Open Forum

Outlining Workers' Compensation Reforms

See how the complex changes will affect you as a treating physician.

BY BETH A. KASE, ESQ.

The 2003-04 workers' compensation reform legislation brings sweeping changes to the system in California. The reforms were enacted in two phases: AB 227 and SB 228, signed by Gov. Gray Davis, became law Jan. 1, 2004, and SB 899, signed by Gov. Arnold Schwarzenegger, became law April 19, 2004. The legislation contains myriad changes that affect you, if you treat patients with occupational injuries.

This article will address the following:

1. The adoption of treatment guidelines.
2. The new medical provider networks.
3. Medical treatment and control within and outside of networks.
4. Reimbursement for treatment under the Official Medical Fee Schedule (OMFS).
5. Permanent disability reports.
6. Changes that affect physician referrals to outpatient surgery clinics in which the physician has a financial interest.

Treatment Guidelines

The basic requirement under Labor Code §4600 remains the same. The employer is required to provide "all medical care reasonably required to cure or relieve the injured worker from the effects of his or her injury." The patient is not responsible for any deductible or co-payment.

The new law defines "reasonably required" care as treatment based upon treatment guidelines to be adopted by the Administrative Director of the Division of Workers' Compensation (AD) and prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medical Practice Guidelines (ACOEM Guidelines).

Under the new law, on or before Dec. 1, 2004, the AD, in consultation with the Commission on Health and Safety and Workers' Compensation (CHSWC), is to adopt after public hearings, guidelines incorporating evidence-based, peer-reviewed, nationally recognized standards of care. The guidelines are to address at least the frequency, duration, intensity and appropriateness of medical treatment common in workers' comp cases. CHSWC and the Division of Workers' Compensation have contracted with the RAND Corp. to solicit and evaluate proposed medical treatment guidelines.

> An **independent** medical review process is a **new feature** of the **workers' comp law.**

Because the treatment guidelines will affect the care you render, it is important that physician associations and specialty societies provide input to the new guidelines in all phases of the process.

The treatment guidelines are not advisory guidelines. They will be presumed correct on the issue of the extent and scope of medical treatment—regardless of the date of injury—supplanting your presumption of correctness as the treating doctor. Accordingly, you must become familiar with the ACOEM Guidelines, as well as the new treatment guidelines, once adopted.

The guidelines are rebuttable in an individual case by a preponderance of the scientific medical evidence demonstrating that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury. You may be asked or required to explain and justify the rationale for diagnostic tests and treatments that fall outside the guidelines. Members of the medical community have commented that the ACOEM Guidelines are conservative and primarily address acute conditions. Based on these comments, you can expect that in certain cases your reasonable treatment plan may fall outside ACOEM Guidelines.

To my knowledge, you do not receive additional reimbursement for the time and effort spent assembling the scientific medical evidence and/or explaining your rationale for diagnostic tests and treatments that fall outside the guidelines.

Medical Provider Networks

Beginning Jan. 1, 2005, an insurer or employer may establish a new or modify an existing medical provider network for medical treatment of injured employees. These networks are closed panels and must be approved by the AD. The following organizations will be deemed approved as networks, provided they meet certain criteria: (1) healthcare organizations previously certified by the AD under Lab. §4600.5, (2) Knox-Keene plans, (3) group disability insurance policies under Insurance Code §106(b) and (4) Taft-Hartley health and welfare funds. It is likely that some existing workers' comp networks and other networks will seek to become medical provider networks under the new legislation, and new networks are forming, as well.

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The networks must:

- Consist of physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of non-occupational injuries (goal of at least 25 percent primarily non-occupational physicians);
- Have an adequate number and type of physicians to treat common injuries affecting employees' occupation and covering employees' geographic area;
- Be readily available at reasonable times to employees;
- Not structure physician compensation to achieve a goal of reducing, delaying or denying treatment; and
- Provide treatment in accordance with the medical treatment utilization guidelines discussed above.

Here are some of the pertinent standards applicable to networks:

- Within the network, only a licensed physician in the appropriate scope of practice may modify, delay or deny a request for authorization of treatment. (This governs any internal utilization review process the network may adopt.)
- An employer or insurer has the exclusive right to determine which providers are in the network. (This right greatly enhances the control the employer will have over the network, as the AD may not disapprove a plan solely on the selection of providers.)
- The employer's or insurer's economic profiling policies will be disclosed to the AD and provider. (Economic profiling is permissible.)
- Continuity of care must be provided for up to 12 months after the physician leaves the network, depending on the circumstances.

The statute requires the AD, in consultation with the Department of Managed Health Care, to adopt regulations on or before Nov. 1, 2004, to implement the new medical provider network provisions. These regulations may clarify ambiguities in the new law.

Networks may require contracting physicians to accept fees below the OMFS, although the medical director of the State Compensation Insurance Fund (State Fund), which controls approximately 60 percent of the workers' comp insurance market in California, told me he intends for State Fund contracting physicians to be paid at the OMFS.

