Michael Sullivan
& ASSOCIATES, P.C.

Special Report:

A First Look at SB 863

Michael Sullivan, Esq.
Sure S. Log, Esq.
Prof. David J. Chetcuti

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INTRODUCTION

What the heck just happened?

The introduction, contesting and passage of SB 863 came about in a sudden whirlwind of activity. Some observers are critical of the way the bill went through the system, decrying the secrecy in which it was formed and the lack of informed consent that underpinned the final vote in the Senate. Others point to the bill and note a significant increase in benefits and a reduction in ancillary services, which is just what the doctor ordered for our broken system. At the end of the day, the governor and enough interests on both sides agreed on the bill, and that was that.

For us lowly practitioners, ours is not to reason why but to *figure it out and make it work.*

This booklet is a complete review of all aspects of the new law, which is nothing less than an overhaul of the entire system. While SB 899 in 2004 perhaps had more gravitas, SB 863 cannot be matched in breadth. In the section SB 863: When Laws Take Effect, we list the effective date of each change and enumerate more than 70 items spanning a plethora of areas of the law. And we note that most changes take effect on Jan. 1, 2013, for all dates of injury.

We review each segment of the new law in depth, note its changes and comment on how it will play out. Naturally, there will be many areas where regulations must be developed before we really begin to understand how all this will work. And we have no illusions that we have captured all available insights at this infant stage of development. What we do hope to have achieved here is a comprehensive exposition of this law, one that provides some understanding of what we have, places the law in context and offers a sound basis for visualizing implementation.

I want to thank all who suspended their lives for a 10-day period following passage of the law to work as a team day and night performing the analysis and articulation needed to produce this as quickly as possible. My co-authors, of course, did a lot of the heavy lifting — thank you Professor Dave Chetcuti and Sure Log. Sure, as usual, did the lion's share of the back-breaking work. I want to thank my brother and acting partner Bart Sullivan, and Robert Blanco of our Los Angeles office, both of whom spent time away from their families to lay groundwork on key provisions. Ellen Alperstein, our copy editor, toiled away late each night cleaning up the day's writing. Michael Bell, our executive director, was assisted by Elizabeth Vo in producing this, which is almost harder than writing it. And I want to thank David DePaolo, Rob McCarthy and the whole crew at WorkCompCentral for their insights, collaboration and good-faith help at presenting our point of view to the world. And of course thanks to the families of all these folks, especially my wife Staser and daughter Demetria, who exhibited their usual patience as they watched me digging

into another big project. A shout goes out to my brother John Sullivan who watched over all of us as we did our work. I hereby incorporate by reference my dedication to him (found in Introductory Sections.)

We as a community are about to face another odyssey in this field. As a practitioner, I have never been so excited about doing workers' comp.

Michael Sullivan
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LINKS TO SULLIVAN ON COMP

This booklet is a supplement to "Sullivan on Comp," our comprehensive treatise on the entirety of California workers' compensation. It is found in the online version at the end of the standard chapters, titled Special Report: A Close Look at SB 863. Over the next few months, its contents will be fully integrated into the body of the work. In the meantime, readers of the electronic version will note that we have linked directly to related sections. If you are a subscriber and *logged in*, clicking on any link in the text will take you directly to that topic in the online edition of "Sullivan on Comp" hosted by our partner, WorkCompCentral.

Non-subscribers can learn more at http://www.workcompcentral.com/sullivan.

A NOTE ABOUT STATUTORY AND LEGISLATIVE ABBREVIATIONS

Abbreviations are used throughout the text to reference California legislation, and California and federal legal code statutes. Codes that are less frequently referenced are spelled out. These are the most common abbreviations:

AB - Assembly Bill
BPC - Business and Professions Code
CCR - California Code of Regulations
CCP - Code of Civil Procedure
CFR - Code of Federal Regulations
GC - Government Code
IC - Insurance Code
LC - Labor Code
SB - Senate Bill
UIC - Unemployment Insurance Code
U.S.C. - United States Code
VC - Vehicle Code

1. SB 863: WHEN LAWS TAKE EFFECT

INTRODUCTION

Generally, new laws take effect at the beginning of the following calendar year (Jan. 1, 2013), as long as they are signed by the governor 90 days before January 1 (GC 9600). This is expected to happen for SB 863. The new legislation was not identified as an "urgency statute," and as such, none of the provisions applies immediately with the governor's signature.

Note that procedural changes in the law take effect for all cases regardless of the date of injury, unless there has been a final order for the issue in question. Final orders denote that the time for all appeals has been exhausted. So, come the beginning of the year, there will be a sudden change in many aspects of existing cases. Parties should start looking at their cases differently.

Some statutes such as the permanent disability benefit increase explicitly apply only to injuries occurring on or after Jan. 1, 2013. A few say that they apply only for dates of injury after Jan. 1, 2014. Other statutes apply in 2013 but are dependent on the issuance of supporting regulations. They're all explained below.

LAWS TAKING EFFECT JAN. 1, 2013 FOR ALL DATES OF INJURY

1. **Permanent Disability Payments.** LC 4650(b)(2). Payments of permanent disability not required without an award if applicant has returned to work under certain conditions.
2. **Interpreters.** LC 4600(g) and LC 4620(d). Encoding applicant's entitlement to interpreter at a treating doctor's appointment and defense duty to arrange for it, and encoding applicant's entitlement to an interpreter at a medical-legal evaluation and employer's obligation to arrange it. Both bar provisionally certified interpreters.
3. **Interpreters.** LC 5710 and LC 5811. Defense to make arrangements for interpreters at deposition of applicant on request, and defense general duty to make arrangements for interpreters.
4. **Carve-Outs.** LC 3201.5(i) and LC 3201.7(h). Repealed, eliminating annual requirement for detailed reports to Legislature.
5. **Self-Insurance.** Plethora of changes to administration of self-insureds and changes to administration of public agencies, unlawfully uninsured employers and temporary agencies.
6. **Predesignation.** LC 4600(d). Predesignation if nonindustrial health care is provided by someone other than employer.
7. **MPN Requirements.** LC 4616(a). "Goal that at least 25 percent" of MPN physicians practice nonindustrial health care eliminated.
8. **MPN Requirements.** LC 4616(b). All MPN plans to have quality control procedures, geocoding of network physicians and other approval factors.

9. **MPN Requirements.** LC 4616(g). Notification for parties buying and selling MPN services.
10. **MPN Requirements.** LC 4616(b). MPNs approved for only four years. Commencing Jan. 1, 2014, existing plans deemed approved for a period of four years from date of most recent application or modification.
11. **Proof of MPNs.** LC 4616(b)(1). Presumes MPN status at appeals board once network is approved by administrative director.
12. **Escaping the MPN.** LC 4616.3(b). Loss of medical control for failing to properly notice MPN only if it results in denial of care.
13. **Escaping the MPN.** LC 4616.3(a)(2). Transfer into MPN barred after finding that treatment outside network was allowable; bars payment to physician and relieves defense of "consequences of treatment" after finding that such treatment was improper.
14. **Admissibility of MPN reports.** LC 4605. Medical reporting prepared outside MPN may not be sole basis of award, but must be corroborated.
15. **MPNs and Expedited Hearings.** LC 5502(b). Expedited hearings over MPN issues, as well as disputes over medical treatment appointments or medical-legal examinations.
16. **Appearance by Nonlawyers.** LC 4907. Expanded grounds on which nonlawyers may be barred from appearing before appeals board.
17. **Treatment Limitations.** LC 4604.5(c)(2). More than 24 therapy visits not a waiver of objection to future requests.
18. **Chiropractors.** LC 4600(c). Chiropractor as treating physician terminated once 24-adjustment maximum has been reached.
19. **Chiropractors.** LC 139.2(h)(3)(B). Liberalized restrictions of requirements for chiropractors to become QMEs.
20. **Limitations on Home Health Care.** LC 4600(h). Home health care must be prescribed by doctor of medicine or osteopathy, and no liability exists for more than 14 days before prescription.
21. **Limitations on Home Health Care.** LC 4603.2(b)(1). New reporting and itemization requirements.
22. **Limitations on Home Health Care.** LC 5307.8. No services provided before injury by a member of applicant's household are compensable.
23. **Voucher.** LC 4658.5(d) and LC 4658.7(f). Two- or five-year time limit on use of voucher issued after Jan. 1, 2013.
24. **Voucher.** LC 4658.5(e) and LC 4658.7(i). Injuries occurring during use of voucher not compensable.
25. **QME Process.** LC 139.2(h)(3)(B). QMEs may not conduct examinations at more than 10 offices.
26. **QME Process — In "Pro Pers".** LC 139.2(h)(1). Medical Unit to give preference to in *pro per* cases in sending out QME panels.
27. **QME Process — In "Pro Pers".** LC 139.2(h)(1). *Pro per* has right to choose a QME if panel not issued 20 days from request, rather than 15. Must be within a reasonable geographic area.
28. **QME Process — In "Pro Pers".** LC 4061(d)(1). Parties in an unrepresented case may seek supplemental report to correct "factual errors" within 30 days of receiving panel report.
29. **QME Process — Represented Cases.** LC 4062.2(b). Requirement that parties negotiate for AME before obtaining QME eliminated.
30. **QME Process — Represented Cases.** LC 4062.2(c). Requirement that parties negotiate for AME after receiving QME panel eliminated.
31. **QME Process — Represented Cases.** LC 4062.2(f). Parties allowed to use AME at any time.
32. **Communications With AMEs.** LC 4062.3. Communication with AMEs regarded as distinct from QMEs.
33. **Communications With AMEs and QMEs.** LC 4062.3(f). Communications considered improper ex parte with AMEs and QMEs limited.
34. **Attorneys' Fees.** LC 4064(c) and LC 4063. If employer files DOR (not an application) and in *pro per* applicant gets a lawyer, attorney's fees owed for services "in connection with the DOR."

35. **Attorneys' Fees.** LC 4066. Repealed. Had provided that attorneys' fees owed if employer filed application to contest AME.
36. **Utilization Review.** LC 4610(g)(6). UR denials remain in effect for 12 months.
37. **Utilization Review.** LC 4610(g)(7). Employer not required to submit request for treatment to UR if claim or body part at issue.
38. **Independent Bill Review.** LC 4603.2(b)(2). New requirements for medical providers to serve employers with documents and information. Also time limits for paying for or objecting to bills changed from "working days" to calendar days.
39. **Independent Bill Review.** LC 4603.2(e)(1) and LC 4622(b). If a bill is reduced by employer, second request for payment must be made within 90 days or lien is waived.
40. **Liens.** LC 4903.05(b). Almost all liens must be filed over Internet or using proper optical recognition forms.
41. **Liens.** LC 4903.05(c). Filing fee required for all liens filed on or after Jan. 1, 2013.
42. **Liens.** LC 4903.06. Activation fee required for all liens filed before Jan. 1, 2013. Must be paid by Jan. 1, 2014, or with first DOR/lien conference.
43. **Liens.** LC 4903.07. Activation and filing fees recoverable under specific conditions, including favorable award.
44. **Liens.** LC 4903.1(b). Toughened conditions for HMOs and like entities when they should have known injury was work related.
45. **Liens.** LC 4903.5. Statute of limitations allow only three years from services provided for filing liens, and 18 months for services provided after July 1, 2013.
46. **Liens.** LC 4903.6. Time restrictions when lien may be filed limited to after time periods have passed for IMR and IBR.
47. **Liens.** LC 4903.6(b). Lien claimants required to notify parties when they obtain or change representation.
48. **Liens.** LC 4903.06(d). Nonphysician lien claimants not entitled to receive private medical information about applicant.
49. **Liens.** LC 4903.8. Assignment of liens to other parties restricted except in rare circumstances.
50. **Illegal Referrals.** LC 139.32. Referrals in the system restricted further from physicians to just about any interested party.
51. **Vocational Experts.** LC 5703(j). Opinions of vocational experts allowed as evidence.

LAWS TAKING EFFECT JAN. 1, 2013 BUT REQUIRING ADMINISTRATIVE ACTION FIRST

1. **Interpreters.** GC 11435.30(c) and GC 11435.35(c). Administrative director to contract with outside agency to establish, or establish on his or her own, list of interpreters certified at WCAB and medical exams. Various changes in the Labor Code allow use of certified interpreters only.
2. **Permanent Disability.** LC 4660.1. 2013 schedule to be developed; age and occupation modifiers from 2005 schedule used until then.
3. **Return-to-Work Program.** LC 139.48. Agency established and managed by administrative director to distribute $120 million dollars per year to injured workers lacking fair permanent disability compensation.
4. **Limitations on Home Health Care.** LC 4600(h) and 5307.8. Administrative director to create fee schedule for home health-care services not covered by OMFS. To be adopted by July 1, 2013.
5. **Independent Bill Review.** LC 139.5, LC 4603.6. All disputes over costs of medical services reviewed by third party. Administrative director to make rules and contract with experts.
6. **Fee Schedules.** LC 5307.1. Administrative director to create new schedule of fees to include physician and nonphysician services. Modification of fees to outpatient surgery centers and home health care.

7. **Fee Schedules.** LC 5307.9. Administrative director to create new schedule of fees for copy services.

LAWS TAKING EFFECT FOR DATES OF INJURY ON OR AFTER JAN. 1, 2013

1. **Death Benefits.** LC 4701(a)(3). Burial expenses raised to $10,000.
2. **Permanent Disability.** LC 4453(d)(8) and LC 4453(d)(9). Increase in the weekly benefit, both minimum and maximum; another increase for DOI on or after Jan. 1, 2014.
3. **Permanent Disability.** LC 4658(e). Fifteen percent bump removed.
4. **Permanent Disability.** LC 4660.1. New standards for rating impairment include elimination of the DFEC modifier and 1.4 multiplier for all impairments.
5. **Permanent Disability.** LC 4660.1(c)(1). Permanent disability add-ons for sleep dysfunction, sexual dysfunction and psychiatric disorders disallowed for most cases.
6. **Voucher.** LC 4658.7(b). New standards for what precipitates employer's time limit to offer work to applicant to avoid liability for voucher.
7. **Voucher.** LC 4658.7(c). Employer has 20 days from new 60-day period to provide offer of voucher.
8. **Voucher.** LC 4658.7(d). Voucher amount changed to flat rate of $6,000.
9. **Voucher.** LC 4658.7(e). Expanded list of services for which a voucher may be used.
10. **Voucher.** LC 4658.7(g). Voucher may not be settled or commuted.
11. **Independent Medical Review.** LC 4610.5 and LC 4610.6. All disputes concerning medical care denied by UR to be resolved solely by the IMR process. As of July 1, 2013, applies to all dates of injury.

LAWS TAKING EFFECT ON JAN. 1, 2014 FOR ALL DATES OF INJURY

1. **MPN Requirements.** LC 4616(a)(3). Treating physician in MPN to send written acknowledgment of being a member.
2. **MPN Requirements.** LC 4616(a)(4). All MPNs to post Internet roster of physicians, updated quarterly.
3. **MPN Requirements.** LC 4616(a)(5). All MPNs to provide telephone assistance to injured workers trying to locate a treating physician in the network.

2. PERMANENT DISABILITY REFORMED

SB 863 was the result of a deal: Applicants get more permanent disability, and employers get the benefit of many reforms. The amount of money to be received by employees for each percentage of disability has been increased for future claims, potentially by hundreds of millions of dollars. Changes, however, were enacted to eliminate questionable claims of disability-related physical injuries, making it more difficult to reach the same percentage of permanent disability. The increase and the employers' benefits are the result of statutory changes for injuries starting Jan. 1, 2013.

INCREASES IN PERMANENT DISABILITY — CHANGING THE WEEKLY RATE

It's well known that, on a finding of permanent and stationary status, permanent disability is paid out every two weeks to injured workers. The benefit is paid for a certain number of weeks at a determined rate. (For a general discussion of this, see "Sullivan on Comp" Section 10.61 Compensation Rate.) New LC 4658(e) establishes the number of weeks for injuries on or after Jan. 1, 2013, but the weeks were not changed by SB 863. The amount of weekly permanent disability, however, has been increased.

There are statutory minimums and maximums for the weekly rate of permanent disability. They are established by statutory minimums and maximums for the applicant's average weekly earnings, which are defined in LC 4453. Permanent disability is two-thirds of earnings within those limits. Applicants with sufficient earnings usually can hit the maximum.

Permanent disability was enhanced in part by increasing the statutory maximum allowable wage for purposes of calculating permanent disability. The increases are found in the new LC 4453(d)(8), which concerns injuries occurring on or after Jan. 1, 2013, and the new LC 4453(d)(9), which applies to injuries occurring on or after Jan. 1, 2014.

Under both statutory provisions, the minimum earnings rate for purposes of calculating permanent disability is $240 per week. So the minimum permanent disability rate is $160 per week — two-thirds of $240. This is higher than the previous rate — for dates of injury on or after Jan. 1, 2006, the minimum permanent disability was $130 per week.

The maximum earnings rate is a little more complicated. For dates of injury on or after Jan. 1, 2013, the maximum rate is: $345 for injuries with permanent disability less than 55 percent; $405 for injuries with permanent disability between 55 and 69 percent; and $435 for injuries with permanent disability between 70 and 99 percent. They result in permanent disability rates of $230, $270 and $290 per week respectively.

The raise is even higher for cases with a date of injury on or after Jan. 1, 2014. Their minimums remain the same, but the maximum earnings is always $435. So as long as the applicant's wage is sufficient, his or her permanent disability rate is $290, regardless of the percentage of partial permanent disability.

This is a big increase. For cases with dates of injury before Jan. 1, 2006, the maximum weekly permanent disability payment, depending on the percentage of disability, was between $230 and $270. Assuming that the applicant's wage sustains the calculation, permanent disability can more than double in smaller cases, and do much better in medium or larger cases. As discussed below, there have been changes in the way the rating string is done as well. Altogether, this should lead to more than a 50 percent increase in permanent disability introduced over the next few years.

COMMENCEMENT OF PERMANENT DISABILITY PAYMENTS

Generally, LC 4650(b) provides that if an injury causes permanent disability, the first payment must be made within 14 days after the date of the last payment of temporary disability. (For a full discussion of the general process, see "Sullivan on Comp" Section 10.62 Payment of Permanent Disability Indemnity.) The employer is required to continue these payments until its reasonable estimate of permanent disability indemnity due has been paid, and if that amount has been determined, until it has been paid.

LC 4650(b), however, was amended to provide that a worker is not automatically entitled to permanent disability indemnity benefits following the last payment of temporary disability. The new LC 4650(b)(2) provides, "Prior to an award of permanent disability indemnity, a permanent disability indemnity payment shall not be required if the employer has offered the employee a position that pays at least 85 percent of the wages and compensation paid to the employee at the time of injury or if the employee is employed in a position that pays at least 100 percent of the wages and compensation paid to the employee at the time of injury."

So permanent disability payments need not be made if (1) the employer makes the offer of a position that pays at least 85 percent of "wages and compensation," or (2) the applicant is working at the time the payment is owed and making what he or she did at the time of injury. A variety of issues here are immediately apparent.

Because the language in the first possibility provides that only an offer is required, it seems that the employer may delay the payment of permanent disability even if the employee does not accept the offer. It is unclear how long the employee has to accept the offer. Also, it would seem that the employer may delay to the point of an award regardless of whether the applicant accepts the offer, whether the offer is for work that is undesirable or even whether the offer is accepted and the employment ultimately does not work out; there is a money requirement, but no longevity is demanded statutorily.

There is no clear guidance on what, exactly, the offer must look like. Must it be in writing, or is an oral offer sufficient? Presumably, the offer must be made in good faith. Certainly a written offer is easier to prove in court. There are standards now for written offers that are required to avoid liability for a voucher[1] or a 15 percent increase under LC 4658,[2] and of course no employer wants to violate the FEHA requirements,[3] so employers are motivated now to provide solid offers of work. But there's little doubt that there will be considerable litigation over the nature of the required offer.

[1] See "Sullivan on Comp" Section 11.3 Supplemental Job Displacement Benefit.
[2] See "Sullivan on Comp" Section 11.4 Adjustment of Permanent Disability Payments for an Offer of Work.
[3] See "Sullivan on Comp" Chapter 11: Return To Work.

The employer is not required to commence permanent disability indemnity if the employee is working at a job that pays at least 100 percent of the wages and compensation at the time of injury. This is so even if that job is with another employer. It does not seem to matter how long the applicant has been off work, or whether wage rates have changed over that time.

It is not clear, however, what happens if the applicant's employment situation changes before an award issues. Does the employer have to start advances if circumstances change? Suppose an employed applicant is on permanent and stationary status, and initially is returned to his old job. Permanent disability advances are not made. Later, the applicant becomes unemployed, or makes less money. It may be that the applicant can move in and out of a status in which he or she is entitled to weekly payments. If so, the odd effect is to provide some reward to the applicant who is no longer working, especially in cases in which the applicant is entitled to the minimum permanent disability weekly rate.

Understanding what, exactly, constitutes "wages and compensation" will be another challenge. What is included in that language and what is not? It is likely the courts will turn for guidance to the body of law on what may and may not be used to calculate the average weekly earnings for purposes of figuring indemnity benefits. This law is discussed in depth in "Sullivan on Comp" Section 8.2 Benefits Included in Calculation of Average Weekly Earnings.

Along these lines, it is notable that the payment of permanent disability is not required to be made in such return-to-work cases except on the issuance of an award. It is quite common in workers' compensation cases for an award to issue only after the parties have worked through the issues and settled the case. Once the award issues, permanent disability is paid retroactively to the applicant's last payment of temporary disability or permanent and stationary date, as it normally would. So in these cases a lump sum will be common.

This should have some broad effects. Applicants who are in *pro per* will be more motivated financially to consent to claims adjusters' requests that they sign a stipulation. Sometimes permanent disability advances can be a barrier to settlement, and this rule may help with that problem. Perhaps applicants will be more motivated to resolve cases more quickly if no payments are being made along the way.

Note that this is a procedural change, and there is no provision that it applies only as of a certain date, or that it applies only to certain dates of injury. So when the bill goes into effect in 2013, this change should apply to all cases lacking a final order to the contrary. This may be a bit sudden. Claims adjusters will be challenged to look at their existing caseload and determine whether permanent disability benefits will be stopped.

ELIMINATION OF 15 PERCENT ADJUSTMENT FOR RETURN TO WORK

LC 4658(d)(2) provides that for injuries occurring on or after Jan. 1, 2005, permanent disability benefits must be increased by 15 percent if the employer does not offer the injured employee regular, modified or alternative work within 60 days of the disability becoming permanent and stationary. And LC 4658(d)(3) requires PD benefits to be decreased by 15 percent if the employer does offer the injured employee regular, modified or alternative work within 60 days of the disability becoming P&S. This rule is discussed in depth in "Sullivan on Comp" Section 11.4 Adjustment of Permanent Disability Payments for an Offer of Work.

Many claims adjusters will breathe a sigh of relief that this procedure has been eliminated entirely. LC 4658(e), which applies to injuries occurring on or after Jan. 1, 2013, contains no provision allowing for an adjustment of permanent disability benefits based on the employer's ability to return an injured employee to work. So the 15 percent permanent disability adjustment has been eliminated for injuries occurring on

or after Jan. 1, 2013. This is a boon for employers, because the finances usually worked against them, and because of the difficulties administrating this part of the benefit.

A NEW PERMANENT DISABILITY SCHEDULE

When LC 4660 was amended in 2004, the administrative director was mandated to produce a new schedule for rating permanent disabilities. This commonly was called the 2005 Schedule, as it applied to injuries occurring on or after Jan. 1, 2005.[4] This schedule remains in place for all dates of injury from Jan. 1, 2005 through the end of 2012. But there will be a new schedule for dates of injury on or after Jan. 1, 2013, and that schedule will be fundamentally different from its predecessors.

Characteristics of the 2013 Schedule

Under LC 4660, the 2005 Schedule was required to take into account "the nature of the physical injury or disfigurement" incorporating "the descriptions and measurements of physical impairment and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition)." The schedule also was required to take into account the age and occupation of the injured employee at the time of injury. These statutory standards resulted in a "rating string" for the well-known schedule, featuring a basic impairment percentage determined under the AMA guides, and then an adjustment for the injured worker's (1) age; (2) occupation; and (3) diminished future earning capacity (DFEC).

As part of SB 863, LC 4660 was amended to apply only to injuries occurring before Jan. 1, 2013. For injuries occurring on or after that date, LC 4660.1 was added, under which the rating string will look much the same, but there are some truly fundamental changes. The administrative director is charged with creating the new schedule.

Like the 2005 Schedule, LC 4660.1(b) requires the "nature of the physical injury or disfigurement" to incorporate "the descriptions and measurements of physical impairment and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition)". So the first step in the rating process still is determining the appropriate impairment under the AMA guides.

But the DFEC part of the rating string has been eliminated. The new LC 4660.1(a) simply does not require it. Instead, under LC 4660.1(b), the impairment rating under the AMA guides is to be increased in every case by a 1.4 multiplier. That is, once the impairment has been determined, it is increased by 40 percent. This is a big change; it is a benefit increase. Under the 2005 Schedule, the DFEC modifier would adjust the rating from 1.1 to 1.4. Under the new structure, the applicant in every case receives what was previously the maximum possible adjustment. All workers and all injuries will be treated equally, a point some people might find objectionable.

