AB-1422 Workers' compensation insurance: fraud. (2017-2018)

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Assembly Bill No. 1422

CHAPTER 300

An act to amend Sections 139.21, 4603.2, and 4615 of the Labor Code, relating to workers' compensation insurance.

[Approved by Governor September 26, 2017. Filed with Secretary of State September 26, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1422, Daly. Workers' compensation insurance: fraud.

Existing law governing workers' compensation requires a lien filed by or on behalf of a physician or provider of medical treatment services or medical-legal services, and any accrual of interest related to the lien, to be automatically stayed upon the filing of criminal charges against that physician or provider for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the Medicare or Medi-Cal programs. Existing law makes the stay effective from the time of the filing of the charges until the disposition of the criminal proceedings.

This bill, among other things, would revise and recast these provisions to require the liens of a physician, practitioner, or provider and the liens of an entity controlled by a physician, practitioner, or provider who has been charged with specified crimes involving the federal Medicare or Medicaid programs, the Medi-Cal program, or the workers' compensation system to be automatically stayed, along with any interest accruing, until disposition of the criminal proceedings, except as provided. The bill would also provide that upon conviction of a physician, practitioner, or provider of those specified crimes the automatic stay would be required to remain in effect for any liens not dismissed, as specified, until the commencement of lien consolidation procedures, as provided. The Administrative Director of the Workers' Compensation System would be authorized to adopt regulations to implement these provisions.

Existing law requires the administrative director to promptly suspend any physician, practitioner, or provider from participating in the workers' compensation system as a physician, practitioner, or provider if the individual or entity has been convicted of certain crimes, including crimes involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient, or if the individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs or the individual's license, certificate, or approval to provide health care has been surrendered or revoked. Existing law establishes procedures for the adjudication of any liens of a physician, practitioner, or provider who is suspended pursuant to this provision.

This bill, among other things, would provide that an entity would be subject to suspension as described above if it is controlled, as defined, by an individual who has been convicted of the specified crimes. The bill would specify that the suspension requirements also apply to crimes involving fraud or abuse of the federal Medicaid program and financial crimes that relate to the federal Medicaid program. The bill would authorize the administrative director to adopt regulations specifying any exemptions that would not serve as a basis for exclusion under these provisions.

This bill would also make conforming changes.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 139.21 of the Labor Code is amended to read:

139.21. (a) (1) The administrative director shall promptly suspend, pursuant to subdivision (b), any physician, practitioner, or provider from participating in the workers' compensation system as a physician, practitioner, or provider if the individual or entity meets any of the following criteria:

(A) The individual or entity has been convicted of any felony or misdemeanor and that crime comes within any of the following descriptions:

(i) It involves fraud or abuse of the federal Medicare or Medicaid programs, the Medi-Cal program, or the workers' compensation system, or fraud or abuse of any patient.

(ii) It relates to the conduct of the individual's medical practice as it pertains to patient care.

(iii) It is a financial crime that relates to the federal Medicare or Medicaid programs, the Medi-Cal program, or the workers' compensation system.

(iv) It is otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(B) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs or the Medi-Cal program.

(C) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(D) The entity is controlled by an individual who has been convicted of a felony or misdemeanor described in subparagraph (A).

(E) The changes made to clauses (i) and (iii) of subparagraph (A) and subparagraph (B) during the 2017–18 Regular Session of the Legislature do not constitute a change in, but are declaratory of, the existing law.

(2) The administrative director shall exercise due diligence to identify physicians, practitioners, or providers who have been suspended pursuant to subparagraph (B) of paragraph (1) by accessing the quarterly updates to the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

(3) For purposes of this section and Section 4615, an entity is controlled by an individual if the individual is an officer or a director of the entity, or a shareholder with a 10 percent or greater interest in the entity.

(4) For purposes of this section and Section 4615, an individual or entity is considered to have been convicted of a crime if any of the following applies:

(A) A judgment of conviction has been entered by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged.

