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OVERVIEW

OF

SENATE BILL 863

Presented by:
Glenn L. Silverii

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CALCULATING PERMANENT DISABILITY (PD)

(Labor Code §4660.1)

Applies to injuries occurring on or after January 1, 2013

DFEC Eliminated

The diminished future earnings capacity (DFEC), for purposes of calculating permanent disability is repealed. (LC §4660.1(a))

Multiplier is 1.4

When calculating permanent disability, the employee's Whole Person Impairment (WPI) will be multiplied by an adjustment factor of 1.4. (LC §4660.1(b))

15% ADJUSTMENT OF PD EITHER UP OR DOWN ELIMINATED

(Labor Code §4658(e))

Applies to injuries occurring on or after January 1, 2013

For injuries occurring on or after 1/1/13, the 15% adjustment for PD (either up or down) is eliminated. (LC §4658(e)).

PERMANENT DISABILITY ADVANCES (PDAs)

(Labor Code §4650(b)(2))

Effective after January 1, 2013, regardless of date of injury

PDAs Can Be Withheld

Prior to an award of permanent disability indemnity, a permanent disability payment shall not be required if the employer has offered the employee a position that pays at least 85% 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% of the wages in compensation paid at the time of injury.

When an award of permanent disability indemnity is made, the amount due shall be calculated from the last date for which temporary disability indemnity was paid, or the date the employee's disability became permanent & stationary, whichever is earlier.

DEATH BENEFITS

(Labor Code §4701)

Applies to injuries occurring on or after January 1, 2013

Labor Code §4701 has been amended to provide that in death cases, the employer is liable up to $10,000.00 for reasonable expenses of the employees burial. (LC §4701(a)(3)).

NO INCREASE IN IMPAIRMENT RATINGS FOR SLEEP, SEXUAL DYSFUNCTION AND PSYCHIATRIC DISORDER

(Labor Code Section 4660.1)

Applies to injuries occurring on or after January 1, 2013

Except as provided below, there will be no increases in impairment ratings for sleep and sexual dysfunction or psychiatric disorder, or any combination thereof. However, the injured employee can obtain treatment for sleep and sexual dysfunction or psychiatric disorder, if any, that are consequence of an industrial injury. (LC§4660.1(c)).

Exception for Psychiatric Injury

An increased impairment rating for psychiatric disorder can result if there is a compensable psychiatric injury resulting from either of the following:

(1) Being the victim of a violent act or direct exposure to a significant violent act within the meaning of Section 3208.3.

(2) Catastrophic injury, including, but not limited to loss of a limb, paralysis, severe burn, or severe head injury. (LC §4660.1(c)(2)(a)(b))

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS/VOUCHER

(Labor Code §4658.7)

Applies to injuries occurring on or after January 1, 2013

Eligibility for Supplemental Job Displacement Benefit

If the injury causes permanent partial disability, the injured employee (IE) shall be entitled to Supplemental Job Displacement Benefit (SJDB), unless the employer makes an offer of regular, modified or alternative work that meets the following criteria:

(1) Offer is made no later than 60 days after receipt by the claims administrator of the first report from either the PTP, an AME, or a PQME finding that disability has become permanent & stationary and that the injury has caused permanent partial disability.

  (a) If the employer or claims administrator has provided the physician with the job description of the employee's regular work, proposed modified work, proposed alternative work, the physician shall 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.

  (b) The claims administrator shall forward 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.

(2) The offer is for regular, modified or alternative work lasting at least 12 months.

(3) The SJDB should be offered to the employee within 20 days after the expiration of the time for making an offer of regular, modified or alternative work.

(4) The SJDB should be in the form of a voucher up to $6,000.00.

Voucher Can Be Applied to the Following Expenses:

The voucher may be applied to any of the following expenses, at the choice of the injured employee:

(a) 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 states Eligible Training Provider List (ETPL), including payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement.

(b) Payment for occupational licensing or for professional certification fees, related examination fees and examination preparation course fees.

(c) Payment for services of licensed placement agencies, vocational or return to work counseling, and resume preparation, all up to the combined limit of 10% of the amount of the voucher.

(d) Purchase of tools required by training or educational program which the employee is enrolled.

(e) Purchase of computer equipment, up to $1,000.00.

(f) Up to $500.00 as miscellaneous expense reimbursement or advance, payable upon request and without need for itemized documentation or accounting. Employee shall not be entitled to any other voucher payment for transportation, travel expenses, telephone or internet access, clothing or uniforms, or incidental expenses. ***Comment:*** *Expect requests for $500.00 reimbursement.*

Expiration of the Voucher

The voucher expires **2 years** after the date the voucher is furnished to the employee, or **5 years** after the date of injury, whichever is later. An employee shall not be entitled to payment or reimbursement of any expenses that have not been incurred and submitted with appropriate documentation to the employer prior to the expiration date (LC§ 4658.7(f)).

Settlement of the Voucher Not Permitted

Settlement or commutation of the claim for SJDB is not permitted (LC §4658.7(g)).

Employer Not Liable

The employer is not liable for compensation for injuries incurred by the employee while utilizing the voucher. (Labor Code §4658.7(i)).

RETURN TO WORK SUPPLEMENT

(Labor Code §139.48)

Applies to injuries occurring on or after January 1, 2013

The Department of Industrial Relations (DIR) will administer a program for supplemental payments to injured employees with "disproportionately low permanent disability" in comparison to the future loss of earnings. The DIR is to implement regulations establishing eligibility and procedures for employees to obtain any supplemental payments and will be administered by the DIR and not the WCAB.

INTERPRETERS
(Labor Code §4620(d))

Labor Code Section 4620 is amended to provide for interpreters, as follows:

Injured Worker Entitled to Interpreter

If the injured employee cannot effectively communicate with an examining 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 the medical examination.

Upon request of the injured employee, the insurance carrier shall pay the costs of the interpreter services, set forth in the fee schedule adopted by the AD. The insurance carrier should not be required to pay for the services of an interpreter who is provisionally certified unless either an insurance carrier consents in advance to the selection of the individual who provides interpreting services or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code. (LC §4620(d)). Also see LC §4600(f) and (g).

MEDICAL TREATMENT

(Labor Code §4604.5))

The Labor Code still provides that an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy and 24 physical therapy visits per industrial injury, except as modified for post-surgical physical medicine and rehabilitation services.

The section has been amended to provide that authorization for treatment beyond the limits shall not be deemed a waiver of the limits with respect to future requests for authorization. (LC §4604.5(c)(2)).

Chiropractor as PTP

A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits (24). (LC §4600(c)).

