

DWC UPDATE



George Parisotto, Acting Administrative Director
Division Of Workers' Compensation

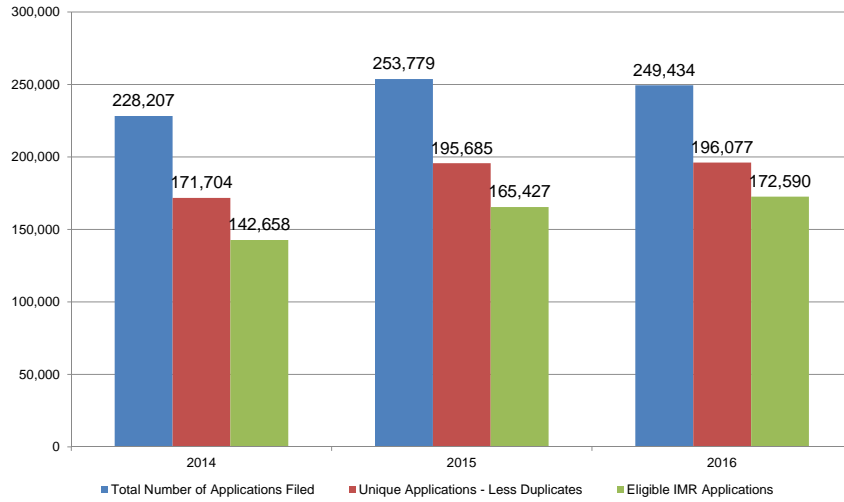
Alan Hersh, DWC Attorney – Special Counsel III
Division of Workers' Compensation

