

California Workers' Compensation Update 2016

Numerous bills affecting California Workers' Compensation were enacted in 2016. The changes brought about by these bills are highlighted below.

Utilization Review

Language added to the Labor Code clarifies that only a licensed physician within the same scope as the requesting physician can modify or delay a medical treatment request. [AB2503, §4610(e); SB1160, §4610(g)] A physician submitting a request for authorization shall submit the request with supporting documentation to the claims administrator, or other entity according to rules adopted by the Administrative Director. [AB2503, §4610(e)]

For dates of injury on or after January 1, 2018, where treatment is being provided by a member of the medical provider network or health care organization, pre-designated physician, employer-selected physician or an employer-selected facility, requests for authorization received within the first thirty (30) days from the date of injury are not, in most cases, subject to prospective utilization review. Exceptions [SB1160, §4610(c)] are:

Nonemergency surgery	Imaging and radiology services	Psychological treatment
Home health care services	Electrodiagnostic medicine	Medications not authorized by the drug formulary
Durable medical equipment whose aggregate exceeds \$250		
Any other services designated by the Administrative Director or authorized by the employer		

Treatment must consistent with the medical treatment utilization schedule (MTUS), and the initial report must be submitted within five (5) days following the initial visit [SB1160, §4610(b)], otherwise, the employer can require all requests for treatment to undergo prospective review. [SB1160, §4610(e)]

The claims administrator can perform retrospective review on any of the exceptions in order to determine compliance with the MTUS or drug formulary. A pattern and practice of failure to follow either can result in prospective review of all treatment requests, removal from the network, or the filing of a petition to request a change in physicians. [SB1160, §4610(f)] By March 1, 2019, the Administrative Director is to contract with an independent firm to study the impact of the provision of medical treatment within the first 30 days after a claim is filed, for claims filed during period 1/1/17 - 1/1/19, and report to Senate and Assembly Committees by January 1, 2020. [SB1160, §4610(q)]

A non-physician cannot deny a request for treatment for reasons of medical necessity or insufficient information. This includes denials at the fourteenth (14) day due to a failure to provide requested information. An employer, insurer, TPA, or other entity providing UR services cannot offer financial incentives based on modifications or denials, and an insurer or TPA cannot refer to a UR provider where it has a financial interest, unless prior notice is given both to the employer and the Administrative Director. [SB1160, §4610(g)]

On or before July 1, 2018, all UR providers (except for certain exceptions to the public sector), must be accredited by the Utilization Review Accreditation Commission (URAC), employers or insurers

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must submit their UR plans to the Administrative Director for approval, and the employer or insurer must publish their approved plan on the employer's insurer's, or utilization review organization's public website. [SB1160, §4610(g)]

Utilization review conducted on medical requests for drugs listed in the drug formulary must be completed within 5 working days from receipt of the request; there is no allowance up to 14 days for supporting documentation. [SB1160, §4610(i)] Additionally, with respect to UR disputes pertaining to drugs listed in the formulary, the state utilization review organization (currently, Maximus) also has only 5 working days to review a request for independent medical review (IMR) [SB1160, §4610.6(d)] Medical requests and supporting documentation can be provided electronically, once the associated rules are promulgated by the Administrative Director (A.D.). [SB1160, §4610(i)] The A.D. is to develop a system for mandatory reporting of electronic documents, as well as adopt regulations specifying the transmission format and timeframes for submission. [SB1160, §4610(o)] It is likely the A.D. will follow IAABC standards for electronic reporting.

Final decisions to approve, modify or deny must be communicated to the requesting physician within 24 hours by phone or fax, or, if agreed by the parties, secure email. However, if communications to the physician is by phone, the claims administrator must follow up in writing to the physician and employee within 24 hours for concurrent review, or 2 business days for prospective review. If the denial is based on incomplete or insufficient information, the decision must list the reason, specific description of the information needed, and the dates and times the UR physician attempted to obtain the information. [SB1160, §4610(i)] If the claim administrator or UR physician is unable to make a determination, the requesting physician must be immediately notified in writing as to what information is needed. [SB1160, §4610(j)]

The claims administrator must maintain telephone access during California business hours for physicians to request authorization and to conduct peer-to-peer discussions. [SB1160, §4610(n)]

The 12- month timeframe for a UR decision to remains in effect without further action with regard to a subsequent request from the same physician has been expanded to include a subsequent request from another physician within the same practice group. [SB1160, 4610(k)]

Effective January 1, 2018, disputes over medical UR determinations pertaining to drugs listed in the state drug formulary are to be resolved through the independent medical review process (IMR). [SB1160, §4610.5(a)] While the reforms fail to address the period from 7/1/17 (the date the drug formulary goes into effect), to 1/1/18, it is believed the IMR process will also apply.

Medical Treatment

The treating physician must electronically file a first report of injury with the Division of Workers' Compensation and copy the insurer or self-insured employer within 5 days of the initial examination. If the treatment is, or suspected to be, related to pesticide poisoning, the physician must file a report with the local health officer within

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24 hours of the initial examination. [SB1160, §6409] (Though this section is effective January 1, 2017, the Administrative Director will need to first promulgate rules for electronic reporting.)