Per LC 4660.1(d), the administrative director is authorized to formulate a schedule of occupational and age modifiers. Until that schedule is amended, injuries occurring on or after Jan. 1, 2013, will be rated using the occupational and age modifiers of the 2005 Schedule, without regard for the modifiers for DFEC. That is, until the new schedule is adopted, permanent disability will be rated using the 2005 Schedule, except that the modifiers for diminished future earning capacity will not apply.

[4] The 2005 Schedule is discussed in depth in "Sullivan on Comp" Section 10.15 Use of the 2005 Permanent Disability Schedule.

Elimination of Add-On for Sleep Dysfunction, Sexual Dysfunction and Compensable Psychiatric Disorder

LC 4660.1(c)(1) states that "[T]here shall be no increases in impairment rating for sleep dysfunction, sexual dysfunction, and compensable psychiatric disorder, or any combination thereof, arising out of a compensable physical injury." So injured workers no longer are allowed to add permanent disability for sleep dysfunction, sexual dysfunction and/or a psychiatric disorder that flows from a physical injury.

Where does this new rule come from? Following the enactment of SB 899 and the 2005 Schedule, applicant attorneys often reacted to the reduction in permanent disability by adding claims of sleep dysfunction, sexual dysfunction and psychiatric disorder in order to increase the permanent disability of injured workers. Section 1 of SB 863 explains that "in enacting subdivision (c) of Section 4660.1 of the Labor Code, the Legislature intends to eliminate questionable claims of disability when alleged to be caused by a disabling physical injury arising out of and in the course of employment."

Note that such add-ons to permanent disability are prohibited only when they arise out of a compensable "physical" injury. Obviously, that term can be debatable; it probably will include internal as well as orthopedic injuries. Will it include such things as rheumatological claims? (Perhaps guidance can be found in the case law pertaining to the distinction between psychological and physical injuries as discussed in "Sullivan on Comp" Section 5.29 Psychiatric Injury — In General.) In any case, it is clear that psychological, sleeping or sexual issues can result in permanent disability if they stand on their own, or if the physical injury is a result of one of them. It is not difficult to see issues arising under LC 3208.3 (for example, the predominant cause standard or the good-faith personnel defense)[5] if there is a psychological condition from both a compensable consequence to physical injury and an independent source. Heavy litigation is sure to ensue.

It is clear that this is a prohibition against permanent disability only. Nothing is said about other benefits — such as medical treatment or temporary disability — being prohibited, so they won't be. This perspective explicitly is validated by LC 4660.1(c)(1), which states that "Nothing in this section shall limit the ability of an injured employee to obtain treatment for sleep dysfunction, sexual dysfunction, or psychiatric disorder, if any, that are a consequence of an industrial injury."

There are explicit exceptions to this rule. LC 4660.1(c)(2)(A) provides that a compensable psychiatric disorder may increase the impairment rating if it "resulted from being a victim of a violent act or from direct exposure to a significant violent act within the meaning of Section 3208.3." This language exactly mirrors that of LC 3208.3(b)(2), which states that the "predominant cause" standard required for compensability of psychiatric claims is lowered to a "substantial cause" standard when this sort of violence occurs. There is little case law defining this term (see "Sullivan on Comp" Section 5.30 Psychiatric Injury — Predominant Cause and Actual Events of Employment).

Another exception is laid out in LC 4660.1(c)(2)(B), which allows for an increase to the permanent disability rating in cases of "catastrophic injury, including, but not limited to, loss of a limb, paralysis, severe burn, or severe head injury." The term "catastrophic injury" appears nowhere in the Labor Code or the regulations, with the singular and unhelpful exception being CCR 9767.9; that regulation simply mentions the term in association with the "serious and chronic condition" exception that applies in cases in which care is transferred into a medical provider network (for a full discussion, see "Sullivan on Comp" Section 7.57 MPN — Transfer of Care). We may look to the exceptions to the two-year restriction on temporary disability; LC 4656(c)(3) (discussed in full in "Sullivan on Comp" Section 9.14 Time Limits on Payments on or After April 19, 2004) does list amputation and severe burns, so the case law there probably

[5] See several sections of "Sullivan on Comp" Chapter 5: Injury that discuss this statute.

will coincide. At the end of the day, though, the courts will have to tell us what this means in borderline cases.

New Schedule Applies in Cases of Both Permanent Partial and Permanent Total Disability

Per LC 4660.1(a), the new PD schedule must be used "[i]n determining the percentages of permanent partial or permanent total disability." This change eliminates any interpretation that the new permanent disability schedule applies only to cases of permanent partial disability, and not to cases of permanent total disability.

Why is this important? Several cases have held that the 2005 Schedule adopted under LC 4660 applies only to permanent partial disability. Those cases reasoned that because LC 4660 is used for determining "the percentages of permanent disability," and LC 4662 allows the appeals board to determine permanent total disability "in accordance with the fact," LC 4660 applies only to cases involving permanent partial disability, and that LC 4662 applies to cases involving permanent total disability.[6]

Because LC 4660.1(a) provides that the new schedule applies in cases of both permanent partial and permanent partial disability, the appeals board may not simply reject the use of the schedule to find permanent total disability based on the amorphous standards of LC 4662. Note, however, that this does not mean that LC 4662 is invalidated in cases in which there is a valid conclusive presumption of total permanent disability. LC 4660.1(g) states that "Nothing in this section shall preclude a finding of permanent total disability in accordance with Section 4662."

Rebutting the New Schedule

LC 4660.1(d) also provides, "The Schedule for Rating Permanent Disability pursuant to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) and the schedule of occupational modifiers ... shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." This language has long been interpreted to mean that a permanent disability rating based on the schedule is rebuttable.[7]

As stated in *Milpitas Unified School District v. WCAB (Guzman),*[8] "A statute providing that a fact or group of facts is prima facie evidence of another fact establishes a rebuttable presumption. Accordingly, as prima facie evidence the Schedule is not absolute, binding and final. It is therefore not to be considered all of the evidence on the degree or percentage of disability. Being prima facie it establishes only presumptive evidence (which) may be controverted and overcome."[9] So the new schedule for injuries on or after Jan. 1, 2013 will be rebuttable.

There is a long line of cases and many considerations on the issue of how and when the schedule may be rebutted (see "Sullivan on Comp" Section 10.17 Getting Away from the Schedule). There will be challenges to the existing judicial framework.

What appears undisturbed by SB 863 are the *Almaraz/Guzman* cases, which allow the "nature of the physical injury or disfigurement" under the AMA guides to be rebutted by evidence within the "four

[6] See e.g., *Edwards v. Caltrans,* 2011 Cal. Wrk. Comp. P.D. LEXIS 429; *Cordova v. Garaventa Enterprises,* 2011 Cal. Wrk. Comp. P.D. LEXIS 523; *Coca-Cola Enterprises, Inc. v. WCAB (Jaramillo)* (2012) 77 CCC 445 (writ denied). For a full discussion, see "Sullivan on Comp" Section 10.2 Permanent Disability — Partial and Total.
[7] See *Universal City Studios, Inc. v. WCAB (Lewis)* (1979) 44 CCC 1133, 1143; *Glass v. WCAB* (1980) 45 CCC 441, 449.
[8] (2010) 75 CCC 837.
[9] *Milpitas Unified School District v. WCAB (Guzman)* (2010) 75 CCC 837, 852 (quotations and citations omitted).

corners" of the guides. Those cases allow a physician to utilize any chapter, table or method in the guides to assess an injured worker's whole person impairment, provided that his or her opinion is supported by substantial evidence. New LC 4660.1(h) states that "In enacting the act adding this section, it is not the intent of the Legislature to overrule the holding in Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808." So the *Almaraz/Guzman* cases will remain in effect.

Whether the schedule can be rebutted under *Ogilvie* is not so clear.[10] *Ogilvie* in its original form outlined ways to rebut the DFEC modifier, and in its final form at the Court of Appeal this possibility remained. Obviously, this form of rebuttal would not be a possibility when there is no more DFEC modifier.

Ogilvie, however, emphasized rebuttal of the 2005 Schedule primarily as a rebuttal of the entire schedule. This form of rebuttal seems to remain quite viable — although admittedly the Court of Appeal gave little guidance on the mechanics or actual substantive standard for such a rebuttal. It did uphold the rule in the classic *LeBoeuf* case[11] that an employee effectively rebuts the scheduled rating when he or she will have an overall greater loss of future earnings than reflected in a rating because, due to the industrial injury, he or she is not amenable to rehabilitation.

But there are problems even with this idea. As described above, in some circumstances, increasing permanent disability based on add-ons such as psyche, sleep or sex disorders is prohibited (LC 4660.1(c)(1)). What if there were a case with 10 percent disability due to industrial physical injury, but the psyche portion would have added enough impairment to make the ultimate rating 80 percent? Such an increase would be prohibited. Under *Ogilvie,* would the applicant then be able to rebut the schedule as a whole to show a greater overall impairment? It would seem not, but the rules for such a situation will have to be sorted out.

Vocational Experts

Ogilvie also recognized that "[f]or many years, determining the degree of permanent disability sustained due to an injury involved consideration of the opinions of vocational rehabilitation specialists concerning the employee's ability to compete in the open labor market." Before the passage of SB 863, it was well settled that such evidence, in principle, is admissible. Such evidence is marshaled almost exclusively when a party wishes to try and rebut the schedule.

LC 5703(j) is added, explicitly allowing the appeals board to receive into evidence the testimony of vocational experts. This is the first time that a workers' compensation statute has recognized the legitimacy of this evidence.

This statute provides rules for such evidence, saying that "If vocational expert evidence is otherwise admissible, the evidence shall be produced in the form of written reports. Direct examination of a vocational witness shall not be received at trial except upon a showing of good cause. A continuance may be granted for rebuttal testimony if a report that was not served sufficiently in advance of the close of discovery to permit rebuttal is admitted into evidence."

So, like that of medical experts, the evidence from a vocational expert must be produced in the form of a written report, and testimony at trial is permitted only on a showing of good cause.

Sworn statements are required. LC 5703 (j)(1) goes on to state that bills from such experts are admissible only in the same way as doctors' bills (described in LC 5703(a)); that is, they must state, under penalty of

[10] *Ogilvie v. WCAB* (2011) 76 CCC 624.
[11] *LeBoeuf v. WCAB* (1983) 48 CCC 587.

perjury, that they are true and correct to the best knowledge of the physician. LC 5703 (j)(2) states that "Reports are admissible under this subdivision only if the vocational expert has further stated in the body of the report that the contents of the report are true and correct to the best knowledge of the vocational expert. The statement shall be made in compliance with the requirements applicable to medical reports pursuant to subdivision (a)." The referenced subdivision (a) requires that "In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury."

Although the opinions of vocational experts now are admissible, so far no clear rules have been established on how a vocational expert's opinion should be used at trial. Can a vocational expert's opinion alone support an award, or must it be consistent with a medical opinion? Suppose an AME reports that an applicant is not 100 percent disabled, but the vocational expert reports that the applicant cannot return to work based on his or her injuries? Which opinion should prevail? At least one recent panel decision has concluded that a vocational expert's opinion is not substantial evidence if it is inconsistent with the physician's findings.[12] The roles of vocational experts and medical experts in determining an applicant's permanent disability will need to be clarified further by the courts.

NEW RETURN-TO-WORK PAYMENTS

In the final hours of negotiating SB 863, concerns remained that some applicants would not receive adequate permanent disability. In an effort to close this perceived gap, it was agreed that a special fund would be created for these claimants.

Under the new LC 139.48, a "return-to-work program" is to be created. It is to be a creature of regulation and overseen and administered by the director of Industrial Relations. The program is to be funded by employers to a total annual amount of $120 million. This money is to come from "non-General Funds of the Workers' Compensation Administration Revolving Fund." That fund is established by LC 62.5 (the statute did not have to be amended by SB 863 to refer to this change, as a previous return-to-work program was enacted and repealed under LC 139.48). Because this fund is established by employer contributions, the millions required will derive from assessments against California employers.

How this will work, what it will provide injured workers (money or services?), the criteria used for eligibility and just about all particular aspects of this new law will have to await regulations. The statute says that it is created "for the purpose of making supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss." This doesn't seem like a return-to-work program per se, as it calls for payment of money. The administrative director's discretion may or may not be circumscribed by this. The statute goes on to say that "Eligibility for payments and the amount of payments shall be determined by regulations adopted by the director, based on findings from studies conducted by the director in consultation with the Commission on Health and Safety and Workers' Compensation." So unspecified studies and a regulatory plan must be created. Because the statute does not specifically say, it probably applies to all dates of injury once the required regulations are enacted.

Litigation is sure to follow. One wonders how the provisions of this program will relate to an applicant's right to try and rebut the permanent disability schedule. If the applicant does rebut the schedule, does he or she have the right to monies from the program? Or if the applicant fails to rebut the schedule in court, will collateral estoppel apply? Could there be credit issues?

[12] *Jones v. Los Angeles Unified School District,* 2012 Cal. Wrk. Comp. P.D. LEXIS 296.

These and other issues will have to be resolved in the court system for many years after the regulations are enacted. What we do know now is that the appeals board will have the ultimate say. The statute provides that “Determinations of the director shall be subject to review at the trial level of the appeals board upon the same grounds as prescribed for petitions for reconsideration.” So if there is an issue, a trial *de novo* is in order.

3. SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

A few changes were made to the rules regarding vouchers for cases before the end of 2012. For injuries occurring on or after Jan. 1, 2013, the voucher program is outlined in the new LC 4658.7. This section makes several changes to that program, including the conditions under which an injured worker is entitled to the voucher, the amount of the voucher and the expenses for which it may be used. It also specifies that settlement of a claim for the voucher is not permitted. All are very significant changes.

For a complete discussion of the voucher see "Sullivan on Comp" Section 11.3 Supplemental Job Displacement Benefit.

CHANGES TO VOUCHER RULES FOR DATE OF INJURY BEFORE JAN. 1, 2013

LC 4658.5 establishes supplemental job displacement benefit, commonly called the voucher, for all dates of injury on or after Jan. 1, 2004, and before Jan. 1, 2013. Before SB 863, there was no time limit on how long the employee had to use the voucher. To rectify this, LC 4658.5(d) states that "A voucher issued on or after January 1, 2013, shall expire two years after the date the voucher is furnished to the employee or five years after the date of injury, whichever is later."

So the statute provides a time limit of two years after the date the voucher is furnished or five years after the date of injury, but the time limit applies only to a voucher issued on or after Jan. 1, 2013, regardless of the date of injury. It does not address vouchers issued before 2013. This may be a mistake, or it may be an attempt to protect vouchers issued before Jan. 1, 2013. Either way, LC 4658.5(d) does not state any time limit for vouchers issued before Jan. 1, 2013. Still, there is a limit on all vouchers issued after Jan. 1, 2013, regardless of the date of injury.

Also, added language in LC 4658.5(e) specifies that an employer is not liable for injuries incurred by the employee while using the voucher. That's an important point, too. In years past, there was a benefit called vocational rehabilitation. Injuries occurring while participating in that benefit were compensable.[1] The question was open, however, whether that idea held true for use of the voucher, but not anymore.

ELIGIBILITY FOR SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

The conditions under which an injured worker is eligible for the supplemental job displacement benefit for dates of injury after Jan. 1, 2013 are established in LC 4658.7(b). It entitles a permanently partially disabled

[1] For a discussion of vocational rehabilitation see "Sullivan on Comp" Section 11.2 Vocational Rehabilitation — Repealed.

worker to the voucher unless, the employer makes an offer of regular, modified or alternative work, as defined in LC 4658.1, that meets these criteria:

1. The offer is made no later than 60 days after receipt of the first report received from either the primary treating physician, an agreed medical evaluator or a qualified medical evaluator finding that the disability from all conditions for which compensation is claimed has become permanent and stationary, and that the injury has caused permanent partial disability.
2. The offer is for regular, modified or alternative work lasting at least 12 months.

LC 4658.1 defines regular work as the employee's usual occupation or the position in which he or she was engaged at the time of injury and offers wages and compensation equivalent to those paid to the employee at the time of injury. "Modified work" is "regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury." "Alternative work" is "work that the employee has the ability to perform, that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury." All forms of work must be located within reasonable commuting distance of the employee's residence at the time of injury.

Per LC 4658.6, for dates of injury before Jan. 1, 2013, the employer would have to offer the applicant work within 30 days of terminating temporary disability payments to avoid the voucher. And the offer would have to: (1) be within the applicant's ability to perform the essential functions of the job; (2) last at least 12 months; (3) have compensation within 85 percent of the wages the applicant made at the time of injury; and (4) be located within a reasonable commuting distance. So, per 4658.7 and LC 4658.1, all of those requirements remain for dates of injury after Jan. 1, 2013, including work that must last for 12 months.

The time for issuance of the offer, however, changes. Instead of requiring an offer of regular, modified or alternative work within 30 days of the termination of temporary disability, LC 4658.7 allows the employer to offer regular, modified or alternative work within 60 days of receipt of a report finding that all conditions have become permanent and stationary and that the injury has caused permanent partial disability. The statute specifies that the report must be from a primary treating physician, an AME or a QME. So a report from a secondary treating physician would not trigger the 60-day time period.

Furthermore, the statute requires that the medical report that precipitates the offer must be made on a specific form created by the administrative director. The duty to determine whether regular, modified or alternative work is available is not triggered (at least for purposes of the voucher) until the employer receives this form notifying it that the applicant is permanent and stationary for all injuries. Until the form is created, the claims adjuster appears to have unlimited time to make the offer.

Per LC 4658.7(h)(2), the form is required to fully inform "the employer of work capacities and of activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work." This is intended to make it easier for an employer to perform the return-to-work analysis and understand the injured worker's work capacities so that it can make an informed decision.

Under LC 4658.7(b)(1)(A), the employer or claims adjuster has the option of providing the physician with a job description "of the employee's regular work, proposed modified work, or proposed alternative work." If the option is exercised, the physician is to "evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description."

Under LC 4658.7(b)(1)(B), the claims adjuster is to send the form to the employer "for the purpose of fully informing the employer of work capacities and activity restrictions resulting from the injury that are relevant to potential regular, modified, or alternative work." So this process dovetails with the interactive process. (For a full discussion of the employer's obligation to try and return the applicant to work, see "Sullivan on Comp" Section 11.9 Business Realities Defense.)

PAYMENT AND USE OF THE SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

LC 4658.7(c) requires an employer to offer an injured worker the supplemental job displacement benefit within 20 days after the window for making an offer of regular, modified or alternative work. So if the employer cannot offer the employee work within the 60-day period, it has 20 days to offer the voucher.

LC 4658.7(d) provides that the voucher may be redeemed for as much as an aggregate $6,000. For injuries occurring before Jan. 1, 2013, the amount varied from $4,000 to $10,000, depending on the level of disability. Now, for injuries on or after Jan. 1, 2013, all permanently partially disabled workers who are not timely returned to work are entitled to the same $6,000 for the voucher.

The expenses for which an injured worker could use the voucher were limited for injuries occurring before Jan. 1, 2013. An injured worker could use the voucher for payment of tuition, fees, books and other expenses required by the school for retraining and skill enhancement. He or she also could use 10 percent of the voucher for vocational or return-to-work counseling.

For injuries on or after Jan. 1, 2013, LC 4658.7(e) expands the expenses for which the voucher may be used. It allows it to be applied to:

1. payment for education-related retraining or skill enhancement, or both, at a California public school or with a provider that is certified and on the state's Eligible Training Provider List (ETPL), including payment of tuition, fees, books and other expenses required by the school for retraining or skill enhancement;
2. payment for occupational licensing or professional certification fees, related examination fees and examination preparation course fees;
3. payment for the services of licensed placement agencies, vocational or return-to-work counseling and resume preparation, for as much as a combined 10 percent of the amount of the voucher;
4. purchase of tools required by a training or educational program in which the employee is enrolled;
5. purchase of computer equipment for as much as $1,000;
6. as much as $500 for miscellaneous expense reimbursement or advance, payable on request without itemized documentation or accounting. The employee is not entitled to any other voucher payment for transportation, travel, telephone or Internet access, clothing or uniforms or incidental expenses.

This last provision may be especially significant. Use of the voucher has been quite rare since its inception. A $500 incentive may peak interest, especially given the new ease of use. The $1,000 for computer equipment no doubt will be quite a draw as well. Certainly, the defense will take the position that the money is not payable unless the employee shows that he or she is using the voucher for education.

Time for use of the voucher is limited. Per LC 4658.7(f), it expires two years after the date it is furnished, or five years after the date of injury, whichever is later. In addition, an employee is not entitled to payment or reimbursement of any expenses that have not been incurred *and* submitted to the employer with

appropriate documentation before the expiration date. So even if the employee timely incurred the expenses, the employer is not required to reimburse him or her if they were not timely submitted.

Also, an employer is not liable for compensation for injuries incurred by the employee while using the voucher.

NO SETTLEMENT OR COMMUTATION

LC 4658.7(g) precludes settlement or commutation of a claim for the supplemental job displacement benefit for injuries occurring on or after Jan. 1, 2013. So the benefit may be used only for the purposes outlined in the statute. Note that no similar prohibition was enacted for injuries occurring before Jan. 1, 2013. So the voucher still may be settled for older injuries.

Given this new rule, and the projected expanded use of the benefit, one wonders if applicant attorneys will begin to send letters asking the claims adjuster to withhold 15 percent from all monies paid, and, via petition, seek these fees after use of the voucher, as they did with vocational rehabilitation. If this is found to be appropriate, it may be a new revenue source for them.

4. MEDICAL TREATMENT LIMITATIONS

SB 863 made several changes affecting medical treatment for injured workers. The Legislature has reinforced the statutory limits on chiropractic care, occupational therapy and physical therapy established in LC 4604.5(d), and restricted the use of chiropractors as primary treating physicians. It also has made changes to the availability of home health care, limiting the individuals who can recommend it to doctors and restricting the amount of home health care available. Also, a home health-care fee schedule has been created.

STATUTORY LIMITS ON TREATMENT

LC 4604.5(d) has been redesignated as LC 4604.5(c). It still provides that for injuries occurring on or after Jan. 1, 2004, an employee will be entitled to no more than 24 chiropractic, 24 occupational therapy and 24 physical therapy visits per industrial injury. LC 4604.5(c)(2) still provides that the limits do not apply when the employer authorizes additional visits in writing. (For a full discussion, see "Sullivan on Comp" Section 7.22 Statutory Limitations on Therapy.)

But now, LC 4604.5(c)(2) also clarifies that payment or authorization beyond the 24-visit limits will not be deemed a waiver of them with respect to future requests for authorization. This change specifically is noted to be declaratory of existing law.

So if an employer either intentionally or unintentionally provides or authorizes more than 24 chiropractic, occupational therapy or physical therapy visits, it does not waive the right to deny further requests for treatment on the grounds that they exceed the statutory limits. Because this amendment is declaratory of existing law, it applies to all injuries occurring on or after Jan. 1, 2004, not just those occurring after the amendment.

LIMITATIONS ON CHIROPRACTORS AS TREATING PHYSICIANS

LC 4600(c) is amended to add this sentence: "A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allows by subdivision (d) of Section 4604.5." (Per the above, this reference is wrong — the prohibition has been changed to subdivision (c) of LC 4604.5; the error probably won't make any difference.) So this statute is intended to stop chiropractors from lingering as the primary treating physician in a case, and probably is meant to discourage chiropractors from taking that role in the first place.

Previously, case law allowed a chiropractor to continue as the primary treating physician after the visit cap defined in LC 4604.5 (d) had been reached.[1] Now, chiropractors may remain as a primary treating physician only until the applicant has received 24 chiropractic visits. (For a full discussion on the role of chiropractors in treatment, see "Sullivan on Comp" Section 7.12 Treatment by Authorized Physician.)

This change probably will be effective in its effort to reduce the number of chiropractors selected as primary treating physicians. An attentive chiropractor can get around this, though, simply by stopping treatments when the limit is approaching.

LIMITATIONS ON HOME HEALTH CARE

One of the specific purposes of SB 863 was to limit the provision of home health-care services as medical treatment to specific circumstances. Accordingly, the new LC 4600(h) provides that home health-care services will be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her industrial injury, and the care is prescribed "by a physician or surgeon licensed per Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code." Those references concern doctors of medicine and doctors of osteopathy. So a request for home health-care services is appropriate only from those practitioners. Requests for home health care from chiropractors, psychologists, acupuncturists and nurses needn't be honored.

LC 4600(h) adds that the employer will not be liable for home health-care services that are provided more than 14 days before the date of the employer's receipt of the physician's prescription. This language is intended to prevent claims for retroactive home health care made months or even years after an injured employee began receiving it, frequently from a spouse or family member.[2] This change represents a resolution of disputes in the case law about how much notice an employer is entitled to before liability for this kind of service exists.[3]

Because nothing saves claims for retroactive home health care made before the effective date of SB 863, this provision probably will apply to all future claims for such care. If there is no final order disposing of these claims before Jan. 1, 2013, they will be subject to the new standards. So this statute is the death knell of what is probably millions in home health-care claims.

