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Workers' Comp

California Senate Bill 1160: New Utilization Review Regulations Take Effect January 1, 2018

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11 MIN READ

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With an effective date of January 1, 2018 for California Senate Bill (SB) 1160 rapidly closing in, many stakeholders in our industry are continuing to analyze the kind of impact the bill may have for injured workers receiving quicker access to medical treatment, utilization review (UR) volumes, and controlled costs for those in our industry. SB 1160, which Governor Jerry Brown signed in September of 2016, received the support from both labor representatives who advocated for injured workers getting appropriate care and quicker treatment, and business representatives who wanted to control costs. The principal changes are with utilization review and liens. The process of obtaining medical treatment is frequently seen as a driving factor in a claimant's decision to seek treatment outside of their network, or employer-chosen physician. If an injured worker is being denied treatment, or is having their treatment delayed when following the rules for accessing workers' compensation treatment, it may drive them to seek treatment from a source outside their network; typically hiring an attorney who then directs them outside of the employer-chosen physician,[i] which can lead to extended medical liens and increased litigation costs. For these reasons, labor representatives were generally in favor of the bill because it promised to speed up the authorization process for injured workers receiving the care they needed during the first month of treatment. At the same time, business representatives by and large saw the benefit of the bill having the potential to keep an increased amount of claims out of litigation in the first month following a worker's injury, and were too, in favor of passing of the bill..

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Utilization Review: Removal of Prospective Review

SB 1160 focuses primarily on provisions related to workers' compensation UR and liens; with one of the most interesting provisions being that medical treatment for injured workers will not be subject to prospective review in the first 30 days following the date of injury. The intent behind this was to streamline the UR process and guarantee that injured workers received timely and appropriate medical treatment.[ii] There are however, a few exceptions to the prospective UR ban; and several requirements and notes to keep in mind below:

- The treating providers must render treatment consistent with the medical treatment utilization schedule (MTUS), including the new California drug formulary, in order to be exempt from utilization review within the first 30 days following an injury—or risk being removed as the predesignated treating physician, employer- selected physician or member of the MPN or HCO.
- According to Labor Code Section 6409, employer chosen physicians treating injured workers must file a complete request for authorization with the Division of Workers' Compensation (DWC)[iii] and the employer, or if insured, with the employer's insurer within five days following an initial visit and evaluation, including a treatment plan. Prospective decisions regarding requests for medications covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. There is no extension of the turnaround time to 14 calendar days.
- There remains a list of treatments that are still subject to utilization review. The services listed out below still require physicians to file a complete request for authorization and receive prior approval. They are: surgical procedures, non-formulary medications, psychological treatment, home health, electro-diagnostic studies, imaging studies and durable medical equipment[iv]
- To avoid liens related to delivery of medical care in the first 30 days of the claim, employers and insurers can retrospectively review treatment delivered within the first 30 days of the claim action to remove physicians from treating workers if they are not compliant with the MTUS and American College of Occupational and Environmental Medicine (ACOEM) guidelines—a reactive and complicated effort that may further disrupt and delay resolution of the claim.

It is too soon to measure the effectiveness of these actions and whether or not they will achieve the intended outcomes of SB 1160: reduced cost and faster access to better treatment. However, a preliminary analysis conducted on a large insurance carrier shows that the guidelines in the bill could have an impact on overall UR volumes—some things to keep in mind as a carrier, when thinking through the next year's strategic planning.

An Example of How SB 1160 Impacts a Carrier's UR Program

Analysis of a large insurance carrier with a robust UR program allowing adjusters to rapidly approve the initial treatments following a claim, found many treatments occurring in the first 30 days of network-enrolled claims that will require preauthorization by means of the SB 1160 guidelines. Among the treatments provided within the first 30 days of a claim, the SB 1160 preauthorization requirements resulted in a 3 percent increase in overall UR volume related to treatments that would require UR that would have before been approved by the adjuster. A separate, yet positive finding for this carrier, was that approximately 16 percent of the treatment requests within the first 30 days of the claim that had been managed at the adjuster level would no longer require approval prior to the claimant receiving treatment, giving claims administrators the opportunity to focus on other activities that would have positive impacts on the claim outcomes. Based on our findings, this carrier could expect to see a 13 percent decrease in the total number of requests for authorization that would have required authorization prior to the claimant receiving treatment. Reviews by physicians are expected to have limited impact from SB 1160, with only a 1 percent potential change identified on analysis. The use of UR programs that meet the new standards established by SB 1160 in mid-2018, including accreditation and UR data reporting requirements, will also require some planning for carrier and claims administrators who have internal processes for review of treatment request. All of these items are significant factors for an insurer establishing their 2018 goals and objectives.

