Date of Hearing: April 23, 2025

ASSEMBLY COMMITTEE ON INSURANCE
Lisa Calderon, Chair
AB 1048 (Chen) – As Amended April 10, 2025

SUBJECT: Workers' compensation

SUMMARY: This bill clarifies that payment disputes, for the purposes of independent bill review (IBR), include contract disputes involving a discount or reduction from the official medical fee schedule (OMFS), and provides specific conditions for determinations by the IBR in such circumstances. Specifically, **this bill**:

1) Clarifies that, for purposes of IBR, a payment dispute includes a contract dispute involving a discount or reduction from the OMFS that was applied to a medical treatment bill.

2) Requires that, if the dispute only involves a percentage discount or reduction that results in IBR upholding the discount or reduction, IBR provide the rationale for that ruling in a written decision to the medical provider, and include the medical provider contract or contracts relied upon to uphold the discount or reduction; and clarifies that the IBR organization is not required to provide the medical provider with a contract to which the medical provider is not a party.

3) If the payer cannot produce a valid medical provider contract or contracts justifying the discount or reduction, requires the IBR organization to award the medical provider payment for the disputed medical treatment bill that is consistent with the OMFS.

EXISTING LAW:

1) Establishes a workers' compensation system that provides benefits to an employee who suffers from an injury or illness that arises out of, and in the course of, employment, irrespective of fault. (California Constitution Article XIV, Section 4)

2) Establishes DWC within the Department of Industrial Relations (DIR) and charges it with monitoring the administration of workers' compensation claims and providing administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers' compensation benefits. (Labor (Lab.) Code Sections 3200 et. seq.)

3) Requires that a provider of services for an injured worker eligible for workers' compensation benefits 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, any prescription or referral from the primary treating physician, and any evidence of authorization for the services to the employer, or to the insurer or third-party claims administrator as established through written agreement. (Lab. Code Section 4603.2(b)(1)(A))

4) Provides that, if the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review, which the employer must respond to within 14 days with a final written determination on each of the items or amounts

in dispute; and provides that, if the provider contests the amount paid after receipt of the second review, the provider shall request an IBR. (Lab. Code Section 4603.2(e))

5) Provides that, if the only dispute between a medical provider and the employer is the amount of payment, and the provider has received a second bill review by the claims administrator that did not resolve the dispute, the provider may request an IBR within 30 calendar days of service of the second review. (Lab. Code Section 4603.6(a))

6) Upon receipt of a request for IBR and the required fee, requires the administrative director (AD) of DWC to assign the request to an independent bill reviewer within 30 days, and requires the reviewer to review the materials submitted by the parties and make a written determination of any additional amounts to be paid to the medical provider, and state the reasons for the determination. (Lab. Code Section 4603.6(d) and (e))

7) Provides that the determination of the IBR is final and binding on all parties unless an aggrieved party files with the Workers' Compensation Appeals Board (WCAB) a verified appeal from the medical bill review determination within 20 days of the service of the determination; and provides that the determination shall be presumed correct and shall be set aside only upon clear and convincing evidence that the determination was procured by fraud, that the IBR was subject to a material conflict of interest, that the determination was the result of bias on the basis of a protected class, or that the determination was the result of a plainly erroneous express or implied finding of fact. (Lab. Code Section 4603.6(f))

8) Requires the AD to, after public hearings, adopt and revise periodically an OMFS that establishes reasonable maximum fees paid for medical services provided to workers' compensation patients. (Lab. Code Section 5307.1)

9) Authorizes a medical provider and a contracting agent, employer, or carrier to contract for reimbursement rates that differ from the OMFS, so long as those rates do not exceed the rates established by the OMFS. (Lab. Code Section 5307.11)

FISCAL EFFECT: Unknown.

COMMENTS:

1) *Purpose*: According to the author:

> This bill addresses the need for greater transparency and accountability in the workers' compensation system, particularly in resolving contract disputes between payers and medical providers. By defining payment disputes to include contract disputes related to discounts or reduction of medical bills, the bill clarifies that these disputes can be handled under the existing Independent Bill Review (IBR) process. Just line in any other dispute resolved through the Independent Bill Review process, IBR would issue a written decision to the medical provider, along with the relevant contract. This ensures a fairer, more transparent process for resolving disputes and fosters better communication between all parties.

This bill is sponsored by the California Orthopedic Association (COA).

2) *Workers' compensation and Independent Bill Review*: At its core, the workers' compensation system relies on a so-called "grand bargain." If a worker is injured on the job, the employer must pay for the worker's medical treatment, including monetary benefits if the injury is permanent. In exchange for receiving the guarantee of such treatment, the worker surrenders the right to sue the employer for monetary damages in civil court. All employers are required to secure the payment of workers' compensation either by receiving approval from DIR to self-insure in accordance with substantial requirements, or by obtaining workers' compensation insurance coverage from an authorized insurer. The Labor Code explicitly asserts that it is the policy of the state to "vigorously enforce" this law.