HOME HEALTH CARE

(Labor Code §4600(h))

Applies to injuries occurring on or after January 1, 2013

Home Health Care (HHC) shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the affects of the injury and prescribed by a licensed physician or surgeon. The employer is not liable for HHC services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription. (LC §4600(h) (applies to all dates of injury).

An attorneys fee for recovery of HHC fees may be awarded (LC §5307.8)

On or before July 1, 2013, the Administrative Director (AD), shall adopt a schedule for payment of home health care services provided in accordance with Section 4600. (LC §5307.8)

INDEPENDENT MEDICAL REVIEW (IMR)

(Labor Code §139.5)

Labor Code §139.5 has been added which provides that the AD shall contract with one or more IMR organizations to conduct reviews.

UTILIZATION REVIEW

(Labor Code §4610)

Labor Code Section 4610 pertaining to Utilization Review has been amended as follows:

UR Decision to Remain Effective for 12 Months

A UR 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 UR decision. (LC §4610(g)(7)).

UR Deferred When Claim Denied

UR of treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended. (LC §4610(g)(7)).

If Claim Becomes Compensable

If UR is deferred, and it is finally determined that the employer is liable for treatment, the time for the employer to conduct retrospective UR shall begin on the date of the determination of the employers liability becomes final, and the time for the employer to conduct prospective UR shall commence from the date of the employers receipt of a treatment recommendation after the determination of the employers liability (LC §4610(g)(8).

Review or Appeal of UR Decision

A UR decision may be reviewed or appealed only by Independent Medical Review (IMR) pursuant to Section 4610.5.
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 UR decision unless the UR decision is overturned by IMR.

APPLICABILITY OF UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

(Labor Code §4610.5(a)

Timeline for Implementing UR and IMR

Any dispute over a UR decision which will involve the IMR process applies to any injury occurring on or after **January 1, 2013**. (LC §4610.5(a)(1).

Applies to any dispute over a UR decision if the decision is communicated to the requesting physician on or after **July 1, 2013**, regardless of the date of injury. (LC §4610.5(a)(2)).

UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

Any dispute over a UR decision can now only be reviewed or appealed by an IMR. The new legislation establishes that the IMR process to be used to resolve disputes over UR decisions for injuries occurring on or after January 1, 2013, and for any decision that is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury. The purpose of the IMR review is to determine the medical necessity of the disputed medical treatment.

To implement the IMR process, Labor Code §4610.5 and §4610.6 have been added to the Labor Code and provide as follows:

Request for IMR by Injured Worker

Only the employee may submit a request for IMR review to the Division **no later than 30 days** after the service of the UR decision to the employee. (LC §4610.5(h)(1)).

If Employer Disputes Liability for Treatment

At the time of the UR decision if the employer is also disputing liability for the treatment for any reason besides medical necessity, time for the employee to submit a request for IMR to the AD or AD designee is extended to 30 days after service of notice to the employee showing that the other dispute of liability has been resolved. (LC §4610.5(h)(2)).

Duty of Administrative Director (AD)

The AD shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an IMR has been approved, in whole or in part, and if not approved, the reasons therefore. (LC §4610(5)(k).

Duties of Employer

Upon notice from the AD that an independent review organization has been assigned, the employer shall provide to the IMR organization all the following documents **within 10 days** of notice of assignment:

(1) Copy of all of the employee's medical records in the possession of the employer or under the control of the employer relative to each of the following:
   - (A) An employee's current medical condition;
   - (B) The medical treatment being provided by the employer;
   - (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 regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for disputed treatment. (LC §4610.5(1)(3))
(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 the 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 shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided. (LC §4610.5(1)(4)

Newly Developed or Discovered Relevant Medical Records

Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the IMR organization shall be forwarded immediately to the IMR organization. The employer shall concurrently provide a copy of the medical records to the employee or to the employees treating physician, unless offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable State and Federal laws. (LC §4610.5(m).

Imminent and/or Serious Threat to Health of Employee

If there is an imminent and serious threat to the health of the employee as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents shall be delivered to the IMR organization within 24 hours of approval of the request for review. (LC §4610.5(n)).

Notification to the Employee

The employer shall promptly issue a notification to the employee, after submitting all of the required material to the IMR organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee. (LC §4610.5(o))

Scope of Review by Independent Medical Review Organization

The IMR organization review shall be limited to an examination of the medical necessity of the disputed medical treatment. (LC §4610.6(a).

Duty of IMR

The IMR shall promptly review all pertinent medical records, reports and any other information submitted. If the reviewer requests information from any of the parties, a copy of the request and the response shall be provided to all of the parties. (LC §4610.6(b)).

Determination by IMR

The IMR shall make its determination in writing, and in layperson's terms to the extent practical, **within 30 days** of receipt of the request for review and supporting documentation, or within less time as prescribed by the AD. (LC §410.(d)).

If the disputed medical treatment has not been provided and the employee's provider or the AD certifies in writing that an imminent and serious threat to the health of the employee may exist, 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 employee, the analyses and determinations of the reviewer shall be expedited and

rendered **within 3 days** of receipt of the information. Subject to the approval of the AD, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended up to 3 days in extraordinary circumstances or for good cause. (LC §4610.6(d)).

Determination of IMR

The determination shall state whether the disputed health care service is medically necessary and shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings to support the determination. If more than one medical professional reviews the case, the recommendations of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service. (LC §4610.6(e)).

What IMR Shall Provide

The IMR organization shall provide to the AD, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The IMR organization shall keep the names of the reviewers confidential and all communications with entities or individuals outside the IMR organization. IMR organization shall provide each of the separate reviewer's analyses and determinations. (LC §4610.6(f)).

Determination of the AD

The determination of the IMR organization is deemed to be the determination of the AD and shall be binding on all parties. (LC §4610.6(g)).

Appeal of AD Determination

The determination of the AD can only be reviewed by a verified appeal filed with the WCAB and served on all interested parties **within 30 days** or the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the AD shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The AD acted without or in excess of the AD's powers;
(2) The determination of the AD was procured by fraud;
(3) The IMR was subject to material conflict of interest that is in violation of Section 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 expressed or implied finding of fact provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion. (LC §4610.6(h)).

If Determination of AD is Reversed

If the determination of the AD is reversed, the dispute shall be remanded to the AD to submit the dispute to IMR by a different independent review organization. In the event that a different IMR organization is not available after remand, the AD shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the IMR organization. (LC §4610.6(i)).

