Ingber & Weinberg, LLP

MICRO SURVIVAL GUIDE

2015

Edition 4.0

Including AD Regulations

And Case Law Updates

By Corey A. Ingber

Edition No.: 4.0

Revised: 1/5/2015

Color Key

BLUE..... **NEW DEVELOPMENT AND/ OR FURTHER ANALYSIS**
DARK RED..... **ADMINISTRATIVE REGULATION**
GREEN..... **NEW CASE DECISION**
RED..... **NEW/UPDATE FOR 2014-2015**

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WHAT TAKES PLACE WHEN?	8-13

WHAT TAKES EFFECT WHEN?

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
PD	▪ 1.4 multiplier ▪ No FEC adjustment ▪ Limits on psyche, sleep and sexual dysfunction add on	**X** **X** **X**		
PD RATES	▪ Minimum: to 160 per week ▪ Maximum: to 270 (55%-69%) ▪ Maximum: to 290 (70%-99%) ▪ Maximum: to 290 (1$-99%) Provision	**X** **X** **X**		**X (DOI)**
SJDB	▪ Statute of Limitations: 2yr/5yr ▪ New SJDB to $6,000 ▪ Advance of $500 ▪ Computer Equipment ▪ New form re; work capacities ▪ No settlement of SJDB	**X** **X** **X** **X** **DOI 1/1/2013** **X** **X**	**X**[i] **1/1/2013**	**1/1/2014**

	▪ No commutation of SJDB	**X**		
QME PROCESS	▪ Elimination of "AME" Dance ▪ 2nd Opinion Surgery process gone ▪ Relaxation of communications		**X** **X** **X**	
IMR and IMRO	▪ Medical Necessity Disputes Taken Away from QME and to IMR	**X** Until 7/1/2013 – effective for all decisions after that date regardless of DOI		
TREATMENT BILLS **SECOND REVIEW** **EOR** **IBR AND IBRO**	▪ Explanation of Review ▪ Request for 2nd Review ▪ IBR and IBRO process ▪ Deemed Final		**X** **X** **X** **X**	
MPN	▪ Physicians Included With Written Acknowledgment ▪ MPN Must Place Roster of Physicians on Web Site ▪ All Approved MPN's posted by AD			**X** **X** **X**

		DOI 1/1/2013	1/1/2013	1/1/2014
	▪ Medical Access Assistants with available hours ▪ AD Powers to Investigate ▪ Plan Approval 4 years ▪ Contesting MPN being "Validly Constituted" ▪ Schedule of Penalties ▪ Notice Poster –Limitations under Valdez		**X** **X** **X** **X** **X**	**X**
LIENS	▪ $150 Filing Fee Liens filed after: ▪ With Proof of Paid Filing Fee ▪ $100 Activation Fee for all existing and prior lien ▪ Statute of Limitations –3 years from date of services provided ▪ Statute of Limitations—18 months from date of services provided ▪ Restriction on Assignments		**X** **X** **X** Paid at time of filing of DOR, at Lien Conference if not filing DOR but no later than 1/1/2014 **X** **7/1/2013** **X**	**X** This the drop date time for payment of activation fee or liens are dismissed
MEDICAL LEGAL	▪ Qualified interpreters --exams		**X**	

		DOI: 1/1/2013	1/1/2013	1/1/2014
VOCATIONAL EXPERTS **FEE SCHEDULES:** **COPY SERVICES'** **VOC EXPERTS;** **INTERPRETERS:**	▪ 2nd Review and IBR added ▪ IBR Covers Medical-Legal Expenses ▪ Fee Schedule for Voc Experts ▪ Fee Schedule for Copy Services ▪ Fee Schedule for Interpreters During Treatment		**X** **X** **X** **X** **X**	
MEDICAL TREATMENT UNDER 4600: **FEE SCHEDULES:** **HOME HEALTH CARE**	▪ For treatment after 1/1/14 based upon RBRVS ▪ Home Health Care: Adopt Fee Schedule ▪ Home Health Care: Limitations and Prescriptions For: (14 days) ▪ Limitations on "Chiropractic Visits" ▪ Interpreters During Treatment		On or before 7/1/2013 **X** **X** **X** **X**	**X**
UTILIZATION REVIEW	▪ Not Needed if Disputing Injury/Body part ▪ Effective for 12 months ▪ All Disputes over UR Decisions go to IMR and not Through QME Process	**X (and on or after 7/1/2013 regardless of DOI**	**X** **X**	

		DOI: 1/1/2013	1/1/2013	1/1/2014
	▪ UR decisions no tied to MTUS ▪ Approval for Retroactive Decisions No Longer Need to be Communicated ▪ Retrospective UR deferred and Timing of Resumption	 **X** And for all UR decisions on or after 7/1/2013 regardless of DOI	**X** **X** **X**	
CONSULTING REPORTS	▪ Limitations on LC 4605 reports		**X**	
PD ADVANCES 4650(b)(2)	▪ No PD advances prior to an Award if all conditions met		**X**	
DEATH BENEFITS	▪ Burial to $10,000	**X**		
MISCELLEANOUS **120 MIL FUND** **EXPEDITED HEARING** **INTERPRETERS**	 ▪ Return to Work Program and the 120 million Fund under 139.48 ▪ MPN Issues added To Expedited Hearing ▪ Responsibility of Interpreters not to Advocate		 **X** **X** **X**	

EVIDENCE ALLOWED	▪ Reports of Vocational Experts permitted and live testimony	DOI: 1/1/2013	1/1/2013 **X**	1/1//2014
ATTORNEY FEES **REMOVAL** **FINANCIAL**	▪ Attorney Fees: filing Application for Non-represented Workers eliminated ▪ Attorney Fees Permitted for Home Health Care Issues ▪ WCAB Power Expands to Remove Non-Attorneys ▪ More Limitations on Financial Interests		**X** **X** **X** **X**	

SUMMARY OF SB 863
And the New AD Regulations

Please consider this Micro Guide as a changing but "one stop" reference source. As the AD promulgates new and additional regulations, including changes to existing regulations, we will be updating our Guide accordingly. Also, we intend to provide comment and analysis upon further developments, including case law.