February 23, 2017 and March 2, 2017

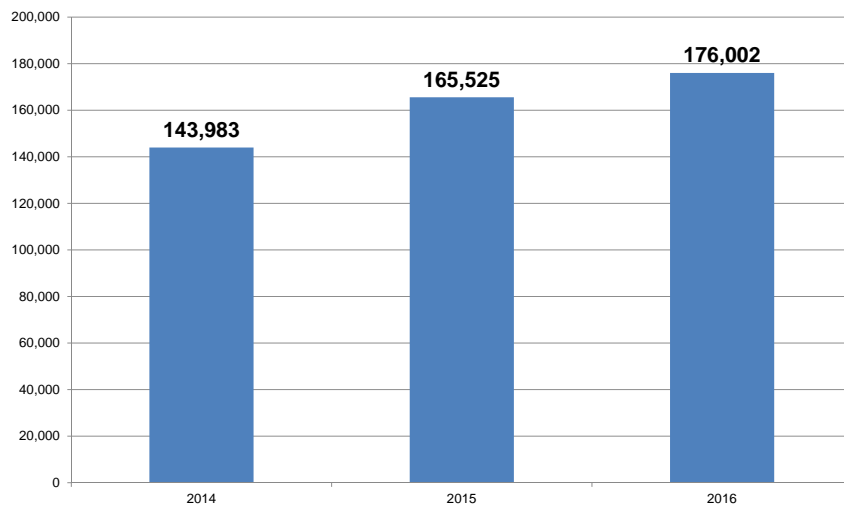
IMR

Data Trends

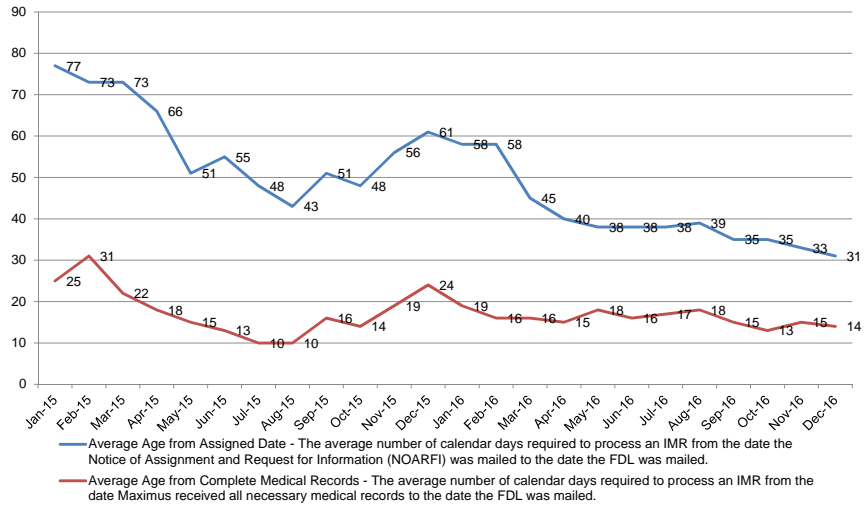
IMR Application Filings



IMR Final Determination Letters (FDL's) Issued

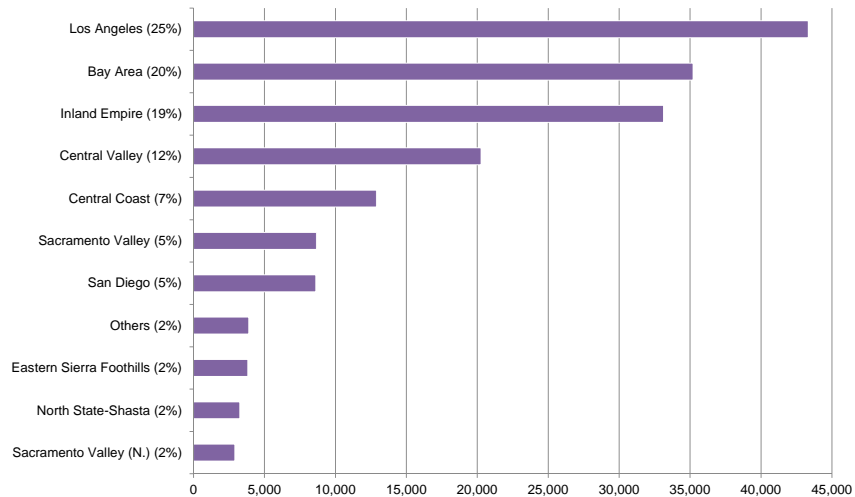


IMR – Timeliness of Decisions

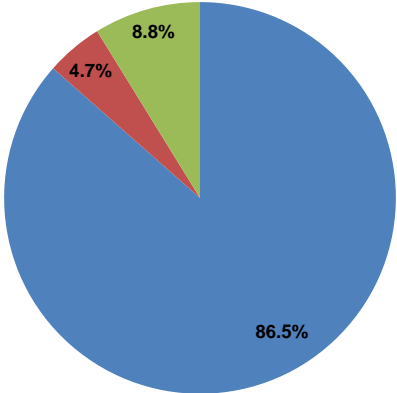


IMR – Geography of Injured Workers

(2016 Case Decisions)

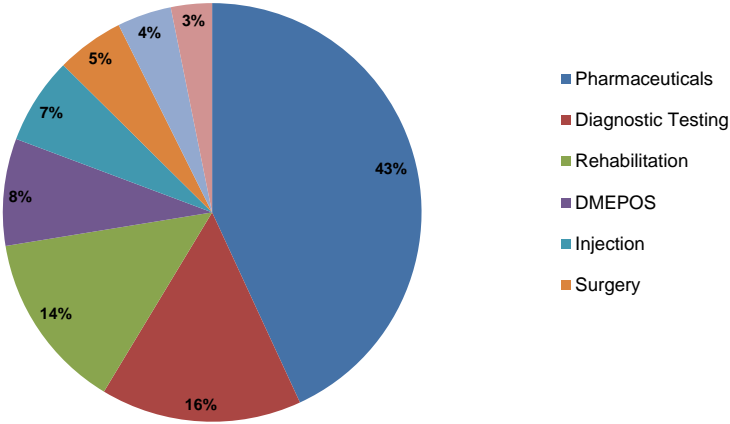


IMR – Case Decisions (2016)



■ Uphold (152,310) ■ Partial Overturn (8,254) ■ Overturn (15,438)

IMR – Treatment Categories (Q4 2016)