Duties of Employer

Upon receiving the determination of the AD that a disputed health care service is medically necessary, the employer shall promptly implement the decision, unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, **within 20 days,** subject to resolution of any remaining issue of the amount of payment, pursuant to sections 4603.2 to 4603.6. If services have not yet been rendered, the employer shall authorize the services **within 5 working days** of the written determination from the IMR organization, or sooner if appropriate for the nature of the employees medical condition, and shall inform the employee and provider of the authorization. (LC §4610.6(j)).

Failure to Make Payment

Failure to pay for services already provided or to authorize services not yet rendered within the time requirements is a violation of this section and in addition to any other fines, penalties and other remedies available to the AD, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the AD, not to exceed $5,000.00 for each day the decision is not implemented. The administrative penalty shall be paid to the Workers' Compensation Administration Revolving Fund. (LC §4610.6(k)).

Cost of IMR

The cost of IMR and the administration of the IMR system shall be born by employers through a fee system established by the AD. (LC §4610.6(l)).

AME/PQME PROCESS

(Labor Code §4061, §4062, & §4062.2)

Labor Code Sections 4061, §4062 and §4062.2 have been amended, which result in a change in the AME/PQME process.

Labor Code Sections 4061 & §4062 do not apply to an employee's dispute of the Medical Provider Network treating physician's diagnosis or treatment recommendations and/or dispute of UR, which are resolved by Labor Code §4610, §4616.3 & §4616.4. (LC §4061 & §4062).

Labor Code §4061 provides that if either the employee or employer objects to the medical determination made by the PTP concerning the existence or extent of permanent impairment and limitations, or need for future medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in §4062.2. (§4061(b)).

Unrepresented Employee

If either the employee or employer objects to medical determination by the PTP concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and if the employee is not represented by an attorney, the employer shall immediately provide the employee with the form prescribed by the Medical Director with which to request assignment of a panel of 3 Qualified Medical Evaluators. Either party may request a comprehensive medical evaluation to determine permanent disability or the need for future medical care and the evaluation shall be obtained only by the procedure provided in Section 4062.1. (LC §4061(c)).

Comment: *The language pertaining to a dispute for continuing medical care, is eliminated, since disputes for medical treatment will be resolved by UR and IMR. It is further noted that Labor Code §4062.1 has not been changed.*

Unrepresented Employee

Within 30 days of receipt of the report from the QME, the unrepresented employee or employer may request one supplemental report seeking correction of factual errors in the report. These requests shall be made in writing .

A request made by the employer shall be provided to the employee, and any request made by the employee shall be provided to the employer, insurance carrier, or claims administrator, at the time the request is sent to the evaluator. A request for correction that is made by the employer shall also inform the employee of the availability of information and assistance officer to assist him or her in responding to the request if necessary (LC §4061(d)(1)).

Obtaining a Rating

The QME who has evaluated the unrepresented employee shall serve the medical report and the summary form on the employee, employer and AD. The unrepresented employee or employer may submit the report for calculation of permanent disability rating. **Within 20 days** of receipt of the medical report, the AD shall calculate the permanent disability rating and serve the rating on the employee and employer (LC §4061(e)).

Apportionment

Any comprehensive medical report concerning an unrepresented employee that indicates that part or all of the employee's permanent impairment or limitations may be subject to apportionment subject to sections 4663 and 4664, shall first be submitted by the AD to a workers' compensation judge who may refer the report back to the QME for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law (LC §4061(f).

Comment: *Provisions of LC §4061 pertaining to apportionment, reconsideration of a recommended rating, commencing payment of*

compensation, agreeing to stipulated findings, the existence or extent of permanent impairment, have not been amended and are the same as in the prior LC §4061, but are now contained in LC §4061(f) to (i).

LABOR CODE §4062

Labor Code §4062 has been amended as follows:

Objection to PTP

If either the employee or employer object to a medical determination made by the PTP concerning any medical issues not covered by 4060 or 4061, are not subject to section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney, or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issues shall be obtained as provided by in section 4062.2, and no other medical evaluations shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the Medical Director with which to request an assignment of a Panel of 3 QMEs, the evaluation shall be obtained as provided in section 4062.2, and no other medical evaluation shall be obtained (LC §4062(a)).

Employee Objects to Treatment

If the employee objects to a decision pursuant to 4610 to modify, delay, or deny a request for authorization of medical treatment made by the PTP, the objection shall be resolved only in accordance with the IMR process established in section 4610.5 (LC §4062(b)).

If the employee objects to the diagnosis or recommendation of medical treatment by a physician within the employer's MPN, the objection shall be resolved only in accordance with the IMR process established in sections 4616.3 and 4616.4. (LC §4062(c)).

Comment: *LC* §4062 has been significantly shortened. **The second opinion for spinal surgery in form section 4062(b) is repealed as of 1/1/13, regardless of date of injury.**

Labor Code sections 4061 and 4062 no longer apply to decisions and disputes regarding diagnosis or treatment. The medical-legal evaluator will address causation, temporary and permanent disability, apportionment and future medical care.

LABOR CODE SECTION 4062.2

Labor Code section 4062.2 has been amended as follows:

Obtaining PQME

No earlier than the **first working day** that is **at least 10 days** after the day of mailing of a request for medical evaluation pursuant to Labor Code section 4060, or the **first working day** that is **at least 10 days** after the date of mailing of an objection pursuant to Labor Code sections 4061 or 4062, either party may request the assignment of a 3 member panel of QMEs to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party, if it has been made known to the party submitting the request and the specialty of the treating physician. The party submitting the request form shall serve a copy of the form on the other party (LC §4062.2(b)).

Comment: *The parties are no longer required to offer an AME. For disputes pursuant to LC §4060 (which pertain to AOE/COE), appears to require that a party mail a request for a medical evaluation to the opposing party, and then on the first working day that is at least 10 days after the mailing of said request, the party may submit a written request for assignment of a QME list to the Medical Director.*

Striking PQME

Within 10 days of assignment of the panel by the AD, each party may strike one name from the panel. The remaining QME shall serve as the medical evaluator. If a party fails to exercise the right to strike a name

from the panel **within 10 days** of assignment of the panel by the AD, the other party may select any physician who remains on the panel to serve as the medical evaluator. The AD may describe the form, manner or both by which the parties shall conduct the selection process (LC §4062.2(c)).

Comment: *The period of 10 days is extended by the 5 days for mailing.*

Arranging Medical Appointment

The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment **within 10 days** after the medical evaluator is selected, the employer may arrange the appointment and notify the employee of the arrangements. The employee shall not unreasonably refuse to participate in the evaluation (LC §4062.2(d)).

Employee Ceases to be Represented

If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later ceases to be represented, he or she shall not be entitled to an additional evaluation. (LC §4062.2(e)).