LABOR CODE	SUBJECT	ADDITIONS/CHANGES[ii]/ + REGULATIONS + DEVELOPING CASE LAW +NEW FOR 2014/15
4660 4660.1 (NEW)	**PERMANENT DISABILITY**	• Labor Code **4660** is left intact for injuries prior to 1/1/2013 • **For injuries on or after 1/1/2013**, new **Section 4660.1 applies** • The 2005 *PDRS* ***does not apply*** to injuries on and after 1/1/2013. Instead the 2005 PDRS is effectively being *replaced* by two schedules; the first being the "**The Schedule for Rating Permanent Disabilities Pursuant to the AMA Guides**" and the other being the "**Schedule of Age and Occupational Modifiers.**" Therefore, when reference is made to the "Schedule" or the "PDRS," it now means *both* the AMA Guides and the Schedule of Age and Occupational Modifiers[iii] • Under current Lab C 4660, the FEC ranking is established within ratios of earning losses by body parts across eight rankings ranging in an FEC adjustment factors from 10% to a maximum of 40%. While the FEC is technically "gone" for injuries on or after 1/1/2013, it is being replaced by a **standard 1.40 upward adjustment factor against the impairment standard FOR ALL BODY PARTS**. So, before going to the new schedule (AMA Guides + Schedule of Age and Occupational Modifiers) you will multiply the Guides based impairment by **1.40** then adjust for age and occupation in order to determine the percentage of PD

		• The new "**Schedule for Rating Permanent Disabilities Pursuant to the AMA Guides**" and the "**Schedule of Age and Occupational Modifiers**" will both being considered prima facie evidence and therefore rebuttable. ***[NOTE***: Does this mean that Ogilvie is still alive and well? The answer here is likely "yes" since it can still be argued that if both schedules are rebuttable and since *Almaraz/Guzman* II is still very much in "play" then Ogilvie could be used to support the argument that an injured worker will sustain a *far greater* level of PD because of wage loss as he or she is unable to compete in the open labor market. And that loss is greater than the PD afforded under the Schedule because this injured worker will suffer a much higher PD "loss" resulting from the uniqueness of his or her occupation being impacted on his or her individual future earning capacity] **[*NOTE:*** If you go down to section **139.48**, Ogilvie is seemingly very much still alive, since the AD will have a 120 million dollar fund from which eligible workers will be entitled to supplemental payments if PD is found to be "disproportionately low" in comparison to their respective loss of earnings. We don't know what the criteria for eligibility will be, or the basis upon which funds will be distributed, but it is expected that any form of distribution will be based upon some measurable entitlement criteria directly related to the *old FEC* and the issues routinely being raised under Ogilvie. Therefore, "Ogilvie" ghosts appear to be both alive and well within SB 863. This also appears to be something outside of the WCAB, but who knows right now • FEC is technically eliminated but we question whether Ogilvie really disappears • ***Quick Refresh: Guzman II: 8/19/2010: (Milpitas Unified School District v. WCAB (Guzman) 187 Cal. App 4th 808, 75 CCC 837:*** *Court holds that the AMA Guides 5th should be used as "intended" by its authors and this means taking into account the whole book, including instructions and the use of "clinical judgment." This permits a physician to go beyond the chapters, tables and strict protocols of the Guides. To support a case for "rebuttal" the physician must therefore explain why departure from the impairment percentages is necessary and how it was arrived at. The California Supreme Court denied review on 11/10/2010, so for now this 6th DCA decision is good law until another district decides otherwise.*

		• ***Quick Refresh:*** ***Ogilvie III:*** *Decided on 7/39/3011 by the 1st DCA: Ogilvie v. WCAB: (197 Cal App 4th 1262); 76 CCC 624: Here, the Court upholds three (3) methods by which to rebut the FEC component of the PDRS: (1) Showing of a factual error in the application of a formula or in the preparation of the PDRS: (2) The injury impairs applicant's rehabilitation and: (3) Nature or severity of the injury was not captured within sampling of data used to produce the FEC. The California Supreme Court has granted review, but has neither decertified nor vacated the lower court's opinion, so it stands, for now* • **Adds adjustment factor of 1.4** against the WPI determined under the AMA Guides, 5th, before going to the Schedule of Age and Occupational Modifiers. **Every impairment standard will therefore be upward adjusted by 40% before modifications for occupation and age to determine adjusted PD** • Under the 2005 PDRS, the FEC is determined by an assigned FEC rank across 8 levels, with a range of between a 10% and maximum 40% adjustment. Under SB 863 revisions, the body parts which will be the *most upwardly impacted* are fingers, elbows, knees, ankles, feet, toes and hips • **No increases in impairment ratings for the compensable consequences of a physical injury resulting in psyche, sleep or sexual dysfunction, or any combination thereof**: Exceptions are being a victim of a violent act or direct exposure to a significant violent act, a catastrophic injury which includes, but is not limited to things such as loss of a limb, paralysis, a severe burn or severe head injury. (***NOTE:*** This should hopefully reduce what now appears to be a standard "routine" of many physicians, who report compensable consequences. ***NOTE FROM COREY*****:** I think we will be seeing more CT claims for "straight psychiatric" injuries in order to circumvent this new PD limitation. Or, we may expect some PTP's will simply shift from psyche, sleep and sexual dysfunction to GERD, IBS and hypertension as the new "add ons" du jour. • **Nothing herein *is intended to overrule Guzman II* [*NOTE:*** If anything, I fully expect that "chapter and table shopping" within the Guides will become the near norm and that we will likely face expansive discussions on why the tables or specific applications of the Guides are not as accurate as "hybrid" and "analogy based" ratings resulting from creative

		combinations and mixtures using different parts of the Guides, all tied together with the connective tissue being the ADL's.] • **WHAT ABOUT PSYCHIATRIC INJURIES**? A careful read here will demonstrate that since the 2005 PDRS is technically inapplicable, then seemingly there exists no actual method by which to determine impairment for compensable psychiatric injuries, whether secondary to a physical injury or provable independently. [***NOTE*:** This is likely to generate one of the first challenges to SB 863 and it remains unclear whether there is a present basis to continue to use the GAF, which is a vestige of the 2005 PDRS. The GAF was originally intended as a clinical tool to assess patients in a mental health facility. It is taken from the DSM-IV-TR and it is a very subjective scale which weights either "symptom severity" or "function" along a numeric scale. Under SB 899, an actual PD rating schedule was mandated ("PDRS"). However, under SB 863 and newly written section 4660.1, for injuries on and after 1/1/2013, there is no actual PDRS. Instead there are the AMA Guides 5th and the Schedule of Age and Occupational Modifiers. But if you look carefully, there is no actual vehicle with which to come up with a rating for psyche impairment. Turning to the Guides, please note that Chapter 14 specifically does not set forth any actual percentage impairment ratings for emotional disturbance based upon their stated belief that such measures are not accurate. As stated on page 361, *"Percentages are not provided to estimate mental impairment in this edition of the Guides. Unlike cases with some organ systems, there are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist."*[iv] You can expect some physicians may use Table 14-1 on pp. 363 denoting impairments from Class 1 to Class 5 but without percentages. Here, it wouldn't be hard for the physicians to then base estimates of impairment using ADL's as their underlying rationale. This would echo the old "work functions" which were the basis for the 1997 PDRS. Or they may simply continue to use the GAF and then using an Almaraz/Guzman discussion, indicate why a GAF based impairment or an impairment improvised by ADL's is "more accurate" then not having a basis upon which to actually determine psychiatric impairment. I would expect that pending regulations, most physicians will continue to use the old "GAF" method and it seems likely that few might object, in the absence of any further near term clarification of this issue

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- **EXAMPLES OF PD CHANGES UNDER SB 863**

