

California Orthopaedic Association

**SUMMARY of STATE and FEDERAL
LEGISLATIVE/REGULATORY ISSUES
2003-2004 LEGISLATIVE SESSION**

WORKERS' COMPENSATION

There was incredible pressure from employers on state legislators to enact Workers' Compensation reform that would rein in escalating costs. Workers' Compensation premiums have increased over 300% in the last 3 years; partially due to artificially low premiums as carriers competed for more business; and, partially due to increasing disability costs and higher utilization of medical services.

In 2003, twenty bills emerged as key Workers' Compensation bills covering a wide range of issues including transitioning the Official Medical Fee Schedule (OMFS) to Medicare's RBRVS, developing a fee schedule for outpatient surgical facilities, and reining in fraud and over-utilization. The bills were ultimately sent to a Workers' Compensation Conference Committee to develop consensus legislation. Conferees were seeking \$6.2 billion in savings system wide.

The Conference Committee's report was amended into SB 228 (Alarcon) and AB 227 (Vargas) and approved by the Legislature and signed into law by Governor Gray Davis. The bills will be effective January 1, 2004, unless otherwise specified in the bill.

Additional reforms continued in 2004 and were enacted in SB 899. Key provisions of SB 899 established medical provider networks, treatment guidelines, independent medical review, and revised permanent disability ratings. Some of the reforms were effective immediately, others will be effective January 1, 2005.

Major components of the 2004 reforms:

Treatment Guidelines

- The basic requirement under Labor Code Section 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 new law defines "reasonably required" care as treatment based upon treatment guidelines to be adopted by the Administrative Director (AD) of the Division of Workers' Compensation, and prior to the adoption of these guidelines, the American College of Occupational and Environmental Medicine's Occupational Medical Practice Guidelines (ACOEM).
- The AD, in consultation with Commission on Health and Safety and Workers' Compensation (CHSWC), shall by December 1, 2004, adopt treatment guidelines that incorporate 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' Compensation cases.
- The guidelines will be presumed to be correct on the issue of the extent and scope of medical treatment--regardless of the date of injury--replacing the presumption of the treating physician.
- 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 injury. You may be asked to justify your position by providing evidence-based medical evidence to support your position. No additional payment is provided for your research time.

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 workers.
- These networks must be approved by the AD.
- Health Care Organizations (HCOs) will be deemed approved networks.
- The network must: 1) consist of physicians primarily engaged in the treatment of occupational injuries --25% of the physicians must be engaged in non-occupational injuries; 2) have an adequate number and type of physicians to treat common injuries and cover employees' geographic area; 3) not structure physician reimbursement to achieve a goal of reducing, delaying, or denying treatment; and 4) provide treatment consistent with the medical treatment utilization guidelines adopted by the AD.
- The employer or insurer has the exclusive right to determine which physicians are in their network. The AD cannot disapprove of a network due to the selection of physicians in the network.
- Economic profiling of the physicians is permitted.
- Within the network, only a licensed physician in the appropriate specialty applicable to the injury may modify, delay, or deny a request for authorization for treatment.
- Continuity of care must be provided for up to 12 months after the physician leaves the network.
- DWC is required to enact implementing regulations by November 1, 2004.

Medical Treatment and Control

- If the employer chooses not to form a medical provider network, the basic treatment rule remains unchanged. The employer has medical control for the first 30 days and then the injured worker can select a physician of their choice.
- If the employer establishes a network, employees who did not pre-designate a personal physician prior to their injury, must receive care only through the network. The employer selects the first treating physician within the network. After the first visit, the injured worker may choose a different physician within the network. The injured worker may seek a second and third opinion if he/she disagrees with 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 and/or treatment are still in dispute after the third opinion, the injured worker may request an independent medical review (IMR) by filing an application with the AD. The IMR physician contracts directly with the AD and is not part of the medical provider network. The AD is required to adopt the findings of the IMR. No additional exams or reports will be admissible by the Workers' Compensation Appeals Board on issues of medical treatment under the network.
- If the IMR finds that the disputed treatment is consistent with the utilization guidelines, the injured worker may go within or outside the network for treatment.
- The employer is required to provide medical care up to \$10,000 after the employee files a claim and the injury is accepted or denied. Previously employees had to wait up to 90 days for the employer to accept or deny the claim. As a result of this new liability on employers, COA believes that employers will be seeking expedited AOE-COE hearings to determine whether the claim is work-related.

