

AMENDED IN SENATE MAY 10, 2006

AMENDED IN SENATE JULY 6, 2005

AMENDED IN SENATE JUNE 23, 2005

AMENDED IN ASSEMBLY APRIL 18, 2005

CALIFORNIA LEGISLATURE—2005—06 REGULAR SESSION

ASSEMBLY BILL

No. 409

Introduced by Assembly Member Yee

February 15, 2005

~~An act to amend Section 14838 of the Government Code, relating to state contracts.~~ *An act to amend Sections 4600, 4610, and 4616 of the Labor Code, relating to workers' compensation.*

LEGISLATIVE COUNSEL'S DIGEST

AB 409, as amended, Yee. ~~State contracts: small business bidding preference.~~ *Workers' compensation: medical treatment.*

(1) Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law, until April 30, 2007, provides an employee with the right to be treated by his or her personal physician from the date of injury if specified conditions are met.

This bill would require the personal physician to be the employee's regular treating physician licensed in this state as a physician and surgeon, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner and acting within the scope of their respective practice.

(2) Existing law requires every employer to establish a utilization review process, either directly or through its insurer or an entity with which an employer or insurer contracts for these services, in accordance with specified criteria, and authorizes the Administrative Director of the Division of Workers' Compensation to assess administrative penalties for failure to meet certain requirements.

This bill, among other things, would instead require the administrative director to establish a utilization review process, as specified, and establish a utilization review unit operated and managed by a medical director within the division. The bill would require the medical director to employ or designate utilization review physicians to approve, modify, delay, or deny requests for authorization for treatment. It would also require the administrative director to establish a fee schedule for requests by insurers for utilization review. These fees would be deposited into the Utilization Review Unit Fund, created by the bill, to be used, upon appropriation by the Legislature, for purposes of the management and expenses of the utilization review unit.

(3) Existing law authorizes an insurer or employer to establish or modify a medical provider network and provides the employer or insurer with the exclusive right to determine the members of the network.

This bill would provide that membership within a network shall not be unreasonably denied in specified circumstances.

~~Existing law requires state agencies to give small businesses or microbusinesses a 5% preference in contracts for construction, the provision of information technology, the procurement of goods, or the delivery of services, and to establish a subcontracting participation goal for small businesses on contracts with a preference for those bidders who meet the goal.~~

~~This bill would increase the maximum percentage of the bidding preference afforded by state agencies to small businesses and microbusinesses and the subcontracting participation goal to 10%.~~

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

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

1 SECTION 1. Section 4600 of the Labor Code is amended to
2 read:

1 4600. (a) Medical, surgical, chiropractic, acupuncture, and
2 hospital treatment, including nursing, medicines, medical and
3 surgical supplies, crutches, and apparatus, including orthotic and
4 prosthetic devices and services, that is reasonably required to
5 cure or relieve the injured worker from the effects of his or her
6 injury shall be provided by the employer. In the case of his or her
7 neglect or refusal reasonably to do so, the employer is liable for
8 the reasonable expense incurred by or on behalf of the employee
9 in providing treatment.

10 (b) As used in this division and notwithstanding any other
11 provision of law, medical treatment that is reasonably required to
12 cure or relieve the injured worker from the effects of his or her
13 injury means treatment that is based upon the guidelines adopted
14 by the administrative director pursuant to Section 5307.27 or,
15 prior to the adoption of those guidelines, the updated American
16 College of Occupational and Environmental Medicine's
17 Occupational Medicine Practice Guidelines.

18 (c) Unless the employer or the employer's insurer has
19 established a medical provider network as provided for in Section
20 4616, after 30 days from the date the injury is reported, the
21 employee may be treated by a physician of his or her own choice
22 or at a facility of his or her own choice within a reasonable
23 geographic area.

24 (d) (1) If an employee has notified his or her employer in
25 writing prior to the date of injury that he or she has a personal
26 physician, *as described in Section 3209.3*, the employee shall
27 have the right to be treated by that physician from the date of
28 injury if either of the following conditions exist:

29 (A) The employer provides nonoccupational group health
30 coverage in a health care service plan, licensed pursuant to
31 Chapter 2.2 (commencing with Section 1340) of Division 2 of
32 the Health and Safety Code.

33 (B) The employer provides nonoccupational health coverage
34 in a group health plan or a group health insurance policy as
35 described in Section 4616.7.