<table>
<tr><th>EXAMPLE</th><th>2005</th><th>2013</th></tr>
<tr><td>46 year old school teacher
Right knee
Requires use of short brace, Table 17-5 or 15% WPI</td><td>17.05 15{2} 17 214F 17 18</td><td>17.05 15 21 214F 21 22</td></tr>
<tr><td>35 year old carpenter
Back
DRE III 13%</td><td>15.03 13[5] 17 380H 21 20</td><td>15.03 13 18 380H 22 21</td></tr>
<tr><td>46 year old electrician
Back: DRE IV 23%
Neck: DRE IV 28%
Heart: Class 2 20%</td><td>15.03 23[5] 29 380H 35 39
15.01 28[5] 36 380H 42 46
3.01 20[5] 25 380H 30 33

46 C 39 C 33 = 78
@270 = 151,537.50</td><td>15.03 23 32 380H 38 42
15.01 28 39 380H 45 49
3.01 20 28 380H 34 38

49 C 42 C 38 = 81
@290 = 176,682.50</td></tr>
</table>

Remember: SB 863 increases PD on two levels: (1) The rates go up by increasing minimums and maximum rates for PD over 54% and; (2) Every impairment standard is automatically multiplied by 1.4. (40%). And don't forget that rates go up again for *all PD* for injuries on or after 1/1/2014

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<tr>
<td>4453(b)(8)

4453(b)(9)</td>
<td>AWW AND PD RATES

Current AWW and Rates:
2006 to 12/31/2012</td>
<td>4453(b)(8): Injuries on or after 1/1/2013

PD TO 54%:</td>
</tr>
</table>

PD

1-69	MINIMUM: AWW 195 = 130.00 MAXIMUM: AWW 345 = 230.00
70-99	MINIMUM: AWW 195 = 130.00 MAXIMUM: AWW 405 = 270.00

- MINIMUM: AWW 240 minimum = 160.00
- MAXIMUM: AWW 345 maximum =230.00

PD @ 55 -69:

- MINIMUM: AWW 240= 160.00
- MAXIMUM: AWW 405 = 270.00

PD @70-99:

- MINIMUM: AWW 240 = 160.00
- MAXIMUM: AWW 435 = 290.00

4458(b)(9)" Injuries on or after 1/1/2014:

PD @1-99:

- MINIMUM: AWW 240 = 160.00
- MAXIMUM: AWW 435= 290.00

Some Illustrations 1/1/13 @ MAXIMUM vs. 2006

	2005		**SB863**	**%**
15	11,615	230	11.615	SAME
20	17,365	230	17,365	SAME
30	30,130	230	"	"
45	54,280	230	"	"
55	71,587.50	270	84,037.50	+17.4

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<table>
<tr><td>65</td><td>89,987.50</td><td>270</td><td>105,637.50</td><td>+17.4</td></tr>
<tr><td>70</td><td>116,977.50</td><td>290</td><td>125,642.50</td><td>+7.4</td></tr>
<tr><td>85</td><td>181,777.50</td><td>290</td><td>195,242.50</td><td>+7.4</td></tr>
<tr><td>90</td><td>203,377.50</td><td>290</td><td>218,442.50</td><td>+7.4</td></tr>
<tr><td>99</td><td>242,257.50</td><td>290</td><td>260,202.50</td><td>+7.4</td></tr>
</table>

The number of weeks is the same as 2006 (the multipliers remain the same) so the difference is the AWW resulting in a higher PD rate from 2006 maximum impacting PD starting at 55-69 (230 to 270) and 70-99 (270 to 290)
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<td>4658(e)</td>
<td>PERMANENT DISABILITY: WEEKS AND 15% BUMP UP/DOWN: ELIMINATED</td>
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Labor Code 4658(d)(2) containing the infamous “15% bump up/bump down still applies to injuries prior to 1/1/2013
For injuries on or after 1/1/2013: new sub-section (e) eliminates the entire 15% increase or decrease provision
The number of weeks for 2/3d of AWW allowed for each 1% of PD remains the same for PD from 1-99% (The formula found on Table 15 of the Labor Code remains unchanged)[v]

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<td>4658.5
4658.7 NEW</td>
<td>SJDB

Regulations filed with OAL 12/14/12 [Emergency]

Revised Regulations filed with Sec. of State 11/8/2013. Regulations became effective 1/1/2014</td>
<td>

4658.5: Adds new sub (d) for injuries prior to 1/1/2013 where the SJDB issues after 1/1/2013, it shall expire 2 years from date furnished to employee or 5 years from date of injury, whichever is later
Employee not entitled to payment or reimbursement of expenses that have not been incurred and submitted with appropriate documentation prior to expiration date of voucher
Slight modifications to Notice of Offer of Modified or Alternative Work for injuries between 1/1/2004 and 12/2012; adding word “inclusive” to clarify time period.

Injuries 1/1/2013 and after:

4658.7: New “Supplemental Job Displacement Nontransferable Voucher” for injuries on or after 1/1/2013:

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Voucher obligation now arises when there is any amount of PPD and no offer is made within 60 days of the Claims Administrator receiving the first report from a PTP, QME or AME in proper form, finding disability from all conditions for which compensation claimed is permanent and stationary AND injury has caused PPD (see below since the regulation appears to be inconsistent with the timing of the statute)[For injuries between 1/1/04-12/31/12, the “trigger” remains the date upon which TD terminated, so the offer must be made within 30 days from that time, in order to avoid liability for the SJDB]
AMENDED REGULATIONS: 1/1/2014. The AD has changed slightly the timing of when the offer of regular, modified or alternative work is to be made. Under prior 8 CCR 10133.31 (b), the offer was to be made within 60 days of receipt by the claims administrator of the Physician’s Return-To-Work & Voucher Report [DWC-AD 10133.36]. Now, (b) has been changed this to add that the offer is to be made within 60 days of the form 10133.36 but adds, “that indicates the work capacities and activity restrictions that are relevant to regular work, modified work, or alternative work.” 10133.3(c): provides that if the employee has lost no time from work or has returned to the same job for the same employer, is deemed to have been offered and accepted regular work in accordance with the criteria set forth under Lab C 4658.(b). Under revised 10133.34(b)(1), the claims administrator may serve the offer or work on behalf of the employer
NEW DWC FORMS:

<table>
<tr>
<td>10133.32</td>
<td>SUPPLEMENTAL JOB DISPLACEMENT NONTRANSFERABLE VOUCHER FORM

New Voucher Form adopted as of 1/1/2014</td>
<td>Provides for direct reimbursement to the school or a certified provider. Upon the voluntarily withdrawal from program, employee may not be entitled to full reimbursement

