§ 4610. Employers to establish utilization review process; Criteria; Administrative penalties

(a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, ~~delay,~~ 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, 2017, emergency treatment services and medical treatment rendered for an accepted body part or condition by a physician or provider in a medical provider network or health care organization, or by a physician predesignated pursuant to Section 4600, within the 30 days following the initial date of injury shall be authorized without prospective utilization review, except as provided in subsection (c) below. For treatment rendered by a medical provider network physician, health care organization physician, or predesignated physician, the report required under Section 6409 shall be submitted by the physician within five days following the employee's initial visit and evaluation.

(c) Unless subject to a prior authorization by the claims administrator, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a physician or provider in a medical provider network or health care organization, or through a predesignated physician within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1) Services provided for a condition or occupational injury or illness that is not addressed in the medical treatment utilization schedule guidelines adopted pursuant to Section 5307.27.

(2) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.

(3) Inpatient and outpatient surgery, including all necessary pre- and post-surgical services.

(4) Psychological treatment services.

(5) Home health care services.

(6) Imaging and radiology services, excluding x-rays.

(7) All medically-indicated Durable Medical Equipment exceeding $250 in total amount in value.

(8) Electrodiagnostic medicine, including but not limited to electromyography and nerve conduction studies.

(9) Any service designated and defined through rules adopted by the administrative director.

(d) Any request for payment for treatment provided under subdivision (b) of the section shall comply with section 4603.2 and be submitted to the employer, or its insurer or claims administrator within 30 days of the date when the service was provided.

(e) If a physician fails to submit the Section 6409 report pursuant to 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) of this section solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(1) If it is found after retrospective 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 or the physician or provider in a 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 review and the requirement for prospective utilization review for all subsequent medical treatment.

(2) The results of retrospective 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.

~~(b)~~ (g) Every 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)~~ (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. The policies and procedures shall include an internal second review process which is optional for employees following a denial or modification of a treatment request based on medical necessity, and mandatory for all denials due to incomplete or insufficient information under subdivisions (i) and (j), as prescribed under rules adopted by the administrative director. ~~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)~~ (2) ~~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, delay, or deny requests for authorization, the employer 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 Section 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, ~~delays,~~ 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)~~ (3) 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 or due to incomplete or insufficient information under subdivisions (i) and (j).

(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 every three years thereafter, or more frequently if deemed necessary by the administrative director, 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, 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. The administrative director may adopt rules to require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(5) 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, physicians, and made available to the public.

~~(f)~~ (h) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, ~~delay,~~ 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, ~~delay,~~ 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. No charge

shall be required for an employee whose physician's request for medical treatment services is under review.

~~(g)~~ (*i*) In determining whether to approve, modify, ~~delay,~~ 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 a request for authorization for medical treatment and supporting ~~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. 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 receipt of 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)~~ (3) When the employee's condition is such that 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, delay, 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)~~ (4) (A) (i) Final d~~D~~ecisions to approve, modify, ~~delay,~~ 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 by telephone, secure email, or facsimile within 24 hours of the decision.

(ii) No final decision to modify, delay or deny a request for treatment shall be issued without notifying the requesting physician by secure email of the preliminary decision and providing an opportunity for the physician to respond, as set forth in rules adopted by the administrative director.

(B) Decisions resulting in modification~~, delay,~~ 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 subdivision (*i*)(4)(A) was by telephone, ~~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 modified or denied ~~not approved in full~~, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

~~(B)~~ (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. Any 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 such a way as to minimize 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. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

~~(4)~~ (5) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify~~, delay,~~ 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 ~~or delay~~ a medical service is due to incomplete or insufficient information, the decision shall specify all of the following: the reason for the decision~~, and specify~~ a specific description of the information that is needed, the date(s) and time(s) of attempts made to contact the physician to obtain the necessary information, the name of the person making the request for the additional information, the name of the individual to whom the request for information was communicated if not made directly to the physician, and a description of the manner in which the request was communicated.

~~(5)~~ (j)(1) 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, ~~delay,~~ or deny requests for authorization, the employer 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 subdivision (*i*) ~~paragraph~~ (1), ~~or~~ (2), or (3) 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, ~~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 that must be provided by the physician for a determination to be made, ~~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 subdivision (*i*)~~paragraph~~ (1) ~~or~~ (2), or (3).