   The workers' compensation system has several formal mechanisms for resolving disputes among interested parties. When the injured worker and the employer disagree on details pertaining to the injury, the qualified medical evaluation (QME) process evaluates the disputed facts and provides a medical-legal report to the parties, which can then seek judgement by a workers' compensation administrative law judge, and can further appeal to the WCAB. When the injured worker disagrees with a utilization review decision denying or modifying the treatment plan based on medical necessity, the independent medical review (IMR) process relies on a neutral organization to evaluate the medical necessity of the treatment plan. And when a medical provider and employer or insurer disagree on payment for medical services provided, the medical provider can submit the bill for a Second Bill Review (SBR) by the claims administrator, and any remaining dispute can be resolved through the IBR process.

   The IBR process is intended to expediently resolve billing disputes where the only issue is the amount to be paid for the provided medical service. DWC's website describes the IBR process as follows:

   > Medical treatment and medical-legal billing disputes are resolved through an independent bill review (IBR) process. A medical provider who disagrees with the amount paid by a claims administrator on a properly documented bill may apply for IBR. IBR applies to any medical service bill where the date of service is on or after Jan. 1, 2013 and where the fee is determined by a fee schedule established by the DWC. […]
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   > Upon referral by the administrative director (AD), the independent bill review organization (IBRO) assigns an independent bill reviewer to examine all documents submitted, apply the appropriate fee schedule (i.e., Official Medical Fee Schedule, Medical Legal Fee Schedule, Contract Reimbursement Rates per Labor Code 5307.11), and issue a written determination within 60 days of the assignment to IBR.
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   > If the determination finds any additional amount of money is owed to the provider, the determination shall also order the claims administrator to pay the additional sum owed and reimburse the provider the amount of the filing fee.
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   > The IBR determination is deemed the determination of the AD and it is binding on all parties.

   DWC contracts with a single organization, Maximus, to provide all IMR and IBR services. Maximus describes itself as "a leading strategic partner to governments across the globe [that] helps improve the delivery of public services amid complex technology, health, economic, environmental, and social challenges." To request IBR, the medical provider can

apply online through the Maximus Federal Services IBR tracking system, or can submit a hard copy, including required and/or supporting documentation and a check or money order for the IBR fee of $180.

3) *Silent PPO discounting*: DWC, after public hearing, sets and updates the OMFS that establishes the reasonable maximum fees to be paid for medical services provided to workers' compensation patients. However, Section 5307.11 of the Labor Code authorizes a medical provider and a contracting agent, employer, or insurer to contract for reimbursement rates that differ from the OMFS, so long as they do not exceed the OMFS rate.

   In many cases, these arrangements are mutually beneficial. The insurer sends business to the medical provider and, in exchange, the medical provider offers services for a discounted rate to the insurer. These arrangements are known as Preferred Provider Organizations, or PPOs, because insurers indicate preference for injured workers to seek treatment through those providers in exchange for the discounted rates. In some cases, especially for smaller insurers and employers who self-insure, such arrangements are made through an intermediary organization rather than directly. These networks solicit a panel of providers, and then broker discounts with insurers on behalf of those providers to direct them additional business.

   This system has, unfortunately, given rise to an untoward practice known as "silent PPO discounting," in which the network leases their provider list, including the discounted rates they've brokered with insurers for those providers, to other insurers. Rather than honoring the discounted rate the insurer has directly negotiated with the provider, the insurers instead pay the lowest rate that provider has agreed to with *any* insurer, or "double dip" on discounts, adding both the discount they've directly negotiated with the provider and the discount they've secured through the network.

   As an example, Dr. Smith contracts with Insurer X to provide a 15% discount from the OMFS in exchange for Insurer X directing injured workers to them. Dr. Smith also contracts with Network A, which secures Dr. Smith preferred arrangements with Insurers Y and Z for discounts of 20%. Network A then leases its provider list, and the database detailing their discounts, to Insurer X. Dr. Smith provides medical care for a patient covered by Insurer X, but rather than receiving payment discounted by 15% from the OMFS, receives payment discounted by 20%, or in some cases, 35%. Dr. Smith receives no additional business as a result of the larger discount, since Insurer X was already contracted with Dr. Smith for the lesser discount.

   This bill would allow Dr. Smith to dispute the additional discount through the IBR process, and, if successful, receive payment in the amount dictated by the OMFS. If the IBR determines that the payment provided was appropriate, this bill would also require the IBR to provide Dr. Smith with the relevant contract to which Dr. Smith is a party that supports the discounted rate. Notably, the bill does not require the IBR to provide Dr. Smith with any contract to which she is not a party, though these contracts can be considered in the IBR process.

