**Senate Bill 863 Implementation Guide**

***(Revised November 7, 2012)***

***Note:*** *This is not intended to be a section by section analysis of the bill*

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| Subject | Code Section | Authority | Dates | Description | Recommendation |
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| Certified Interpreters | Gov’t Code §§ 11435.30; 11435.35; Labor Code §§ 4600, 5811 | DWC | 01/01/13 | Allows AD to develop testing and certification procedures for administrative hearing and medical examination interpreters or to contract for those procedures.  Sec. 4600 authorizes the AD to establish criteria for interpreters during treatment. Does not require certification under the Gov’t Code provisions | Contract out for initial certification process  Certification regulations for treatment should borrow significantly from DMHC regulations. See:  28 CCR § 1300.67.04  Develop a fee schedule for interpreters in med-legal beyond the current regulations (8 CCR §§ 9795.1 et seq.) and a new one for treatment.  The fee schedule should address rates for less common languages using the “designated language” criteria and regulations adopted thereunder pursuant to Government Code § 68562(a).  ***Note*** that any such regulation should preserve the ability of an MPN to provide interpreters |
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| Workers’ Compensation Administration Revolving Fund (WCARF) | Labor Code § 62.5 | DWC | 01/01/13 | Adds the costs of administering the public self-insured program by DIR to the Revolving Fund  Funds the RTW Program at $120M annually | Assessment levels need to be determined in time for 01/01/13 insurance renewals  ***Note*** the number of assessment rates that sunset on 07/01/13 |
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| Return to Work Program | Labor Code § 138.48 | DWC | 01/01/13 | Establishes a $120M fund for making supplemental payments to injured workers whose PD benefits are “disproportionately low” in comparison to earnings loss | Requires substantial rulemaking to define scope of benefit. This is likely better commenced through a workshop rather than straight to rule making so that expectations are clear from the outset as to eligibility. A CHSWC study is required before regulations are adopted. There is no timeframe for the study to be completed.  ***Note*** that in 2005 the DWC completed a new series of studies in anticipation of revising the DFEC component (now repealed) of the PDRS. This may not qualify for the study referred to in this new program, but it does reference prior RAND (and CHSWC funded) work considerably. |
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| Financial Interest Disclosure | Labor Code § 139.32 | DWC | 01/01/13 | Requires disclosure of any financial interest in any entity providing services. | From a regulatory perspective, the DWC should promulgate a disclosure form and provide some guidance as to whom the form must be disclosed. |
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| Independent Medical Review (IMR) | Labor Code §§ 139.5, 4062, 4610.5, 4610.6, 4903.6, 5502 | DWC/WCAB | 01/01/13  07/01/13  01/01/14  01/01/15 | Authorizes the AD to contract with independent medical review organizations (IRO) to conduct IMR.  ***Note*** that effective 01/01/15 the contract will have to be let by competitive bid.  ***Note*** that the AD has authority to adopt by regulation other requirements for IROs  ***Note*** effective 01/01/14 a reviewer cannot be a QME.  ***Note*** New Labor Code § 139.5(c)(1) requires an IRO to have a California licensed medical director who shall be “responsible for advising the contractor on clinical issues”. Is this intended to include a situation where the Medical Director is advising an IMR physician on the applicability of standards to the specific UR decision under review?  ***Note*** The IMR provisions borrow extensively from the statutes creating IMR in the Health & Safety Code [even to the point where the cut and paste uses the word “plan” in Labor Code § 4610.5(i)].  ***Note*** New Labor Code § 4610.6(m) gives the DWC the discretion to publish IMR decisions. This can be as simple as doing what is currently done in the Department of Managed Health Care and providing access to the complete list of IMR decisions or the Division may want to consider a more significant linkage between utilization review (UR) regulations, the UR penalty regulations, and the medical treatment utilization schedule (MTUS). | Initial ability to contract with Department of Managed Health Care IROs will allow IMR to be available on 01/01/13  Forms will need to be developed for the worker to request IMR.  