LC 4603.2(b)(1) is amended to clarify that home health-care service providers are subject to the same reporting requirements as other medical services providers if they want to be paid. With a request for payment, home health-care providers must submit an itemization of the services rendered and the charge for each, a copy of all reports showing the services were performed, the prescription or referral from the primary treating physician and any evidence of authorization for the services that may have been received.

In addition, LC 4600(h) provides that home health-care services are subject to LC 5307.1 or LC 5307.8. The former pertains to the Official Medical Fee Schedule (OMFS) and the latter is a new statute requiring the administrative director to adopt a schedule for payment of home health services not covered by the OMFS. The home health-care services schedule must be adopted on or before July 1, 2013, and must define the maximum hours and fees for that care. The schedule must be based on the regulations adopted "pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code." Welfare and Institutions Code 12303.4 generally limits services to 195 hours per month, but allows for 283 hours per month if someone requires in-home supportive care for at least 20 hours for

[1] *Compton v. Atwater Elementary School District,* 2012 Cal. Wrk. Comp. P.D. LEXIS 16.
[2] See *Allgreen Landscape v. WCAB (Mota)* (2012) 77 CCC 541, 542 (writ denied).
[3] For a complete discussion of the tortured case law in this area see "Sullivan on Comp" Section 7.3 Scope of Care — Applied Cases.

bowel and bladder care, dressing, oral hygiene, grooming, food preparation, moving out of bed, bathing or ambulation.

LC 5307.8 establishes that no fees will be paid for any services, including those provided by a member of the employee's household, if they had been performed regularly in the same manner and to the same degree before the date of injury. This is intended to prevent a spouse or family member from recovering for services provided before the employee was injured. So if an injured employee's spouse did all of the cooking and cleaning before the industrial injury, the employer would not be required to pay for those services unless they were performed in a different manner and to a different degree. That is, if the spouse must do additional or different work, those services would be compensable.

LC 5307.8 also establishes that an appropriate attorney's fee for recovery of home health-care fees may be awarded in accordance with LC 4906 and any applicable rules and regulations. LC 4906 pertains to attorneys' fees paid from an injured employee's recovery, so any such fees awarded under LC 5307.8 also would come from an employee's recovery. But if an applicant previously received an award of home health care, and an employer unreasonably delays or refuses to provide the treatment, attorneys' fees still might be available per LC 5814.5. (For a full discussion of attorneys' fees, see "Sullivan on Comp" Section 15.96 Attorneys' Fees — Lien Against the Employee's Compensation.)

5. MEDICAL PROVIDER NETWORK

SB 863 has made several changes to the MPN statutes. The changes affect the conditions under which an employee may predesignate a personal physician outside the MPN, as well as the requirements for employers or insurers who wish to establish or continue using MPNs.

The changes also strengthen an employer's ability to enforce treatment within an MPN, and place significant barriers to treatment outside the network. SB 863 explicitly provides that employers are not liable for payment of treatment impermissibly obtained outside of an MPN, and that employers are not liable for any consequences of treatment impermissibly obtained. It also provides that MPN issues may be heard at expedited hearings.

PREDESIGNATION OF PERSONAL PHYSICIAN

Per LC 4600(d), an employee still may treat outside of an employer's MPN if he or she properly predesignates a personal physician in writing before the date of injury. (The concept of predesignation is discussed fully in "Sullivan on Comp" Section 7.49 Predesignation of Treating Physician.)

LC 4600(d) is amended, however, to grant the employee a right to be treated by his or her personal physician only if the employee has health-care coverage for nonindustrial injuries or illnesses in a plan, policy or fund as described in LC 4616.7. Previously, predesignation was permitted only if the employer provided regular health-care insurance to its employees.

The change seems to be that the employer no longer must be the provider of coverage. It appears from this language that if the applicant has health-care coverage from a source other than the employer (such as a spouse's insurance), he or she could predesignate a physician. So this is an expansion of the right to predesignate. A look at LC 4616.7 shows approval of health-care organizations or groups of physicians, so a fee-for-service relationship with a physician or Medicare may not be enough.

This is a procedural change, so it will apply to all dates of injury as of Jan. 1, 2013, unless there is a final order.

CHANGES IN MPN REQUIREMENTS AND APPROVAL PROCESS

LC 4616 allows employers or insurers to establish or modify an MPN for the purpose of providing treatment to industrially injured workers. SB 863 amended that section to alter some of the requirements for MPNs as well as the process for approving them. Per LC 4616(h), regulations to implement these changes are to be enacted by Nov. 1, 2014. They will be needed — much of the current regulatory scheme

will be defunct in light of these radical changes. This subject is discussed in general in "Sullivan on Comp" Section 7.53 MPN — Establishment and Maintenance.

Changes in MPN Requirements

LC 4616(a)(1) provides that an MPN still must include physicians primarily engaged in the treatment of occupational injuries, but the goal that at least 25 percent of them be engaged in the treatment of nonoccupational injuries has been eliminated. This was always an ambiguous requirement that was difficult to implement.

LC 4616(a)(2) is unchanged, but subdivisions (3) (4) and (5) have been added, each of which constitutes substantial change to take effect for all dates of injury as of Jan. 1, 2014.

LC 4616(a)(3) is designed to addresses situations in which a network physician refuses to treat or professes not to know that he or she is in the network. These situations have occurred because all MPNs are broad and, in all candor, some are administered sloppily. This provision states that a treating physician will be included in an MPN only if, at the time of agreeing or renewing an agreement to be in the MPN, the physician or an authorized employee provides a separate written acknowledgment that the physician elects to be a member of the MPN. The acknowledgment does not apply to a physician who is part of a medical group that elects to be part of the MPN.

The next two changes in LC 4616 were enacted to help injured workers find treating doctors within an MPN. LC 4616(a)(4) provides that commencing Jan. 1, 2014, every MPN must post on its website a roster of all treating physicians within the network, and requires that this information must be updated quarterly. Every MPN also must provide to the administrative director the Web address of the MPN and its roster of treating physicians. The administrative director will post the Web address of every approved MPN on the DIR website.

Commencing Jan. 1, 2014, every MPN must provide, per LC 4616(a)(5), one or more individuals within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, as well as subsequent physicians if necessary. The medical access assistant must be accessible from 7 a.m. to 8 p.m. Monday through Saturday via a toll-free number to respond to injured employees, contact physicians and schedule appointments. Regulations regarding the medical access assistant are to be promulgated by the administrative director before July 1, 2013.

Per LC 4616(b)(2)and LC 4616(b)(3), every MPN must establish and follow procedures continuously to review the quality of care, performance of medical personnel, utilization of services and facilities and costs. Also, every MPN must submit geocoding of its network for re-approval to establish that the number and geographic location of physicians in the MPN meet the required standards.

Finally, LC 4616(g) is added to place notification requirements on parties that would buy and sell MPNs. It states that as of Jan. 1, 2013, every contracting agent that "sells, leases, assigns, transfers, or conveys" an MPN to another entity must disclose whether that MPN is allowed contractually to be sold or otherwise manipulated in the market. This provision probably exists to stop vendors from selling an MPN's services and then selling off the contract without full disclosure.

Approval of an MPN

LC 4616(b) still provides that the administrative director must approve a plan submitted by an employer or insurer for an MPN if the requirements of LC 4616 are met. LC 4616(b)(1) is amended, however, to

approve MPNs for a period of only four years. Commencing Jan. 1, 2014, existing approved plans are deemed approved for four years from the most recent application or modification approval date. Plans for re-approval of an MPN must be submitted at least six months before the expiration of the four-year period.

Proof of an MPN at Court

As noted below, unless suspended or revoked by the administrative director, the approval of an MPN by the director per LC 4616(b)(5) is binding on all individuals and all courts. LC 4616(b)(1) provides that on showing that the MPN was approved or deemed approved by the administrative director, there is a conclusive presumption at the appeals board that the MPN was formed validly.

This is a codification and expansion of the well-known *Clifton* case, which held that a defendant may satisfy its burden of proving it has a properly established MPN by asserting that it has an approved MPN, and requesting judicial notice of the inclusion of its MPN in the list of approved MPNs on the administrative director's website.[1] Following SB 863, the presumption is conclusive, and is therefore not rebuttable by any evidence. Applicants will be precluded from arguing that they can treat outside of MPNs on the grounds that they were invalidly formed.

Policing of MPNs and Appeal

The administrative director is given great power to make sure that MPNs run correctly. Per LC 4616(b)(4), the administrative director is authorized to investigate complaints and to conduct random reviews of approved MPNs. Per LC 4616(b)(5), approval of an MPN may be denied, revoked or suspended for failure to comply with LC 4616. Anyone who contends that an MPN is not validly constituted may petition the administrative director to suspend or revoke approval of it. Because anyone may do this, those involved in a dispute at the local appeals board may be inclined to identify this threat to opponents.

In addition, the administrative director has authority to establish a schedule of administrative penalties, not exceeding $5,000 per violation, or probation, or both in lieu of revocation or suspension for less severe violations.

LC 4616(b)(5) provides that unless suspended or revoked by the administrative director, approval of an MPN is binding on all individuals and all courts. It also provides that the administrative director's determination may be reviewed only by an appeal filed as an original proceeding before the reconsideration unit of the appeals board. The appeal must be based on the same grounds and within the same time limits applicable to a petition for reconsideration from a decision of a WCJ.

Currently, CCR 9767.13 and CCR 9767.14 provide that if the administrative director denies approval of an MPN or suspends or revokes it, the MPN applicant may request a re-evaluation by the administrative director or may appeal the decision by filing a petition and a DOR within 20 days of the decision at the district office of the WCAB closest to the MPN applicant's principal place of business. These options are no longer available; LC 4616(b)(5) now provides that the administrative director's opinion may be reviewed *only* by an appeal filed in a manner similar to a petition for reconsideration. Still, it may be possible to reapply for approval of an MPN if the initial application is rejected.

MPN NOTIFICATION REQUIREMENTS

The language regarding an employer's MPN notice requirements in LC 4616.3(b) was amended. It reads: "The employer shall notify the employee of the existence of the medical provider network established

[1] *Clifton v. Sears Holding Corp.,* 2012 Cal. Wrk. Comp. P.D. LEXIS 1.

pursuant to this article, the employee's right to change treating physicians within the network after the first visit, and the method by which the list of participating providers may be accessed by the employee." This simply adds a requirement that the existence of the network be identified. It's not a big change — regulations that specify the notices required already include that.

More important is a new sentence: "The employer's failure to provide notice as required by this subdivision or failure to post the notice as required by Section 3550 shall not be a basis for the employee to treat outside the network unless it is shown that the failure to provide notice resulted in a denial of medical care." This is very significant language designed to transform a point of continuing litigation. There are a lot of notice requirements for an MPN, including written notices at the time of hire and again on injury, and notices to be posted at work. (A complete exposition of these requirements is found in "Sullivan on Comp" Section 7.54 MPN — Notice Requirements.) Does failure to provide or post a notice mean that the applicant may escape the MPN? Under this new law, not unless the failure to notice results in a "denial" of medical care.

This is a more stringent standard than what the courts have applied in the past. Before the passage of SB 863, the leading case in the area was the WCAB's *en banc* decision in *Knight v. United Parcel Service.*[2] In that case, the appeals board held that an employer's or insurer's failure to provide the required notice of rights under the MPN that results in a "neglect or refusal" to provide reasonable medical treatment renders the employer or insurer liable for reasonable treatment self-procured by the employee. The new statutory language goes even further, requiring an actual denial of medical care.

What constitutes a denial of medical care as opposed to a neglect or refusal? Suppose an applicant reports an injury, but the employer does nothing and doesn't send the applicant to a doctor. Is this a denial of care? Perhaps so, despite the fact that the employer did not specifically tell the applicant that he or she could not have medical care. But suppose an applicant reports an injury, and the employer simply refers the applicant to the MPN website. Perhaps this could be seen as a mere neglect of care, because LC 4616.3(a) requires the employer to arrange the initial medical evaluation. There is a large body of law that discusses the meaning of refusal or neglect to provide care (see "Sullivan on Comp" Section 7.52 Employer's Neglect or Refusal to Furnish Medical Care), but denial of care is a new standard that must be considered. There are a lot of possibilities here. Defining this standard will be the job of the courts, and will involve a lot of litigation.

Regarding the obligation to post notices, it is significant that LC 3550(e) was not amended. The statute deems a failure to post the required notice an automatic permit for an employee to be treated by his or her personal physician. But now, per LC 4616.3(b), failure to post the LC 3550 notice alone will not allow an employee automatically to treat outside of the MPN. LC 4616.3(b) is more specific to the issue and should control. Its standard is whether the failure to notice resulted in a denial of medical care. It is hard to imagine that failure to hang a poster could be blamed for that.

DETERMINATIONS REGARDING WHETHER AN EMPLOYEE IMPERMISSIBLY TREATED OUTSIDE AN MPN

There are many reasons why it may be explicitly permissible for an applicant to treat outside of an MPN, or may be justified in doing so. For a general discussion of this, see Sullivan On Comp 7.56 MPN — Escaping the Network. LC 4603.2 was amended to describe what happens after the appeals board has decided whether or not an employee's treatment outside the MPN was valid.

[2] (2006) 71 CCC 1423 (appeals board *en banc*).

Medical Treatment If Employee Permissibly Treated Outside of an MPN

Per LC 4603.2(a)(2),[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 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." So if the appeals board concludes that an employee was permitted to self-procure treatment outside of an employer's MPN, the employee is permitted to continue treating with that physician.

This is a big change. Previously, the appeals board held that employers could transfer an employee into an MPN at any time.[4] Accordingly, several cases concluded that an employer could transfer an employee into an MPN even if it initially denied a claim and the employee was forced to self-procure care.[5] For further discussion, see "Sullivan on Comp" Section 7.57 MPN — Transfer of Care. At the end of the day, all cases could be transferred into the network.

But under LC 4603.2(a)(2), a refusal to provide care might mean that the employer forever loses medical control. If the appeals board finds that the applicant was entitled to treat outside of an MPN, the applicant may continue treating with the non-MPN doctor. So whether an employer chooses to accept or deny a claim will have serious long-term consequences over the life of a claim. If the employer chooses to accept a claim, it will have the right to enforce treatment within an MPN, but may lose the right to challenge compensability if it later discovers that the claim is questionable. In contrast, if the employer denies a claim, forcing the employee to treat outside the MPN, the employee would have a right to continue treating with the non-MPN doctor if the case is found to be compensable. The same sort of considerations will apply as the employer deliberates denying the compensability of claimed body parts.

LC 4603.2(a)(2), however, does limit the employee to treatment with "that physician." So even if the employee is found to be entitled to treat with a non-MPN physician at the employer's expense, the employee may not transfer his or her care to another doctor. It is unclear what happens if the physician becomes unavailable or no longer wishes to treat the applicant. It may be possible to transfer the applicant into the MPN at that point, but this issue will need to be clarified by administrative regulations or case law.

LC 4603.2(a)(2) also provides that in the event the appeals board determines that the employee was entitled to select the non-MPN physician, the employer must pay from the date of the initial examination if the physician's report was submitted within five working days of it. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee will not be required to pay for any services before the date the physician's report was submitted.

So a non-MPN physician must notify an employer that he or she is treating an injured worker, and the non-MPN physician's failure to timely do so will relieve the employer from payment for the services before the physician's report is submitted. Note that LC 4603.2(a)(1) was amended to add that physicians are to submit their reports in accordance with LC 6409, which specifies the legal forms used for such reports. It may be argued that failure to use the forms is a lack of compliance.

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[3] It should be noted that there are minor changes to LC 4603(a)(1). Previously, when a physician was selected, the employer was to be notified of his or her name and address. The language now reads the "name of the medical group." Also, the physician is to submit regular medical reports; added language reads "as required by Section 6409," which refers to the forms the physician is supposed to use to make reports.
[4] See *Babbitt v. Ow Jing dba National Market* (2007) 72 CCC 70 (appeals board *en banc*).
[5] See *Montes v. WCAB* (2008) 73 CCC 709 (writ denied); *Barrett Business Services, Inc., dba Manning Foods v. WCAB (Desiderio)* (2008) 74 CCC 49 (writ denied).

Medical Treatment If Employee Impermissibly Treated Outside of an MPN

Per LC 4603.2(a)(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 shall have no liability for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network."

So if the appeals board determines that the employee impermissibly treated outside of an MPN, there are two consequences: (1) the employer is not liable for any treatment provided by or at the direction of that physician; and (2) the employer is not liable for any consequences of the treatment obtained outside of the MPN.

The first consequence has ramifications for the physician who must risk not getting paid if the treatment is found to be impermissible. Furthermore, because LC 4603.2(a)(3) precludes payment "at the direction of that physician," the employer would not be liable for any referrals made by the non-MPN physician. In addition, per the new LC 4903.1(b), if the services are rendered by specified providers including a health-care provider and health-care service plan, the provider may not file a lien to recover any payment from the employee if the physician knew or in the exercise of reasonable diligence should have known that the condition was caused by the employment.

The second consequence has potential ramifications for the employee. Generally, as discussed in "Sullivan on Comp" Section 5.65 Compensable Consequence Injuries, an employer is liable for subsequent injuries caused by the original injury. But because LC 4603.2(a)(3) precludes liability for "any consequences" of the treatment obtained outside the MPN, such injuries would not be compensable if the appeals board determines that the employee impermissibly treated outside of an MPN.

For example, when an employee sustains an injury traveling to or from a physician's office for treatment for an industrial injury, generally the injury is a compensable consequence of the original injury.[6] If, however, such an accident occurred while an applicant was treating impermissibly outside of an MPN, the employee would have no remedy against the employer for the accident. Not only would the employer not be liable for any new medical treatment caused by the accident, the employer would not be liable for any indemnity, temporary or permanent, that otherwise would be payable.

The diligent defense practitioner no doubt will see almost endless possibilities when it comes to the term "consequences of treatment," and will strain to tie in as many benefits as possible. Maybe the treatment was unnecessary or went on too long, and as a result the applicant became overweight or addicted to medications. Or maybe there was a surgery that did not go well and the applicant had more permanent disability than he or she otherwise would have had. Applicant attorneys probably will question whether a consequence of care that is linked to other causal factors, such as a natural degradation or an unrelated compensable consequence, should be recognized under the statute. They will object to improper apportionment of causation. In short, significant litigation is sure to ensue.

MEDICAL TREATMENT AT AN EMPLOYEE'S OWN EXPENSE

LC 4605 also was amended. A minor modification was made to make the section gender neutral. LC 4605 still provides that an employee has the right to a consulting or attending physician of his or her choice "at his or her own expense." This is a long-standing principle in workers' compensation; LC 4605 is discussed in depth in "Sullivan on Comp" Section 7.56 MPN — Escaping the Network.

[6] *Laines v. WCAB* (1975) 40 CCC 365.

More significant are new sentences in LC 4605 stating, "Any report prepared by consulting or attending physicians pursuant to this section shall not be the sole basis of an award of compensation. A qualified medical evaluator or authorized treating physician shall address any report procured pursuant to this section and shall indicate whether he or she agrees or disagrees with the findings or opinions stated in the report, and shall identify the bases for this opinion."

These amendments were intended to address the decision of *Valdez v. WCAB,*[7] which held that non-MPN reports are admissible in workers' compensation proceedings. *Valdez* concerned employers, who feared that the admissibility of these reports would result in an expectation that benefits would have to be paid solely based on them during a period when medical control was in dispute. They felt that the admissibility of the reports would undermine the system of medical control established by the MPN process.

This change addresses these concerns. While self-procured reports under LC 4605 remain admissible, any report obtained under that section no longer may be the sole basis of an award. This probably means that these reports by themselves do not serve as the basis for required action by the employer, as they cannot result in an award. They need corroboration.

The self-procured doctor's report must be reviewed by a QME or "authorized treating physician." Who is an "authorized treating physician" is not specified by the statute. Presumably, if an employer has an MPN, any report obtained pursuant to LC 4605 would need to be reviewed by an MPN doctor if it is determined that the employee impermissibly treated outside the network. But if an employee is found to be entitled to treat outside of an MPN, is unlikely that the employee's doctor would be considered a report at the employee's "own expense," but rather treatment that the employer would be obligated to pay for. In any event, a QME or "authorized treating physician" must address any report obtained pursuant to LC 4605, must report whether he or she disagrees with the findings or opinions stated in the report and must identify the bases for the opinion.

So although reports at an employee's "own expense" are admissible in workers' compensation proceedings, they will have limited value in the future. They cannot support an award on their own, and must be reviewed by a QME or authorized treating physician. If the report was not reviewed, it cannot be relied on. So the appeals board would not be relying on the report obtained under LC 4605 to support a decision, but the report of the QME or authorized treating physician.

EXPEDITED HEARING FOR MPN ISSUES

LC 5502(b) requires the administrative director to establish a priority calendar for issues requiring an expedited hearing and decision. This has been amended so that whether the injured employee is required to obtain treatment within an MPN is now one of the issues that may be heard at an expedited hearing. Previously, some cases had allowed MPN issues to be heard at an expedited hearing.[8] Now, this is explicitly permitted by statute. (For a complete discussion of expedited hearings, see "Sullivan on Comp" Section 15.24 Expedited Hearing.)

In addition, LC 5502(b) provides that "[W]hen an expedited hearing is requested pursuant to paragraph (2) [which pertains to MPN issues], no other issue may be heard until the medical provider network dispute is resolved."[9] So if there is a dispute over whether an employee is required to treat within an MPN, that issue

[7] (2012) 77 CCC 506.
[8] See *Babbitt v. Ow Jing dba National Market* (2007) 72 CCC 70 (appeals board *en banc*); *Sarmiento (Perez) v. Payroll Management Group, Inc.,* 2012 Cal. Wrk. Comp. P.D. LEXIS 258.
[9] Note that a mistake was made when numbering this section of the Labor Code. Subdivision (b) is followed by a series of points identified as A through D, then followed by numbers 5 and 6. They all should have been numbered. In any case, it is fairly clear that the reference to point 2 in the statute actually references point B. It is also of note that the addition of MPNs as a ground for expedited hearing is not the only one. Now,

must be heard first, before other issues such as entitlement to medical treatment and entitlement to temporary disability may be heard.

expedited hearings also are allowed for “A medical treatment appointment or medical-legal examination.” This is a big change and is discussed elsewhere in this narrative.

6. UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

Since 2004, every employer or insurer has been required to establish a medical treatment utilization review process in order to handle issues regarding the reasonableness and necessity of medical treatment recommended by doctors. Sometimes the review approves the treatment, leaving the employer with no remedy, and sometimes the review results in a recommendation that the proposed treatment be delayed or modified. In the latter case, the course before SB 863 was enacted was to contest the UR finding by way of the medical-legal process. The process of utilization review and particularly for resolving UR disputes is discussed in depth in "Sullivan on Comp" Section 7.41 Utilization Review — Dispute Resolution.

No longer, however, are disputes following a decision by utilization review to deny or modify a request for treatment subject to the medical-legal process of LC 4062, LC 4062.1 and LC 4062.2. SB 863 creates a new "independent medical review process" (IMR) to resolve them. SB 863 declares that independent medical review "is a new state function" pursuant to GC 19130(b)(2). Fundamentally, such disputes are submitted to a third party preselected by the state whose decision on review is final.

This new process applies to all injuries occurring on or after Jan. 1, 2013. It also applies to all UR decisions communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury. Under this process, if an injured worker chooses to challenge a UR decision to deny or modify requests for treatment, the worker must request an independent medical review from an organization contracted by the administrative director. Time limits for requesting and carrying out the IMR are established.

In enacting and establishing the independent medical review process, the Legislature believes that "the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers injured in the course of employment." It also believes that "having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy."

The Legislature adds that the independent medical review process "will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations performed by qualified medical evaluators." It deemed "[t]he existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes costly and time-consuming, ..." It

also found that the existing process "prolongs disputes and causes delays in medical treatment of injured workers ... [and] the process of selection of qualified medical evaluators can bias the outcomes."

Accordingly, SB 863 requires "that final determinations made pursuant to the ... independent medical review processes be presumed to be correct and be set aside only as specified." As discussed below, the independent medical review process is designed to provide an efficient and speedy method for resolving disputes over medical treatment. It's designed to eliminate the litigation of medical treatment disputes, and gives the parties limited options for appealing an independent medical reviewer's decision.

STATUTORY AUTHORITY FOR INDEPENDENT MEDICAL REVIEW

SB 863 added LC 139.5 to establish the independent medical review. Per LC 139.5(f), the Legislature finds that the services of independent medical review "are of such a special and unique nature that they must be contracted out." LC 139.5(a) authorizes the administrative director to contract with one or more IMR organizations to conduct reviews pursuant to the Labor Code sections related to medical treatment, commencing with LC 4600. The organizations must be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in the state. The administrative director also is authorized to establish additional requirements, including conflict-of-interest standards, an organization must meet to qualify.

Because the independent medical review process must go into effect for injuries occurring on or after Jan. 1, 2013, the administrative director is authorized to designate independent review organizations under contract with the Department of Managed Health Care (per Health and Safety Code 1374.32) to conduct reviews until IMR organizations are finalized. The administrative director will use an interagency agreement, and initially may contract with the same organizations under contract with the Department of Managed Care on substantially the same terms without competitive bidding until Jan. 1, 2015.