Parties can Agree to an Agreed Medical Evaluator (AME)

The parties may agree to an AME at any time, except as to an issue subject to the IMR process established pursuant to section 4610.5. A panel shall not be requested on any issue that has been agreed to submit to an AME unless the agreement has been canceled by written mutual consent. (LC §4062.2(f)).

LIENS

(Labor Code §4903.05 & §4903.06)

Labor Code § 4903.05 and §4903.06 have been added to the Labor Code and are as follows:

Filing of Lien

Every lien claimant shall file its lien with the WCAB in writing upon a form approved by the WCAB. The lien shall be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service upon the injured worker or, if deceased, upon the worker's dependants, the employer, the insurer, and their respective attorneys or other agents of record. Medical records shall be filed only if they are relevant to the issues being raised by the lien. (LC §4903.05(a)).

Electronic Filing

Lien claims shall be filed with the WCAB electronically using the form approved by the WCAB. The lien shall be accompanied by a proof of service and any other documents that may be required by the WCAB. (LC §4903.05(b)).

Filing Fee

All liens filed on or after January 1, 2013 shall be subject to a filing fee. (LC §4903.05(c)).

(1) Lien claimant shall pay a filing fee of $150.00 to the Division of Workers' Compensation prior to filing a lien and shall include proof that the filing fee has been paid. The fee shall be collected through an electronic payment system that accepts major credit cards and any additional forms of electronic payment selected by the AD. If the AD contracts with a service provider for processing of electronic payments any processing fee shall be absorbed by the Division and not added to the fee charged to the lien filer. (LC §4903.05(c)(1)).

(2) **On or after January 1, 2013**, liens submitted for filing that do not comply with these regulations shall be invalid, even if lodged with the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien. (LC §4903.05(c)(2)).
(3) The claims of two or more providers of goods or services shall not be merged into a single lien (LC §4903.05(c)(3)).
(4) The filing fee shall be collected by the AD. All fees shall be deposited in the Workers' Compensation Administrative Revolving Fund and applied for purposes of that fund. (LC §4903.05(c)(4)).
(5) The AD shall adopt reasonable rules and regulations governing the procedure for the collection of the filing fee. (LC §4903.05(c)(5)).
(6) Any lien filed for goods or services that are not the proper subject of a lien may be dismissed upon request of a party by verified petition or on appeals board's own motion. If the lien is dismissed, the lien claimant will not be entitled to reimbursement of the filing fee. (LC §4903.05(c)(6)).
(7) No filing fee shall be required for a lien filed by a health care service plan, a group disability insurer under a policy issued in the State, a self-insured employee welfare benefit plan, or a publically funded program providing medical benefits on a non-industrial basis. (LC §4903.05(c)(7)).

Liens Filed Prior to January 1, 2013

Any lien filed prior to January 1, 2013 and any cost that was filed as a lien **prior to January 1, 2013** shall be subject to a lien activation fee unless the lien claimant provides proof of having paid a filing fee. (LC §4903.06(a)).

Activation Fee of $100.00

The lien claimant shall pay a lien activation fee of $100.00 to the Division of Workers' Compensation **on or before January 1, 2014**. The fee shall be collected through an electronic payment system. (LC §4903.06(a)(1)).

(1) The lien claimant shall include proof of payment of the filing fee or lien activation fee with a Declaration of Readiness to Proceed (LC §4903.06(a)(2)).

Failure to Pay Activation Fee

All lien claimants that do not file the declaration of readiness to proceed and that remain a lien claimant of record at the time of the lien conference shall submit proof of payment of the activation fee at the lien conference. If the fee has not been paid or no proof of payment is available, the lien shall be dismissed with prejudice. (LC §4903.06(a)(4)).

Dismissal of Lien Claim

Any lien filed prior to January 1, 2013 and any cost that was filed as a lien **prior to January 1, 2013**, for which the filing fee or lien activation fee has not been paid by January 1, 2014 is dismissed by operation of law. (LC §4903.06(a)(5)).

Reimbursement of Lien Filing Fee

A lien claimant shall be entitled to an Order or Award for reimbursement of a lien filing fee or lien activation fee, together with interest at the rate allowed on civil judgments, only if all the following conditions are satisfied:

1) Not less than **30 days** before filing the lien for which the filing fee was paid or filing the declaration of readiness to proceed for which the lien activation fee was paid, the lien claimant has made a written demand for settlement of the lien claim for a clearly stated sum which shall be inclusive of all claims of debt, interest, penalty, or other claims potentially recovered on the lien.

2) The defendant fails to accept the settlement demand in writing **within 20 days** of receipt of the demand for settlement, or within any additional time as may be provided by written demand.

3) After submission of the lien dispute to the appeals board or an arbitrator a final Award is made in favor of the lien claimant of a specified sum that is equal to or greater than the amount of the

settlement demand. The amount of the interest and filing fee or lien activation fee shall be considered in determining whether the Award is equal to or greater than the demand. (LC §4903.07(a)).

Parties Can Agree to Reimbursement of Filing or Activation Fee

The Labor Code does not preclude an order or award of reimbursement of the filing fee or activation fee pursuant to the expressed terms of an agreed disposition of the lien dispute. (LC §4903.07(b)).

Statute of Limitations for Lien Claims

A lien claim for expenses shall not be filed **after 3 years** from the date the services were provided, nor more than **18 months** after the date the services were provided, if the services were provided on or **after July 1, 2013**. (LC §4903.5(a)).

Time Limits for Filing Lien

Except as necessary to meet the requirements of Section 4903.5, a lien claim or Application for Adjudication shall not be filed or served until both of the following have occurred:

1. Sixty (60) days have elapsed after the date of acceptance or rejection of the claim, or expiration of the **90 day time period** for an investigation, whichever date is earlier.

2. Either of the following:

   (a) **A forty-five (45)** day time period to pay medical treatment bills pursuant to Section 4603.02 has expired and if the employer objected to the amount of the bill, the reasonable fee has been determined pursuant to Section 4603.6, and if authorization for the medical treatment has been disputed pursuant to Section 4610, and medical necessity of the medical treatment has been determined pursuant to Sections 4610.5 & 4610.6.

(b) The time period for payment of medical/legal expenses pursuant to Section 4622 has expired and if the employer objected to the amount of the bill, the reasonable fee has been determined pursuant to Section 4603.6. (LC §4903.6(a)).

Notification by Lien Claimant

All lien claimants shall notify the employer and the employer's representative and the employee and his or her representative, and the appeals board **within 5 working days** of obtaining, changing, or discharging representation by an attorney or non attorney representative. The notice shall set forth the legal name, address, telephone number of the attorney, or non attorney representative. (LC §4903.6(b)).

