EK HEALTH
Transforming Managed Care℠

Compliance and Regulations Newsletter

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CALIFORNIA

MPN Medical Review Bill Signed by Governor

Senate Bill 914, which requires the use of the Medical Treatment Utilization Schedule to resolve treatment disputes handled through a medical provider network's independent review process was approved by California's Gov. Jerry Brown. Language in the previous law requiring the use of the American College of Occupational and Environmental Medicine treatment guidelines for in-network reviews was deleted and the new law specifies that the MTUS is the proper guideline for MPN reviews. MPN independent reviews are separate from the independent medical review process created by Senate Bill 863. The bill passed unanimously in both the Senate with a vote of 36-0 on April 11th, and the Assembly with a vote of 79-0 on June 30th. Governor Brown signed the bill into law on July 22nd.

Potential Impact

Having the new law specify the Medical Treatment Utilization Schedule gives clear direction to reviewers which treatment guidelines should be utilized in the decision making process.

Source

Work Comp Bills to be Discussed in Upcoming for Assembly Appropriations Hearing

The California Assembly Appropriations Committee will meet on August 3rd to review bills that would prohibit offering providers incentives to deny treatment requests, require verification of interpreters at depositions, and lift the cap on rehabilitative services and allow better data collection.

Senate Bill 563 would prohibit utilization review companies from offering incentives to physicians to delay or deny treatment requests. The bill would also give the Division of Workers' Compensation authority to review UR contracts to ensure they do not include prohibited inducements.

The Committee will also discuss Senate Bill 1379 that would require interpreters at depositions to state on the record their name as listed on his or her court certification or registration and their current certification or registration number. This information will be verified by the board or judge ordering the deposition, the party giving the deposition testimony, or his or her representative. Senate Bill 1160 would lift the 24-visit cap on chiropractic care, physical therapy, and occupational therapy for rehabilitative services if the cap is not in accordance with evidence-based standards or the Medical Treatment Utilization Schedule.

SB1160 would increase annual penalty assessments for administrators who violate data reporting requirements from $5000.00 to $10,000.00 and require the administrative director to post a list of claims administrators who are in violation of data reporting requirements on the DWC's website.

The bill would require each utilization review process to be accredited on or before July 1, 2018, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including timeliness in issuing a decision, the scope of medical material used in issuing a utilization review decision, and requiring a policy preventing financial incentives to providers based on the utilization review decision. The bill would require the administrative director to adopt rules for the selection of an independent, nonprofit organization for certification purposes. Each utilization review process must receive accreditation every three years or more frequently if deemed necessary by the administrative director.

Potential Impact

SB563

This bill would ensure objectivity in the decision-making process. Determinations would be based on medical facts instead of personal opinions.

SB1379

Verifying the identification and certification should reduce if not eliminate possible cases of abuse.

SB1160

There is a possibility of increased payments should the 24-visit limit be removed. Higher penalty assessments may occur if data reporting requirements are not followed. UR firms would need to complete an initial accreditation process and renew every three years.

Source 1
Source 2
Source 3

COLORADO

Division Proposes Changes to Fee Schedule and Billing Rules

The Colorado Division of Workers' Compensation has proposed changes to its fee schedule that would mandate the use of ICD-10 codes and establish a rule for reimbursement of over-the-counter medications.

Proposed changes to some conversion factors used to calculate reimbursement rates based on the Resource-Based Relative Value Scale (RBRVS) fee schedule are noted below.
If approved, the conversion factor for radiology would decrease from $93.00 to $71.99, and the conversion factor for pathology would decrease from $77.62 to $68.31.

Increases have also been proposed for conversion factors for physical medicine from $40.24 to $41.14 and for evaluation and management services from $48.50 to $50.20. Conversion factors for anesthesia would remain unchanged at $55.61 and surgery at $68.01.

The Division has proposed adding a new section to the fee schedule for reimbursement of over-the-counter medications using the National Drug Code and average wholesale price set by the manufacturer. Dispensing fees would not be paid for over-the-counter medications.

A new section has also been proposed for reimbursement of any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medication containing only over-the-counter active ingredients. Reimbursement would be the lesser of the cost to the provider or $30.00 per 30-day supply for any application except a patch. A patch would be reimbursed at $70.00.

Another proposed change would require all provider bills, including hospital outpatient bills, to list the appropriate diagnosis code using the current ICD-10. A public hearing will be held on the proposed rules on August 17th.

Potential Impact
If approved, reimbursement rules would be established for over-the-counter medication and topical medications containing only over-the-counter active ingredients. Significant reductions would be in effect for radiology and pathology services, while evaluation & management and physical medicine services will increase by small percentages.

Source

HAWAII

Governor Approves Bill Allowing Electronic Submission of Treatment Plans

House Bill 2017 was signed by Governor David Ige and allows providers treating of injured workers to submit treatment plans by mail or fax.

Starting January 1, 2021, the bill requires employers to allow physicians to submit workers' compensation treatment plans to employers by mail, facsimile, or secure electronic means. A treatment plan shall be deemed accepted if an employer fails to file an objection to the treatment plan, documentary evidence supporting the denial, and a copy of the denied treatment plan which has also been provided to the physician and the injured worker.

An employer may file an objection to an accepted treatment plan if new documented evidence supporting the denial is received by the employer.

HB 2017 gives employers 10 days to object to a treatment request. The employer is required to file an objection with the Department of Labor and Industrial Relations and must include a copy of the treatment plan as well as evidence to support the denial.
If the employer does not file an objection within 10 days, the treatment plan would be deemed accepted.

Potential Impact
Being able to fax treatment plans should result in providers receiving a response sooner than waiting for plans submitted by mail. Employers will need to respond promptly and accordingly especially if filing an objection.

Source

LOUISIANA

Omitted Fee Schedule Codes Listed in Emergency Provision

The Louisiana Workforce Commission Office of Workers' Compensation issued an emergency provision to provide radiology CPT codes omitted in a 2014 update. Other codes in the fee schedule were not affected.

This emergency rule was effective June 20, 2016, and remains in effect for a period of 120 days.
The rule applies to 55 CPT codes including X-rays, CT scans and MRIs.

Fee schedule allowances for the missing CPT codes can be found using the source link below.

Potential Impact

The omission of these codes may not have allowed for the appropriate review of bills including the omitted CPT codes.

Source 1
Source 2

NEW JERSEY

Bill Would Require Electronic Filing of Medical Bills

Assembly Bill 3401 passed the Assembly 63-5 on June 30th and was then referred to the Senate Labor Committee on July 14th.

This bill would require employers, insurance carriers, and third-party administrators to comply with the guidelines based on the International Association of Industrial Accident Boards and Commissions (IAIABC) Workers' Compensation Electronic Medical Billing Rule and Companion Guide and accept electronic claims for the payment of medical services.

AB 3401 would also require providers to submit medical bills on standardized forms, ensure confidentiality of electronically submitted medical information, and provides that payment for a complete electronic medical bill be paid within 60 days.

Potential Impact

AB 3401 would mandate the use of standard billing forms and payment deadlines, both for which New Jersey does not currently have guidelines.

Source