

AMENDED IN ASSEMBLY JUNE 14, 2016

AMENDED IN SENATE APRIL 19, 2016

**SENATE BILL**

**No. 1175**

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**Introduced by Senator Mendoza**

February 18, 2016

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An act to amend Sections 4603.2, 4603.4, and 4625 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 1175, as amended, Mendoza. Workers' compensation: requests for payment.

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 the employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, as specified, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Existing law requires a provider of those services to submit, among other documents, its request for payment with an itemization of services provided and the charge for each service. Existing law also requires the employer to reimburse the employee for his or her medical-legal expenses, as specified.

This bill would require, effective for services on or after January 1, 2017, that requests for payment with an itemization of services provided and the charge for each service be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The bill would also require, effective for services provided on or after January 1, 2017, that all bills

for medical-legal evaluation or medical-legal expense be submitted to the employer within 12 months of the date of service in the manner prescribed by the administrative director. The bill would provide that requests for payment and bills for medical-legal charges are barred unless timely submitted. The bill would require the administrative director to adopt rules to implement the 12-month limitation period, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
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

1 physician outside of the medical provider network, the employer  
2 shall have no liability for treatment provided by or at the direction  
3 of that physician or for any consequences of the treatment obtained  
4 outside the network.

5 (b) (1) (A) A provider of services provided pursuant to Section  
6 4600, including, but not limited to, physicians, hospitals,  
7 pharmacies, interpreters, copy services, transportation services,  
8 and home health care services, shall submit its request for payment  
9 with an itemization of services provided and the charge for each  
10 service, a copy of all reports showing the services performed, the  
11 prescription or referral from the primary treating physician if the  
12 services were performed by a person other than the primary treating  
13 physician, and any evidence of authorization for the services that  
14 may have been received. This section does not prohibit an  
15 employer, insurer, or third-party claims administrator from  
16 establishing, through written agreement, an alternative manual or  
17 electronic request for payment with providers for services provided  
18 pursuant to Section 4600.

19 (B) Effective for services provided on or after January 1, 2017,  
20 the request for payment with an itemization of services provided  
21 and the charge for each service shall be submitted to the employer  
22 within 12 months of the date of service or within 12 months of the  
23 date of discharge for inpatient facility services. The administrative  
24 director shall adopt rules to implement the 12-month limitation  
25 period. The rules shall define circumstances that constitute good  
26 cause for an exception to the 12-month period, including provisions  
27 to address the circumstances of a nonoccupational injury or illness  
28 later found to be a compensable injury or illness. The request for  
29 payment is barred unless timely submitted.

30 (C) Notwithstanding the requirements of this paragraph, a copy  
31 of the prescription shall not be required with a request for payment  
32 for pharmacy services, unless the provider of services has entered  
33 into a written agreement, as provided in this paragraph, that  
34 requires a copy of a prescription for a pharmacy service.

35 (D) This section does not preclude an employer, insurer,  
36 pharmacy benefits manager, or third-party claims administrator  
37 from requesting a copy of the prescription during a review of any  
38 records of prescription drugs that were dispensed by a pharmacy.

39 (2) Except as provided in subdivision (d) of Section 4603.4, or  
40 under contracts authorized under Section 5307.11, payment for

1 medical treatment provided or prescribed by the treating physician  
2 selected by the employee or designated by the employer shall be  
3 made at reasonable maximum amounts in the official medical fee  
4 schedule, pursuant to Section 5307.1, in effect on the date of  
5 service. Payments shall be made by the employer with an  
6 explanation of review pursuant to Section 4603.3 within 45 days  
7 after receipt of each separate, itemization of medical services  
8 provided, together with any required reports and any written  
9 authorization for services that may have been received by the  
10 physician. If the itemization or a portion thereof is contested,  
11 denied, or considered incomplete, the physician shall be notified,  
12 in the explanation of review, that the itemization is contested,  
13 denied, or considered incomplete, within 30 days after receipt of  
14 the itemization by the employer. An explanation of review that  
15 states an itemization is incomplete shall also state all additional  
16 information required to make a decision. A properly documented  
17 list of services provided and not paid at the rates then in effect  
18 under Section 5307.1 within the 45-day period shall be paid at the  
19 rates then in effect and increased by 15 percent, together with  
20 interest at the same rate as judgments in civil actions retroactive  
21 to the date of receipt of the itemization, unless the employer does  
22 both of the following:

