MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
October 13, 2016

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1244	Gray	Worker's Compensation: Providers	Chaptered, #852	Reco: Support	8/19/16
AB 2024	Wood	Critical Access Hospitals: Employment	Chaptered, #496	Neutral	8/15/16
AB 2744	Gordon	Healing Arts: Referrals	Chaptered, #360	Neutral	8/8/16
AB 2745	Holden	Healing Arts: Licensing and Certification	Chaptered, #303	Sponsor/Support	4/25/16
SB 482	Lara	Controlled Substances: CURES Database	Chaptered, #708	Support	8/19/16
SB 1160	Mendoza	Workers' Compensation	Chaptered, #868	Supported provisions contained in SB 563 (Pan) that are now in this bill.	8/29/16
SB 1174	McGuire	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications	Chaptered, #840	Support if Amended	8/19/16
SB 1177	Galgiani	Physician and Suregon Health and Wellness Program	Chaptered, #591	Support	8/18/16
SB 1189	Pan & Jackson	Postmortem Examinations or Autopsies	Chaptered, #787	Support	8/19/16
SB 1261	Stone	Physicians and Surgeons: Licensure Exemption	Chaptered, #239	Neutral	5/3/16
SB 1478	Sen. B&P	Health Omnibus	Chaptered, #489	Sponsor/Support MBC Provisions	8/18/16

Pink – Sponsored Bills, Green – Chaptered

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1244
Author: Gray
Chapter: 852
Bill Date: August 19, 2016, Amended
Subject: Workers' Compensation
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill specifies the circumstances in which a medical provider must be suspended from participating in the workers' compensation system. This bill also ensures that the appropriate licensing board is notified of the suspension and provides for communication between various state agencies, among other provisions.

BACKGROUND

The workers' compensation system in California provides benefits to an employee who suffers from an injury or illness that arises out of, and in the course of employment, irrespective of fault. This system requires all employers to secure payment of benefits by either securing the consent of the Department of Industrial Relations to self-insure or by securing insurance against liability from an insurance company authorized by the state. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to utilization review (UR). UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

Existing law requires the director of the Department of Health Care Services (DHCS) to suspend any or all payments to a medical service provider if there is a credible allegation of fraud against the Medi-Cal system or if a provider has been convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of medical services.

ANALYSIS

This bill requires the administrative director (AD) of the Division of Workers'

Compensation (DWC) to suspend medical service providers from participating in any capacity in the workers' compensation system if the provider:

- Is convicted of a felony or misdemeanor and that crime comes within any of the following descriptions:
    - Involves fraud or abuse of the Medi-Cal program, Medicare program, workers' compensation system, or fraud or abuse of any patient;
    - Relates to the conduct of the individual's medical practice as it pertains to patient care;
    - Is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system; and
    - Is substantially related to the qualifications, functions, or duties of a provider of services.
- Is suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.
- License, certificate, or approval to provide health care has been surrendered or revoked.

This bill would require the AD to provide written notice to the medical provider who has been identified as eligible for suspension. This bill would require the DWC to hold a hearing on the suspension of a medical provider within 30 days of a request. Such a request would stay any suspension of a medical provider. If, during the hearing, the AD finds that the medical provider is eligible for suspension due to the reasons listed above, the AD must suspend the medical provider immediately. Upon suspension, the AD must notify the relevant licensing, certification, or registration board, including the Medical Board. This bill would also require the director of DHCS to notify the AD of the DWC if a medical provider is added to the Suspended or Ineligible Provider List (this notification from DHCS is already required to be provided to the Medical Board).

This bill seeks to combat workers' compensation fraud by changing the incentives facing medical providers in the California workers' compensation system. Specifically, this bill would create a suspension process for medical providers who commit serious crimes or are involved in fraudulent activity that is modeled after the suspension process for Medi-Cal, including requiring notification to the appropriate licensing board. This bill will ensure that the Medical Board is notified when a physician is suspended by the DWC, which will help to ensure consumer protection. This bill also provides for communication between the DWC and DHCS, which will also help to protect consumers. For these reasons, the Board took a support position on this bill.

FISCAL: None to the Board

SUPPORT: American Insurance Association; Association of California Insurance Companies; California Association of Highway Patrolmen; California Chamber of Commerce; California Coalition on Workers' Compensation; California Conference Board of the Amalgamated Transit Union; California Conference of Machinists; California Labor Federation; California Professional Firefighters; California State

Association of Counties; California Teamsters Public Affairs Council; Engineers & Scientists of CA, IFPTE Local 20, AFL-CIO; International Longshore & Warehouse Union; Los Angeles County Professional Peace Officers Association; Medical Board of California; Organization of SMUD Employees; Professional & Technical Engineers, IFPTE Local 21, AFL-CIO; San Luis Obispo County Employees Association; Service Employees International Union; State Building and Construction Trades Council; UNITE-HERE, AFL-CIO; and Utility Workers Union of America, AFL-CIO

OPPOSITION: California Neurological Society
California Society for Industrial Medicine and Surgery
California Society of Physical Medicine and Rehabilitation

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Reach out to the AD of the DWC to establish a process for the Board to receive suspension information from the DWC

Assembly Bill No. 1244

CHAPTER 852

An act to amend Section 4906 of, and to add Section 139.21 to, the Labor Code, and to amend Section 14123 of the Welfare and Institutions Code, relating to workers' compensation.

[Approved by Governor September 30, 2016. Filed with Secretary of State September 30, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1244, Gray. Workers' compensation.

Under existing law, the Director of Health Care Services is authorized, for purposes of administering the Medi-Cal program, to suspend a provider of service from further participation under the program for specified reasons, including conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Existing law requires the director, upon receipt of written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid programs, to promptly suspend the practitioner from participation in the Medi-Cal program.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury.

Existing law authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for the provision of medical treatment to injured employees and requires the administrative director to contract with individual physicians or an independent medical review organization to perform medical provider network independent medical reviews.

This bill would require the administrative director to promptly suspend any physician, practitioner, or provider from participating in the workers' compensation system if as a physician, practitioner, or provider the individual or entity meets specified criteria, including if that individual has been convicted of any felony or misdemeanor involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, if that individual's license, certificate, or approval to provide health care has been surrendered or revoked, or if that individual or entity has been

suspended, due to fraud or abuse, from participation in the Medicare or Medicaid programs. The bill would require the administrative director to adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system pursuant to these provisions, as specified, and would require the administrative director to furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request that hearing. The bill would also require the administrative director to promptly notify the appropriate state licensing, certifying, or registering authority of a physician's, practitioner's, or provider's suspension and to update the division's databases of qualified medical evaluators and medical provider networks. The bill would require the administrative director to notify the chief judge of the division of a suspension under these provisions, as specified, and post a notice on the department's Internet Web site. The bill would enact special lien proceedings for the adjudication of any liens of a physician, practitioner, or provider who has been suspended pursuant to these provisions because he or she has been convicted of a felony or misdemeanor that meets specified criteria.

The bill would also require the Director of Health Care Services to notify the administrative director of a suspension of a physician from participation in the Medi-Cal program imposed pursuant to the provisions described above authorizing the director to suspend a provider of service from participation.

Existing law establishes the Workers' Compensation Appeals Board to exercise all judicial powers vested in it, as specified, including workers' compensation proceedings for the recovery of compensation, or concerning any right or liability arising out of or incidental to the recovery of compensation. Existing law vests the appeals board with full power, authority, and jurisdiction to try and determine finally those matters, subject only to the review by the courts, as specified. Existing law authorizes the appeals board to determine, and allow as liens against any sum to be paid as compensation, as specified, a reasonable attorney's fee for legal services and disbursements in connection with those legal services. Existing law provides that a charge, claim, or agreement for those legal services or disbursements is not enforceable, valid, or binding in excess of a reasonable amount.

Existing law also requires an attorney to furnish to the employee a written disclosure form describing the procedures available to the injured employee or his or her dependents and specified information regarding attorney's fees. Existing law requires that a copy of the disclosure form be signed by the employee and the attorney and sent to the employer, or insurer or 3rd-party administrator, if either is known, by the attorney within 15 days of the employee's and attorney's execution of the form. Existing law also requires the employee, the insurer, the employer, and the attorneys for each party to sign and file with the board a statement, signed under penalty of perjury, attesting that the signatories have not violated specified laws prohibiting conflicts of interest.

Existing law authorizes the appeals board, a workers' compensation judge, or any party to the action or proceeding, as specified, to cause the deposition of witnesses in any investigation or hearing before the appeals board, and provides that the deponent is entitled to receive specified benefits, such as reasonable expenses of transportation, meals, and lodging, as specified.

This bill would prohibit payment for legal services or disbursements in connection with those legal services, or expenses relating to the deposition of witnesses, incurred under the provisions described above, as specified, prior to the filing of the disclosure form with the appeals board and the sending of that form to the employer, or to the insurer or 3rd-party administrator, if either is known, by the attorney. The bill would require the disclosure form described above to contain a paragraph setting forth the exact location of the district office of the appeals board at which the employee's case will be filed and to include a specified statement. The bill would impose other requirements regarding the signing and content of the form, including that the form be signed under penalty of perjury by the attorney representing the employee, and would require the form to be filed with the appeals board.

The bill would also require an attorney who subsequently assumes the representation of the employee in the same action or proceeding to complete and sign under penalty of perjury a disclosure form that meets the above-described requirements and the statement attesting that the signatories have not violated specified laws prohibiting conflicts of interest. The bill would require the attorney to file the form and statement with the appeals board, and send them to the employer, or insurer or 3rd-party administrator, if either is known, within 15 days of the employee's and attorney's execution of the form and statement.

By expanding the scope of the crime of perjury under these provisions, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 139.21 is added to the Labor Code, immediately following Section 139.2, to read:

139.21. (a) (1) The administrative director shall promptly suspend, pursuant to subdivision (b), any physician, practitioner, or provider from participating in the workers' compensation system as a physician, practitioner, or provider if the individual or entity meets any of the following criteria:

(A) The individual has been convicted of any felony or misdemeanor and that crime comes within any of the following descriptions:

(i) It involves fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient.

(ii) It relates to the conduct of the individual's medical practice as it pertains to patient care.

(iii) It is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system.

(iv) It is otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(B) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.

(C) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(2) The administrative director shall exercise due diligence to identify physicians, practitioners, or providers who have been suspended as described in subdivision (a) by accessing the quarterly updates to the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

(b) (1) The administrative director shall adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the administrative director is required to suspend the physician, practitioner, or provider pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the physician, practitioner, or provider requests a hearing and, in that hearing, the physician, practitioner, or provider provides proof that paragraph (1) of subdivision (a) is not applicable. The physician, practitioner, or provider may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the administrative director finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician, practitioner, or provider.

(3) The administrative director shall have power and jurisdiction to do all things necessary or convenient to conduct the hearings provided for in paragraph (2). The hearings and investigations may be conducted by any designated hearing officer appointed by the administrative director. Any authorized person conducting that hearing or investigation may administer oaths, subpoena and require the attendance of witnesses and the production of books or papers, and cause the depositions of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil cases in the superior court of this state under Title 4

(commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure.

(c) The administrative director shall promptly notify the physician's, practitioner's, or provider's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the division's qualified medical evaluator and medical provider network databases, as appropriate.

(d) Upon suspension of a physician, practitioner, or provider pursuant to this section, the administrative director shall give notice of the suspension to the chief judge of the division, and the chief judge shall promptly thereafter provide written notification of the suspension to district offices and all workers' compensation judges. The method of notification to all district offices and to all workers' compensation judges shall be in a manner determined by the chief judge in his or her discretion. The administrative director shall also post notification of the suspension on the department's Internet Web site.

(e) The following procedures shall apply for the adjudication of any liens of a physician, practitioner, or provider suspended pursuant to subparagraph (A) of paragraph (1) of subdivision (a), including any liens filed by or on behalf of the physician, practitioner, or provider or any clinic, group or corporation in which the suspended physician, practitioner, or provider has an ownership interest.

(1) If the disposition of the criminal proceeding provides for or requires, whether by plea agreement or by judgment, dismissal of liens and forfeiture of sums claimed therein, as specified in the criminal disposition, all of those liens shall be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding, and orders notifying of those dismissals may and shall be entered by workers' compensation judges.

(2) If the disposition of the criminal proceeding fails to specify the disposition to be made of lien filings in the workers' compensation system as set forth in paragraph (1), all liens pending in any workers' compensation case in any district office within the state shall be consolidated and adjudicated in a special lien proceeding as described in subdivisions (f) to (i), inclusive.

(f) After notice of suspension, pursuant to subdivision (d), and if subdivision (e) applies, the administrative director shall appoint a special lien proceeding attorney, who shall be an attorney employed by the division or by the department. The special lien proceeding attorney shall, based on the information that is available, identify liens subject to disposition pursuant to subdivision (e), and workers' compensation cases in which those liens are pending, and shall notify the chief judge regarding those liens. Based on this information, the chief judge shall identify a district office for a consolidated special lien proceeding to adjudicate those liens, and shall appoint a workers' compensation judge to preside over that proceeding.

(g) It shall be a presumption affecting the burden of proof that all liens to be adjudicated in the special lien proceeding, and all underlying bills for

service and claims for compensation asserted therein, arise from the conduct subjecting the physician, practitioner, or provider to suspension, and that payment is not due and should not be made on those liens because they arise from, or are connected to, criminal, fraudulent, or abusive conduct or activity. A lien claimant shall not have the right to payment unless he or she rebuts that presumption by a preponderance of the evidence.

(h) The special lien proceedings shall be governed by the same laws, regulations, and procedures that govern all other matters before the appeals board. The administrative director shall promulgate regulations for the implementation of this section.

(i) If it is determined in a special lien proceeding that a lien does not arise from the conduct subjecting a physician, practitioner, or provider to suspension, the workers' compensation judge shall have the discretion to adjudicate the lien or transfer the lien back to the district office having venue over the case in which the lien was filed.

(j) At any time following suspension, a physician, practitioner, or provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice, which shall constitute a final disposition of the claim for compensation asserted therein.

(k) The provisions of this section shall not affect, amend, alter, or in any way apply to the provisions of Section 139.2.

SEC. 2. Section 4906 of the Labor Code is amended to read:

4906. (a) A charge, claim, or agreement for the legal services or disbursements mentioned in subdivision (a) of Section 4903, or for the expense mentioned in subdivision (b) of Section 4903, is not enforceable, valid, or binding in excess of a reasonable amount. The appeals board may determine what constitutes a reasonable amount, but payment pursuant to subdivision (a) of Section 4903 or Section 5710 shall not be allowed for any services or expenses incurred prior to the filing of the disclosure form described in subdivision (e) with the appeals board and the sending of that form to the employer, or to the insurer or third-party administrator, if either is known, by the attorney.

(b) An attorney or agent shall not demand or accept any fee from an employee or dependent of an employee for the purpose of representing the employee or dependent of an employee in any proceeding of the division, appeals board, or any appellate procedure related thereto until the amount of the fee has been approved or set by the appeals board.

(c) Any fee agreement shall be submitted to the appeals board for approval within 10 days after the agreement is made.

(d) In establishing a reasonable attorney's fee, consideration shall be given to the responsibility assumed by the attorney, the care exercised in representing the applicant, the time involved, and the results obtained.

(e) At the initial consultation, an attorney shall furnish the employee a written disclosure form promulgated by the administrative director which shall clearly and prominently describe the procedures available to the injured employee or his or her dependents. The disclosure form shall describe this section, the range of attorney's fees customarily approved by the appeals

board, and the attorney's fees provisions of Section 4064 and the extent to which an employee may receive compensation without incurring attorney's fees. The disclosure form shall include the telephone number of the administrative director together with the statement that the employee may receive answers at that number to questions concerning entitlement to compensation or the procedures to follow to receive compensation. A copy of the disclosure form shall be signed by the employee and the attorney and filed with the appeals board and sent to the employer, or insurer or third-party administrator, if either is known, by the attorney within 15 days of the employee's and attorney's execution thereof.

(f) The disclosure form set forth in subdivision (e) shall contain, prominently stated, the following statement:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

(g) (1) The disclosure form described in subdivision (e) shall also contain a paragraph setting forth the exact location of the district office of the appeals board at which the employee's case will be filed. This paragraph shall also contain, prominently displayed, the following statement:

"The employee has been advised of the district office at which his or her case will be filed and that he or she may be required to attend conferences or hearings at this location at his or her own expense."

(2) The disclosure form may not be signed by the employee until he or she has been advised of the location at which his or her case will be filed, has met with or personally spoken with an attorney licensed by the State Bar of California who is regularly employed by the firm by which the employee will be represented, and has been advised of his or her rights as set forth in subdivision (e) and the provisions of paragraph (1). The name of this individual shall be clearly and legibly set forth on the disclosure form.

(3) The disclosure form shall include the actual date the disclosure form was signed by both the employee and the attorney and shall be signed under penalty of perjury by the attorney representing the employee, or an attorney licensed by the State Bar of California who is regularly employed by his or her firm. A copy of the disclosure form containing all of the required information shall be given to the employee when he or she signs the disclosure form.

(h) In addition to the disclosure form, the employee, the insurer, the employer, and the attorneys for each party shall sign under penalty of perjury and file with the board a statement, with the complete application or answer, and in addition to the disclosure required pursuant to subdivision (g), that they have not violated Section 139.3 and that they have not offered,

delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

(i) An attorney who subsequently assumes the representation of the employee in the same action or proceeding shall complete a disclosure form that meets all of the requirements of this section and the statement required by subdivision (h). Both the form and the statement shall be signed under penalty of perjury by the attorney or an attorney licensed by the State Bar of California who is regularly employed by his or her firm. Both the disclosure form and the statement shall be filed with the appeals board and sent to the employer, or insurer or third-party administrator, if either is known, by the attorney within 15 days of the employee's and attorney's execution of the form and statement. Payment pursuant to subdivision (a) of Section 4903 or Section 5710 shall not be allowed for any services or expenses incurred prior to the filing of the disclosure form described in subdivision (e) with the appeals board and the sending of that form to the employer, or to the insurer or third-party administrator, if either is known, by the attorney.

SEC. 3. Section 14123 of the Welfare and Institutions Code is amended to read:

14123. Participation in the Medi-Cal program by a provider of service is subject to suspension in order to protect the health of the recipients and the funds appropriated to carry out this chapter.

(a) (1) The director may suspend a provider of service from further participation under the Medi-Cal program for violation of any provision of this chapter or Chapter 8 (commencing with Section 14200) or any rule or regulation promulgated by the director pursuant to those chapters. The suspension may be for an indefinite or specified period of time and with or without conditions, or may be imposed with the operation of the suspension stayed or probation granted. The director shall suspend a provider of service for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.