~~(6)~~ (k) A utilization review decision to modify~~, delay~~, 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 any 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.

~~(7)~~ (*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.

(~~8~~) (m) If utilization review is deferred pursuant to ~~paragraph (7)~~ 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 (1)~~ subdivision (*i*)(2) 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~~) (n) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services. Every physician requesting treatment shall maintain secure email access to communicate with an employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, regarding treatment requests and utilization review decisions.

(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 section, "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.

~~(i)~~ (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.

§4610.5. Review of Utilization Review Decision.

(a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(3) Any dispute occurring on or after January 1, 2018 over medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) "Disputed medical treatment" means medical treatment that has been modified~~, delayed,~~ or denied by a utilization review decision on the basis of medical necessity.

(2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27:~~in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:~~

(A) The guidelines, including the drug formuary, adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify~~, delay,~~ or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402. "Utilization review decision" may also mean a determination, occurring on or after January 1, 2018, by a physician

regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27

(4) Unless otherwise indicated by context, "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.

(d) (1) Except as provided in subdivision (h), if either the employee or the employee's physician disputes the utilization review decision, they may request a second review from the employer within 10 calendar days after service of the written communication issued under Section 4610(e)(4)(B) advising of the decision. The request for a second review shall be submitted to the employer in the manner set forth in the employer's utilization review policies and procedures approved by the administrative director under Section 4610(c)(5), and may include additional information supporting the request for authorization that was denied or modified by the utilization review decision.

(2) If a second review is requested, an employee is only entitled to seek independent medical review of the second review decision and shall not file a request for independent medical review of the initial utilization review decision. The period for requesting independent medical review shall be tolled until completion of the second review process.

(3) Within 10 calendar days of a request for second review, the employer shall respond in writing with a second review decision that either approves, modifies, or denies the request for treatment. If the employer fails to issue a timely decision under this subdivision, the treatment dispute shall go directly to independent medical review for resolution.

(4) If the employee disputes the second review decision, the employee may request an independent medical review as provided for in this section.

(5) If the employer issued a utilization review decision denying a treatment request due to incomplete or insufficient information, the matter shall be submitted for a second review, as set forth in rules adopted by the administrative director.

(e) () Except as provided in subdivision (h), if a utilization review or ~~If a utilization~~ second review decision denies~~,~~ or modifies~~, or delays~~ a treatment recommendation based on medical necessity, the employee may request an independent medical review as provided by this section.

~~(e)~~ (f) A utilization review decision, or ~~utilization~~ second review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision or second review decision unless the utilization review or ~~utilization~~ second review decision is overturned by independent medical review in accordance with this section.

~~(f)~~ (g) Except as provided in subdivision (h), as ~~As~~ part of its notification to the employee regarding ~~an initial utilization~~ an initial utilization review and a second review decision based on medical necessity

that denies~~,~~ or modifies~~, or delays~~ a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review. The employee may also request independent medical review electronically under rules adopted by the administrative director. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that ~~the~~ (i) the initial utilization review decision is final unless the employee requests a second review or independent medical review and (ii) a second review decision is final unless the employee requests independent medical review, under the process as defined by the administrative director. ~~utilization review decision is final unless the employee requests independent medical review.~~

(2) Notice that if an employee chooses to request independent medical review of an initial utilization review decision, under the process as defined by the administrative director, the employee may not seek a second review decision. If the employee seeks a second review decision, the employee may only obtain independent medical review of the second review decision.

(3~~2~~) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(4~~3~~) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

~~(g)~~ (h) On or after January 1, 2018, upon a determination by the employer that a medication prescribed by a physician pursuant to the drug formulary adopted pursuant to Section 5307.27, is not medically necessary, the employer shall immediately request independent medical review under rules adopted by the administrative director. A request under this subdivision shall include documentation of the employee's current medical condition and the medication prescribed under the formulary.

(i) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment. Notice of the authorization, or any settlement

or award that may resolve the medical treatment dispute, shall be communicated to the independent medical review organization by the employer.

~~(h)~~ (j) (1) The employee may submit a request for independent medical review to the division no later than 30 days after the service of the utilization review or ~~utilization~~ second review decision to the employee. The request may be made electronically under rules adopted by the administrative director.