Illustrating a few Claim Scenarios

Our findings definitely indicate that SB 1160 appears to have the potential for the positive impacts intended—faster access to care and reducing liens. The following claim scenarios and stories are to help provide an illustration of what you can potentially expect from SB 1160. Take Jim, a 47-year-old male mechanic, who experiences a workplace injury on January 2, 2018. He was working on a car in the auto shop at his job when a tire explodes and punctures his arm causing injuries to his left arm and hand. His employer calls an ambulance and Jim is taken to the closest Emergency Room for treatment.

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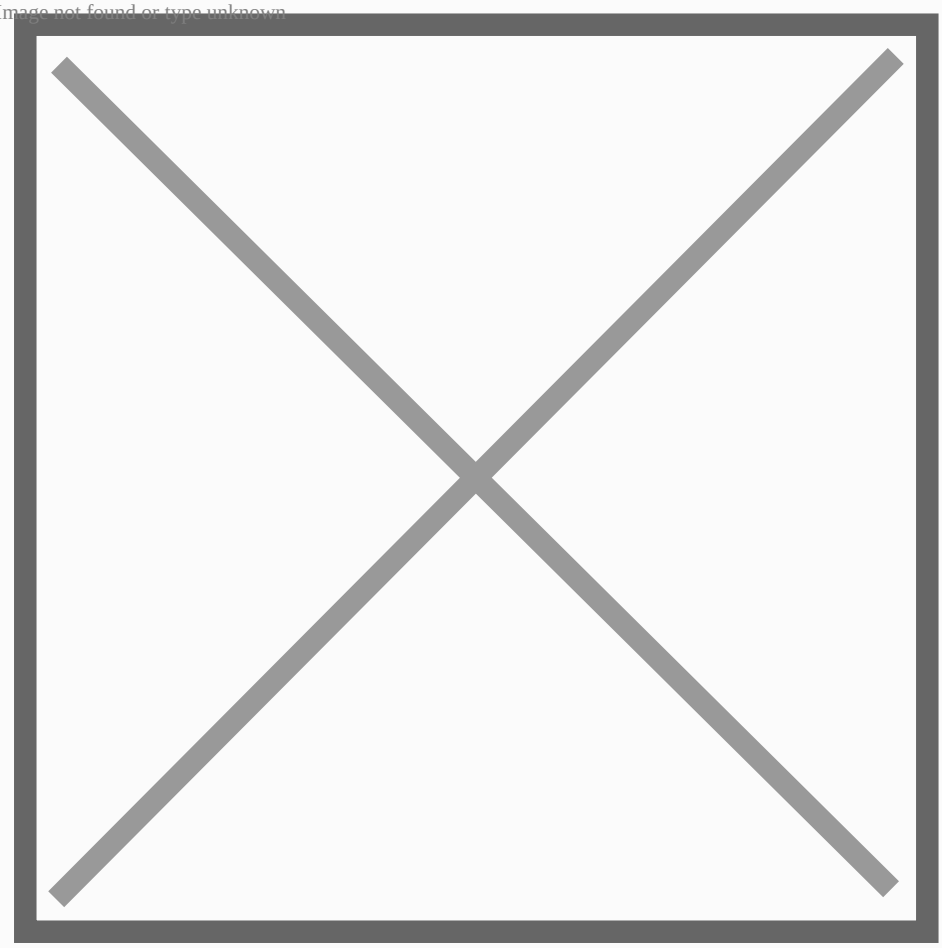

After taking the necessary steps with his employer to access his workers' compensation network, Jim finds an orthopedist, and makes an appointment the next day.

Jim suffered several fractured fingers, and is fortunate to able to be stabilized and treated. He is sent home with a referral to see an orthopedist, and to use anti-inflammatories and ice for pain. After taking the necessary steps with his employer to access his workers' compensation network, Jim finds an orthopedist, and makes an appointment the next day. The orthopedist files a first report of injury (FROI), indicating Jim's treatment plan will include surgery, medications, bracing and occupational therapy.

