

California Orthopaedic Association

**SUMMARY of STATE and FEDERAL  
LEGISLATIVE/REGULATORY ISSUES  
2005-2006 LEGISLATIVE SESSION**

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**DIGITAL RADIOLOGIC TECHNOLOGY**

**SB 1670 (Aanestad)**, a COA-sponsored bill which will allow limited licensed x-ray technicians (XTs) to operate digital radiologic equipment after they complete 20 hours in continuing education credits in digital radiographic technology. Previously the Radiologic Health Branch had adopted a regulation that prohibited XT's from operating digital equipment. This has become more and more of a problem for orthopaedic offices as they convert their analog equipment to digital or install digital equipment. Orthopaedic surgeons want to continue to use their staff to operate this new equipment. Without this change, only certified radiologic technologists are allowed to operate digital equipment. Since the availability of CRTs is limited and the cost of hiring them significantly greater, this prohibition could have limited an orthopaedic surgeon's ability to have in-office radiologic services.

COA, working with the California Podiatric Association and the California Radiologic Society, was successful in passing SB 1670. The Governor has signed the bill into law.

**WORKERS' COMPENSATION**

In 2005, under the direction of the Administrative Director of the Division of Workers' Compensation, Andrea Hoch, there has been a flurry of emergency regulations implementing the 2004 Workers' Compensation reforms. We saw regulations in the following areas:

- Medical-Legal Fee Schedule
- Medical Provider Networks
- Utilization Review Standards
- Utilization Review Audit Penalties
- Predesignation of a Personal Physician
- Official Medical Fee Schedule – Physician Services
- Workers' Compensation Information System

**Medical-Legal Fee Schedule**

As originally proposed, the Division of Workers' Compensation regulations proposed a 20% increase for some services in the Medical-Legal Fee Schedule, however, they would also have made it more difficult to qualify as a ML103 evaluation; thus, the original draft represented a significant decrease for musculoskeletal evaluations. After testimony from business that they are unable to schedule AME and QME evaluations in a timely manner and adamant opposition from COA, CMA and other medical organizations, the DWC revised its proposal.

The revised regulations implemented July 1, 2006, enact a 25% across-the-board increase to the conversion factor, but continues the revised complexity factors in order to qualify as an ML103. While this is good news, COA is monitoring whether the implementation of the revised ML103 criteria results in complex musculoskeletal evaluations being downcoded to a ML102 level. COA also continues to urge DWC to expand the complexity factors under ML103 to include factors for multiple injuries and hand evaluations involving two or more digits.

### **Medical Provider Networks Regulations**

The MPN regulations established the framework for Workers' Compensation carriers and self-insured employers to form their medical provider networks. Controversial aspects of these regulations included:

- 1) In spite of opposition from COA, CMA, and other medical organizations, DWC refused to clearly state that carriers and self-insured employers must have a direct contract with physicians in their network before claiming he/she is part of the network. The final language in the regulations was more specific, but many physicians continue to be included in these networks without having a direct contract; and,
- 2) The regulations were not retroactive to MPNs approved prior to enactment of the regulations. Over 600 MPNs were approved prior to the enactment of the regulations. As of October, 2006 over 900 MPNs have been approved. COA conducted a survey of its members in June, 2006 which found that the 2004/2005 reforms have had a negative impact on injured workers' access to musculoskeletal care. There is a statewide trend of orthopaedic surgeons deliberating limiting the number of injured workers they treat or completely dropping out of the system as they become frustrated with the utilization review system, reimbursement levels, or their inability to obtain authorization for medical services that they believe are medically necessary for their patients.

### **Utilization Review Standards Regulations**

#### **Utilization Review Audit Penalties**

The Utilization Review Standards regulations implemented the UR process mandated in the 2004 reforms and included the use of the ACOEM Practice Guidelines when making UR decisions. Much confusion over this part of the reforms continues to exist. Even though the Labor Code merely mandated that each carrier/self-insured employer have a UR process, some carriers continue to believe that they must send all requests for services through a formal UR process prior to approval. This has caused a delay in medical treatment and controversies between treating physicians and utilization reviewers.

COA members report patient harm as a result of these delays. COA has asked the Medical Director of DWC to visit orthopaedic practices to hear firsthand about the UR problems. To date, meetings have been held or are scheduled in the Inland Empire District, Los Padres District and the Sacramento Valley District.

Again, despite opposition from COA, CMA, and other medical organizations, the final regulations allow out-of-state providers to function as reviewers. Medicine has adamantly objected to this practice as we argue that these UR decisions are the practice of medicine. Thus, DWC is allowing physicians to practice medicine in California without a license. The Medical Board of California joined medicine in opposing these regulations, but to no avail. COA is continuing to work with CMA to exhaust all options, including legal action, to stop out-of-state providers from practicing medicine in California without a license.