36 (2) For purposes of paragraph (1), a personal physician shall
37 meet all of the following conditions:

38 (A) The physician is the employee's regular *treating* physician
39 ~~and surgeon, licensed pursuant to Chapter 5 (commencing with~~

1 ~~Section 2000) of Division 2 of the Business and Professions~~
 2 ~~Code, as described in Section 3209.3.~~

3 (B) The physician is the employee's primary-care treating
 4 physician and has previously directed the medical treatment of
 5 the employee, and who retains the employee's medical records,
 6 including his or her medical history.

7 (C) The physician agrees to be predesignated.

8 (3) If the employer provides nonoccupational health care
 9 pursuant to Chapter 2.2 (commencing with Section 1340) of
 10 Division 2 of the Health and Safety Code, and the employer is
 11 notified pursuant to paragraph (1), all medical treatment,
 12 utilization review of medical treatment, access to medical
 13 treatment, and other medical treatment issues shall be governed
 14 by Chapter 2.2 (commencing with Section 1340) of Division 2 of
 15 the Health and Safety Code. Disputes regarding the provision of
 16 medical treatment shall be resolved pursuant to Article 5.55
 17 (commencing with Section 1374.30) of Chapter 2.2 of Division 2
 18 of the Health and Safety Code.

19 (4) If the employer provides nonoccupational health care, as
 20 described in Section 4616.7, all medical treatment, utilization
 21 review of medical treatment, access to medical treatment, and
 22 other medical treatment issues shall be governed by the
 23 applicable provisions of the Insurance Code.

24 (5) The insurer may require prior authorization of any
 25 nonemergency treatment or diagnostic service and may conduct
 26 reasonably necessary utilization review pursuant to Section 4610.

27 (6) The maximum percentage of all employees who are
 28 covered under paragraph (1) that may be predesignated at any
 29 time in the state is 7 percent.

30 (7) If any court finds that any portion of this subdivision is
 31 invalid or in violation of any state or federal law, then this
 32 subdivision shall be inoperative.

33 (8) The division shall conduct an evaluation of this program
 34 and present its findings to the Governor and the Legislature on or
 35 before March 1, 2006.

36 (9) This subdivision shall remain in effect only until April 30,
 37 2007, and as of that date is repealed, unless a later enacted
 38 statute, that is enacted before April 30, 2007, deletes or extends
 39 that date.

1 (e) (1) When at the request of the employer, the employer's
2 insurer, the administrative director, the appeals board, or a
3 workers' compensation administrative law judge, the employee
4 submits to examination by a physician, he or she shall be entitled
5 to receive, in addition to all other benefits herein provided, all
6 reasonable expenses of transportation, meals, and lodging
7 incident to reporting for the examination, together with one day
8 of temporary disability indemnity for each day of wages lost in
9 submitting to the examination.

10 (2) Regardless of the date of injury, "reasonable expenses of
11 transportation" includes mileage fees from the employee's home
12 to the place of the examination and back at the rate of twenty-one
13 cents (\$0.21) a mile or the mileage rate adopted by the Director
14 of the Department of Personnel Administration pursuant to
15 Section 19820 of the Government Code, whichever is higher,
16 plus any bridge tolls. The mileage and tolls shall be paid to the
17 employee at the time he or she is given notification of the time
18 and place of the examination.

19 (f) When at the request of the employer, the employer's
20 insurer, the administrative director, the appeals board, or a
21 workers' compensation administrative law judge, an employee
22 submits to examination by a physician and the employee does not
23 proficiently speak or understand the English language, he or she
24 shall be entitled to the services of a qualified interpreter in
25 accordance with conditions and a fee schedule prescribed by the
26 administrative director. These services shall be provided by the
27 employer. For purposes of this section, "qualified interpreter"
28 means a language interpreter certified, or deemed certified,
29 pursuant to Article 8 (commencing with Section 11435.05) of
30 Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566
31 of, the Government Code.

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

33 4610. (a) For purposes of this section, "utilization review"
34 means utilization review or utilization management functions that
35 prospectively, retrospectively, or concurrently review and
36 approve, modify, delay, or deny, based in whole or in part on
37 medical necessity to cure and relieve, treatment
38 recommendations by physicians, as ~~defined~~ *described* in Section
39 3209.3, prior to, retrospectively, or concurrent with the provision
40 of medical treatment services pursuant to Section 4600.

