

**2017-
2018**

California
Orthopaedic
Association

**2017 – 2018 LEGISLATIVE
SESSION WRAP-UP**

The California Legislature has adjourned for the year and will reconvene for one day after the November General Election on December 3rd to swear-in the newly elected legislators. They'll also adopt joint rules for the 2019-2020 Legislative Session and then adjourn again only to return to Sacramento the first week in January. Below are some highlights of this legislative session.

CALIFORNIA LEGISLATIVE/REGULATORY UPDATE

AB 2423 (Holden): Physical Therapy Services for Kids Eligible under the Federal IDEA Program

COA had a tumultuous journey with CMA and other stakeholders on this bill. Podiatry, Family Physicians and Pediatricians followed CMA's lead and stayed "neutral" on this bill, while COA opposed the legislation. AB 2423 allows physical therapists to treat kids under the federal Individuals with Disabilities Education Act (IDEA) who qualify for the Individualized Family Service Plan (IFSP) or the Individualized Education Plan (IEP) for unlimited number of services for an unlimited amount of time without a medical diagnosis.

Physical therapists work with local schools in the development of the IEP which can often run for the entire school year. Under existing law, physical therapists felt they were limited to 12 visits over no more than 45 days and; thus, the reason they needed the exemption. They said that the services being rendered were not typical rehabilitative services, but more services to help the student navigate the school environment – ambulation, negotiating stairs, etc.

COA opposed this exemption believing that it was in the best interest of these children to have a physician involved in their care and the development of the IEP, and most especially, making the diagnosis of the underlying medical condition causing the student's disability, before the physical therapist begin their services which could span several years while the student is in school. These students certainly also qualify to be evaluated by a physician under federal law, however, schools seemed reluctant to routinely involve physicians in the development of the IEP.

Legislators were also very reluctant to enact any state barriers to students receiving services they qualified for under federal law.

While CMA took a neutral position on the bill out of concern that AB 2423 (Holden) would conflict with federal law, COA was still able to work with CMA and Assembly Member Holden (D-Pasadena) to craft intent language to narrow the applicability of the physical therapy direct access exemption. The intent language below (although does not carry the weight of law) allows COA to memorialize the very narrow nature of the direct access exemption and that the exemption is limited only to the "educational setting" and does NOT apply to the clinical setting. The benefit of this intent language is to clarify the Legislature's thought process but to also guard against physical therapy using this bill as a "trojan horse" if and when physical therapy comes forward with a major scope of practice.

(a) The intent of this act is to provide physical therapists with an exemption from the 45 calendar days or 12 visits, whichever occurs first, direct access limitation described in paragraph (4) of subdivision (a) of Section 2620.1 of the Business and Professions Code in order to enable them to provide services that are within the scope of their practice under the federal Individuals with

Disabilities Education Act (IDEA) under a school-developed Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP).

(b) Services under the IEP are intended to provide students with assistance to enable the student to progress in the educational setting.

It is important to note, that the law continues to require a physical therapist to immediately refer the child to a physician and surgeon or podiatrist should they believe that there is an underlying medical condition causing the problem which is beyond the scope of their practice. It's hard to believe that these disabled children will not have an underlying medical condition causing their disability demanding an immediate referral. COA will continue to monitor how this narrow exemption is implemented by physical therapists.

COA Position: Oppose to Neutral

STATUS: Signed into law

AB 3110 (Mullin) – Certification of Athletic Trainers

This bill would have enacted the Athletic Training Practice Act, which would establish the Athletic Trainer Board. On or after January 1, 2021, this bill would have prohibited a person from practicing as an athletic trainer or using certain titles or terms without being registered with the board. Furthermore, the bill would define the practice of athletic training and would specify requirements for registration as an athletic trainer, including graduating from a professional degree program in athletic training and would require a registrant to render athletic training services only under the supervision of a physician and surgeon.

This was the latest attempt to license athletic trainers who have been seeking such recognition for over 15 years by way of nearly a dozen legislative attempts. This bill was supported by “organized medicine” including CMA and COA. It was opposed by physical therapy, occupational therapy and nurses. The bill ultimately died a similar death as the other legislative attempts by being held in the Appropriations Committee due to general fund costs. COA will reach out to the athletic trainers to regroup and help on devising a better fiscal strategy for passage of legislation during the next session.

COA Position: Support

STATUS: Died in the Senate Appropriations Committee.