DWC is also proposing a schedule of fines and penalties for carriers/employers who do not establish and maintain a UR system that conforms to the requirements in the Labor Code.

#### **Predesignation of Personal Physician**

These regulations were less controversial, however, COA objected to the regulations which exclude physician specialists from being designated as an injured worker's personal physician. The regulations limit the personal physician to primary care specialties. COA believes that, in some cases, an orthopaedic surgeon or other medical specialty physician may more appropriately be the primary care physician and that the injured worker should not be precluded from so identifying them as such. The

#### **Official Medical Fee Schedule – Physician Services**

Regulations adopted in 2005 made only minor changes to the OMFS. The changes corrected errors made when the 5% reduction was implemented in 2004, primarily in the physical medical services. Further regulations to the OMFS-Physician Services are expected in early 2007 and may include efforts to adopt the RBRVS system. This would not necessarily mean that the Medicare multiplier would also be

adopted. COA opposes a transition to RBRVS that would significantly reduce reimbursement rates for orthopaedic surgeons.

### **Workers' Compensation Information Systems**

DWC proposed regulations establishing standards for carriers/self-insured employers to electronically submit data to DWC. In addition, carriers/self-insured employers will be required to accept electronic claims by July 1, 2006. This deadline has been extended to 2007. While carriers/employers will be required to accept, health care providers are not required to submit electronic claims. DWC is working on establishing a uniform claim form (HCFA 1500) and uniform Explanation of Review messages that would be mandated to be used on the EOB to promote clearer communications between the carrier/employer and health care providers. COA has urged any electronic submission of claims data must also include the ability to electronically submit reports. DWC is also working to expand the PR-2 form to include a uniform form for treatment authorization requests and a form for physical medicine providers to report progress to the carrier and referring physician.

### **Workers' Compensation Legislation**

**SB 292 (Speier) – Repackaged Medications.** This bill, in its original form, would have prohibited physicians from dispensing medications in their offices and establish a fee schedule set at 100% of Medi-Cal levels for repackaged medications. The bill intended to close a loophole created in the 2004 reforms when the reimbursement for other medications was set at 100% of Medi-Cal rates and included a physician dispensing fee. COA opposed the bill and was successful in removing language prohibiting in-office dispensing. Ultimately the bill was defeated.

The Division of Workers' Compensation, however, has introduced regulations similar to the provisions of SB 292. Reimbursement levels remain controversial and to date the Division has not moved forward with these regulations.

**AB 681 (Vargas)** – This bill would have delayed the update of the Official Medical Fee Schedule – physician services from January 1, 2006 to January 1, 2011. The bill was opposed by employers and the insurance industry. It missed its legislative deadlines and has died.

## **Scope of Practice Issues**

### **Radiology – In-Office Diagnostic Testing**

There have been four separate bills introduced in 2005 which could have had a negative impact on an orthopaedic surgeon's ability to have in-office MRI and CT Scans:

- SB 736 (Speier)
- AB 516 (Yee)
- SB 700 (Aanestad)
- AB 929 (Oropeza)
- AB 1572 (Dymally)

Due to COA's lobbying efforts, the bills have either been amended to remove COA's concerns or have died.

Late in the Legislative Session, SB 736 was gutted and amended to prohibit physicians from billing for the technical component of diagnostic services that were not rendered by the physician. This was intended to prohibit the referring physician from billing for the technical service if he/she did not perform the service. It would have affected current lease arrangements where the physician is billing for both the technical and professional component of the service.

COA opposed the bill for several reasons:

1. This bill was amended late in the session and had not been heard by other policy committees.
2. There is already federal and state law defining appropriate lease arrangements. Current definitions do not prohibit physicians from billing both services.

3. It was unclear what impact this bill would have had on existing laws and whether it would have a negative impact on legitimate lease arrangements.

It is expected that the California Radiological Society, the sponsors of the bill, will reintroduce the bill in the next legislative session.

As originally introduced, AB 516 would have repealed an exemption under the self-referral laws that allows physicians to provide in-office diagnostic services for their patients. The bill would have allowed only radiologists to continue to perform MRI, CT Scans, or PET Scans on equipment in which they had a financial interest. Due to COA opposition, the bill was not heard in Committee and has died.

SB 700 proposed to establish a new radiology category called a “radiology assistant.” A radiology assistant would be a “super” certified radiologic technologist who could only work under the supervision of a radiologist. The State Radiologic Health Branch would have been charged with adopting regulations to establish protocols for these radiology assistants that are consistent with guidelines adopted by the American College of Radiology. The ACR could then establish standards allowing only radiology assistants to perform the high end diagnostic test; and thus, eliminate these tests from physicians’ offices. Due to COA opposition, the bill did not meet its legislative deadlines and has died.

