

SB 1160 (Mendoza)

SUMMARY

- Provides that, with respect to medical treatment that is provided through a medical provider network (MPN), a health care organization (HCO), other employer-directed provider, or a pre-designated physician, no prospective UR is required for the first 30 days of treatment.
- Provides several exceptions to the "no UR" rule, including surgery, medications not covered by the formulary, psychological treatment, diagnostic imaging (x-rays not included), durable medical equipment (DME) if total costs for all DME exceeds \$250, and home health care services.
- Requires any treatment provided within the first 30 days to be reported to the employer or claims administrator - failure by the provider to properly report treatment can lead to revocation of the "no UR" rule for that provider.
- Authorizes an employer to conduct retrospective UR to ensure compliance with evidence-based medicine standards, and if a pattern of non-compliance is discovered, the "no UR" rule could be revoked or the provider removed from the MPN.
- Any request for payment for treatment provided under subdivision (b) (within 30 days of the initial injury and rendered without prior authorization) 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.

(SB 1175 (Mendoza) related to deadlines for submitting requests for payment also passed and was signed into law in 2016. SB 1175 requires that, for treatment provided on or after January 1, 2017, the medical provider must submit the request for payment within 12 months of the date of service or 12 months of the date of discharge for inpatient facility services. Unless otherwise allowed, any request for payment submitted after 12 months would be barred. SB 1175 also requires that billings for medical-legal services be submitted within 12 months of the date of service, unless otherwise allowed. Any request for payment submitted after 12 months would be barred.)

UR Process Approval:

- Prohibits explicitly an employer or claims administrator from providing a UR organization with financial incentives to deny or modify treatment.
- Requires financial interest disclosure of UR entities be shared with DWC.
- Requires any UR organization to be accredited by an entity specified by the DWC, subject to exceptions for certain public entities that have internal systems approved by the DWC. The entity must be independent and non-profit. Until the rules are approved by the AD, the entity will be URAC.
- Provides authority to the DWC to approve UR processes.
- Clarifies that Request for Authorization (RFAs) for medical treatment be sent to the claims administrator. This will save providers administrative costs as they will no longer have to investigate where to send the RFA. Payors still must process the RFA within the previous timelines – 5 days/14 days if requesting additional information.

UR and Medical Guideline Modernization:

- Requires, through the URAC accreditation process, the availability of peer-to-peer communication in the event of a UR modification or denial.
- Requires the AD to develop a mandatory electronic system for sharing documents necessary to conduct UR.

- Adopts new procedures designed to better facilitate delivery of information for purposes of IMR.
- Establishes an expedited five-day time frame for IMR decisions related to medications on the formulary.
- Provides that MTUS may be updated with evidence-based medicine standards by an expedited process.

Anti-Fraud Measures:

- Requires, for liens filed on or after January 1, 2017, a lien filer to specify in the lien filing the basis upon which the lien is authorized.
- Requires these same data elements to be added to pre-existing liens, but allows until July 1, 2017, for lien filers to comply.
- Provides that the failure to comply with the requirements noted above results in a dismissal of the lien with prejudice.
- Provides that in the event a lien filer is charged with workers' compensation fraud, Medi-Cal fraud, or Medicare fraud, all liens are stayed pending resolution of the charges.
- Prohibits, for liens on or after January 1, 2017, any assignment of liens unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all rights, 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.
- Clarifies existing law on liens assigned between 2013 and 2016 by codifying Chorn v. WCAB (Workers' Compensation Appeals Board) (2016), 2016 Cal. App. LEXIS 232 and states these amendments to be declaratory of existing law.