Medical treatment reasonably required to cure or relieve from the effects of the injury is defined as based upon the Medical Treatment Utilization Schedule (MTUS) and drug formulary. Though the hierarchy of standards has been removed, the MTUS must still incorporate an evidence-based, peer-reviewed, national standard of care. [SB1160, §4610.5(c)], Updates to the MTUS are exempt from the formal rulemaking process, though a comment period and public hearing must still be provided. Updates are to be posted on the state website [SB1160, §5307.27]

The Drug Formulary is to be phased in for injuries prior to July 1, 2017. [SB1160, §5307.27(c)]

A healthcare practitioner (HCP), must consult the Controlled Substance Utilization Review and Evaluation System (CURES - California's Prescription Drug Monitoring Program), before prescribing, ordering, or furnishing Schedule II, III, or IV drugs for the first time and at least every four (4) months thereafter if the drug is still part of the treatment plan. There are some limited exceptions to requiring one to consult CURES for the first time, but even those require consulting CURES subsequently, at least every four (4) months if the drug is still part of the treatment plan. Failure to consult CURES can result in administrative sanctions by the state licensing board, though this section is not operative until six months after the Department of Justice certifies CURES for statewide use. [SB482, §11165.4(a)] CURES data cannot be disclosed, sold or transferred to a third party unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. An HCP can provide a patient with a copy of the patient's CURES patient activity report, in accordance to this subsection, as well as federal and state privacy laws and regulations. [SB482, §11165] Individuals acting in good faith are not subject to civil or administrative liability arising from false, incomplete, or inaccurate information contained in CURES, or from any resulting failure of CURES to accurately or timely report information. [SB482, §11165.1]

Electronic Data Reporting (EDI)

Effective January 1, 2017, the \$5,000 penalty cap on EDI violations has been raised to \$10,000. The Administrative Director is to publish annually report listing EDI violators on the state's website. [SB1160, §138.6(d)]

Liens

Effective January 1, 2017, liens filed by a lien claimant charged with workers' compensation fraud, medical billing fraud, insurance fraud, or fraud against Medicare or Medi-Cal programs, are automatically stayed. The Administrative Director (A.D.), is to publish a list of stayed liens of providers whose liens have been stayed. The stay is in effect from when charges are filed until the disposition of the lien. [SB1160, §4615(a)] Additionally, applicant attorney fee liens must be filed electronically. [SB1160, §4903.5(b)] On or before July 1, 2018, the A.D. shall publish a fee schedule for applicant attorney deposition fees. [SB1160, §5710]

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Liens filed after January 1, 2017, must be accompanied by a declaration under penalty of perjury, stating the basis upon which lien is authorized to be filed, as well as a full statement or voucher in support of the lien, and filed on all the parties. Existing liens have until July 1, 2017 to file the same declaration. Failure to file or filing a false declaration results in dismissal of the lien with prejudice by operation of law. [SB1160, §4903.5]

Evidence of ownership is required before payment can be issued on a lien. For liens filed after January 1, 2017, liens cannot be assigned unless the provider is no longer in business and a complete transfer to assignee has taken place. Assignments in violation of this are invalid by operation of law. [SB1160, §4903.8]

Medical Fraud

The Administrative Director (A.D.) is to adopt regulations to suspend providers from participating in the workers' compensation system if convicted of certain fraud or abuse, or had their license revoked. Providers may appeal the suspension and request a due process hearing. The A.D. is to post a list of the suspended providers on its website, and update its QME and MPN databases. [SB1244, §139.21] The Director of Healthcare Services is to notify the Administrative Director of the Division of Workers' Compensation of any suspensions from the Medi-Cal program. [AB1244, §14123]

Miscellaneous

On or before 1/1/18, the Administrative Director is to promulgate rules:

- Regarding notice to injured workers as to how then can access medical treatment outside of the workers' compensation system when their claim has been denied. [SB1160, §138.4(f)]
- Establishing criteria to verify the identity and credentials of interpreters within the workers' compensation system [SB1160, §5811(c)]

No applicant attorney fees are payable prior to the applicant signing a disclosure form. This applies to both the initial and any subsequent attorney. [AB1244, §4906]

Effective January 1, 2017, only the following employees can opt out of coverage:

- Officers and directors of companies who own at least 15% of the company, or
- Are a general partner, or
- A managing partner of a LLC

Additionally, they must sign a written waiver. This rule applies to existing as well as new policies. [AB2883, §§3351-3352]

For medical services provided on or after 1/1/17, itemized bills must be submitted within 12 months from the date of service, or 12 months from the date of discharge for inpatient services. Bills submitted beyond these timeframes are barred. The timeframes can only be extended for good cause. [SB1175, §4603.2] The Administrative Director is to develop appropriate regulations for the submission of both paper and electronic bills. [SB1175, §4603.4] Medical-Legal bills have similar timeframes. [SB1175, §4625]