1 (b) ~~Every employer~~ *The administrative director shall establish*
 2 *a utilization review process in compliance with this section. This*
 3 *utilization review process shall be free from conflicts of interest,*
 4 *either directly or indirectly, through its an insurer or an entity*
 5 *with which an employer or insurer contracts for these services.*

6 (c) ~~Each~~ *The utilization review process shall be governed by*
 7 *written policies and procedures. These policies and procedures*
 8 *shall ensure that decisions based on the medical necessity to cure*
 9 *and relieve of proposed medical treatment services are consistent*
 10 *with the schedule for medical treatment utilization adopted*
 11 *pursuant to Section 5307.27. Prior to adoption of the schedule,*
 12 *these policies and procedures shall be consistent with the*
 13 *recommended standards set forth in the American College of*
 14 *Occupational and Environmental Medicine Occupational*
 15 *Medical Practice Guidelines. These policies and procedures, and*
 16 *a description of the utilization process, shall be filed with*
 17 *adopted by the administrative director and shall be disclosed by*
 18 *the employer to employers, employees, physicians, and the public*
 19 *upon request if requested.*

20 (d) (1) *If an employer, insurer, or other entity subject to this*
 21 *section requests medical information from a physician in order to*
 22 *determine whether to approve, modify, delay, or deny requests*
 23 *for authorization, the employer insurer shall request only the*
 24 *information reasonably necessary to make the determination. The*
 25 *employer, insurer, or other entity insurer shall only approve*
 26 *requests for treatment and shall not modify, delay, or deny*
 27 *authorization for treatment. The insurer shall submit for*
 28 *utilization review, pursuant to this section, any request for*
 29 *treatment that has not been approved by the insurer.*

30 (2) *The administrative director shall establish a utilization*
 31 *review unit within the Division of Workers' Compensation.*

32 (3) *The administrative director shall employ or designate a*
 33 *medical director to operate and manage the utilization review*
 34 *unit who holds an unrestricted license to practice medicine in this*
 35 *state issued pursuant to Section 2050 or Section 2450 of the*
 36 *Business and Professions Code. The medical director shall ensure*
 37 *that the process by which the employer insurer or other entity*
 38 *reviews and approves, modifies, delays, or denies requests by*
 39 *physicians prior to, retrospectively, or concurrent with the*
 40 *provision of medical treatment services, complies with the*

1 requirements of this section. Nothing in this section shall be
2 construed as restricting the existing authority of the Medical
3 Board of California.

4 *(4) Only the utilization review unit, at the request of the*
5 *insurer or self-insured employer, shall modify, delay, or deny*
6 *requests for authorization for treatment.*

7 *(5) The medical director shall employ or designate utilization*
8 *review physicians, as described in Section 3209.3, to timely*
9 *approve, modify, delay, or deny requests for authorization for*
10 *treatment as provided in this section.*

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

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

21 (1) Developed with involvement from actively practicing
22 physicians.

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

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

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

33 (5) Available to the public upon request. ~~An employer insurer~~
34 ~~shall only~~ be required to disclose the criteria or guidelines
35 *adopted by the administrative director* for the specific procedures
36 or conditions requested. *The administrative director shall make*
37 *the adopted criteria or guidelines available to an insurer by*
38 *electronic means in order that an insurer may provide, on*
39 *request, current and accurate information to the public. An*
40 ~~employer insurer~~ may charge members of the public reasonable

1 copying and postage expenses related to disclosing criteria or
2 guidelines pursuant to this paragraph. ~~Criteria or guidelines may~~
3 ~~also be made available through electronic means.~~ No charge shall
4 be required for an employee whose physician's request for
5 medical treatment services ~~is under~~ *has been forwarded to the*
6 *utilization review unit by the insurer for review.*

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

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

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

34 (3) (A) Decisions to approve, modify, delay, or deny requests
35 by physicians for authorization prior to, or concurrent with, the
36 provision of medical treatment services to employees shall be
37 communicated to the requesting physician within 24 hours of the
38 decision. Decisions resulting in modification, delay, or denial of
39 all or part of the requested health care service shall be
40 communicated to physicians initially by telephone or facsimile,

1 and to the physician and employee in writing within 24 hours for
2 concurrent review, or within two business days of the decision
3 for prospective review, as prescribed by the administrative
4 director. If the request is not approved in full, disputes shall be
5 resolved in accordance with Section 4062. If a request to perform
6 spinal surgery is denied, disputes shall be resolved in accordance
7 with subdivision (b) of Section 4062.