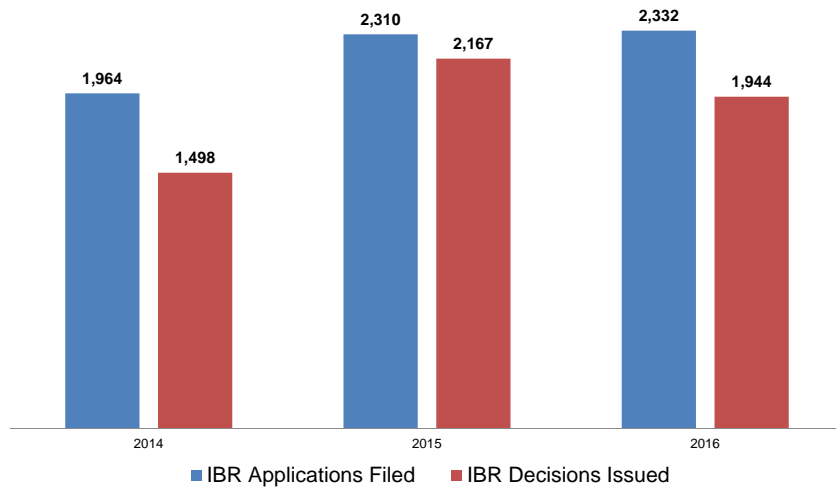
IMR – Most Requested Pharmaceuticals by Drug Class (2016 Decisions)

<u>Drug Class</u>	<u>Total</u>	<u>% of All Pharma Requests</u>
Opioids	44,981	30%
NSAIDs	20,768	14%
Muscle Relaxants	20,393	14%
Topical Analgesics	11,259	8%
Proton Pump Inhibitors	9,627	6%
Total	107,028	72%

IBR

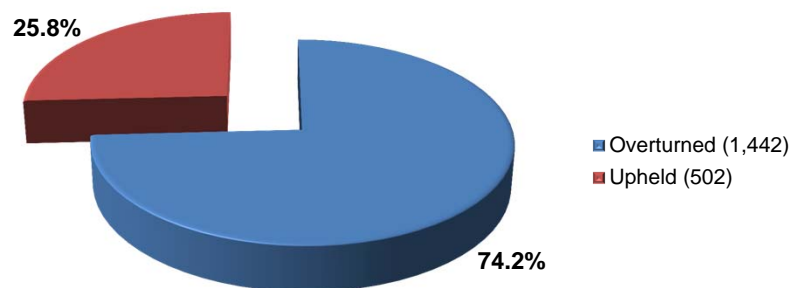
Data Trends

Independent Bill Review (IBR)

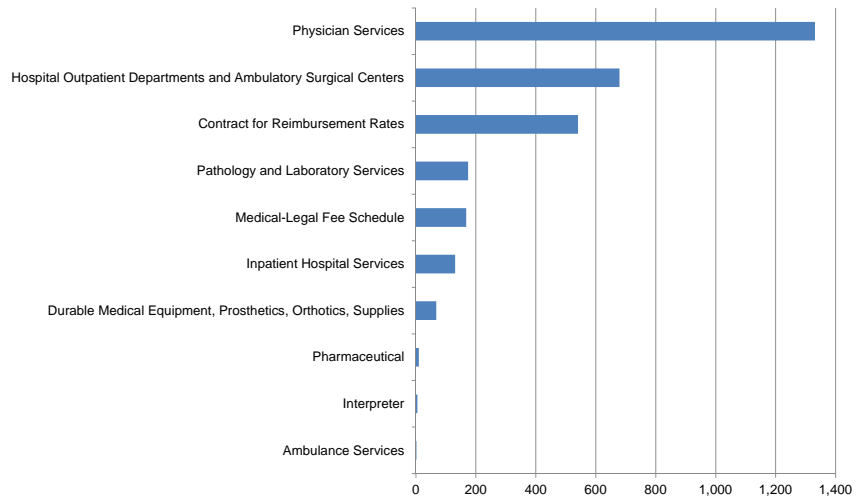


IBR Payment Decisions (2016)

3 out of 4 cases are awarded *at least a partial amount* of their request.