(2) If at the time of a utilization review decision or second review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision ~~(f)~~ (g) at the time of notification of its ~~utilization~~ utilization review or second review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced 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, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

~~(i)~~ (k) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars ($5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

~~(j)~~ (*l*) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

~~(k)~~ (m) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for

independent medical review, a request for independent medical review shall be deferred if at the time of ~~a utilization~~ a utilization review or the second review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

~~(l)~~ (n) Except for requests for independent medical review made pursuant to subdivision (h), upon ~~Upon~~ notice from the administrative director that an independent review organization has been assigned, the employer shall electronically provide to the independent medical review organization under rules adopted by the administrative director a copy and list all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employee's current medical condition.

(B) The medical treatment being provided by the employer.

(C) The request for authorization and utilization review decision.

(D) The request for second review and the second review decision.

~~The disputed medical treatment requested by the employee.~~

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny~~,~~ or modify~~, or delay~~ the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

~~(m)~~ (o) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

~~(n)~~ (p) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision ~~(l)~~ (n) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

~~(o)~~ (p) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

(q) The claims administrator who issued the utilization review decision in dispute shall notify the independent medical review organization if there is a change in claims administrator responsible for the claim. Notice shall be given to the independent medical review organization within 5 days of the change in administrator taking effect.

§ 4610.6 Independent medical review organization to conduct review of utilization review decision; procedure upon final determination of review.

(a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) (1) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, and shall be issued:

(A) For a medical treatment dispute submitted for review under subdivision (g) of Section 4610.5, within 30 days of the receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(B) For a dispute over medication prescribed pursuant to the drug formulary submitted under subdivision (h) of Section 4610.5(h), within 10 days of the receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(C) If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.

(2) Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee' s provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not

available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars ($5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(*l*) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

§5307.3. Adoption of medical treatment utilization schedule; Inclusion of drug formulary.

(a) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases. Evidence-based updates to the utilization schedule shall be made through an order exempt from Sections 5307.3 and 5307.4, and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), allowing prior comment by the public before their effective date. All orders issued pursuant to this subdivision shall be published on the Internet Web site of the Division of Workers' Compensation.

(b) On or before July 1, 2017, the medical treatment utilization schedule adopted by the administrative director shall include a drug formulary using evidence-based medicine. Nothing in this section shall prohibit the authorization of medications that are not in the formulary when the variance is demonstrated, consistent with subdivision (a) of Section 4604.5.

(c) The drug formulary shall include a phased implementation for workers injured prior to July 1, 2017, in order to ensure injured workers safely transition to medications pursuant to the formulary.

(d) This section shall apply to all prescribers and dispensers of medications serving injured workers under the workers' compensation system. On or before December 1, 2004, the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.

§4903.05. Filing of written lien claim required; form; fee.

(a) Every lien claimant shall file its lien with the appeals board in writing upon a form approved by the appeals board. The lien shall be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service upon the injured worker or, if deceased, upon the worker's dependents, the employer, the insurer, and the respective attorneys or other agents of record. Medical records shall be filed only if they are relevant to the issues being raised by the lien.

(b) Any lien claim for expenses under subdivision (b) of Section 4903 or for claims of costs shall be filed with the appeals board electronically using the form approved by the appeals board. The lien shall be accompanied by a proof of service and any other documents that may be required by the appeals board. The service requirements for Section 4603.2 are not modified by this section.

(c) (1) Any lien claim for expenses under subdivision (b) of section 4903 that is subject to a filing fee under this section shall be accompanied at the time of filing by a declaration stating under penalty of perjury that the lien claimant:

(A) Is the employee's treating physician providing care through a medical provider network; or

(B) Is the Agreed Medical Evaluator or Qualified Medical Evaluator; or

(C) Is authorized by the employer or claims administrator to provide treatment under Labor Code section 4600; or

(D) Has made a diligent search and determined that the employer does not have a medical provider network in place; or

(E) Has documentation that medical treatment has been unreasonably delayed or refused to the employee; and

(F) The dispute is not subject to Independent Bill Review under section 4603.6.