Filing of Declaration of Readiness to Proceed

A Declaration of Readiness to Proceed shall not be filed for a lien until the underlying case has been resolved or where the applicant chooses not to proceed with his or her case. (LC §4903.6(c)).

INDEPENDENT BILL REVIEW

(Labor Code §139.5)

Labor Code §139.5 has been added which provides that the Administrative Director (AD) shall contract with one or more independent bill review organizations to conduct bill reviews. To enable the independent bill review program to go into effect for injuries occurring on or after January 1, 2013, the AD can contract with independent bill review organizations under contract with the Department of Managed Health Care, which can be designated by the AD to conduct reviews. (LC §139.5(a)(1).

LABOR CODE §4603.2 HAS BEEN AMENDED TO PERTAIN TO THE PAYMENT OF BILLS AND THE BILL REVIEW PROCESS

Employer Not Liable for Treatment Outside of the Medical Provider Network (MPN)

When the employer objects to the employees selection of a physician on the grounds that the physician is not within the MPN and there is a final determination that the employee was not entitled to select a physician outside the MPN, the employer shall have no liability for treatment provided by or at the direction of that physician or any consequences of the treatment obtained outside the MPN. (LC §4603.2(a)(3)).

Documentation and Information to be Provided to Employer/Insurance Carrier, by Provider and/or Vendor

Any provider of services including but not limited to physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment which includes the following information and documents:

(1) Itemization of services provided and the charge for each service;
(2) A copy of all reports showing the services performed;

(3) The prescription or referral from the primary treating physician (PTP) if the services were performed by a person other than the PTP;
(4) Any evidence of authorization for the services that may have been received. (LC §4603.2(b)(1))

Time for Payments

Payments shall be made by the employer with an explanation of review (EOR) pursuant to Section 4603.3 within **45 days after receipt** of each separate, itemization of medical services performed, together with any required reports or any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the EOR, that the itemization is contested, denied or considered incomplete, within **30 days after receipt** of the itemization by the employer. An EOR that states an itemization is incomplete shall also state all additional information required to make a decision. Any properly documented list of services provided and not paid within the **45 day period** shall be paid at the rates in effect, and increased by 15%, together with interest at the same rate as judgments in civil actions retroactive to the date of the receipt of the itemization, unless the employer does both of the following:

(a) Pays the provider at the rate in effect within the 45 day period;

(b) Advises, in an EOR and pursuant to Section 4603.3 the physician, or other provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advise that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph. (LC §4603.2(a)(2).

Duplicate Submissions

Duplicate submissions for medical services itemizations, for which an EOR has previously been 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 for failing to respond to the duplicate submission.

Medical Provider Disputes the Amount Paid

If the medical provider disputes the amount paid, the provider can request a second review **within 90 days** of the service of the EOR or an Order of the WCAB resolving the threshold issue as stated in the EOR. The request for a second review shall be submitted to the employer on a form prescribed by the AD and shall include all of the following:

(A) The date of the EOR and the claim number or other unique identifying number provided on the EOR;
(B) The item and amount in dispute
(C) The additional payment requested and the reason therefore
(D) The additional information provided in response to a request in the first EOR or any other additional information provided in support of the additional payment requested (LC §4603.2(e)(1)).

Provider Does Not Request A Second Review

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 other payment (LC §4603.2(e)(2)).

Employers Response

Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute should be

made **within 21 days** of receipt of the request for second review. The time limit may be extended by mutual written agreement.(LC §4603.2(e)(3))

Independent Bill Review

If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6. (LC §4603.2(e)(4)).

Requirements of Explanation of Review (EOR)

Upon payment, adjustment, or denial of a complete or incomplete itemization for medical services, an employer shall provide an EOR in the manner prescribed by the AD that shall include all of the following:

(1) Statement of the items or procedures bill and 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 incomplete itemization;
(5) If a denial of payment is for some reason other than a fee dispute, the reason for the denial;
(6) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing the EOR shall 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, pursuant to Section 4603.6 (LC §4603.3)

Electronic Billing

Payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made with an EOR by the employer within **15 working days** after electronic receipt of an itemized electronic billing for services at or

below the maximum fees provided in the Official Medical Fee Schedule (OMFS). If the billing is contested, denied, or incomplete, payment shall be made with an EOR of any uncontested amounts within **15 working days** after electronic receipt of the billing. (LC §4603.4(d))

INDEPENDENT BILL REVIEW (IBR)

(Labor Code §4603.6)

Applies to injuries on or after January 1, 2013

Labor Code §4603.6 has been added to the Labor Code. It provides as follows:

Provider Requests IBR

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 IBR within **30 calendar days** of service of the second review. If the provider fails to request an IBR within **30 days** the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. 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 IBR and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final. (LC §4603.6(a).

Request for IBR

A request for IBR shall be made on a form prescribed by the AD and shall include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the EOR, the request for second review together with any supporting documentation submitted with the request and the final explanation of the second review. The AD may require that request for IBR be submitted electronically. A copy of the request, together with all required documents shall be served on the employer. Only the request form and proof of payment of the fee required shall be filed with the AD. Upon notice of assignment of the IBR, the requesting party shall submit the documents listed in this subdivision to the IBR within **10 days**. (LC §4603.6(b).

Payment of Fee to AD

The provider shall pay to the AD a fee to cover the reasonable estimated cost of IBR and administration of the IBR program. If any additional payment is found owing from the employer to the medical provider, the employer shall reimburse the provider for the fee in addition to the amount found owing. (LC §4603.6(c)).

AD Makes Assignment to IBR

Upon receipt of the request for IBR and the required fee, the AD or its designee, shall assign the request to IBR within **30 days** and notify the medical provider and employer of the independent reviewer assigned. (LC §4603.6(d))

Duties of Independent Bill Reviewer

After review of the materials submitted by the parties, the IBR shall issue a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination. The IBR may request additional documents from either the medical provider or employer. If additional documents are requested, the parties shall provide the requested documents within 30 days and shall provide the other party with copies of any documents submitted to the independent reviewer. The independent reviewer shall 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 receipt of the AD's assignment.** A written determination of the IBR shall be sent to the AD and provided to both the medical provider and employer. (LC §4603.6(e)).

Determination of IBR Is Determination of AD

The determination of the IBR is deemed a determination and order of the AD. The determination is deemed final and binding on all parties unless an aggrieved party files with the WCAB a verified appeal from the medical bill review determination of the AD **within 20 days of**

service of the determination. The medical bill review determination of the AD shall be presumed to be correct and shall be set aside only upon clear and convincing evidence of 1 or more of the following grounds for appeal:

(1) The AD acted without or in excess of his or her powers;
(2) The determination of the AD was procured by fraud;
(3) The IBR was subject to material conflict of interest that is a violation of Section 139.5
(4) The determination was a 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 plainly erroneous express or implied finding of fact provided that the mistake of fact is matter of ordinary knowledge based on the information submitted for review and not a matter that is subject to expert opinion. (LC §4603.6(f)).