Penalties for Late Payment

- The penalty for late payment of providers' billings has been increased from 10% to 15%.

Permanent Disability Reports

- Permanent disability reports will be required to use the American Medical Association Guides to the Evaluation of Permanent Impairment – 5th Edition for all injuries that result in permanent disability.
- The effective date of this provision is expected to be January 1, 2005 once the DWC has enacted implementing regulations.

- 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.

Major components of the 2003 reforms:

Official Medical (Treatment) Fee Schedule (OMFS)

- Reduces reimbursement for “physician services” by 5% from the existing OMFS reimbursement levels for 2004 and 2005.
It is unclear whether physical therapists will be subject to these reductions or will be reimbursed at 120% of Medicare since they are not “physicians” under the Official Medical Fee Schedule.
- Procedures currently reimbursed at or less than Medicare rates, will not be reduced. These procedures primarily include Evaluation and Management and some minor surgical procedures.
- Medicare’s RBRVS was not adopted. The OMFS will continue to be based on the California Relative Value Scale.
- Caps chiropractic visits at 24 per injury and physical therapy services at 24 visits per injury. The insurance carrier has the ability to authorize more visits.
- The existing OMFS Ground Rules are still in effect.
- The Administrative Director is required to update the OMFS by January 1, 2006. The AD can utilize multiple conversion factors in this update and must set rates adequate to ensure reasonable standard of care for injured workers.
- The Administrative Director is required to perform an annual study on injured workers’ access to medical treatment.
- These changes do not affect the Medical-Legal Fee Schedule.
- Medical providers can continue to direct contract with carriers.

COA supported efforts by the California Medical Association to resist any reductions to the OMFS and to allocate \$700 million new dollars to bring all codes up to Medicare, 2003 reimbursement levels, but it became clear that there was no support for this proposal.

At one point in the negotiations, there was a proposal that would have reduced the OMFS by 10% for the next two years and then transitioned the fee schedule to a Medicare RBRVS system with additional 10% reductions each year for the next 5 years, resulting in 60% reductions. Negotiators also suggested transitioning the OMFS to a Medicare RBRVS system setting the reimbursement levels at 120% of Medicare. This would have reduced commonly performed orthopaedic procedures by 40%-66%. In the final report, these proposals were rejected and a 5% reduction approved.

Spine Procedures

- “Spinal surgery,” not defined in the bill and to be defined in regulations, will be subject to a second opinion. If the employer objects to the surgery, there will be a process for requiring a second opinion. The physician providing the second opinion will have to be either an orthopaedic surgeon or a neurosurgeon and cannot be affiliated with the requesting physician, the same group or facility, or with the manufacturer of the device, etc. The bill does not specify that the reviewing physician must be board certified in their specialty, although DWC is expected to enact regulations requiring board certification. If the reviewing physician disagrees with the need for surgery, the employer will not be liable for the costs of the surgery or disability benefits that may result. A lien cannot be filed against the employer for these costs.
- The Commission on Health and Safety, and Workers’ Compensation (CHSWC) will be studying spinal surgery second opinions and issue a report by 6/30/2006.

Prohibition on Physicians Referring Patients to Outpatient Surgical Facilities In Which They Have a Financial Interest

- Physicians will continue to be allowed to refer their patients to outpatient surgical facilities in which they have a financial interest as long as they obtain prior authorization for the service and disclose their financial interest.

Legislators initially considered these referrals to be fraudulent. COA worked hard to convince legislators that surgeons utilize outpatient surgical facilities as an extension of their office. It was not a matter of whether the surgery was going to be performed, but where the surgery would take place. If these surgeries were forced into an inpatient setting, surgeries would be delayed and costs increased. COA argued that tighter utilization review would rein in unnecessary medical services and opposed the outright ban on physician referrals.

Outpatient Surgical Facilities – Fee Schedule

- Establishes a fee schedule for outpatient surgical facilities.
- Sets reimbursement levels for both freestanding and hospital-owned outpatient facilities at 120% of Medicare's fee schedule for hospital-owned outpatient facilities (Medicare's APC fee schedule).

