practices. No  
94 fees shall be levied upon insurers or self-insured employers making reports required by this section.

95 (4) Communications regarding decisions to approve requests by physicians shall specify the  
96 specific medical treatment service approved. Responses regarding decisions to modify, delay, or  
97 deny medical treatment services requested by physicians shall include a clear and concise  
98 explanation of the reasons for the employer's decision, a description of the criteria or guidelines  
99 used, and the clinical reasons for the decisions regarding medical necessity.

100 (5) If the employer, insurer, or other entity cannot make a decision within the timeframes  
101 specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the  
102 information reasonably necessary and requested, because the employer requires consultation by an  
103 expert reviewer, or because the employer has asked that an additional examination or test be  
104 performed upon the employee that is reasonable and consistent with good medical practice, the  
105 employer shall immediately notify the physician and the employee, in writing, that the employer  
106 cannot make a decision within the required timeframe, and specify the information requested but not  
107 received, the expert reviewer to be consulted, or the additional examinations or tests required. The  
108 employer shall also notify the physician and employee of the anticipated date on which a decision  
109 may be rendered. Upon receipt of all information reasonably necessary and requested by the  
110 employer, the employer shall approve, modify, or deny the request for authorization within the  
111 timeframes specified in paragraph (1) or (2).

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

114 (i) The administrative director shall develop a uniform Utilization Review request form for  
115 physicians seeking approval of treatment. This form shall require sufficient information from the  
116 requesting physician that will enable the applicant or applicant's counsel to be able to determine that  
117 responses to this request are in compliance with Labor Code section 4610 [Second Enacted  
118 Section]. This form shall at least include the following information: 1. The name of the doctor making  
119 the request, 2. The medical treatment requested, 3. Whether the request is an emergency or non-  
120 emergency request, 4. For emergency requests, the nature of the emergency in the terms of the  
121 criteria of Labor Code 4610(g)(2), 5. The requesting physician's opinion regarding what should be  
122 the timely response given the nature of the employee's condition, 6. Whether the request is a  
123 prospective or concurrent request, 7. The date and time of the request. A copy of this written request  
124 shall be simultaneously sent to the authorizing party, the applicant and applicant's counsel by the  
125 same mode whether by fax, mail, or e-mail.

126 (j) The responding party shall in his/her/their authorization or denial of medical treatment  
127 simultaneously send it to the requesting physician, the applicant and applicant's counsel by the same  
128 mode whether by fax, mail, or e-mail. Also, the responding party shall indicate the day and hour

129 he/she/they made this decision regarding this request. The responding party shall further indicate  
130 where a free copy of his/her/their utilization review process may be viewed on the Internet, or shall  
131 serve a copy of his/her/their utilization review process upon the physician, applicant, and applicant's  
132 counsel free of charge each time he/she/they give a response to a request.

133 ~~(i)(k)~~ If the administrative director determines that the employer, insurer, or other entity  
134 subject to this section has failed to meet any of the timeframes in this section, or has failed to meet  
135 any other requirement of this section, the administrative director may assess, by order,  
136 administrative penalties for each failure. A proceeding for the issuance of an order assessing  
137 administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing  
138 with regard to, the person affected. The administrative penalties shall not be deemed to be an  
139 exclusive remedy for the administrative director. These penalties shall be deposited in the Workers'  
140 Compensation Administration Revolving Fund.

(Proposed new language underlined; language to be deleted stricken.)

PROPONENT: Los Angeles County Bar Association

#### STATEMENT OF REASONS

Existing Law: Utilization review is governed by Labor Code section 4610 [second enacted section] and 8 California Code of Regulations section 9792.6 et. seq. (Emergency Regulation December 2004). 8 CCR 9792.6(k) (Emergency Regulation December 2004) requires the physician to make the request on Form DLSR 5021, section 14006, or in the format for Primary Treating Physician progress report, in subdivision (f) of section 9785. However, this form does not require the physician to serve this report on the applicant or applicant's counsel at the same time as the request is given to the claims administrator, nor does it require the doctor to indicate whether this is an emergency or non-emergency request and the time period a decision is needed given the applicant's medical condition. Code of Regulations, 8 CCR section 9792.9(k) (Emergency Regulation December 2004) requires that notice be given to applicant and applicant's counsel but does not require information regarding the hour when the decision was made. Labor Code section 4610(f)(5) currently provides that the utilization review process of the employer shall be given at no charge upon request.

This Resolution: Would require the requesting physician to serve a copy of the request for approval of treatment to the applicant and applicant's counsel when the request is made so that the applicant and applicant's counsel may determine whether or not the responding party replied in a timely manner.

The Problem: The applicant is injured and is in pain and medical treatment is delayed pending approval of medical treatment. If neither applicant nor applicant's counsel have notice of the date of the request, and of whether the request is an emergency or non-emergency request, they have no basis to know that the response is timely, until the response is served. If the approving party takes weeks to respond, applicant or applicant's counsel do not know medical treatment is being delayed. Further, without knowing the exact time of the decision, applicant's counsel has no way of knowing whether the responding party has complied with Labor Code section 4610(g)(3)(A). The need to request the utilization review process of the employer under Labor Code section 4610(f)(5) causes unnecessary delay in getting approval of medical treatment.

#### IMPACT STATEMENT

This proposed resolution would affect 8 CCR sections 9792.6(k), 9792.9(b)(3), 9792.9(f)(2), 9792.9(f)(3), and 9792.9(i) (Emergency Regulation December 2004). Emergency Regulation December 2004 may be found at [http://www.dir.ca.gov/dwc/DWCPropReqs/UR\\_approvedRegulations.pdf](http://www.dir.ca.gov/dwc/DWCPropReqs/UR_approvedRegulations.pdf) The manner in which the regulations would be affected is that the regulations in no way address the issue raised in the resolution and, accordingly, would need to be amended to incorporate the additional service requirements.

AUTHOR AND/OR PERMANENT CONTACT: David Biggs, 4300 Long Beach Boulevard, Suite 310, Long Beach, CA 90807, voice 562-422-0062 x24, fax 562-422-0074, e-mail david\_w\_biggs@hotmail.com

RESPONSIBLE FLOOR DELEGATE: Gerald C. Benezra

## **COUNTERARGUMENT**

### **SAN DIEGO COUNTY BAR ASSOCIATION**

According to Labor Code section 4610(f)(5), employees are already entitled to a copy of the UR process free of charge if the physician=s request for medical treatment services is under review. Therefore, the amendments to 4610(f)(5) are unnecessary. Amended sections 4610(i)(7) and 4610(j) would require service by the same mode (fax, email, or mail) to the requesting physician, applicant, and applicant=s counsel. But not all of those individuals may prefer or even have access to the same modes of communication. The last sentence of amended 4610(j) is redundant, as the prior language already requires service of the decision upon the parties.