(2) If the provider of service is a clinic, group, corporation, or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization, of a crime described in paragraph (1) shall result in the suspension of that organization and the individual convicted if the director believes that suspension would be in the best interest of the Medi-Cal program. If the provider of service is a political subdivision of the state or other government agency, the conviction of the person in charge of the facility of a crime described in paragraph (1) may result in the suspension of that facility. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of the fact that the conviction occurred. A plea or verdict of guilty, or a conviction following

a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(3) After conviction, but before the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, the director, if he or she believes that suspension would be in the best interests of the Medi-Cal program, may order the suspension of a provider of service. When the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence irrespective of any subsequent order under Section 1203.4 of the Penal Code allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment, the director shall order the suspension of a provider of service. The suspension shall not take effect earlier than the date of the director's order. Suspension following a conviction is not subject to the proceedings required in subdivision (c). However, the director may grant an informal hearing at the request of the provider of service to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension provided for in this subdivision.

(4) If the provider of service appeals the conviction and the conviction is reversed, the provider may apply for reinstatement to the Medi-Cal program after the conviction is reversed. Notwithstanding Section 14124.6, the application for reinstatement shall not be subject to the one-year waiting period for the filing of a reinstatement petition pursuant to Section 11522 of the Government Code.

(b) Whenever the director receives written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid programs, the director shall promptly suspend the practitioner from participation in the Medi-Cal program and notify the Administrative Director of the Division of Workers' Compensation of the suspension, in accordance with paragraph (2) of subdivision (e). This automatic suspension is not subject to the proceedings required in subdivision (c). No payment from state or federal funds may be made for any item or service rendered by the practitioner during the period of suspension.

(c) The proceedings for suspension shall be conducted pursuant to Section 100171 of the Health and Safety Code. The director may temporarily suspend any provider of service prior to any hearing when in his or her opinion that action is necessary to protect the public welfare or the interests of the Medi-Cal program. The director shall notify the provider of service of the temporary suspension and the effective date thereof and at the same time serve the provider with an accusation. The accusation and all proceedings thereafter shall be in accordance with Section 100171 of the Health and Safety Code. Upon receipt of a notice of defense by the provider, the director shall set the matter for hearing within 30 days after receipt of the notice. The temporary suspension shall remain in effect until such time as the

hearing is completed and the director has made a final determination on the merits. The temporary suspension shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. This subdivision does not apply where the suspension of a provider is based upon the conviction of any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare program. In those instances, suspension shall be automatic.

(d) (1) The suspension by the director of any provider of service shall preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies the provider has provided under the program, except for services or supplies provided prior to the suspension. No clinic, group, corporation, or other association which is a provider of service shall submit claims for payment to the Medi-Cal program for any services or supplies provided by a person within the organization who has been suspended or revoked by the director, except for services or supplies provided prior to the suspension.

(2) If the provisions of this chapter, Chapter 8 (commencing with Section 14200), or the regulations promulgated by the director are violated by a provider of service that is a clinic, group, corporation, or other association, the director may suspend the organization and any individual person within the organization who is responsible for the violation.

(e) (1) Notice of the suspension shall be sent by the director to the provider's state licensing, certifying, or registering authority, along with the evidence upon which the suspension was based.

(2) At the same time notice is provided pursuant to paragraph (1), the director shall provide written notification of the suspension to the Administrative Director of the Division of Workers' Compensation, for purposes of Section 139.21 of the Labor Code.

(f) In addition to the bases for suspension contained in subdivisions (a) and (b), the director may suspend a provider of service from further participation under the Medi-Cal dental program for the provision of services that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. The suspension shall be subject to the requirements contained in subdivisions (a) to (e), inclusive.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2024
Author: Wood
Chapter: 496
Bill Date: August 15, 2016, Amended
Subject: Critical Access Hospitals: Employment
Sponsor: Author
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes, until January 1, 2024, a federally certified critical access hospital (CAH) to employ physicians and charge for professional services. A CAH can only employ physicians if the medical staff concurs by an affirmative vote that employing physicians is in the best interest of the communities served by the CAH and if the CAH does not interfere with, control or otherwise direct the professional judgement of a physician. This bill requires the Office of Statewide Health Planning and Development (OSHPD), on or before July 1, 2023, to provide a report to the Legislature regarding the impact of CAH's employing physicians and their ability to recruit and retain physicians between January 1, 2017 and January 1, 2023, inclusive. This bill requires the CAHs to also submit reports to OSHPD on an annual basis.

BACKGROUND:

Current law (commonly referred to as the "ban on the corporate practice of medicine" – Business and Professions Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

Most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, and certain non-profit organizations. California is one of only a few states that prohibits the employment of physicians by hospitals.

SB 376 (Chesbro, Chapter 411, Statutes of 2003) directed the Board to establish a pilot program to provide for the direct employment of physicians by qualified district hospitals. The bill was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire, and employ physicians as full-time, paid staff in rural or underserved communities meeting specified criteria. The goal of the legislation was to improve the ability of district hospitals to attract physicians. However, participation in the pilot was very limited, with only five participating hospitals and six participating physicians, and the Board was

hindered in making a full evaluation due to lack of participation. The pilot expired on January 1, 2011.

ANALYSIS

This bill establishes a pilot program for federally certified CAHs to employ physicians and would require OSHPD to provide a report to the Legislature containing data about the impact of CAH's employing physicians and their ability to recruit and retain physicians between January 1, 2017, and January 1, 2023, inclusive. The report would be due on or before July 1, 2023, and the pilot program would end on January 1, 2024. This bill would also require CAHs that are employing physicians to submit to OSHPD on an annual basis. The report must include data elements that are required by OSHPD and be submitted to OSHPD in the format they require. This bill would specify that the CAH shall not interfere with, control, or otherwise direct the professional judgment of a physician in a manner prohibited by the ban on the corporate practice of medicine.

The author states that he is sympathetic to the concerns about interference with the clinical judgment of any health care provider. There are a number of exceptions to the ban on the corporate practice of medicine currently allowed. The 26 CAHs are in rural communities that have difficulty recruiting and retaining physicians. Allowing these CAHs to employ physicians will help to provide economic security adequate to recruit physicians who will have to relocate to these rural communities where CAHs are located.

The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine. That being said, CAHs are in remote, rural areas and this bill would help these hospitals to recruit and retain physicians, which will improve access to care in these rural communities. In addition, this bill is a pilot program that will be evaluated and the bill makes it clear that the CAH must not interfere with, control or otherwise direct the professional judgement of a physician. The Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: Adventist Health; Alliance of Catholic Health Care; Association of California Healthcare Districts; Banner Lassen Medical Center; California Hospital Association; California Special Districts Association; Catalina Island Medical Center; Eastern Plumas Health Care; Fairchild Medical Center; Glenn Medical Center; Health Access California; Jerold Phelps Community Hospital; Kern Valley Healthcare District; Loma Linda University Health; Mayers Memorial Hospital District; Mendocino Coast District Hospital; Modoc Medical Center; Northern Inyo Healthcare District; Rural County Representatives of California; San Bernardino Mountains Community Hospital; Santa Ynez Valley Cottage Hospital; Sutter Lakeside Hospital; Tehachapi Valley Healthcare District; and

Trinity Hospital

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website

Assembly Bill No. 2024

CHAPTER 496

An act to amend Section 2401 of the Business and Professions Code, relating to healing arts.

[Approved by Governor September 23, 2016. Filed with Secretary of State September 23, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2024, Wood. Critical access hospitals: employment.

Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons or doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. Existing law establishes the Office of Statewide Health Planning and Development, which succeeds to and is vested with all the duties, powers, responsibilities, and jurisdiction of the State Department of Public Health relating to health planning and research development.

This bill, until January 1, 2024, would also authorize a federally certified critical access hospital to employ those medical professionals and charge for professional services rendered by those medical professionals if the medical staff concur by an affirmative vote that the professional's employment is in the best interest of the communities served by the hospital and the hospital does not direct or interfere with the professional judgment of a physician and surgeon, as specified. The bill would require the office, on or before July 1, 2023, to provide a report to the Legislature containing data on the impact of this authorization on federally certified critical access hospitals and their ability to recruit and retain physicians and surgeons, as specified. The bill would, on and after July 1, 2017, and until July 1, 2023, require a federally critical access hospital employing those medical professionals under this authorization to submit a report, on or before July 1 of each year, to the office as specified.

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

SECTION 1. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to

teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(e) (1) Notwithstanding Section 2400, until January 1, 2024, a federally certified critical access hospital may employ licensees and charge for professional services rendered by those licensees to patients, provided both of the following conditions are met:

(A) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(B) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(2) (A) On or before July 1, 2023, the Office of Statewide Health Planning and Development shall provide a report to the Legislature containing data about the impact of paragraph (1) on federally certified critical access hospitals and their ability to recruit and retain physicians and

surgeons between January 1, 2017, and January 1, 2023, inclusive. This report shall be submitted in compliance with Section 9795 of the Government Code. The requirement for submitting a report imposed under this subparagraph is inoperative on July 1, 2027.

(B) The office shall determine the format of the report, as well as the methods and data elements to be utilized in the development of the report.

(C) On and after July 1, 2017, a federally certified critical access hospital that is employing licensees and charging for professional services rendered by those licensees to patients under this section shall submit to the office, on or before July 1 of each year, a report for any year in which that hospital has employed or is employing licensees and charging for professional services rendered by those licensees to patients. The report shall include data elements as required by the office and shall be submitted in a format as required by the office. The requirement for submitting reports imposed under this subparagraph shall be inoperative on July 1, 2023.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2744
Author: Gordon
Chapter: 360
Bill Date: August 8, 2016, Amended
Subject: Healing Arts: Referrals
Sponsor: The Internet Association
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the payment or receipt of consideration for advertising, where a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients that is prohibited in existing law.

BACKGROUND

Existing law, Business and Professions Code Section 650, prohibits the offer of a commission as compensation for referring a patient. Existing law does allow payment for services other than the referral of a patient. This statute is several decades old, and was put into place before online advertising became available. In the past, if a physician wanted to advertise for his or her services, they could take out an advertisement in the yellow pages, a newspaper, a billboard, or run a commercial on radio or television. In these instances, the advertisement could include a coupon or special offer.

Now, physicians and other health care professionals can advertise online and offer purchase vouchers for service in online market places such as Groupon, Living Social, and others. For online voucher advertising companies, the health care professional decides whether to advertise and what service to make available for purchase (which is not an essential health benefit), the cost of the service, how many vouchers to offer, and for how long. The health care professional pays the online advertising network for making the offer available, generally a percentage of the price of the purchased service. Once a consumer purchases a voucher through this form of online advertising, the consumer contacts the health care professional to set an appointment, just as they would if responding to any other form of advertisement.

Per a 1994 Attorney General Opinion, a referral exists when a third party independent entity who individually has contact with a person in need of health care selects a professional to render the same. Online marketplaces do not select a health care professional, but rather make the advertisements and vouchers available on its website.

Currently, the Attorney General's Opinion Unit is in the process of researching and drafting a formal opinion on the question of whether a health care professional may offer

online discounts for their services through a third-party internet marketer. The opinion request, 13-1203, is currently pending completion in the AG's office. At this time, the completion date is unknown.

ANALYSIS

This bill would expressly provide that payment or receipt of consideration for advertising, where a licensee offers or sells services through a third-party advertiser, does not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. This bill would specify that the fee paid to the third-party advertiser must be commensurate with the service provided by the third-party advertiser. This bill would require the purchaser to receive a refund of the full purchase price, as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee, if the licensee determines, after consultation with the purchaser of the service, that the service is not appropriate for the purchaser. It must be disclosed in the advertisement that this consultation is required and the purchaser will receive a refund if not eligible to receive the service. This bill would specify that it does not apply to basic health care services or essential health benefits, as specified. This bill would require the entity that provides the advertising to demonstrate that the licensee consented in writing to the requirements of this bill. This bill would require a third-party advertiser to make advertisements available to prospective purchasers for all services of licensees in the applicable geographic region.

Board staff has already looked at the issue of Internet advertising for physicians with companies like Groupon and Living Social, and does not believe that these arrangements are in violation of existing referral law. This bill would make it clear that this type of advertising is not in violation of existing law and would add protections for consumers to be refunded if the service is not appropriate. For these reasons, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: The Internet Association (Sponsor)
Groupon

OPPOSITION: California Medical Association
California Society of Plastic Surgeons

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website

Assembly Bill No. 2744

CHAPTER 360

An act to amend Section 650 of the Business and Professions Code, relating to the healing arts.

[Approved by Governor September 14, 2016. Filed with Secretary of State September 14, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2744, Gordon. Healing arts: referrals.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, it is unlawful for licensed healing arts practitioners, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person. Existing law makes a violation of this provision a public offense punishable upon a first conviction by imprisonment, as specified, or a fine not exceeding $50,000, or by imprisonment and that fine.

This bill would provide that the payment or receipt of consideration for advertising, wherein a licensed healing arts practitioner offers or sells services through a third-party advertiser, does not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. The bill would require that the fee paid to the third-party advertiser be commensurate with the service provided by the third-party advertiser. The bill would require the purchaser of the service to receive a refund of the full purchase price if the licensee determines, after consultation with the purchaser, that the service provided by the licensee is not appropriate for the purchaser, or if the purchaser elects not to receive the service for any reason and requests a refund, as specified. The bill would require that a licensee disclose in the advertisement that a consultation is required and that the purchaser will receive a refund if not eligible to receive the service. The bill would specify that these provisions do not apply to basic health care services or essential health benefits, as defined. The bill would also provide that the entity that provides advertising is required to be able to demonstrate that the licensee consented in writing to these provisions. The bill would require a third-party advertiser to make available to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser in the applicable geographic region and to disclose, in any advertisement offering a discount price for a service, the regular, nondiscounted price for that service.

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

SECTION 1. Section 650 of the Business and Professions Code is amended to read:

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training

services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and subsequently amended versions.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) Notwithstanding the other subdivisions of this section or any other provision of law, the payment or receipt of consideration for advertising, wherein a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. The fee paid to the third-party advertiser shall be commensurate with the service provided by the third-party advertiser. If the licensee determines, after consultation with the purchaser of the service, that the service provided by the licensee is not appropriate for the purchaser or if the purchaser elects not to receive the service for any reason and requests a refund, the purchaser shall receive a refund of the full purchase price as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee. The licensee shall disclose in the advertisement that a consultation is required and that the purchaser will receive a refund if not eligible to receive the service. This subdivision shall not apply to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, or essential health benefits, as defined in Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code. The entity that provides the advertising shall be able to demonstrate that the licensee consented in writing to the requirements of this subdivision. A third-party advertiser shall make available to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser in the applicable geographic region. In any advertisement offering a discount price for a service, the licensee shall also disclose the regular, nondiscounted price for that service.

(h) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding fifty thousand dollars ($50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by that imprisonment and a fine of fifty thousand dollars ($50,000).

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2745
Author: Holden
Chapter: 303
Bill Date: April 25, 2016, Amended
Subject: Healing Arts: Licensing and Certification
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill makes clarifying changes to existing law to assist the Board in its licensing and enforcement functions.

ANALYSIS

This bill clarifies the Board's authority for the allied health licensees/registrants overseen by the Board. It allows the Board to revoke or deny a license/registration for registered sex offenders, allows the Board to take disciplinary action for excessive use of drugs or alcohol, allows allied health licensees/registrants to petition the Board for license/registration reinstatement, and allows the Board to use probation as a disciplinary option for allied health licensees/registrants.

Existing law only allows new physician and surgeon applicants and disabled status licensees to apply for a limited practice license (LPL). This bill allows all physician and surgeon licensees to apply for an LPL at any time. This bill would ensure that physicians who have a disabled status license and want to change to an LPL meet the same requirements in existing law for an LPL.

This bill clarifies that the Board can deny a post graduate training authorization letter for the same reasons it can deny a physician applicant's license in existing law.

This bill clarifies existing law related to investigations of a deceased patient. Existing law allows the Board to obtain a copy of the medical records of a deceased patient without the approval of the next of kin if the Board is unsuccessful in locating or contacting the patients' next of kin after reasonable efforts. Existing law requires the Board to contact the physician that owns the records, however, in many cases the records do not reside with the physician. This bill allows the Board to send a written request for medical records to the facility where the care occurred or where the records are located. This will ensure that the Board's investigation is not hindered.

This bill cleans up existing law to ensure that the Board's authority to perform its

regulatory oversight of licensees/registrants is clearly defined and aligned with current law. This is a Board-sponsored bill.

FISCAL: None

SUPPORT: Medical Board of California (Sponsor)
AFSCME

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website
- Revise the LPL application
- Develop appropriate reinstatement forms
- Add violation codes to the BreEZe system and make other necessary changes to BreEZe related to probation fees

Assembly Bill No. 2745

CHAPTER 303

An act to amend Sections 2088, 2221, 2225, 2441, 2519, 2520, 2529, 3576, and 3577 of, and to add Sections 2522, 2523, 2529.1, 2529.6, 3576.1, 3576.2, and 3576.3 to, the Business and Professions Code, relating to healing arts, and making an appropriation therefor.

[Approved by Governor September 12, 2016. Filed with Secretary of State September 12, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2745, Holden. Healing arts: licensing and certification.

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law authorizes an applicant for a physician's and surgeon's license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license fee and signs an agreement agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. Existing law makes any person who knowingly provides false information in this agreement subject to any sanctions available to the board. Existing law authorizes the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license. Violation of specified provisions of the act is a crime. Existing law establishes the Contingent Fund of the Medical Board of California, a continuously appropriated fund.

This bill would specify that a licensee who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability is authorized to receive the limited license if the above-described conditions are met, including payment of the appropriate fee. By adding fees for deposit into the Contingent Fund of the Medical Board of California, this bill would make an appropriation.

This bill would also authorize the board to deny a postgraduate training authorization to an applicant who is guilty of unprofessional conduct or of any cause for revocation or suspension of a license.

(2) Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician.

This bill would require the board to agree to this limit, would authorize the board to require an independent clinical evaluation, and would subject a person who knowingly provides false information in the agreement to sanctions. By modifying the scope of the crime of perjury, this bill would impose a state-mandated local program.

(3) Existing law authorizes the board, in any investigation that involves the death of a patient, to inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely to determine the extent to which the death was the result of the physician and surgeon's violation of the Medical Practice Act, if the board provides a written request to the physician and surgeon that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts.

This bill would authorize the board to provide the written request to the facility where the medical records are located or the care to the deceased patient was provided.