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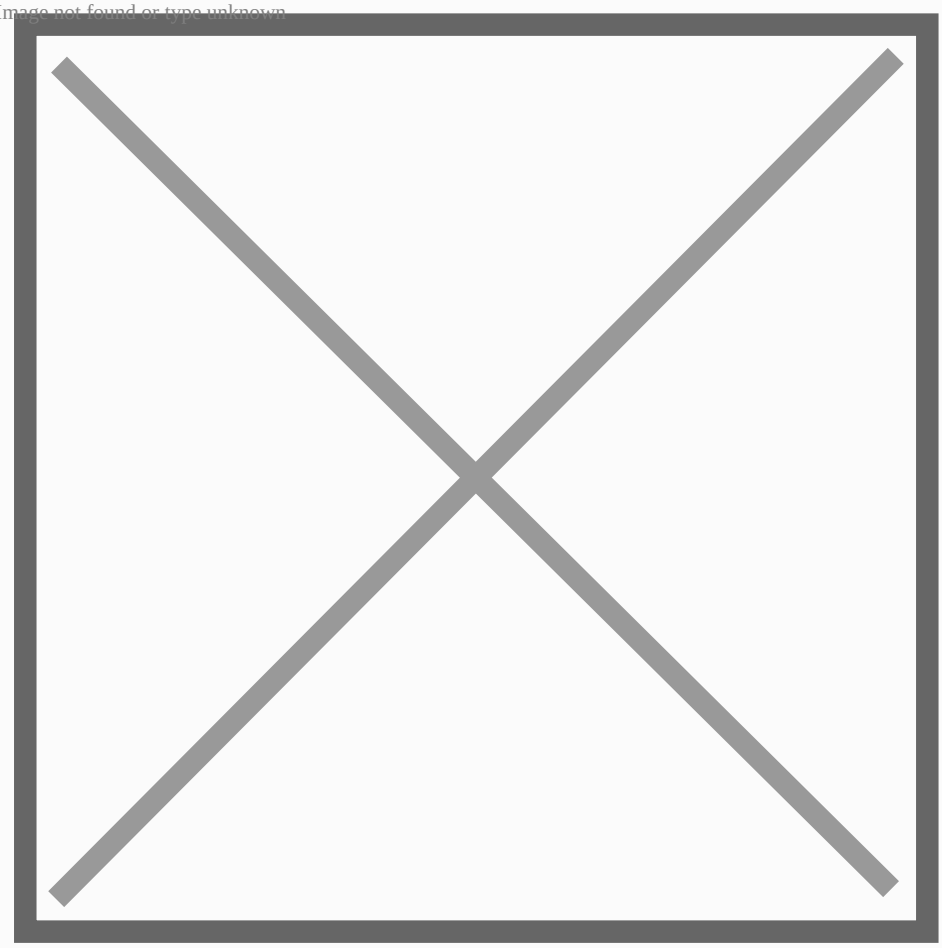

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Mike Loader reported an injury with his employer the same day. It had been an especially busy holiday season on the docks, and as he was bending down to lift a box, he felt a pull in his back. As the day went on the pull progressed to pain, and he told his employer he had injured himself. Mike's employer sends him to the local occupational medicine clinic they use for work injuries. Mike is examined, and the clinical provider files a FROI five days later with a treatment plan indicating they expect Mike needing rest, medications, a brace and physical therapy to recover from his injury.

Both Jim and Mike are able to quickly access care within their employer or carrier-selected providers. Just like before SB 1160, Jim's emergency room treatment did not require authorization. Jim's network orthopedist, being well versed on SB 1160 changes and recognizing Jim's recovery requires early intervention, submits a preauthorization request for the surgery and the braces planned to be used to improve Jim's recovery. Mike's provider takes a bit more time to file his treatment plan, but because none of the treatments he recommends require preauthorization, Mike is able to start physical therapy at the occupational medicine clinic three days after first being seen. Both injured workers are able to access medical treatment quickly, but before SB 1160, Mike might have had to wait 5 days to 14 days to get approval for physical therapy. Some carriers would have had the adjuster approve Mike's initial treatment prior to SB 1160, and some would have had a UR agent review the treatment. With SB 1160, Mike does not need to wait for approval because he is treating with the provider his employer directed him to.