Because the IMR provisions apply to injuries occurring on and after 01/01/13, DWC should consider emergency regulations to promulgate the forms necessary to be able to process IMR requests on the effective date. (IMR will apply regardless of date of injury by 07/01/13)  Either the DWC or the WCAB will need to develop forms for appealing IMR decisions  The DWC will need to develop an audit/penalty structure for enforcement of Secs. 4610.5(i) and 4610.6(k)  ***Note*** Current IMR regulations, 8 CCR §§ 9768.1 apply only to IMR under the MPN statutes.  ***Note*** timeframes and documentation requirements for processing IMR  ***Note*** As mentioned in other comments, there needs to be a clarification of which IMR process (“UR” IMR or “MPN” IMR is to be used under what circumstances.)  ***Note***: Consideration should be given to adopting the regulations of the DMHC regarding post-IMR filing additional information: “Any medical records or other relevant matters not available at the time of the Department's initial notification, or that result from the enrollee's on-going medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as possible upon receipt by the health plan, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases.” [28 CCR 1300.74.30(k)(1)] |
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| Spinal Surgery Second Opinion | Labor Code § 4062 | DWC/WCAB | 01/01/13 | This provision is repealed but silent as to whether it applies prospectively. | May want to consider amending 8 CCR §§ 9788.01 to clarify whether this procedure is repealed regardless of date of injury. |
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| WCAB jurisdiction over medical treatment disputes | Labor Code § 4062 | DWC/WCAB | 01/01/13 | There are separate procedures for IMR under new Labor Code § 4610.5 (resulting from a UR decision under Sec. 4610) and IMR under an MPN (resulting from the processes in Labor Code §§ 4616.3 and 4616.4) | There are several potential issues here. The first is that new Sec. 4062(c) states that MPN IMR can be used to dispute a “diagnosis”. This is not correct. While the second and third opinion processes apply to diagnosis, IMR applies only to treatment or diagnostic service. [Sec. 4616.4(b)] Also, current DWC regulations define a “health care provider” to include an MPN for purposes of UR standards under Sec. 4610. [8 CCR § 9792.6(i)]  Clarification is needed to make certain the employer and the injured work know which IMR process can be utilized for what treatment. |
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| QME Panel Requests | Labor Code § 4062.2 | DWC/WCAB | 01/01/13 | Amends statute to create new timeframes in which to request QME panels and prohibits an AME on requests subject to IMR under Labor Code § 4610.5 | The instructions on various QME request forms will have to be changed to reflect the new timeframes and limitations.  ***Note*** New Labor Code § 4062.2(f) would allow an AME when there is a request for IMR under an MPN |
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| Chiropractor as treating physicians | Labor Code § 4600 | DWC/WCAB |  | Prohibits a chiropractor from being a “treating physician” after the maximum number of visits allowed under Labor Code § 4604.5(d). (Note incorrect statutory reference)  But isn’t the issue whether after 24 visits (or however many more authorized by the claims administrator) the chiropractor is the *primary* treating physician (PTP) and not simply a treating physician? It would seem that the PTP as defined in Labor Code § 4061.5 and 8 CCR § 9785 does not lose that status once his or her ability to treat is ended by operation of Sec. 4604.5. Indeed, 8 CCR § 9785(a)(1) only requires the PTP to examine the injured worker “at least once” and then “has monitored the effect of the treatment thereafter”. In other words, the PTP does more than treat. | This does not precisely track the definition of “primary treating physician” under Labor Code § 4061.5. The DWC will need to revise the definition of PTP in 8 CCR § 9785(a)(1).  The statutory language raises the question of whether a chiropractor can continue to be the treating physician if the payer authorizes additional visits.  The statutory language also raises the issue of whether a chiropractor can continue to be the PTP and “primarily responsible” for the care of the injured worker after the visit cap has been reached.  Another option would be simply to do nothing given that current regulations state that controversies arising from Sec. 9785, which now would likely include this issue, are to be resolved per Sections 4603 or 4604. [8 CCR § 9785(h)] In this case, forbearance may prove to be the best option. |