(4) Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Medical Board of California. Under the act, the board is authorized to suspend or revoke the license of a midwife for specified conduct, including unprofessional conduct consisting of, among other things, incompetence or gross negligence in carrying out the usual functions of a licensed midwife. A violation of the act is a crime.

This bill would authorize the board to place a license on probation and establish a fee for monitoring a licensee on probation. The bill would also authorize a person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a license for a person required to register as a sex offender, except as specified.

(5) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified.

The bill would include within the definition of unprofessional conduct, among other things, the use of any controlled substance, or the use of any dangerous drugs, as specified, or of alcoholic beverages, as specified. The bill would also require the revocation of a registration for a person required to register as a sex offender, except as specified.

(6) Existing law prohibits a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless he or she is registered as a certified polysomnographic technologist, is supervised and directed by a licensed

physician and surgeon, and meets certain other requirements. Existing law requires polysomnographic technologists to apply to and register with the Medical Board of California and to pay specified fees to be fixed by the board at no more than $100 each, and to renew their registration biennially for a fee of no more than $150. Existing law requires the deposit of those fees in the Contingent Fund of the Medical Board of California. Existing law authorizes a registration to be suspended, revoked, or otherwise subject to discipline for specified conduct.

This bill would also authorize a registration to be placed on probation if a registrant engages in that conduct and would establish a fee for monitoring a registrant on probation. By increasing fees for deposit into the Contingent Fund, this bill would make an appropriation. The bill would authorize a person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a registration for a person required to register as a sex offender, except as specified. The bill would authorize the suspension or revocation of a registration for unprofessional conduct, as defined.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Appropriation: yes.

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

SECTION 1. Section 2088 of the Business and Professions Code is amended to read:

2088. (a) An applicant for a physician's and surgeon's license or a physician's and surgeon's licensee who is otherwise eligible for that license but is unable to practice some aspects of medicine safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the appropriate initial or renewal license fee.

(2) Signs an agreement on a form prescribed by the board in which the applicant or licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the applicant or licensee described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a limited license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to subdivision (a) shall be subject to any sanctions available to the board.

SEC. 2. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may deny a physician's and surgeon's certificate or postgraduate training authorization letter to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license. The board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the licensee's activities shall be supervised by another physician and surgeon.

(2) Total or partial restrictions on drug prescribing privileges for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

(5) Enrollment and successful completion of a clinical training program.

(6) Abstention from the use of alcohol or drugs.

(7) Restrictions against engaging in certain types of medical practice.

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

(c) The board shall deny a physician's and surgeon's certificate to an applicant who is required to register pursuant to Section 290 of the Penal Code. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(d) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of his or her application, except that the board may, in its discretion and for good cause demonstrated, permit reapplication after not less than one year has elapsed from the effective date of the denial.

SEC. 3. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any

patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c) (1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine,

the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 4. Section 2441 of the Business and Professions Code is amended to read:

2441. (a) Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of medicine unless and until the licensee pays the current renewal fee and does either of the following:

(1) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his or her ability to practice medicine safely.

(2) Signs an agreement on a form prescribed by the board, signed under penalty of perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the licensee described in paragraph (2) of subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a disabled status license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to paragraph (2) of subdivision (a) shall be subject to any sanctions available to the board.

SEC. 5. Section 2519 of the Business and Professions Code is amended to read:

2519. The board may suspend, revoke, or place on probation the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising that is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that this use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for

a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

(j) Failing to do any of the following when required pursuant to Section 2507:

(1) Consult with a physician and surgeon.

(2) Refer a client to a physician and surgeon.

(3) Transfer a client to a hospital.

SEC. 6. Section 2520 of the Business and Professions Code is amended to read:

2520. (a) (1) The fee to be paid upon the filing of a license application shall be fixed by the board at not less than seventy-five dollars ($75) nor more than three hundred dollars ($300).

(2) The fee for renewal of the midwife license shall be fixed by the board at not less than fifty dollars ($50) nor more than two hundred dollars ($200).

(3) The delinquency fee for renewal of the midwife license shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25) nor more than fifty dollars ($50).

(4) The fee for the examination shall be the cost of administering the examination to the applicant, as determined by the organization that has entered into a contract with the board for the purposes set forth in subdivision (a) of Section 2512.5. Notwithstanding subdivision (c), that fee may be collected and retained by that organization.

(b) The fee for monitoring a licensee on probation shall be the cost of monitoring, as fixed by the board.

(c) The fees prescribed by this article shall be deposited in the Licensed Midwifery Fund, which is hereby established, and shall be available, upon appropriation, to the board for the purposes of this article.

SEC. 7. Section 2522 is added to the Business and Professions Code, to read:

2522. (a) A person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the license or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from midwives licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the license was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a license or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 8. Section 2523 is added to the Business and Professions Code, to read:

2523. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the license of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a license pursuant to this section shall be conducted in accordance with chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 9. Section 2529 of the Business and Professions Code is amended to read:

2529. (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco

Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrists," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, 2234, 2235, and 2529.1

SEC. 10. Section 2529.1 is added to the Business and Professions Code, to read:

2529.1. (a) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 11. Section 2529.6 is added to the Business and Professions Code, to read:

2529.6. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex

offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 12. Section 3576 of the Business and Professions Code is amended to read:

3576. (a) A registration under this chapter may be denied, suspended, revoked, placed on probation, or otherwise subjected to discipline for any of the following by the holder:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant.

(2) An act of dishonesty or fraud.

(3) Committing any act or being convicted of a crime constituting grounds for denial of licensure or registration under Section 480.

(4) Violating or attempting to violate this chapter or any regulation adopted under this chapter.

(b) Proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all powers granted therein.

SEC. 13. Section 3576.1 is added to the Business and Professions Code, to read:

3576.1. (a) A person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the registration or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a registration surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a registration surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from polysomnographic technologists registered in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section

11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the registration was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a registration or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 14. Section 3576.2 is added to the Business and Professions Code, to read:

3576.2. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 15. Section 3576.3 is added to the Business and Professions Code, to read:

3576.3. (a) The board may suspend or revoke the registration of a polysomnographic technologist, polysomnographic technician, or polysomnographic trainee for unprofessional conduct as described in this section.

(b) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability

of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(c) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 16. Section 3577 of the Business and Professions Code is amended to read:

3577. (a) Each person who applies for registration under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(b) Each person to whom registration is granted under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(c) The registration shall expire after two years. The registration may be renewed biennially at a fee which shall be paid into the Contingent Fund of the Medical Board of California to be fixed by the board at a sum not in excess of one hundred fifty dollars ($150).

(d) The fee for monitoring a registrant on probation shall be the cost of monitoring, as fixed by the board.

(e) The money in the Contingent Fund of the Medical Board of California that is collected pursuant to this section shall be used for the administration of this chapter.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 482
Author:	Lara
Chapter:	708
Bill Date:	August 19, 2016, Amended
Subject:	Controlled Substances: CURES Database
Sponsor:	Consumer Attorneys of California and California Narcotics Officers
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires all prescribers issuing Schedules II, III or IV drugs to access and consult the CURES database before prescribing a Schedule II, III or IV controlled substance, under specified conditions.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General's Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

According to the author's office, other states that have required prescribers to check their drug monitoring systems have seen significantly improved public health outcomes. In 2012, Tennessee required prescribers to check the state's PDMP before

prescribing painkillers, and, within one year, they saw a 36% drop in patients who were seeing multiple prescribers to obtain the same drugs. In Virginia, the number of doctor-shoppers fell by 73% after use of the database became mandatory. In Oklahoma, which requires mandatory checks for methadone, overdoses fell about 21% in one year. New York also requires prescribers to check their state drug monitoring systems and has seen dramatic decreases in drug overdoses and deaths.

ANALYSIS

This bill requires a health care practitioner that is authorized to prescribe, order, administer or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment. This bill requires a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed. If a health care practitioner is exempted from checking CURES before prescribing a controlled substance for the first time pursuant to this bill, they are required to consult CURES before subsequently prescribing a controlled substance to the patient at least every four months thereafter if the substance remains part of the treatment of the patient. This bill defines "first time" to mean the initial occurrence in which a health care practitioner intends to prescribe, order, administer, furnish or dispense a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to that patient.

This bill specifies that a prescriber, pharmacist, or any person acting on their behalf, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate or misattributed information submitted to, reported by or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

This bill specifies that the duty to consult CURES does not apply to veterinarians or pharmacists.

This bill specifies that the requirement to consult the CURES database does not apply to a health care practitioner in any of the following circumstances:

- If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:
    - A licensed clinic,
    - An outpatient setting,
    - A health facility, or
    - A county medical facility.
- If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital if the quantity of the controlled substance does not exceed a non-

refillable seven-day supply of the controlled substance, to be used in accordance with the directions for use.

- If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure, if the quantity of the controlled substance does not exceed a non-refillable five-day supply and is in a licensed clinic, an outpatient setting, a health facility, a county medical facility or a place of practice.
- If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care.
- If all of the following circumstances are satisfied:
    - It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.
    - Another health care practitioner or designee authorized to access CURES is not reasonably available.
    - The quantity of controlled substance does not exceed a non-refillable five-day supply, to be used in accordance with the directions for use and no refill of the controlled substance is allowed.
      Note: If a health care practitioner falls under this exemption, he or she must document the reason CURES was not consulted in the patient's medical record.
- If the CURES database is not operational, as determined by DOJ, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the failure that is reasonably within his or her control.
- If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of the health care practitioner.
- If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a non-refillable five-day supply if the controlled substance were used in accordance with the directions for use.

This bill specifies that if a health care practitioner fails to consult the CURES database, he or she shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

This bill specifies that it does not create a private cause of action against a health care practitioner and does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

This bill specifies that it is not operative until six months after DOJ certifies that the CURES database is ready for statewide use and that DOJ has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in the Budget Act of 2016. This bill requires DOJ to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification.

This bill specifies that the provisions of the bill are severable and if any provision is held invalid, that invalidity shall not affect other provisions of this bill.

This bill specifies that a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping." Requiring all prescribers to consult the CURES system will allow prescribers to make informed decisions about their patient's care. This bill also ensures that the CURES system will have the capacity to handle this workload before the bill becomes operative. For these reasons, the Board took a support position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: Consumer Attorneys of California and California Narcotics Officers' Association (co-sponsors); Acclamation Insurance Management Services; American Insurance Association; Blue Shield of California; California Chamber of Commerce; California Dental Association; California Pharmacists Association; California Teamsters; Center for Public Interest Law; Children's Advocacy Institute; Consumer Watchdog; Medical Board of California; National Alliance on Mental Illness; Pacific Business Group on Health; Peace Officers Research Association of California; PRIUM; Small Business California and Teamsters

OPPOSITION: Association of Northern California Oncologists
Doctor's Company
The US Oncology Network

IMPLEMENTATION:

- Newsletter article(s), including a stand-alone article
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website
- Send an email blast to all physicians before the bill becomes effective
- Work with physician associations/organizations to provide information to physicians

Senate Bill No. 482

CHAPTER 708

An act to amend Sections 11165 and 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances.

[Approved by Governor September 27, 2016. Filed with Secretary of State September 27, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 482, Lara. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, administer, furnish, or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. The bill would exempt a veterinarian and a pharmacist from this requirement. The bill would also exempt a health care practitioner from this requirement under specified circumstances, including, among others, if prescribing, ordering, administering, or furnishing a controlled substance to a patient receiving hospice care, to a patient admitted to a specified facility for use while on facility premises, or to a patient as part of a treatment for a surgical procedure in a specified facility if the quantity of the controlled substance does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use. The bill would require, if a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient pursuant to one of those exemptions, the health care practitioner to consult the CURES database before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every 4 months thereafter if the substance remains part of the treatment of the patient.

This bill would provide that a health care practitioner who fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. The bill would make the above-mentioned provisions operative 6 months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, user support, and education, as specified.

This bill would also exempt a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

Existing law requires the operation of the CURES database to comply with all applicable federal and state privacy and security laws and regulations. Existing law authorizes the disclosure of data obtained from the CURES database to agencies and entities only for specified purposes and requires the Department of Justice to establish policies, procedures, and regulations regarding the use, access, disclosure, and security of the information within the CURES database.

This bill would authorize a health care practitioner to provide a patient with a copy of the patient's CURES patient activity report if no additional CURES data is provided. The bill would also prohibit a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances from obtaining data from the CURES database.

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

SECTION 1. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department

shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

SEC. 2. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled

substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising

from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

SEC. 3. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription

in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1160
Author:	Mendoza
Chapter:	868
Bill Date:	August 29, 2016, Amended
Subject:	Workers' Compensation
Sponsor:	California Professional Firefighters (Co-sponsor)
	California Labor Federation, AFL-CIO (Co-sponsor)
Position:	Supported provisions contained in SB 563 (Pan)

DESCRIPTION OF CURRENT LEGISLATION:

The provisions contained in SB 563 (Pan), which the Medical Board of California (Board) supported, were amended into this bill. This bill makes a series of significant, wide-ranging changes to the Division of Workers' Compensation's (DWC) operation and utilization review (UR) processes, approval of UR processes, fraud prevention, and lien filing and collection. The provisions that were previously included in SB 563 and that impact the Board ensure that physicians involved in authorizing injured worker medical care on behalf of the employer and/or payor are not being inappropriately incentivized to modify, delay, or deny requests for medically necessary services. This bill includes many other provisions.

BACKGROUND

In California's workers' compensation system, an employer or insurer cannot deny treatment. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to UR. UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

In April 2013, the Board reaffirmed that engaging in UR is the practice of medicine and stated that the Board will not automatically deem UR complaints as non-jurisdictional. In addition, the Board stated it will review UR complaints against California-licensed physicians to determine if a quality of care issue is present, and if so, the complaint will follow the normal complaint review process.

ANALYSIS

This bill makes a series of significant, wide-ranging changes to the DWC's operation and utilization review (UR) processes, approval of UR processes, fraud prevention, and lien filing and collection. This bill prohibits an employer, or any entity conducting UR on behalf of an employer, from providing any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician. This bill gives the DWC administrative director (AD) the authority to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting UR on behalf of the employer, and the UR physician. This bill prohibits an insurer or third-party administrator from referring a claim for review to a UR organization in which it has a financial interest, unless that interest is disclosed to the employer. This bill provides that any information obtained by the AD relating to these contracts is not subject to disclosure pursuant to the Public Records Act. This bill includes many other provisions that impact the DWC, but not the Board.

UR has increasingly become an area of concern from a variety of stakeholders. Both injured workers and medical providers report delays and denials of medical care due to the UR process. This bill seeks to address the reported challenges with UR and will ensure that UR decisions are based on the best available medical science. There is currently no explicit prohibition in law related to UR to ensure that a physician's judgment for medical necessity is not compromised by financial incentives. This bill will promote the Board's mission of consumer protection and the Board took a support position on the provisions in this bill that were previously included in SB 563 (Pan).

FISCAL: None to the Board

SUPPORT: California Professional Firefighters (Sponsor); California Labor Federation, AFL-CIO (Sponsor); Acclamation Insurance Management Services; California Alliance of Self-Insured Groups; California Medical Association; California Occupational Medicine Physicians; Communication Workers of America, District 9; Orange County Professional Firefighters Association, Local 3631; Risk Insurance Management Society; Small Business California; U.S. HealthWorks Medical Group; UPS; and Western Occupational and Environmental Association

OPPOSITION: California Neurology Society; California Society of Industrial Medicine and Surgery; California Society of Physical Medicine and Rehabilitation; California Workers' Compensation Interpreters Association; California Workers' Compensation Services Association; and Voters Injured at WORK

IMPLEMENTATION:

- Newsletter article(s) and stand-alone article
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 1160

CHAPTER 868

An act to amend Sections 138.4, 138.6, 4610.5, 4610.6, 4903.05, 4903.8, 5307.27, 5710, 5811, and 6409 of, to amend, repeal, and add Section 4610 of, and to add Section 4615 to, the Labor Code, relating to workers' compensation.

[Approved by Governor September 30, 2016. Filed with Secretary of State September 30, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1160, Mendoza. Workers' compensation.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires the administrative director to develop and make available informational material written in plain language that describes the overall workers' compensation claims process, as specified.

This bill would require the administrative director to adopt regulations to provide employees with notice regarding access to medical treatment following the denial of a claim under the workers' compensation system.

Existing law requires the Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations to develop a workers' compensation information system in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, with certain data to be collected electronically and to be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. Existing law requires the administrative director to assess an administrative penalty of not more than $5,000 in a single year against a claims administrator for a violation of those data reporting requirements.

This bill would increase that penalty assessment to not more than $10,000. The bill would require the administrative director to post on the Division of Workers' Compensation Internet Web site a list of claims administrators who are in violation of the data reporting requirements.

Existing law requires every employer to establish a utilization review process, and defines "utilization review" as 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, prior to, retrospectively, or concurrent with providing medical treatment services. Existing law also provides for an independent medical

review process to resolve disputes over utilization review decisions, as defined.

This bill would revise and recast provisions relating to utilization review, as specified, with regard to injuries occurring on or after January 1, 2018. Among other things, the bill would set forth the medical treatment services that would be subject to prospective utilization review under these provisions, as provided. The bill would authorize retrospective utilization review for treatment provided under these provisions under limited circumstances, as specified. The bill would establish procedures for prospective and retrospective utilization reviews and set forth provisions for removal of a physician or provider under designated circumstances. On and after January 1, 2018, the bill would establish new procedures for reviewing determinations regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted by the administrative director, as provided. The bill would make conforming changes to related provisions to implement these changes.

The bill would, commencing July 1, 2018, require each utilization review process to be accredited 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 bill would require the administrative director to adopt rules to implement the selection of an independent, nonprofit organization for accreditation purposes, as specified. The bill would authorize the administrative director to adopt rules to require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation and provide for certain exemptions. The bill would require the administrative director to develop a system for electronic reporting of documents related to utilization review performed by each employer, to be administered by the division. The bill would require the administrative director, on or after March 1, 2019, to contract with an outside independent research organization to evaluate and report on the impact of provision of medical treatment within the first 30 days after a claim is filed, for claims filed on or after January 1, 2017, to January 1, 2019. The bill would require the report to be completed before January 1, 2020, and to be distributed to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance.

Existing law requires every lien claimant to file its lien with the appeals board in writing upon a form approved by the appeals board. Existing law requires a lien to be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement, as specified.

This bill would require certain lien claimants that file a lien under these provisions to do so by filing a declaration, under penalty of perjury, that includes specified information. The bill would require current lien claimants to also file the declaration by a specified date. The bill would make a failure

to file a declaration under these provisions grounds for dismissal of a lien. Because the bill would expand the crime of perjury, the bill would impose a state-mandated local program.

