Workers' Comp Legislative Activity

May 15, 2020 – July 1, 2020

CALIFORNIA

AB 1107

Actions:
05/26/2020 Amended
04/22/2020 Amended
05/16/2019 Referred to Senate Labor, Public Employment, & Retirement Committee
05/02/2019 Passed Assembly
04/24/2019 Hearing held; passed Committee
04/22/2019 Amended
03/26/2019 Amended
03/25/2019 Referred to Assembly Insurance Committee
02/21/2019 Introduced

Summary: Summary for 03/26/2019 Version: This measure exempts medical treatment requested by a primary or secondary treating physician from the utilization review process and from dispute on the grounds of medical necessity if either: (i.) the employee suffers from a serious chronic condition; or (ii.) the requested treatment has been previously authorized by the employer and the employer fails to demonstrate a change in the employees circumstances or condition which would render the treatment no longer reasonably required to cure or relieve the employee from the effects of the industrial injury.

The measure also exempts medical treatment requested by a primary or secondary treating physician from the utilization review process and from dispute on the grounds of medical necessity if the employer has established a medical provider network pursuant to Section 4616 and the requesting physician is a member of the medical provider network.

Summary for 4/22/2019 Version: The measure makes a final determination of the Administrative Director of the Division of Workers Compensation conclusive evidence that medical treatment was unreasonably delayed or denied.

Outlook: This measure was amended out of the Workman's Compensation scope April 22. The measure now pertains to government communications. This measure remains eligible for consideration by the Senate Labor, Public Employment, and Retirement Committee.

Bill Links:
5/26/2020 Version
4/22/2020 Version
4/22/2019 Version
3/26/2019 Version

CALIFORNIA

AB 2294

Actions: 05/04/2020 Amended
04/24/2020 Referred to Assembly Insurance Committee
02/14/2020 Introduced

Summary: Summary for 5/4/2020 Version: Specifically, this measure amends sections 139.5, 4603.2, 4603.6, 4610, 4616, 4616.2, and 5307.1 of the Labor Code to impose new requirements on medical provider networks, requiring a participating provider to participate at each location at which they treat patients for 8 or more hours per week, on a monthly average.

This measure also prohibits authorizations or certifications issued by a carrier, claims administrator, medical provider network, or utilization review entity from providing instruction or imposing a requirement as to the location of where a treatment takes place or the provider who will perform the treatment. This measure prohibits a vendor, provider, or group within the medical provider from being preferentially cited on an authorization or certification and would require the Administrative Director or the Division of Workers' Compensation to impose a fine of $10,000 per authorization or certification that preferentially directs care within a medical provider network.

This measure requires all treatment authorization or certification, adjuster correspondence, or billing explanation of review or explanation of benefits to include the medical provider network identification number, medical provider network name, and the name of the network covering the claimant provided in that correspondence. This measure would require the Administrative Director to fine a medical provider network $5,000 per document that fails to include required network information.

This measure requires the administrative director to maintain a written record of compliance and approval for all plans and modifications and to approve the plan or modification in writing and with attestation of compliance. This measure would require the Administrative Director to fine a medical provider network $50,000 per occurrence, and to fine a carrier utilizing a medical network $50,000, if the administrative director determines that a medical provider network failed to meet the access standard for a given specialty and denied an injured worker the right to seek care outside of the medical provider network.

This measure also requires the Administrative Director to adopt a medical fee schedule establishing reasonable minimum fees paid for medical services other than physician services, drug and pharmacy services, health care facility fees, home care facility fees, home health care, and all other treatment care, services, and goods. This measure would prohibit an insurance carrier, agent, or third-party contracting entity from contracting with providers of medical services for rates less than the official medical fee schedule adopted by the Administrative Director.

This measure requires a provider to be reimbursed with all fees associated with the filing of the review if that provider is found to be owed additional reimbursement by an independent medical review organization. This measure further requires that if the reimbursement is not made, a penalty of $1,000 per month will accrue. This measure requires that if prospective or concurrent decision of a request for authorization is not made within 5 days from transmission of the request for authorization, or if a final decision is not properly communicated, as specified, that the request for authorization be presumed authorized.

This measure requires the administrative director, no later than January 1, 2022, to ensure that the Electronic Adjudication Management System (EAMS) contains the medical provider network identification number for each injured worker contained in EAMS. This measure requires the administrative director, by July 1, 2022, to report to the Legislature on the status of the EAMS requirement.

This measure gives a provider the right to file a petition for determination of non-independent bill review for matters not eligible for independent bill review. This measure requires a defendant to be deemed to have waived all objections to a providers billing, if one of 2 conditions occurs. This measure requires that a defendant be liable for a fee of not less than $500 if the workers compensation appeals board determines that the defendant failed to comply with various requirements as a result of bad faith or tactics.

This measure requires that a provider be liable for a fee of not less than $500 if the workers compensation appeals board determines that the provider improperly asserted that a defendant failed to comply with requirements.

Outlook: This measure was amended. This measure awaits further consideration before the Committee.

Bill Links: 5/4/2020 Version

NEW YORK

AB 8117

Actions: 05/28/2020 Amended
01/08/2020 Re-referred to Assembly Labor Committee
06/03/2019 Introduced; referred to Assembly Labor Committee

Summary: Summary for 5/28/2020 Version

This measure allows an employer or carrier to contract with a network pharmacy and encourage claimants to use it, however claimants ultimately may obtain prescribed medications at the pharmacy or pharmacies of their choice, so long as that pharmacy is

registered as a resident, in-state pharmacy. The measure further provides that the employer or carrier will be liable for the charges for such prescriptions in accordance with the workers' compensation fee schedule.

The measure does not apply to out-of-state pharmacies or compound medications that the claimant is prescribed.

The measure mandates any pharmacist can be permitted to dispense medication to a claimant outside of the network where the carrier has refused to pay for the claimant's medication and the claimant is unable to access a network pharmacy, the claimant's medication needs to be reauthorized monthly, and is authorized, but is denied because the carrier failed to respond to the reauthorization, medical reports were not filed for reauthorization or a filed medical report contains a defect, the medication has been authorized in the past, however, the carrier denies authorization claiming that the medical treatment guidelines do not support reauthorization, an independent medical examiner disagrees with reauthorization; reauthorization has been denied because maximum medical improvement has been reached, or the case is in the process of being settled.

The measure mandates any pharmacy that agrees to dispense medication to a claimant follow the fee schedule prescribed. follow all treatment guidelines, follow the New York state workers' compensation pharmacy formulary, verify that the medication is causally related to the claimant's work-related injuries; and assume all liability for the medication if a case is not established or if the medication is not later approved.

The measure stipulates upon approval of any medication dispensed by a pharmacy, for such pharmacy to be entitled to receive prompt payment for such medication from the carrier within ten days of such approval, and may be permitted to continue to provide such medication to the claimant after such claimant's case has been established outside of the network.

The measure will take effect upon enactment.

Outlook: This measure has been amended. This measure awaits further consideration from the chair.

Bill Links: 5/28/2020 Version
6/3/2019 Version