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| Predesignation | Labor Code § 4600(d)(4) |  |  | It should be noted that while the amendments to Sec. 4600 incrementally expand the ability to predesignate by de-linking the receipt of health care from an employer sponsored plan, the amendments still do not allow for predesignation when there is an individual policy issued by a disability insurer. [Labor Code § 4600(d)(4)] | Other than the need to do conforming changes to the current predesignation regulation, 8 CCR § 9780.1, the changes to the predesignation law in Labor Code § 4600 would appear to be self-executing. |
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| Unauthorized providers | Labor Code §§ 4603.2, 4616.3, 4903.1, 5502 | DWC/WCAB | 01/01/13 | Establishes a procedure for addressing disputes over whether an injured worker is properly treating outside the network.  ***Note*** that the provisions of Sec. 4603.2(a)(2) would appear to preclude transition of care back into the MPN if the injured worker is authorized to treat outside the MPN. The reference to the continuity of care provisions in Labor Code § 4616.2 is misplaced as this is not a continuity of care issue.  Amendments to the MPN statutes state that a failure to provide notice is insufficient grounds to obtain treatment outside the MPN unless the failure to provide notice resulted in a denial of care.  The network treatment issue is eligible for an expedited hearing. | There will need to be regulations regarding the contents of the petition to adjudicate this issue as well as the timeframes for service and other procedural issues created by this change.  8 CCR § 9767.9 (transfer of care regulations) will need to be revised to reflect the new procedures in Sec. 4603.2(a)(2)  ***Note*** There is a disconnect between the provisions of Sec. 4603.2(a)(2) and new lien provisions in Sec. 4903.1(b). The latter suggests that the employer has no liability for payment (except for narrow circumstances) even if the physician properly submits a first report and it is adjudicated that the treatment outside the MPN is proper. |
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| Billing Documentation | Labor Code § 4603.2 | DWC | 01/01/13 | Requires various documentation requirements for all providers of medical services  ***Note*** Labor Code § 4603.2(b)(1) now states that photocopying is a medical benefit under § 4600. This will make the 15% + interest penalty apply to these services.  ***Note*** Labor Code § 4603.2(b)(1) states that payers can by contract establish “alternative” manual or electronic requests for payment for medical service providers. This would seem to be in direct conflict with Sec. 4603.4. | This will likely affect the standardized medical treatment forms set forth in the Guide adopted pursuant to 8 CCR §§  9792.5.2. |
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| Second Request for Review | Labor Code § 4603.2 | DWC | 01/01/13 | If the initial EOR does not resolve the billing, the provider may request a second review. A second review is required before independent bill review (IBR) can be requested. | New forms need to be adopted for the second review request. [Labor Code § 4603.2(e)]  ***Note*** Timeframes for processing requests |
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| Explanation of Benefits (EOR) | Labor Code § 4603.3 | DWC | 01/01/13 | Sets forth new EOR requirements | Emergency regulations would be appropriate for this new form given that it also has to inform the payee of rights to IBR.  ***Note*** This will affect the forms set forth in the Guide adopted pursuant to 8 CCR § §9792.5.2 as well as e-billing requirements. |
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| Independent Bill Review (IBR) | Labor Code §§ 4603.3, 4603.6, 4622, 4903.6  ***Note*** IBR applies both to medical treatment billing disputes and med-legal billing disputes | DWC | 01/01/13 | Establishes an independent review for billing disputes.  ***Note*** The provisions of the IBR statutes give limited jurisdiction to the WCAB to review a decision after IBR. In addition, the lien statutes would seem to not allow a lien to be filed if medical treatment is subject to IBR [Sec. 4903(b)]. If that is the case, then the only purpose of still allowing a “lien” post IMR and IBR would appear to be to secure payment rather than to dispute the amount. [Sec. 4903.6(a)] | New forms need to be adopted for providers to request IBR.  ***Note*** Timeframes for processing requests  ***Note*** There will still be liens on denied cases and where there is a dispute over whether there is a compensable new and further condition of disability on an accepted injury.  ***Note*** The DWC should consider specifying the calculation of time when these various rights are triggered or extinguished. This issue was addressed in a different context in the Messele case last year as it related to when QME panels were properly requested.  