The bill would also automatically stay any physician or provider lien upon the filing of criminal charges against that person or entity for specified offenses involving medical fraud, as provided. The bill would authorize the administrative director to adopt regulations to implement that provision. The bill would state findings and declarations of the Legislature in connection with these provisions.

Existing law prohibits the assignment of a lien under these provisions, except under limited circumstances, as specified.

This bill would, for liens filed after January 1, 2017, invalidate any assignment of a lien made in violation of these provisions, by operation of law.

Existing law requires the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, to adopt, after public hearings, a medical treatment utilization schedule to incorporate evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission, as specified.

This bill would authorize the administrative director to make updates to the utilization schedule by order, which would not be subject to the Administrative Procedure Act, as specified. The bill would require any order adopted pursuant to these provisions to be published on the Internet Web site of the division.

Existing law requires a deponent to receive certain expenses and reimbursements if an 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. Existing law authorizes the deponent to receive a reasonable allowance for attorney's fees, if represented by an attorney licensed in this state.

This bill would authorize the administrative director to determine the range of reasonable fees to be paid to a deponent.

Existing law provides that it is the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter. Existing law sets forth the qualifications of a qualified interpreter for these purposes, and provides for the settings under which a qualified interpreter may render services.

This bill would require the administrative director to promulgate regulations establishing criteria to verify the identity and credentials of individuals that provide interpreter services under these provisions.

Existing law requires physicians, as defined, who attend to injured or ill employees to file reports with specific information prescribed by law.

This bill would revise those reporting requirements, as prescribed.

This bill would incorporate changes to Section 4610 of the Labor Code proposed by AB 2503, to be operative as specified if both bills are enacted.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public

officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 138.4 of the Labor Code is amended to read:

138.4. (a) For the purpose of this section, "claims administrator" means a self-administered workers' compensation insurer; or a self-administered self-insured employer; or a self-administered legally uninsured employer; or a self-administered joint powers authority; or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer, or a joint powers authority.

(b) With respect to injuries resulting in lost time beyond the employee's work shift at the time of injury or medical treatment beyond first aid:

(1) If the claims administrator obtains knowledge that the employer has not provided a claim form or a notice of potential eligibility for benefits to the employee, it shall provide the form and notice to the employee within three working days of its knowledge that the form or notice was not provided.

(2) If the claims administrator cannot determine if the employer has provided a claim form and notice of potential eligibility for benefits to the employee, the claims administrator shall provide the form and notice to the employee within 30 days of the administrator's date of knowledge of the claim.

(c) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall prescribe reasonable rules and regulations, including notice of the right to consult with an attorney, where appropriate, for serving on the employee (or employee's dependents, in the case of death), the following:

(1) Notices dealing with the payment, nonpayment, or delay in payment of temporary disability, permanent disability, supplemental job displacement, and death benefits.

(2) Notices of any change in the amount or type of benefits being provided, the termination of benefits, the rejection of any liability for compensation, and an accounting of benefits paid.

(3) Notices of rights to select the primary treating physician, written continuity of care policies, requests for a comprehensive medical evaluation, and offers of regular, modified, or alternative work.

(d) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall develop, make fully accessible on the department's Internet Web site, and make available at

district offices informational material written in plain language that describes the overall workers' compensation claims process, including the rights and obligations of employees and employers at every stage of a claim when a notice is required.

(e) Each notice prescribed by the administrative director shall be written in plain language, shall reference the informational material described in subdivision (d) to enable employees to understand the context of the notices, and shall clearly state the Internet Web site address and contact information that an employee may use to access the informational material.

(f) On or before January 1, 2018, the administrative director shall adopt regulations to provide employees with notice that they may access medical treatment outside of the workers' compensation system following the denial of their claim.

SEC. 2. Section 138.6 of the Labor Code is amended to read:

138.6. (a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a cost-efficient workers' compensation information system, which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.

(b) The information system shall do the following:

(1) Assist the department to manage the workers' compensation system in an effective and efficient manner.

(2) Facilitate the evaluation of the efficiency and effectiveness of the delivery system.

(3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.

(4) Provide statistical data for research into specific aspects of the workers' compensation program.

(c) The data collected electronically shall be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. The administrative director may adopt regulations authorizing the use of other nationally recognized data transmission formats in addition to those set forth in the Electronic Data Interchange System for the transmission of data required pursuant to this section. The administrative director shall accept data transmissions in any authorized format. If the administrative director determines that any authorized data transmission format is not in general use by claims administrators, conflicts with the requirements of state or federal law, or is obsolete, the administrative director may adopt regulations eliminating that data transmission format from those authorized pursuant to this subdivision.

(d) (1) The administrative director shall assess an administrative penalty against a claims administrator for a violation of data reporting requirements adopted pursuant to this section. The administrative director shall promulgate a schedule of penalties providing for an assessment of no more than ten thousand dollars ($10,000) against a claims administrator in any single year, calculated as follows:

(A) No more than one hundred dollars ($100) multiplied by the number of violations in that year that resulted in a required data report not being submitted or not being accepted.

(B) No more than fifty dollars ($50) multiplied by the number of violations in that year that resulted in a required report being late or accepted with an error.

(C) Multiple errors in a single report shall be counted as a single violation.

(D) No penalty shall be assessed pursuant to Section 129.5 for any violation of data reporting requirements for which a penalty has been or may be assessed pursuant to this section.

(2) The schedule promulgated by the administrative director pursuant to paragraph (1) shall establish threshold rates of violations that shall be excluded from the calculation of the assessment, as follows:

(A) The threshold rate for reports that are not submitted or are submitted but not accepted shall not be less than 3 percent of the number of reports that are required to be filed by or on behalf of the claims administrator.

(B) The threshold rate for reports that are accepted with an error shall not be less than 3 percent of the number of reports that are accepted with an error.

(C) The administrative director shall set higher threshold rates as appropriate in recognition of the fact that the data necessary for timely and accurate reporting may not be always available to a claims administrator or the claims administrator's agents.

(D) The administrative director may establish higher thresholds for particular data elements that commonly are not reasonably available.

(3) The administrative director may estimate the number of required data reports that are not submitted by comparing a statistically valid sample of data available to the administrative director from other sources with the data reported pursuant to this section.

(4) All penalties assessed pursuant to this section shall be deposited in the Workers' Compensation Administration Revolving Fund.

(5) The administrative director shall publish an annual report disclosing the compliance rates of claims administrators and post the report and a list of claims administrators who are in violation of the data reporting requirements on the Internet Web site of the Division of Workers' Compensation.

SEC. 3. Section 4610 of the Labor Code is amended to read:

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

(b) 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) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, 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 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) 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 or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

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

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

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

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

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of

medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of 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) 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 decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. 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) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

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

(6) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and

the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

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

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

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

SEC. 3.5. Section 4610 of the Labor Code is amended to read:

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

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

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination. The employer,

insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physician's practice, requested by the physician, shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

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

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

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

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

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

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

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of the information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

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

(3) (A) Decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

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

used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

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

(6) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

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

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for

the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

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

SEC. 4. Section 4610 is added to the Labor Code, to read:

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

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

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

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

(2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.

(3) Psychological treatment services.

(4) Home health care services.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.

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

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

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

(e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

(f) An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.

(1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

(2) The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

(g) 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.

(1) Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment

utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(2) 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, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(3) (A) 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 or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j).

(B) (i) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

(ii) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization review services.

(II) The insurer or third-party administrator's financial interest in the entity.

(C) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical

material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

(5) On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site.

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

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

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

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

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(i) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees, all of the following requirements shall be met:

(1) Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the request for authorization for medical treatment. 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.

(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 decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(4) (A) Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

(B) Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A) was by telephone, within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(C) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a

concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. 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.

(5) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify all of the following:

(A) The reason for the decision.

(B) A specific description of the information that is needed.

(C) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.

(D) A description of the manner in which the request was communicated.

(j) (1) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, 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 paragraph (1), (2), or (3) of subdivision (i) because the employer or other entity is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i).

(k) A utilization review decision to modify, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to 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.

(*l*) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(m) If utilization review is deferred pursuant to subdivision (*l*), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (2) of subdivision (i) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(n) Every employer, insurer, or other entity subject to this section shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.

(o) The administrative director shall develop a system for the mandatory electronic reporting of documents related to every utilization review performed by each employer, which shall be administered by the Division of Workers' Compensation. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe for their submission. For purposes of this subdivision, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

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

(q) The administrative director shall contract with an outside, independent research organization on or after March 1, 2019, to evaluate the impact of the provision of medical treatment within the first 30 days after a claim is filed, for a claim filed on or after January 1, 2017, and before January 1, 2019. The report shall be provided to the administrative director, the Senate

Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance before January 1, 2020.

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

SEC. 4.5. Section 4610 is added to the Labor Code, to read:

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

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

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

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

(2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.

(3) Psychological treatment services.

(4) Home health care services.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.

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

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

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

(e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

(f) An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.

(1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

(2) The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

(g) Each employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(1) Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(2) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(3) (A) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physician's practice, requested by the physician, shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j).

(B) (i) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

(ii) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization review services.

(II) The insurer or third-party administrator's financial interest in the entity.

(C) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review

services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

(5) On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site.

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

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

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

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

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

(i) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of

medical treatment services to employees, all of the following requirements shall be met:

(1) Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

(2) In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of the information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

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

(4) (A) Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

(B) Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A) was by telephone, within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(C) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate

for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

(5) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify all of the following:

(A) The reason for the decision.

(B) A specific description of the information that is needed.

(C) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.

(D) A description of the manner in which the request was communicated.

(j) (1) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination.

(2) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) because the employer or other entity is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information

reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i).

(k) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(*l*) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(m) If utilization review is deferred pursuant to subdivision (*l*), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (2) of subdivision (i) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(n) Each employer, insurer, or other entity subject to this section shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.

(o) The administrative director shall develop a system for the mandatory electronic reporting of documents related to every utilization review performed by each employer, which shall be administered by the Division of Workers' Compensation. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe for their submission. For purposes of this subdivision, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

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

(q) The administrative director shall contract with an outside, independent research organization on or after March 1, 2019, to evaluate the impact of the provision of medical treatment within the first 30 days after a claim is filed, for a claim filed on or after January 1, 2017, and before January 1, 2019. The report shall be provided to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance before January 1, 2020.

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

SEC. 5. Section 4610.5 of the Labor Code is amended to read:

4610.5. (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 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:

(A) The guidelines, including the drug formulary, 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 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) If a utilization review decision denies or modifies a treatment recommendation based on medical necessity, the employee may request an independent medical review as provided by this section.

(e) A utilization 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 modified or denied by a utilization review decision, unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision based on medical necessity that denies or modifies 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 utilization review decision is final unless the employee requests independent medical review.

(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.

(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) 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, any settlement or award that may resolve the medical treatment dispute, or the requesting physician withdrawing the request for treatment, shall be communicated to the independent medical review organization by the employer within five days.

(h) (1) The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

(A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.

(B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization 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) at the time of notification of its utilization 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) 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) 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) 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 review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(*l*) 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 of 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.

(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 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) 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) 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*) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) 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.

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

SEC. 6. Section 4610.6 of the Labor Code is amended to read:

4610.6. (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 the determination shall be issued, as follows:

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

(B) For all other medical treatment disputes submitted for review under subdivision (h) of Section 4610.5, within 30 days of 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.

SEC. 7. Section 4615 is added to the Labor Code, to read:

4615. (a) 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 4621, 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 an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the Medicare or Medi-Cal programs. 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.

(b) The administrative director shall promptly post on the division's Internet Web site the names of any physician or provider of medical treatment services whose liens were stayed pursuant to this section.

SEC. 8. Section 4903.05 of the Labor Code is amended to read:

4903.05. (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. For liens filed on or after January 1, 2017, the lien shall also be accompanied by an original bill in addition to either the full statement or itemized voucher supporting the lien. 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) For liens filed on or after January 1, 2017, 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 dispute is not subject to an independent bill review and independent medical review under Sections

4603.6 and 4610.5, respectively, that the lien claimant satisfies one of the following:

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

(B) Is the agreed medical evaluator or qualified medical evaluator.

(C) Has provided treatment authorized by the employer or claims administrator under Section 4610.

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

(E) Has documentation that medical treatment has been neglected or unreasonably refused to the employee as provided by Section 4600.

(F) Can show that the expense was incurred for an emergency medical condition, as defined by subdivision (b) of Section 1317.1 of the Health and Safety Code.

(G) Is a certified interpreter rendering services during a medical-legal examination, a copy service providing medical-legal services, or has an expense allowed as a lien under rules adopted by the administrative director.

(2) Lien claimants shall have until July 1, 2017, to file a declaration pursuant to paragraph (1) for any lien claim filed before January 1, 2017, for expenses pursuant to subdivision (b) of Section 4903 that is subject to a filing fee under this section.

(3) The failure to file a signed declaration under this subdivision shall result in the dismissal of the lien with prejudice by operation of law. Filing of a false declaration shall be grounds for dismissal with prejudice after notice.

(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.

SEC. 9. Section 4903.8 of the Labor Code is amended to read:

4903.8. (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, who is the lien owner, and not to an assignee 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.

(2) All liens filed pursuant to subdivision (b) of Section 4903 shall be filed in the name of the lien owner only, and no payment shall be made to any lien claimant without evidence that he or she is the owner of that lien.

(3) 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.

(4) For liens filed after January 1, 2017, 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. The assignment of a lien, in violation of this paragraph is invalid by operation of 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.

SEC. 10. Section 5307.27 of the Labor Code is amended to read:

5307.27. (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), but the administrative director shall allow at least a 30-day period for public comment and a public hearing. The administrative director shall provide responses to submitted comments prior to the effective date of the updates. 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.

SEC. 11. Section 5710 of the Labor Code is amended to read:

5710. (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. The administrative director shall, on or before July 1, 2018, determine the range of reasonable fees to be paid.

(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.

SEC. 12. Section 5811 of the Labor Code is amended to read:

5811. (a) No fees shall be charged by the clerk of any court for the performance of any official service required by this division, except for the docketing of awards as judgments and for certified copies of transcripts thereof. In all proceedings under this division before the appeals board, costs as between the parties may be allowed by the appeals board.

(b) (1) It shall be the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter.

(2) A qualified interpreter is a language interpreter who is 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 duty of an interpreter is to accurately and impartially translate oral communications and transliterate written materials, and not to act as an agent or advocate. An interpreter shall not disclose to any person who is not an immediate participant in the communications the content of the conversations or documents that the interpreter has interpreted or transliterated unless the disclosure is compelled by court order. An attempt by any party or attorney to obtain disclosure is a bad faith tactic that is subject to Section 5813.

Interpreter fees that are reasonably, actually, and necessarily incurred shall be paid by the employer under this section, provided they are in accordance with the fee schedule adopted by the administrative director.

A qualified interpreter may render services during the following:

(A) A deposition.

(B) An appeals board hearing.

(C) A medical treatment appointment or medical-legal examination.

(D) During those settings which the administrative director determines are reasonably necessary to ascertain the validity or extent of injury to an employee who does not proficiently speak or understand the English language.

(c) The administrative director shall promulgate regulations establishing criteria to verify the identity and credentials of individuals who provide interpreter services in all necessary settings and proceedings within the workers' compensation system. Those regulations shall be adopted no later than January 1, 2018.

SEC. 13. Section 6409 of the Labor Code is amended to read:

6409. (a) Every physician as defined in Section 3209.3 who attends any injured employee shall file a complete report of 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 with the Division of Workers' Compensation and the

employer, or if insured, with the employer's insurer, within five days of the initial examination. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall also, 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.

SEC. 14. The Legislature finds and declares that Sections 4 and 4.5 of this act, which add Section 4610 to the Labor Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitations on the people's rights of access set forth in this act are necessary to protect the privacy and integrity of information submitted to the Administrative Director of the Division of Workers' Compensation pursuant to Section 4610 of the Labor Code.

SEC. 15. The amendment of paragraphs (1) and (2) of subdivision (a) of Section 4903.8 of the Labor Code made by this act does not constitute a change in, but is declaratory of, existing law.

SEC. 16. The Legislature finds and declares the following:

(a) Section 4 of Article XIV of the California Constitution vests the Legislature with plenary power to create and to enforce a complete system of workers' compensation by appropriate legislation, and that plenary power includes, without limitation, the power and authority to make full provision for the manner and means by which any lien for compensation for those services may be filed or enforced within the workers' compensation system.

(b) Despite prior legislative action to reform the lien filing and recovery process within the workers' compensation system, including Senate Bill 863 in 2012, there continues to be abuse of the lien process within the workers' compensation system by some providers of medical treatment and other medical-legal services who have engaged in fraud or other criminal conduct within the workers' compensation system, or who have engaged in medical billing fraud, insurance fraud, or fraud against the federal Medicare or Medi-Cal systems.

(c) Notwithstanding fraudulent and criminal conduct by some providers of medical treatment or other medical-legal services, those providers have continued to file and to collect on liens within the workers' compensation

system while criminal charges alleging fraud within the workers' compensation system, or medical billing or insurance fraud, or fraud within the federal Medicare or Medi-Cal systems, are pending against those providers.

(d) The ability of providers of medical treatment or other medical-legal services to continue to file and to collect on liens, while criminal charges are pending against the provider, including through the use of lien or collection assignments, has created excessive and unnecessary administrative burdens for the workers' compensation system, has resulted in pressure on employers and insurers to settle liens that may in fact have arisen from prior or ongoing criminal conduct, has threatened the health and safety of workers who may be referred for or receive medical treatment or other medical-legal services that not reasonable and necessary, has allowed continued funding of fraudulent practices through ongoing lien collections during the pendency of criminal proceedings, and has undermined public confidence in the workers' compensation system.

(e) Therefore, in order to ensure the efficient, just, and orderly administration of the workers' compensation system, and to accomplish substantial justice in all cases, the Legislature declares that it is necessary to enact legislation to provide that any lien filed by, or for recovery of compensation for services rendered by, any provider of medical treatment or other medical-legal services shall be automatically stayed upon the filing of criminal charges against that provider for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the federal Medicare or Medi-Cal programs, and that the stay shall remain in effect until the resolution of the criminal proceedings.

SEC. 17. (a) Section 3.5 of this bill incorporates amendments to Section 4610 of the Labor Code proposed by both this bill and Assembly Bill 2503. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2017, (2) each bill amends Section 4610 of the Labor Code, and (3) this bill is enacted after Assembly Bill 2503, in which case Section 3 of this bill shall not become operative.