If Order of AD Is Reversed

If the determination of the AD is reversed, the dispute shall be remanded to the AD to submit the dispute to IBR by a different independent review organization. In the event that a different IBR organization is not available after remand, the AD shall submit the dispute to the original bill review organization for a review by a different reviewer within the organization. In no event shall the WCAB or any other higher court make a determination of ultimate fact contrary to the determination of the bill review organization. (LC §4603.6(g)).

Payment

Once the IBR has made a determination regarding additional amounts to be paid to the medical provider, the employer shall pay the additional amounts per the timely payment requirements set forth in sections 4603.2 (**45 days after receipt)** and Section 4603.4 (within **15 working days after electronic receipt** of the billing). (LC §4603.6(h)).

COPY SERVICES
(Labor Code §5307.9)

On or before December 31, 2013, the AD shall adopt a schedule of reasonable maximum fees payable for copy and related services, including, but not limited to, records or documents that have been reproduced or recorded in paper, electronic, film, digital, or other format. The schedule shall specify the services allowed and shall require specificity when billing for these services.

FEE SCHEDULE FOR VOCATIONAL EXPERTS

(Labor Code §5307.7)

Applies To All Dates of Injury

On or before January 1, 2013, the AD shall adopt a fee schedule that will establish reasonable fees paid for services provided by vocational experts, including, but not limited to, vocational evaluations and expert testimony determined to be reasonable, actual, and necessary by the Appeals Board. (LC §5307.7(a))

A vocational expert will be not paid, and the WCAB will not allow, vocational expert fees in excess of those that are reasonable, actual, and necessary, or that are not consistent with the fee schedule adopted by the AD. (LC §5307.7(d))

II

CHART OF MINIMUM AND MAXIMUM TEMPORARY AND PERMANENT DISABILITY RATES AND MILEAGE REIMBURSEMENT RATE

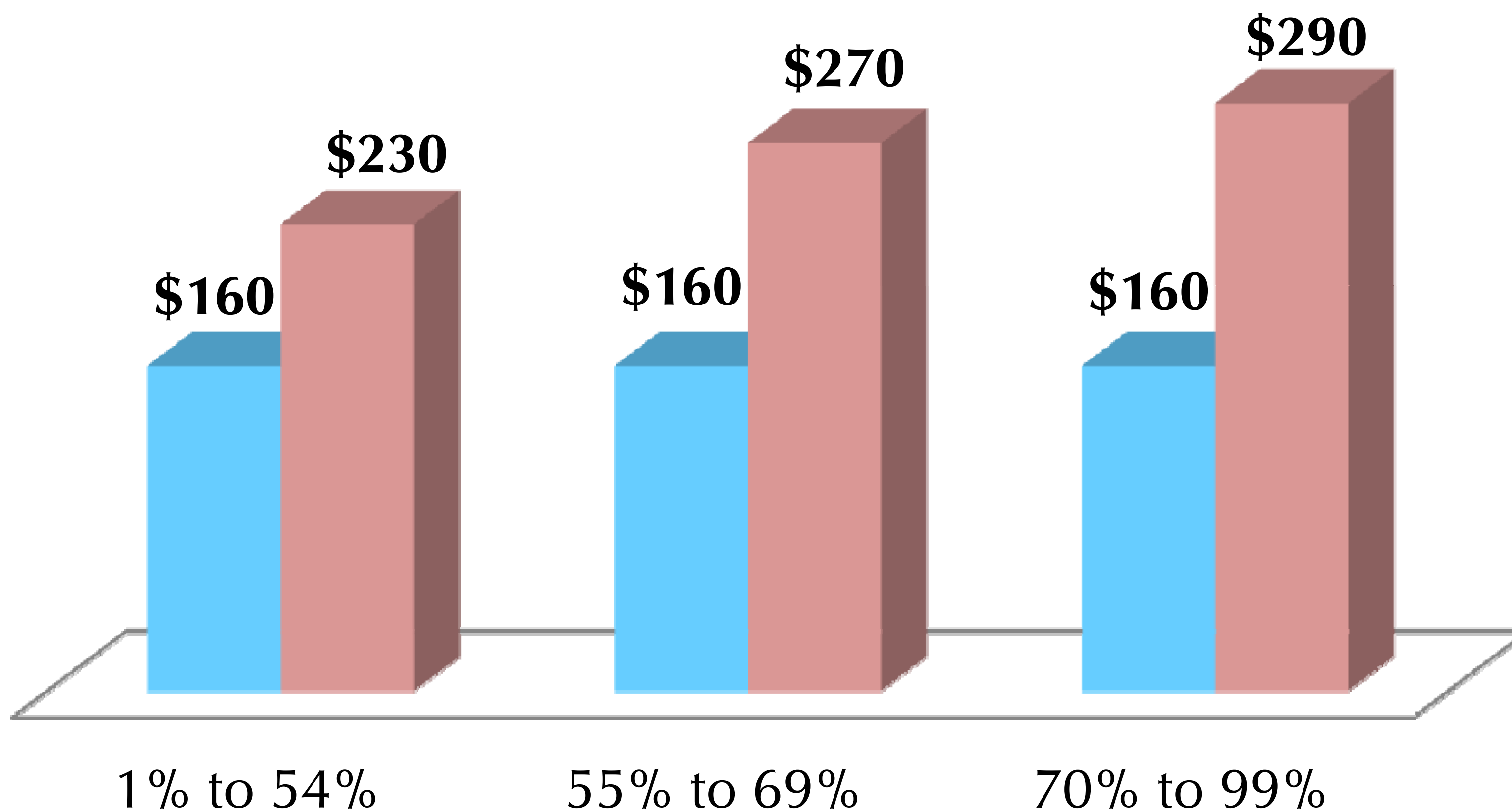
PERMANENT DISABILITY

MINIMUM & MAXIMUM WEEKLY RATE

For injuries on or after January 1, 2013

(Labor Code section 4453(b)(8))