IBR Fee Schedule Categories (2016)



COURT CASES

Court Cases

- *Ramirez v. WCAB*. Court of Appeal, 4th Appellate District. Constitutionality of IMR process. Oral argument set for 3/14/17.
- *Zuniga v. WCAB*. Court of Appeal, 1st Appellate District. Constitutionality of IMR process.
- See *Stevens v. WCAB, et. al.* (2015) 241 Cal.App.4th 1074.
- *King v. Comppartners*. Court of Appeal, 3rd Appellate District. On appeal to CA Supreme Court.
- District Court of Appeal held injured worker could assert civil tort claim against UR doctor for failing to warn about the potential consequences assoc. with abrupt withdrawal of psychotropic meds. Found a Dr.- patient relationship existed.

Court Cases Continued IMR Deadline to Issue Determination

- *CHP v. WCAB (Margaris)*. 248 Cal.App.4th 349 (2016). Court of Appeal, 4th App. District. CA. Supreme Court den. rev. on 9/14/16. Labor Code §4610.5. Held: IMR deadline to issue determination is directory, not mandatory.
- *Hallmark Marketing v. WCAB (Southard)*. Court of Appeal, 3rd App. District. Oral argument set for 4/17/17. WCAB panel concluded IMR deadline to issue determination is mandatory, not directory.
- *Baker v. WCAB*. Court of Appeal, 3rd App. District. Oral argument set for 4/17/17. WCAB panel concluded IMR deadline to issue determination is directory, not mandatory.

LAWS AND REGULATIONS

The screenshot displays the website for the State of California Department of Industrial Relations, specifically the Division of Workers' Compensation (DWC) Physician Education page. The header includes the CA.GOV logo, the department name, and navigation links for Home, Labor Law, Cal/OSHA - Safety & Health, Workers' Comp, Self Insurance, Apprenticeship, Director's Office, and Boards. A search bar is also present. The main content area features a banner image of a doctor's hands and a stethoscope, with the heading "DWC Physician Education". Below the banner, text states: "Available now online and coming soon to mobile app! Free CME* credit. Physicians treating in the California workers' compensation system are required to follow the evidence-based recommendations in the DWC medical treatment utilization schedule (MTUS). The online course below provides helpful instruction. In the first training module, learn to maximize patient recovery, function, and return-to-work considerations using the MTUS." A "You will learn:" section lists three bullet points: "What the MTUS is and how to use it", "How to navigate the MTUS treatment guidelines and apply recommendations via case scenarios", and "When to consider recommendations outside of the MTUS guidelines for the care of your patient". A right-hand sidebar contains "Quick Links" (Online QME Form 106 Panel Request, DWC Physician Education, Search for a workers' comp case, Know my rights, What to do if you get hurt on the job, Find a fact sheet or I&A guide, Forms, Reports, publications & schedules, File a complaint, Pay my bill online) and "About DWC" (Contact Us, Locations, Court calendar). The URL <http://www.dir.ca.gov/dwc/CaliforniaDWCCME.htm> is provided at the bottom.

State of California
Department of Industrial Relations
Press Room | Contact DIR | CA.gov | Índice en español

CA.GOV Home Labor Law Cal/OSHA - Safety & Health Workers' Comp Self Insurance Apprenticeship Director's Office Boards

Division of Workers' Compensation (DWC) | DWC Physician Education

DWC Physician Education

Available now online and coming soon to mobile app! Free CME* credit.

Physicians treating in the California workers' compensation system are required to follow the evidence-based recommendations in the DWC medical treatment utilization schedule (MTUS). The online course below provides helpful instruction.

In the first training module, learn to maximize patient recovery, function, and return-to-work considerations using the MTUS.

You will learn:

- What the MTUS is and how to use it
- How to navigate the MTUS treatment guidelines and apply recommendations via case scenarios
- When to consider recommendations outside of the MTUS guidelines for the care of your patient

Quick Links

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Formulary and MTUS

- Will shortly initiate rulemaking to establish an evidence-based drug formulary and update all MTUS evidence-based treatment guidelines.
- Recommendations made by RAND, who conducted a review and analysis of existing drug formularies.
 - Looked at: Washington State, Texas, Ohio, ODG, ACOEM, and MediCal/Medicaid
 - Recommendation: Treatment guidelines and the formulary should incorporate the evidence-based standards of care that best meet the needs of California's injured workers.
 - Recommendation: Consistency. Most MTUS guidelines are based on ACOEM. A formulary based on the ACOEM guidelines will enable consistency with the MTUS guidelines.
 - The ACOEM guidelines have a more rigorous, transparent development process.