(b) Section 4.5 of this bill incorporates, in Section 4610 of the Labor Code as proposed to be added by this bill, amendments to Section 4610 of the Labor Code that are proposed by Assembly Bill 2503. It shall only become operative if (1) both bills are enacted on or before January 1, 2017, (2) Assembly Bill 2503 amends Section 4610 of the Labor Code, and (3) this bill adds Section 4610 to the Labor Code, in which case, regardless of the order in which this bill and Assembly Bill 2503 are enacted, Section 4 of this bill shall not become operative.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1174
Author:	McGuire
Chapter:	840
Bill Date:	August 19, 2016, Amended
Subject:	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications
Sponsor:	National Center for Youth Law
Current Position:	Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill adds to the Medical Board of California's (Board) priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill requires the Board to confidentially collect and analyze data submitted by the Department of Health Care Services (DHCS) and the Department of Social Services (DSS), related to physicians prescribing psychotropic medications to foster children.

BACKGROUND

In August 2014, the Board received a letter from Senator Lieu, who was at the time the Chair of the Senate Business, Professions and Economic Development Committee. The letter asked the Board to look into the issue of inappropriate prescribing of psychotropic medication to foster children. The Board receives very few complaints regarding foster children being prescribed psychotropic medications, so the Board researched other avenues to identify physicians who may be inappropriately prescribing. The Board met with DHCS and DSS regarding what data was available, what could be provided to the Board, and what data would assist in the identification of inappropriately prescribing physicians. After many meetings, a Data Use Agreement (DUA) was finalized in April 2015 requesting a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more. For each child that fit into this category, the Board requested a list of the medications prescribed, the start and stop date for each medication, the prescriber's name and contact information, the child's birth date, and any other information that DHCS and DSS thought might be relevant to assist in this process.

Upon receipt of the information requested in the DUA in 2015, the Board secured an expert pediatric psychiatrist to review the information and determine any physician who may be potentially prescribing inappropriately. It is important to note that once a physician is identified, the Board's normal complaint process will be followed, including obtaining medical records, conducting a physician interview and having an expert physician review the case. The complaint and investigation process is confidential, and nothing is public until an accusation is filed. Upon review by the Board's expert, it was determined that additional information was

needed to identify physicians that may warrant additional investigation. The new information includes diagnosis associated with the medication, dosage of medication prescribed, schedule of dosage, and weight of the child/adolescent. The Board obtained this information in June and it was reviewed by the Board's expert. The Board's expert has confirmed that the additional information is sufficient to identify potential inappropriate prescribers for further review by the Board.

ANALYSIS

This bill adds to the Board's priorities acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor. Although the Board already has excessive prescribing of controlled substances in its priorities, many psychotropic medications are not controlled substances, so they would not be covered in the Board's existing priorities.

This bill requires DHCS and DSS to provide data to the Board on an annual basis, pursuant to a data-sharing agreement, including, but not limited to, pharmacy claims data for all foster children who are or have been on three or more psychotropic medications for 90 days or more. The data shall be drawn from existing data sources maintained by the departments. Prior to the release of the data, personal identifiers must be removed and a unique identifier shall be submitted. For each foster child who falls into this category, the following information shall be submitted to the Board:

- A list of the psychotropic medications prescribed.
- The start and stop dates, if any, for each psychotropic medication prescribed.
- The prescriber's name and contact information.
- The child or adolescent's year of birth.
- Any other information that is de-identified and necessary to the Board to allow the Board to exercise its statutory authority as an oversight entity.
- The unit and quantity of the medication and the number of days' supply of the medication.

This bill requires the Board to review this data on a quarterly basis to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, conduct an investigation. This bill specifies that the Board shall contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the Board. This bill requires the consultant to consider the treatment guidelines published by DHCS and DSS when assessing prescribing patterns.

If the Board investigates a physician for inappropriate prescribing and concludes that there is a violation of law, the Board must take appropriate disciplinary action. This bill requires the Board to report this data annually to the Legislature in its annual report.

This bill requires DHCS to disseminate its treatment guidelines on an annual basis through its existing communications with Medi-Cal providers.

On or before January 1, 2022, this bill requires the Board, in conjunction with DHCS and DSS, to conduct an internal review of its data, investigative, and disciplinary activities undertaken for the purpose of determining the efficacy of these activities and the Board must revise its procedures, if determined to be necessary. This bill would sunset in 10 years, as it will only remain in effect until January 1, 2027, unless a later enacted statute deletes or extends that date.

According to the author, over the past fifteen years the rate of foster youth prescribed psychotropic medication has increased 1,400 percent. Nearly 1 in 4 California foster teens are prescribed psychotropic drugs, and of those nearly 60 percent were prescribed an anti-psychotic, the drug class most susceptible to debilitating side effects. There have been several Senate hearings on this issue, and according to the hearing background information, concerns over the use of psychotropic medications among children have been well documented in research journals and the mainstream media for more than a decade.

Anecdotally, the Board does not receive complaints regarding inappropriate prescribing of psychotropic medications to foster children. The data that will be required to be submitted to the Board pursuant to this bill will ensure that the Board can review prescribing data on an on-going basis to help identify physicians who may be inappropriately prescribing. The data the Board has received under the DUA is only a snapshot in time, for a 6 month time period in 2014. Any information that can help the Board identify inappropriate prescribing can be utilized as a tool for the Board to use in its complaint and investigation process. However, once a possible inappropriate prescriber is identified, the Board will still have to go through its normal complaint and investigation process.

This bill will further the Board's mission of consumer protection for a very vulnerable population. The Board did request a three- to five-year sunset date be included in this bill to allow the Board to determine if the data provided is useful to the Board in assisting with identifying physicians who may be inappropriately prescribing and pursuing investigations. The author instead included a 10-year sunset date, but also included language to require the Board to do an internal review in five years. This review would consider the efficacy of the data in relation to the Board's investigative and disciplinary actions and would allow the Board to revise its data review procedures, if necessary.

FISCAL: This bill will result in minor and absorbable fiscal impact to have an expert pediatric psychiatrist review the data and report the results to the Legislature, DHCS and DSS on an on-going basis. This is currently being done now, but not on an on-going basis.

SUPPORT: National Center for Youth Law (Sponsor); Bay Area Youth Center; California Youth Connection; California Youth Empowerment Network;

Children Now; Consumer Attorneys of California; Consumer Watchdog; Contra Costa County; Family Voices of California; First Focus Campaign for Children; John Burton Foundation; Kids in Common; Madera County Department of Social Services; Medical Board of California (if amended); Peers Envisioning and Engaging in Recovery Services; San Luis Obispo County Department of Social Services; Sunny Hills Services; Therapists for Peace and Justice; Woodland Community College and Foster and Kinship Care Education; Youth Law Center; and two individuals

OPPOSITION: California Academy of Child and Adolescent Psychiatry

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Meet with DHCS and DSS to work out the details of the DUA to ensure the Board receives the required data and can review it on a quarterly basis beginning January 1, 2017
- Identify additional pediatric psychiatrist consultants that can perform the initial data review and identify possible inappropriate prescribing for further review
- Formalize the process with DSS for requesting authorizations for medical records for de-identified foster youth so these investigations are not delayed
- Amend the Board's Annual Report to include complaints, investigations, and disciplinary actions taken as a result of the data review and subsequent investigation

Senate Bill No. 1174

CHAPTER 840

An act to amend Section 2220.05 of, and to add and repeal Section 2245 of, the Business and Professions Code, and to add and repeal Section 14028 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 29, 2016. Filed with Secretary of State September 29, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1174, McGuire. Medi-Cal: children: prescribing patterns: psychotropic medications.

Existing law, the Medical Practice Act, among other things provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board's responsibilities include enforcement of the disciplinary and criminal provisions of the act.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a statewide system of child welfare services, administered by the State Department of Social Services, with the intent that all children are entitled to be safe and free from abuse and neglect.

This bill would, until January 1, 2027, require the State Department of Health Care Services and the State Department of Social Services, pursuant to a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care using data provided by the State Department of Health Care Services and the State Department of Social Services, as prescribed. The bill would require that the data concerning psychotropic medications and related services be drawn from existing data sources maintained by the departments and shared pursuant to a data-sharing agreement and would require that, every 5 years, the board, the State Department of Health Care Services, and the State Department of Social Services consult and revise the methodology, if determined to be necessary. The bill would require the board to contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the board. Commencing July 1, 2017, the bill would require the board to report annually to the Legislature, the State Department of Health Care Services, and the

State Department of Social Services the results of the analysis of the data. The bill would, until January 1, 2027, require the board to review the data in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and conduct an investigation, if warranted, and would require the board to take disciplinary action, as specified. The bill would require the board, on or before January 1, 2022, to conduct an internal review of those activities and to revise procedures relating to those activities, if determined to be necessary. The bill would require the State Department of Health Care Services to disseminate treatment guidelines on an annual basis through its existing communications with Medi-Cal providers, as specified. The bill would require the board to handle on a priority basis investigations of repeated acts of excessive prescribing, furnishing, or administering psychotropic medications to a minor, as specified.

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

SECTION 1. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(7) Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 2. Section 2245 is added to the Business and Professions Code, to read:

2245. (a) The Medical Board of California on a quarterly basis shall review the data provided pursuant to Section 14028 of the Welfare and Institutions Code by the State Department of Health Care Services and the State Department of Social Services in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, shall conduct an investigation.

(b) The State Department of Health Care Services shall disseminate the treatment guidelines on an annual basis through its existing communications with Medi-Cal providers, such as the department's Internet Web site or provider bulletins.

(c) If, after an investigation, the Medical Board of California concludes that there was a violation of law, the board shall take disciplinary action, as appropriate, as authorized by Section 2227.

(d) If, after an investigation, the Medical Board of California concludes that there was excessive prescribing of psychotropic medications inconsistent with the standard of care, the board shall take action, as appropriate, as authorized by Section 2227.

(e) (1) Notwithstanding Section 10231.5 of the Government Code, commencing July 1, 2017, the Medical Board of California shall report annually to the Legislature, the State Department of Health Care Services, and the State Department of Social Services the results of the analysis of data described in Section 14028 of the Welfare and Institutions Code.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(f) On or before January 1, 2022, and in conjunction with the consultation with the State Department of Social Services and the State Department of Health Care Services required by subdivision (a) of Section 14028 of the Welfare and Institutions Code, the Medical Board of California shall conduct an internal review of its data review, investigative, and disciplinary activities undertaken pursuant to this section for the purpose of determining the

efficacy of those activities and shall revise its procedures relating to those activities, if determined to be necessary.

(g) This section shall remain in effect only until January 1, 2027, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2027, deletes or extends that date.

SEC. 3. Section 14028 is added to the Welfare and Institutions Code, to read:

14028. (a) (1) In order to ensure appropriate oversight of psychotropic medications prescribed for children, pursuant to Section 2245 of the Business and Professions Code, the department and the State Department of Social Services, pursuant to a data-sharing agreement that shall meet the requirements of all applicable state and federal laws and regulations, shall provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for individuals described in subparagraphs (B) and (C) of paragraph (1) of subdivision (c). The data concerning psychotropic medications and related services shall be drawn from existing data sources maintained by the departments. Every five years, the Medical Board of California, the department, and the State Department of Social Services shall consult and revise the methodology, if determined to be necessary.

(2) At minimum, the department, on an annual basis, shall share with the Medical Board of California data, including, but not limited to, pharmacy claims data for all foster children who are or have been on three or more psychotropic medications for 90 days or more. Prior to the release of this data, personal identifiers such as name, date of birth, address, and social security number shall be removed and a unique identifier shall be submitted. For each foster child who falls into these categories, the department shall submit the following information to the board:

(A) A list of the psychotropic medications prescribed.

(B) The start and stop dates, if any, for each psychotropic medication prescribed.

(C) The prescriber's name and contact information.

(D) The child's or adolescent's year of birth.

(E) Any other information that is deidentified and necessary to the Medical Board of California to allow the board to exercise its statutory authority as an oversight entity.

(F) The unit and quantity of the medication and the number of days' supply of the medication.

(b) The Medical Board of California shall contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the board pursuant to subdivision (a). The consultant shall consider the treatment guidelines published by the department and the State Department of Social Services when assessing prescribing patterns.

(c) The Medical Board of California, pursuant to subdivision (a), shall analyze prescribing patterns by population for both of the following:

(1) Children adjudged as dependent children under Section 300 and placed in foster care.

(2) A minor adjudged a ward of the court under Section 601 or 602 who has been removed from the physical custody of the parent and placed into foster care.

(d) This section shall remain in effect only until January 1, 2027, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2027, deletes or extends that date.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1177
Author: Galgiani
Chapter: 591
Bill Date: August 18, 2016, Amended
Subject: Physician and Surgeon Health and Wellness Program
Sponsor: California Medical Association (CMA)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes the establishment of a Physician and Surgeon Health and Wellness Program (PHWP) within the Medical Board of California (Board). The PHWP will provide for early identification of, and appropriate interventions to support a licensee in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety. This bill authorizes the Board to contract with a private third-party independent administering entity to administer the program.

BACKGROUND

The Board's Diversion Program was a monitoring program for substance abusing physicians (and some physicians with mental impairment) that ensured physicians were complying with the requirements of their agreement with the Diversion Program. The terms included abstaining from drugs and/or alcohol, biological fluid testing, attending group therapy, etc. Senate Bill 761 (Ridley-Thomas), which was the vehicle to extend the dates of the Board's Diversion Program from January 1, 2009 through January 1, 2011, did not pass out of the Legislature. During the hearings for this bill, the discussion and debate surrounding the Board's Diversion Program centered on the multiple audits indicating concerns with the Diversion Program and its protection of the consumers of California. The Board's Diversion Program was very different than any other board's Diversion Programs within the Department of Consumer Affairs (DCA). The Board's Diversion Program was run by the Board itself, not by an outside vendor, was staffed by civil service employees hired by the Board, and was subject to the budget/legislative process for any changes in the number of staff needed to run the Diversion Program. Based upon the concerns over the safety of patients, the Legislature did not approve the continuation of this Diversion Program and it became inoperative on July 1, 2008.

The Board and its staff developed a transition plan for the individuals that were in the Diversion Program on July 1, 2008. The plan not only transitioned the individuals in the Program to other monitoring programs, but also identified how the Board would perform its mission of consumer protection with individuals who were found to have a substance abuse

problem without the existence of a Diversion Program for physicians.

Under the Diversion Program, physicians who were found to only have a substance abuse problem or mental impairment were allowed to enter the Diversion Program without any record of disciplinary action. If the physician successfully completed the Board's Diversion Program the public never became aware of the issue. The Board determined that the best way to ensure physicians with a substance abuse problem were not endangering the public would be to continue the biological fluid testing requirements. The Board contracted with a vendor to provide these services. Today, without the Diversion Program, when an individual is identified to have an abuse problem, the Board pursues disciplinary action and, if action is taken, the physician is normally placed on probation with terms and conditions including submitting to biological fluid testing. It is up to the physicians to seek a program that will assist them in maintaining abstinence.

With the elimination of the Board's Diversion Program, the Board also knew there would be a need for information regarding physician wellness and resources to assist physicians seeking wellness. Therefore, the Board established a Wellness Committee whose main function was to provide articles for the Board's Newsletter regarding physician wellness, locate resources for physicians who are struggling with impairment issues, and entertain presentations on physician wellness. The information gathered by the Wellness Committee was then provided to physicians via the Board's website or Newsletter. This Committee has since been consolidated with the Education Committee.

At the Board's October 2015 Board Meeting, after meetings with consumer groups, provider groups, and physician health programs, the Board adopted elements that a physician health program should include, in order to be supported by the Board.

ANALYSIS

This bill authorizes the establishment of a PHWP within the Board. The PHWP would provide early identification of, and appropriate interventions to support a physician in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety and maintain the integrity of the medical profession. The PHWP shall aid a physician with substance abuse issues impacting his or her ability to practice medicine.

If the Board establishes a program, it shall do all the following:

- Provide for the education of all licensed physician and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.
- Offer assistance to a physician in identifying substance abuse problems.
- Evaluate the extent of substance abuse problems and refer the physician to the appropriate treatment by executing a written agreement with the physician participant.

- Provide for the confidential participation by a physician with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. If an investigation occurs after the physician has enrolled in the PHWP, the Board may inquire whether the physician is enrolled in the PHWP and the program shall respond accordingly.
- Comply with the Uniform Standards for Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Business and Professions Code Section 315.

If the Board establishes a PHWP, it would be required to contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the PHWP shall be administered by the Board. The administering entity is required to have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals. The administering entity is required to identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and is required to establish a process for evaluating the effectiveness of such programs. The administering entity is required to provide counseling and support for the physician participant and for the family of any physician referred for treatment. The administering entity will have to make their services available to all licensed California physicians, including those who self-refer to the PHWP. The administering entity is required to have a system for immediately reporting a physician from the program to the Board, including but not limited to, a physician who withdraws or is terminated. The system needs to ensure absolute confidentiality in the communication to the Board. The administering entity cannot provide this information to any other individual or entity unless authorized by the physician participant. The contract entered into with the Board needs to require the administering entity to do the following:

- Provide regular communication to the Board, including annual reports to the Board with program statistics, including, but not limited to, the number of participants, the number of participants referred by the Board as a condition of probation, the number of participants who successfully completed their agreement period, and the number of participants terminated from the program. The reports would not be allowed to disclose any personally identifiable information.
- Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements and its implementing rules and regulations. Any audit conducted must maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and must not disclose any information identifying a program participant.

If the Board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the Board, the Board can terminate the contract.

This bill requires a physician, as a condition of participation in the PHWP, to enter into an individual agreement with the PHWP and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the written agreement. The agreement shall include the following:

- A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program.
- Compliance with terms and conditions of treatment and monitoring.
- Criteria for program completion.
- Criteria for termination of a physician participant from the program.
- Acknowledgement that withdrawal or termination of a physician participant from the program shall be reported to the Board.
- Acknowledgement that expenses related to treatment, monitoring, laboratory tests, and other specified activities shall be paid by the physician participant.

This bill specifies that any agreement entered into would not be considered a disciplinary action or order by the Board and shall not be disclosed to the Board if both of the following apply:

- The physician did not enroll in the PHWP as a condition of probation or as a result of an action by the Board.
- The physician is in compliance with the conditions and procedures in the agreement.

This bill specifies that any oral or written information reported to the Board is confidential and shall not constitute a waiver of any existing evidentiary privileges. However, confidentiality regarding the physician's participation in the program and related records shall not apply if the Board has referred a participant as a condition of probation or as otherwise authorized by this article. This bill specifies that it does not prohibit, require, or otherwise affect the discovery or admissibility of evidence in an action by the Board against a physician based on acts or omissions that are alleged to be grounds for discipline. This bill specifies that participation in the program shall not be a defense to any disciplinary action that may be taken by the Board. The requirements in this bill would not preclude the Board from taking disciplinary action against a physician who is terminated unsuccessfully from the program but the disciplinary action may not include any confidential information unless authorized (the information is only confidential if the participant is not on probation and is complying with his or her individual agreement with the PHWP and if the participant does not withdraw from the program).