NEW VOUCHER: Adds that the employer may give the employee the option to obtain computer equipment directly from</td>
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					the employer **NEW VOUCHER:** Adds a page for request for purchase of computer equipment with the option of employer furnished. It also allows the employee to submit bids from retailers by attaching an "invoice" to the request, so the computer need not be paid for, prior to issuance of the payment request. Or, it permits purchase by the employee with receipt of purchase attached to request
			10133.33	**DESCRIPTION OF EMPLOYEE'S JOB DUTIES** **NEW FORM: 1/1/2014**	To be developed jointly by the employer and employee. This would be referred to the physician who then prepares form 10133.36. This is prepared jointly between employer and employee **Form modified to delete reference to Retraining and Return to Work Unit, since that no longer exists**
			10133.35	**NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK** **NEW FORM: 1/1/2014**	All offers are now on one form NEW FORM: **Adds that employee may object to the offer (as opposed to only accepting or rejecting) if the offered job location is different than the one held at the time of injury and applicant does not believe the offered job is a reasonable commute from his/her residence. Form also adds a "waiver" of the commuting**

					distance issue. Also, eliminates reference to Retraining and Return to Work Unit, since it does not exist **Adds address of DWC in the event of a dispute**
			10133.36	**PHYSICIAN'S RETURN-TO-WORK AND VOUCHER REPORT** **NEW FORM: 1/1/2014**	This was made mandatory under SB 863, to be forwarded to employer for purposes of fully informing employer of work capacities and of activity restrictions, which are relevant to regular, modified or alternative work (Lab C 4658.7(h)] **This form has changed to more fully conform to the PR-4 and also has a "box" for the physician to provide a narrative description of ways in which the impaired activities are limited. Restrictions are rewritten**
			10133.55	**REQUEST FOR DISPUTE RESOLUTION BEFORE THE ADMINISTRATIVE DIRECTOR** **NEW FORM: 1/1/2014**	Same form, same form number, with slight modifications on last page, but nothing substantive Slight changes include the employee "objection" to the offer because of the distance to location. And, they delete reimbursement program as it no longer exists
		▪ **REGULATIONS:** [**10133.31**] **(new)** The offer is made within 60 days after receipt by the Claims AD of the ***Physician's Return-to-Work & Voucher Report***: **DWC-AD 10133.36**).			

		NOTE FROM COREY: The "trigger" for the offer here is different than the statute, since the offer is triggered by ***the receipt of the "form"*** rather than from the date of the (medical) "report" from the PTP. The "instructions" on the form say it is "mandatory" but what happens if the PTP, QME or AME finds P and S and PPD but does not "attach" the form? This could lead to some mischief, since those dates may not coincide and the statute would "trump" the regulation. The safer way to go is to ensure that the offer is made timely based upon the date of receipt of the report, since the "form" may not come until several weeks later. Another "twist here" is that the regulations say that if the Claims AD furnished a job description to the physician, he/she must fill out the bottom of form 10133.36, but what if they don't? What if the form is then deemed incomplete? What makes sense here is that the "time frame" seems to run at least from the date the Claims AD receives the "form" 10133.36, irrespective of whether it is complete or possibly earlier, if the medical report is a P and S evaluation from all injuries, finds PD but the form is not attached. ▪ **NEW MANDATORY FORM**: **[Form: DWC-AD 10133.36]** Claims AD to forward on an AD devised form to employer to inform of work capacities and restrictions which are relevant to potential regular, modified or alternative work. Use of the form is now mandatory per the adopted new regulations ▪ If a physician has been provided a job description [**Form: DWC-AD 10133.33**] the physician shall evaluate and describe in the form whether the capacities and restrictions are compatible with the requirements in the job description. And the physician shall comment on the job description within form AD 1011.33.36, which is attached to the medical report provided to the Claims AD ▪ No SJDB if timely offer is made of regular, modified or alternative work lasting at least 12 months. Physician to respond to a job description furnished by the Claims Administrator ▪ SJDB is due 20 calendar days after the 60 day period required to make the offer of work **SJDB is redeemable in an amount "up to" an aggregate of $6,000 and the benefit is not scaled to any specific level of PD**

		▪ Expanded use of voucher, to include occupational licensing, professional certification fees, examination fees, examination preparatory course fees, purchase of tools required by a training or educational program and resume preparation. Under the $6,000 aggregate sum, payment for resume preparation, services of licensed placement agencies, vocational or return-to-work counseling, all up to a **combined limit of 10%** of the amount of voucher (or not more than $600.00) [**10133.31(e)(1)]:** Payment for education-related training or skill enhancement, or both, at California public school or with provide which is certified by the state's Eligible Training Provider List (EPTL) which includes: ▪ Tuition ▪ Fees ▪ Books ▪ Other expenses required of the school ▪ Occupational licensing fee ▪ Professional certification fee ▪ Related examination fees ▪ Examination preparation course fees ▪ Services of licensed placement agencies (combined limit $600) ▪ Services of vocational or return-to-work counseling (combined limit $600) ▪ Resume preparation (combined limit to $600) ▪ Purchase of required tools

		▪ **Computer Equipment** (reimbursable *after cost is incurred and submitted with appropriate documentation* up to $1,000) (including monitors, software, networking devices, input devices, e.g. keyboard and mouse, peripherals (printers) tablet computers. (games or entertainment media are excluded) The regulations do not specifically state that the computer is required as part of the curriculum of the school or training facility. But the entire voucher is linked to education and training, so without some evidence of enrollment, the computer is not allowable ▪ Up to $500 as a miscellaneous expense reimbursement or advance ▪ **ADVANCE OF $500:** Under the $6,000 aggregate sum, payment to the employee as an advance or reimbursement **up to $500** deemed as a miscellaneous advance without the employee's need to document [***NOTE FROM NONA SACHS:*** Here, the applicant gets an automatic payment of $500 without documentation so expect applicant attorneys to modify their standard transmittal and representation letters to build in automatic demands both for the $500 advance as well as for the computer. [**10133.31(e)(6)]:** The regulation is taken "word for word" from the statute, so no further rules here beyond what the statute says. A further change to the regulation permits the employee to make the request by E mail if this is included in the Voucher form ▪ **COMPUTER EQUIPMENT:** Under the $6,000 aggregate sum**, up to $1,000** for the purchase of computer equipment, which will likely include peripherals such as monitors, keyboard, mouse, software and even tablet computers [***NOTE FROM NONA SACHS:*** This could actually become a routine "demand" by applicant attorneys in which for any case where this is likely to be any level of PD, they issue a demand for a computer and its peripherals. According to the statute, the qualifying elements of the SJDB are the existence of any PD and no offer being made within the 60 day time frame. It is the applicant's "choice" as to how to spend the voucher, so it seems as if computer equipment might well become a "routine" thing in any case where there is PD and no timely offer of work ▪ Voucher expires 2 years from the date it is furnished to employee or 5 years from the date