AB 2741 (Burke) – Arbitrary Limitations Pain Medications - Minors

At the beginning of 2018, there were over 30 bills introduced dealing with the opioid epidemic. Most of them were attempting to “legislate the practice of medicine” without the benefit of any evidence-based or data-driven treatment approaches by arbitrarily limiting the number of pills and/or dosage allowed to be prescribed by a physician and surgeon irrespective of the patient’s pain management needs. This bill was no exception.

This bill would have prohibited a physician and surgeon from prescribing more than a 5-day supply of opioid medication to a minor unless the prescription is for specified uses (i.e. cancer pain management, chronic pain, substance abuse treatment, etc.) This bill would have also required a physician and surgeon to take certain steps before prescribing a minor a course of treatment with opioid medication,

including but not limited to, discussing opioid risks and obtaining verbal consent. Lastly, the bill would make a violation of these provisions unprofessional conduct and would subject the physician and surgeon to discipline by the board charged with regulating his or her license.

COA along with CMA and pediatricians were successful in killing this bill in the Senate Appropriations Committee by principally advocating that although we share concerns about the need for an urgent approach to ensuring appropriate prescribing practices when treating patients (under the age of 18) in order to reduce opioid abuse, this bill was far too prescriptive and would have inadvertently harmed patient access to the full range of medically necessary pain management treatment options.

COA Position: **Oppose**

STATUS: **Died in the Senate BP & ED Committee**

AB 1153 (Low) Podiatry Scope of Practice

As introduced, this bill would have authorized a doctor of podiatric medicine to: 1) perform any procedure directly related to the surgical treatment of the ankle and tendons in a medical facility that grants privileges to the doctor of podiatric medicine to perform the procedure; and, 2) authorizes a doctor of podiatric medicine to treat ulcers resulting from local and systemic etiologies on the leg no further proximal than the tibial tubercle.

Due to COA opposition, the bill was amended to delete subsection 1) and to clarify that in subsection 2), the podiatrist could not treat the underlying medical condition causing the ulcer.

COA Position: **Oppose unless amended to Watch**

STATUS: **As amended, the bill was signed into law.**

AB 1753 (Low) – Controlled Substance Security Prescriptions

AB 1753 requires controlled substance security prescription forms to include a unique serialized number in a format approved by the Department of Justice. The bill did not include any transition period to allow for continued use of the old controlled substance security prescription forms on or after January 1, 2019. Pharmacists and pharmacies will be checking for the serialized numbers on the forms.

Implementation of AB 72 – Patient Surprise Billing

AB 72 was intended to protect patients from surprise medical bills when they are treated at a contracted facility by a non-contracted health care provider. The bill set the reimbursement at 125% of Medicare or the average carrier contracted rate for the specific procedure, whichever is higher. The bill does not apply to emergency room care. The Governor signed the bill into law in 2016.

COA opposed AB 72, not so much because of the surprise billings provisions as we felt that our members would be able to get prior authorization and reach agreement on the reimbursement rate prior to taking the patient to an elective surgery. Rather, COA opposed the bill for the precedent that it would effectively set for reimbursement for non-contracted providers at 125% of Medicare. This has in fact happened. We have seen payors attempt to move their contracted rates to 125% of Medicare. Payors have also resisted paying non-contracted providers more than 125% of Medicare.

The Department of Insurance (DOI) and the Department of Managed Health Care (DMHC) are both charged with the implementation of AB 72 for health plans under their jurisdiction.

During the implementation of AB 72, COA members reported problems with health plans being unwilling to disclose to the non-contracted provider or the patient what they will pay for a particular service under AB 72. Thus, even though the patient is willing to pay an additional cost to have the procedure performed by a surgeon of their choice out-of-network, they are unable to find out what their out-of-pocket costs will be. This is unreasonable and goes exactly against the premise of AB 72 – more cost transparency for patients.

COA has made DOI and the DMHC aware of this problem and we are seeking clarifications in the DOI pending regulations to require the payor to disclose their payment amount to non-contracted providers and patients, upon request.

SB 189 (Bradford) – Mandated Workers’ Compensation Insurance: Definition of an Employee

This bill corrected a problem enacted in 2016 which required physicians who held less than a 15% ownership interest in their medical corporation, to purchase Workers’ Compensation insurance. This resulted in significantly increasing Workers’ Compensation premiums for many orthopaedic practices.

