

Introduced by Senator LaraJanuary 31, 2013

An act to amend Section 4603.2 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 146, as introduced, Lara. Workers' compensation: medical treatment: billing.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury, and generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury.

This bill would delete the requirement that a pharmacy submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. The bill would prohibit a copy of the prescription from being required with a request for payment of pharmacy services, and would give any entity 90 days after January 1, 2014, to resubmit pharmacy bills for payment, originally submitted on or after January 1, 2013, where payment was denied because the bill did not include a copy of the prescription from the treating physician.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 4603.2 of the Labor Code is amended to
2 read:

3 4603.2. (a) (1) Upon selecting a physician pursuant to Section
4 4600, the employee or physician shall notify the employer of the
5 name and address, including the name of the medical group, if
6 applicable, of the physician. The physician shall submit a report
7 to the employer within five working days from the date of the
8 initial examination, as required by Section 6409, and shall submit
9 periodic reports at intervals that may be prescribed by rules and
10 regulations adopted by the administrative director.

11 (2) If the employer objects to the employee’s selection of the
12 physician on the grounds that the physician is not within the
13 medical provider network used by the employer, and there is a
14 final determination that the employee was entitled to select the
15 physician pursuant to Section 4600, the employee shall be entitled
16 to continue treatment with that physician at the employer’s expense
17 in accordance with this division, notwithstanding Section 4616.2.
18 The employer shall be required to pay from the date of the initial
19 examination if the physician’s report was submitted within five
20 working days of the initial examination. If the physician’s report
21 was submitted more than five working days after the initial
22 examination, the employer and the employee shall not be required
23 to pay for any services prior to the date the physician’s report was
24 submitted.

25 (3) If the employer objects to the employee’s selection of the
26 physician on the grounds that the physician is not within the
27 medical provider network used by the employer, and there is a
28 final determination that the employee was not entitled to select a
29 physician outside of the medical provider network, the employer
30 shall have no liability for treatment provided by or at the direction
31 of that physician or for any consequences of the treatment obtained
32 outside the network.

33 (b) (1) Any provider of services provided pursuant to Section
34 4600, including, but not limited to, physicians, hospitals,
35 ~~pharmacies~~, interpreters, copy services, transportation services,

1 and home health care services, shall submit its request for payment
2 with an itemization of services provided and the charge for each
3 service, a copy of all reports showing the services performed, the
4 prescription or referral from the primary treating physician if the
5 services were performed by a person other than the primary treating
6 physician, and any evidence of authorization for the services that
7 may have been received. Nothing in this section shall prohibit an
8 employer, insurer, or third-party claims administrator from
9 establishing, through written agreement, an alternative manual or
10 electronic request for payment with providers for services provided
11 pursuant to Section 4600.

12 (A) *A copy of the prescription shall not be required with a*
13 *request for payment for pharmacy services.*

14 (B) *Notwithstanding timely billing and payment rules established*
15 *by the Division of Workers' Compensation, any entity submitting*
16 *a pharmacy bill for payment, on or after January 1, 2013, and*
17 *denied payment for not including a copy of the prescription from*
18 *the treating physician, shall have 90 days after January 1, 2014,*
19 *to resubmit those bills for payment.*

20 (2) Except as provided in subdivision (d) of Section 4603.4, or
21 under contracts authorized under Section 5307.11, payment for
22 medical treatment provided or prescribed by the treating physician
23 selected by the employee or designated by the employer shall be
24 made at reasonable maximum amounts in the official medical fee
25 schedule, pursuant to Section 5307.1, in effect on the date of
26 service. Payments shall be made by the employer with an
27 explanation of review pursuant to Section 4603.3 within 45 days
28 after receipt of each separate, itemization of medical services
29 provided, together with any required reports and any written
30 authorization for services that may have been received by the
31 physician. If the itemization or a portion thereof is contested,
32 denied, or considered incomplete, the physician shall be notified,
33 in the explanation of review, that the itemization is contested,
34 denied, or considered incomplete, within 30 days after receipt of
35 the itemization by the employer. An explanation of review that
36 states an itemization is incomplete shall also state all additional
37 information required to make a decision. Any properly documented
38 list of services provided and not paid at the rates then in effect
39 under Section 5307.1 within the 45-day period shall be paid at the
40 rates then in effect and increased by 15 percent, together with

1 interest at the same rate as judgments in civil actions retroactive
2 to the date of receipt of the itemization, unless the employer does
3 both of the following:

4 (A) Pays the provider at the rates in effect within the 45-day
5 period.

