Workers' Compensation Reform Legislation:

How It Affects the Treating Podiatrist

By Beth A. Kase, Esq.

The 2003-04 workers' compensation reform legislation brings sweeping changes to the workers' compensation system in California. The reform legislation was enacted in two phases: (1) AB 227 and SB 228 signed by Governor Gray Davis, which became law January 1, 2004 and (2) SB 899 signed by Governor Arnold Schwarzenegger, which became law April 19, 2004. The legislation contains myriad changes that affect you if you treat patients with occupational injuries.

Podiatrists may participate within their scope of practice in all aspects of the reformed workers' compensation system in the same capacity as M.D./D.O. physicians. Podiatrists are included among the definition of "physician" under Labor Code §3209.3 (this is not new), so all changes in the new law that affect M.D./D.O. physicians likewise affect podiatrists.

This article will address the following issues:

1. the adoption of treatment guidelines,
2. the new medical provider networks,
3. medical treatment and control within and outside of the networks,
4. reimbursement for treatment under the Official Medical Fee Schedule (OMFS),
5. permanent disability (PD) reports, and
6. changes that affect your referrals to outpatient surgery clinics in which you have a financial interest.

Treatment Guidelines

The basic requirement under Labor Code §4600 that 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 remains the same. The patient is not responsible for any deductible or co-payment.

The new law defines such "reasonably required" care as treatment that is 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 December 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 commonly associated in workers' compensation cases. CHSWC and the Division of Workers' Compensation have contracted with the RAND Corporation to solicit and evaluate proposed medical treatment guidelines.

Because the treatment guidelines will affect the care you render, it is important that appropriate podiatric treatment standards be incorporated into the guidelines. The CPMA, with the assistance of its legislative advocate, is pressing forward to provide input to the guideline 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 physician. Accordingly, you must become familiar with the ACOEM Guidelines, as well as with the new treatment guidelines, once they are 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 studies and treatment that fall outside the treatment guidelines. Members of the podiatric medical community have commented that the ACOEM Guidelines are conservative and primarily address acute conditions (as opposed to chronic conditions). Based upon these comments, it can be expected that in certain cases, your reasonable treatment plan may fall outside ACOEM Guidelines.

To my knowledge, you do not receive additional reimbursement for your time and effort to assemble the scientific medical evidence and/or explain and justify the rationale for diagnostic studies and treatments that fall outside the treatment review guidelines.

Medical Provider Networks

Beginning January 1, 2005, an insurer or employer may establish a new or modify an existing medical provider network for medical treatment of injured employees, which must be approved by the AD. These networks are closed treating panels. The following organizations will be deemed approved as networks, provided they meet certain criteria: (1) health care 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' compensation networks and

other networks will seek to become medical provider networks under the new legislation, and new networks are forming.

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% primarily non-occupational physicians) (Remember that podiatrists are included in the definition of "physician.")
- Have an adequate number and type of physicians, or other providers, to treat common injuries affecting the employees' occupation and covering the employees' geographic area
- Be readily available at reasonable times to employees
- Not structure physician compensation to achieve goal of reducing, delaying or denying treatment
- Provide treatment in accordance with the medical treatment utilization guidelines discussed above

Some of the pertinent standards applicable to the networks are the following:

- 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. It is unclear how utilization review of podiatric care will be implemented.)
- 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 to the provider. (Economic profiling is permissible.)
- Continuity of care must be provided for up to 12 months after the practitioner 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 November 1, 2004, to implement the new medical provider network provisions of the new law. 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% of the workers' compensation insurance market in California, advised me that his intention is that State Fund contracting physicians will be paid at the OMFS.

Contracts with the new medical provider networks should be carefully reviewed. Medical groups of sufficient size with bargaining leverage, specialists that are in high demand in certain geographic areas, and practitioners and medical groups that have developed relationships with employers may be able to negotiate more favorable contract terms.

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 pre-designate 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 approved by the employer/insurer.

If treatment or diagnosis is still in dispute after the third opinion within the network, the employee may request 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' compensation law. Podiatrists may perform IMR.