Formulary and MTUS (cont.)

- DWC has drafted rules and criteria for the application of the formulary and use of the preferred drug list.
 - **Preferred Drug Criteria**
 - Being noted as a first line therapy weighs in favor of being preferred.
 - Recommended for most acute and or acute/chronic conditions addressed in clinical guidelines weighs in favor of being preferred.
 - A safer adverse effects (risk) profile weighs in favor of being preferred.
 - Drugs listed for the treatment of more common work-related injuries and illnesses weighs in favor of being preferred.
- Only self-administered, outpatient drugs (versus physician administered such as injections) are included on the (global) preferred drug list

Formulary and MTUS (cont.)

- The drug formulary is expected to reduce the need for utilization review (UR) and independent medical review (IMR), processes which consider necessity of proposed treatment.
 - Preferred drugs are not subject to prospective review
 - Must be prescribed consistent with MTUS guidelines
 - Subject to retrospective review
 - Other medically necessary drugs (non-preferred, not listed FDA approved or FDA OTC Monograph) are available to the injured worker when authorized through prospective review
- Formulary: Quarterly Updates
 - P&T committee to evaluate updates to ACOEM formulary on at least a quarterly basis to ensure most recent evidence is reflected

Formulary and MTUS (cont.)

- MTUS guideline updates to ensure alignment with the formulary by implementation (7/1/17)
 - DWK is updating all available chapters
 - Ankle and Foot
 - Cervical and Thoracic Spine
 - Elbow Disorders
 - Eye
 - Hand, Wrist, and Forearm
 - Hip and Groin
 - Knee Disorders
 - Low Back Disorders
 - Shoulder Disorders
 - Additional updates
 - Chronic Pain (by July 2017)
 - Opioids (by July 2017)
 - Mental Health (forthcoming)
- DWK Online physician MTUS training

DRAFT MTUS Preferred Drug List (8 CCR § 9792.27.12)

The MTUS Preferred Drug List must be used in conjunction with the MTUS Guidelines, which contain specific treatment recommendations based on condition and phase of treatment.
 * Preferred / Non-Preferred - *Preferred* indicates drug may be prescribed/dispensed without seeking authorization through Prospective Review if in accordance with MTUS. †Physician dispensed "Preferred" drug limited to 7-day supply without Prospective Review. ‡ Prescription/dispensing of brand name Preferred drug where generic is available requires authorization through Prospective Review. "Non-Preferred" drug requires authorization through Prospective Review prior to prescribing or dispensing. (See 8 CCR §9792.27.1 through §9792.27.11 for complete rules)
 ** First Fill - Indicates Drug may be prescribed/dispensed without Prospective Review: 1) Rx at initial visit within 7 days of injury, and 2) Supply not to exceed #days indicated, and 3) if in accord MTUS. (See 8 CCR § 9792.27.11)

	Drug Ingredient	Preferred / Non-Preferred*	First Fill**	Drug Class	Reference in Guidelines
1	Acetaminophen	Preferred		Analgesics - NonNarcotic	Ankle and Foot Disorders Cervical and Thoracic Spine Disorders Chronic Pain Elbow Disorders Eye Hand, Wrist, and Forearm Disorders Hip and Groin Disorders Knee Disorders Low Back Disorders Shoulder
2	Adalimumab	Non-Preferred		Analgesics - NonNarcotic	Chronic Pain Hip and Groin Disorders Knee Disorders Low Back Disorders
3	Albuterol Sulfate	Preferred		Antibronchodilator and Bronchodilator Agents	Work Related Asthma
4	Alendronate Sodium	Non-Preferred		Endocrine and Metabolic Agents - Hiv-	Chronic Pain Hip and Groin Disorders Knee Disorders Low Back Disorders Shoulder
5	Amantadine HCL	Non-Preferred		Antiparkinson Agents	Chronic Pain Low Back Disorders
6	Amitriptyline HCL	Non-Preferred		Antidepressants	Cervical and Thoracic Spine Disorders Chronic Pain Hip and Groin Disorders Knee Disorders Low Back Disorders Shoulder
7	Azodipine Bezylate	Non-Preferred		Calcium Channel Blockers	Hand, Wrist, and Forearm Disorders
8	Amoxicillin/Clavulanic Acid P	Preferred		Penicillins	Hand, Wrist, and Forearm Disorders
9	Amoxicillin-Sulbactam	Preferred		Penicillins	Hand, Wrist, and Forearm Disorders
10	Aplikan	Non-Preferred		Antiemetics	Ankle and Foot Disorders Hip and Groin Disorders
11	Artificial Tear Ointments	Preferred		Ophthalmic Agents	Eye
12	Ascorbic Acid	Non-Preferred		Vitamins	Ankle and Foot Disorders Cervical and Thoracic Spine Disorders Chronic Pain Low Back Disorders
13	Aspirin	Preferred		Analgesics - NonNarcotic	Ankle and Foot Disorders Cervical and Thoracic Spine Disorders Chronic Pain Elbow Disorders Hand, Wrist, and Forearm Disorders Hip and Groin Disorders Knee Disorders