		of injury, whichever is later ▪ No payment or reimbursement to employee unless there is submitted documentation prior to voucher expiration date ▪ **No settlement or commutation of SDJB is permitted** ▪ The roster of schools is enhanced as it is now based upon the State of California's Eligible Training Provider List ("ETPL") and this includes a range of programs, featuring classroom education, correspondence, internet and broadcast. The list is based upon the recognition of eligibility to receive funds under the Workforce Investment Act (WIA) of 1998. [**10133.31(e)(1) and 1033.58(c**)]: the list is now based upon a very wide number of schools. For injuries on or after 1/1/2013, providers of education-related retraining or skill enhancement shall be certified on the ETPL. See; http://etpl.edd.ca.gov ▪ **10133.31(i):** Claims AD to make reimbursement payments within 45 calendar days from receipt of completed voucher, receipts and documentation
4061	**QME PROCESS**	▪ **4061** shall not apply to utilization review decisions under 4610 ▪ **4061** shall not apply to employee disputes of diagnosis or treatment under MPN per 4616.3 and 4616.4 ▪ For unrepresented employees – Sections (d)(1) and (2) are added which allow an unrepresented employee **or employer** to request one supplemental report from a PQME seeking correction of factual errors in report ▪ PD rating is suspended during this correctional phase of the process ▪ Notice due to employee re: PD replaces "continuing medical care" with "future medical care"
4062	**QME PROCESS**	▪ **4062 (b):** For injuries on or after 1/1/2013 and for UR decisions communicated on or after 7/1/2013, regardless of date of injury, all employee objections to utilization review

		disputes under Lab C 4610 are resolved only through independent medical review (IMR) pursuant to 4610.5 *and not through the QME process* ▪ For injuries on or after 1/1/2013 and for objections to diagnosis of treatment recommendations within the MPM, regardless of the date of injury, all employee objections to diagnosis or treatment recommendations within the MPN are also resolved only through independent medical review (IMR) pursuant to 4610.5 ▪ Second opinion spinal surgical process under 4062(b) is gone as of 1/1/2013 and for all dates of injury
4062.2 139.2	**QME PROCESS** **QME PROCESS** **Regulations filed with OAL 12/20/12** **Revised regulations filed with OAL 9/16/2013**	▪ The QME process in represented cases is changed. **Gone is the "AME" dance, which means we don't have to propose an AME as a precondition to requesting a PQME from the DEU Medical Unit** ▪ **REVISED REGULATIONS: 9/16/2013: The AD has filed new regulations effective 9/16/2013. The changes embodied in these revised regulations are minor. Rule 30: AD now permitted to revoke panel; Rule 33: one year fee period to calendar year: Rule 35: Permitting a letter outlining the "issues" is modified to a letter outlining "the medical determination of the primary treating physician or the compensability issue."** ▪ **"AME DANCE IS GONE" (represented cases): *NOTE FROM COREY*:** Modifications to **8 CCR 30**, still require requesting party to attach a copy of the written objection to the PTP opinion and description of the medical dispute but the language regarding proposed AME is removed from the statute. Revised regulations change Rule 30, to permit the medical director to revoke a panel due to mistake, misrepresentation or if parties have agreed to resolve dispute using an AME ▪ **4062.2(b): 4060 requests** -- the 1st working day which is at least 10 days from giving the other side notice of intent to make a PQME request to the DEU Medical Unit ▪ **4062.2(b): 4061 or 4062 --** the 1st working day which is at least 10 days from a party making a 20 day objection to the reporting of a treating physician

		▪ **4062.2(c):** Once the panel is assigned, gone is the requirement that the parties then "confer" in order to try and agree upon an AME from the panel over a 10 day period and then strike one doctor from the panel within 3 additional days. **Instead, either party may strike one name within 10 days from issuance (plus 5 more days for mailing). If a party fails to strike a name within 10 days (plus 5 for mailing), then the other party can select any of the three as the PQME** ▪ **4062.2(f):** Parties can agree to AME at any time except as to issues for independent medical review (IBR) under 4610.5 ▪ No QME panel to be requested on any issue which has been submitted to an AME unless the agreement has been canceled by mutual written consent ▪ For non-represented injured workers, panel assignments are extended from 15 to 20 working days ▪ Preference in assignment of panels given to non-represented employees ▪ QME shall not conduct evaluations at **more than 10 locations.** Changes to regulations: **[8 CCR 17(b and 31.2]:** On or before 1/1/2013, QME shall notify Medical Director of the street address of the 10 or fewer office locations where the QME will conduct examinations. Between 1/1/2013 and 7/1/2013, no substituted offices without good cause. An individual QME, performing evaluations at more than one office location required to pay additional $100 annual fee per additional office location**.** Each additional office must contain the usual and customary equipment for the type of practice appropriate to the QME specialty. NOTE: 9/16/2013: [This has been amended to now add that nothing shall prevent a QME from adding additional offices up to the maximum of 10.] ▪ **EFFECT OF FAILURE OF QME TO PROVIDE NOTICE OF OFFICE LOCATIONS TO AD**: New **sub (h)** is added **to 8 CCR 33**, so that if the QME has failed to make the notification of office locations (less than 10) to the AD by 1/1/2013, then the Medical Director "shall" designate the QME to be "unavailable." **This means a replacement panel.** (Another tool

		to use when reviewing a QME Panel. Have all of the doctors complied with this?) ▪ **WCAB En Banc:** **Navarro v. City of Montebello** (2014) 79 Cal Comp Cases 328: Labor Code and 8 CCR 35.5(e) do not require that the employee must return to the same QME for an evaluation of a subsequent injury. Therefore, the date of the "filing" or reporting of the injury on the DWC-1 (Claim Form) with the employer will determine which QME must consider which injury. The WCAB therefore made a distinction between returning to the same QME for new medical issues arising from an injury vs. medical issues arising from a different injury, based upon the reporting of that injury. The WCAB also stated in footnote No. 13 that in cases where there are multiple claim forms filed for the same date of injury, the date of the first of those multiple claims would be "significant' in determining which panel QME conducts an evaluation. Finally, the WCAB also stated that it didn't appear to make any difference whether the applicant was or was not represented, since the result would be the same ▪ **WCAB panel decisions:**[vi] **Weaver v. Univ. of Cal.** 2014 Cal. Wrk. Com. P.D. Lexis 162: 8 CCR 35.5(f) requires that unless otherwise agreed upon or upon WCAB Order, a PQME must make himself/herself available for deposition within 120 days of deposition notice. Here, the WCAB Panel concluded that defendant not entitled to a new panel due to calendar "inflexibility" when QME first asked for a longer period but later agreed but defendant sought replacement panel. **Norwood v. San Francisco Municipal Transportation Agency** 2014 Cal. Wrk. Comp. P.D. Lexis 176: Applicant not required to go back to prior AME for a new injury claim when parties agreed to use an AME in 3 cases but not the 4th
4062.3	**COMMUNICATION WITH PQME**	▪ Sub (f) is amended to permit communications with an AME's staff or with the AME as to non-substantial matters such as scheduling of an appointment, missed appointment or furnishing of a record and reports, including availability of report. [***NOTE***: sub (f) refers only to AME's and does not list a PQME so was this a drafting mistake or an omission? This is unclear but it seems the intent was to permit these communications since this has become a problem and there are some cases addressing the issue of contacts with a PQME for non-substantive issues such as "did the applicant show" and "when can we expect the report?" It seems as if the drafters omitted without intent]: ***NOTE FROM COREY:*** Current regulations under 8 CCR 35 and Lab Code 4062.3 deal with