The independent medical reviewer contracts with the AD, and is not part of the network. The independent medical reviewer receives the treating physician's medical records, reports and other information from the employer. He or she conducts a physical exam at the employee's discretion, and may order diagnostic tests.

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

Pre-Designated Physician. The new legislation eliminates the ability for predesignation outside of the group health setting, because an employee may pre-designate only when the employer provides non-occupational group health coverage. The employee must notify the employer of the pre-designated physician prior to the date of injury. Then in the event of injury, the employee may seek treatment by the pre-designated physician. The pre-designated 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. As before, an employee may not select a podiatrist as his or her pre-designated physician. The statute provides that a maximum of 7% of the workforce may pre-designate. Tracking when the 7% maximum is reached appears to be unworkable, and the 7% maximum will likely be ignored.

The pre-designated physician may refer the patient to a podiatrist. At the time of this writing, there is some ambiguity as to whether the podiatrist would need to be part of the group health plan.

Labor representatives are recommending that employees pre-designate a physician because it gives the employee greater control over treatment. Health care practitioners are in a unique position to educate patients about the benefits of pre-designation.

Reimbursement for Treatment

OMFS. All payments will be at the OMFS, except under contracts which 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 January 1, 2004, there is a 5% 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 January 1, 2006.

Time For Payment. The employer is to pay the provider within 45 working days after receipt of a properly itemized billing (changed from 60 days, except that a governmental entity employer has 60 working days to pay). Since the intention was that the time for payment would 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 shall 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% (from 10%).

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 needed to wait 90 days before the employer made a decision to accept responsibility for a claim under the old law. 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 your itemized billings and any needed documentation promptly.

Treating Physician Reports – Permanent Disability

Under the new law, your PD reports will be required to use American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) for all injuries that result in PD (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 PD will be based on causation. Your report must make an apportionment determination of the approximate percentage of the PD that was directly caused by the work injury, as opposed to other factors. Further discussion of the many other changes relating to PD is beyond the scope of this article.

Outpatient Surgery Clinics

Outpatient surgery clinics are added to the list of prohibited physician self-referrals under the workers' compensation setting (not outside of the workers' compensation setting). There is an exception to the self-referral prohibition where (1) the provider discloses the financial relationship to the employer, and the employer pre-authorizes treatment at the center, or (2) 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 upon his or her share of the center's profits would not be precluded from referring surgeries to the surgery clinic without employer pre-authorization. This is an aggressive stance, and the center's profit distribution formula should be analyzed by competent legal counsel before a physician owner proceeds to make any referrals on this basis.

Other Changes

The new law brings other changes beyond those addressed above. A few of these are the following: establishment of an outpatient surgery fee schedule indexed at 120% of the fee paid by Medicare for the same service in the hospital outpatient department, establishment of a new pharmaceutical fee schedule not to exceed 100% of the fee paid by Medi-Cal, a $100 lien-filing fee, cap at 24 physical therapy, 24 chiropractic, and 24 occupational therapy treatments for the life of the claim (the insurer may authorize additional visits in writing), and stronger penalties on fraud.

Conclusion

There are many facets to the new laws that you will need to consider if you desire to treat occupational injuries. Among these, you will need to become familiar with the ACOEM guidelines and the to-be-adopted AD treatment guidelines, make a determination about participating in one or more of the new medical provider networks, learn the new rules relating to PD and the application of the AMA Guides, and obtain pre-authorization for surgeries referred to a surgery center in which you have a financial interest. There is ambiguity surrounding many areas of the law, which will add to the confusion. Regulations will be issued that may offer clarification.

This article does not address all issues that you must consider, nor does this article completely cover any of the issues that have been discussed. This article is not intended to constitute legal advice, and you are advised to consult with an attorney for any related legal matters.

Beth A. Kase is an attorney at Saphier and Heller Law Corporation in Century City. She and the firm counsel doctors, medical groups, hospitals, surgery centers, other health care providers, and medical management companies on business and regulatory health care matters. She can be reached at 310/789-1101.