Outpatient surgical facilities argued that the fee schedule should be set at the 60th percentile of charges based on Ingenix data that was reported to have been approximately 250% of Medicare rates. This proposal was rejected and 120% of Medicare adopted. COA will be monitoring the implementation of this fee schedule to determine whether injured workers' access to surgeries normally performed in an outpatient setting will be negatively impacted by this fee schedule.

Pharmaceuticals

- Generic pharmaceuticals will be required to be dispensed if there is a "generic equivalent" unless the prescribing physician specifies that the brand name drug be dispensed.
- Pharmacy fee schedule will be set at 100% of Medi-Cal rates.

Industrial Medical Council

- The Industrial Medical Council has been abolished and its responsibilities transferred to the Division of Workers' Compensation (DWC).
- The Industrial Medical Council's treatment guidelines have been specifically abolished.
- The IMC's Medical Director position has been transferred to the DWC.

Utilization Review

- Mandates that every employer establish a utilization review process.
- Adopts the treatment guidelines of the American College of Occupational and Environmental Medicine's "Occupational Medical Practice Guidelines" or, if the services are not covered by the guidelines, guidelines from the appropriate professional organization. Guidelines are presumed to be correct so far as the extent and scope of treatment and could be admitted as evidence before the Workers' Compensation Appeals Board.
- Must include a review of requested services by a physician of which services requested are within the scope of their practice.
- Establishes 14 days to review and approve or deny the services or 30 days if retrospective review; 72 hours for urgent care.
- Employers must notify the requesting physician within 24 hours of their review decision.
- Employers can request additional time to make their decision by giving notice to the requesting physician.

The language does not specifically state what happens if the employer does not respond within the stated timeframes. CHSWC is also required to conduct a survey with a report and recommendations on peer-reviewed, nationally recognized standards of care and utilization review standards, including Independent Medical Review.

Electronic Submission of Claims

- Requires the Administrative Director to adopt regulations for the electronic submission of claims by January 1, 2005 and requires all employers to accept electronic submissions by July 1, 2006. It is unclear whether "claims" also includes any required reports. In order to implement this change, it would seem we would also need to adopt a uniform claim form.

- Payment of electronic claims submitted at or below OMFS rates would be within 15 working days. It is unclear if bills electronically submitted at a higher rate would also have to be paid within the 15 working days.

Payment of Treatment Claims

- Currently treatment claims must be paid within 60 days. The reforms call for payment within 45 working days. Governmental entities will have 60 working days to pay. By adding “working” days to this section, this language could delay payment to providers. We don’t believe that was their intent. We will try and correct this language in future legislation.

Presumption of the Primary Treating Physician

- The presumption of the PTP has been repealed for all claims except when the PTP has been pre-selected.

Filing of Liens

- A \$100 filing fee will be charged providers for filing a lien, “for each initial lien.” This filing fee is recoverable in the judgment award.

Vocational Rehabilitation

- Repeals the existing program and creates in its place a voucher system to provide \$4,000-\$10,000 worth of educational assistance to injured workers who are not offered a modified job by their employers.

Employer Assessment

- Employers will be assessed fees to fully fund the Workers’ Compensation Administrative Revolving Fund. Currently employers fund 20% of the costs.

Labor-Management Agreements

- Labor-Management agreements will be allowed to establish a dispute resolution process to resolve disputes instead of having them resolved by the Workers’ Compensation Appeals Board. Previously this was limited to only aerospace and timber industries.

5814 Penalties

- 5814 penalties will not apply to claims handled by California Insurance Guarantee Association.

Insurance Commissioner

- The Insurance Commissioner is charged with developing training materials for claims administrators.

Scope of Practice Issues

Podiatric Expansion

The California Podiatric Medical Association re-introduced their expanded scope of practice bill in 2003, AB 932 (Koretz). As introduced, AB 932 would:

1. expand the podiatric scope of practice to the entire lower extremity including dermatological procedures on the lower leg;
2. allow podiatrists to perform amputations including the entire foot; and
3. allow podiatrists to be the “assistant surgeon” in all type of surgeries.