This bill establishes the Physician and Surgeon Health and Wellness Program Account in the contingent fund of the Board. Any fees collected from participants shall be deposited into this account and upon appropriation by the Legislature, shall be available for support of the program. This bill requires the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP shall pay. The fee is required to be set at a level

sufficient to cover all costs of participating in the PHWP, including any administrative costs incurred by the Board to administer the PHWP. This bill allows the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP. These moneys could not be used to cover costs for individual physicians to participate in the program.

According to the sponsor, this bill will bring California in line with the majority of other states who recognize that wellness and treatment programs serve to enhance public health and provide resources for those in need of help.

The PHWP proposed by this bill is not a diversion program, it will not divert physicians from discipline; this is of utmost importance for consumer protection. The Board will not be running this program, it will be run by a private third-party independent administering entity that will be selected pursuant to the request for proposals process. This bill requires the PHWP to comply with the Uniform Standards and requires any physician participants who terminate or withdraw from the PHWP to be reported to the Board. These are both very important elements for consumer protection. This bill also allows for communication to the Board for those physicians ordered to the PHWP as a condition of probation, which is also important for consumer protection. Clarifying amendments were taken in Business and Professions Code Section 2340.6(c) to make it clear that confidentiality shall not apply if a physician is not in compliance with the conditions and procedures in the agreement. With this amendments, Board staff believes that this bill is in compliance with the Uniform Standards. Board staff also believes that the PHWP proposed by this bill aligns with the Board-approved elements and the Board has taken a support position on this bill.

FISCAL: This bill requires the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP must pay. The fee is required to be set at a level sufficient to cover all costs of participating in the PHWP. Any fees collected by the Board from participants shall be deposited into the newly established Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Board and, upon appropriation by the Legislature, shall be available for support of the program. This bill allows the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP.

The Board will need one staff position at the Associate Governmental Program Analyst level to set up the PHWP and then coordinate with the third-party vendor to implement the PHWP.

SUPPORT: CMA (Sponsor); California Chapter of the American College of Emergency Physicians; California Health Advocates; California Hospital Association; California Primary Care Association; Medical

Board of California; and Union of American Physicians and Dentists

OPPOSITION: Center for Public Interest Law
Consumers Union's Safe Patient Project

IMPLEMENTATION:

- Newsletter article(s) (including several stand-alone articles)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Hire the Associate Governmental Program Analyst position – the first task for this position will be to develop regulations (est. date of completion to hire – January 2017)
- Submit change request for BreEZe to add public secondary status code modifier
- Develop regulations to specify the requirements for the administering entity, including communication from the administering entity to the Board, and shared services for the administering entity to pay the Board for administration costs from participant fees
- Update regulations for the Board's Disciplinary Guidelines and Uniform Standards (this will be one regulatory package with administering entity regulations – estimated regulatory hearing at the October 2017 Board Meeting – the other deadlines will depend on when these regulations are adopted)
- Once regulations are adopted, the Board will issue a request for proposals (RFP) to select an administering entity and will include the requirements in the regulations in the RFP process
- Once the administering entity is selected, the Board will have to adopt regulations to set the fee for participants, which must cover all of the administering entities' fees and any costs to the Board for administering the program
- The Board will work with the administering entity to establish a process for filing complaints when the program notifies the Board of any participants that withdraw or who do not comply with the program requirements (including the Uniform Standards)
- Update the Board's website with information about the new program

Senate Bill No. 1177

CHAPTER 591

An act to add Article 14 (commencing with Section 2340) to Chapter 5 of Division 2 of the Business and Professions Code, relating to healing arts.

[Approved by Governor September 24, 2016. Filed with Secretary of State September 24, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1177, Galgiani. Physician and Surgeon Health and Wellness Program.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards and a designee of the State Department of Health Care Services. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees, whether or not a healing arts board has a formal diversion program.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California within the Department of Consumer Affairs. Existing law requires all moneys paid to and received by the Medical Board of California to be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California, which, except for fine and penalty money, is a continuously appropriated fund.

This bill would authorize the board to establish a Physician and Surgeon Health and Wellness Program for the early identification of, and appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse, as specified. If the board establishes a program, the bill would require the board to contract for the program's administration with a private 3rd-party independent administering entity meeting certain requirements. The bill would require program participants to enter into an individual agreement with the program that includes, among other things, a requirement to pay expenses related to treatment, monitoring, and laboratory tests, as provided.

This bill would create the Physician and Surgeon Health and Wellness Program Account within the Contingent Fund of the Medical Board of California. The bill would require the board to adopt regulations to determine the appropriate fee for a physician and surgeon to participate in the program, as specified. The bill would require these fees to be deposited in the Physician and Surgeon Health and Wellness Program Account and to be available, upon appropriation by the Legislature, for the support of the program. Subject to appropriation by the Legislature, the bill would authorize

the board to use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program, except the bill would prohibit these moneys from being used to cover any costs for individual physician and surgeon participation in the program.

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

SECTION 1. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Physician and Surgeon Health and Wellness Program

2340. (a) The board may establish a Physician and Surgeon Health and Wellness Program for the early identification of, and appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse to ensure that the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. The program, if established, shall aid a physician and surgeon with substance abuse issues impacting his or her ability to practice medicine.

(b) For the purposes of this article, "program" shall mean the Physician and Surgeon Health and Wellness Program.

(c) If the board establishes a program, the program shall meet the requirements of this article.

2340.2. If the board establishes a program, the program shall do all of the following:

(a) Provide for the education of all licensed physicians and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.

(b) Offer assistance to a physician and surgeon in identifying substance abuse problems.

(c) Evaluate the extent of substance abuse problems and refer the physician and surgeon to the appropriate treatment by executing a written agreement with a physician and surgeon participant.

(d) Provide for the confidential participation by a physician and surgeon with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. If an investigation of a physician and surgeon occurs after the physician and surgeon has enrolled in the program, the board may inquire of the program whether the physician and surgeon is enrolled in the program and the program shall respond accordingly.

(e) Comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the department pursuant to Section 315.

2340.4. (a) If the board establishes a program, the board shall contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the program shall be administered by the board pursuant to Article 4 (commencing with Section 10335) of Chapter 2 of Part 2 of Division 2 of the Public Contract Code. However, Section 10425 of the Public Contract Code shall not apply to this subdivision.

(b) The administering entity shall have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals.

(c) The administering entity shall identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and shall establish a process for evaluating the effectiveness of those programs.

(d) The administering entity shall provide counseling and support for the physician and surgeon and for the family of any physician and surgeon referred for treatment.

(e) The administering entity shall make their services available to all licensed California physicians and surgeons, including those who self-refer to the program.

(f) The administering entity shall have a system for immediately reporting a physician and surgeon, including, but not limited to, a physician and surgeon who withdraws or is terminated from the program, to the board. This system shall ensure absolute confidentiality in the communication to the board. The administering entity shall not provide this information to any other individual or entity unless authorized by the participating physician and surgeon or this article.

(g) The contract entered into pursuant to this section shall also require the administering entity to do the following:

(1) Provide regular communication to the board, including annual reports to the board with program statistics, including, but not limited to, the number of participants currently in the program, the number of participants referred by the board as a condition of probation, the number of participants who have successfully completed their agreement period, and the number of participants terminated from the program. In making reports, the administering entity shall not disclose any personally identifiable information relating to any participant.

(2) Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements of this article and its implementing rules and regulations. Any audit conducted pursuant to this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information identifying a program participant.

(h) If the board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the board, the board may terminate the contract.

2340.6. (a) A physician and surgeon shall, as a condition of participation in the program, enter into an individual agreement with the program and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement. The agreement shall include all of the following:

(1) A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program.

(2) Compliance with terms and conditions of treatment and monitoring.

(3) Criteria for program completion.

(4) Criteria for termination of a physician and surgeon participant from the program.

(5) Acknowledgment that withdrawal or termination of a physician and surgeon participant from the program shall be reported to the board.

(6) Acknowledgment that expenses related to treatment, monitoring, laboratory tests, and other activities specified by the program shall be paid by the physician and surgeon participant.

(b) Any agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board and shall not be disclosed to the board if both of the following apply:

(1) The physician and surgeon did not enroll in the program as a condition of probation or as a result of an action by the board.

(2) The physician and surgeon is in compliance with the conditions and procedures in the agreement.

(c) Any oral or written information reported to the board shall remain confidential and shall not constitute a waiver of any existing evidentiary privileges. However, confidentiality regarding the physician and surgeon's participation in the program and related records shall not apply if the board has referred a participant as a condition of probation or as otherwise authorized by this article.

(d) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action by the board against a physician and surgeon based on acts or omissions that are alleged to be grounds for discipline.

(e) Participation in the program shall not be a defense to any disciplinary action that may be taken by the board. This section does not preclude the board from commencing disciplinary action against a physician and surgeon who is terminated unsuccessfully from the program. However, that disciplinary action shall not include as evidence any confidential information unless authorized by this article.

2340.8. (a) The Physician and Surgeon Health and Wellness Program Account is hereby established within the Contingent Fund of the Medical Board of California. Any fees collected by the board pursuant to subdivision (b) shall be deposited in the Physician and Surgeon Health and Wellness Program Account and shall be available, upon appropriation by the Legislature, for the support of the program.

(b) The board shall adopt regulations to determine the appropriate fee that a physician and surgeon participating in the program shall provide to

the board. The fee amount adopted by the board shall be set at a level sufficient to cover all costs for participating in the program, including any administrative costs incurred by the board to administer the program.

(c) Subject to appropriation by the Legislature, the board may use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program under this article, except these moneys shall not be used to cover any costs for individual physician and surgeon participation in the program.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1189
Author:	Pan and Jackson
Chapter:	787
Bill Date:	August 19, 2016, Amended
Subject:	Autopsies: Licensed Physicians and Surgeons
Sponsor:	Union of American Physicians and Dentists (UAPD)
Position	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires that a forensic autopsy be conducted by a licensed physician and surgeon and requires that the results of a forensic autopsy can only be determined by a licensed physician and surgeon.

BACKGROUND

California law does not define the term "autopsy," but a 1970 opinion of the California Attorney General states that an autopsy is a "form of postmortem examination in which a dead body is examined and at least partially dissected for the purpose of ascertaining the cause of death, the nature and extent of lesions of disease, or any other abnormalities present."

The Ventura County District Attorney's (DA) Office published a report in February 2016 entitled "A Report on the Ventura County Medical Examiner Investigation." In this report, the Ventura County DA reviews the investigation it conducted on Ventura County's former Medical Examiner, and discusses the obstacles faced by the DA's office in pursuing criminal action. In the report, it brings up several grey areas of law related to autopsies and who can perform them. The report states that there is no California law that defines an autopsy and there is no statute that clearly defines that performance of an autopsy is the practice of medicine. The report also states there is a need for legislation to clarify whether the performance of an autopsy is included in the practice of medicine.

Fifty of California's 58 counties have sheriff-coroner offices, which means that the two offices are consolidated and the sheriff also serves as the coroner. There are sections in the Government Code that authorize the coroner to perform autopsies. There is also a section in the Health and Safety Code that allows an autopsy to be performed by a coroner or other officer authorized by law to perform autopsies. The definition of the practice of medicine in the Medical Practice Act does not specifically address that conducting an autopsy on a dead body constitutes the practice of medicine. The Ventura County DA's office makes recommendations in the conclusion of its report that the Legislature should consider amending existing law to clarify whether an autopsy is the practice of medicine and to define the term autopsy.

ANALYSIS

This bill expressly states that forensic autopsies can only be conducted by a licensed physician and surgeon. This bill requires that the results of an autopsy may only be determined by a licensed physician and surgeon. This bill defines a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause and manner of death is determined. This bill specifies at the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon, trained county personnel who are necessary to the performance of an autopsy may take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent. This bill defines a postmortem examination to mean the external examination of the body where no manner or cause of death is determined. This bill requires the manner of death to be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the licensed physician and surgeon in the determination of the manner of death.

This bill provides, for health and safety purposes, all persons in the autopsy suite to be informed of the risks presented by blood borne pathogens and they should wear personal protective equipment, as specified. This bill only allows individuals who are directly involved in the investigation of the death of the decedent in the autopsy suite. If an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved in the death of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of an autopsy. This bill allows individuals in the autopsy suite for educational and research purposes at the discretion of the coroner, and in consultation with any licensed physician and surgeon conducting an autopsy. This bill requires police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to the death that is incident to law enforcement activity to be made available to the physician and surgeon who conducts the autopsy prior to the completion of the investigation of the death. This bill makes conforming changes to other portions of the Government Code that reference autopsies.

According to the authors, a medically-trained physician and surgeon is best equipped to determine the results of an autopsy. Clarifying that a medically trained professional should be the one who conducts the autopsy also clarifies ambiguities in existing law. The sponsors of this bill believe that elected officials lack the medical expertise necessary to perform an autopsy to the same degree as a licensed physician and surgeon and this bill seeks to add further legitimacy and authority to death investigations in coroner cases.

The Board believes there are grey areas in the law related to autopsies being the practice of medicine and who can perform autopsies. This bill makes it clear in the law that autopsies can only be performed by licensed physicians and surgeons, which is appropriate. This clarification will assist the Board in its enforcement actions and further the Board's

mission of consumer protection. For these reasons, the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: UAPD (Sponsor)
Consumer Attorneys of California
Medical Board of California
National Association of Medical Examiners
Ventura County District Attorney's Office
Three individuals

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website to include information on the requirements of this bill

Senate Bill No. 1189

CHAPTER 787

An act to amend Sections 27491.4, 27491.41, 27491.43, 27491.46, 27491.47, and 27520 of, and to add Section 27522 to, the Government Code, relating to autopsies.

[Approved by Governor September 28, 2016. Filed with Secretary of State September 28, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1189, Pan. Postmortem examinations or autopsies: forensic pathologists.

Existing law requires a county coroner to inquire into and determine the circumstances, manner, and cause of certain deaths. Existing law either requires or authorizes a county coroner, under certain circumstances, to perform, or cause to be performed, an autopsy on a decedent. Existing law imposes certain requirements on a postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified body or human remains. Existing law requires the coroner to perform an autopsy pursuant to a standardized protocol developed by the State Department of Public Health in any case where an infant has died suddenly and unexpectedly.

Existing law authorizes the board of supervisors of a county to consolidate the duties of certain county offices in one or more of specified combinations, including, but not limited to, sheriff and coroner, district attorney and coroner, and public administrator and coroner. Existing law authorizes the board of supervisors of a county to abolish the office of coroner and provide instead for the office of medical examiner, as specified, and requires the medical examiner to be a licensed physician and surgeon duly qualified as a specialist in pathology.

This bill would require that a forensic autopsy, as defined, be conducted by a licensed physician and surgeon. The bill would require that the results of a forensic autopsy be determined by a licensed physician and surgeon. The bill would require the manner of death to be determined by the coroner or medical examiner of a county. The bill would authorize trained county personnel who are necessary to the performance of an autopsy to take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent at the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon. The bill would require, if a licensed physician and surgeon conducts a forensic autopsy, the coroner or medical examiner to consult with the licensed physician and surgeon in the determination of the manner of death. The bill would require the coroner to conduct an evaluation pursuant to a standardized protocol developed by

the State Department of Public Health in any case where an infant has died suddenly and unexpectedly.

The bill would require, for health and safety purposes, that all persons in the autopsy suite be informed of the risks presented by bloodborne pathogens and be informed that they should wear personal protective equipment, as specified. The bill would require that only individuals who are directly involved in the investigation of the death of the decedent be allowed into the autopsy suite but would permit individuals to be in the autopsy suite for educational and research purposes at the discretion of the coroner, in consultation with any licensed physician and surgeon conducting an autopsy. The bill would prohibit law enforcement personnel directly involved in the death of an individual who died due to involvement of law enforcement activity from being involved with any portion of the postmortem examination or being inside the autopsy suite during the performance of the autopsy. The bill would define a postmortem examination for this purpose to be the external examination of the body where no manner or cause of death is determined.

The bill would require specified materials that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity to be made available to the physician and surgeon who conducts the autopsy prior to the completion of the investigation of the death.

The bill would specify that these provisions shall not be construed to limit the practice of an autopsy for educational or research purposes.

By imposing additional duties upon local officials and law enforcement agencies, this bill would create a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

The bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

SECTION 1. Section 27491.4 of the Government Code is amended to read:

27491.4. (a) For purposes of inquiry the coroner shall, within 24 hours or as soon as feasible thereafter, where the suspected cause of death is sudden infant death syndrome and, in all other cases, the coroner may, in his or her discretion, take possession of the body, which shall include the authority to exhume the body, order it removed to a convenient place, and make or cause to be made a postmortem examination, or cause to be made an autopsy thereon, and make or cause to be made an analysis of the stomach, stomach contents, blood, organs, fluids, or tissues of the body. The detailed medical findings resulting from an inspection of the body or autopsy by an examining licensed physician and surgeon shall be either reduced to writing or

permanently preserved on recording discs or other similar recording media, shall include all positive and negative findings pertinent to establishing the cause of death in accordance with medicolegal practice and this, along with the written opinions and conclusions of the examining licensed physician and surgeon, shall be included in the coroner's record of the death. The coroner shall have the right to retain only those tissues of the body removed at the time of the autopsy as may, in his or her opinion, be necessary or advisable to the inquiry into the case, or for the verification of his or her findings. Only individuals who are directly involved in the investigation of the death of the decedent may be present during the performance of the autopsy.

(b) In any case in which the coroner knows, or has reason to believe, that the deceased has made valid provision for the disposition of his or her body or a part or parts thereof for medical or scientific purposes in accordance with Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code, the coroner shall neither perform nor authorize any other person to perform an autopsy on the body unless the coroner has contacted or attempted to contact the physician last in attendance to the deceased. If the physician cannot be contacted, the coroner shall then notify or attempt to notify one of the following of the need for an autopsy to determine the cause of death: (1) the surviving spouse; (2) a surviving child or parent; (3) a surviving brother or sister; (4) any other kin or person who has acquired the right to control the disposition of the remains. Following a period of 24 hours after attempting to contact the physician last in attendance and notifying or attempting to notify one of the responsible parties listed above, the coroner may authorize the performance of an autopsy, as otherwise authorized or required by law.