6 (B) Advises, in an explanation of review pursuant to Section
7 4603.3, the physician, or another provider of the items being
8 contested, the reasons for contesting these items, and the remedies
9 available to the physician or the other provider if he or she
10 disagrees. In the case of an itemization that includes services
11 provided by a hospital, outpatient surgery center, or independent
12 diagnostic facility, advice that a request has been made for an audit
13 of the itemization shall satisfy the requirements of this paragraph.

14 An employer's liability to a physician or another provider under
15 this section for delayed payments shall not affect its liability to an
16 employee under Section 5814 or any other provision of this
17 division.

18 (3) Notwithstanding paragraph (1), if the employer is a
19 governmental entity, payment for medical treatment provided or
20 prescribed by the treating physician selected by the employee or
21 designated by the employer shall be made within 60 days after
22 receipt of each separate itemization, together with any required
23 reports and any written authorization for services that may have
24 been received by the physician.

25 (4) Duplicate submissions of medical services itemizations, for
26 which an explanation of review was previously provided, shall
27 require no further or additional notification or objection by the
28 employer to the medical provider and shall not subject the employer
29 to any additional penalties or interest pursuant to this section for
30 failing to respond to the duplicate submission. This paragraph shall
31 apply only to duplicate submissions and does not apply to any
32 other penalties or interest that may be applicable to the original
33 submission.

34 (c) Any interest or increase in compensation paid by an insurer
35 pursuant to this section shall be treated in the same manner as an
36 increase in compensation under subdivision (d) of Section 4650
37 for the purposes of any classification of risks and premium rates,
38 and any system of merit rating approved or issued pursuant to
39 Article 2 (commencing with Section 11730) of Chapter 3 of Part
40 3 of Division 2 of the Insurance Code.

1 (d) (1) Whenever an employer or insurer employs an individual
2 or contracts with an entity to conduct a review of an itemization
3 submitted by a physician or medical provider, the employer or
4 insurer shall make available to that individual or entity all
5 documentation submitted together with that itemization by the
6 physician or medical provider. When an individual or entity
7 conducting a itemization review determines that additional
8 information or documentation is necessary to review the
9 itemization, the individual or entity shall contact the claims
10 administrator or insurer to obtain the necessary information or
11 documentation that was submitted by the physician or medical
12 provider pursuant to subdivision (b).

13 (2) An individual or entity reviewing an itemization of service
14 submitted by a physician or medical provider shall not alter the
15 procedure codes listed or recommend reduction of the amount of
16 the payment unless the documentation submitted by the physician
17 or medical provider with the itemization of service has been
18 reviewed by that individual or entity. If the reviewer does not
19 recommend payment for services as itemized by the physician or
20 medical provider, the explanation of review shall provide the
21 physician or medical provider with a specific explanation as to
22 why the reviewer altered the procedure code or changed other parts
23 of the itemization and the specific deficiency in the itemization or
24 documentation that caused the reviewer to conclude that the altered
25 procedure code or amount recommended for payment more
26 accurately represents the service performed.

27 (e) (1) If the provider disputes the amount paid, the provider
28 may request a second review within 90 days of service of the
29 explanation of review or an order of the appeals board resolving
30 the threshold issue as stated in the explanation of review pursuant
31 to paragraph (5) of subdivision (a) of Section 4603.3. The request
32 for a second review shall be submitted to the employer on a form
33 prescribed by the administrative director and shall include all of
34 the following:

35 (A) The date of the explanation of review and the claim number
36 or other unique identifying number provided on the explanation
37 of review.

38 (B) The item and amount in dispute.

39 (C) The additional payment requested and the reason therefor.

- 1 (D) The additional information provided in response to a request
2 in the first explanation of review or any other additional
3 information provided in support of the additional payment
4 requested.
- 5 (2) If the only dispute is the amount of payment and the provider
6 does not request a second review within 90 days, the bill shall be
7 deemed satisfied and neither the employer nor the employee shall
8 be liable for any further payment.
- 9 (3) Within 14 days of a request for second review, the employer
10 shall respond with a final written determination on each of the
11 items or amounts in dispute. Payment of any balance not in dispute
12 shall be made within 21 days of receipt of the request for second
13 review. This time limit may be extended by mutual written
14 agreement.
- 15 (4) If the provider contests the amount paid, after receipt of the
16 second review, the provider shall request an independent bill review
17 as provided for in Section 4603.6.
- 18 (f) Except as provided in paragraph (4) of subdivision (e), the
19 appeals board shall have jurisdiction over disputes arising out of
20 this subdivision pursuant to Section 5304.