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

25 (B) Advises, in an explanation of review pursuant to Section  
26 4603.3, the physician, or another provider of the items being  
27 contested, the reasons for contesting these items, and the remedies  
28 available to the physician or the other provider if he or she  
29 disagrees. In the case of an itemization that includes services  
30 provided by a hospital, outpatient surgery center, or independent  
31 diagnostic facility, advice that a request has been made for an audit  
32 of the itemization shall satisfy the requirements of this paragraph.

33 An employer's liability to a physician or another provider under  
34 this section for delayed payments shall not affect its liability to an  
35 employee under Section 5814 or any other provision of this  
36 division.

37 (3) Notwithstanding paragraph (1), if the employer is a  
38 governmental entity, payment for medical treatment provided or  
39 prescribed by the treating physician selected by the employee or  
40 designated by the employer shall be made within 60 days after

1 receipt of each separate itemization, together with any required  
2 reports and any written authorization for services that may have  
3 been received by the physician.

4 (4) Duplicate submissions of medical services itemizations, for  
5 which an explanation of review was previously provided, shall  
6 require no further or additional notification or objection by the  
7 employer to the medical provider and shall not subject the employer  
8 to any additional penalties or interest pursuant to this section for  
9 failing to respond to the duplicate submission. This paragraph shall  
10 apply only to duplicate submissions and does not apply to any  
11 other penalties or interest that may be applicable to the original  
12 submission.

13 (c) ~~An interest~~ *Interest* or an increase in compensation paid by  
14 an insurer pursuant to this section shall be treated in the same  
15 manner as an increase in compensation under subdivision (d) of  
16 Section 4650 for the purposes of any classification of risks and  
17 premium rates, and any system of merit rating approved or issued  
18 pursuant to Article 2 (commencing with Section 11730) of Chapter  
19 3 of Part 3 of Division 2 of the Insurance Code.

20 (d) (1) Whenever an employer or insurer employs an individual  
21 or contracts with an entity to conduct a review of an itemization  
22 submitted by a physician or medical provider, the employer or  
23 insurer shall make available to that individual or entity all  
24 documentation submitted together with that itemization by the  
25 physician or medical provider. When an individual or entity  
26 conducting an itemization review determines that additional  
27 information or documentation is necessary to review the  
28 itemization, the individual or entity shall contact the claims  
29 administrator or insurer to obtain the necessary information or  
30 documentation that was submitted by the physician or medical  
31 provider pursuant to subdivision (b).

32 (2) An individual or entity reviewing an itemization of service  
33 submitted by a physician or medical provider shall not alter the  
34 procedure codes listed or recommend reduction of the amount of  
35 the payment unless the documentation submitted by the physician  
36 or medical provider with the itemization of service has been  
37 reviewed by that individual or entity. If the reviewer does not  
38 recommend payment for services as itemized by the physician or  
39 medical provider, the explanation of review shall provide the  
40 physician or medical provider with a specific explanation as to

1 why the reviewer altered the procedure code or changed other parts  
2 of the itemization and the specific deficiency in the itemization or  
3 documentation that caused the reviewer to conclude that the altered  
4 procedure code or amount recommended for payment more  
5 accurately represents the service performed.