(2) The failure to file a signed declaration under this subdivision or the filing of a false declaration shall be grounds for dismissal of the lien by operation of law.

(d) All liens filed on or after January 1, 2013, for expenses under subdivision (b) of Section 4903 or for claims of costs shall be subject to a filing fee as provided by this subdivision.

(1) The lien claimant shall pay a filing fee of one hundred fifty dollars ($150) to the Division of Workers' Compensation prior to filing a lien and shall include proof that the filing fee has been paid. The fee shall be collected through an electronic payment system that accepts major credit cards and any additional forms of electronic payment selected by the administrative director. If the administrative director contracts with a service provider for the processing of electronic payments, any processing fee shall be absorbed by the division and not added to the fee charged to the lien filer.

(2) On or after January 1, 2013, a lien submitted for filing that does not comply with paragraph (1) shall be invalid, even if lodged with the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(3) The claims of two or more providers of goods or services shall not be merged into a single lien.

(4) The filing fee shall be collected by the administrative director. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund and applied for the purposes of that fund.

(5) The administrative director shall adopt reasonable rules and regulations governing the procedure for the collection of the filing fee, including emergency regulations as necessary to implement this section.

(6) Any lien filed for goods or services that are not the proper subject of a lien may be dismissed upon request of a party by verified petition or on the appeals board's own motion. If the lien is dismissed, the lien claimant will not be entitled to reimbursement of the filing fee.

(7) No filing fee shall be required for a lien filed by a health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, a group disability insurer under a policy issued in this state pursuant to the provisions of Section 10270.5 of the Insurance Code, a self-insured employee welfare benefit plan, as defined in Section 10121 of the Insurance Code, that is issued in this state, a Taft-Hartley health and welfare fund, or a publicly funded program providing medical benefits on a nonindustrial basis.

§4615. Recovery barred by fraud.

Any physician or provider of medical treatment services under section 4600 or medical-legal services under section 4060 who has pled guilty to, pled no contest to, or has been convicted of workers' compensation fraud, medical billing fraud, insurance fraud, or Medicare or MediCal fraud, shall be barred from pursuing recovery on any medical treatment bill submitted under section 4603.2, any bill for medical-legal expenses submitted under section 4622, or lien filed under 4903.

§4615.1. Stay of liens.

Any lien filed by or on behalf of a physician or provider of medical treatment services under section 4600 or medical-legal services under section 4060, and any accrual of interest related to the lien, shall be automatically stayed upon the filing of criminal charges against that physician or provider for workers' compensation fraud, medical billing fraud, insurance fraud, or Medicare or MediCal fraud. The stay shall be in effect from the time of the filing of the charges until the disposition of the criminal proceedings. The administrative director may promulgate rules for the implementation of this section.

§4903.8. Persons to whom payment of lien to be made; assignment of lien; multiple assignments.

(a) (1) Any order or award for payment of a lien filed pursuant to subdivision (b) of Section 4903 shall be made for payment only to the person who was entitled to payment for the expenses as provided in subdivision (b) of Section 4903 at the time the expenses were incurred~~, and not to an assignee~~. The lien shall not be assigned unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee. Any assignment of a lien, in violation of this paragraph, shall be deemed invalid by operation of law.

(2) Paragraph (1) does not apply to an assignment that was completed prior to January 1, 2013, or that was required by a contract that became enforceable and irrevocable prior to January 1, 2013. This paragraph is declarative of existing law.

(b) If there has been an assignment of a lien, either as an assignment of all right, title, and interest in the accounts receivable or as an assignment for collection, a true and correct copy of the assignment shall be filed and served.

(1) If the lien is filed on or after January 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment shall be served at the time the lien is filed.

(2) If the lien is filed on or after January 1, 2013, and the assignment occurs after the filing of the lien, the copy of the assignment shall be served within 20 days of the date of the assignment.

(3) If the lien is filed before January 1, 2013, the copy of the assignment shall be served by January 1, 2014, or with the filing of a declaration of readiness or at the time of a lien hearing, whichever is earliest.

(c) If there has been more than one assignment of the same receivable or bill, the appeals board may set the matter for hearing on whether the multiple assignments constitute bad-faith actions or tactics that are frivolous, harassing, or intended to cause unnecessary delay or expense. If so found by the appeals board, appropriate sanctions, including costs and attorney's fees, may be awarded against the assignor, assignee, and their respective attorneys.