SB 1160 and AB 1244

- **Labor Code section 4610 (UR)**
- Effective January 1, 2018
- Prospective UR would not be required for emergency services, medications as designated under the new formulary, and services provided by a pre-designated physician, MPN or HCO providers, or employer-selected physicians or facilities within 30 days of the initial date of injury.
- The services must relate to an accepted body part or condition that is addressed by the MTUS, and the treatment plan must be outlined in the report required by Section 6409 and accompanying request for authorization. All treatment rendered must be consistent with the MTUS.

SB 1160

- Specific services, such as surgery, psychological treatment, home health care, MRIs, and DMEs over a total expenditure of \$250 based on OMFS pricing, would require prospective UR
- Bills for treatment rendered under this provision must be submitted within 30 days of the treatment date.

SB 1160

- Providers who fail to timely submit the report and request for authorization outlining the treatment plan may lose their ability to provide treatment to that injured employee that is exempt from prospective UR during the remainder of the 30-day period.
- An employer may conduct retrospective UR for any treatment provided solely for the purpose of determining if the provider is prescribing treatment consistent with the MTUS.
- If providers have a pattern and practice of providing treatment inconsistent with the MTUS, they could lose their ability to provide UR-exempt treatment for any employees or be removed from the MPN. Additionally an employer has the option to file a petition requesting a change of physician.

SB 1160

- Employers and Utilization Review Organizations (UROs) are prohibited from offering financial incentives to physicians based on the number of UR denial or modification decisions they issue.
- Claims administrators cannot refer matters to a UR entity in which the claims administrator has a financial interest unless there is a prior written disclosure to the employer and AD of the name of the UR entity and the financial interest in the UR entity.
- The AD has authority to review contracts between the UR physician and the claims administrator or employer for purposes of enforcing these provisions.
- URAC and DWC approval for UR plans. Certain nonprofit, public sector internal UR programs may be exempted from the accreditation requirement.

SB 1160

- Formulary treatment requests are subject to expedited UR and IMR, requiring a decision within five days from receipt of the treatment request.
- Decisions denying treatment due to lack of sufficient information to make a medical necessity determination must include a specific description of the information needed and document details regarding the attempt to obtain the information.
- A UR decision to modify or deny treatment remains in effect for 12 months with no action needed on similar request by the same physician or another physician within the requesting physician's practice group, unless there is a documented change in material facts.
- There would be mandatory electronic reporting of UR data by claims administrators to DWC.

SB 1160

Labor Code section 4903.05

- All liens for medical treatment subject to the filing fee, must be accompanied by a declaration signed under penalty of perjury affirming that the dispute is not subject to independent bill review and verifying that the lien claimant is eligible to file that lien.
- The declaration requires that the entity filing the lien indicate on what basis they are eligible to file the lien. The list of bases of eligibility includes certified interpreters, copy service providers and entities with an expense allowed as a lien under the AD's rules.
- For liens filed on or after January 1, 2017, the declaration must be filed at the time of filing the lien. For all liens filed before January 1, 2017, the declaration must be filed by July 1, 2017.
- The failure to file the declaration will result in the dismissal of the lien with prejudice. The filing of a false declaration will serve as grounds for dismissal of the lien with prejudice.