The second review request [Sec. 4603.2(e)(1)] and the request for IBR [Sec. 4603.6(a)] reference certain actions that must be taken within a period of time after “service” of the initial EOR or the explanation on second review. If for no other reason than to avoid another dispute over timeframes, it would seem appropriate to by rule establish when the timeframes are calculated both for paper and electronic filings. (Messele applied the general “mailbox” rule extending 5 days onto timeframes that were trigger by a notice sent by regular mail.) If the DWC thinks this is sufficiently dealt with in Labor Code § 5316 then that’s fine, but given the consequences of failure to do things within the designated timeframes this is worth taking a look at. I also think that it would be rather simple to state that Sec. 5316 governs the timeframes for second review and IBR and should be expressly applied. It is appropriate to designate a shorter timeframe for electronic requests than for paper ones as is the case already for payment on e-bills rather than paper bills in Labor Code § 4603.4. |
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| Utilization Review | Labor Code § 4610 | DWC | 01/01/13 | Utilization review was largely unaffected by this legislation. The amendments do clarify that UR is not required when compensability is in dispute.  ***Note*** The specific language relating to UR when there is a compensability dispute is, “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…” The dispute is not over the treatment, but rather over the condition. The italicized language should be removed. | New notices will need to be developed to reflect IMR |
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| Medical Provider Networks (MPNs) | Labor Code §§ 4061, 4062, 4603.2, 4616, 4616.1, 4616.2, 4616.7, | DWC | 01/01/13  01/01/14 | The regulations make extensive changes in the formation of networks. These changes generally will become effective on January 1, 2014. [See: Labor Code §§ 4616(a)(3), (a)(4), and (a)(5)] | Implementation regulations will be required for filings necessary to show compliance with the contract requirements for providers to participate in the MPN.  Regulations will be required to address the addition of “entity that provides network services” into the list of MPNs and to clarify that a payer may discharge its various obligations by contracting with an “entity”.  Regulations for the medical access assistant(s) requirements in Labor Code § 4616(a)(5) must be adopted on or before July 1, 2013.  Regulations will be required to establish the scope of the quality assurance program. (See: 8 CCR § 9774 which established QA requirements for HCOs)  Regulations will be required to establish audit/penalty standards.  Regulations will be required to establish a mechanism whereby an MPN can address primary care shortages.  It would also be appropriate to revisit the need for the various notices in 8 CCR § 9767.12  Given the language in Secs. 4600 and 4603.2 regarding interpreters within the definition of medical benefits, it would be appropriate to make clear that an MPN can provide interpreter services. This could be accomplished by stating an “ancillary service” includes, but is not limited to, the services of a qualified interpreter. [8 CCR § 9767.1(a)(1)]  ***Note*** prior comments regarding med-legal (IMR) and unauthorized treatment |
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| PD Advances | Labor Code § 4650 | DWC | 01/01/13 | Provides that no PD advances are required if the injured worker has been offered employment that pays at least 85% of wages by the employer at injury or is employer in a position that pays 100% of wages by any other employer. | Notice will be required to the injured regarding implementation of this plan.  There is no mention of whether the job offer is within the ability of the injured worker to perform given the work restrictions (See: Labor Code § 4658.7 re: supplemental job displacement benefit.)  There may be a conflict of the employer seeks to not pay PD advances based upon a job offer that would not meet the criteria in the SJDB. |
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| Supplemental Job Displacement Benefit | Labor Code §§ 4658.5, 4658.6, 4658.7 | DWC | 01/01/13 | There are changes both to vouchers issued on claims with dates of injury prior to 01/01/13 issued after 01/01/13 and a new structure for dates of injury after 01/01/13.  ***Note*** that vouchers issued for dates of injury after 01/01/13 cannot be settled. The amount of the voucher is $6000 regardless of the level of PD. | Existing notices will have to be revised to reflect the new statutory limitations on the SJDB.  Consideration should be given to clarifying what to do when there is a P&S report but the injured worker is disputing his or her status. If there is a new P&S report that has different restrictions will a new offer have to be made? |