Minimum Maximum

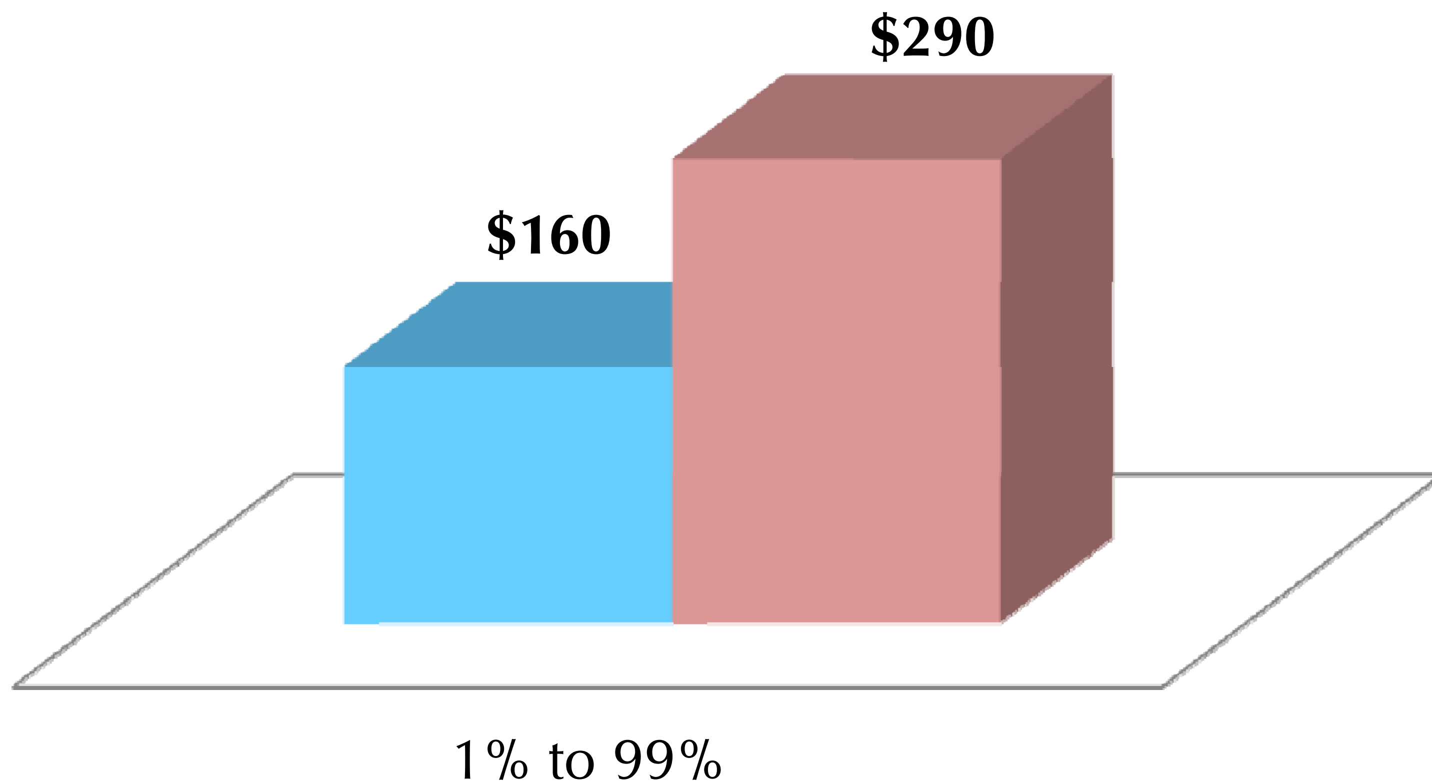


PERMANENT DISABILITY

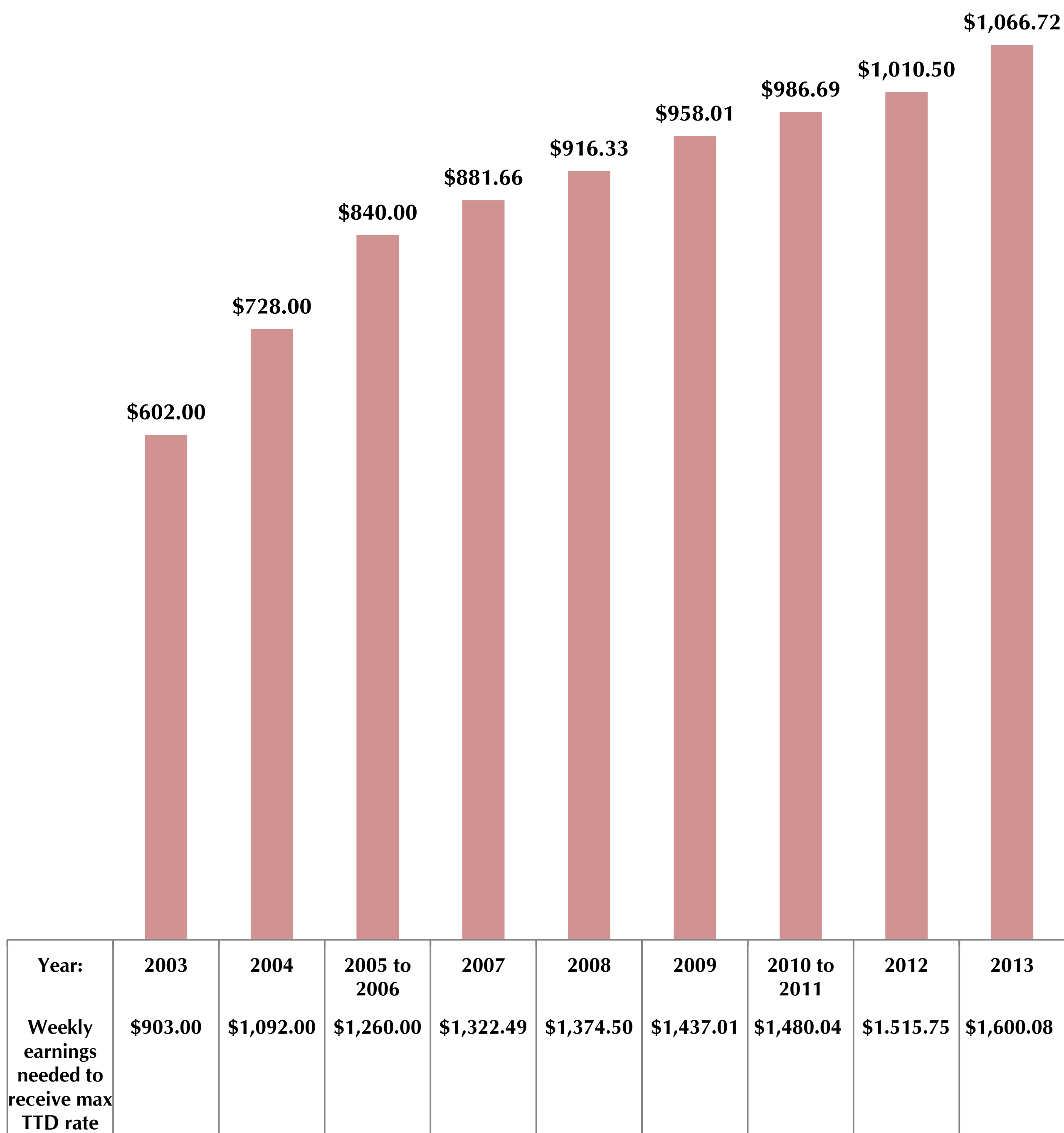
MINIMUM & MAXIMUM WEEKLY RATE

For injuries on or after January 1, 2014

(<u>Labor Code</u> section 4453(b)(9))