SB 1160

Labor Code section 4615

- Liens, and any related accrual of interest, filed by a physician or provider who is criminally charged with workers' compensation fraud, medical billing fraud, insurance fraud, and Medicare or MediCal fraud, shall be automatically stayed pending the disposition of criminal case.

SB 1160

Labor Code section 4903.8

- The original provider of goods or services is the lien owner.
- Liens must be filed in the name of the lien owner only and that no payment shall be made to any lien claimant without evidence that they are the owner of the lien.
- For liens filed on or after January 1, 2017, assignment of liens is barred unless the provider has ceased doing business. Any assignment of a lien by a provider in violation of this provision is invalid by operation of law.

SB 1160

Labor Code section 5710

- The AD is required to determine the range of reasonable fees that attorneys can be paid for depositions.

Labor Code section 5811

- The AD is required to adopt rules by January 1, 2018 for verifying the identity and credentials of interpreters providing services in workers' compensation settings.

Labor Code section 6409.1

- The current Doctor's First Report would be submitted electronically to both the DWC and the employer's claim administrator.

AB 1244

Labor Code section 139.21:

- DWC to suspend any physician, practitioner or provider from participating in the workers' compensation system as a physician, practitioner, or provider, if any of the following apply:
 - The individual has been convicted of any felony or misdemeanor and that crime comes within any of the following descriptions: (1) it involves fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient; (2) it relates to the conduct of the individual's medical practice as it pertains to patient care; (3) it is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system; or (4) it is otherwise substantially related to the qualifications, functions or duties of a provider of services.
 - The individual or entity was suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.
 - The individual's license, certificate or approval to provide health care services has been surrendered or revoked.

AB 1244

- If the disposition of the criminal proceedings provides for dismissal of liens and forfeiture of sums claimed, the liens will be dismissed with prejudice by operation of law.
- If the disposition of the criminal proceedings doesn't address the disposition to be made of the physician's, practitioner's, or provider's liens pending in the workers' compensation system, the liens will be identified, consolidated and subjected to special lien adjudication proceedings.

AB 1244

- The DWC Chief Judge will identify a district office to conduct the consolidated special lien proceeding and appoint a workers' compensation judge to preside over the proceedings. Special lien proceeding attorney employed by DIR or DWC will represent DIR.
- There is a presumption affecting the burden of proof that all liens adjudicated in the special lien proceedings, as well as all underlying bills and claims for compensation, arise from the conduct subjecting the physician, practitioner or provider to suspension. Payment is not due and shall not be made on those liens as they arise from, or are connected to, criminal, fraudulent, or abusive conduct or activity.
- Lien claimant physicians, practitioners, and providers do not have the right to payment unless they rebut the presumption by a preponderance of the evidence.

AB 1244

Labor Code section 4906

- Mandatory written disclosure form, signed by both the injured worker and the attorney, must be filed with WCAB in adjudicated cases.
- The disclosure form will now include a statement that a person making false statements or representations for the purpose of obtaining or denying workers' compensation benefits is guilty of a felony.
- The disclosure form must state the exact location of the district office of the appeals board where the employee's case will be filed and must include a statement affirming that the employee was advised of the location and the fact the employee may be required to appear there at his or her own expense.
- The employee cannot sign the disclosure form until: (1) he has been advised where his case will be filed; (2) he has met with or personally spoken with a licensed attorney who is employed by the firm representing the employee; and, (3) he has been advised of his rights under other provisions in the statute.

SB 1175

- Labor Code sections 4603.2 and 4625. Effective for services on and after 1/1/2017:
- Statute of Limitations for provider requests for payment.
- 12 months of date of service or
- 12 months of date discharge for inpatient facility services.
- Includes medical-legal exams.
- Administrative Director authorized to adopt regulations, including any good cause exception to time limit.

INTERPRETER REGULATIONS

- Draft Interpreter Regulations. Labor Code §5811.
- Fixed fee structure except by mutual agreement.
- Billing Codes and Detailed Invoices.
- Uniform Fee Rates – one for certified, one for provisional.
- IBR for bills re: medical treatment appointments and medical-legal exams.
- Emphasis on certified interpreters over provisionally certified. Rule of 3. Exhaustion of alternative ways to obtain certified interpreters.
- Restriction on claims for multiple double billing.
- Verification of interpreter credential.