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| Permanent Disability Rating Schedule (PDRS) | Labor Code § 4660.1 | DWC | 01/01/13 | Allows the current age and occupational modifiers to be used until a new PDRS is promulgated | No timeframe in which revisions have to be made.  ***Note***: Wage loss study required in subdivision (i). Contrast this with the study also required of the Commission for the new supplemental payments authorized in Labor Code § 138.48 |
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| Liens | Labor Code §§ 4903, 4903.05, 4903.06, 4903.07, 4903.1, 4903.4, 4903.5, 4903.6, 4903.8, 4904, 4905, 4907 | DWC/WCAB | 01/01/13  01/01/14 | This makes significant changes to the lien process as largely outlined by earlier CHSWC studies.  The new requirements include reinstatement of the lien filing fee, a firm statute of limitations, and would appear to limit (or extinguish) lien rights for disputes that are taken to IMR or IBR.  There are significant limitations on the ability of an assignee to seek payment of a lien.  Since the DWC is subject to the provisions of Government Code §§ 6160 et seq. you will be working with General Services to meet the requirements of new Labor Code § 4903.05(c)(1).  ***Note*** Labor Code § 4603.6(c) requires the payer to reimburse the filing fee for IBR if additional amounts are found due. Labor Code § 4903.6(a)(2) seems to preserve the ability of a provider of services to file a lien to collect an amount found due following IBR.  If that is a correct interpretation, it seems unfair to require a lien claimant who has already been reimbursed the cost of IBR to then have to pay a fee to enforce that award and on a pro forma basis automatically get that money back.  This also becomes an issue of clarification for determining whether a lien claimant is entitled to get the filing fee reimbursed per the provisions of new Labor Code § 4903.07. While it is clear that this section isn’t triggered until the process as set out in Sec. 4903.6 has run its course, it would seem axiomatic that if a lien claimant is seeking to enforce an IBR determination none of these steps should have to be taken. This would seem to support either waiving the filing fee for these types of actions (which would then remove such cases from the provisions of Sec. 4903.07) or the Division can clarify that the required steps to be able to get reimbursed under this section are met by going through the process in Labor Code §§ 4603.2, 4603.6, and 4622.  If the DWC and the Appeals Board consider it an acceptable alternative to have the provider seek enforcement of the IBR award through a petition for sanctions under Labor Code § 5813 and 8 CCR §§ 10450 and 10561, then there should be an express statement of that policy. | Labor Code § 4903.05(c)(5) gives the AD express authority to adopt regulations governing the collection of the lien filing fee. This should be considered for emergency regulations.  The DWC will need to adopted regulations governing the process outlined in Sec. 4903.07.  The WCAB will need to make significant changes in its Rules of Procedure to address various issues regarding lien hearings.  The Legislature determined that the provisions regarding assignments are self-executing. (Labor Code § 4903.8) |
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| Fee Schedules | Labor Code §§ 5307.1, 5307.8, 5307.9, 5811 | DWC | 01/01/13  01/01/14  01/01/15  01/01/16  01/01/17 | These provisions either modify or enact a wide range of fee schedules, including moving to an RBRVS system for medical services, deleting the pass through for implantable hardware, and equalizing payments to ambulatory surgery centers. In addition, fee schedules will be established for home health care and interpreter services. | The OMFS revisions are somewhat self-executing with the exception of the ground rule changes outlined in Sec. 5307.1(a)(2)(B) relating to new codes and evaluation and management services provided during a “global period of surgery”.  As for the remaining schedules, it is up to the DWC to decide whether these need to be done on an emergency basis under its authority in Secs. 5307.3 and 5307.4. Given that IBR applies at time of service, the adoption of these schedules will greatly aid the ability to realize the potential of the billing and lien reforms. There is an equally compelling argument to be made that it is better to get the schedules right the first time and limit potential litigation over the schedules that could further delay their implementation. |