THE SENTINEL

KEEPING WATCH OVER WORK COMP LEGAL TRENDS

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Quarterly Newsletter

CALIFORNIA LEGISLATIVE CHANGES

On September 30, 2016 California SB 1160 and AB 2503 were signed into law by Governor Brown. These bills work closely together and result in several changes to the Labor Code that will affect the utilization review process going forward.

As the two bills were closely related, and each edited Labor Code 4610 in different ways, each of the two bills explicitly contemplated that the other bill would be enacted, but each bill also contained contingency provisions that would only become effective if the other bill was enacted first. In addition to the multiple versions of each section, the Cal. Labor Code § 4610 was also amended to create 2 different time periods, pre-1/1/2018 and post -1/1/2018, with a different version of the statute applicable to each time period. As a result, the Chaptered version of SB 1160 and AB 2503 contain multiple versions Cal. Labor Code § 4610. This has created some confusion. For reference, the effective versions are included as an appendix to this document.

LABOR CODE 4610 (PRE 1/1/2018)

- There were many changes to this section which were simply grammatical in nature.
- The term "delay," as a determination type was removed entirely from the section and will no longer be permitted as a valid utilization review determination type.

This Newsletter includes California Legislative Updates, NY Opioid Weaning Process, and an overview of Colorado Rule changes.

The workers' compensation cost containment space is constantly evolving. Managing compliance changes across multiple jurisdictions can be a challenging and almost impossible task.

PRIUM has developed a compliance and regulatory consulting group to assist payers and stakeholders in tracking and managing their ongoing compliance efforts.

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- The following language was added to 4610(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.

- A new paragraph (j) was also added to reflect the effective period of the section:

  (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.

Labor Code 4610 (Post 1/1/2018)

- The new 4610(b) creates a 30 day period following the date of injury where treatment shall not be subject to prospective review unless it is for one of the following treatments outlined in paragraph (c):

  (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.

- 4610(e) states that for a physician who fails to adhere to reporting requirements and the requirement to properly submit an RFA, the 30 day preauthorization outlined in 4610(b) may no longer apply:

  (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.

- 4610(f) states that retrospective review of treatments provided during the 30 day period is permissible, but only to determine if the treatment is consistent with the MTUS. The new section also outlines the process for changing the treating physician if *"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, […]"*
- New Section 4610(g)(3)(B) discussed financial incentives and financial interests. There can be no financial incentive for a reviewing physician to modify or deny treatment and any party that has a financial interest in the entity performing their utilization review must disclose that interest to the DWC.

- 4610(g)(3)(C) permits the administrative director to review contracts between physician reviewers, utilization review companies, and employers/insurers, to ensure compliance with 4610(g)(3)(B).
- 4610(g)(4) requires entities performing utilization review to meet certain accreditation standards by July 1, 2018:

  "*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."*
- 4610(g)(5) requires, prior to July 1, 2018, employers to submit a description of their utilization review process to the administrative director for approval and to make it "*available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site."*
- 4610(h) describes the requirements for the criteria used to evaluate treatment in utilization review, including a requirement that the criteria be consistent with the MTUS.
- 4610 (i) describes the procedural requirements for the utilization review process, including timeframes for making determinations, communication of determinations, and the contents of the determination.
- New Section 4610(o) requires the administrative director to "*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."*
- New Section 4610(q) requires the administrative director to contract with an independent research organization to evaluate the impacts of the 30 day preauthorization exemption period.
- New Section 4610(r) states that the effective date for all changes to Section 4610 shall become operative on January 1, 2018.

Labor Code 4610.5

- Several edits throughout this section were made to correct grammatical errors, remove the term delay, and include "drug formulary" as a dispute category to which this section of the Labor Code will apply.
- 4610.5(f) is edited to permit an employee to request independent medical review (IMR) electronically once that capability is developed by the Division.
- 4610.5(g), regarding termination of the IMR process, now includes the following language requiring proactive communication from the employer in certain circumstances:

  "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."
- 4610.5(h)(1) has been amended to include a separate timeframe for disputes involving the Drug Formulary. The section now reads:

  (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.