		communications to both an AME and QME, so this really appears to be a drafting omission. The same rules should apply to PQME's and AME's. ▪ **Regulations**: changes to **8 CCR 35(b)(1):** Changes this statute to permit the type of clerical communication authorized by 4062.3(f), allowing for oral communications with the AME or staff, relative to non-substantive matters, such as scheduling appointments, missed appointments, furnishing of records and reports and the availability of the pending medical report, unless the WCAB has made a specific finding of an impermissible communication ▪ 8 CCR 35(a)(3) has been changed from a letter "outlining the issues" to a letter outlining the "medical determination of the primary treating physician or the compensability."
4650(b)(1) and (2)	**TIMING OF PD PAYMENTS**	▪ Adds two sub sections to the statute ▪ **FOR ALL DATES OF INJURY** ▪ NO PD advances if all conditions below are met: ▪ **(b)(1):** advancing PD now subject to (b)(2) ▪ **(b)(2) new--No PD advances are payable if prior to an award of PD**, the employer has offered the employee a position paying ***at least 85%*** of the wages and compensation paid at time of injury –or- if employee is employed in a position that pays ***at least 100%*** of the wages and compensation paid at the time of injury ▪ When PD award is made, amount then due will be calculated from the last date upon which TD was paid or the permanent and stationary date, whichever is earlier ▪ Under this statute, if we learn the applicant is working for another employer and earning at least 100% of wages and compensation at time of injury, then no PD advances are required [***NOTE****:* We now have an additional reason to get records from a new employer or the applicant's stipulation as to wages and compensation, otherwise if the compensation is anything lesser, we would have the obligation to advance PD]

		▪ PD WILL BE PAID AT THE MINIMUM AND MAXIMUM RATES (ABOVE) AND NOT AT THE TD RATES AS REFLECTED IN EARLIER DRAFTS OF THE BILL ▪ ***NOTE FROM COREY:*** We now have 2 trigger points at which offers are to be made: 1) **PRIOR TO AN AWARD TO AVOID PD ADVANCE LIABLITY**; and 2) **WITHNIN 60 DAYS OF RECEIPT OF 1ST REPORT FROM PTP, QME OR AME, FINDING DISABLITY FROM ALL** CONDITIONS, THE APPLICANT IS PERMANENT AND STATIONARY AND THERE IS PPD. *Subject to further regulations, it would be ideal if only one offer can be made, but the criteria for the SJDB offer is more extensive; but if the money and benefits are at the 85% level, and then I presume ONE OFFER WOULD COVER BOTH* ▪ ***NOTE FROM COREY:*** What about existing cases where there is PD? Do we use this statute to discontinue paying PD, if the applicable criteria are there? Can this be done? Undoubtedly, this will be a subject of much discussion and analysis. There is no all-inclusive answer right now, as it may depend upon many factors. However, it is a consideration which should be undertaken with great care, especially with unrepresented injured workers. Stopping PD benefits could induce an applicant to go out and hire a lawyer, so an abundance of caution is recommended for non-represented cases. ▪ **WCAB En Banc decision: Brower v. David Jones Construction** (2014) 79 Cal Comp Cases **550.** Applicant's TTD ended under the 104 week cap in 2007 but he was not found permanent and total until 2011, hence there was a gap of four years. The WCAB held that when TTD stops because of the cap before the applicant is determined permanent and stationary, *defendant shall commence PD based on a reasonable estimate of the ultimate level of PD.* And, if the applicant is receiving PPD and then becomes permanent and stationary and 100%, then *defendant shall pay PTD retroactive to the date its statutory obligation to pay TTD terminated. And, COLA's will begin on the first date in January, after the injured worker becomes entitled to receive PTD*
4600	**MEDICAL TREATMENT:** **CHIROPRACTORS**	▪ Under amended **4600(c),** a chiropractor shall not be a treating physician after the employee has received the maximum "chiropractic" visits under the 24 treatment "hard caps" of 4604.5(d)(1). [***NOTE:*** The statute appears to delimit the chiropractor after the

	4600(c)	applicant has actually had chiropractic treatment. However "chiropractic visits" are not defined. Does this mean a PTP examination by a chiropractor or does it also pertain to chiropractic adjustments as opposed to physical therapy? But what about a PTP who examines the applicant every 45 days and refers the applicant for physical therapy? This is very likely to be a subject of intense scrutiny, pending regulations, if any.] NOTE: If early indications in the regulation drafting are an indication, the regulations will likely define "chiropractic visit" and this would cover both medical management and treatment, so that the caps would apply even to a chiropractor who was not providing care but only acting as the "gatekeeper." It is expected this statutory change will be challenged quickly either on a reconsideration and appeal from a WCAB decision or perhaps even with a direct constitutional attack launched in the Superior Court.
	INTERPRETING SERVICES	▪ There is also a slight drafting error since the statute refers to the so-called "hard caps" under sub (d) but under the changes in this statute the "hard cap" are actually now contained in sub (c). Stay tuned ▪ **Interpreters during treatment:** new sub (g) added: Applicant entitled to services of a qualified interpreter if he or she cannot effectively communicate with the treating physician ▪ AD to adopt fee schedule for qualified interpreter fees in accordance with this section ▪ Employer not required to pay for non-certified or provisionally certified interpreters
	HOME HEALTH CARE	▪ **Home Health Care ("HHC")**: new Lab C 4600 sub (h): HHC is considered medical treatment if reasonably required and ***prescribed by a physician and surgeon***. The definition of "prescription" was the subject of dispute and the WCAB has issued an en banc decision which changes the meaning of the word "prescribe." **WCAB En banc decision**: **Hernandez v. Geneva Staffing, Inc.** (2014) 79 Cal Comp Cases 682: Here, the request for HHC was made by Dr. Lee, who reflected that the applicant would need continuous home care from his wife. His report was signed, but there was no formal prescription for HHC. The WCAB held that the AD regulations for HHC applies to all pending, non-final cases. More importantly, they held a "prescription" for HHC is either

		an oral referral communicated directly by a physician to an employer/agent or a signed, dated written referral recommendation or order by a physician. It does not have to be "labelled" or even written in any particular form.
	NURSE CASE MANAGER	▪ **NURSE CASE MANAGER** ("NCM"). For many years, it has been the custom and practice for the claims administrator to decide whether to utilize a NCM and the general practice has also been for the Claims Examiner to select that individual. For the most part, applicant attorneys were not generally engaged in the process, because in most cases, the NCM was assisting the applicant in getting to medical appointments and in the ongoing process of treatment, so the feedback would have been generally positive. But, there have been instances where applicant attorneys have been demanding a new NCM or one of their own choosing. This issue came to the attention of the WCAB, which issued a significant panel decision: **WCAB Significant Panel decision**[vii]: **Patterson v. The Oaks Farm** (2014) 79 Cal Comp Cases 910: Here, applicant had sustained serious injuries when thrown to the grown while training a horse. She had back surgery but still had ongoing problems. Defendant had appointed but then unilaterally terminated a NCM. Applicant objected and filed a DOR for Expedited Hearing. The WCAB held: (1) Provision of a NCM is considered a form of medical treatment; (2) Employer may not unilaterally cease to provide a NCM when there is no evidence of a change in circumstances or condition showing that the services are no longer reasonably required. **NOTE FROM COREY**: Under the holdings of this case, the defendant would have to consider the NCM issue as "medical necessity" and this would have to go to a timely UR decision. The WCAB reference to "change in circumstances" would also appear to be squarely a medical necessity issue. But the "sticky" part here is what if the NCM is not performing properly? Is this a medical necessity issue or is it an issue which must be decided by the WCAB? My advice?: If you encounter an issue with the NCM, such as failing to communicate or other performance issues, then consider a "meet and confer" with the applicant or if represented, with applicant's counsel. Failing that, file a DOR for Expedited Hearing but you need "evidence." This could be a declaration from the examiner or other documentary evidence to detail the performance issues. So long as you admit that a NCM is necessary, then the issue of changing to another (as opposed to termination) would be within the WCAB jurisdiction and the NCM should not be unilaterally terminated, pending a hearing. But the "changed circumstances" would go to medical necessity and that