INDEPENDENT MEDICAL REVIEW ORDERS TO SHOW CAUSE

Timelines for processing IMR applications

- Notice of Assignment and Request for Information (NOARFI) sent by MAXIMUS to claims administrator.
- Claims administrator - provide Maximus complete medical records. Must be received by Maximus within 15 days of mailing of NOARFI. CCR §9792.10.5(a). [12 days if the notification sent electronically.]
- Maximus – Issue IMR decision within 30 days after receipt of complete medical records. Labor Code §4610.6(d).
- 15 + 30 = 45 days from issuance of NOARFI to IMR decision.

IMR Orders to Show Cause

DWC Enforcement of Timelines with Assessment of Administrative Penalties. Labor Code § 4610.5, 8 C.C.R. § 9792.12, § 9792.15.

Violations of Law Triggering Administrative Penalties:

- (a) \$500 per day for untimely response to NOARFI, maximum \$5,000 late fee for each NOARFI. Labor Code §4610.5(i); CCR 9792.12(a).
- (b) Conduct having the effect of delaying IMR.
“An employer shall not engage in any conduct that has the effect of delaying IMR. Engaging in that conduct or failing to promptly comply with the requirements of section 4610.5 (responding to NOARFI) is a violation of the section and, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations, not to exceed five thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. Labor Code section 4610.5(i).

IMR Orders to Show Cause, cont.

- Claims Administrator Liable for Conduct Causing Undue Delay in IMR. Labor Code section 4610.5(i). (See above).
- Duty to Conduct Investigation.
- Title 8 C.C.R. section 10109 (a) and (b) provide that to comply with the time requirements of the Labor Code and the Administrative Director’s regulations, a claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers’ compensation benefit.
- The claims administrator’s investigation must attempt to obtain information needed to determine and timely supply benefits that may be due to employees.

IMR Orders to Show Cause, cont.

- CCR section 9792.9.1(e)(5)(G). "The Application for Independent Medical Review, DWC Form IMR. All fields, except for the signature of the employee, to be completed by the claims administrator."
- The Claims Administrator is jointly and severally liable with the third party administrator for failure to comply. CCR 9792.14(b)
- Notice by Claims Administrator to Maximus necessary to end IMR process. IMR process can be terminated at any time "upon notice by the claims administrator to the independent review organization that the disputed medical treatment has been authorized." CCR 9792.10.6(a).

Order to Show Cause Procedure California Code of Regulations §9792.15

- Administrative Director issues OSC.
- Answer. Within 30 days after the date of service of OSC, claims administrator must answer. Continuance can be granted for good cause if filed w/in 10 answer was due.
- Failure to timely file answer is waiver of CA right to hearing, and all defenses to OSC are deemed waived.
- Any allegation and proposed penalty that is not answered is considered uncontested and the penalty must be paid within 30 days of date of service of OSC.
- In contested cases:
- Administrative Director – Issues Notice of Hearing with designated ALJ, within 60 calendar days after issuance of OSC.
- Hearing to take place no sooner than 90 days after the date of service of the Notice of Hearing.

IMR OSC procedure, cont.

- Pre-hearing conference AD can notice a pre-hearing “informal” settlement conference in an effort to resolve contested matters, discovery matters, and issue subpoenas and protective orders.
- If any issues remain contested, pre-hearing order after conference: lists issues to be decided at hearing.
- Evidentiary hearing.
- Respondent to file written statement at least 30 days before hearing listing factual and basis for each defense, witnesses to be called, and documents to be introduced.
- Hearing. Testimony by witnesses, cross-examination, and introduction of documents.
- Hearing officer issues a Determination and Order Assessing Penalty, if any, with statement of basis for decision.

IMR OSC procedure, cont.

- Administrative Director must either:
 - Adopt or modify the recommended Determination and Order Assessing Penalty, within 60 days, or
 - If AD not act within 60 days, the recommended Determination and Order Assessing Penalty becomes final.
- Penalty must be paid within 30 days.
- Claims Administrator can file Petition Appealing the AD's Determination and Order to the WCAB in same way petitions for reconsideration are appealed.