Workers' Comp

Understanding SB1160: The New California Utilization Review Process

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5 MIN READ

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In the scant months leading up to its signature by California Governor, Jerry Brown, SB1160 gained a tremendous amount of attention from those in the California workers' compensation industry. This bill, which was signed into law on Sept. 30, 2016, speaks to persistent delays and denials of medical care for injured workers, contains reforms that could considerably impact workers' compensation programs and influence utilization review requirements nationwide. The excerpts pulled below from SB1160 Sec. 4.5, are just a handful of utilization review (UR) provisions addressed by the legislature. Based on the highlighted language below, we can expect to see many UR entities in the next year making modifications to their current operations to ensure they are compliant with the new requirements:

- Prospective review of medical treatment will not be required with certain exceptions in the first 30 days following the date of injury occurring on or after Jan. 1, 2018.
- The employer or utilization review entity conducting UR on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a UR physician reviewer based on the number of modification or denial decisions made.
- 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.
- A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review service, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria.

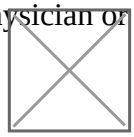
So what does this mean for workers' compensation programs in California? To understand that, we need to look at the various stakeholders that will be impacted by these new changes.

Various Stakeholders

Injured Worker

The bill, effective for work injuries occurring on or after Jan. 1, 2018, focuses on reducing treatment delays for injured workers during the first 30 days following the date of injury. During this 30-day treatment window in an accepted workers' compensation claim, an injured worker, assuming that they are being treated by a medical provider network (MPN) or health care organization (HCO) doctor or another employer-directed doctor/facility, can get the care they need without being subject to "prospective" utilization review —which can result in denial of care when it is most needed. This bill continues the effort to ensure that injured workers are being put on the right path to recovery as quickly as possible.

Treating Providers

Treating physicians are required to follow rules adopted by the administrative director of the Division of Workers' Compensation (DWC) for submitting requests for authorization for medical treatment with supporting documentation to the claims administrator for the employer, insurer or other entity. These rules are meant to help ensure that requests for authorization of treatment will be directed to the appropriate entity to ensure timely processing of the request. Only treatments consistent with the medical treatment utilization schedule (MTUS) are exempt from utilization review in the first 30 days following an injury, and treating physicians must render treatment consistent with the MTUS, including the drug formulary, to avoid being removed as the predesignated treating physician, employer-selected physician or member of the MPN or HCO, or be subjected to prospective review of all further treatment rendered. 

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Electronic reporting of utilization review is mandated under this law, requiring that claims administrators route all UR data to the Division of Workers' Compensation for increased monitoring. The DWC can also review the financial contracts between the employer, UR entity and UR physician reviewers. The new law also prohibits insurers and third party administrators (TPAs) from referring UR services to an entity in which the insurer or TPA has a financial interest unless the insurer/TPA discloses the name of the UR entity and the insurer or TPA's financial interest in the entity to the employer and the DWC.

UR Entities

The bill calls for greater oversight over UR entities by requiring that UR plans that address modification or denial of treatment requests be approved by the DWC and accredited by an independent nonprofit organization by July 1, 2018. Many smaller UR entities who are not currently accredited will have to decide whether to go through the accreditation process or only issue UR authorization decisions. The new statutes should have only minor effects to those UR entities that have practiced in compliance previously. For others, it may end up that these smaller entities will instead choose to partner with other UR entities that are already accredited to avoid operational setbacks.

Industry as a Whole

The workers' compensation industry in California has been seeking managed care cost containment and faster delivery of medically necessary care. SB1160 certainly has the potential to help with both. However, it also puts payors and UR entities in the position of retrospectively monitoring the delivery of treatment and potentially

disrupting that treatment well after the development of a physician-patient relationship. Another factor to consider is the necessity for the provider community to understand the requirements for treating workers' compensation patients as well as the MTUS treatments recommended for the patient's injury. Educating the provider community has been a barrier in prior DWC regulatory changes and payors and UR entities have had to take over that burden, often at the expense of timely delivery of care.

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While the changes made by SB1160 removes potential delays in seeking needed treatment and increases the potential for delivery of consistent, medically necessary care for injured workers, the impact on the MPN, HCO and employer-chosen physician groups could be significant. And as we remove barriers for the injured worker to have access to treatment with limited preauthorization requirements, payors risk losing the managed care cost containment benefits SB1160 brings through increased medical costs in the first 30 days after the injury and extension of the overall claim resolution timeframe due to disruption in the physician-patient relationship. UR Entities and TPAs may be scrambling to meet the accreditation requirements and find innovative solutions to balance the impact of SB1160 on their customers claim cost. Here at Mitchell, our workers' compensation Utilization Management program has been accredited by URAC since 2009. We will continue to monitor the impacts of SB1160 to continue empowering better outcomes for injured workers, payors and the broader workers' compensation industry.

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