SB 1160 CHANGES TAKING EFFECT

EFFECTIVE JANUARY 1, 2018

SB 1160 SECTION 1:

1. **Labor Code 9792.6(f)**

   On or before January 1, 2018, the administrative director shall adopt regulations to provide employees with notice that they may access medical treatment outside the workers' compensation system following the denial of their claim.

SB 1160 SECTION 4.5:

2. **Labor Code 4610(b)**

   For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

   - **Meaning: Automatic Authorization**

     Six Required Conditions:

     1. Dates of injury as of January 1, 2018
     2. Within 30 days of initial injury
     3. Body part or condition accepted as compensable
     4. Treatment included in MTUS
     5. Treatment provided by MPN or predesignated physician
     6. Treatment is not excluded by subdivision (c)

        Pharmaceuticals

        Non-emergency inpatient / outpatient surgery

        Psychological treatment

        Home health care

        Imaging and radiology services, excluding x-rays

        DME combined value over $250

        Electrodiagnostic medicine

        Any other services designated by Administrative Director

   - **DLSR 5021 Form and RFA due within 5 days of the employee's initial visit**

3. **Labor Code 4610(c)**

   Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

   (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

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total value exceeds two hundred fifty dollars ($250), as determined by the 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.

4. **Labor Code 4610(d)**

Any request for payment for treatment provided under subdivision (b) 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.

- **Meaning: Providers must submit their bills within 30 days of date of service**

5. **Labor Code 4610(k)**

A utilization review decision to modify, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendations by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

- **Meaning: UR decisions effective for 12 months for requests made by the same physician, or another physician within the requesting physician's same practice group**

6. **Labor Code 4610(g)(3)(B)(i)**

The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

- **Meaning: UR financial incentives are forbidden**

7. **Labor Code 4610(g)(3)(B)(ii)**

An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization services.

(II) The insurer or third-party administrator's financial interest in the entity.

- **Meaning: UR self-referrals are restricted if there is a financial interest.**

8. **Labor Code 4610(i)(1)**

Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the request for authorization for medical treatment. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

- **Meaning: Formulary prospective UR decisions shall be made no more than 5 working days from date of receipt of the medical treatment request. There is no extension if supporting information is necessary.**

9. **Labor Code 4610(o)**

The administrative director shall 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. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe for their submission. For purposes of this subdivision,

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"employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

- **Meaning: Mandatory UR reporting of documents related to every UR performed by each employer to the state**

SB 1160 SECTION 5:

10. Labor Code 4610.5(a)

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(3) Any dispute occurring on or after January 1, 2018, over medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

- **Meaning: Added that IMR applies to prescribed formulary medication**

LABOR CODE 4610.5(H)

(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.

- **Meaning: IMR requests for formulary medication disputes must be requested within 10 calendar days from the UR decision**

SB 1160 SECTION 6:

11. Labor Code 4610.6(d)(1)

The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, and the determination shall be issued, as follows:

(A) For a dispute over medication prescribed pursuant to the drug formulary submitted under subdivision (h) of Section 4610.5, within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

- **Meaning: IMR decision for formulary medication disputes is due in 5 working days after receipt of documentation.**

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