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

35 (4) Communications regarding decisions to approve requests
36 by physicians shall specify the specific medical treatment service
37 approved. Responses *from a utilization review physician*
38 regarding decisions to modify, delay, or deny medical treatment
39 services requested by physicians shall include a clear and concise
40 explanation of the reasons for the employer's decision, a

1 description of the criteria or guidelines used, and the clinical
2 reasons for the decisions regarding medical necessity.

3 (5) If the ~~employer, insurer, or other entity~~ *utilization review*
4 *physician* cannot make a decision within the timeframes
5 specified in paragraph (1) or (2) because the ~~employer or other~~
6 ~~entity~~ *utilization review physician* is not in receipt of all of the
7 information reasonably necessary and requested, because the
8 ~~employer~~ *utilization review physician* requires consultation by an
9 expert reviewer, or because the ~~employer~~ *utilization review*
10 *physician* has asked that an additional examination or test be
11 performed upon the employee that is reasonable and consistent
12 with good medical practice, the ~~employer~~ *utilization review*
13 *physician* shall immediately notify the physician and the
14 employee, in writing, that the ~~employer~~ *utilization review*
15 *physician* cannot make a decision within the required timeframe,
16 and specify the information requested but not received, the expert
17 reviewer to be consulted, or the additional examinations or tests
18 required. The ~~employer~~ *utilization review physician* shall also
19 notify the *treating* physician and employee of the anticipated date
20 on which a decision may be rendered. Upon receipt of all
21 information reasonably necessary and requested ~~by the employer,~~
22 the ~~employer~~ *utilization review physician* shall approve, modify,
23 or deny the request for authorization within the timeframes
24 specified in paragraph (1) or (2).

25 (h) Every employer, insurer, or other entity subject to this
26 section shall maintain telephone access for *employees and*
27 *physicians* to request authorization for health care ~~services.~~
28 *services and shall post a notice in a common workplace area for*
29 *employees that includes all of the following:*

30 (1) *The telephone number for local emergency services if 911*
31 *services are not locally available.*

32 (2) *The telephone number provided by the insurer to request*
33 *authorization for health care services.*

34 (3) *The telephone number of the utilization review unit to*
35 *request authorization in the event there is no answer or response*
36 *at the number provided for insurer authorization.*

37 (A) *Notice that usage and expenses for utilization review unit*
38 *access shall be paid by the insurer for failure to provide direct*
39 *access to injured workers or treating physicians for*
40 *authorization of treatment.*

1 (B) Notice that the administrative director shall establish
2 guidelines for authorization criteria, access, use, and payment
3 for telephone access for employees and treating physicians.

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

16 (j) The administrative director shall establish a fee schedule
17 for requests for utilization review. Fees shall be payable by the
18 insurer and deposited in the Utilization Review Unit Fund, which
19 is hereby created in the State Treasury. Upon appropriation by
20 the Legislature, all management and operation expenses of the
21 utilization review unit, including payments to employees,
22 utilization review physicians, and telephone access as required
23 for treatment authorization under paragraph (3) of subdivision
24 (h) shall be paid from the Utilization Review Unit Fund.

25 SEC. 3. Section 4616 of the Labor Code is amended to read:

26 4616. (a) (1) On or after January 1, 2005, an insurer or
27 employer may establish or modify a medical provider network
28 for the provision of medical treatment to injured employees. The
29 network shall include physicians primarily engaged in the
30 treatment of occupational injuries and physicians primarily
31 engaged in the treatment of nonoccupational injuries. The goal
32 shall be at least 25 percent of physicians primarily engaged in the
33 treatment of nonoccupational injuries. The administrative
34 director shall encourage the integration of occupational and
35 nonoccupational providers. The number of physicians in the
36 medical provider network shall be sufficient to enable treatment
37 for injuries or conditions to be provided in a timely manner. The
38 provider network shall include an adequate number and type of
39 physicians, as described in Section 3209.3, or other providers, as
40 described in Section 3209.5, to treat common injuries

1 experienced by injured employees based on the type of
2 occupation or industry in which the employee is engaged, and the
3 geographic area where the employees are employed.