   As COA, who sponsor the bill, describe:

   > The Independent Bill Review (IBR) process was intended to provide a streamlined and impartial resolution for billing disputes between medical providers and payers. However, current statute does not explicitly allow providers to challenge reimbursement reductions

> that result from unauthorized or "silent" Preferred Provider Organization (PPO) discounts – particularly those applied to medical treatment bills without the provider's knowledge or consent.
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> These silent discounts can severely undercut the Official Medical Fee Schedule and, in some cases, result in payments even lower than Medicare rates. […] When providers face unreasonable and opaque reimbursement reductions, many are forced to limit or stop treating workers' compensation patients altogether. As more providers exit the system, injured workers face growing delays and difficulty accessing timely, high-quality care, particularly for specialty services. AB 1048 addresses this critical gap by clarifying that medical treatment payment disputes involving contract-based reductions fall within the scope of the IBR process. By restoring financial transparency and predictability, AB 1048 will encourage more providers to remain in or return to the Worker's Compensation system, thereby strengthening the provider network and improving access to care for the Californians who need it most.

If a provider has contracted for a discounted rate with the insurer, but the insurer relies on a silent PPO discount that is determined through the IBR to be without contractual merit, the provider would be entitled to the OMFS rate of payment for their services, rather than discounted rate they negotiated directly with the insurer. This would serve as a deterrent against silent PPO discounting, as doing so could result in significant cost increases to the insurer should the practice be detected and disputed.

4) *Opponent concerns*: This bill is opposed by a coalition of business interests and insurers including the California Coalition on Workers' Compensation (CCWC), the California Chamber of Commerce (CalChamber), and the American Property Casualty Insurance Association (APCIA), who raise concerns regarding the expertise of IBR reviewers to resolve contract disputes and the potential for the bill to interfere with binding dispute resolution provisions that may be included in contracts between providers and insurers. According to that coalition:

> Under AB 1048, [IBR would be asked] to resolve complicated contract disputes related to billing. IBR reviewers are typically insurance and billing professionals who are quite good at resolving routine billing issues. IBR is not, however, staffed by attorneys and judges who are able to resolve legal disputes around contract application.
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> Many of the contracts subject to IBR under AB 1048 have binding dispute resolution provisions that would be interfered with by funneling the disputes into IBR. These provisions can include internal appeals processes, arbitration, and/or venue selection for dispute resolution. […] From our perspective it is bad public policy to move these disputes from qualified arbitrators or judges and into the IBR system.

Under existing law, it is not clear whether contract disputes related to discounted rates fall within the purview of the IBR process. Because existing law provides the IBR process as a mechanism for resolving disputes where "the only dispute between a medical provider and the employer is the amount of payment and the provider has received a second bill review by the claims administrator that did not resolve the dispute," medical providers may in fact already be able to avail themselves of the IBR process for resolving these contract disputes. Should this be the case, this bill would be clarifying in specifying that such disputes can utilize the IBR process, and simply detail additional conditions around determinations made

by the IBR. Because the contentions raised by the opponents are specific to the use of the IBR process for resolving disputes regarding contract application, and not to the provisions of the bill that detail conditions around IBR determinations in these cases, if the IBR process can already be used in these circumstances, these contentions would be without merit.

Staff notes that the bill in print does not *require* that the IBR process be utilized to resolve contract application disputes between providers and insurers – rather, it clarifies that it is available for these types of disputes at the discretion of the provider. Should the contract between the provider and the insurer detail alternative binding dispute resolution procedures, the provider can utilize those procedures should they view them as fairer, more efficient, and/or less costly than the IBR process (note that the provider must surrender the filing fee to request an IBR). The provider is not precluded from resolving disputes in that manner. However, in cases where the binding dispute resolution process provided for in the contract is clearly favorable to the insurer, a provider may be more inclined to utilize the impartial IBR process.

The merit of the opponents' concern regarding the expertise of independent bill reviewers in contract application disputes is unclear. Maximus employs nearly 40,000 workers across a diverse array of functions, only a fraction of which serve as independent bill reviewers. Some of these workers likely have the requisite expertise to resolve these contract disputes. The author and sponsors contend that the contracts in question are generally straightforward, and do not require substantial expertise to interpret. Additionally, nothing in the bill or in the statutes detailing the IBR process prohibit the reviewer from consulting with legal experts regarding contract law. That said, if the requisite expertise is not available through Maximus at present, Maximus may need to acquire such expertise should this bill become law.

5) *Prior legislation*:

SB 863 (De León, Ch. 363, Stats. 2012) enacted major reforms to the workers' compensation system, including establishing the IMR and IBR processes for resolving disputes.

SB 899 (Poochigian, Ch. 34, Stats. 2004) enacted major reforms to the workers' compensation system, including authorizing medical provider networks (MPNs), and revising the qualified medical evaluator and utilization review processes.

REGISTERED SUPPORT / OPPOSITION:

Support

California Medical Association (CMA)
California Orthopedic Association
California Podiatric Medical Association

Oppose

American Property Casualty Insurance Association
California Association of Joint Powers Authorities
California Chamber of Commerce
California Coalition on Workers Compensation

California Food Producers
Urban Counties of California (UCC)

Analysis Prepared by: Landon Klein / INS. / (916) 319-2086