So, for a period of two years, the same independent review organizations under contract with the Department of Managed Health Care may carry out the function of independent medical review in workers' compensation. In fact, the IMR process is patterned after the program at the Department of Managed Health Care. Currently, that department contracts with only one independent review organization, Maximus. So it may well be that this organization will be conducting independent medical reviews for the next couple of years.

Per LC 139.5(b), the independent medical review organization contracted by the administrative director is considered a consultant, and enjoys general protection for communications with that status. The independent medical review organization may be entitled to other privileges or immunity afforded by law, except that nothing in LC 139.5 may be construed to alter the law regarding the confidentiality of medical records.

LC 139.5(c)(d) also establish several criteria for the independent medical review organization. It must employ a medical director and avoid any conflicts of interest. The requirements for medical professionals selected by the organization are defined in LC 139.5(d)(4). The physicians must be familiar with the guidelines and protocols in the area of treatment under review. The reviewing physician must hold an M.D. or D.O. degree and have no history of disciplinary action. As of Jan. 1, 2014, the physician must not hold appointment as a QME pursuant to LC 139.2[1] — a physician serving as an independent medical reviewer may not be a QME after that date. It looks like some physicians will have some choices to make.

[1] Note the statute incorrectly refers to LC 139.32, which is the new statute prohibiting illegal referrals by an interested party. LC 139.2 is the section that deals with appointment of QMEs.

JURISDICTION OVER UTILIZATION REVIEW DISPUTES

LC 4604 was amended to ensure that medical treatment disputes are controlled exclusively by the independent medical review process. Previously, that section stated that "controversies between employer and employee arising under this chapter [which includes disputes over medical treatment] shall be determined by the appeals board, upon the request of either party." So the appeals board was given exclusive jurisdiction to resolve medical treatment disputes.

Now, LC 4604 provides that "controversies between employer and employee arising under this chapter shall be determined by the appeals board, *except as otherwise provided by Section 4610.5*" (emphasis added). As discussed below, LC 4610.5 establishes the procedures for requesting an independent medical review.

MODIFICATION TO UTILIZATION REVIEW PROCESS

LC 4610 governs the utilization review process. Several insubstantial changes were made to reflect that the medical treatment utilization schedule has been adopted pursuant to LC 5307.27. Also, LC 4610(g)(1) was amended so that only a denial of treatment through the retrospective utilization review process must be communicated. That's a good fix — there is really no need to tell the applicant if a bill is paid.

Also, several amendments were made to ensure that UR disputes are resolved through the independent medical review process, and no other. LC 4610(g)(3)(A) states that if a request for treatment "is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062." Similarly, LC 4610(g)(3)(B) applies to concurrent review and states that "[i]f the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062."

Other significant changes were made to address unresolved issues of how employers and insurers should deal with the situation in which a physician requests the same treatment after it has been denied, and whether treatment for a denied claim or body part must be sent through the UR process. They are discussed below.

Duration of a Utilization Review Decision

LC 4610(g)(6) was added. It provides that "[a] utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision."

This section addresses the problem of doctors requesting a treatment after a utilization review decision has denied it. Previously, there was no guidance on how employers were required to address such requests. In *SCIF v. WCAB (Sandhagen),*[2] the California Supreme Court stated that the "Legislature intended for employers to use the utilization review process when reviewing and resolving *any and all* requests for medical treatment." So, arguably, all requests for treatment, even those for treatment previously denied, were subject to utilization review. But, it made little sense that employers repeatedly would have to deny requests for the same care.

[2] (2008) 73 CCC 981.

Per LC 4610(g)(6), an employer is not required to take any action if the same doctor recommends the same treatment previously denied, delayed or modified by utilization review. An employer is required to undertake UR of the same treatment only if the same doctor's recommendation is "supported by a documented change in the facts." What constitutes a documented change sufficient to require another utilization review is not specified; it's not clear, for example, whether there must be new objective findings or whether increased subjective complaints would suffice. But the statute clearly places the onus on the physician to explain why a documented change exists.

Note, however, that the employer is not required to take action on a request for the same treatment if the recommendation is made only by the "same physician." The statute recognizes that if another physician recommends the treatment, the request still would need to be sent through utilization review. Whether the other physician must be a new primary treating physician, or whether a secondary treating physician may recommend the treatment is not specified. Generally, per CCR 9785 and LC 4061.5, the primary treating physician is responsible for incorporating the findings of other physicians. So far, as discussed in "Sullivan on Comp" Section 7.39 Utilization Review — Process, there are conflicting panel decisions on whether a request for treatment must come from the primary treating physician.[3] This will need to be clarified.

Utilization Review in a Denied Case or Disputed Body Part

LC 4610(g)(7) was added to address whether utilization review is required in denied cases or requests for treatment for disputed body parts. It states, "Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062." So, under LC 4610(g)(7), an employer is not required to submit a treatment recommendation to utilization review when a claim is denied or when it is disputing liability for a body part or condition. It can wait for the resolution of the issue.

This is good for employers. Before SB 863 it was not clear whether UR was required even if the claim was denied or body parts were contested. They are, after all, different grounds for contesting proposed medical care from the reasonableness and necessity of the proposed care. There was a tough choice to be made. If the claim was denied and the defense lost the issue of industrial injury or body part, it might find itself in a bad position regarding utilization review. If it was not performed when medical care was requested, the time limits usually would pass. So unless the employer wanted to hedge its bets by sending the request for care to utilization review, and incur that cost, a denial meant risking a loss of ability to contest unreasonable or unnecessary care. Now, the statute clarifies that utilization review is not required for denied cases or disputed body parts.

So how does this work? LC 4610(g)(8) adds, "If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability."

Two outcomes here impose time limits and one does not, for a total of three possibilities:

1. If the service has been provided, it is retrospective care by definition. The employer's limits for retrospective UR run from the time the determination becomes final.

[3] Compare *Andrews v. Law Offices of Kenneth Reynolds,* 2011 Cal. Wrk. Comp. P.D. LEXIS 3 with *Alvarado v. Brothers Towing of Norco,* 2011 Cal. Wrk. Comp. P.D. LEXIS 514.

2. If the services have not been provided, and a determination is made, the time limits begin once the employer receives a request for care only after the determination even though the determination is not final.
3. In situations in which the request for care was made before the determination, but was not provided, no time limits apply until a new request is made.

In the first situation, the applicant requests care, and it is deferred because the care or body part is denied. But the care is provided anyway, possibly on a lien basis. The employer may conduct retroactive utilization review to determine whether the procedure performed was reasonable and necessary, and the time limit begins on the date the determination becomes final. A decision is considered final after the appellate process has been exhausted.[4] For example, suppose back surgery was requested and utilization review was deferred because the employer was denying injury, but the surgery was still provided. If the case went to trial and the employer lost and decided not to pursue a petition for reconsideration, the time limit would begin on the 20th day after the findings and award issued (plus five days for mailing).

In the second scenario, again the care is denied, but is not provided by the requesting doctor. Instead, after the determination in favor of the applicant, the applicant sends a doctor's report properly requesting the back surgery. Here, the employer would need to send the surgery to request for utilization review within the normal time limit, even if the case is on appeal. If the employer had reasonable grounds for appeal, it seems that it could ignore a certification by utilization review in favor of the care for the duration of the appeals process. But if it does not submit the request to utilization review in timely fashion, it loses the right later to deny the care based on UR denial.

In the third situation, the employee and his or her physician request the back surgery, and utilization review is deferred because injury is at issue. The case goes to trial and the applicant wins. After the determination, the applicant does not make another request for the medical care. In this situation the law is silent, and there does not appear to be a time limit until the new request is made. Why? It seems that the Legislature has made a deliberate decision not to force the employer, on an adverse court determination, to review all past claims for care. Perhaps the feeling was that such claims might be old or no longer needed, and that a fresh assessment of the applicant's needs is required when the other issues are resolved. Be that as it may, it would seem that the law requires another step to request medical care if the applicant wants the UR clock to start running.

INDEPENDENT MEDICAL REVIEW

The procedures for the independent medical review process are established in LC 4610.5 and LC 4610.6. These sections describe the time limits for requesting independent medical review, how the process is to be conducted and the limited appeals process following a decision by the reviewer. Much of how this works will have to be described in administrative regulations. But we have skeleton of the system now.

Application of the Independent Medical Review Process

LC 4610.5(a) specifies that the independent medical review process applies to any dispute about a utilization review decision regarding treatment for an injury occurring on or after Jan. 1, 2013. It applies to all dates of injury if the decision to modify, delay or deny a request for treatment is communicated to the requesting physician on or after July 1, 2013. So for injuries before Jan. 1, 2013, the date the decision is communicated to the physician determines whether the independent medical review process applies, not the date the physician requests the treatment. In the not-too-distant-future, all cases will be subject to this process.

[4] *Marsh v. WCAB* (2005) 70 CCC 787, 794; *Green v. WCAB* (2005) 70 CCC 294, 306.

Independent Medical Review Is the Exclusive Remedy for an Employee to Challenge a Utilization Review Decision

LC 4610.5(d) states, "If a utilization review decision denies, modifies, or delays a treatment recommendation, the employee may request an independent medical review as provided by this section." LC 4610.5(e) adds, "A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section."

Together, these subsections establish that independent medical review is the exclusive option for an employee who wishes to dispute a utilization review decision. The employee "may" request independent medical review to challenge a UR decision, or the employee may accept the decision. If the employee elects to challenge the decision, however, it may be reviewed or challenged only by independent medical review.

The statute still does not provide any option for employers to challenge a utilization review decision authorizing the recommended treatment. So if the requested treatment is approved by UR, normally it must be authorized by the employer. But as discussed above, the employer has the option to send a request for treatment to utilization review even if it is disputing liability for the injury. If the employer is disputing liability on grounds other than medical necessity, it still may be able to continue objecting to the medical treatment on those grounds.

LC 4610.5(g) gives the employer the option to terminate the IMR process at any time by giving written authorization of the disputed treatment.

Notification Requirements

LC 4610.5(f) describes an employer's notification duties regarding the independent medical review process. As part of its notification to the employee regarding an initial utilization review decision that denies, modifies or delays a treatment recommendation, the employer must provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director to initiate an independent medical review.

The employer must include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form, which will be developed by the administrative director, must include:

1. notice that the UR decision is final unless the employee requests independent medical review;
2. a statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee has consulted on the matter, to be signed by the employee;
3. notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding:
    A. the treating physician's recommendation indicating that the disputed treatment is medically necessary for the employee's condition;
    B. medical information or justification that a disputed urgent or emergency treatment was medically necessary for the employee's condition;
    C. reasonable information supporting the employee's position that the disputed treatment is or was medically necessary for the employee's condition, including all information

> provided to the employee by the employer or the treating physician still in the employee's possession concerning the employer's or physician's decision regarding the disputed medical treatment, as well as any additional material the employee believes is relevant.

There's a lot here; the form only begins to explain the rules for how a party may communicate to the IMR. As noted below, this will be a topic of some interest.

Time Limits for Requesting Independent Medical Review

Per LC 4610.5(h)(1), the employee must submit a request for independent medical review no later than 30 days after service of the utilization review decision. But is not clear whether the mail-box rule of CCR 10507 would apply. (This can involve a five-day extension. For a full discussion of service rules see "Sullivan on Comp" Section 15.10 Service of Documents.) Of course, the employee may simply choose to accept the result instead.

If the case is denied, or the body part in question is contested, the 30-day rule does not apply; it is held in abeyance pending resolution of the denial. Per LC 4610.5(h)(2), if, at the time of a UR decision, the employer also is disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for IMR is extended 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved. This provides indefinite extensions when there is a dispute over injury or body parts, as discussed above.

The time limits also are extended if the employer fails to provide the required notices. LC 4610.5(h)(3) states that if the employer fails to comply with its notification requirements,[5] the time limitations for the employee to submit a request for independent medical review do not begin to run until the employer provides the required notice to the employee. So, as with many service requirements in workers' compensation, failure to notice results in estoppel.

The statute does not specify what happens if an employee does not timely request an independent medical review. Presumably, a utilization review decision stands and is effective for 12 months, per LC 4610(g)(6), unless there is a documented change in the employee's medical condition or another physician requests the treatment.

Submission of Request for Independent Medical Review by Medical Providers

LC 4610.5(h)(4) allows certain medical providers to submit requests for independent medical review. It states, "A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf."

This provision recognizes that in some situations, a medical provider may be required to provide emergency medical treatment to an injured employee. So the medical provider needn't rely solely on the injured employee to protect its claim for payment. It may request an independent medical review on its own initiative.

This statute says that a request submitted by a medical provider pursuant to LC 4610.5(h)(4) must be submitted within the same time limitations applicable to an employee. So it seems this request also may be made only within 30 days from utilization review rejection. As an emergency situation, one would imagine

[5] Note that LC 4610.5(h)(3) incorrectly refers subsection (e), rather than subsection (f), where the notification requirement is contained.

that this would not be an issue. If it were, perhaps the emergency care physician would be considered another physician making the request — as noted above, that may be allowed.

Penalties for Delaying the Independent Medical Review Process

LC 4610.5(i) specifically prohibits an employer from engaging in any conduct that has the effect of delaying the independent review process. It establishes penalties that may be imposed on an employer that does, or violates the provisions of LC 4610.5.

In addition to any fines, penalties and other remedies available to the administrative director, if the employer violates LC 4610.5, it will be subject to an administrative penalty in an amount determined by regulations to be adopted by the administrative director, but not to exceed $5,000 for each day that proper notification to the employee is delayed. The administrative penalties are to be paid to the Workers' Compensation Administration Revolving Fund.

Approval of Independent Medical Review Request

It's clear that the first step in the process will be to submit the request for independent medical review to the administrative director, who will act as a gatekeeper to the organization(s) performing the actual review. LC 4610.5(k) requires the administrative director to review requests expeditiously and notify the employee and the employer in writing if the request for an independent medical review has been approved. If it is not approved, the reasons for rejection must be given.

It is hard to imagine why there would be a rejection at this level. There are, of course, certain prerequisites, such as a rejection of the proposed care by utilization review. Again, regulations must be enacted to clarify this process. Presumably, if the request passes muster, the administrative director will forward the request to independent medical review for a decision.

Of course, if there appears to be a medical necessity issue, the dispute must be resolved pursuant to an independent medical review. But LC 4610.5(k) adds that "unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity."

As noted above, the 30-day time limit for the applicant to request the independent medical review is deferred when there is a threshold issue such as denial of the claim as a whole or denial of a body part. This language appears to deal with cases in which the independent medical review has been requested despite the presence of those issues. That is, despite the fact that there is a denial of injury or body part, the request for care was made and submitted to UR and was rejected, and now the applicant has requested IMR.

It seems that the independent medical review is to proceed in this situation as long as the employer consents. The phrase "unless the employer agrees that the case is eligible for independent medical review" seems to mean that if the employer agrees, the independent medical review is to proceed despite the threshold issue. If the employer does not agree, the process is deferred pending resolution of the threshold issue. As discussed above, if there is a determination in the applicant's favor on the threshold issue of injury or body part, a fresh request for care must be made to impose UR time limits on the employer. So it's likely that the employer would not give consent to independent medical review before that determination is made.

Communication with and Provision of Documents to the Independent Medical Reviewer

Communication with AMEs and QMEs under LC 4062.3, as well as the provision of documentation and information to these physicians, is a complex and difficult area. Communication and provision of documents and information to the independent medical reviewer seems as though it will be considerably more liberal, especially for the applicant.

As described above, LC 4610.5(f) requires the administrative director to produce regulations concerning notices to the applicant the employer must provide. Because this will be primarily a creature of regulation, we do not know yet exactly what the notices will say. We do know, however, that by this statute they are required to inform the applicant of his or her right to provide information or documentation, either directly or through his or her physician, regarding:

A. the treating physician's recommendation that the disputed medical treatment is necessary for the employee's medical condition;
B. medical information or justification that a disputed urgent care or emergency treatment was necessary for the employee's medical condition;
C. reasonable information supporting the employee's position that the disputed treatment is or was necessary for the employee's medical condition, including all information provided to him or her by the employer or by the treating physician, still in his or her possession, concerning the employer's or the physician's decision regarding the disputed treatment, as well as any additional material the employee believes is relevant.

This is extremely broad language allowing, it seems, for almost anything aside from direct oral communication with the reviewer. The statute allows for the applicant to provide otherwise undefined "medical information or justification," "reasonable information supporting the employee's position" and "any additional material that the employee believes is relevant." It is hard to imagine what may not be included here.

Next, there is the curious LC 4610.5(j), which allows the employee to designate a parent, guardian, conservator, relative or "other designee" as an agent to act on his or her behalf. It is unclear why this is needed. An applicant with an attorney obviously has an agent, so perhaps this is designed to help an inarticulate in *pro per* advance his or her position. Certainly, this is unrestrictive language, as it seems the applicant may choose anyone to act as an advocate (it does not, for example, come close to the standards established for a guardian *ad litem*).

The statute, however, provides that this designation must come after the utilization review decision, as the language specifies that a designation before the decision will not be valid. Perhaps this provision is meant to make sure that family members or others do not insert themselves into the applicant's case except for this limited purpose.

In addition, LC 4610.5(j) allows the requesting physician to join with or otherwise assist the employee in seeking independent medical review. In fact, the requesting physician may advocate on the employee's behalf. Taken as a whole, this statutory scheme is designed to get everything and anything the applicant wishes, whether document, fact, opinion or advocacy, in front of the reviewer.

Finally, there is the employer's affirmative obligation to serve documents. After the administrative director has given notice that an independent medical review organization has been assigned, LC 4610.5(l) requires

the employer to provide documents to the review organization. Within 10 days of the notice of assignment, the employer is required to provide:

1. a copy of all of the employee's medical records in the employer's possession or under the control of the employer relevant to:
    A. the employee's current medical condition;
    B. the medical treatment being provided by the employer; and
    C. the disputed medical treatment requested by the employee.
2. a copy of all information provided to the employee by the employer concerning employer and provider decisions about the disputed treatment;
3. a copy of any materials the employee or the employee's provider submitted to the employer in support of his or her request for the disputed treatment; and
4. a copy of any other relevant documents or information used by the employer or its UR organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its UR organization explaining the reasons for the decision to deny, modify or delay the recommended treatment on the basis of medical necessity.

The employer must provide a copy of the all documents concurrently to the employee and the requesting physician, except those previously provided, as long as a list of them is supplied. LC 4610.5(o) also requires the employer to issue a notification promptly to the employee after submitting all of the required materials. The notice must list the documents submitted and include copies of materials not previously provided to the employee.

The statute does not require that an employer provide the independent medical review organization with all of its medical records; it is required only to provide medical records relevant to the current condition, the treatment provided and the disputed treatment requested. So it may be unnecessary for an employer to send psychiatric medical records for a treatment request for an orthopedic injury. It may be unnecessary to send stale or old records describing the applicant's earlier medical condition.

The statute leaves it up to the employer to determine what records are relevant. So the parties might disagree about that. Also, note that nothing in the law as yet requires the employee to serve copies on the employer of what it sends to the reviewer. It seems only logical, however, that coming regulations will resolve that.

Per LC 4610.5(m), any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the IMR organization must be forwarded immediately to it. The employer also must provide a copy of such records to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records must be maintained per state and federal laws.

LC 4610.5(n) provides that if there is an imminent and serious threat to the health of the employee, all necessary information and documents must be delivered to the independent medical review organization within 24 hours of approval of the request for review. An "imminent and serious threat to the health of the employee" is defined under Health and Safety Code 1374.33(c) as "including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the [applicant]."

Review by the Independent Medical Review Organization

LC 4610.6 describes how an independent medical review organization is required to act on receipt of a case. The organization must conduct a review "limited to an examination of the medical necessity of the disputed issue."

Per LC 139.5(c)(2), the IMR organization is required to select reviewers for a case who do not have a conflict of interest with the parties or the physician involved in the medical dispute. The independent medical reviewer or reviewers selected must examine all pertinent medical records of the employee, all of the provider reports and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any party, a copy of the request and the response must be provided to all of them.

Following review of records, the reviewers must determine whether the disputed health-care service is necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in LC 4610.5(c). That statute allows the independent medical reviewer to rely on the following, except that reliance on a lower ranked standard is allowed only if every higher ranked standard is inapplicable to the employee's medical condition:

A. the guidelines adopted by the administrative director pursuant to LC 5307.27;
B. peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
C. nationally recognized professional standards;
D. expert opinion;
E. generally accepted standards of medical practice;
F. treatments likely to provide a benefit to a patient for conditions for which other treatments are not clinically effective.

The independent medical reviewer normally is required to rely on the Medical Treatment Utilization Schedule (MTUS) adopted by the administrative director, and may rely on outside sources only if it is inapplicable to the applicant's medical condition.

LC 4610.6(d) requires the organization to complete its review within 30 days of receipt of the request for review and supporting documents, or within less time if prescribed by the administrative director. If the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee exists, then the determination must be expedited and rendered within three days of receipt of the information. The administrative director may extend the deadlines for regular and expedited reviews for as long as three days in extraordinary circumstances or for good cause.

The decision is to use "layperson's terms to the maximum extent practicable." LC 4610.6(e) requires the decision to state whether the disputed medical treatment is medically necessary and cite the relevant documents to support its decision. If more than one professional reviews the case, the recommendation of the majority will prevail. But if the medical reviewers are evenly split on whether the treatment should be provided, the statute provides that the decision will favor providing the service.

LC 4610.6(f) provides that the independent medical review organization must provide the administrative director, the parties and the medical provider with the analyses and determinations of each of the medical professionals who review the case, as well as a description of their qualifications. Their names, however, are to be kept confidential.

Appeal of Independent Medical Review Determination

LC 4610.6(g) deems the determination of the independent review organization to be the determination of the administrative director, and is binding on all the parties. LC 4610.6(h) provides that the parties may appeal the determination only by filing a verified appeal for a hearing with the appeals board within 30 days of the date of mailing of the determination.

The determination of the administrative director is presumed to be correct and may be set aside only on proof by clear and convincing evidence that:

1. The administrative director acted without or in excess of the administrative director's powers.
2. The determination was procured by fraud.
3. The independent medical reviewer was subject to a material conflict of interest that is in violation of LC 139.5.
4. The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability. And/or
5. The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review per LC 4610.5 and not a matter subject to expert opinion.

The independent medical reviewer's decision is intended to be the last word on the medical treatment dispute. The parties may appeal the decision based only on limited grounds that are difficult to prove, particularly given that the parties are not entitled to know the identity of the physicians who performed the review. Moreover, a party challenging the decision must establish one of the grounds for setting it aside by clear and convincing evidence, rather than the usual preponderance of the evidence standard required in all other workers' compensation issues.

Furthermore, even if a party prevails in its appeal of the determination, the party is not entitled to a final determination of the treatment issue in its favor. Instead, LC 4610.6(i) directs the dispute to be remanded to the administrative director to submit the dispute to independent medical review by a different review organization. If a different organization is not available, the administrative director must submit the dispute to the original organization for review by a different reviewer. LC 4610.6(i) specifically precludes a WCJ, the appeals board or any higher court to make a determination of medical necessity contrary to the determination of the independent medical review organization.

Certainly, there are due process concerns in allowing an administrative decision to be the last word over the medical treatment dispute. But the process was intended to eliminate litigation of medical treatment disputes to enable resolution in a speedy and cost-effective manner. Accordingly, the Legislature explained that "the establishment of independent medical review and provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review of such decisions." Because the Legislature has plenary power over workers' compensation, legal challenges to the process will be very difficult.

In anticipation of possible legal challenges, the Legislature also added LC 4610.6(n). It states, "If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby." It is likely that LC 4610.6(n) was added to address any constitutional challenges to the independent medical review process, particularly the appeals process. Under LC 4610.6(n), if the appeals

process is found to be unconstitutional, the remainder of the independent medical review process would still be valid.

Employer's Actions Following a Determination in Favor of Treatment

LC 4610.6(j) provides that on receiving the determination that a disputed health-care service is medically necessary, the employer must implement the decision promptly unless it also has disputed liability for any reason besides medical necessity. The employer must implement the decision after a final order regarding the liability issue is decided against it.

In the case of reimbursement for services already rendered, the employer must reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment, per LC 4603.2 - LC 4603.6. Those sections relate to payment of medical expenses (LC 4603.2), notification regarding payment, adjustment or denial of medical services (LC 4603.3), submission and payment of electronic claims for medical payment (LC 4603.4) and independent bill review (LC 4603.6).

In the case of services not yet rendered, the employer must authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition. The employer also is required to inform the employee and provider of the authorization.

Penalties for Failure to Pay Pursuant to a Decision

If an employer fails to timely pay for services or authorize services following a determination, it faces very steep penalties. Per LC 4610.6(k), in addition to any other fines, penalties and other remedies available to the administrative director, the employer will be subject to an administrative penalty in an amount determined by regulations to be adopted by the administrative director. They may not exceed $5,000 for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

Financing the Independent Medical Review Process

LC 4610.6(l) requires that the costs for administration of the independent medical review process are to be borne by employers through a fee system established by the administrative director. After considering relevant information on program costs, the administrative director must establish a reasonable, per-case reimbursement schedule to pay the costs of IMR organization reviews and the cost of administering the review system. The fees may vary depending on the type of medical condition under review and other factors.