Ultimately, the bill was amended to clarify that amputations of the entire foot would not be allowed. COA opposed the original as well as the amended version of the bill primarily because the podiatric community has not demonstrated that there is a shortage of physicians willing to perform these services and concern that all podiatrists are not well trained to perform these procedures or to handle complications that may result from these procedures. This would particularly be true of podiatrists who have not completed any formal surgical training. The California Society of Dermatology and

Dermatologic Surgery, the California Society of Anesthesiologists, and the California Medical Association joined us in our opposition. The bill missed its legislative deadlines in 2003 and became a two-year bill.

In the fall of 2003, at the request of the podiatric association, legislative staff, representatives of the COA, and CMA toured the podiatric college in Oakland to see first-hand their training program. COA continued discussions with the representatives of the podiatric association and the podiatric board on amendments to the bill and we ultimately were successful in agreeing on the amendments.

AB 932 was amended to allow only those podiatrists who have an ankle certification to:

1. Perform surgical treatment of the ankle;
2. Function as an assistant at surgery under the direct supervision of a physician and surgeon not as an assistant surgeon; and,
3. Perform a partial foot amputation limited to the Chopart's joint.

AB 932 also increases the podiatric licensure requirements in California to require:

1. A podiatrist to have completed at least a two-year postgraduate podiatric medical and surgical training program in a general acute care setting. Prior to this change, podiatrists could be licensed in California without any formal residency training.
2. The Board of Podiatric Medicine to require a passing score by the National Board of Podiatric Medical Examiners one standard error of measurement higher than required by the NBPME as a passing scale score on the national exam.

These higher standards will help ensure well-trained podiatrists are licensed in California. COA is also working with the podiatric association and the Board of Podiatric Medicine to develop hospital privileging guidelines for podiatrists based on their specific residency training. These privileging guidelines will be sent to all general acute care hospitals in California.

Podiatric Residency Training Programs/Podiatrists Performing History and Physicals

In 2003, the Board of Podiatric Medicine also inserted language into AB 1777, a bill authored by the Assembly Business and Professions Committee, which would have: 1) deleted the requirement that podiatric residencies be in general acute care hospitals; and, 2) stated that podiatrists were trained to perform a complete history and physical.

COA objected to both of these provisions. Because this bill was supposed to contain only uncontroversial licensure, COA's opposition caused this language to be removed from the bill. In its amended version which removed COA's opposition, the bill has passed and signed into law.

Physical Therapists

SB 77 (Burton) would have expanded a physical therapist's scope of practice to allow them to independently diagnose (thereby resulting in patients accessing physical therapists directly), perform manipulations, and provide wound care. The ability to perform manipulations was ultimately removed from the bill.

COA representatives met with the leadership of the Physical Therapy Association to discuss amendments to the bill. In these discussions, it was agreed that physical therapists are not qualified to make a full "medical diagnosis" and that their intent was only to make a "functional diagnosis." The physical therapists will be proposing amendments to clarify this intent and to clearly state that this change is not to infer that they are making a medical diagnosis.

Due to opposition from COA, the California Chiropractic Association, and the California Medical Association, the bill missed its legislative deadlines and became a two-year bill.

In 2004, the bill was significantly amended. In its amended form, the bill only clarifies that physical therapists are involved in fitness and wellness care. In this form, the bill passed and was signed into law.

Dentists Performing Cosmetic Surgery

Senator John Burton introduced SB 1336, a bill that would have allowed dentists who are maxiofacial surgeons to perform cosmetic surgery. The bill would have effectively set up two standards of care for cosmetic surgery, a medical standard and a dental standard. The dentists argued that in the emergency room in the case of severe trauma, they make incisions that are similar to those used in cosmetic surgery and; thus, they should be allowed to expand their scope of practice to include cosmetic procedures.

Strongly opposed to the bill were the CMA, the plastic surgeons, and dermatologists. While not directly affecting orthopaedic surgeons, COA took an oppose position on the bill. In spite of this opposition, the bill passed the Legislature but, was vetoed by Governor Schwarzenegger.

Prescription of Pain Management

SB 1782 (Aanestad) would require that the California District Attorneys Association develop protocols for the development and implementation of investigations in connection with a physician's prescription of medication to patients. The bill requires them to consult with designated medical specialty organizations. The COA was listed as one of the organizations that is to be consulted in the development of the protocols. The bill was signed into law.