- 4610.5(l) has been amended to require the employer to electronically send the required information to the independent review organization. The required information now includes the Request for Authorization and the Utilization Review Determination. 4610.5(l)(C)
- New Section 4610.5(p) requires the claims administrator to notify the independent review organization if there is a change in the claims administrator responsible for the claim within 5 business days of the change.

Labor Code 4610.6

- New Section 4610.6(d) requires the independent review organization to issue a determination for disputed medications pursuant to the drug formulary within five working days of the receipt of the request. Determinations for all other medical treatment disputes will be issued within 30 days of the request.

Labor Code 6409

- 6409(a) was amended extensively and now includes the requirement that the treating physician file the first report of injury with the division within five days of the initial examination.

Other Changes

- Several edits were made to Labor Code sections 4615, 4903.05, and 4903.8 dealing with liens and how the lien process will change going forward.

New York Opioid Weaning Hearings

The New York State Workers' Compensation Board (WCB) recently issued Subject No. 046-892, announcing a new hearing purpose for opioid weaning issues.

Under this new process, the Carrier/Employer may request a hearing to determine whether weaning from opioids is recommended. The WCB has updated the Form RFA-2 "Request for Further Action by Carrier/ Employer" to include a new hearing purpose under the form's "medical issues" section.

If a Carrier/Employer wishes to initiate a hearing on the issue of opioid weaning, they will need to submit the properly completed RFA-2 along with a report from either an Independent Medical Examination or a Records Review which *"indicates weaning goals and recommended weaning program or resources."*

Once the RFA-2 is filed, and the WCB notifies the Claimant that a hearing has been requested, the Claimant will have an opportunity to submit a report from their prescribing physician outlining the medications, whether or not the medications (as prescribed) comply with the Non-Acute Pain Medical Treatment Guidelines (NAP-MTG), and commentary on the weaning plan discussed in the Carrier's submission. The Claimant will have until the date of the hearing to prepare their report.

The WCB has stated that the Workers' Compensation Law Judge (WCLJ) will issue one of three rulings:

1. *"Insufficient proof that there is a need for continuing long-term opioid use and the claimant must be weaned from the narcotic medication(s);*
2. *Insufficient proof that there is a need for continuing long-term opioid use and the claimant must be weaned from the narcotic medication(s), and enrolled in an addiction treatment program;*
3. *Claimant demonstrated the opioid use was effective in terms of improved function and reduction of pain, and that weaning will be unnecessary at this time."*

The Carrier/Employer must cover the costs of a weaning plan ordered by a WCLJ.

Colorado Division Rule 16 Update

The Colorado Division of Workers' Compensation has updated Division Rule 16 which will affect the utilization review process beginning in 2017.

New Rule 16-11(B)(2)

The rule states in part: "After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, …"

Previously, payers could rely solely on the information provided by the requesting physician, however this new language creates an explicit requirement that payers must supplement the documentation provided by the requesting physician if the requesting physician references a document in their request, but does not provide it.

The new rules do not provide for any additional time for payers to comply with this request as a response to a request for prior authorization must still be submitted within 7 business days.

New Rule 16(9) - Notification

New Rule 16-9(C)(1)(a) requires the provider **to** submit notification to the payer to certify **that** the proposed service or treatment is medically necessary and consistent with the Medical Treatment Guidelines. The payer reviewing a notification submission is entitled to rely on that certification and the provider who incorrectly applies the Guidelines may be subject to penalties.

Payers should take note that they must timely respond to notifications and prior authorization requests as failure to timely respond results in a deemed authorizing of payment. The Rule requires payers to respond even if there has been no admission of liability, the proposed treatment is not related to an admitted injury, the request is not from an Authorized Treating Provider, etc.

For more information about any of these topics, or for copies of any referenced documents, rules, publications, or laws, please contact PRIUM's compliance team at: compliance@prium.net or reach out to your account manager

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