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<td>would be referred timely to UR

▪ Employer not responsible for home health care services that are provided more than 14 days prior to the employer's receipt of the physician's prescription</td>
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<td>4610(g)

4610.5 (new)</td>
<td>CHANGES TO UTILIZATION REVIEW

9792.1
9792.10.1
RFA

Regulations filed with OAL 12/20/12</td>
<td>▪ CHANGES TO UTILZATION REVIEW STATUTES: The regulations implementing the statutory changes to UR have been divided between injuries prior to 1/1/2013 and UR decisions before 7/1/2013 vs. those which relate to injuries on or after 1/1/2013 and UR decisions after 7/1/2013.

Side by Side Comparison
<table>
<tr><th></th><th>INJURIES PRIOR TO 1/1/2013 and 7/1/2013</th><th>INJURIES ON AND AFTER 1/1/2013 AND UR REQUESTS MADE ON OR AFTER 7/1/2013</th></tr>
<tr><td>DEFINITIONS</td><td>9792.6: No changes in definitions to existing regulations</td><td>9792.6.1: Minor wording changes to existing definitions. Adds definitions of "denial," "dispute liability, "MTUS," "modification," and redefines UR process as including new DWC Form RFA. UR process begins when the Claims AD receives the RFA.</td></tr>
<tr><td>UR PROCEDURES AND TIME FRAMES</td><td>9792.9(b): DEFERRAL: UR deferred if liability for injury disputed or dispute over treatment on grounds other than necessity (b)(1): Dispute must be raised NO Later than 5 business days from RFA. This notice must contain certain elements,</td><td>New: 9792.9.1:

▪ Request for authorization must be on new DWC Form RFA

▪ The form is an attachment to the treating physician's progress report (PR-2), First Report or any equivalent report which requests authorization

▪ This is mandatory

▪ This initiates the UR process</td></tr>
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	UTILIZATION REVIEW			including a "clear, concise and appropriate" explanation of the reasons. MANDATORY LANGUAGE under (b)(1)(E) beginning with "You have a right to disagree with decisions affecting your claim….." 9792.9(b)(2) If liability is finally determined adversely to Claims AD, then time for conducting retrospective UR begins with the date upon which the liability became final Regulations relating to the communications of UR decisions remain the same, but they change after 7/1/2013 to incorporate the new changes to UR, including use of IMR	▪ Provider may use SINGLE REQUEST ▪ Provider can make MULTIPLE REQUESTS on the form ▪ Fax or E mail: Form is deemed received by Claims AD or UR by FAX or by E mail if there is a receiving "date stamp" ▪ If no receiving date stamp, then date transmitted is deemed date received ▪ RFA transmitted after 5:30 p.m., Pacific Time, deemed to be received the following business day except for expedited or concurrent review ▪ Requesting physician must indicate whether there is need for expedited review on the form ▪ By mail: absence documented receipt date, RFA deemed received 5 business days after deposit in mail ▪ Certified mail: deemed received on the date entered on returned receipt ▪ Telephone access required from 9:00 a.m. Pacific Time to 5:30 p.m. for health care providers to request authorization ▪ All Claims AD's shall have fax numbers ▪ All Claims AD's must have process for receiving requests after business hours

				and mandated notice form language	(voice mail, fax or E mail address is okay) ▪ RFA may be deferred if Claims AD disputes liability on grounds other than necessity
	UTILIZATION REVIEW				
			UR DECISIONS	9797.9 (o): effective for 12 months from the date of the decision without further action unless supported by a documented change in the facts material to the basis for the UR decision.	PROSPECTIVE, CONCURRENT AND EXPEDITED REVIEW: 9792.9.1.(c)(3): shall be made within 5 business days from the receipt of the completed DWC + RFA, but no more than 14 calendar days from initial receipt ▪ Expedited: 72 hours ▪ If information necessary but not included in the RFA form, may be requested by reviewer or non-physician reviewer within 5 business days from RFA ▪ RFA may be denied if the additional information sought is not received within 14 days from RFA. The denial must also state that it will be reconsidered upon request of the required information RETROSPECTIVE: within 30 days of receipt of medical information necessary to make determination. Payment or partial payment within 30 days of the RFA shall be deemed a retrospective approval, even if a portion of the bill is contested, denied or considered incomplete DECISIONS TO APPROVE: The regulations expand what must go into a decision to approve: date of approval, specific treatment requested and the specific service being approved

	UTILIZATION REVIEW				COMMUNICATING: Decisions for prospective, concurrent and expedited now include E mail as well as telephone and fax DECISIONS TO MODIFY, DELAY OR DENY PROSPECTIVE, CONCURRENT OR EXPEDITED REVIEW: ▪ Within 24 hrs. and by phone, fax or E mail ▪ Followed by written notice: 24 hours for concurrent; 72 hours for expedited and 2 business days for prospective ▪ CONTENTS OF DECISION ARE EXPANDED: (9792.9.1(e): adds language explaining reasons for deny based upon incomplete or insufficient information. Big change: The Application for Independent Medical Review, DWC Form IMR-1 with all fields except signature of the employee, to be completed by Claims AD and *the application shall include an addressed envelope and the postage may be paid for mailing to the AD* ▪ *A Clear statement advising that all disputes are to be resolved in accordance with 4610.5 and 4610.6* and that an objection to the utilization review decision must be communicated by the injured worker or by representative or attorney *within 30 calendar days from receipt of UR decision.*

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<td>UTILIZATION REVIEW</td>
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<td>▪ Mandatory language also required: re: right to disagree with UR decision, please call Claims Examiner @ phone #, or attorney</td>
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<td>DISPUTES</td>
<td>Disputes are resolved through the 4062 QME process until 7/1/2013, after which disputes will be resolved exclusively through IMR</td>
<td>Non-UR disputes are guided by: [9792.9.1(b)(1)];

▪ 5 business days to issue written decision deferring UR

▪ Mandatory language under (b)(1)(E)

▪ If deferred issue is finally decided that Claims AD is liable, then time to conduct retrospective UR runs from the date the determination is final