Independent Medical Review Determination Not Conclusive Evidence of Unreasonable Delay

LC 4610.1 was amended, but it still provides that an employee is not entitled to an increase in compensation under LC 5814 for unreasonable delay in the provision of medical treatment for the time necessary to complete the UR process. It is amended to state, "A determination by the appeals board or a final determination of the administrative director pursuant to independent medical review that medical treatment is appropriate shall not be conclusive evidence that medical treatment was unreasonably delayed or denied for the purposes of penalties pursuant to Section 5814."

So the fact that the independent medical reviewer determines that a requested treatment is reasonable and necessary does not automatically render the employer liable for LC 5814 penalties. The employee still must prove that the treatment was unreasonably delayed or refused. If the employer relies on a timely completed utilization review decision to deny medical treatment, it is likely that it would have genuine doubt, which is all that's required to defeat a claim of LC 5814 penalties. (For a full discussion of this see "Sullivan on Comp" Section 13.23 Unreasonable Delay — Failure to Pay Medical Treatment Benefits.)

7. LIEN REFORM

Numerous changes were made by SB 863 to deal with the perceived problem of liens within the workers' compensation system. Changes were made to the documentation for payment of medical services, and to require declarations under penalty of perjury (see 8. Independent Bill Review). A lien filing fee of $150 is implemented for liens filed on or after Jan. 1, 2013, and a lien activation fee is implemented for liens before then. Lien claimants have additional notification requirements when they obtain representation and when liens are assigned. SB 863 also enacted penalties for lien claimants who fail to comply with these new provisions.

FILING REQUIREMENTS

LC 4903.05 was added as part of SB 863. It describes the filing requirements for a lien, which previously were contained in former LC 4903.1(c). Per LC 4903.05(a), a lien claimant still must file a lien with the appeals board in the form approved by the board. The lien also must be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service. Medical records must be filed only if they are relevant to the issues being raised by the lien.[1]

The new LC 4903.05(b) requires that liens for medical treatment (under LC 4903(b)) must be filed electronically using the form approved by the appeals board. This appears to codify CCR 10770, which was enacted earlier in 2012 to obligate almost all lien claimants to file via the Internet or with an optical recognition form. Only a few types of lien claimants are excepted from this obligation, including liens for burial expenses, child support and living expenses. LC 4903.05(b) also includes liens for "claim for costs"; this term is not defined, but probably is intended to capture liens encompassed by CCR 10770. This area is explored in depth in "Sullivan on Comp" Section 15.89 Liens — Filing Procedure.

FILING FEE

LC 4903.05(c) adds a new filing fee for liens filed on or after Jan. 1, 2013. The fee applies to liens under LC 4903(b), which relates to medical treatment or medical-legal expense, or for claims of costs. Again, what constitutes a "claim for costs" is not perfectly clear. One thing, however, is clear: If a lien is not properly submitted with proof that the filing fee has been paid, it will be deemed invalid and will not preserve or extend the time limit for filing the lien. Obviously, this has been instituted to make sure that lien claimants think it through before trying to get paid on a dubious billing.

[1] Note that the requirement of attaching an itemization or voucher appears to contradict CCR 10770, which states that "[N]o amended liens and no documentation in support of any lien (original or amended) will be accepted. If an original lien is filed with supporting documentation, the original lien shall be filed but not the supporting documentation."

A lien claimant is required to pay a $150 filing fee to the DWC before filing a lien. The claimant must include proof that the filing fee is paid. The fee will be collected through an electronic payment system that accepts major credit cards and other forms of electronic payment selected by the administrative director. The director is authorized to contract with a service provider for the processing of electronic payments, but a processing fee must not be absorbed by the division and must not add to the fee charged to the lien claimant. The Legislature, no doubt, is visualizing the outsourcing of this process, and with good reason — filing fees have proved to be too costly when handled in-house at the appeals board.

The statute requires that claims of two or more providers may not be merged into a single lien. Each provider is required to file a separate lien and pay separate filing fees. The filing fees must be deposited into the Workers' Compensation Administration Revolving Fund. The administrative director must adopt reasonable rules and regulations regarding the procedures for the collection of filing fees.

Any lien filed for goods and services that are not the proper subject of a lien may be dismissed at the request of a party or on the appeals board's own motion. If dismissed, the filing fee will not be reimbursed.

Certain providers explicitly are excluded from payment of the filing fee. They are:

1. a health-care service plan licensed per Health and Safety Code 1349;
2. a group disability insurer under a policy issued in California per IC 10270.5;
3. a self-insured employee welfare benefit plan issued in California as defined by IC 10121;
4. a Taft-Hartley health and welfare fund; and
5. a publicly funded program providing medical benefits on a nonindustrial basis.

ACTIVATION FEE

The filing fee applies to liens filed on or after Jan. 1, 2013. For liens filed before then, LC 4903.06 implements a new "activation fee."

Like the filing fee, the activation fee applies to medical treatment and medical-legal liens under LC 4903(b), and liens for costs. A lien claimant may avoid paying an activation fee only if it provides proof of having paid a filing fee as required by former LC 4903.05 (this existed briefly from 2003 legislation). The statute places the affirmative burden on the lien claimant to show that it previously paid the filing fee. This exception will apply only in the rarest of cases.

Otherwise, a lien claimant must file a lien activation fee of $100 to the DWC on or before Jan. 1, 2014. The activation fee is to be collected in the same manner as the filing fee for liens filed on or after Jan. 1, 2013. So lien claimants have every incentive to get all liens resolved or litigated before 2014, and as soon as possible.

They also have an incentive to resolve before any court appearance. Per LC 4903.06(a)(4), a lien claimant must include proof of payment of the filing fee or activation fee on filing a declaration of readiness to proceed. This provision will take effect for all dates of injury on or after Jan. 1, 2013; as of that date, the fee must be paid when a DOR is filed. So a lien claimant will want to resolve by phone or file a DOR before the end of 2012.

That statute also requires that all lien claimants that did not file the DOR and that remain a lien claimant at the time of a lien conference must submit proof of payment of the activation fee at the conference. If the fee has not been paid or no proof of payment is made, the lien "shall" be dismissed with prejudice. This too goes into effect for all dates of injury as of Jan. 1, 2013. So lien claimants who do not file a DOR will want their matter heard and completed by the end of 2012. One can imagine a lien claimant negotiating with a

defendant in court in 2013, trying to resolve, knowing that the fee will have to be paid to avoid dismissal if resolution is not reached.

Note that under this scheme the lien claimant who files the DOR before Jan. 1, 2013, apparently needn't post the fee at the lien conference as the others do, and may wait until 2014. This gives lien claimants who file a DOR the longest time to resolve or litigate, and provides every lien claimant in California with strong motivation to file a DOR as soon as possible, and certainly before 2013. This may leave some lien claimants in a quandary: If they have many liens worth only small amounts of money, trying to staff a plethora of lien conferences may be cost prohibitive. It will be very hard for these kinds of lien claimants to operate.

A catch-all provision contained in LC 4903.06(a)(5) provides that a lien filed before to Jan. 1, 2013, for which a filing fee or activation fee has not been paid by Jan. 1, 2014, will be dismissed by operation of law. So by the end of 2013, all liens must have been resolved, filed a fee or been dismissed.

Again, certain lien claimants are exempt from paying the activation fee. They are the same claimants who are not required to pay the lien filing fee for liens filed on or after Jan. 1, 2013.

REIMBURSEMENT OF THE LIEN FILING FEE AND ACTIVATION FEE

LC 4903.07 describes the limited situation in which lien claimants may receive reimbursement of the lien filing fee or lien activation fee. A claimant may be reimbursed, along with interest at the rate allowed for civil judgments, only if all of these conditions are satisfied:

1. The lien claimant made written demand for settlement of the lien for a clearly stated sum inclusive of all claims of debt, interest, penalty or other claims potentially recoverable on the lien not fewer than 30 days before filing the lien for which the filing fee was paid or filing the DOR for which the lien activation fee was paid.
2. The defendant failed to accept the settlement demand in writing within 20 days of receiving it, or within any additional time granted by the demand.
3. A final award is made in favor of the lien claimant of a specified sum equal to or greater than the amount of the settlement demand after submission of the lien dispute to the appeals board or an arbitrator. The amount of the interest and filing fee or lien activation fee will not be considered in determining whether the award is equal to or greater than the demand.

So in order to be reimbursed for lien filing or activation fees, the lien claimant must proceed to trial and receive an award that was equal to or greater than the amount demanded. This is rare in a high-volume litigation environment, so once the fee is paid it must be considered lost by the claimant. Realistically, the only way that the lien claimant will recover it is from the defendant.

LC 4903.07(b) specifically provides that nothing precludes an order or award of reimbursement of a filing or activation fee pursuant to the express terms of an agreed disposition of a lien dispute. The appeals board may not award reimbursement of the fee on its own unless the conditions of LC 4903.07 are satisfied. But the parties may agree to reimburse the lien claimant's fee as part of a settlement. So lien claimants and defendants will be involved in the proverbial game of chicken. They may have a number for settlement, but will reimbursement of the fee be added to it or not?

NO RECOVERY FOR NONAUTHORIZED TREATMENT OF KNOWN INDUSTRIAL CONDITION

LC 4903.1 allows a lien for benefits paid or services provided by a health-care provider; a health-care service plan; a group disability policy; or a self-insured employer welfare plan. Former LC 4903.1(b) was eliminated, and a new subsection (b) was added.

Eliminating this section in its previous form was important because, at the time of submitting the case for settlement, it called on parties to file liens that had been served on them. As discussed below, this little-known section had caused some stir, because, arguably, under some circumstances it could force defendants to blow their own statute of limitation defense.[2] With the new rules about filing fees, this provision certainly would not have been feasible.

LC 4903.1(b) does not allow payment or reimbursement of these kinds of medical treatment expenses if, at the time the expense was incurred, the provider either knew or in the exercise of reasonable diligence should have known[3] that the condition being treated was caused by the employee's employment. LC 4903.1(b) precludes recovery whether payable by the employer or payable as a lien against the employee's recovery. Furthermore, it provides that the employee will have no liability for the expense.

LC 4903.1(b), however, defines several exceptions to this general rule. It says that a medical provider may recover if it knew or should have known that the employee's condition was industrial under any of these conditions:

1. The expense was authorized by the employer.
2. The expense was furnished while the employer failed or refused to furnish treatment as required by LC 5402(c).
3. The expense was necessarily incurred for an emergency medical condition.

The term "emergency medical condition" is defined by Health and Safety Code 1317.1(b). It states that an "emergency medical condition" manifests by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any body organ or part.

Before enactment of this provision, these kinds of liens usually were defended only by the statute of limitations (as discussed next). That is, large health-care organizations would become aware after the fact (even if they should have known) that the treatment provided was compensable under workers' compensation, and would file a lien. Sometimes this lien was filed right away, and sometimes very late in the game. They would proceed to recover on the theory that LC 4600 allowed for all reasonable care. This language places an additional barrier to such liens. Regardless of how much time has passed, the conditions established here must be met. This serves the dual function of having the nonindustrial providers take greater responsibility for screening industrial cases ahead of time, and enforcing respect for the rules concerning medical control.

[2] There was an attempt in 2012 to close this possible loophole by enacting regulations as described in "Sullivan on Comp" Section 6.51 Statute of Limitations for Filing a Lien.

[3] This "knew or in the exercise of reasonable diligence should have known" standard certainly will be tested in the courts. There is no precedent for what constitutes knowledge by physicians or medical groups. There are two places in the law where a court might seek guidance, the applicant's required knowledge of cumulative trauma injury under LC 5412, which is found in "Sullivan on Comp" Section 5.5 Cumulative Injury, and an employer's knowledge of industrial injury, which is discussed in "Sullivan on Comp" Section 5.16 Presumption of Injury — 90-Day Rule.

STATUTE OF LIMITATIONS

The statute of limitations for filing a lien under LC 4903.5 for medical expenses has been amended. Former LC 4903.5 provided that a lien must be filed from the latest of:

1. six months from the date on which the appeals board issues a final decision, findings or order, including an order approving a compromise and release, or award, on the merits of the claim;
2. five years from the date of the injury for which the services were provided; or
3. one year from the date the services were provided.

LC 4903.5 was amended so that a lien for medical expenses must be filed no more than three years after the date services were provided. For services provided on or after July 1, 2013, a lien may be filed no more than 18 months after the date they were provided.

Notwithstanding these limits, certain medical providers may file a lien within 12 months after the entity knew or in the exercise of reasonable diligence should have known that an industrial injury was being claimed. Even in these cases, though, the lien may not be filed more than five years from the date the services were provided. These providers are:

1. a health-care service plan licensed per Health and Safety Code 1349;
2. a group disability insurer under a policy issued in California per IC 10270.5;
3. a self-insured employee welfare benefit plan as defined by IC 10121 issued in California;
4. a Taft-Hartley health and welfare fund;
5. a publicly funded program providing medical benefits on a nonindustrial basis.

Additional changes were made to the Labor Code to further strengthen the statute of limitations. As discussed in "Sullivan on Comp" Section 6.51 Statute of Limitations for Filing a Lien, some cases interpreted former LC 4904(a)[4] and former LC 4903.1(b)[5] as creating a loophole in the statute of limitations under LC 4903.5 for cases in which partial payments were made. The argument went that a partial payment by an employer created notice of a lien under former LC 4904(a), and that employers had a duty to file such liens with the appeals board under former LC 4903.1(b). So if the employer failed to serve such lien claimants with an order or settlement, the statute of limitation under LC 4903.5 would be tolled.

Although these so-called "zombie" liens were addressed by the WCAB's amendments to CCR 10770 on May 21, 2012, SB 863 further compromises their viability. LC 4904(a) was amended to clarify that only notice of a claim allowable as a lien in favor of the Employment Development Department creates a lien against compensation. And the language of former LC 4903.1(b) requiring parties to file any liens served on them at the time a C&R is submitted was eliminated altogether. So lien claimants have an affirmative duty to timely file their liens.

TIME TO FILE LIENS

LC 4903.6 places restrictions on filing liens with the appeals board. It has been amended so that, except as necessary to avoid violating the statute of limitations (under LC 4903.5, as above), the lien is not to be filed with the appeals board unless two conditions are met:

[4] Former LC 4904(a) stated in pertinent part, "If notice is given in writing to the insurer, or to the employer if uninsured, setting forth the nature and extent of any claim that is allowable as a lien, the claim is a lien against any amount thereafter payable as compensation, subject to the determination of the amount and approval of the lien by the appeals board."
[5] Former LC 4903.1(b) stated in pertinent part, "When a compromise of claim or an award is submitted to the appeals board ... the parties shall file ... any liens served on the parties."

1. Sixty days have elapsed after the date of acceptance or rejection of liability for the claim, or expiration of the time for investigation of liability per LC 5402(b), whichever date is earlier.
2. Either:
    A. The time allowed for payment of medical treatment bills per LC 4603.2 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined per LC 4603.6, and, if authorization for the medical treatment has been disputed per LC 4610, the necessity of the medical treatment has been determined per LC 4610.5 and LC 4610.6. Or
    B. The time allowed for payment of medical-legal expenses per LC 4622 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined per LC 4603.6.

So a lien may not be filed or served until 60 days after the claim has been accepted or denied or 60 days after the 90-day investigation period, whichever is earlier. Nor may a lien be filed and served until after the 45-day period defined in LC 4603.2 or the 60-day period for payment defined in LC 4622 has expired. If the employer disputes the amount of the bill, the lien may not be filed until the after the independent bill review process established in LC 4603.6 has been completed and it has been determined that the fee is reasonable. Also, if the employer disputes authorization in its entirety, the lien may not be filed until after the independent medical review process established in LC 4610.5 and LC 4610.6 has been completed and it has been determined that the treatment was medically necessary.

NOTIFICATION OF REPRESENTATION

LC 4903.6 was amended to place notice requirements on lien claimants when they obtain or change representation. LC 4903.6(b) requires all lien claimants under LC 4903 to notify the employer, the employee, their respective representative, if any, and the appeals board within five days of obtaining, changing or discharging representation by an attorney or nonattorney representative. The notification must include the legal name, address and telephone number of the attorney or nonattorney representative.

This requirement places new notification requirements on lien claimants. Generally, lien claimants do not appear at lien conferences — they have someone from their office appear. They hire a lien collection service to represent them at appeals board hearings, and it is not uncommon for a defendant not to know whom it would be dealing with until arriving at the appeals board. Now, just like regular parties, lien claimants must notify the parties and the appeals board if they have obtained attorney or nonattorney representation.

RESTRICTIONS ON ENTITLEMENT TO MEDICAL INFORMATION

LC 4903.6(d) was added to restrict the disclosure of medical information to some lien claimants. With the exception of a lien for services provided by a physician per LC 3209.3, it prohibits lien claimants from receiving any medical information about an injured worker without prior written approval of the appeals board. Most liens are for medical treatment or for medical-legal services, and are filed by lien claimant physicians; as such, most are not subject to this restriction. A full discussion of the definition of physician is given in “Sullivan on Comp” Section 7.12 Treatment by Authorized Physician.

For nonphysicians, however, the restrictions are serious. The statute defines the term “medical information” as in “subdivision (g) of Section 50.05 of the Civil Code.” But this appears to be a typo as the term “medical information” is defined in Civil Code section 56.05(g). It is defined as “any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical

history, mental or physical condition, or treatment." So LC 4903.6(d) precludes disclosure of practically all medical information about an injured worker. (Several sections discuss privacy in "Sullivan on Comp" Chapter 14: Discovery and Settlement, but Civil Code 56 is discussed in particular in Section 14.16 Privacy — General Privacy Law, HIPAA and CMIA.)

A nonphysician lien claimant may receive medical information only with written approval of the appeals board. Even if the nonphysician claimant receives an order, it is not automatically entitled to all of the employee's medical information. The statute says that any order authorizing disclosure of medical information to a lien claimant other than a physician must specify the information to be provided to the lien claimant and include a finding that such information is relevant to the proof of the matter for which the information is sought.

The appeals board is required to adopt reasonable regulations to ensure compliance with LC 4903.6(c). It also must take further steps as necessary to enforce the regulations, including, but not limited to, imposition of sanctions per LC 5813. When it does, it must consider changes to CCR 10608 and related regulations, which currently mandate service of medical reports on all parties, including lien claimants, after a case is established with the appeals board. This area is covered in depth in "Sullivan on Comp" Section 14.7 Service of Medical Reports.

ASSIGNMENT OF LIENS AND DECLARATIONS UNDER PENALTY OF PERJURY

LC 4903.8 is added to severely limit assignment of liens. LC 4903.8(a) says that any order or award for payment of a lien for medical treatment must be only to the person who was entitled to it for the expenses at the time they were incurred, and not to an assignee. Payment may be made to the assignee only if the original lien claimant has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title and interests in the remaining accounts receivable to the assignee. So if the original lien claimant is still in business, payment must be made to that party.

It appears that this statute will go into effect as of Jan. 1, 2013, regardless of the date of injury. It seems to apply even in cases in which assignment has been long made. This can cause serious difficulty for lienholders who have paid out of pocket for liens and now must go through the original service providers to get paid. This situation seems certain to lead to litigation over entitlements.

Assignments have to be filed with the appeals board. Per LC 4903.8(b), if there has been an assignment of a lien, either as an assignment of all right, title and interest in the accounts receivable or as an assignment for collection, a true and correct copy of the assignment must be filed and served. If a lien is filed on or after Jan. 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment must be served at the time the lien is filed. If a lien is filed on or after Jan. 1, 2013, and the assignment occurs after it's filed, the copy of the assignment must be served within 20 days of the date of the assignment. If a lien is filed before Jan. 1, 2013, the copy of the assignment must be served by Jan. 1, 2014, or with the filing of a DOR or at the time of a lien hearing, whichever is earlier.

Per LC 4903.8(c), if there has been more than one assignment of the same receivable or bill, the appeals board may set the matter for hearing on whether the multiple assignments constitute bad-faith actions or tactics that are frivolous, harassing or intended to cause unnecessary delay or expense. If this is found by the appeals board, it may issue appropriate sanctions, including costs and attorneys' fees, against the assignor, assignee and their respective attorneys. Obviously, this provision is made in response to perceived abuse in the area.

Per LC 4903.8(d), lien claimants now must file declarations with their liens under penalty of perjury. For a lien filed on or after Jan. 1, 2013, the declaration must be filed at the time of filing of the lien. For liens filed before Jan. 1, 2013, the declaration must be filed at the earliest of the filing of a DOR, a lien hearing or Jan. 1, 2014. A lien claimant must file one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring:

1. The services or products described in the bill for services or products were provided to the injured employee. And
2. The billing statement attached to the lien accurately describes the services or products provided to the injured employee.

Note that 4903.8(d) does not specify that the declarations must be filed only in situations with an assignment of interest. Read literally, it would apply to the filings of all liens. If this is so, the declarations will have to be included in the list of items lien claimants must provide, as articulated in 8. Independent Bill Review. But this requirement is placed in the statute in such a way as to make it reasonable to interpret the provision as applying only if there has been an assignment.

Per LC 4903.8(e), a lien for medical expenses submitted for filing on or after Jan. 1, 2013, that does not comply with its requirements will be deemed invalid, whether or not accepted for filing by the appeals board. Such a filing will not operate to preserve or extend any time limit for filing of the lien.

LC 4903.8(g) provides that these requirements will take effect without regulatory action. The appeals board and the administrative director, however, have discretion to formulate regulations and forms for implementation of LC 4903.8.

8. INDEPENDENT BILL REVIEW

Once entitlement is established, what is a medical service, worth? The reasonable amount for medical services is a frequent point of contention in workers' compensation. Despite the Official Medical Fee Schedule (OMFS) that establishes reasonable maximum fees for medical services, defendants and lien claimants still argue over what is reasonable, and particularly how a case applies to the schedule. Some such disputes center on whether the services are properly coded. Other disputes revolve around the appropriate value for a given service. Formerly, if the disputes could not be resolved, defendants and lien claimants were forced to try the issue before a WCJ, who often was ill-equipped to adjudicate. (For a full discussion of the OMFS, see "Sullivan on Comp" Section 7.69 Official Medical Fee Schedule.)

SB 863 establishes a new independent bill review process. The intention is to eliminate litigation at the appeals board over billing disputes. In establishing the process, the Legislature stated, "Existing law does not provide for medical billing and payment experts to resolve billing disputes, and billing issues are frequently submitted to workers' compensation judges without the benefit of independent and unbiased findings on these issues." The Legislature added, "Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system."

The new independent bill review process is designed resolve disputes over medical billing quickly. It relieves WCJs of making decisions about disputes and gives that authority to independently contracted expert bill reviewers, whose decisions are be the last word on the amount to be paid for a medical procedure.

STATUTORY AUTHORITY FOR INDEPENDENT BILL REVIEW

To establish the independent bill review process, SB 863 added LC 139.5. The Legislature found that "[t]he need for independent and unbiased findings and determinations requires that this new function be contracted." Accordingly, LC 139.5(a) provides that the administrative director must contract with one or more independent bill review organizations to conduct reviews. LC 139.5 also establishes the criteria for the independent bill review organization.

AMENDMENTS TO PROCEDURES AND TIME LIMITS FOR PAYING MEDICAL TREATMENT BILLS

LC 4603.2 establishes the procedures and time limits for payment of medical treatment charges. The section was amended and subsections were added to ensure that medical billing disputes are resolved through the independent bill review process. Changes also were made to the rules regarding documents

that must be submitted as a condition of entitlement to payment, and time limits for payment of medical treatment services.

Changes to Documents That Must Be Submitted with Request for Payment

Previously, a medical provider was required to provide only an "itemization of medical services provided, together with any required reports and any written authorization for services." This language remains in LC 4603.2(b)(2), but new LC 4603.2(b)(1) describes additional documents that must be submitted. It states, "Any 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."

So providers must attach a copy of all reports showing the services performed. They also must attach the prescription or referral from the primary treating physician so that the employer can confirm that the treatment was provided by an authorized primary treating physician.

Note that to some extent, these new statutory requirements are a codification of lien regulations CCR 10770 and CCR 10770.5 that were enacted earlier in 2012. CCR 10770 requires a "full statement or itemized voucher" supporting a lien claim, and must include:

A. any amount(s) previously paid by any source for each itemized service;
B. a statement that clearly and specifically establishes the basis for the claim for additional payment;
C. proof that the lien claimant is the service provider or owner of the alleged debt; and
D. a declaration under penalty of perjury under the laws of the State of California that all of the information provided is true and correct.

Under CCR 10770.5 a verification in a certain format is required as well. Under penalty of perjury, the verification must contain a statement, per CCR 10770.5(a), specifying in detail the facts establishing that the time for payment of the bill has elapsed.

Together these require a lien claimant to submit:

1. an itemization of services provided and the charge for each service, along with any amount(s) previously paid by any source for each itemized service;
2. a statement that clearly and specifically establishes the basis for the claim for additional payment;
3. a copy of all reports showing the services performed;
4. 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;
5. proof that the lien claimant is the service provider or owner of the alleged debt (this may be addressed by adding certain language to the declaration);
6. a declaration under penalty of perjury under the laws of the State of California that all of the information provided is true and correct;
7. the name, mailing address and telephone number of a person with authority to resolve the claim on behalf of a claimant (CCR 10770(d)); and
8. the verification required under CCR 10770.5.