(d) At the time of filing of a lien on or after January 1, 2013, or in the case of a lien filed before January 1, 2013, at the earliest of the filing of a declaration of readiness, a lien hearing, or January 1, 2014, supporting documentation shall be filed including one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring both of the following:

(1) The services or products described in the bill for services or products were actually provided to the injured employee.

(2) The billing statement attached to the lien truly and accurately describes the services or products that were provided to the injured employee.

(e) A lien submitted for filing on or after January 1, 2013, for expenses provided in subdivision (b) of Section 4903, that does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(f) This section shall take effect without regulatory action. The appeals board and the administrative director may promulgate regulations and forms for the implementation of this section.

§5710. Deposition of witnesses.

(a) The appeals board, a workers' compensation judge, or any party to the action or proceeding, may, in any investigation or hearing before the appeals board, cause the deposition of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil actions in the superior courts of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure. To that end the attendance of witnesses and the production of records may be required. Depositions may be taken outside the state before any officer authorized to administer oaths. The appeals board or a workers' compensation judge in any proceeding before the appeals board may cause evidence to be taken in other jurisdictions before the agency authorized to hear workers' compensation matters in those other jurisdictions.

(b) If the employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits as a dependent of an injured employee, the deponent is entitled to receive in addition to all other benefits:

(1) All reasonable expenses of transportation, meals, and lodging incident to the deposition.

(2) Reimbursement for any loss of wages incurred during attendance at the deposition.

(3) One copy of the transcript of the deposition, without cost.

(4) A reasonable allowance for attorney's fees for the deponent, if represented by an attorney licensed by the State Bar of this state. The fee shall be discretionary with, and, if allowed, shall be set by, the appeals board, but shall be paid by the employer or his or her insurer. <u>The administrative director shall determine the range of reasonable fees to be paid. The range shall be based on the average hourly rate paid to attorneys who are certified specialists in the area of workers' compensation throughout the state. The administrative director shall update the range of fees no less than biennially.</u>

(5) If interpretation services are required because the injured employee or deponent does not proficiently speak or understand the English language, upon a request from either, the employer shall pay for the services of a language interpreter certified or deemed certified pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code. The fee to be paid by the employer shall be in accordance with the fee schedule adopted by the administrative director and shall include any other deposition-related events as permitted by the administrative director.

§ 6409. Reports of injury or illness

(a) ~~Every~~ The first physician as defined in Section 3209.3 who attends any injured employee shall file a complete report of ~~every~~ that occupational injury or occupational illness in a manner prescribed by the administrative director of the Division of Workers' Compensation. The report shall include a diagnosis, the injured employee's description of how the injury or illness occurred, any treatment rendered at the time of the examination, any work restrictions resulting from the injury or illness, a treatment plan, and other content as prescribed by the administrative director. The form shall be filed electronically ~~to the employee~~ with the Division of Workers' Compensation and the employer, or if insured, with the employer's insurer, ~~on forms prescribed for that purpose by the Department of Industrial Relations. A portion of the form shall be completed by the injured employee, if he or she is able to do so, describing how the injury or illness occurred. The form shall be filed~~ within five days of the initial examination. ~~Inability or failure of an injured employee to complete his or her portion of the form shall not affect the employee's rights under this code, and shall not excuse any delay in filing the form. The employer or insurer, as the case may be, shall file the physician's report with the department within five days of receipt. Each report of occupational injury or occupational illness shall indicate the social security number of the injured employee.~~ If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall also, ~~file a complete report, which need not include the affidavit required pursuant to this section, with the department, and~~ within 24 hours of the initial examination, file a complete report with the local health officer by facsimile transmission or other means. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall not be compensated for the initial diagnosis and treatment unless the report is filed with the Division of Workers' Compensation, the employer, or if insured, with the employer's insurer, and includes or is accompanied by a signed affidavit which certifies that a copy of the report was filed with the local health officer pursuant to this section.

(b) As used in this section, "occupational illness" means any abnormal condition or disorder caused by exposure to environmental factors associated with employment, including acute and chronic illnesses or diseases which may be caused by inhalation, absorption, ingestion, or direct contact.