(c) Nothing in this section shall be deemed to prohibit the discretion of the coroner to cause to be conducted an autopsy upon any victim of sudden, unexpected, or unexplained death or any death known or suspected of resulting from an accident, suicide, or apparent criminal means, or other death, as described in Section 27491.

SEC. 2. Section 27491.41 of the Government Code is amended to read:

27491.41. (a) For purposes of this section, "sudden infant death syndrome" means the sudden death of any infant that is unexpected by the history of the infant and where a thorough postmortem examination fails to demonstrate an adequate cause of death.

(b) The Legislature finds and declares that sudden infant death syndrome, also referred to as SIDS, is the leading cause of death for children under age one, striking one out of every 500 children. The Legislature finds and declares that sudden infant death syndrome is a serious problem within the State of California, and that the public interest is served by research and study of sudden infant death syndrome and its potential causes and indications.

(c) (1) To facilitate these purposes, the coroner shall, within 24 hours or as soon thereafter as feasible, cause an autopsy to be performed in any case where an infant has died suddenly and unexpectedly.

(2) However, if the attending licensed physician and surgeon desires to certify that the cause of death is sudden infant death syndrome, an autopsy may be performed at the discretion of the coroner. If the coroner causes an autopsy to be performed pursuant to this section, he or she shall also certify the cause of death.

(d) The autopsy shall be conducted pursuant to a standardized protocol developed by the State Department of Public Health. The protocol is exempt from the procedural requirements pertaining to the adoption of administrative rules and regulations pursuant to Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The protocol shall be followed by all coroners throughout the state when conducting an evaluation as part of an autopsy required by this section. The coroner shall state on the certificate of death that sudden infant death syndrome was the cause of death when the coroner's findings are consistent with the definition of sudden infant death syndrome specified in the standardized autopsy protocol. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, and criteria for any specific tissue sampling, and any other requirements. The protocol may also require that specific tissue samples shall be provided to a central tissue repository designated by the State Department of Public Health.

(f) The State Department of Public Health shall establish procedures and protocols for access by researchers to any tissues, or other materials or data authorized by this section. Research may be conducted by any individual with a valid scientific interest and prior approval from the State Committee for the Protection of Human Subjects. The tissue samples, the materials, and all data shall be subject to the confidentiality requirements of Section 103850 of the Health and Safety Code.

(g) The coroner may take tissue samples for research purposes from infants who have died suddenly and unexpectedly without consent of the responsible adult if the tissue removal is not likely to result in any visible disfigurement.

(h) A coroner or licensed physician and surgeon shall not be liable for damages in a civil action for any act or omission done in compliance with this section.

(i) Consent of any person is not required before undertaking the autopsy required by this section.

SEC. 3. Section 27491.43 of the Government Code is amended to read:

27491.43. (a) (1) Notwithstanding any other law, except as otherwise provided in this section, in any case in which the coroner, before the beginning of an autopsy, dissection, or removal of corneal tissue, pituitary glands, or any other organ, tissue, or fluid, has received a certificate of religious belief, executed by the decedent as provided in subdivision (b), that the procedure would be contrary to his or her religious belief, the coroner shall neither perform, nor order the performance of, that procedure on the body of the decedent.

(2) If, before beginning the procedure, the coroner is informed by a relative or a friend of the decedent that the decedent had executed a certificate of religious belief, the coroner shall not order an autopsy to be performed, except as otherwise provided in this section, for 48 hours. If the certificate is produced within 48 hours, the case shall be governed by this section. If the certificate is not produced within that time, the case shall be governed by the other provisions of this article.

(b) Any person, 18 years of age or older, may execute a certificate of religious belief which shall state in clear and unambiguous language that any postmortem anatomical dissection or that specified procedures would violate the religious convictions of the person. The certificate shall be signed and dated by the person in the presence of at least two witnesses. Each witness shall also sign the certificate and shall print on the certificate his or her name and residence address.

(c) Notwithstanding the existence of a certificate, the coroner may at any time cause an autopsy to be performed or any other procedure if he or she has a reasonable suspicion that the death was caused by the criminal act of another or by a contagious disease constituting a public health hazard.

(d) (1) If a certificate is produced, and if subdivision (c) does not apply, the coroner may petition the superior court, without fee, for an order authorizing an autopsy or other procedure or for an order setting aside the certificate as invalid. Notice of the proceeding shall be given to the person who produced the certificate. The proceeding shall have preference over all other cases.

(2) The court shall set aside the certificate if it finds that the certificate was not properly executed or that it does not clearly state the decedent's religious objection to the proposed procedure.

(3) The court may order an autopsy or other procedure despite a valid certificate if it finds that the cause of death is not evident, and that the interest of the public in determining the cause of death outweighs its interest in permitting the decedent and like persons fully to exercise their religious convictions.

(4) Any procedure performed pursuant to paragraph (3) shall be the least intrusive procedure consistent with the order of the court.

(5) If the petition is denied, and no stay is granted, the body of the deceased shall immediately be released to the person authorized to control its disposition.

(e) In any case in which the circumstances, manner, or cause of death is not determined because of the provisions of this section, the coroner may state on the certificate of death that an autopsy was not conducted because of the provisions of this section.

(f) A coroner shall not be liable for damages in a civil action for any act or omission taken in compliance with the provisions of this section.

SEC. 4. Section 27491.46 of the Government Code is amended to read:

27491.46. (a) The coroner shall have the right to retain pituitary glands solely for transmission to a university, for use in research or the advancement of medical science, in those cases in which the coroner has required an

autopsy to be performed pursuant to this chapter, and during a 48-hour period following such autopsy the body has not been claimed and the coroner has not been informed of any relatives of the decedent.

(b) In the course of any autopsy, the coroner may cause to be removed the pituitary gland from the body for transmittal to any public agency for use in manufacturing a hormone necessary for the physical growth of persons who are, or may become, hypopituitary dwarfs, if the coroner has no knowledge of objection to the removal and release of the pituitary gland having been made by the decedent or any other person specified in Section 7151.5 of the Health and Safety Code. Neither the coroner nor the medical examiner authorizing the removal of the pituitary gland, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of the pituitary gland pursuant to this section, shall incur civil liability for the removal of the pituitary gland in an action brought by any person who did not object prior to the removal of the pituitary gland, nor be subject to criminal prosecution for removal of the pituitary gland pursuant to the authority of this section.

Nothing in this subdivision shall supersede the terms of any gift made pursuant to Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code.

SEC. 5. Section 27491.47 of the Government Code is amended to read:

27491.47. (a) Notwithstanding any other law, the coroner may, in the course of an autopsy, authorize the removal and release of corneal eye tissue from a body within the coroner's custody, if all of the following conditions are met:

(1) The autopsy has otherwise been authorized.

(2) The coroner has no knowledge of objection to the removal and release of corneal tissue having been made by the decedent or any other person specified in Section 7151 of the Health and Safety Code and has obtained any one of the following:

(A) A dated and signed written consent by the donor or any other person specified in Section 7151 of the Health and Safety Code on a form that clearly indicates the general intended use of the tissue and contains the signature of at least one witness.

(B) Proof of the existence of a recorded telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code in the form of an audio recording of the conversation or a transcript of the recorded conversation, which indicates the general intended use of the tissue.

(C) A document recording a verbal telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code, witnessed and signed by no fewer than two members of the requesting entity, hospital, eye bank, or procurement organization, memorializing the consenting person's knowledge of and consent to the general intended use of the gift.

The form of consent obtained under subparagraph (A), (B), or (C) shall be kept on file by the requesting entity and the official agency for a minimum of three years.

(3) The removal of the tissue will not unnecessarily mutilate the body, be accomplished by enucleation, nor interfere with the autopsy.

(4) The tissue will be removed by a licensed physician and surgeon or a trained transplant technician.

(5) The tissue will be released to a public or nonprofit facility for transplant, therapeutic, or scientific purposes.

(b) Neither the coroner nor medical examiner authorizing the removal of the corneal tissue, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of corneal tissue pursuant to this section, shall incur civil liability for the removal in an action brought by any person who did not object prior to the removal of the corneal tissue, nor be subject to criminal prosecution for the removal of the corneal tissue pursuant to this section.

(c) This section shall not be construed to interfere with the ability of a person to make an anatomical gift pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

SEC. 6. Section 27520 of the Government Code is amended to read:

27520. (a) The coroner shall cause to be performed an autopsy on a decedent, for which an autopsy has not already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner shall cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(b) The coroner may cause to be performed an autopsy on a decedent, for which an autopsy has already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner may cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(c) The cost of an autopsy requested pursuant to either subdivision (a) or (b) shall be borne by the person requesting that it be performed.

SEC. 7. Section 27522 is added to the Government Code, to read:

27522. (a) A forensic autopsy shall only be conducted by a licensed physician and surgeon. The results of a forensic autopsy shall only be determined by a licensed physician and surgeon.

(b) A forensic autopsy shall be defined as an examination of a body of a decedent to generate medical evidence for which the cause of death is determined. At the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon, trained county personnel who are necessary to the performance of an autopsy may take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent.

(c) For purposes of this section, a postmortem examination shall be defined as the external examination of the body where no manner or cause of death is determined.

(d) For purposes of this section, the manner of death shall be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner or medical examiner shall consult with the licensed physician and surgeon in the determination of the manner of death.

(e) For health and safety purposes, all persons in the autopsy suite shall be informed of the risks presented by bloodborne pathogens and that they should wear personal protective equipment in accordance with the requirements described in Section 5193 of Title 8 of the California Code of Regulations or its successor.

(f) (1) Only individuals who are directly involved in the investigation of the death of the decedent shall be allowed into the autopsy suite.

(2) If an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved in the death of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of the autopsy.

(3) Notwithstanding paragraph (1), individuals may be permitted in the autopsy suite for educational and research purposes at the discretion of the coroner and in consultation with any licensed physician and surgeon conducting an autopsy.

(g) Any police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity shall be made available to the physician and surgeon who conducts the autopsy prior to the completion of the investigation of the death.

(h) This section shall not be construed to limit the practice of an autopsy for educational or research purposes.

SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1261
Author: Stone
Chapter: 239
Bill Date: May 3, 2016, Amended
Subject: Physicians and Surgeons: Fee Exemption: Residency
Sponsor: California Primary Care Association (CPCA)
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill deletes the requirement in existing law that a physician and surgeon must reside in California in order to get the license and renewal fees waived for providing volunteer services.

BACKGROND

Currently, the initial or renewal license fee is waived for a physician and surgeon who resides in California, has a California address of record, and certifies to the Medical Board of California (Board) that the initial or renewal license is for the sole purpose of providing voluntary, unpaid service. A voluntary service physician licensee whose initial and/or renewal license fee has been waived pursuant to Business and Professions Code sections 2083 and 2442 must comply with the continuing medical education requirements.

ANALYSIS

SB 1261 deletes the California residency requirement for voluntary status licenses. This bill allows an out-of-state individual to apply for a California license and ask for it to be put in voluntary status, or a current California licensee who resides out of state can request that his or her license be placed in voluntary status. These options result in the initial license fee and/or subsequent renewal fees being waived. In order to be issued a voluntary status license, a licensee must certify to the Board that the sole purpose of his or her license is to provide voluntary, unpaid service. This bill may encourage more licensed physicians to provide volunteer services in California. The Board has taken a neutral position on this bill.

FISCAL: Minor and absorbable

SUPPORT: None on file

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff
- Update the Board's website regarding voluntary status licenses
- Update the Board's voluntary status license application and initial license application

Senate Bill No. 1261

CHAPTER 239

An act to amend Sections 2083 and 2442 of the Business and Professions Code, relating to healing arts.

[Approved by Governor August 29, 2016. Filed with Secretary of State August 29, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1261, Stone. Physicians and surgeons: fee exemption: residency.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and establishes specific requirements for licensure and renewal. That act generally requires that an application for a certificate be accompanied by the fee required by the act, but requires the waiver of the fee for a physician and surgeon residing in California who certifies to the board that the license is for the sole purpose of providing voluntary, unpaid service. The act establishes a parallel fee waiver requirement for the renewal of a physician and surgeon's certificate.

This bill would remove from those application and renewal fee waiver provisions the requirement that a physician and surgeon reside in California.

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

SECTION 1. Section 2083 of the Business and Professions Code is amended to read:

2083. (a) Except as provided in subdivision (b), each application for a certificate shall be accompanied by the fee required by this chapter and shall be filed with the Division of Licensing.

(b) The license fee shall be waived for a physician and surgeon who certifies to the Medical Board of California that the issuance of the license is for the sole purpose of providing voluntary, unpaid service.

SEC. 2. Section 2442 of the Business and Professions Code is amended to read:

2442. The renewal fee shall be waived for a physician and surgeon who certifies to the Medical Board of California that license renewal is for the sole purpose of providing voluntary, unpaid service.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1478
Author:	Senate Business, Professions and Economic Development Committee
Chapter:	489
Bill Date:	August 18, 2016, Amended
Subject:	Healing Arts
Sponsor:	Author and affected healing arts boards
Position:	Support provisions related to the Medical Board of California

DESCRIPTION OF CURRENT LEGISLATION:

This bill was the vehicle by which omnibus legislation was carried by the Senate Business, Professions and Economic Development Committee. This analysis only includes the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). This bill deletes outdated sections of the BPC that are related to the Board. This bill also clarifies that the annual fee for the Controlled Substance Utilization Review and Evaluation System (CURES) shall not be applied to licensees in retired or inactive status, while this portion was not sponsored by the Board, it will impact the Board's licensees.

ANALYSIS

- This bill deletes BPC Section 2029 that requires the Board to keep copies of complaints for 10 years. The Board already has its own record retention schedule and BPC Section 2227.5 only requires the Board to keep complaints for seven years or until the statute of limitations has expired, whichever is shorter. BPC Section 2230.5 sets forth the statute of limitations for filing an accusation, which is three years from the date the Board finds out about the event or seven years from the date of the event, whichever occurs first. Both of these section of law make BPC 2029 inapplicable.

- This bill deletes the task force created in BPC Section 852, as it no longer exists.

- This bill also deletes Sections 2380-2392 of the BPC, which created the Bureau of Medical Statistics in the Board. The Bureau of Medical Statistics does not exist, so this change is code clean up only.

These changes will remove outdated and inapplicable sections from the BPC and the Board was pleased to sponsor/support these provisions in SB 1478.

This bill was amended and now clarifies that the annual fee for CURES shall not be applied to licensees in retired or inactive status. This provision was not sponsored by the Board, but it will impact the Board's licensees with a license in retired or inactive status.

FISCAL: None

SUPPORT: Medical Board of California

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Submit a request for changes to BreEZE to exclude the CURES fee from physician renewal transactions when the retired fee exempt modifier or inactive secondary status code modifiers are present, effective 7/1/2017
- Update the Board's website to specify that CURES fees do not need to be paid by licensees with a license in retired or inactive status

Senate Bill No. 1478

CHAPTER 489

An act to amend Sections 27, 208, 1632, 1634.1, 2467, 2541.3, 2541.6, 2545, 2550, 2550.1, 2552, 2553, 2554, 2555, 2555.1, 2558, 2559, 2559.2, 2559.3, 2559.5, 2561, 2563, 3027, 4980.36, 4980.37, 4980.43, 4980.78, 4980.79, 4980.81, 4992.05, 4996.3, 4996.18, 4996.23, 4999.12, 4999.40, 4999.47, 4999.52, 4999.60, 4999.61, and 4999.120 of, to add Sections 4980.09 and 4999.12.5 to, to repeal Sections 852, 2029, 2540.1, 4980.40.5, and 4999.54 of, and to repeal Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 22, 2016. Filed with Secretary of State September 22, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, Committee on Business, Professions and Economic Development. Healing arts.

Existing law provides for the licensure and regulation of healing arts professions and vocations by boards within the Department of Consumer Affairs.

(1) Existing law requires a Controlled Substance Utilization Review and Evaluation System (CURES) fee of $6 to be assessed annually, at the time of license renewal, on specified licensees to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees.

The bill would, beginning July 1, 2017, except as specified, exempt licensees issued a license placed in a retired or inactive status from the CURES fee requirement.

(2) Existing law establishes the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the task force to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency, identify the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices and assess the need for voluntary certification standards and examinations for cultural and linguistic competency.

This bill would delete those provisions.

(3) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. Existing law requires each applicant to, among other things, successfully complete the Part I and Part II written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

This bill would instead require the applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(4) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.

Existing law requires the board to keep a copy of a complaint it receives regarding the poor quality of care rendered by a licensee for 10 years from the date the board receives the complaint, as provided.

This bill would delete that requirement.

Existing law creates the Bureau of Medical Statistics within the board. Under existing law, the purpose of the bureau is to provide the board with statistical information necessary to carry out their functions of licensing, medical education, medical quality, and enforcement.

This bill would abolish that bureau.

(5) Under existing law, the California Board of Podiatric Medicine is responsible for the certification and regulation of the practice of podiatric medicine. Existing law requires the board to annually elect one of its members to act as president and vice president.

This bill would instead require the board to elect from its members a president, a vice president, and a secretary.

(6) Under existing law, any person who violates any of the provisions governing prescription lenses is subject to a specified fine per violation. Existing law requires the fines from licensed physicians and surgeons and registered dispensing opticians to be available upon appropriation to the Medical Board of California for the purposes of administration and enforcement. Existing law requires the fines from licensed optometrists to be deposited into the Optometry Fund and to be available upon appropriation to the State Board of Optometry for the purposes of administration and enforcement. Beginning January 1, 2016, existing law makes the State Board of Optometry responsible for the registration and regulation of registered dispensing opticians.

This bill would instead require fines from registered dispensing opticians to be deposited in the Dispensing Opticians Fund and to be available upon appropriation to the State Board of Optometry.

(7) The Board of Behavioral Sciences is responsible for administering, among others, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

(A) Existing law, the Licensed Marriage and Family Therapist Act, provides for the regulation of the practice of marriage and family therapy by the Board of Behavioral Sciences. A violation of the act is a crime. Existing law requires the licensure of marriage and family therapists and the registration of marriage and family therapist interns. Under existing law, an “intern” is defined as an unlicensed person who has earned his or her master’s or doctoral degree qualifying him or her for licensure and is registered with the board. Existing law prohibits the abbreviation “MFTI”

from being used in an advertisement unless the title "marriage and family therapist registered intern" appears in the advertisement.

Existing law, the Licensed Professional Clinical Counselor Act, provides for the regulation of the practice of professional clinical counseling by the Board of Behavioral Sciences. Existing law requires the licensure of professional clinical counselors and the registration of professional clinical counselor interns. Under existing law, an "intern" is defined as an unlicensed person who meets specified requirements for registration and is registered with the board.