Failure to submit any of this will be fatal to the lien. This topic is discussed in depth in "Sullivan on Comp" Section 15.89 Liens — Filing Procedure.

Changes to Time Limits for Payment

LC 4603.2(b)(2) shortens the period for an employer to make payment. It states, "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." Previously, the employer was required to make payment within "45 working days." Now, it must make payment within 45 calendar days. Likewise, the language in the bill used to provide that the employer had 30 "working days" to object to a bill if it was not going to make payment; now this standard has been changed to just "days." This is a good change — the term "working days" could cause confusion.

The time limits for payment of or objection to electronic bills, however, are unchanged. LC 4603.4(d) was amended to require an employer to attach an explanation of review with a payment. But it still requires that payment must be made within 15 working days after receipt of an itemized electronic bill. It's possible that the drafters just missed this point.

Explanation of Review

LC 4603.3 is new. It requires the employer to provide an explanation of review. (LC 4603.2(b)(2) is amended to use this term as well.) LC 4603.3(a) requires that on payment, adjustment or denial of a complete or incomplete itemization of medical services, an employer must provide an explanation of review in the manner prescribed by the administrative director that includes:

1. a statement of the items or procedures billed and the amounts requested by the provider to be paid;
2. the amount paid;
3. the basis for any adjustment, change or denial of the item or procedure billed;
4. the additional information required to make a decision for an incomplete itemization;
5. the reason for the denial of payment if it's not a fee dispute; and
6. information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review must inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill per LC 4603.6.

So to comply with the requirements of LC 4603.3, employers must establish new forms for their explanation of reviews. LC 4603.3(b) permits the administrative director to adopt regulations requiring the use of electronic explanations of review. Curiously, this still is required in the case of payment, which seems silly — why review something that is paid? — so perhaps the regulations will treat this as a requirement only when partial payment is made.

Duplicate Submissions

LC 4603.2(b)(4) was added to address how employers were required to deal with duplicate submissions. It states, "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."

So if an employer has issued an explanation of review explaining why the medical provider was not paid or was only partially paid, the employer is not required to take any additional action for a duplicate submission. As discussed below, if the medical provider does not timely respond to an explanation of review, it will lose any right to further payment. LC 4603.2(b)(4) explains that this right is not preserved by a duplicate submission.

This rule works hand in hand with the relatively new lien regulations established in 2012. CCR 10770(b) deliberately limits the documents to be filed with the appeals board, requiring that only the original lien is to be filed. The same is not true for service of liens; lien claimants are required to serve all original liens, amended liens and supporting documentation on the parties. CCR 10770(c)(1) requires that all original and amended lien claims with a full statement or itemized voucher supporting the lien and a proof of service must be served. Amended liens require the full service too, under CCR 10770(c)(3). So it's easy to imagine a claims adjuster being surrounded by mail; duplicate objections would be a concern. (Again, this topic is discussed in depth in "Sullivan on Comp" Section 15.89 Liens — Filing Procedure.)

Still, the claims adjuster must not be capricious. LC 4603.2(b)(4) applies only to duplicate submissions and not to any other penalties or interest that may be applicable to the original submission. So every lien received should be inspected to see if there is something new.

SECOND REVIEW AS A PREREQUISITE TO INDEPENDENT BILL REVIEW

LC 4603.2(e) is added to establish the procedure a medical treatment provider must follow before initiating the independent medical bill review process. Failure to follow the procedure will prevent a medical provider from recovering any additional payments.

Request for Second Review

Per LC 4603.2(e)(1), a provider who disagrees with the amount paid by the employer must request that the employer reconsider its findings. The request must be made 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." So a medical provider must request a second review within: (1) 90 days of an explanation of review; or (2) 90 days of an order from the appeals board resolving the threshold issue stated in the explanation of review. Time limit (2) applies when an employer disputes liability for reasons other than the amount paid (for example, denial of injury or body parts).

The request for a second review is to be submitted to the employer on a form prescribed by the administrative director. The form must include:

1. the date of the explanation of review and the claim number or other unique identifying number on the explanation of review;
2. the item and amount in dispute;
3. the additional payment requested and reason for it; and
4. 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.

Failure to Request a Second Review

LC 4602.3(e)(2) states, "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." So for the bill to be lost, there must be no dispute except the amount owed.

This does not cover cases with other issues with the billing, such as a denial of injury, a contested body part or alleged improper treatment outside a proper MPN.

Because of the restrictions in LC 4603.2(e)(1), it may be that failure to timely request a second review 90 days from an appeals board order also will bar further recovery. Perhaps regulations will clarify.

Employer's Response to Request for Second Review

Per LC 4602.3(e)(3), the employer must respond promptly to a request for a second review. The statute requires the employer to respond with a final written determination on each of the items or amounts in dispute within 14 days of a request for second review. In addition, payment of any balance not in dispute must be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

Per LC 4602.3(e)(4), if, after receipt of the second review, the medical provider still contests the amount paid, the provider must request an independent bill review under LC 4603.6.

The statute is silent on the consequence to the employer if this response is late or nonexistent. Presumably, the independent bill review will be allowed in this instance once the time period has run, as any other reality would put the medical biller in an untenable position.

Zombie Liens

It is worth noting that the 90-day period to request a second review mimics the 90 days to request additional payment after a partial payment that was adopted with the significant lien regulations enacted in 2012. Those regulations were adopted in part to eliminate so-called "zombie liens." They arose when medical services were provided, but only partial payment was made. As discussed in full in "Sullivan on Comp" Section 6.51 Statute of Limitations for Filing a Lien, some cases allowed these liens to avoid the statutes of limitations.

CCR 10770(b)(3)and (4) were enacted to close this loophole; they imposed a requirement that medical providers request additional payment within 90 days after a partial payment. As discussed in Lien Reform, SB 863 made further changes to eliminate these liens. Now, instead of 90 days to request additional payment, medical providers have 90 days to request a second review.

AMENDMENT TO PROCESS FOR PAYMENT OF MEDICAL-LEGAL EXPENSES

LC 4622 outlines the procedures for payment of medical-legal expenses. This section also was amended to steer disputes regarding payment of medical-legal charges to the independent bill review process. As outlined below, the procedures for disputing medical-legal charges are similar to those for disputing medical treatment charges. (This topic is discussed in depth in "Sullivan on Comp" Section 14.65 Payment of or Objection to Medical-Legal Expenses.)

Objection to and Payment of Medical-Legal Expenses

LC 4622(a) still requires the employer to pay medical-legal expenses within 60 days after receipt of each separate written billing and report. It was amended to provide that if the employer, within the 60-day

period, contests the reasonableness of the fees, services and expenses, it must issue an explanation of review as required by LC 4603.3 (described above). Then, the employer must make payment within 20 days of an order directing payment by the appeals board or the administrative director, per LC 4603.6 (which establishes the independent bill review procedure).

Request for Second Review

Per LC 4622(b), if the provider contests the amount paid, the provider may request a second review within 90 days of the service of the explanation of review. The request must be submitted to the employer on a form prescribed by the administrative director. It must include:

1. the date of the explanation of review and the claim number or other unique identifying number on the explanation of review;
2. the party or parties requesting the service;
3. any item and amount in dispute;
4. the additional payment requested and the reason for it; and
5. any additional information requested in the original explanation of review and any other information provided in support of the additional payment requested.

If the provider does not request a second review within 90 days, the bill will be deemed satisfied and neither the employer nor the employee will be liable for any further payment.

Employer's Response to Request for Second Review

LC 4622(b)(3) requires an employer to respond with a final written determination of the items or the amount in dispute within 14 days of the request for second review. If the provider still contests the amount paid after receipt of the second review, the provider must request an independent bill review.

Disputes Over Issues Other Than Amount of the Charges

LC 4622(c) describes the dispute process when the employer disputes the medical-legal charges for reasons other than the amount paid. Although medical-legal charges generally are payable even if the employee is denied recovery, as discussed in "Sullivan on Comp" Section 14.65 Payment of or Objection to Medical-Legal Expenses, in some situations, medical-legal charges are not payable. For example, the Court of Appeal has recognized that payment may be denied to a medical-legal lien claimant who prepared a report in good faith if the worker fraudulently sought the report.[1]

An objection still is required of the provider in this situation. The statute reads that "If the provider does not object to the denial within 90 days, neither the employer nor the employee shall be liable for the amount that was denied." This 90-day period runs from the service of the explanation of review that objected to all or part of the bill.

Of course, independent bill review cannot resolve issues beyond the reasonable value of medical services, so the matter must go to court. When an objection is made, the statute mandates that the employer take action, apparently without regard to the case-in-chief: "[T]he employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection." Presumably, the employer's petition must enumerate specific grounds why it believes the medical-legal charges should not be paid. Evidently, the Legislature does not want these disputes waiting for resolution

[1] *Beverly Hills Multispecialty Group, Inc. v. WCAB* (1994) 59 CCC 461.

of the case-in-chief. As a practical matter, it is unlikely that the appeals board will hear this as a bifurcated issue. But if the defendant does what it's supposed to, the matter at least will come before a WCJ.

If the employer wins, of course nothing is owed; LC 4622(c) even goes so far as to allow restitution of any amounts paid that were not owed. It does not describe what happens if the medical provider prevails. Presumably, the employer must pay the charges pursuant to the fee schedule, and if there is a dispute whether the payments were proper, it would go to the independent bill review process. Again, a regulatory scheme is needed here.

INDEPENDENT BILL REVIEW

The independent bill review process is established in newly minted LC 4603.6. It describes the time limits for requesting an independent bill review, the procedures to be followed and the limited appeals process allowed following a decision by the independent bill reviewer.

Time Limits for Requesting Independent Bill Review

LC 4603.6(a) provides that if the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the employer's second review. If the provider fails to request an independent bill review within 30 days, the bill will be deemed satisfied, and neither the employer nor the employee will be liable for any further payment.

The time limit for requesting an independent medical review when an employer disputes more than just the amount paid is more difficult to discern. LC 4603.6(a) states, "If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622."

We await regulations to better understand how this will work. It is unclear what the time limitation is when there is a dispute over a threshold issue and also a dispute over the reasonable value of the service. It is clear that the threshold issue is to be resolved first, but we don't know if a request for independent bill review is simply on hold until then, or if another request is required. If it is, it's uncertain if this will be 30 days from resolution of the threshold issue, or 90 days, in accordance with LC 4603.2(e)(1). The statutes simply do not give enough guidance.

Form for Requesting Independent Bill Review

LC 4603.6(b) requires that a request for independent review be made on a form prescribed by the administrative director. The request must include:

1. copies of the original billing itemization;
2. any supporting documents that were furnished with the original billing;
3. the explanation of review;
4. the request for second review together with any supporting documentation submitted with it;
5. the final explanation of the second review.

The administrative director may require that requests for independent bill review be submitted electronically. A copy of the request, together with all required documents, must be served on the employer.

Note, however, that only the request form and the proof of payment of the fee must be filed with the administrative director. On notice of assignment of the independent bill reviewer, the requesting party must submit all the required documents to the reviewer within 10 days.

Independent Bill Review Fees

LC 4603.6(c) requires the provider to pay a fee to the administrative director when seeking review. Obviously, this deters the provider. The administrative director must determine what these fees will be. They are not to be excessive; rather, they are to be only enough to cover the reasonable estimated cost of independent bill review and administration of the review program. The administrative director may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation adopted by the administrative director.

If any additional payment is found owing from the employer to the medical provider, the employer must reimburse the provider for the fee in addition to the amount found owing. This deters the employer. So both parties are invested in the outcome before they start the process.

The fees mentioned in LC 4603.6(c) are of an "all or nothing" nature. If, for example, a provider seeks an additional payment of $10,000 through the independent review process, and a finding is issued allowing an additional payment of only 25 cents, the employer is penalized and must reimburse the provider the full cost of the independent review because an additional payment of 25 cents is due to the provider. The only way an employer may escape reimbursement for the cost of the independent review is when the provider is entitled to no additional payment.

Employers may find the fee somewhat unfair. But it must be remembered the medical provider must front the costs of the independent bill review fee, and would lose the entire fee if the reviewer determines that the bill appropriately was paid. So both employers and medical providers should attempt to determine the reasonable value of services as accurately as possible — or resolve the issues before going forward.

Independent Bill Review Process and Determination

Per LC 4603.6(d), on receipt of a request for independent bill review and the required fee, the administrative director or the administrative director's designee must assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the reviewer assigned. There are no secret identities here as there are with independent medical review.

Under LC 4603.6(e), the independent bill reviewer must 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. If necessary, the independent bill reviewer may request additional documents from the medical provider or employer. The employer has no obligation to serve medical reports on the provider unless the reports are requested by the reviewer. If additional documents are requested, the parties must respond with them within 30 days and must provide the other party with copies of any documents submitted to the reviewer.

It may be of note that this statute has nothing in the way of restricting ex parte communication, oral or otherwise. In fact, the reviewer is encouraged to seek any documentation, and perhaps even information, from any party. This is much different from the rules surrounding independent medical review or communications with medical-legal evaluators. Perhaps the drafters thought that this simpler process did

not require protection against abuse. Perhaps we will see some rules built into this in the regulatory scheme.

The independent reviewer must make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination within 60 days of the receipt of the administrative director's assignment. The written determination of the reviewer must be sent to the administrative director and provided to both the medical provider and the employer.

Appeal of the Independent Bill Review Determination

Per LC 4603.6(f), the determination of the independent bill reviewer is deemed a determination and order of the administrative director. The determination is final and binding on all parties unless an aggrieved party files with the appeals board a verified appeal from the medical bill review determination. The appeals must be filed within 20 days of the service of the determination.

The independent bill review determination is presumed to be correct and may be set aside only on clear and convincing evidence of one or more of these grounds for appeal:

1. The administrative director acted without or in excess of his or her powers.
2. The determination of the administrative director was procured by fraud.
3. The independent bill reviewer was subject to a material conflict of interest in violation of LC 139.5.
4. The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability.
5. The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake is a matter of ordinary knowledge based on the information submitted for review and not a matter subject to expert opinion.

The independent bill review process is designed to be the last word on the reasonable amount for medical services. So the grounds for appeal are limited. Furthermore, the decision may be set aside only on a showing of clear and convincing evidence, which is a higher standard than the usual preponderance of the evidence standard required in all other workers' compensation issues.

In addition per LC 4603.6(g), if the determination of the administrative director is reversed, the dispute must be remanded to the administrative director to submit the dispute to independent bill review by a different independent bill review organization or a different reviewer within the original bill review organization if a different review organization is not available. In no event, however, shall the appeals board or any higher court make a determination of ultimate fact contrary to the determination of the bill review organization.

Time Limits on Payment

Once the independent bill reviewer has made a determination regarding additional amounts to be paid to the medical provider, the employer must pay them per the timely payment requirements defined in LC 4603.2 and LC 4603.4. Again, these sections require payments to be made within 45 days for normal requests for payment, and 15 days for electronic receipt of an itemized billing. Per LC 4622(a), the employer must make payment for medical-legal charges within 20 days of service of the determination.

The statute presumes that it is possible for an employer only to underpay a medical bill; it provides no remedy if the independent bill reviewer determines that the employer overpaid. Because there is no

statutory authority for reimbursement of the employer, the medical provider may not be required to pay the employer back for any over payments.

AMENDMENTS TO THE FEE SCHEDULE

The Official Medical Fee Schedule is established in LC 5307.1. Previously, it required the administrative director periodically to adopt and revise an OMFS that establishes reasonable maximum fees paid for medical services, drugs and pharmacy services, health-care facility fees, home health care and other goods and services. But LC 5307.1 provided that the OMFS was to be established for medical services "other than physician services."

SB 863 amends LC 5307.1 to require the administrative director to adopt an OMFS for physician and nonphysician services. It changes the maximum value for services performed in an ambulatory surgical center. It added LC 5307.8 to give the administrative director specific directions for the fee schedule for home health-care services. It also added LC 5307.9, which establishes a fee schedule for copy services.

Fee Schedule for Physician and Nonphysician Services

LC 5307.1 was amended to add subsection (a)(2) to require a fee schedule for physician and nonphysician services. Nonphysician services include, but are not limited to, physician assistant, nurse practitioner and physical therapist services. The fee schedule is to be established on the "resource-based relative value scale." This system is used by Medicare and Medicaid to determine the value for physician services.

In order for physician and nonphysician services to be paid, the employer's liability for medical treatment, including issues of reasonableness, necessity, frequency and duration must be determined in accordance with LC 4600. This fee schedule must be updated annually to reflect changes to the procedure codes, relative weights and the adjustment factor. Per LC 5307.1(g)(3)(D), the "relative value scale adjustment factor" means "the annual factor applied by the federal Centers for Medicare and Medicaid Services to the Medicare conversion factor to make changes in relative value units for the physician fee schedule budget neutral."

The administrative director is instructed that the maximum reasonable fees paid must not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services as it appeared on July 1, 2012, before application of the adjustment factor. Any service not covered under the Medicare program will be paid at the rate established by LC 5307.1(d), which provides that the maximum fee must not exceed 120 percent of the fee paid by Medicare for services that require comparable resources.

The administrative director is given some time to formulate the new fee schedule. LC 5307.1(a)(2)(A)(iv) grants a four-year transition between the estimated aggregate maximum allowable under the OMFS for physician services before Jan. 1, 2014, and the relative value scale at 120 percent of the Medicare conversion factors. LC 5307.1(a)(2)(B) adds that the OMFS must include payment ground rules that differ from those of Medicare, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery.

LC 5307.1(a)(2)(C) establishes how physician and nonphysician services are to be paid before the adoption of a resource-based relative value scale OMFS. Commencing Jan. 1, 2014, and continuing until the administrative director has adopted the appropriate fee schedule, the maximum reasonable fees for physician and nonphysician practitioner services must be in accordance with the fee-related structure and rules of the Medicare payment system for those services except that an average statewide geographic

adjustment factor of 1.078 will apply in lieu of Medicare's locality-specific geographic adjustment factors. The statute then establishes the conversion factors to be used for different procedures through 2017.

Per LC 5307.1(k), except as revised by the administrative director, the OMFS rates for physician services in effect on Dec. 31, 2012, will remain in effect until Jan. 1, 2014.

Fees for Hospital Outpatient Department and Ambulatory Surgical Center

Previously, LC 5307.1(c) decreed that the maximum fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, were not to exceed 120 percent of the fees paid by Medicare for services that required comparable resources. The maximum fees for services in a hospital outpatient department were not changed by SB 863. But the maximum fees for services in an ambulatory surgical center were reduced. Now, those fees must not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

Per LC 5307.1(c)(2), the DIR must study the feasibility of establishing an ambulatory surgical facility fee not subject to a fee paid by Medicare for outpatient department services and set at 85 percent of the diagnostic-related group (DRG) fee paid by Medicare for the same services performed in a hospital inpatient department. This must be reported to the Senate Labor Committee and Assembly Insurance Committee no later than July 1, 2013.

Fees for Vocational Experts

LC 5307.7 required the administrative director to establish a fee schedule for the reasonable hourly fee paid for services provided by vocational experts. A minor change was made to clarify that vocational experts were not to be paid fees inconsistent with the fee schedule.

Fees for Home Health Care

LC 5307.1 required the administrative director to establish a fee schedule establishing the reasonable maximum fees paid for medical services, including home health care. LC 5307.8 was added requiring the administrative director to establish a fee schedule for home health care not otherwise covered by a Medicare fee schedule or by the OMFS. As discussed in Medical Treatment Limitations, the new fee schedule must be based on the maximum services hours and fees established in specified sections of the Welfare and Institutions Code.

Fees for Copy Services

SB 863 added LC 5307.9 requiring the administrative director to establish a schedule of maximum allowable fees for copy and related services. This schedule is to cover copy services including, but not limited to, records or documents that have been reproduced or recorded in paper, electronic, film, digital or other format.

The fee schedule must specify the services allowed and require specificity in billing for them. In addition, the schedule must not allow payment for services provided within 30 days of a request by an injured worker or his or her authorized representative to an employer, claims administrator or workers' compensation insurer for copies of records in the employer's, claims administrator's or workers' compensation insurer's possession that are relevant to the employee's claim.

It is not uncommon for an employee's attorney to subpoena records even though they have been subpoenaed by the defendant. The idea is that the employee should request these documents first from an employer, in order to avoid duplicate copy requests. The employee may subpoena the records only if they are not provided by the employer.

The schedule will apply to all copy and related services regardless of whether the costs are claimed under the authority of LC 4600 (medical treatment), LC 4620 (medical-legal) or LC 5811 (costs). The statute, however, allows the employer and the copy service provider to contract for costs outside the fee schedule.

Fees for Implantable Medical Devices

LC 5318, which related to fees for implantable medical devices, hardware and instrumentation for DRGs 004, 496, 497, 498, 519 and 520, has been repealed. It was operative only until the administrative director adopted a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries.

LC 5307.1(m) requires the administrative director, on or before July 1, 2013, to adopt a regulation specifying an additional reimbursement for MS-DRGs 028, 029, 030, 453, 454, 455, and 456 to ensure that the aggregate reimbursement is sufficient to cover costs, including the implantable medical device, hardware, and instrumentation. This regulation shall be repealed as of Jan. 1, 2014, unless extended by the administrative director.

Fees for Interpreters

SB 863 changed several provisions requiring interpreters to be paid pursuant to the fee schedule adopted by the administrative director. This is discussed in Interpreters.

9. THE MEDICAL-LEGAL PROCESS

SB 863 made several changes to the medical-legal process, which, of course, is how medical evidence is obtained to resolve disputed issues. (This subject is fully discussed in several sections of "Sullivan on Comp" Chapter 14: Discovery and Settlement.) The bill changed the qualification requirements of QMEs, and particularly those for chiropractors. It limited the scope of medical-legal evaluations, eliminating the ability of QMEs and AMEs to decide disputed medical treatment issues. And it made procedural changes for obtaining panel QMEs in cases involving both unrepresented and represented employees.

CHANGES TO QUALIFICATION REQUIREMENTS

Existing law establishes certain requirements relating to QMEs who evaluate medical-legal issues (See "Sullivan on Comp" Section 14.57 Appointment and Reappointment of Qualified Medical Evaluators.) SB 863 modifies the requirements for chiropractors to become QMEs, and limits the number of locations from which QMEs may conduct evaluations.

Chiropractor QME Qualifications

SB 863 drastically lowered the barrier for chiropractors to become QMEs by amending LC 139.2(b)(4)(a). Previously, a chiropractor was to have completed a chiropractic postgraduate specialty program including a minimum of 300 hours taught by a school or college recognized by the administrative director, the Board of Chiropractic Examiners and the Council on Chiropractic Education. This requirement has been eliminated.

Now, a chiropractor is required only to have been certified in California workers' compensation evaluation by a provider recognized by the administrative director. So it's easier for chiropractors to qualify as QMEs, and should cause an increase in the number of chiropractors functioning in that capacity.

Limitation on Number of Offices

LC 139.2(h)(3)(B) always required the administrative director, or the medical director appointed pursuant to LC 122, to send a panel of randomly selected QMEs who were within the "general geographic area of the employee's residence." Previously, there was no statutory limit to the number of offices from which a QME could practice. So, in order for a QME to maximize his or her chances of being put on any given panel, it became common for QMEs to operate from more than one office, and sometimes dozens or even hundreds of them, traveling about to do examinations while centralizing the administrative functions of their practices.

LC 139.2(h)(3)(B) adds a sentence stating, "An evaluator shall not conduct qualified medical evaluations at more than 10 offices." The statute does not explain what happens to QMEs who currently have more than 10 offices or by what date they must reduce the number, although presumably the practice is banned as of Jan. 1, 2013, when this provision is scheduled to take effect. This will need to be clarified by administrative regulations.

LIMITATION ON SCOPE OF MEDICAL-LEGAL EXAMINATIONS

As discussed in Utilization Review and Independent Medical Review, SB 863 creates a new independent medical review process to resolve disputes regarding medical treatment. Now, if an injured worker challenges a utilization review decision to deny or modify requests for treatment, he or she must request an independent medical review to determine whether the requested medical treatment is reasonable and necessary. The independent medical review process was intended to be the only option for resolving disputes regarding requests for medical treatment. Accordingly, various provisions of the Labor Code relating to the medical-legal process were amended.

LC 4061 was amended and an introduction was added stating, "This section shall not apply to the employee's dispute of a utilization review decision under Section 4610, nor to the employee's dispute of the medical provider network treating physician's diagnosis or treatment recommendations under Sections 4616.3 and 4616.4." So LC 4061, which deals with situations in which temporary disability in an accepted case is coming to an end, may not be used to resolve medical treatment disputes that should be resolved via utilization review under LC 4610. Such disputes must be resolved by the new independent medical review process. Also, LC 4061 may not be used to resolve disputes over an MPN doctor's diagnosis and treatment recommendations. Those should be resolved by the little-used process for a second and third opinion, or ultimately an independent medical review under LC 4616.3 and LC 4616.4.