(B) There has been a verdict or finding of guilt by a federal, state, or local court.

(C) A plea of guilty has been accepted by a federal, state, or local court.

(5) Notwithstanding the initiation or completion of a prior suspension pursuant to this section, the administrative director may amend an existing notice of suspension or commence a subsequent suspension proceeding based upon new or additional grounds for suspending the physician, practitioner, or provider pursuant to paragraph (1).

(6) The administrative director may adopt regulations specifying any exemptions that shall not serve as the basis for exclusion under paragraph (1).

(b) (1) The administrative director shall adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the administrative director is required to suspend the physician, practitioner, or provider pursuant to subdivision (a) after 30 days from the date the

notice is mailed unless the physician, practitioner, or provider requests a hearing and, in that hearing, the physician, practitioner, or provider provides proof that paragraph (1) of subdivision (a) is not applicable. The physician, practitioner, or provider may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the administrative director finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician, practitioner, or provider.

(3) The administrative director shall have power and jurisdiction to do all things necessary or convenient to conduct the hearings provided for in paragraph (2). The hearings and investigations may be conducted by any designated hearing officer appointed by the administrative director. Any authorized person conducting that hearing or investigation may administer oaths, subpoena and require the attendance of witnesses and the production of books or papers, and cause the depositions of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil cases in the superior court of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure.

(c) The administrative director shall promptly notify the physician's, practitioner's, or provider's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the division's qualified medical evaluator and medical provider network databases, as appropriate.

(d) Upon suspension of a physician, practitioner, or provider pursuant to this section, the administrative director shall give notice of the suspension to the chief judge of the division, and the chief judge or his or her designee shall promptly thereafter provide written notification of the suspension to district offices and all workers' compensation judges. The method of notification to all district offices and to all workers' compensation judges shall be in a manner determined by the chief judge in his or her discretion. The administrative director shall also post notification of the suspension on the department's Internet Web site.

(e) The following procedures apply for the adjudication of any liens of a physician, practitioner, or provider suspended pursuant to subparagraph (A) or (D) of paragraph (1) of subdivision (a), including any liens filed by or on behalf of the physician, practitioner, or provider or any entity controlled by the suspended physician, practitioner, or provider:

(1) If the disposition of the criminal proceeding provides for or requires, whether by plea agreement or by judgment, dismissal of liens and forfeiture of sums claimed therein, as specified in the criminal disposition, all of those liens shall be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding, and orders notifying of those dismissals shall be entered by workers' compensation judges.

(2) All liens that have not been dismissed in accordance with paragraph (1) and remain pending in any workers' compensation case in any district office within the state shall be consolidated and adjudicated in a special lien proceeding as described in subdivisions (f) to (i), inclusive.

(f) After notice of suspension, pursuant to subdivision (d), and if subdivision (e) applies, the administrative director shall appoint a special lien proceeding attorney, who shall be an attorney employed by the division or by the department. The special lien proceeding attorney shall, based on the information that is available, identify liens subject to disposition pursuant to subdivision (e), and workers' compensation cases in which those liens are pending, and shall notify the chief judge regarding those liens. Based on this information, the chief judge or his or her designee shall identify a district office for a consolidated special lien proceeding to adjudicate those liens, and shall appoint a workers' compensation judge to preside over that proceeding.

(g) It shall be a presumption affecting the burden of proof that all liens to be adjudicated in the special lien proceeding, and all underlying bills for service and claims for compensation asserted therein, arise from the conduct subjecting the physician, practitioner, or provider to suspension, and that payment is not due and should not be made on those liens because they arise from, or are connected to, criminal, fraudulent, or abusive conduct or activity. A lien claimant shall not have the right to payment unless he or she rebuts that presumption by a preponderance of the evidence.

(h) The special lien proceedings shall be governed by the same laws, regulations, and procedures that govern all other matters before the appeals board. The administrative director may adopt regulations for the implementation of this section.