4 (2) Medical treatment for injuries shall be readily available at
5 reasonable times to all employees. To the extent feasible, all
6 medical treatment for injuries shall be readily accessible to all
7 employees. With respect to availability and accessibility of
8 treatment, the administrative director shall consider the needs of
9 rural areas, specifically those in which health facilities are
10 located at least 30 miles apart.

11 (b) The employer or insurer shall submit a plan for the medical
12 provider network to the administrative director for approval. The
13 administrative director shall approve the plan if he or she
14 determines that the plan meets the requirements of this section. If
15 the administrative director does not act on the plan within 60
16 days of submitting the plan, it shall be deemed approved.

17 (c) Physician compensation may not be structured in order to
18 achieve the goal of reducing, delaying, or denying medical
19 treatment or restricting access to medical treatment.

20 (d) (1) If the employer or insurer meets the requirements of
21 this section, the administrative director may not withhold
22 approval or disapprove an employer's or insurer's medical
23 provider network based solely on the selection of providers. In
24 developing a medical provider network, an employer or insurer
25 shall have the exclusive right to determine the members of their
26 network.

27 (2) *When any willing primary treating physician licensed in
28 this state applies for membership within a network, membership
29 shall not be unreasonably denied, if the primary treating
30 physician satisfies both of the following:*

31 (A) *The primary treating physician meets the description of a
32 physician under Section 3209.3 and is willing to accept the terms
33 and conditions of the network provider contract.*

34 (B) *The primary treating physician has no history of
35 disciplinary action or sanctions, including, but not limited to,
36 loss of staff privileges or participation restrictions taken or
37 pending by any hospital, government, or regulatory body.*

38 (3) *At any time a patient may recommend membership of their
39 primary treating physician in their employer medical provider
40 network. Membership shall not be unreasonably denied if the*

1 *primary treating physician applies for membership and satisfies*
2 *all of the following:*

3 (A) *The primary treating physician applies for treatment and*
4 *is willing to accept the terms of the network provider agreement.*

5 (B) *The primary treating physician satisfies both of the*
6 *requirements of paragraph (2).*

7 (C) *The primary treating physician has previously directed*
8 *medical treatment of the employee and retains the employee's*
9 *medical records including his or her medical history.*

10 (4) *If the primary treating physician satisfies both of the*
11 *requirements under paragraph (2) and has applied for*
12 *membership in the network, as recommended by the patient*
13 *under paragraph (3), and is denied membership, the patient shall*
14 *have the option to leave the network if both of the following*
15 *conditions are met:*

16 (A) *The primary treating physician is willing to accept*
17 *management and care of the patient in compliance with the*
18 *duties and responsibilities of a primary treating physician as set*
19 *forth pursuant to this code.*

20 (B) *The primary treating physician is willing to accept*
21 *payment in accordance with the official medical fee schedule*
22 *adopted by the administrative director.*

23 (5) *The primary treating physician shall have the option to*
24 *leave the network at any time if both of the following conditions*
25 *are met:*

26 (A) *The primary treating physician is willing to accept*
27 *management and care of the patient in compliance with the*
28 *duties and responsibilities of a primary treating physician*
29 *pursuant to this code.*

30 (B) *The primary treating physician is willing to accept a*
31 *reduction of 10 percent of the payment under the official medical*
32 *fee schedule adopted by the administrative director.*

33 (e) *All treatment provided shall be provided in accordance*
34 *with the medical treatment utilization schedule established*
35 *pursuant to Section 5307.27 or the American College of*
36 *Occupational Medicine's Occupational Medicine Practice*
37 *Guidelines, as appropriate.*

38 (f) *No person other than a licensed physician licensed in this*
39 *state who is competent to evaluate the specific clinical issues*
40 *involved in the medical treatment services, when these services*

1 are within the scope of the physician’s practice, may modify,
2 delay, or deny requests for authorization of medical treatment.

3 (g) On or before November 1, 2004, the administrative
4 director, in consultation with the Department of Managed Health
5 Care, shall adopt regulations implementing this article. The
6 administrative director shall develop regulations that establish
7 procedures for purposes of making medical provider network
8 modifications.