Physician contracts with any new medical provider networks should be carefully reviewed. Physician groups of sufficient size with bargaining leverage, specialty physicians that are in high demand in certain geographic areas, and physicians and physician groups that have developed relationships with employers may be able to negotiate more favorable contract terms.

Physicians are in a **unique position** to educate patients about the **benefits** of **predesignation.**

Medical Treatment and Control

Basic rule (no network): Unless the employer uses a medical treatment network or the employee has predesignated a physician, the basic rule remains that the employer has medical control for the first 30 days, and then the employee gets the right to select the treating doctor.

Basic rule (with network): If the employer establishes a network, employees who did not predesignate a personal physician prior to the injury must receive care only through the network. The employer selects the first treating physician within the network. After the first visit, the employee may choose another treating physician within the network. The employee may seek second and third opinions within the network if the employee disputes the diagnosis or treatment. An out-of-network specialist is permitted if the network does not have a physician who can provide the approved treatment.

If the diagnosis or treatment is still in dispute after the third opinion within the network, the employee may request an independent medical review (IMR) by filing an IMR Application with the AD. The IMR process, which applies to treatment or diagnosis disputes for employees treated within a network, is a new feature of the workers' comp law.

The IMR physician contracts with the AD, and is not part of the network. The AD will adopt the independent medical reviewer's findings. No additional exams or reports will be admissible by the Workers' Compensation Appeals Board on issues of medical treatment under the networks. In other words, an employee within a network who objects to the IMR outcome may not request an exam through the AME or QME process.

If the IMR finds that the disputed diagnosis or treatment is consistent with the utilization guidelines, the employee may go within or outside the network for treatment. The legislation does not specify who will pay the cost of the IMR.

Predesignated Physician: The new legislation eliminates the ability for predesignation outside the group health setting, because an employee may predesignate only when the employer provides non-occupational group health coverage. The employee must notify the employer prior to the date of injury. Then in the event of an injury, the employee may seek treatment by the predesignated physician. The predesignated physician must be the employee's primary care physician, who has previously treated the employee, holds the employee's medical records and agrees to be predesignated. The statute says a maximum of 7 percent of the workforce may predesignate. Tracking when 7 percent is reached appears to be unworkable, and the maximum will likely be ignored.

Labor representatives are recommending that employees predesignate because it gives employees greater control. Physicians are in a unique position to educate patients about the benefits of predesignation.

Reimbursement

OMFS: All payments will be at the OMFS, except under contracts that provide for payment above or below the fee schedule. Absent a contract to the contrary, the payor has no obligation to pay above the fee schedule.

Effective Jan. 1, 2004, there is a 5 percent reduction to OMFS rates for physician services to be implemented in the aggregate, but OMFS rates for any service shall not be below Medicare rates for the same service. You should look to the fee schedule in effect on the date of service, not the date of payment. The AD will have the authority to adopt a new OMFS for physicians as of Jan. 1, 2006.

Time for Payment: The employer is to pay you within 45 working days after receipt of a properly itemized billing (changed from 60

days, except that a government-entity employer has 60 working days to pay). Since the intention was that the time for payment be reduced, it is anticipated that cleanup legislation will change the time period to 45 days (rather than 45 working days) because 45 working days is longer than 60 days. For itemized electronic billing, payment is to be made within 15 working days after electronic receipt. Rules require all employers to accept electronic claims by July 1, 2006, but providers are not required to bill electronically. The penalty for late payment has been increased to 15 percent, up from 10 percent.

Early Medical Treatment: The employer is required to provide medical care up to $10,000 after the employee's claim form is filed and until it is accepted or rejected. This is a great benefit to employees who might have had to wait 90 days under the old law before the employer made a decision whether to accept responsibility. It is unclear how medical fees will be tracked to determine which services fall within the $10,000 amount. In the meantime, to be in the best position for payment, you should submit itemized billings and any needed documentation promptly.

Permanent Disability Reports

Under the new law, your permanent disability reports will be required to use *American Medical Association Guides to the Evaluation of Permanent Impairment (5th Edition)* for all injuries that result in permanent disability. (The effective date for this change is unclear at this time.) You will need to become familiar with these guides, if you aren't already.

Apportionment of permanent disability will be based on causation, and your report must make an apportionment determination of the approximate percentage of the disability directly caused by the work injury, as opposed to other factors. Further discussion of the many other changes relating to permanent disability is beyond the scope of this article.

Outpatient Surgery Clinics

Outpatient surgery clinics are added to the list of prohibited physician self-referrals in the workers' comp setting. There is an exception to the self-referral prohibition where the physician discloses the financial relationship to the employer, and the employer preauthorizes treatment at the center, or the recipient of the referral does not compensate the physician for the referral.

This latter exception is unclear. Some lawyers have taken the position that a physician owner's profit share does not constitute compensation for the referral, so that a physician whose only compensation is based on his or her share of the clinic's profits would not be precluded from referring surgeries to the clinic without employer preauthorization. This is an aggressive stance, and the clinic's profit distribution formula should be analyzed by competent legal counsel before a physician owner makes any referrals on this basis. ■

This article is not intended to constitute legal advice. You should consult with an attorney regarding these matters.

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