Also, there are changes to LC 4061(b) and LC 4061(c) which now state that objections "to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for *future* medical care" must be resolved pursuant to LC 4062.2 and LC 4062.1, respectively (emphasis added). Previously, LC 4061(b) and LC 4061(c) provided that the medical-legal procedures of LC 4062.2 and LC 4062.1 would be utilized for disputes regarding "the need for *continuing* medical care" (emphasis added). Again, these changes reflect that continuing medical care issues must be resolved by the independent medical review process.

LC 4062, which covers any medical issues not covered by LC 4060 or LC 4061, also was amended. Former LC 4062(b), which related to the second opinion spinal surgery process, has been eliminated. LC 4062(b) now states, "If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5." LC 4062(c) states, "If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the employer's medical provider network established pursuant to Section 4616, the objection shall be resolved only in accordance with the independent medical review process established in Sections 4616.3 and 4616.4." Spinal surgery issues, like all other medical treatment issues, must be decided by independent medical review.

LC 4062.2 was amended so that the parties may agree to an AME, "except as to issues to the independent medical review process established pursuant to Section 4610.5." Also, LC 4064(a) was amended and a sentence added stating, "Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms, except medical treatment recommendations, which are subject to utilization review as provided by Section 4610, and objections to

utilization review determinations, which are subject to independent medical review as provided by Section 4610.5."

Together, these changes ensure that the independent medical review process is the sole process for resolving disputes regarding ongoing or continuing medical treatment issues. Such issues may not be referred to or decided by panel QMEs or AMEs. Such doctors still are required to address issues such as causation, temporary disability, permanent disability, apportionment and future medical care. But the reasonableness and necessity of all medical treatment is the exclusive domain of the independent medical review process.

CHANGES TO MEDICAL-LEGAL PROCESS IN CASES INVOLVING UNREPRESENTED EMPLOYEES

Generally, LC 4062.1 establishes the procedure for requesting a panel QME in cases involving unrepresented employees. Although it was not modified by SB 863, several other sections were amended. An administrative change was made in LC 139.2(h)(1) requiring the medical director to give preference in assigning panels to cases in which the employee is not represented. This acknowledges the strict time limits imposed on the administrative director for assigning panel QMEs in unrepresented cases. Other, more substantive changes, also were enacted.

Time for Assignment of a Panel QME

LC 139.2(h)(1) still requires the medical director to assign a three-member panel of QMEs in unrepresented cases within five workings days of a request. It is amended, however, to provide that if a panel is not assigned within 20 working days, the employee has a right to choose a QME to perform the evaluation. Previously, the employee had a right to choose a QME if the assignment was not made within 15 working days. So now the medical director has an extra week to assign a panel.

Free Choice of QME Limited to Reasonable Geographic Area

LC 139.2(h)(1) also is amended to limit the employee's choice of QMEs if the medical director does not timely assign a QME panel. Previously, if a QME panel was not timely assigned, the employee had the right to be evaluated by "any qualified medical evaluator of his or her choice." This free choice of QMEs was unrestricted. So an unrepresented worker who lived in San Francisco, theoretically, could request an evaluation with a panel QME in San Diego, and per LC 4062.1(c), an employer would be required to furnish payment of the estimated travel expenses.

LC 139.2(h)(1) now provides that if the medical director does not timely issue a QME panel, the employee has the right to obtain a QME of his or her choice "within a reasonable geographic area." What constitutes a "reasonable geographic area" is not defined in the statute. The term is explained in CCR 9780(h)[1] based on consideration of several factors, rather than any specific mileage limits. As discussed in "Sullivan on Comp" Section 7.50 Medical Control If There Is No Established Network, the courts have been fairly liberal in determining whether a physician is within a "reasonable geographic area," at least for the purposes of medical treatment. It is not clear whether the same standards will apply for medical-legal examinations, as medical-legal evaluations are different from medical treatment.

[1] (CCR 9780(h) states, "'Reasonable geographic area' within the context of Labor Code section 4600 shall be determined by giving consideration to: (1) The employee's place of residence, place of employment and place where the injury occurred; and (2) The availability of physicians in the fields of practice, and facilities offering treatment reasonably required to cure or relieve the employee from the effects of the injury; (3) The employee's medical history; (4) The employee's primary language.

Request for Supplemental Report

LC 4061(d) is amended, and former subsection (d) is moved to subsection (e). LC 4061(d)(1) now states, "Within 30 days of receipt of a report from a qualified medical evaluator who has evaluated an unrepresented employee, the unrepresented employee or the employer may each request one supplemental report seeking correction of factual errors in the report." LC 4061(d)(1) restricts the conditions under which a supplemental report obtained from a medical-legal evaluator for issues covered by LC 4061 in unrepresented cases may be sought.

The statute specifies that either party may request a supplemental report within 30 days. It does not, however, specify any penalties for failure to request a supplemental report within 30 days, or if the right is lost after that period. It is possible that failure to request a supplemental report within 30 days leaves the parties in a precarious position with respect to generation of further medical-legal evidence.

Furthermore, the statute specifies that the supplemental report is limited to "seeking correction of factual errors in the report." What this means probably will be disputed by the parties. Is a supplemental report requested to address errors in logical reasoning allowed? Can a supplemental report be requested to reconsider medical conclusions when the facts are correct? What about situations in which the physician simply fails to address an issue?

It may be that, to the extent that medical opinions are based on factual errors, a supplemental report could be requested. And parties have a well-established right to present rebuttal evidence to a medical opinion.[2] So the parties may be allowed to request supplemental reports on more than just seeking correction of factual errors, but this must be clarified.

LC 4061(d)(1) adds that a request for a supplemental report must be in writing and served on the opposing party at the time it is sent to the QME. Also, a request made by the employer must inform the employee of the availability of information and officers to assist him or her in responding to the request.

LC 4061(e) still allows the parties to submit a "treating physician's evaluation" for a permanent disability rating, and requires the administrative director to calculate the rating within 20 days of receipt. The statute still has not been amended to allow the parties to submit a QME's report for a permanent disability rating, although this is a generally accepted practice. Moreover, LC 4061(d)(2) provides that the permanent disability rating procedure defined in LC 4061(e) should not be invoked when a supplemental report is requested from a QME per LC 4061(d)(1). So the parties may submit reports of a QME for a permanent disability rating.

CHANGES TO MEDICAL-LEGAL PROCESS IN CASES INVOLVING REPRESENTED EMPLOYEES

LC 4062.2 establishes the procedure for requesting a panel QME in cases involving represented employees. It was amended to streamline the procedure.

Requests for Panel QME

LC 4062.2(b) eliminates the requirement that the parties must propose an AME before requesting a panel QME. Now, it states, "No earlier than the first working day that is at least 10 days after the date of mailing of a request for a medical evaluation pursuant to Section 4060 or the first working day that is at least 10 days after the date of mailing of an objection pursuant to Sections 4061 or 4062, either party may request

[2] See LC 5704; *Edgar v. WCAB* (1966) 31 CCC 376.

the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation."

So the parties still must object to a treating physician's recommendation pursuant to LC 4061 and LC 4062 in order to receive a panel QME under those sections. But even though LC 4060 was not amended, LC 4062.2(b) includes a new requirement that a party must request a medical evaluation pursuant to LC 4060 more than 10 days before a request for a panel of QMEs. LC 4060 relates to cases in which there are disputes over the compensability of an injury; that is, when a case is denied, but has no requirement that the parties object to a treating doctor's opinion or request an evaluation before requesting a panel QME. So, before SB 863, the parties could request a QME to resolve a disputed case without any prerequisite actions, other than to negotiate for an AME. Now, LC 4062.2(b) seemingly requires them to mail a request for an evaluation under LC 4060 more than 10 days before requesting a QME panel. This probably means nothing more than a letter notifying the opposing party that a panel QME will be requested, but this must be clarified.

Also, LC 4062.2 provides that a QME may be requested at least 10 days after the "date of mailing of a request" under LC 4060 or objection pursuant to LC 4061 and LC 4062. Because the statute specifies that the request may be made at least 10 days after the "date of mailing," it may be that the mail-box rule of CCR 10507 and *Messele*[3] do not apply. This also must be clarified by administrative regulations or the courts.

Striking of Panel QMEs

LC 4062.2(c) also amends the procedure and time limits for striking a doctor on receipt of a QME panel. The parties no longer are required to "confer and attempt to agree upon an agreed medical evaluator from the panel." In addition, instead of striking a doctor 10 days after assignment, the parties now may strike one name from the panel "[w]ithin 10 days of assignment of the panel by the administrative director."

Again, the statute specifies that the strike must be within 10 days of the assignment of the panel. So it may well be that the mail-box rule does not apply and that the date of assignment of the panel, not the receipt of notice of the panel, sets the time limit for striking. Some cases hold that the time to strike under the former statute commenced on the date the panel was assigned.[4]

LC 4062.2(c) states that if a party fails to exercise the right to strike a name from the panel within 10 days of assignment of the panel, the other party has the right to designate any remaining physician to serve as the panel QME. The administrative director is authorized to prescribe the form, the manner, or both, by which the parties must conduct the selection process. Until the administrative director clarifies when the strikes must take place, the parties do well to strike a name within 10 days of the assignment of the panel, without adding time for mailing.

No Unreasonable Refusal to Participate

LC 4062.2(d) remains. It still provides that the represented employee initially is responsible for arranging the appointment for the examination, but that the employer may do so if it's not done within 10 days of the QME selection. There's a new sentence, however, stating, "The employee shall not unreasonably refuse to participate in the evaluation."

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[3] *Messele v. Pitco Foods, Inc.* (2011) 76 CCC 956 (appeals board *en banc*). For a full discussion see "Sullivan on Comp" Section 15.10 Service of Documents.

[4] See *Alvarado v. WCAB* (2007) 72 CCC 1142 (writ denied).

The statute does not define what it means to "unreasonably refuse to participate." This probably will need to be decided by the appeals board on a case-by-case basis. The statute also does not specify any consequences for an employee who unreasonably refuses to participate in a QME examination. But LC 4053 and LC 4054, which provide for suspension and barring of proceedings for a refusal to submit to medical examination, were unchanged and probably will apply. (This is discussed fully in "Sullivan On Comp" Section 14.67 Compelling Attendance at Medical Examinations.)

Agreements to Proceed to Agreed Medical Evaluator

LC 4062.2 no longer requires the parties to negotiate for an AME before requesting a panel QME. Nevertheless, LC 4062.2(f) states, "The parties may agree to an agreed medical evaluator at any time, except as to issues subject to the independent medical review process established pursuant to Section 4610.5." Because the parties may agree to use an AME "at any time," the statute seemingly allows the parties to use one even after a panel QME has evaluated the applicant.

The reverse, however, is not true. LC 4062.2(f) adds, "A panel shall not be requested pursuant to subdivision (b) on any issue that has been agreed to be submitted to or has been submitted to an agreed medical evaluator unless the agreement has been canceled by mutual written consent." So if the parties have agreed to use an AME, a QME panel will not be assigned unless the agreement has been canceled by mutual written consent. This prevents a party from unilaterally canceling an AME agreement after it is made.

Although the statute provides that an agreement to use an AME may be canceled only by mutual written consent, it does not specify whether an agreement may be formed only by written consent. As discussed in "Sullivan on Comp" Section 15.60 Evidence at Trial — Effect of a Stipulation, however, the appeals board has been reluctant to enforce oral agreements. So AME agreements should be documented in writing.

COMMUNICATIONS WITH QMES AND AMES

LC 4062.3, which relates to communications with QMEs and AMEs, has been amended. It establishes distinct rules for communication with AMEs and QMEs. It changes how the parties may communicate with AMEs. It also defines communications, albeit poorly, that may constitute ex parte communications with AMEs.

Providing Information to and Communicating with QMES and AMES

Previously, the provisions regarding communications with QMEs and AMEs generally coincided; that is, the rules that applied to QME also applied to AMEs. Now, distinct provisions govern the information that may be provided to each, as well as the communications with each.

The rules regarding communications with QMEs remain the same. Generally speaking, per LC 4062.3(b) and (e), all information a party proposes to send to a QME and all communications with a QME still must be served on the opposing party 20 days before it is provided to the QME. This is discussed fully in "Sullivan on Comp" Section 14.41 Communications with AME and QME.

The rules regarding communications with AMEs have been modified. LC 4062.3(c) still provides that the parties must agree on the information to be provided to an AME. But LC 4062.3(e) is amended so that communications with AMEs no longer must be served on the opposing party 20 days before the evaluation. Instead, a new subsection (f) was added.

It states, "Communications with an agreed medical evaluator shall be in writing, and shall be served on the opposing party when sent to the agreed medical evaluator." So there is no time limit before a party may communicate with an AME — the party simply must ensure that the communication is served concurrently on the opposing party when it is sent to the AME.

Because LC 4062.3(c) requires the parties to agree on the information that must be provided to an AME, however, there may be limits to what a party unilaterally may send to an AME. The distinction is between what constitutes "information" and what constitutes "communication." As discussed in "Sullivan on Comp" Section 14.41 Communications with AME and QME, a series of appeals board decisions have determined that advocacy letters are considered "nonmedical information" and, therefore, may not be sent to AMEs or QMEs without the other party's consent.

So although it is likely that a party unilaterally may ask an AME to clarify certain comments or address certain issues, letters that advocate on behalf of a party may fall within the scope of "information" that must be agreed on, rather than "communications" that may be sent freely. Obviously, this issue cries out for further development by regulation or case law.

Ex Parte Communications with AMEs and QMEs

LC 4062.3(f) also states, "Oral or written communications with physician staff or, as applicable, with the agreed medical evaluator, relative to nonsubstantial matters such as the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, do not constitute ex parte communication in violation of this section unless the appeals board has made a specific finding of an impermissible ex parte communication." This language appears to address the case of *Alvarez v. WCAB (Parades).*[5]

In *Alvarez,* the QME called the defense attorney and requested medical records he could not locate. The defense attorney told the doctor that he should not be calling and hung up. The attorney then notified the applicant's attorney about the call. The appeals board initially found that the communication was not prohibited, but the Court of Appeal held that LC 4062.3 explicitly precluded any ex parte communication between a panel QME and a party, and that such a communication allows the aggrieved party to seek a new evaluation from another evaluator. Having taken the hard line, the court, oddly, added that communications that are so insignificant or inconsequential as not to be covered by LC 4062.3 would not be subject to sanctions. The court asked the appeals board to decide whether the communication was impermissible based on the standard it established, but on remand, the board determined that the communication was about the "operative proceedings" of the case, sufficient enough to require a new evaluation.[6] The result: Ex parte communications about "operative proceedings" allowed a party to replace the evaluator; what the term meant, however, was uncertain.

LC 4062.3(f) appears to be an awkward attempt to minimize *Alvarez.* LC 4062.3(f) makes a general statement that communications relating to the scheduling of appointments, missed appointments, the furnishing of records and reports and the availability of the report, do not constitute ex parte communications. It adds, however, that such statements are permissible "unless the appeals board has made a specific finding of an impermissible ex parte communication." So, essentially, it says that such communications are not prohibited, unless the appeals board says they are prohibited. Accordingly, LC 4062.3(c) doesn't necessarily protect communications between a party and an AME regarding topics such as scheduling and furnishing of records. The appeals board is left to decide whether the communications are prohibited.

[5] (2010) 75 CCC 817.
[6] *Alvarez v. Andromeda Entertainment,* 2010 Cal. Wrk. Comp. P.D. LEXIS 637.

Furthermore, LC 4062.3(f) applies only to communications with AMEs. There is no similar protection for communications between a party and a QME. It is unclear why the rules are not articulated the same way for both QMEs and AMEs. Is this an effort to encourage AME use? Perhaps, or maybe this was just overlooked. Whatever the reasons, it certainly appears that different rules for communications were intended for the two different types of medical-legal examiners.

To make matters worse, LC 4062.3(g), which prohibits communications with AMEs and QMEs, references only subsection (e), which relates only to communications with QMEs, and not (f), which relates to communications with AMEs. A similar mistake is made in LC 4062.3(i), which allows an employee to communicate with a QME in the course of the examination without violating LC 4062.3(e) and (g). But no similar exception is made for communications with AMEs under LC 4062.3(f).

Cleanup legislation is necessary to correct and/or clarify these provisions.

PAYMENT OF MEDICAL BENEFITS FOLLOWING RECEIPT OF MEDICAL-LEGAL REPORT

LC 4063 has been amended to require that if an AME or QME has resolved any issue that requires the employer to provide compensation, it must, except as provided in LC 4650(b)(2), commence payment of compensation, or file a DOR. It also eliminates the requirement that the employer file an application.

As in Permanent Disability, LC 4650(b)(2) provides that before an award of permanent disability, the employer is not required to advance permanent disability indemnity if it has offered the employee a position that pays 85 percent of the wages and compensation at the time of injury, or if the employee is employed in a position that pays 100 percent of the wages at the time of injury. Absent this, an employer must file a DOR or pay benefits.

PAYMENT OF MEDICAL-LEGAL EVALUATIONS AND ELIMINATION OF DUTY TO FILE APPLICATION

LC 4064(a) still requires the employer to pay for the costs of each reasonable and necessary medical-legal evaluation obtained pursuant to LC 4060, LC 4061 and LC 4062. As discussed above, it was amended to provide that each medical-legal evaluation must address "all contested issues arising from all injuries reported on one or more claims forms," except for issues subject to independent medical review. If more than one claim is filed, the new language requires a QME or AME to address all issues for all injuries claimed by an injured employee. (LC 4064 is discussed in depth in "Sullivan on Comp" Section 14.35 Reporting Under LC 4064.)

LC 4064(c) also was amended to provide that if an employee is unrepresented at the time an employer files a DOR, the employer will be liable for all attorneys' fees incurred by the employee in connection with the DOR. Previously, this provision provided that, when an employee was unrepresented, if an employer filed an application for adjudication rather than a DOR, the employer was liable for all attorneys' fees in connection with the application.

As discussed in "Sullivan on Comp" Section 15.97 Attorneys' Fees — Paid by the Employer, these fees are paid in addition to the compensation awarded to an employee, and potentially were awarded for all of the applicant attorney's activities through settlement of the claim. So this is a welcome relief for employers, who often were faced with a quandary of a deposition or subpoenas — which, as a matter of jurisdiction, require an application — but having to pay significant attorneys' fees if they filed an application.

The amendment does not relieve employers of the risk of attorneys' fees entirely. Rather, it limits them to the events prompted by the employee in connection with the DOR. It is not clear exactly what fees will be considered to be incurred by the employee in connection with a DOR. Nevertheless, the statute provides that the employer is not liable for all fees after the filing of a DOR, only those in connection with the document. It's possible that the fees incurred in connection with the DOR could take several conferences or trials. But it appears that after the issues defined in the DOR have been resolved, the defendant no longer would be liable for LC 4064(c) fees.

ELIMINATION OF FEES TO CONTEST AME OPINION

Former LC 4066 provided that if an employer filed an application for adjudication to contest a medical evaluation prepared by an AME, the employer was liable for attorneys' fees, regardless of the outcome. This section has been repealed. So employers no longer face the threat of attorneys' fees if they need to file an application to contest an AME's findings before the appeals board.

Practically speaking, LC 4066 was never applied. AMEs are permissible only when an employee is represented by an attorney, and, in order to protect against the statute of limitations, applicant attorneys generally would file an application for adjudication on assuming representation.

EXPEDITED HEARING FOR MEDICAL-LEGAL ISSUES

LC 5502(b) limits the issues that may be heard at expedited hearing. It was amended by SB 863 so that issues relating to "[a] medical treatment appointment or medical-legal examination" now may be heard at an expedited hearing. So if the parties have a dispute regarding whether the medical-legal process was followed properly, or whether an employee may be compelled to attend a medical-legal examination, it may be heard on an expedited basis.

10. INTERPRETERS

SB 863 made several changes to the law regarding interpreter services. Both the Government Code and the Labor Code were modified. Rules were enacted regarding the use of interpreters at medical treatment appointments, medical legal examinations, depositions and appeals board hearings. In addition, the duties of an interpreter have been codified along with a requirement that interpreters are to be paid pursuant to a fee schedule adopted by the administrative director.

GOVERNMENT CODE MODIFICATION

Government Code changes require the administrative director to establish lists of certified interpreters for both workers' compensation hearings and medical examinations.

GC 11435.30 adds subsection (c), which provides that the administrative director may establish, or contract with an independent organization to establish, maintain, administer and publish annually an updated list of "certified administrative hearing interpreters" who it has determined meet the requirements for interpreting skills and linguistic abilities "for the purposes of administrative hearings conducted pursuant to proceedings of the Workers' Compensation Appeals Board." GC11435.30(c)(2)(A) requires the administrative director to collect a fee for each interpreter seeking certification. The fee amount is yet to be determined.

GC 11435.35 added subsection (c) which also provides that the administrative director may establish or contract with an independent organization to establish, maintain administer and publish annually an updated list of "certified medical examination interpreters" who it has determined meet the requirements for interpreting skills and linguistic abilities "for the purposes of medical examinations conducted pursuant to proceedings of the Workers' Compensation Appeals Board, and medical examinations conducted pursuant to Division 4 (commencing with Section 3200 of the Labor Code)." GC 11435.35(c)(2) provides that the administrative director must collect a fee for each interpreter seeking certification. Again, the amount is yet to be determined.

The changes indicate that the administrative director must establish separate lists for interpreters at certified administrative hearings and at medical examinations. It is not clear from the statute whether an interpreter may apply to be on both lists simultaneously, and if separate fees will be required.

The Labor Code is modified in several places to ensure that only interpreters who are certified and on these lists are used in the system. The intention is to deny the use of "provisionally certified" interpreters. These are people who send in bills for interpreting services but are not certified. They were commonly

used before SB 863, a practice often maligned as abusive, hence this reform. The changes that follow would invalidate CCR 9795.1(f) and CCR 9785.1(e), which allowed for the use of noncertified interpreters.

INTERPRETERS AT MEDICAL TREATMENT APPOINTMENTS

LC 4600 requires the employer to provide medical treatment that is reasonably required to cure or relieve an employee from the effects of his or her injury. As discussed in "Sullivan on Comp" Section 7.4 Reasonable Expenses Incidental to Treatment, in *Guitron v. Santa Fe Extruders,*[1] the appeals board *en banc* held that per the employer's obligation to provide medical treatment to cure or relieve the injured worker, it is required to provide reasonably required interpreter services during medical treatment appointments for an injured worker who is unable to speak, understand or communicate in English.

Now, this right is codified in LC 4600(g), which states, "If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments."

But *Guitron* also held that to recover its charges for interpreter services, the interpreter lien claimant has the burden of proving, among other things, that the services it provided were reasonably required, that they were provided, that the interpreter was qualified to provide them and that the fees were reasonable. There is no reason why interpreters would not be required to meet the same burden of proof after the amendments.

To that end, LC 4600(g) also defines a qualified interpreter for the purposes of an examination. It states, "To be a qualified interpreter for purposes of medical treatment appointments, an interpreter ... shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code." LC 4600(g) also states, "An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code."

So the employer does not have to pay for an interpreter who is not certified, unless it consents, or the interpreter is required in a language that is not designated in GC 11435.40. That section covers the most commonly spoken foreign languages.[2] The statute recognizes that an employee may designate the interpreter if finding one may be difficult. But the practice in which staff or other noncertified personnel at a doctor's office send in bills for interpreting services is at an end.

INTERPRETERS AT MEDICAL-LEGAL EXAMINATIONS

LC 4600(f) allows for interpreters at medical-legal examinations at the request of the employer, the administrative director, the appeals board or a WCJ. LC 4620 is amended and reinforces this right.

LC 4620(d) has been added and states, "If the injured employee cannot effectively communicate with an examining physician because he or she cannot proficiently speak or understand the English language, the

[1] (2011) 76 CCC 228 (appeals board *en banc*).
[2] GC 11435.40(a) states, "The State Personnel Board shall designate the languages for which certification shall be established under Sections 11435.30 and 11435.35. The languages designated shall include, but not be limited to, Spanish, Tagalog, Arabic, Cantonese, Japanese, Korean, Portuguese, and Vietnamese until the State Personnel Board finds that there is an insufficient need for interpreting assistance in these languages."

injured employee is entitled to the services of a qualified interpreter during the medical examination. ... An employer shall not be required to pay for the services of an interpreter who is provisionally certified unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code."

A careful reading of LC 4620(d) reveals that an injured employee may continue to select and arrange interpreter services and request that the employer pay the bill. But, once again, a provisionally certified interpreter selected by the employee requires the employer's consent before the selection, unless the language is not designated in GC 11435.40. Failure to seek the appropriate consent will relieve the employer from the obligation to pay the interpreter service fee.

INTERPRETERS AT DEPOSITIONS

LC 5710(b)(5), which relates to interpreters at deposition, has been amended. It states, "If the injured employee or any other deponent does not proficiently speak or understand the English language, upon a request from either, the employer shall pay for the services of a language interpreter certified or deemed certified pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code."

The statute does not specify who is to arrange the interpreter. In provides only that an injured employee or other deponent may request it. But LC 5710(b)(5) requires the employer to pay for it.

INTERPRETERS AT HEARINGS

LC 5811(b) has been amended to add several provisions concerning interpreter involvement. LC 5811(b)(1) reaffirms that for WCAB hearings and conferences, any party producing a witness requiring an interpreter is responsible for arranging for the presence of a qualified interpreter.