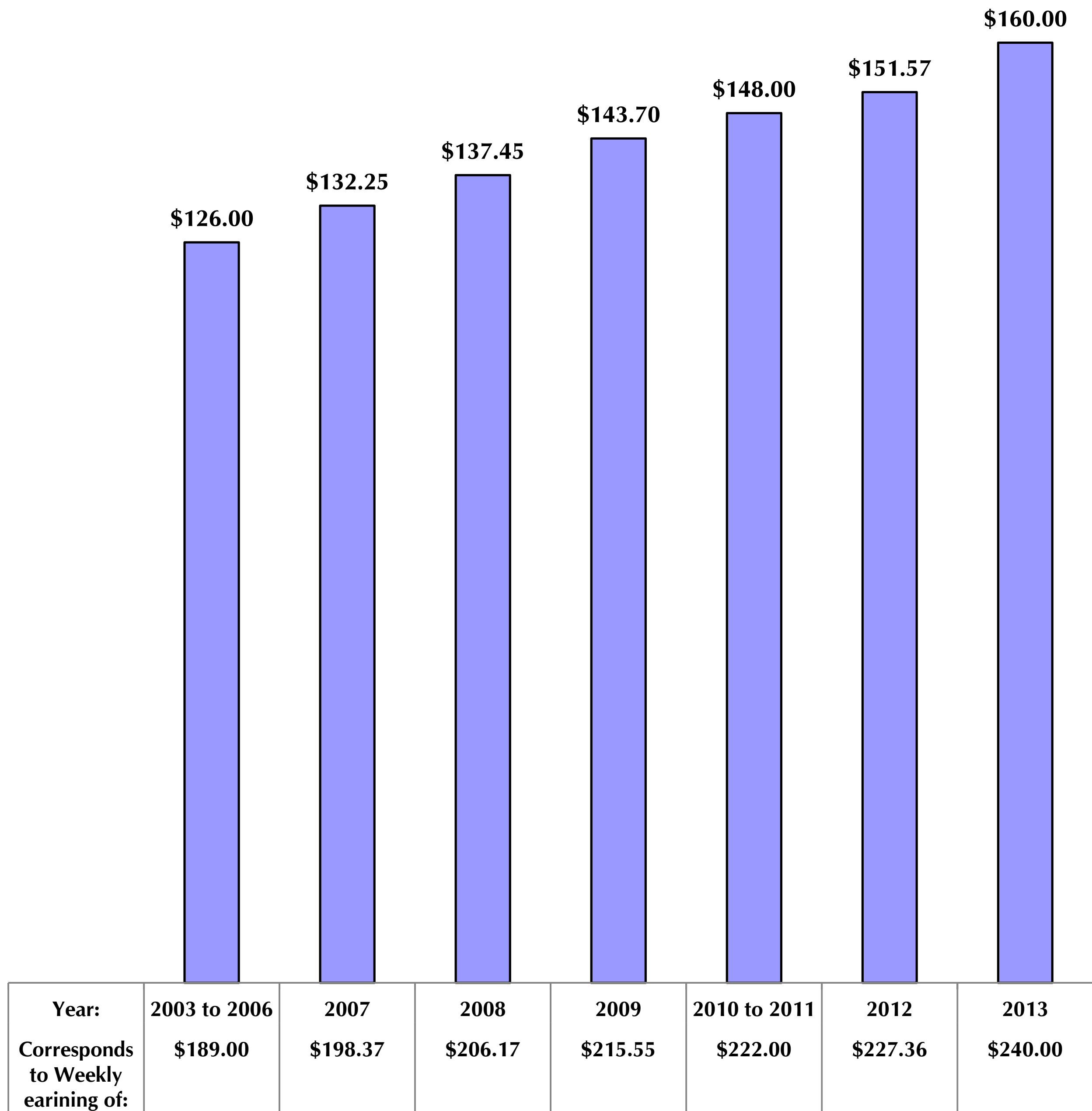
MAXIMUM WEEKLY TOTAL TEMPORARY DISABILITY RATE



Year:	2003	2004	2005 to 2006	2007	2008	2009	2010 to 2011	2012	2013
Weekly earnings needed to receive max TTD rate	$903.00	$1,092.00	$1,260.00	$1,322.49	$1,374.50	$1,437.01	$1,480.04	$1.515.75	$1,600.08

Reminder: Remember that pursuant to Labor Code section 4661.5, that payments made more than two years from the date of injury, the amount of payment is governed by the law in effect on the date of payment.

MINIMUM WEEKLY TOTAL TEMPORARY DISABILITY RATE



Year:	2003 to 2006	2007	2008	2009	2010 to 2011	2012	2013
Corresponds to Weekly earining of:	$189.00	$198.37	$206.17	$215.55	$222.00	$227.36	$240.00

Reminder: Remember that pursuant to Labor Code section 4661.5, that payments made more than two years from the date of injury, the amount of payment is governed by the law in effect on the date of payment.

MILEAGE REIMBURSEMENT RATE

Begin Date	End Date	Rate
1/1/2013	*	$0.565
7/1/2011	12/31/2012	$0.555
1/1/2011	6/30/2011	$0.510
1/1/2010	12/31/2010	$0.500
1/1/2009	12/31/2009	$0.550
7/1/2008	12/31/2008	$0.585
1/1/2008	6/30/2008	$0.505
1/1/2007	12/31/2007	$0.485
1/1/2006	12/31/2006	$0.445
9/1/2005	12/31/2005	$0.485
1/1/2005	8/31/2005	$0.405
1/1/2004	12/31/2004	$0.375
1/1/2003	12/31/2003	$0.360
1/1/2002	12/31/2002	$0.365
1/1/2001	12/31/2001	$0.345
1/1/2000	12/31/2000	$0.325
1/1/1999	12/31/1999	$0.310
1/1/1998	12/31/1998	$0.325

The mileage reimbursement rate applies to all travel, regardless of the date of injury.
* *Subject to next adjustment*

This publication is current as of December 18, 2012