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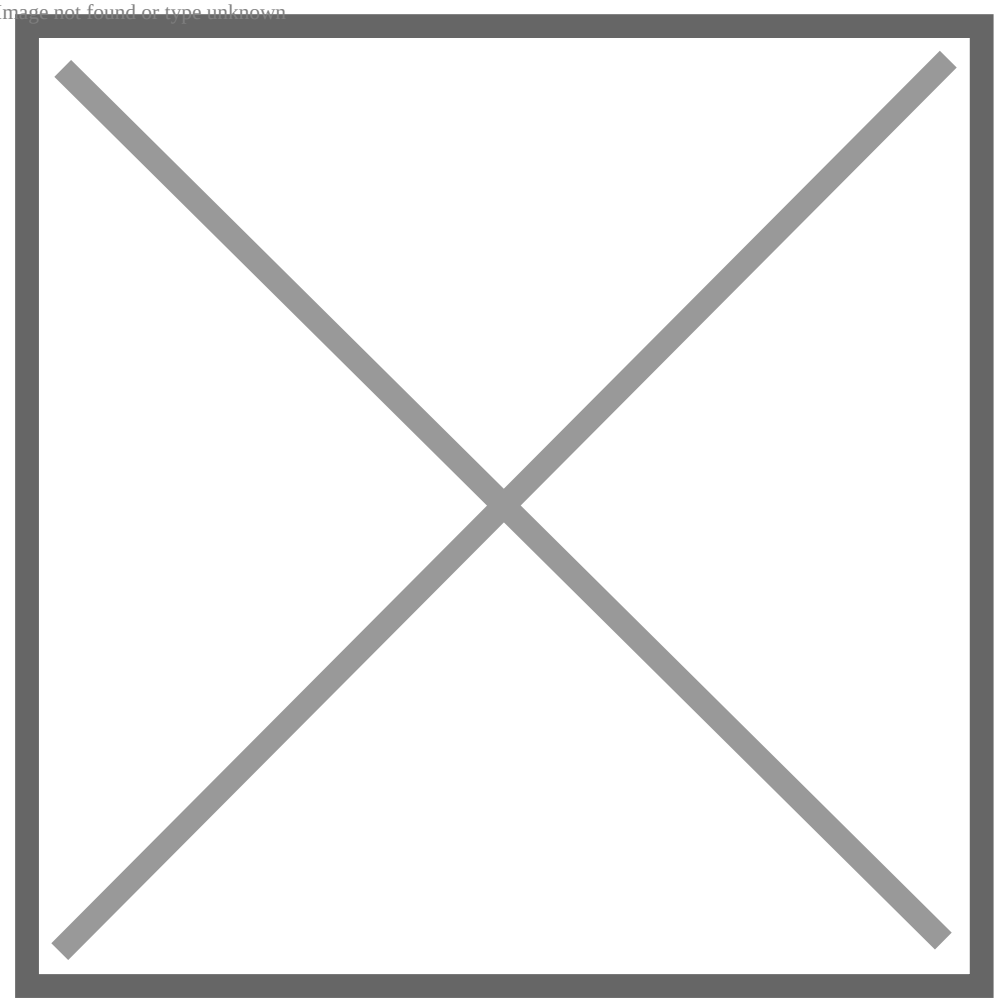

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Jim, on the other hand, will still need to wait for preauthorization before he can have the surgery needed to fix his fractured fingers, regardless of being within the first 30 days of his injury and being treated in his employer's network. To make matters worse, the anti-inflammatories and ice he had been given were not doing much to control the pain and swelling in his injured hand while he waited to get the treatment he needed. Several of Jim's friends suggested he go see a different doctor or perhaps the attorney who helped them with their claim a few years back. It's this access to care scenario that has been identified as contributing to the current lien issue in California. Although it's only been a few days since Jim was injured and he has gotten medical treatment; the anxiety of a work injury, the potential loss of financial stability and waiting to get treatment the doctor said he needed in order to have use of his hand back might send Jim looking for an attorney to get him the treatment he needs—putting Jim's claim in a lien scenario. Fortunately, the adjuster working Jim's claim had more time to address this; as she no longer receives as many adjuster approvals for her new claims since SB 1160 went into effect. Jim's adjuster is able to get the authorization request for Jim's surgery to the UR agent as soon as she receives it and asks for expedited review. Jim's surgery gets approved the next day and the adjuster also assigns a nurse case manager to help Jim with his surgery experience. Jim's nurse case manager helps get his surgery scheduled, prepares him for what to expect and makes sure the brace his doctor ordered gets delivered. The nurse case manager also made sure Jim's post-operative medicine got submitted for preauthorization early, because the opiate prescribed requires pre-authorization under the new SB 1160 formulary. Jim's employer understands the dangerous outcomes opiate use can have, and when Jim's prescription is received for preauthorization they activate their opiate program to ensure the medicine meets guideline recommendations and educate Jim about