9 ~~SECTION 1. Section 14838 of the Government Code is~~
10 ~~amended to read:~~

11 ~~14838. In order to facilitate the participation of small~~
12 ~~business, including microbusiness, in the provision of goods,~~
13 ~~information technology, and services to the state, and in the~~
14 ~~construction (including alteration, demolition, repair, or~~
15 ~~improvement) of state facilities, the directors of General Services~~
16 ~~and other state agencies that enter those contracts, each within~~
17 ~~their respective areas of responsibility, shall do all of the~~
18 ~~following:~~

19 ~~(a) Establish goals, consistent with those established by the~~
20 ~~Office of Small Business Certification and Resources, for the~~
21 ~~extent of participation of small businesses, including~~
22 ~~microbusinesses, in the provision of goods, information~~
23 ~~technology, and services to the state, and in the construction of~~
24 ~~state facilities.~~

25 ~~(b) Provide for small business preference, or nonsmall~~
26 ~~business preference for bidders that provide for small business~~
27 ~~and microbusiness subcontractor participation, in the award of~~
28 ~~contracts for goods, information technology, services, and~~
29 ~~construction, as follows:~~

30 ~~(1) In solicitations where an award is to be made to the lowest~~
31 ~~responsible bidder meeting specifications, the preference to small~~
32 ~~business and microbusiness shall be 10 percent of the lowest~~
33 ~~responsible bidder meeting specifications. The preference to~~
34 ~~nonsmall business bidders that provide for small business or~~
35 ~~microbusiness subcontractor participation shall be, up to a~~
36 ~~maximum of 10 percent of the lowest responsible bidder meeting~~
37 ~~specifications, determined according to rules and regulations~~
38 ~~established by the Department of General Services.~~

39 ~~(2) In solicitations where an award is to be made to the highest~~
40 ~~scored bidder based on evaluation factors in addition to price, the~~

1 preference to small business or microbusiness shall be 10 percent
2 of the highest responsible bidder's total score. The preference to
3 nonsmall business bidders that provide for small business or
4 microbusiness subcontractor participation shall be up to a
5 maximum 10 percent of the highest responsible bidder's total
6 score, determined according to rules and regulations established
7 by the Department of General Services.

8 (3) The preferences under paragraphs (1) and (2) may not be
9 awarded to a noncompliant bidder and may not be used to
10 achieve any applicable minimum requirements.

11 (4) The preference under paragraph (1) may not exceed fifty
12 thousand dollars (\$50,000) for any bid, and the combined cost of
13 preferences granted pursuant to paragraph (1) and any other
14 provision of law may not exceed one hundred thousand dollars
15 (\$100,000). In bids in which the state has reserved the right to
16 make multiple awards, this fifty thousand dollar (\$50,000)
17 maximum preference cost shall be applied, to the extent possible,
18 so as to maximize the dollar participation of small businesses,
19 including microbusiness, in the contract award.

20 (e) Give special consideration to small businesses and
21 microbusinesses by both:

22 (1) Reducing the experience required.

23 (2) Reducing the level of inventory normally required.

24 (d) Give special assistance to small businesses and
25 microbusinesses in the preparation and submission of the
26 information requested in Section 14310.

27 (e) Under the authorization granted in Section 10163 of the
28 Public Contract Code, make awards, whenever feasible, to small
29 business and microbusiness bidders for each project bid upon
30 within their prequalification rating. This may be accomplished by
31 dividing major projects into subprojects so as to allow a small
32 business or microbusiness contractor to qualify to bid on these
33 subprojects.

34 (f) Small business and microbusiness bidders qualified in
35 accordance with the provisions of this chapter shall have
36 precedence over nonsmall business bidders in that the application
37 of any bidder preference for which nonsmall business bidders
38 may be eligible under this provision or any other provision of law
39 shall not result in the denial of the award to a small business or
40 microbusiness bidder. In the event of a precise tie between the

1 ~~low responsible bid of a bidder meeting specifications of a small~~
2 ~~business or microbusiness, and the low responsible bid of a~~
3 ~~bidder meeting the specifications of a disabled veteran-owned~~
4 ~~small business or microbusiness, the contract shall be awarded to~~
5 ~~the disabled veteran-owned small business or microbusiness.~~
6 ~~This provision applies if the small business or microbusiness~~
7 ~~bidder is the lowest responsible bidder, as well as if the small~~
8 ~~business or microbusiness bidder is eligible for award as the~~
9 ~~result of application of the small business and microbusiness~~
10 ~~bidder preference granted by subdivision (b).~~

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