SB 189 (Bradford) expanded the exemptions to purchase Workers’ Compensation insurance to all owners of a professional corporation who are a practitioner rendering professional services for which the professional corporation was organized. This created an exemption for physicians regardless of their ownership interest as long as they filed a waiver with their Workers’ Compensation carrier stating under penalty of perjury that he/she is covered by a health insurance policy or health care service plan.

COA members identified this problem early and it was a high COA priority to correct this problem.

COA Position: **Support**
STATUS: **Signed into law**

Workers’ Compensation Regulations

Medical-Legal Fee Schedule

The Division of Workers’ Compensation (DWC) is in the beginning stages of investigating potential changes to the Medical-Legal Fee Schedule. COA participated in a regulatory hearing to discuss potential options for reform. COA is also expected to be invited to be part of a DWC Work Group to develop a packet of reforms. Indications are that this discussion may expand into a broader discussion of Workers’ Compensation reforms including the treating fee schedule.

Official Medical Fee Schedule – Physician Services – Geographic Cost of Practice Index (GCPIs)

DWC has adopted the CMS Medicare methodology for adjusting for geographic practice cost variations throughout California. Previously, DWC used an average of the California Medicare GCPI adjustments. COA supported this change as CMS has recently updated their regional GCPIs making them more reflective of the practice costs in the region.

Pharmacy & Therapeutics Committee.

SB 1160 enacted in 2016, established a Pharmacy & Therapeutics Committee to assist DWC in the implementation and ongoing maintenance of their new drug formulary. COA has successfully

recommended one of its members to serve on the Committee. The Committee held its first meeting in 2018. During the Committee discussions, confusion emerged as to whether medications exempted under the drug formulary, still needed to be listed on the Request for Authorization (RFA) and approved. From language in the Drug Formulary, it seemed that the answer to this question was “No,” however, pharmacists on the Committee indicated that without the prior authorization, pharmacies likely will not get paid for the medication and injured workers will have a difficult time obtaining needed medications. DWC is in the process of clarifying this issue.

SB 617 (Bradford) (2017) and SB 899 (Bradford) – Apportioning to Heredity and Genetic Disease

In a case titled, the City of Jackson vs Workers’ Compensation Appeals Board, the court found that the law governing apportionment of disability permits the determination of causation to include, “heritability and genetics,” which may result in the reduction of an individual worker’s benefits due to his or her heredity or genetic makeup. The QME in this case, apportioned a high percentage of the injured worker’s injury to genetics. This caused concern with members of the Legislature who felt this was unfair. Their concerns prompted a discussion trying to define what would be considered a genetic disease, whether providers would be able to reliably test whether an injured worker had a genetic disease, and whether the Division of Workers’ Compensation should develop guidelines for apportioning to the genetic disease.

In 2018, SB 899 (Bradford) became the vehicle for this issue.

COA members spent time educating legislative staff regarding the importance of defining what is a genetic disease and providing them with the latest research in this area. We discussed the difficulties in testing to definitively say what portion of an injury should be attributed to genetic disease. In spite of stakeholder consensus on the issue, the bill was vetoed by the Governor. In the Governor’s veto message, he stated:

“I am returning Senate Bill 899 without my signature. Consistent with current law, this measure seeks to preclude a physician from using race, gender, or national origin as a basis for apportionment. I am vetoing this bill for many of the same reasons that I returned a similar measure in 2011 - Assembly Bill 1155. This bill is unnecessary as it would not change existing law and may disturb settled court decisions, which already provide protection from the inappropriate application of the apportionment statutes. Additionally, the proposed wording of the amended statute may create ambiguities in the law, resulting in increased litigation, costs for employers and confusion for injured workers and their representatives.”

COA Position: Watch
STATUS: Bill vetoed by the Governor.

Federal Issue

Sports Medicine Licensure Clarity Act of 2017

The U.S. Senate and House of Representatives have approved the Sports Medicine Licensure Clarity Act of 2017 which provides legal protections for traveling team physicians and safeguards injured athletes’ timely access to health care professionals who know their medical history when the team is playing out-of-state. The Act provides liability protections to physicians to cover them while treating an injured athlete out-of-state. There are still some restrictions on being licensed in both states since federal law cannot change state licensure requirements. This bill, however, takes a good first step in protecting a physician from liability.

California has long had a law allowing physicians to travel to California with their team and to treat their athletes should they be injured during the game. This is, however, has been a problem for California physicians when they travel with a team to other states.

COA Position: **Support**
STATUS: **Signed into law**