the negative impacts opiates can have on his health and recovery. Jim’s surgery is completed and he goes home with everything he needs for his recovery. Meanwhile, Mike has been very compliant with completing his treatment so he can get back to work. After his first few visits of physical therapy, Mike realized he was experiencing more pain rather than positive outcomes, and he had his doubts. His employer was great about putting him on modi ed duty at a desk and the occupational medicine clinic decided that when he wasn’t getting better after the first few visits of therapy that they would increase the frequency and add some massages. He is still within the first 30 days of his injury and the occupational medicine clinic knows that physical therapy no longer requires preauthorization under SB 1160. Unfortunately, by the time Mike’s adjuster receives the bills, Mike has had 18 physical therapy sessions with mostly passive treatment that won’t get him ready for working on the docks again. Now that SB 1160 took away preauthorization on some treatments he is worried about the reserves he set based on the FROI, and quickly sends Mike’s bills for retrospective review to see if the occupational medicine clinic is staying within the treatment guidelines for Mike’s lumbar strain. All he can do now is make the occupational clinic get preauthorization for any further treatment on Mike’s claim, if the retrospective review shows the treatment did not meet guidelines. Mike’s employer really likes the occupational medicine clinic that is close to their shop and it has hours that work for their employees. The adjuster hopes SB 1160 won’t cause problems with his customer and wonders what might happen if this clinic has a pattern of treating outside the guidelines and has to be removed from the network.

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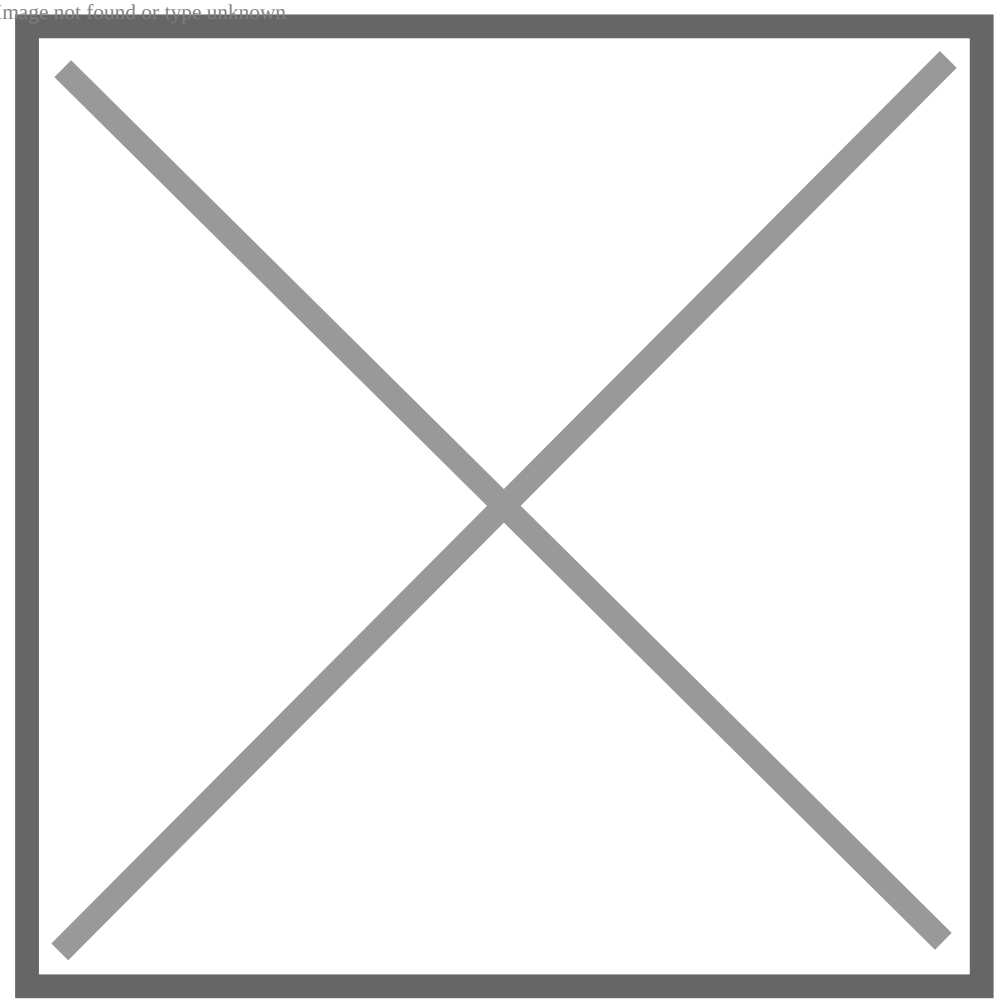

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Conclusion

Time will tell whether the changes SB 1160 made in the beginning of these two claim scenarios will result in the outcomes that the bill's supporters fought for. As Mitchell moves forward implementing SB 1160, we will continue to monitor how best we can combat challenges while continuing to deliver improved outcomes.

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