Physicians' Ability to File Suit Against Carriers

Senator Joe Dunn introduced SB 1569 which will clarify that a physician may file a lawsuit against a carrier who arbitrarily implements unfair contract terms or changes the contracted reimbursement rates without notifying the physician and violates other provisions of the Knox-Keene Act. This is a CMA-sponsored bill that is needed as courts have questioned whether physicians are entitled to bring suit against a carrier. COA supported this bill. The bill was vetoed by the Governor.

Medical Staff – Self-Governance

SB 1325 by Senator Sheila Kuehl, was introduced by CMA in response to problems with Community Memorial Hospital in Ventura when the hospital administration unseated duly elected members of the medical staff executive committee and replaced them with hand-picked appointees of the hospital board, unilaterally amended medical staff by-laws, took control of medical staff funds, and disciplined physicians on the medical staff for disruptive behavior. The bill specifies certain rights of the medical staff that would be included in a hospital medical staff self-governance. Orthopaedic surgeons were directly involved in the Ventura dispute. COA supported the bill. The bill was signed into law.

Triplicate Prescriptions

SB 151 has enacted changes to the triplicate prescription laws. As of July 1, 2004, the triplicate prescription forms are being phased out and will no longer be available from the Department of Justice.

On January 1, 2005, all written prescriptions for controlled substances (Schedules II-V) must be on the new tamper-resistance prescription form. Phone and fax prescriptions for Schedule III-V medications will still be permitted using an ordinary prescription form.

Physicians who write a prescription for either Schedule II or III controlled substances and dispense the controlled substance from their office must, on a monthly basis, report these prescriptions to the Department of Justice's "Controlled Substances Utilization Review and Evaluation System (CURES). They must maintain a record of the prescribed medications in the patient's record and maintain a separate log of Schedule II drugs prescribed. Physicians who do not dispense Schedule II or III controlled substances in their office, have no reporting requirement.

This is a CMA-sponsored bill which had as one of its goals to have a uniform prescription form for all controlled substances. This bill may have been well intended but is having unintended consequences.

The new tamper resistant forms are significantly higher in cost. Triplicate prescription forms had previously cost \$7 for a pad of 100 forms. Printers are charging \$30-\$50 for a pad of 50 of the new tamper resistant forms. The problem was made worse when the Department of Justice insisted that the reporting requirement be expanded to include Schedule III medications. CMA is working with printers to reduce the cost of these prescription forms. COA is making our members aware that they can continue to use their regular prescription forms if they fax in the prescriptions.

Bone and Joint Decade

At COA's request, Senator Tom Torlakson introduced SCR 93 which declares the week of October 12-20, 2004 as Bone and Joint Decade National Awareness Week. The bill was signed into law.

Task Force on Youth and Workplace Wellness

Clarence Shields, M.D., orthopaedic surgeon from Los Angeles, represents COA on the Task Force on Youth and Workplace Wellness established by Senator Tom Torlakson. The Task Force has been involved in developing protocols for schools to implement health awareness programs and a model healthy school policy. In addition, COA has urged the Task Force to focus its efforts on high school athletic programs, better conditioning of the athletes, and injury prevention. We have provided the Task Force with a copy of the AAOS Sedentary Video which shows the inactivity of children today. The Task Force is considering circulating the video to schools throughout California to be included in their health awareness programs.

The PTA circulated a flyer to its members informing them of the AAOS public service videos and encouraging them to show them at their meetings.

In addition, COA has supported legislation calling for athletic trainers to become more involved in high school athletic programs.

Labeling of Generic Prescriptions

As part of our activities with the California Access to Specialty Care Coalition, COA became aware that some pharmacies are not disclosing on the medication label, the name of the generic manufacturer of the medication as required by state law. Pharmacy changes in the manufacturer of a generic medication can have a negative impact on the effectiveness of the medication or can result in unusual side effects for the patient. If the manufacturer is not disclosed on the medication label, it is difficult for the patient and the prescribing physician to know that there has been a manufacturer change.

COA brought this problem to the attention of the Board of Pharmacy who has agreed to remind pharmacies of this labeling requirement and monitor the issue to ensure compliance.