AB 929 would have required the Radiologic Health Branch to adopt regulations that require personnel and facilities using radiation-producing equipment to maintain and implement quality assurance standards that meet or exceed those for mammography. Again the mammography standards required that the standards be consistent with guidelines from the American College of Radiology. The bill was amended to remove COA’s concerns. As amended, the bill was signed by the Governor.

AB 1572 would have established “diagnostic radiologists” and specify that only diagnostic radiologists can perform and bill for diagnostic tests under the Workers’ Compensation system. The bill would have required all injured workers be referred to the diagnostic radiologist. Only radiologists could qualify to be a diagnostic radiologist. COA met with the sponsors of the bill and they agreed to drop the bill in this form.

#### **AB 1185 (Koretz) – Chiropractic Services**

This bill would have required a health care service plan to offer chiropractic services. The chiropractic services must be available to the insured without a referral from a primary care physician and would require that sufficient numbers of chiropractors be part of the plan to ensure good access. COA opposed the bill and it has died.

#### **Acupuncture Bills**

AB 1113 – Allowed acupuncturists to make diagnoses within their scope of practice – Vetoed

AB 1114 – Acupuncturist CME 30 hours to 40 hours – Signed into law

AB 1115 – Acupuncturist Assistant – Vetoed

AB 1116 – Acupuncturist Training – Signed into law

AB 1117 – Changes Oriental to Asian Medicine - Signed into law

SB 356 - Defines Chinese or Oriental Massage – Died

AB 1549 – Allows Acupuncturists to Perform Disability Evaluations – Died

The most controversial bills that COA opposed were AB 1113 and AB 1549.

#### **Podiatric Training Requirements**

As part of SB 1111, the Omnibus bill by the Department of Consumer Affairs, the bill would have reworded and renumbered the Business and Professions Code Section laying out training requirements for podiatrists. In doing this renumbering, sections requiring that podiatrists graduate from an approved podiatric college; that they pass Parts I and II of the National Boards, and they satisfactorily pass a postgraduate training program, were deleted. When COA brought this to the Committee’s attention, the sections were restored.

## **Physician Continuing Medical Education**

AB 1195 (Coto) was a bill that as originally introduced, would have mandated that physicians attend 16 hours of continuing medical education courses in cultural and linguistic issues each year. COA and CMA opposed this bill. CMA sought amendments to the bill that would not mandate a set number of CME hours, but requires all California-based providers of CME to include cultural and linguistic issues in each course they hold. How the CME would be provided was not specified. Even though CMA's legislative office went neutral on the bill once their amendments were accepted, CMA's Institute for Medical Quality, the accreditor of CME organizations, continued to oppose the bill. COA did not oppose CMA's amendments, although we would have preferred a one-time requirement. As written CME providers will have to include this issue in all of their CME courses, whatever their length, forever. As amended, the bill passed and was signed into law.

## **Medi-Cal TAR Requirement**

The California Podiatric Association asked that CMA help them to remove Medi-Cal TAR requirements on podiatric services. CMA contacted COA and urged us to support these efforts. In reviewing the list of procedures on which they sought to have the TAR removed, we found the list contained many procedures beyond the scope of practice of a podiatrist. We urged CMA to focus on a broader review of the TAR program attempting to streamline the system for all providers rather than focus on only the podiatric problem.

Upon a second review, the podiatrists agreed that codes on the list were a mistake and revamped the list. With the revised list reflecting codes within the podiatry scope of practice and with the provision that the TAR would only be removed if the patient was referred to the podiatrist by a physician and surgeon, COA removed its objection to CMA helping the podiatrists with this issue. CMA and the California Podiatric Association have met with the Department of Health Services to discuss this issue.

## **Chiropractic Manipulations Under Anesthesia**

The Board of Chiropractic Examiners proposed regulations that would define the standards under which chiropractors could perform manipulation under anesthesia. COA, the Osteopathic Physicians and Surgeons, and CMA opposed these regulations citing significant risk to patients when manipulations are performed under anesthesia and patients are unable to tell the provider when they are in substantial pain. The regulations were defeated.

## **Federal Legislation**

### **Medicare Reductions**

Congress is proposing a 5.1% reduction in Medicare reimbursement rates as of January 1, 2007. In addition, as a result of the five year review, other orthopaedic codes are proposed to be reduced. COA is joining with the AMA, AAOS, and CMA in opposing these reductions. Medicine has been pushing for at least a two-year fix to the SGR Medicare reimbursement formula. Members of Congress have been sympathetic, but overwhelmed by other more immediate demands for monies as natural disasters and the war.

### **Physical Therapy – Direct Access to Patients**

Physical therapists continue to seek changes on the federal level that would allow them to treat patients without a referral from a physician and surgeon. COA defeated similar efforts on a state level in 2004. We continue to work with the AAOS to oppose these changes on a federal level.