6 (e) (1) If the provider disputes the amount paid, the provider  
7 may request a second review within 90 days of service of the  
8 explanation of review or an order of the appeals board resolving  
9 the threshold issue as stated in the explanation of review pursuant  
10 to paragraph (5) of subdivision (a) of Section 4603.3. The request  
11 for a second review shall be submitted to the employer on a form  
12 prescribed by the administrative director and shall include all of  
13 the following:

14 (A) The date of the explanation of review and the claim number  
15 or other unique identifying number provided on the explanation  
16 of review.

17 (B) The item and amount in dispute.

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

19 (D) The additional information provided in response to a request  
20 in the first explanation of review or any other additional  
21 information provided in support of the additional payment  
22 requested.

23 (2) If the only dispute is the amount of payment and the provider  
24 does not request a second review within 90 days, the bill shall be  
25 deemed satisfied and neither the employer nor the employee shall  
26 be liable for any further payment.

27 (3) Within 14 days of a request for second review, the employer  
28 shall respond with a final written determination on each of the  
29 items or amounts in dispute. Payment of any balance not in dispute  
30 shall be made within 21 days of receipt of the request for second  
31 review. This time limit may be extended by mutual written  
32 agreement.

33 (4) If the provider contests the amount paid, after receipt of the  
34 second review, the provider shall request an independent bill review  
35 as provided for in Section 4603.6.

36 (f) Except as provided in paragraph (4) of subdivision (e), the  
37 appeals board shall have jurisdiction over disputes arising out of  
38 this subdivision pursuant to Section 5304.

39 SEC. 2. Section 4603.4 of the Labor Code is amended to read:

1 4603.4. (a) The administrative director shall adopt rules and  
2 regulations to do all of the following:

3 (1) Ensure that all health care providers and facilities submit  
4 medical bills for payment on standardized forms.

5 (2) Require acceptance by employers of electronic claims for  
6 payment of medical services.

7 (3) Ensure confidentiality of medical information submitted on  
8 electronic claims for payment of medical services.

9 (4) Require the timely submission of paper or electronic bills  
10 in conformity with subparagraph (B) of paragraph (1) of  
11 subdivision (b) of Section 4603.2.

12 (b) To the extent feasible, standards adopted pursuant to  
13 subdivision (a) shall be consistent with existing standards under  
14 the federal Health Insurance Portability and Accountability Act  
15 of 1996.

16 (c) Require all employers to accept electronic claims for  
17 payment of medical services.

18 (d) Payment for medical treatment provided or prescribed by  
19 the treating physician selected by the employee or designated by  
20 the employer shall be made with an explanation of review by the  
21 employer within 15 working days after electronic receipt of an  
22 itemized electronic billing for services at or below the maximum  
23 fees provided in the official medical fee schedule adopted pursuant  
24 to Section 5307.1. If the billing is contested, denied, or incomplete,  
25 payment shall be made with an explanation of review of any  
26 uncontested amounts within 15 working days after electronic  
27 receipt of the billing, and payment of the balance shall be made  
28 in accordance with Section 4603.2.

29 SEC. 3. Section 4625 of the Labor Code is amended to read:

30 4625. (a) Effective for services provided on or after January  
31 1, 2017, all bills for medical-legal evaluation or medical-legal  
32 expense shall be submitted to the employer within 12 months of  
33 the date of service in the manner prescribed by the administrative  
34 director. The administrative director shall adopt rules to define  
35 circumstances that constitute good cause for an exception to the  
36 12-month period. Bills for medical-legal charges are barred unless  
37 timely submitted.

38 (b) Notwithstanding subdivision (d) of Section 4628, all charges  
39 for medical-legal expenses for which the employer is liable that  
40 are not in excess of those set forth in the official medical-legal fee

1 schedule adopted pursuant to Section 5307.6 shall be paid promptly  
2 pursuant to Section 4622.  
3 (c) If the employer contests the reasonableness of the charges  
4 it has paid, the employer may file a petition with the appeals board  
5 to obtain reimbursement of the charges from the physician that are  
6 considered to be unreasonable.

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