(i) If it is determined in a special lien proceeding that a lien does not arise from the conduct subjecting a physician, practitioner, or provider to suspension, the workers' compensation judge shall have the discretion to adjudicate the lien or transfer the lien back to the district office having venue over the case in which the lien was filed.

(j) At any time following suspension, a physician, practitioner, or provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice, which shall constitute a final disposition of the claim for compensation asserted therein.

(k) The provisions of this section do not affect, amend, alter, or in any way apply to the provisions of Section 139.2.

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

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

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

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer is not liable for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) (A) A provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall 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. This section does not prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(B) Effective for services provided on or after January 1, 2017, the request for payment with an itemization of services provided and the charge for each service shall 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 administrative director shall adopt rules to implement the 12-month limitation period. The rules shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. The request for payment is barred unless timely submitted.

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

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

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. A properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:

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

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

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

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

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

(5) (A) An employer may defer objecting to or paying any bill submitted by, or on behalf of, a provider whose liens are stayed pursuant to Section 4615, and the time limits for taking any action prescribed by paragraphs (2) and (3) shall not commence until the stay is lifted pursuant to Section 4615.

(B) An employer may object to any bill submitted by, or on behalf of, a provider who has been suspended pursuant to Section 139.21.

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

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

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

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

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

(B) The item and amount in dispute.

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

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

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

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

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

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

SEC. 3. Section 4615 of the Labor Code is amended to read:

4615. (a) Upon the filing of criminal charges against a physician, practitioner, or provider for any crime described in subparagraph (A) of paragraph (1) of subdivision (a) of Section 139.21, the following shall occur:

(1) Any lien filed by, or on behalf of, the physician, practitioner, or provider or any entity controlled, as defined in paragraph (3) of subdivision (a) of Section 139.21, by the physician, practitioner, or provider for medical treatment services under Section 4600 or medical-legal services under Section 4621, and any accrual of interest related to the lien, shall be automatically stayed.

(2) Except as provided in subdivisions (b) and (c), the stay shall be in effect from the time of the filing of the charges until the disposition of the criminal proceedings.

(b) Upon conviction, as defined in paragraph (4) of subdivision (a) of Section 139.21, of the physician, practitioner, or provider for any crime described in subparagraph (A) of paragraph (1) of subdivision (a) of Section 139.21, the automatic stay shall remain in effect for any liens not dismissed pursuant to paragraph (1) of subdivision (e) of Section 139.21 until the commencement of lien consolidation procedures under paragraph (2) of subdivision (e) of Section 139.21.

(c) The automatic stay required by this section shall not preclude a physician, practitioner, or provider from requesting the dismissal with prejudice and forfeiture of sums claimed therein of any liens subject to the stay. Upon the receipt of that request and for good cause shown, the chief judge of the Division of Workers Compensation or his or her designee may lift the stay as to one or more of those liens and order that they be dismissed with prejudice.

(d) The administrative director shall promptly post on the division's Internet Web site the names of any physician, practitioner, or provider of medical treatment services whose liens are stayed pursuant to this section.

(e) The automatic stay required by this section shall not preclude the appeals board from inquiring into and determining within a workers' compensation proceeding whether a lien is stayed pursuant to subdivision (a) or whether a lien claimant is controlled by a physician, practitioner, or provider.

(f) The administrative director may adopt rules for the implementation of this section.

(g) Notwithstanding this section, the filing of new or additional criminal charges against a physician, practitioner, or provider who has been suspended pursuant to subparagraph (A) of paragraph (1) of subdivision (a) of Section 139.21 shall not stay liens that are subject to consolidation and adjudication pursuant to subdivisions (e) to (i), inclusive, of Section 139.21, unless a determination has been made pursuant to subdivision (i) of Section 139.21 that a lien did not arise from the conduct that subjected the physician, practitioner, or provider to suspension.