This bill, commencing January 1, 2018, would provide that certain specified titles using the term "intern" or any reference to the term "intern" in those acts shall be deemed to be a reference to an "associate," as specified. Because this bill would change the definition of a crime in the Licensed Marriage and Family Therapist Act, it would impose a state-mandated local program.

(B) The Licensed Marriage and Family Therapist Act generally requires specified applicants for licensure and registration to meet certain educational degree requirements, including having obtained that degree from a school, college, or university that, among other things, is accredited by a regional accrediting agency recognized by the United States Department of Education.

This bill would authorize that accreditation to be by a regional or national institutional accrediting agency recognized by the United States Department of Education.

Existing law requires these applicants to meet specified educational requirements, including a minimum of two semester units of instruction in the diagnosis, assessment, prognosis, and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer-reviewed literature. Existing law requires these specified educational requirements to include at least one semester unit or 15 hours of instruction in psychological testing and at least one semester unit or 15 hours of instruction in psychopharmacology.

This bill would recast that instruction in psychological testing and psychopharmacology as a separate educational requirement.

Under the Licensed Marriage and Family Therapist Act, a specified doctoral or master's degree approved by the Bureau for Private Postsecondary and Vocational Education as of June 30, 2007, is considered by the Board of Behavioral Sciences to meet the specified licensure and registration requirements if the degree is conferred on or before July 1, 2010. As an alternative, existing law requires the Board of Behavioral Sciences to accept those doctoral or master's degrees as equivalent degrees if those degrees are conferred by educational institutions accredited by specified associations.

This bill would delete those provisions.

(C) Under the Licensed Marriage and Family Therapist Act, an applicant for licensure is required to complete experience related to the practice of marriage and family therapy under the supervision of a supervisor. Existing

law requires an applicant seeking licensure as a professional clinical counselor or a marriage and family therapist to possess a degree that contains a practicum coursework requirement that may be satisfied by conducting face-to-face counseling. Existing law requires applicants, trainees who are unlicensed persons enrolled in an educational program to qualify for licensure, and interns who are unlicensed persons who have completed an educational program and is registered with the board to be at all times under the supervision of a supervisor. Existing law requires interns and trainees to only gain supervised experience as an employee or volunteer and prohibits experience from being gained as an independent contractor. Similarly, the Licensed Professional Clinical Counselor Act requires clinical counselor trainees, interns, and applicants to perform services only as an employee or as a volunteer. The Licensed Professional Clinical Counselor Act prohibits gaining mental health experience by interns or trainees as an independent contractor.

The Clinical Social Worker Practice Act requires applicants to complete supervised experience related to the practice of clinical social work.

This bill would prohibit these persons from being employed as independent contractors and from gaining experience for work performed as an independent contractor reported on a specified tax form. The bill would specify that the face-to-face counseling requirement of the practicum coursework be face-to-face counseling of individuals, couples, families, or groups.

(D) Existing law, the Clinical Social Worker Practice Act, requires applicants for licensure as a clinical social worker to pass a clinical examination. Existing regulatory law requires the clinical examination to be the Association of Social Work Boards Clinical Examination. Existing law authorizes a fee for the clinical examination in the amount of $100.

This bill would specify that the fee only applies to a board-administered clinical examination.

(E) The Licensed Professional Clinical Counselor Act defines the term "accredited" for the purposes of the act to mean a school, college, or university accredited by the Western Association of Schools and Colleges, or its equivalent regional accrediting association. The act requires each educational institution preparing applicants to qualify for licensure to notify each of its students in writing that its degree program is designed to meet specified examination eligibility or registration requirements and to certify to the Board of Behavioral Sciences that it has provided that notice. The act requires the Board of Behavioral Sciences to accept education gained while residing outside of California if the education is substantially equivalent, as specified.

This bill would re-define "accredited" to mean a school, college, or university accredited by a regional or national institutional accrediting agency that is recognized by the United States Department of Education. The bill would additionally require an applicant for registration or licensure to submit to the Board of Behavioral Sciences a certification from the applicant's educational institution specifying that the curriculum and

coursework complies with those examination eligibility or registration requirements. The bill would instead require the board to accept education gained from an out-of-state school if the education is substantially similar.

(8) This bill would additionally delete various obsolete provisions, make conforming changes, and make other nonsubstantive changes.

(9) This bill would incorporate additional changes to Section 1632 of the Business and Professions Code proposed by AB 2331, that would become operative only if AB 2331 and this bill are both chaptered and become effective on or before January 1, 2017, and this bill is chaptered last.

(10) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 27 of the Business and Professions Code, as amended by Section 1 of Chapter 32 of the Statutes of 2016, is amended to read:

27. (a) Each entity specified in subdivisions (c), (d), and (e) shall provide on the Internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the Internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action, including accusations filed pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee's address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of his or her home address, as the address of record. This section shall not preclude an entity from also requiring a licensee, who has provided a post office box number or other alternative mailing address as his or her address of record, to provide a physical business address or residence address only for the entity's internal administrative use and not for disclosure as the licensee's address of record or disclosure on the Internet.

(b) In providing information on the Internet, each entity specified in subdivisions (c) and (d) shall comply with the Department of Consumer Affairs' guidelines for access to public records.

(c) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Board for Professional Engineers, Land Surveyors, and Geologists shall disclose information on its registrants and licensees.

(2) The Bureau of Automotive Repair shall disclose information on its licensees, including auto repair dealers, smog stations, lamp and brake stations, smog check technicians, and smog inspection certification stations.

(3) The Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation shall disclose information on its licensees and registrants, including major appliance repair dealers, combination dealers (electronic and appliance), electronic repair dealers, service contract sellers, and service contract administrators.

(4) The Cemetery and Funeral Bureau shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, cemetery managers, crematory managers, cemetery authorities, crematories, cremated remains disposers, embalmers, funeral establishments, and funeral directors.

(5) The Professional Fiduciaries Bureau shall disclose information on its licensees.

(6) The Contractors' State License Board shall disclose information on its licensees and registrants in accordance with Chapter 9 (commencing with Section 7000) of Division 3. In addition to information related to licenses as specified in subdivision (a), the board shall also disclose information provided to the board by the Labor Commissioner pursuant to Section 98.9 of the Labor Code.

(7) The Bureau for Private Postsecondary Education shall disclose information on private postsecondary institutions under its jurisdiction, including disclosure of notices to comply issued pursuant to Section 94935 of the Education Code.

(8) The California Board of Accountancy shall disclose information on its licensees and registrants.

(9) The California Architects Board shall disclose information on its licensees, including architects and landscape architects.

(10) The State Athletic Commission shall disclose information on its licensees and registrants.

(11) The State Board of Barbering and Cosmetology shall disclose information on its licensees.

(12) The State Board of Guide Dogs for the Blind shall disclose information on its licensees and registrants.

(13) The Acupuncture Board shall disclose information on its licensees.

(14) The Board of Behavioral Sciences shall disclose information on its licensees, including licensed marriage and family therapists, licensed clinical social workers, licensed educational psychologists, and licensed professional clinical counselors.

(15) The Dental Board of California shall disclose information on its licensees.

(16) The State Board of Optometry shall disclose information on its licensees and registrants.

(17) The Board of Psychology shall disclose information on its licensees, including psychologists, psychological assistants, and registered psychologists.

(d) The State Board of Chiropractic Examiners shall disclose information on its licensees.

(e) The Structural Pest Control Board shall disclose information on its licensees, including applicators, field representatives, and operators in the areas of fumigation, general pest and wood destroying pests and organisms, and wood roof cleaning and treatment.

(f) The Bureau of Medical Cannabis Regulation shall disclose information on its licensees.

(g) "Internet" for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

SEC. 2. Section 208 of the Business and Professions Code is amended to read:

208. (a) Beginning April 1, 2014, a Controlled Substance Utilization Review and Evaluation System (CURES) fee of six dollars ($6) shall be assessed annually on each of the licensees specified in subdivision (b) to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees. The fee assessed pursuant to this subdivision shall be billed and collected by the regulating agency of each licensee at the time of the licensee's license renewal. If the reasonable regulatory cost of operating and maintaining CURES is less than six dollars ($6) per licensee, the Department of Consumer Affairs may, by regulation, reduce the fee established by this section to the reasonable regulatory cost.

(b) (1) Licensees authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances or pharmacists licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2.

(2) Beginning July 1, 2017, licensees issued a license that has been placed in a retired or inactive status pursuant to a statute or regulation are exempt from the CURES fee requirement in subdivision (a). This exemption shall not apply to licensees whose license has been placed in a retired or inactive status if the licensee is at any time authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Wholesalers, third-party logistics providers, nonresident wholesalers, and nonresident third-party logistics providers of dangerous drugs licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2.

(4) Nongovernmental clinics licensed pursuant to Article 13 (commencing with Section 4180) and Article 14 (commencing with Section 4190) of Chapter 9 of Division 2.

(5) Nongovernmental pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2.

(c) The funds collected pursuant to subdivision (a) shall be deposited in the CURES Fund, which is hereby created within the State Treasury. Moneys

in the CURES Fund shall, upon appropriation by the Legislature, be available to the Department of Consumer Affairs to reimburse the Department of Justice for costs to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(d) The Department of Consumer Affairs shall contract with the Department of Justice on behalf of the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Board of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board, the State Board of Optometry, and the California Board of Podiatric Medicine to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

SEC. 3. Section 852 of the Business and Professions Code is repealed.

SEC. 4. Section 1632 of the Business and Professions Code is amended to read:

1632. (a) The board shall require each applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(b) The board shall require each applicant to successfully complete an examination in California law and ethics developed and administered by the board. The board shall provide a separate application for this examination. The board shall ensure that the law and ethics examination reflects current law and regulations, and ensure that the examinations are randomized. Applicants shall submit this application and required fee to the board in order to take this examination. In addition to the aforementioned application, the only other requirement for taking this examination shall be certification from the dean of the qualifying dental school attended by the applicant that the applicant has graduated, or will graduate, or is expected to graduate. Applicants who submit completed applications and certification from the dean at least 15 days prior to a scheduled examination shall be scheduled to take the examination. Successful results of the examination shall, as established by board regulation, remain valid for two years from the date that the applicant is notified of having passed the examination.

(c) Except as otherwise provided in Section 1632.5, the board shall require each applicant to have taken and received a passing score on one of the following:

(1) A portfolio examination of the applicant's competence to enter the practice of dentistry. This examination shall be conducted while the applicant is enrolled in a dental school program at a board-approved school located in California. This examination shall utilize uniform standards of clinical experiences and competencies, as approved by the board pursuant to Section 1632.1. The applicant shall pass a final assessment of the submitted portfolio at the end of his or her dental school program. Before any portfolio assessment may be submitted to the board, the applicant shall remit the required fee to the board to be deposited into the State Dentistry Fund, and a letter of good standing signed by the dean of his or her dental school or

MEDICAL BOARD OF CALIFORNIA
TRACKER II BILLS
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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Chaptered, #251	03/28/16
AB 72	Bonta	Health Care Coverage: Out-of-Network Coverage	Chaptered, #492	08/25/16
AB 635	Atkins	Medical Interpretation Services	Chaptered, #600	08/18/16
AB 741	Williams	Mental Health: Community Care Facilities	Vetoed	08/19/16
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	Vetoed	04/12/16
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	Chaptered, #493	08/16/16
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	Vetoed	08/18/16
AB 923	Steinorth	Respiratory Care Practitioners	Chaptered, #253	08/01/16
AB 1001	Maienschein	Child Abuse: Reporting: Foster Family Agencies	Chaptered, #850	08/18/16
AB 1033	Garcia, E.	Economic Impact Analysis: Small Business Definition	Chaptered, #346	05/02/16
AB 1067	Gipson	Foster Children: Rights	Chaptered, #851	08/17/16
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	Chaptered, #316	08/15/16
AB 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	Chaptered, #603	08/18/16
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	Chaptered, #374	06/28/16
AB 1639	Maienschein	Pupil Health: The Eric Paredes Sudden Cardiac Arrest Prevention Act	Chaptered, #792	08/15/16
AB 1668	Calderon	Investigational Drugs, Biological Products, and Devices	Chaptered, #684	08/15/16
AB 1696	Holden	Medi-Cal: Tobacco Cessation Services	Chaptered, #606	08/15/16
AB 1703	Santiago	Inmates: Medical Treatment	Chaptered, #65	
AB 1748	Mayes	Pupils: Pupil Health: Opioid Antagonist	Chaptered, #557	08/01/16
AB 1763	Gipson	Health Care Coverage: Colorectal Cancer: Screening and Testing	Vetoed	06/27/16
AB 1795	Atkins	Health Care Programs: Cancer	Chaptered, #608	08/24/16
AB 1823	Bonilla	California Cancer Clinical Trials Program	Chaptered, #661	08/19/16
AB 1831	Low	Health Care Coverage: Prescription Drugs: Refills	Vetoed	08/15/16
AB 1836	Maienschein	Mental Health: Referral of Conservatees	Chaptered, #819	08/02/16
AB 1864	Cooley	Inquests: Sudden Unexplained Death in Childhood	Vetoed	08/15/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1887	Low	State Government: Discrimination: Travel	Chaptered, #687	08/15/16
AB 1954	Burke	Health Care Coverage: Reproductive Health Care Services	Chaptered, #495	08/17/16
AB 2048	Gray	National Health Service Corps State Loan Repayment Program	Chaptered, #454	08/15/16
AB 2083	Chu	Interagency Child Death Review	Chaptered, #297	06/14/16
AB 2086	Cooley	Workers' Compensation: Neuropsychologists	Vetoed	08/01/16
AB 2105	Rodriguez	Workforce Development: Allied Health Professionals	Chaptered, #410	08/10/16
AB 2115	Wood	Health Care Coverage: Disclosures	Vetoed	08/17/16
AB 2119	Chu	Medical Information: Disclosure: Medical Examiners and Forensic Pathologists	Chaptered, #690	08/15/16
AB 2179	Gipson	Hepatitis C Testing	Vetoed	08/16/16
AB 2193	Salas	California Board of Podiatric Medicine: Physician Assistant Board: Extension	Chaptered, #459	08/16/16
AB 2235	Thurmond	Board of Dentistry: Pediatric Anesthesia: Committee	Chaptered, #519	08/16/16
AB 2311	Brown	Emergency Services	Chaptered, #520	08/15/16
AB 2317	Mullin	California State University: Doctor of Audiology Degrees	Chaptered, #267	06/29/16
AB 2325	Bonilla	Ken Maddy California Cancer Registry	Chaptered, #354	08/10/16
AB 2394	Garcia, E.	Medi-Cal: Non-Medical Transportation	Chaptered, #615	08/16/16
AB 2404	Cooley	Public Employees' Retirement System: Optional Settlements	Chaptered, #199	08/02/16
AB 2503	Obernolte	Workers' Compensation: Utilization Review	Chaptered, #885	08/29/16
AB 2640	Gipson	Public Health: HIV	Chaptered, #670	08/15/16
AB 2696	Gaines, B.	Diabetes Prevention and Management	Chaptered, #108	04/18/16
AB 2737	Bonta	Nonprovider Health Care Districts	Chaptered, #421	06/20/16
AB 2828	Chau	Personal Information: Privacy Breach	Chaptered, #337	05/27/16
AB 2843	Chau	Public Records: Employee Contact Information	Chaptered, #830	08/18/16
AB 2844	Bloom	Public Contracts: Discrimination	Chaptered, #581	08/19/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2853	Gatto	Public Records	Chaptered, #275	06/16/16
AB 2859	Low	Professions and Vocations: Retired Category: Licenses	Chaptered, #473	08/03/16
AB 2883	Ins. Comm.	Workers' Compensation: Employees	Chaptered, #205	08/02/16
ACR 119	Chiu	Physician Anesthesiologist Week	Chaptered, #15	02/01/16
SB 3	Leno	Minimum Wage: Adjustment	Chaptered, #4	03/28/16
SB 10	Lara	Health Care Coverage: Immigration Status	Chaptered, #22	05/27/16
SB 24	Hill	California Public Employees' Pension Reform Act	Chaptered, #531	08/18/16
SB 66	Leyva	Career Technical Education	Chaptered, #770	08/18/16
SB 139	Galgiani	Controlled Substances	Chaptered, #624	08/18/16
SB 253	Monning	Juveniles: Psychotropic Medication	Vetoed	08/04/16
SB 441	Wolk	California Public Records Act: Exemptions	Chaptered, #477	06/22/16
SB 547	Liu	Aging and Long-Term Care Services, Supports and Program. Coord.	Vetoed	08/01/16
SB 826	Leno	Budget Act of 2016	Chaptered, #23	05/25/16
SB 914	Mendoza	Workers' Compensation: Medical Provider Networks	Chaptered, #84	01/26/16
SB 923	Hernandez	Health Care Coverage: Cost Sharing Changes	Chaptered, #192	05/31/16
SB 950	Nielsen	Excluded Employees: Arbitration	Vetoed	06/29/16
SB 999	Pavley	Health Insurance: Contraceptives: Annual Supply	Chaptered, #499	08/19/16
SB 1039	Hill	Professions and Vocations	Chaptered, #799	08/25/16
SB 1076	Hernandez	General Acute Care Hospitals: Observation Services	Chaptered, #723	08/18/16
SB 1090	Mitchell	Sexually Transmitted Diseases: Outreach and Screening Services	Vetoed	08/15/16
SB 1091	Liu	Long-Term Care Insurance	Chaptered, #589	08/18/16
SB 1095	Pan	Newborn Screening Program	Chaptered, #393	08/15/16
SB 1135	Monning	Health Care Coverage: Notice of Timely Access to Care	Chaptered, #500	08/15/16
SB 1139	Lara	Health Professionals: Medical Residency Programs: Undocumented Immigrants	Chaptered, #786	08/15/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1159	Hernandez	California Health Care Cost and Quality Database	Chaptered, #727	08/19/16
SB 1193	Hill	Healing Arts	Chaptered, #484	08/18/16
SB 1229	Jackson	Home-Generated Pharmaceutical Waste: Secure Drug Take-Back Bins	Chaptered, #238	06/27/16
SB 1234	De Leon	Retirement Savings Plans	Chaptered, #804	08/18/16
SB 1348	Cannella	Licensure Applications: Military Experience	Chaptered, #174	05/31/16
SB 1466	Mitchell	Early and Periodic Screening, Diagnosis, and Treatment Program	Vetoed	08/15/16
SCR 117	Pan	Palliative Care	Chaptered, #96	
SR 55	Bates	Relative to Drug Facts Week	Sen. Adopted	
SR 71	Berryhill	Relative to Organ Donation	Sen. Adopted	