LC 5811(b)(2) has been added. It defines a qualified interpreter as someone who is certified, or deemed certified, pursuant to GC 11435.05 (Title 2, Division 3, Part 1, Chapter 4.5, Article 8), or GC 68566. This means that the interpreter is on the administrative director's list.

A new sentence describes the duties of an interpreter. It states, "The duty of an interpreter is to accurately and impartially translate oral communications and transliterate written materials, and not to act as an agent or advocate. An interpreter shall not disclose to any person who is not an immediate participant in the communications the content of the conversations or documents that the interpreter has interpreted or transliterated unless the disclosure is compelled by court order. An attempt by any party or attorney to obtain disclosure is a bad faith tactic that is subject to Section 5813." Presumably, these sentiments would apply to certified interpreters whether at court or in a doctor's office or deposition.

LC 5811(b)(2) also was amended to describe the following venues where a qualified interpreter may render services (adding medical appointments to the list):

1. a deposition;
2. an appeals board hearing;
3. a medical treatment appointment or medical-legal examination;
4. settings the administrative director determines are reasonably necessary to ascertain the validity or extent of injury to an employee who does not proficiently speak or understand the English language.

INTERPRETER FEES

Various sections of the Labor Code were amended to provide that interpreters were to be paid per a fee schedule adopted by the administrative director. LC 4600(g) requires interpreters at medical treatment appointments to be paid per the fee schedule. The same goes for interpreters at medical-legal evaluations (LC 4620(d)), depositions (LC 5710(b)) and at appeals board hearings (LC 5811(b)(2)).

A limited interpreter fee schedule exists under CCR 9795.3. It remains to be seen if the administrative director simply will restate the existing fee schedule, modify it or develop a whole new one.

11. DEATH BENEFITS

Paragraph (3) has been added to LC 4701(a) raising the maximum burial expense from $5,000 to as much as $10,000 for injuries resulting in death occurring on or after Jan. 1, 2013. (See "Sullivan on Comp" Section 12.17 Burial Expense for a full exposition on this subject.)

In addition, it should be noted that Assembly Bill 2451 is before the governor. If it's signed into law, LC 5406(c)(1) will be added to the Labor Code. This statute, under certain circumstances, would extend the statute of limitations for a dependent of a public safety officer to file a claim for death benefits from 240 weeks to 480 weeks from the date of injury, and in no event more than one year from the date of death.

These are the circumstances that would extend the statute of limitations. Both criteria must be met:

1. The proceedings are brought for the collection of benefits by, or on behalf of, a person who was a dependent on the date of death. The extent of dependency would be determined by the facts as they existed at the employee's time of death.
2. The injury causing death is either one as defined in LC 3212.1 (cancer presumption), in LC 3212.6 (tuberculosis), or in LC 3212.8 (blood-borne infectious disease) to persons described by those sections.

12. REMOVAL OF THE PRIVILEGE TO APPEAR BEFORE THE WCAB

The appeals board's authority to remove, deny or suspend the privilege of individuals to appear as representatives before the appeals board pursuant to LC 4907 has been amended. As discussed in "Sullivan on Comp" Section 15.80 Removal of the Privilege to Represent a Party, more than 30 years ago, the California Supreme Court held that the appeals board's disciplinary power per LC 4907 could not be applied to attorneys.[1] The Labor Code finally was amended so that the appeals board's disciplinary power applies to anyone "except attorneys admitted to practice in the Supreme Court of the state."

But LC 4907 still may be used to discipline nonattorney representatives. Now, it specifies that nonattorney representatives may be removed, denied or suspended by the appeals board for:

1. a violation of Division 4, Part 3, Chapter 1 of the Labor Code commencing with LC 4900, the rules of the appeals board or the rules of the administrative director; or
2. other good cause, including, but not limited to, failure to pay a final order of sanctions, attorneys' fees or costs issued under LC 5813.

LC 4907(b) also requires that nonattorney representatives be held to the same professional standards of conduct as attorneys. The appeals board previously held *en banc* that nonattorney representatives must comply with the state Bar rules if they represent a party in workers' compensation proceedings.[2] So LC 4907(b) appears to be a codification of the existing law.

[1] *Hustedt v. WCAB* (1981) 46 CCC 1284.
[2] *In re Discipline, Suspension or Removal of the Privilege of Louis Moran to Appear in Proceedings before the Board* (1980) 45 CCC 519, 525 (appeals board *en banc*).

13. CARVE-OUTS / ALTERNATE DISPUTE RESOLUTION PROGRAMS

LC 3201.7 requires the DIR and the courts of this state to recognize as valid and binding any labor-management agreement that meets certain conditions. As discussed in "Sullivan on Comp" Section 3.5 Carve-Outs, it allows eligible employees and employers to opt to be part of a carve-out program (also known as alternate dispute resolution programs, or ADRs) for exclusive "initial" jurisdiction to adjudicate workers' compensation injuries through a collective bargaining agreement.

LC 3201.7(c) specifies the employers that are eligible for this program. LC 3201.7 was amended and subdivision (c)(4) was added authorizing "[t]he State of California" as an employer for the purposes of these carve-outs.

Several other nonsubstantive changes were made. When carve-out programs were introduced in California in 1993, the law required the DWC to produce a report by June 30, 1996, and annually thereafter. On request, the DWC also was required to notify members of the Legislature of the report's availability. The report was to include program details. The statutory authority calling for the production of the annual reports was found under LC 3201.5(i) and LC 3201.7(h). SB 863 eliminates those sections of the Labor Code. The annual report no longer is required.

Note that LC 3201.5(h) and LC 3201.7(g) have not been repealed; they still require that the DWC report annually to the director of the DIR regarding "the number of collective bargaining agreements received and the number of employees covered by these agreements."

14. SELF-INSURANCE

SB 863 has brought several changes to the existing self-insurance laws of California, some of which are minor; others have significant impact on the self-insured employer. Changes have been made to many different areas.

SELF-INSUREDS — DEPOSITS AND STANDARDS

Strict rules have always governed the mandatory deposits required of self-insureds. Often, they have been seen as onerous by the parties required to make the deposits. Changes have been made to provide relief, and steps have been taken to avoid abuse. (Self-insurance is described in depth in Chapter 3: The Business of Insurance of "Sullivan on Comp.")

Changes in Security Deposit Requirements

The revision of LC 3701(b) is of major importance. It does away with the current method of calculating a self-insured's minimum security deposit. Previously, that deposit was calculated at 125 percent of the private self-insured's estimated future liability for compensation plus 10 percent of the self-insured's estimated future liability for compensation to secure payment of all administrative and legal costs related to or arising from the employer's self-insurance program. It was subject to a minimum security deposit of $220,000. SB 863 has eliminated this entire method of calculating the minimum security deposit.

The new method of determining the minimum self-insured security deposit will be based on an actuarial report that each self-insured must calculate as of December 31 every year. Unless otherwise permitted by regulation, the deposit will be an amount equal to the self-insured's projected losses, net of specific excess insurance coverage, if any, and inclusive of incurred but not reported (IBNR) liabilities, allocated loss adjustment expense and unallocated loss adjustment expense. The actuarial report must project the expected losses and expenses at the expected actuarial confidence level pursuant to the qualifications prescribed by the director of Self Insurance Plans (SIP) in regulations to be developed. If the self-insured is in compliance, the amount of the self-insurer's security deposit will be acceptable to the Self-Insurers' Security Fund (SISF).

This new method of calculating the security fund is a major development for self-insured employers who no longer are required to overfund their future workers' compensation claims liability by 25 percent. The blanket 10 percent add-on for administrative and legal costs also is eliminated and replaced by an actuarial projection. Last, the minimum deposit of $220,000 is no longer applicable, as the revision in the law clearly states that the deposit should be equal to the amount of the actuarial projection.

Return of Security Deposit Overpayments

A sentence has been added to LC 3701.3 concerning a self-insurer's refund of sums held in excess of the required security deposit. The sentence reads: "This section shall not apply to any security posted as part of the composite deposit, or to any security turned over to the Self-Insurers' Security Fund following an order of default under Section 3701.5."

The new sentence is self-explanatory, as security funds following an order of default are suspect and usually subject to additional scrutiny for adequacy purposes.

Payment of Claims

A sentence has been added to LC 3701.5 concerning administration and payment of claims when the director determines that the security deposit has not been made available for the payment of compensation. The sentence reads: "If the director arranges for administration and payment by any person other than the fund, the fund shall not have responsibility for claims administration or payment of claims."

This sentence is a clarification of the law. When a third party has been retained by the director to administer and pay claims for a given self-insurer, the fund no longer is responsible to issue claim payments or to administer the claim. The parties of interest should deal with the third-party administrator.

LC 3701.5(d) has been eliminated so that the director no longer is required to audit a self-insured employer who either fails to pay workers' compensation as required or fails to make available security deposits for payment of compensation. Although under such circumstances the director still may conduct an audit, it is no longer mandatory.

Failure to Timely Pay Security Deposit

LC 3701.8(d) has been amended to allow the director not only to penalize a private self-insuring employer a minimum of 10 percent for failing to timely pay the security deposit assessment, but the director now charges interest on any unpaid amount at the prejudgment rate. The penalty and interest no longer are required to be added to the composite deposit held by the director, but are to be paid directly to the Self-Insurers' Security Fund. This amendment means that, in addition to charging a penalty for late or nonpayment of the security deposit assessment, the director is required to charge the self-insuring employer both penalty and interest.

Assessments

LC 3745(b) has been amended to eliminate limitations and restrictions on the amount a self-insurer may be assessed by the fund. Instead, the fund may assess each member on a pro rata basis.

The restriction that assessments collected under this subdivision may be used only for purposes of this article also was eliminated.

Expanded Grounds to Revoke Self-Insurance Certificate

LC 3702(a) has been amended to add another reason under good cause to revoke a certificate of consent to self-insure. A recommendation by the Self-Insurers' Security Fund to revoke the certificate of consent is included in the reasons previously established as good cause to revoke a certificate.

Posting and Notification of Excess Coverage

LC 3702.8(f) has been amended to require the director to notify the Self-Insurers' Security Fund, in addition to the CIGA, whenever a special excess workers' compensation insurance policy is posted.

This amendment to the law allows the fund to be notified whenever a special excess workers' compensation insurance policy is posted with the director. Any such posting will discharge the obligation of the SISF, per LC 3744, to pay claims in the event of an insolvency of a private employer to the extent of coverage of compensation liabilities under the special excess workers' compensation insurance policy.

UNLAWFULLY UNINSURED EMPLOYERS

Several provisions have been added to strengthen resistance to employers who do not secure workers' compensation insurance. Again, a general discussion of willful uninsurance may be found in "Sullivan on Comp" Chapter 3: The Business of Insurance.

Limitations on the Right to Self-Insure

A new sentence in LC 3701.7(d) concerns employers attempting to self-insure after having been unlawfully uninsured. It reads: "A certificate of consent to self-insure shall not be granted to an applicant that has had a period of unlawful uninsurance without the written approval of the Self-Insurers' Security Fund."

The period of unlawful uninsurance is not specified and can be interpreted as applying to any period of unlawful uninsurance over the employer's existence.

Definition of Insolvent Self-Insurer

LC 3744(a) is amended to define the term "insolvent self-insurer." For purposes of this section, "insolvent self-insurer" includes the entity to which the certificate of consent to self-insure was issued, any guarantor of the entity's liabilities under the certificate, any member of a self-insurance group to which the certificate was issued and any employer who obtained employees from a self-insured employer under LC 3602(d).

LC 3744(2) was added to express the intent of the Legislature. It reads: "The Legislature finds and declares that the amendments made to this subdivision by the act adding this paragraph are declaratory of existing law."

So the revisions in this subparagraph are simply clarification of existing law and not new law per se.

LC 3744(e) was added to declare that any action to recover compensation paid and liability assumed by the Self-Insurers' Security Fund must have venue in the Superior Court of California, County of Sacramento. In addition, all actions in which the Self-Insurers' Security Fund and two or more members or former members of one self-insurance group are parties must be consolidated if requested by the fund.

TEMPORARY EMPLOYMENT AGENCIES AND SELF-INSURANCE

LC 3701.9 was added to prohibit temporary employment agencies from self-insuring for workers' compensation. LC 3701.9(a) states:

"A certificate of consent to self-insure shall not be issued after January 1, 2013, to any of the following:

1. A professional employer organization.

2. A leasing employer, as defined in Section 606.5 of the Unemployment Insurance Code.
3. A temporary services employer, as defined in Section 606.5 of the Unemployment Insurance Code.
4. Any employer, regardless of name or form of organization, which the director determines to be in the business of providing employees to other employers."

Regarding any temporary employment agency currently self-insured, LC 3701.9(b) states: "A certificate of consent to self-insure that has been issued to any employer described in subdivision (a) shall be revoked by the director no later than January 1, 2015."

The impact of this new law on current and potential temporary employment agencies is profound: They are forbidden to self-insure for workers' compensation. Should a temporary employment agency attempt to bypass the law under the umbrella of a corporate parent, the issuance of a certificate to self-insure may be refused under the broad powers granted to the director under LC 3701.9(a)(4). Certificates will be revoked within two years for agencies currently self-insured.

AUTHORIZATION TO ADOPT, AMEND AND REPEAL REGULATIONS

LC 3702.10(j) is amended to allow the director to regulate the workers' compensation self-insurance obligations of self-insurance groups and professional employer organizations and leasing and temporary services employers, as defined in UIC 606.5, holding certificates of consent to self-insure.

Per LC 3701.9(b), current certificates of consent to self-insure will be revoked for temporary employment agencies by Jan. 1, 2015. In anticipation of the administrative procedures for revocation, LC 3702.10(j) was amended to provide the director with additional authority over temporary employment agencies to adopt, amend or repeal regulations as deemed necessary.

REGULATION OF PUBLIC AGENCIES

Changes have been made to the administration of self-insured public agencies. A detailed narrative on this subject is found in "Sullivan on Comp" Section 3.27 Self-Insurance — Public Self-Insured Employers.

Annual Reporting

There is a slight change in the self-insured annual reporting requirements, but it applies only to public self-insurers. LC 3702.2(a) has been amended to add these requirements for public self-insurers:

"Public self-insured employers shall provide detailed information as the director determines necessary to evaluate the costs of administration, workers' compensation benefit expenditures, and solvency and performance of the public self-insured employer workers' compensation programs, on a schedule established by the director. The director may grant deferrals to public self-insured employers that are not yet capable of accurately reporting the information required, giving priority to bringing larger programs into compliance with the more detailed reporting."

The impact of this provision is that public self-insured programs are under more scrutiny because more detailed reporting is required. The extent of the additional detail is yet to be developed by the director.

CHSWC Investigation

LC 3702.4 has been added to require the Commission on Health and Safety and Workers' Compensation to conduct an examination of the public self-insured program and publish on its website a preliminary report

and recommendations for improvement of the program no later than Oct. 1, 2013. A final report is due no later than Dec. 31, 2013. The recommendations will address costs of administration, workers' compensation benefit expenditures and solvency and performance of public self-insured workers' compensation programs, as well as provisions in the event of insolvencies.

This section of the Labor Code will be repealed as of Jan. 1, 2015, unless another statute is enacted before Jan. 1, 2015, deleting or extending that date.

No significant impact on public self-insured programs is anticipated by enacting this law other than submitting to an audit.

Payment for Public Administration Costs

LC 3702.5(a)(1) is amended to read: "The cost of administration of the public self-insured program by the Director of Industrial Relations shall be borne by the Workers' Compensation Administration Revolving Fund."

This addition to the code relieves the general fund from bearing the cost of administration of public self-insured programs.

SELF-INSURERS' SECURITY FUND

LC 3742 has been amended regarding the Self-Insurers' Security Fund for private insurers. LC 3742(a) now states that a private self-insurer must participate as a member in the fund unless its liabilities have been turned over to the fund pursuant to LC 3701.5, at which time its membership is relinquished.

Changes made to LC 3742(b) increase the number of the fund's board of trustees from seven to eight. In addition, a board trustee's tenure has changed. Trustees will be elected to four-year terms, and will serve until their successors are elected and assume office, per the bylaws of the fund.

LC 3746 was amended slightly to state that the fund (as opposed to the trustees) will contract for an independent certified audit of its financial activities. Also, at the election of the fund, the annual report of its financial activities may be posted on the fund's website.

15. ILLEGAL REFERRALS

The Labor Code contains several provisions that prohibit referring a person to another entity in exchange for consideration, whether in the form of money or something else. LC 3215, LC 3219 and LC 3820(b)(3) generally prohibit anyone from offering or receiving compensation or inducements for referring clients or patients. In addition, LC 139.3 specifically prohibits a physician from referring an injured worker for treatment or testing to a facility in which he or she has a financial interest. A detailed discussion on this point is found in "Sullivan on Comp" Section 7.67 Medical Expense — Prohibited Referrals.

SB 863 enacted LC 139.32 to "additionally prohibit, except as specified, an interested party, as defined, from referring a person for certain services relating to workers' compensation provided by another entity, if the interested party has a financial interest in the other entity, as defined." LC 139.32 is modeled after LC 139.3. But it creates a new crime and new penalties applicable to all interested parties, not just physicians.

DEFINITIONS

LC 139.32(a) begins with a series of definitions of terms used throughout the statute. LC 139.32(a)(1) defines a "financial interest in another entity" as:

A. any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy or other form of direct or indirect payment, whether in money or otherwise, between the interested party and the other entity to which the employee is referred for services; or
B. an agreement, debt instrument or lease or rental agreement between the interested party and the other entity that provides compensation based on, in whole or in part, the volume or value of the services provided as a result of referrals.

So a "financial interest in another entity" includes almost any situation in which a referring party would benefit financially from the referral.

The term "interested party" is broadly defined in LC 139.32(a)(12) to encompass most of the participants in a workers' compensation claim. It means:

A. an injured employee;
B. the employer of an injured employee, and, if the employer is insured, its insurer;

C. a claims administrator;[1]
D. an attorney-at-law or law firm representing or advising an employee regarding a claim for compensation;
E. a representative or agent of an interested party, including an employee of an interested party or any individual acting on behalf of an interested party, including the immediate family or employee of the interested party;[2] and
F. a provider of any medical services or products.

The term "service" also is defined broadly. Per LC 139.32(a)(3), "service" means, but is not limited to:

A. a determination regarding an employee's eligibility for compensation, including a determination of a permanent disability rating under LC 4660 and an evaluation of an employee's future earnings capacity resulting from an occupational injury or illness;
B. services to review the itemization of medical services denoted on a medical bill submitted under LC 4603.2;
C. copy and document reproduction services;
D. interpreter services;
E. medical services, including the provision of any medical products such as surgical hardware or durable medical equipment;
F. transportation services;
G. services in connection with utilization review pursuant to LC 4610.

Accordingly, LC 139.32 applies to all of the major participants in any given workers' compensation claim as well as all the services normally required. The clear intention of LC 139.32 is to preclude any interested party from financially benefiting from a referral.

WHAT IS PROHIBITED?

The prohibitions of LC 139.32 are enumerated in subdivisions (b), (c) and (d), but subject to the exceptions in (h) and (i). LC 139.32(b) requires all interested parties to disclose any financial interest in an entity providing services. LC 139.32(c) states, "Except as otherwise permitted by law, it is unlawful for an interested party other than a claims administrator or a network service provider to refer a person for services provided by another entity, or to use services provided by another entity, if the other entity will be paid for those services pursuant to Division 4 (commencing with Section 3200) and the interested party has a financial interest in the other entity."

LC 139.32(d)(1) states, "It is unlawful for an interested party to enter into an arrangement or scheme, such as a cross-referral arrangement, that the interested party knows, or should know, has a purpose of ensuring referrals by the interested party to a particular entity that, if the interested party directly made referrals to that other entity, would be in violation of this section." LC 139.32(d)(2) adds, "It is unlawful for an interested party to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement to refer a person for services."

Together, these provisions prohibit an interested party from: (1) referring a person for any paid services if the interested party has a financial interest in referral; (2) entering an agreement to refer persons to another entity in exchange for return referrals; and (3) receiving any compensation or inducement for a referral.

[1] This includes, but is not limited to, a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured employer, a third-party claims administrator for an insurer, a self-insured employer, a joint powers authority or a legally uninsured employer or a subsidiary of a claims administrator;
[2] immediate family includes spouses, children, parents and spouses of children.

PENALTIES FOR PROHIBITED REFERRALS

> If services were performed based on a prohibited referral, the service provider is not entitled to payment. LC 139.32(e) prohibits an entity who received a prohibited referral for presenting a claim for payment. LC 139.32(f) says that an insurer or other payor must not knowingly pay a charge or lien for any services resulting from a referral or use of services in violation of LC 132.32.

The statute imposes criminal penalties. Violations, per LC 139.32(g), will result in a misdemeanor. If an interested party is a corporation, any director or officer of the corporation who knowingly concurs in a violation is guilty of a misdemeanor.

LC 139.32(g) also covers possible licensing and disciplinary action. It requires the appropriate licensing authority for any person who violates these rules to review the facts and circumstances of any conviction and take appropriate disciplinary action if the licensee has committed unprofessional conduct. The licensing authority also may act on its own discretion independent of the initiation or completion of a criminal prosecution.

Furthermore, LC 139.32(g) allows for civil penalties of as much as $15,000 for each offense. The penalties may be enforced by the insurance commissioner, attorney general or a district attorney.

If the interested party is a claims administrator, violation of LC 139.32 constitutes a general business practice that discharges or administers compensation obligations in a dishonest manner. The claims administrator will be subject to a civil penalty which, per LC 129.5(e), is not to exceed $100,000. If an interested party is an attorney, violation of LC 139.32 (b) or (c) will be referred to the Board of Governors of the State Bar of California, which must review the facts and circumstances of any violation and take appropriate disciplinary action if the attorney has committed unprofessional conduct. Note that the statute does not require referral for violations of subdivision (d), which relates to cross-referral arrangements and compensation or inducements for referrals.

Also, any determination regarding an employee's eligibility for compensation will be void if that service was provided in violation of LC 139.32. So, even if there is an award in favor of a service provider, it will be void if it is determined that the service was performed as a result of a prohibited referral.

EXCEPTIONS TO THE PROHIBITED REFERRALS

Despite the broad prohibitions regarding referrals established in LC 139.32, there are exceptions. Per LC 139.32(h), these arrangements between an interested party and another entity do not constitute a "financial interest in another entity":

1. a loan between an interested party and another entity, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured and the loan terms are not affected by either the interested party's referral of any employee or the volume of services provided by the entity that receives the referral;
2. a lease of space or equipment between an interested party and another entity if the lease is written, has commercially reasonable terms, a fixed periodic rent payment, a term of one year or longer and the lease payments are not affected by either the interested party's referral of any person or the volume of services provided by the entity that receives the referral;
3. an interested party's ownership of the corporate investment securities of another entity, including shares, bonds or other debt instruments purchased on terms available to the general public through a licensed securities exchange or NASDAQ.

So if an interested party has a loan, has leased space or equipment or has a corporate investment security from an entity receiving the referral that would be available and allowable to anyone else, and there is no indication these transactions were affected by the referrals, the transactions do not constitute a "financial interest in another entity," and referrals would not be prohibited.

LC 139.32(i) also specifies that the prohibitions do not apply to:

1. services performed by, or determinations of compensation issues made by, employees of an interested party in the course of that employment;
2. a referral for legal services if it is not prohibited by the Rules of Professional Conduct of the State Bar; or
3. a physician's referral that is exempted by LC 139.31 from the prohibitions prescribed by LC 139.3.

About Michael Sullivan & Associates

Michael Sullivan & Associates, P.C. is a dynamic, aggressive firm that provides high-quality litigation in defense of workers' compensation claims, employment issues and insurance litigation. It has offices throughout Southern California.

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Michael Sullivan & Associates, P.C.
Los Angeles | Orange | San Diego | Westlake Village
310.337.4480 | SullivanOnComp@mikeslaw.com
www.mikeslaw.com

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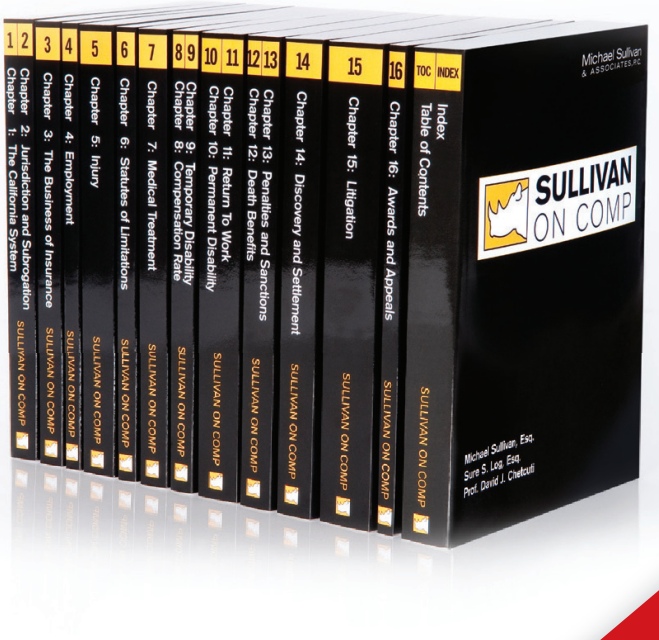

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