▪ Prospective UR decisions will then run from the date that the Claims AD gets a new RFA after final determination of liability

UR disputes: 9792.9.1: are now handled through the IMR and IMRO process of 4610.5 and 4610.6, not through the QME process under 4062.</td>
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▪ (g)(7): Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment (body part) for which treatment is recommended

▪ (c): UR decisions are consistent with the MTUS and no longer refer to ACOEM Guidelines

▪ (g)(6): UR decision shall remain effective for 12 months from the date of decision without further action with regard to further recommendation by same physician for same
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		treatment, unless further recommendation is supported by documented change in facts [(9792.9.1 (h)]: UR decisions remains in effect unless there is a further recommendation which is supported by a documented change in the facts material to the basis of the utilization review decision
	UTILIZATION REVIEW	▪ (g)(8): If UR is deferred because of (g)(7) but employer is found liable for the injury and treatment, then retrospective UR commences on the date that the employer's liability becomes final. Prospective UR would begin from date of employer's receipt of treatment recommendation after determination of liability ▪ (g)(1): Approval for retroactive UR decisions no longer need to be communicated ▪ REGULATIONS: 8 CCR 9792.9.1, 9792.10.1 and DWC Form RFA
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		THE ATTACKS ON UR AND IMR: FROM DUBON I TO DUBON II AND BODAM
	INDEPENDENT MEDICAL REVIEW [IMR]	• The attacks on UR and IMR intensified in 2014, with many applicant attorneys choosing to file DOR's for Expedited Hearings, in order to challenge the validity of a UR decision while simultaneously filing for IMR. This "two track" strategy caused a lot of hearings to take place and there was much uncertainty over which body, the WCAB or IMR, had the authority to determine procedural compliance and validity of a UR decision • **DUBON I: UR DEEMED DEFECTIVE FOR EITHER MATERIAL PROCEDURAL DEFECTS OR UNTIMLINESS**: On 2/27/2014, the WCAB issued its En Banc decision in Jose Dubon v. World Restoration, Inc.; and SCIF (2014) 79 Cal Comp Cases 313 (Dubon I) . The applicant had challenged the procedural validity of the underlying utilization review decision, so it was asserted that the WCAB had jurisdiction over the medical necessity dispute, even though that dispute had already gone through the UR process. Essentially, it was maintained that defendant had not sent the requesting physician all of the medical reports but only 18 pages were in fact received and it was further alleged that the UR

		physician did not indicate what reports upon which he was relying. The WCAB held: [1] that a UR decision is deemed invalid if it suffers from "material procedural defects, that undermine the integrity of the UR decision." However, "minor technical or immaterial defects" do not defeat the UR decision and therefore it fully remains within the IMR process." [2] The WCAB has jurisdiction over the underlying issues of material procedural deficiency and timeliness: [3] If the employee prevails on the procedural deficiency or untimeliness argument, then the WCAB has jurisdiction to decide the underlying disputed medical necessity issue, but subject to proof. [4] The right to have UR decisions reviewed through IMR is at the decision of the employee, but it presupposes a valid UR determination • In the aftermath of Dubon I, there were continuing efforts to sidetrack and defeat UR and IMR. In one **WCAB Panel Decision** reported by Work Comp Central on 4/4/2014, in **Weilman v TIG** (2014) the WCAB determined a UR decision was invalid because the reviewing physicians had *failed to sign their reports*. But, this decision was also coupled with the fact that the WCAB stated that the defendant had failed to provide the AME reports to UR and this was sufficient to undermine the integrity of the UR decision. **And a well-known applicant's attorney even filed a writ of mandate (mandamus) before the 1st District Court of Appeal, claiming that the IMR statute was a violation of Article IV of the California Constitution.**[viii] From 2/27/2014 to 10/6/2014, it remained unsettled as to what acts were deemed "material defects" compared to those acts which were otherwise deemed immaterial or minor technical defects • On 5/22/2014, the WCAB granted reconsideration in order to further study both the legal and factual issues raised by SCIF on reconsideration, but it also ordered that Dubon would remain in effect and binding • **DUBON II: WCAB NARROWS DUBON I TO ENCOMPASS ONLY UNTIMLINESS**. On 10/6/2014, the WCAB issued its Opinion and Decision after Reconsideration, or "Dubon II. (2014) 79 Cal Comp Cases 1298.[ix] ➢ An untimely UR decision is not subject to IMR

		➢ Only the WCAB has authority to determine the untimeliness of a UR decision, not IMR. This is because the untimeliness issue is a "legal" dispute, which is within the WCAB's jurisdiction ➢ All other procedural or other disputes over UR will be determined only through IMR, subject to the appeals process within the statutes and regulations. These disputes would include, among others: (1) The sufficiency of whether the proper or accurate medical records, including physician reports, were ever sent to the Physician Reviewer;[x] (2) Whether the Physician Reviewer considered these records and if so, which ones: (3) Whether ACOEM or MTUS was properly applied; (4) Incomplete listing of medical records sent to UR; (5) Physician Reviewer fails to state his/her clinical reasoning, including proper use of medical criteria. ALL OF THESE ISSUES WILL BE DETERMINED ONLY BY IMR, NOT THE WCAB ➢ When a UR decision is timely, then IMR is the "sole vehicle" `for reviewing UR expert opinions[xi] ➢ The "bottom line?" Medical decisions, including the use of medical criteria, what documents were referred to UR, and the like, shall be left to the expertise of medical professionals. And, the legal dispute over timeliness shall be left to the expertise of the WCAB ➢ The WCAB held that defects in procedural compliance can be fixed either in the 2nd appeal process, if any or in the IMR process (such as furnishing previously unfurnished medical records) • **NOW WHAT? / MORE RFA'S FOR EXPEDITED REVIEW?** The issue of what is a defective UR decision is decided…for now. But, the Court of Appeal or even the Supreme Court may have the ultimate determination. But it is safe to predict that there will be intensive scrutiny accorded to the TIME LINE AND TIME FRAMES associated with UR decisions under Lab C 4610(g) and the governing regulations. Since we now have **time** as the sole and remaining element, under which a UR decision can be contested and therefore default to the WCAB for the determination of medical necessity, our concern is that more

		PTP's will be issuing requests for expedited review. This would shorten the time within which to respond and therefore potentially bolster a defense of untimely UR review • Perhaps the most important question is what happens when defendant contests whether an RFA is qualified under the expedited review statute and regulations? Who decides this? The regulations indicate that if the request for expedited review is not reasonably supported by the evidence then the normal 5 business days is in effect.[xii] But how is this determined? It could matter if the sole argument is that we were late "if" the RFA qualified as an expedited review rather, than a prospective one • **WATCH FOR THE LATE FAX**: 9792.9.1(a)(1): Normally, an RFA received after 5:30 p.m. Pacific Time, will be deemed to have been "received" the next business day, **except for an expedited review.** ***EXAMPLE:*** Fax for RFA / Expedited Review received Friday, 11/7/2014 at 7:30 p.m. PST. The first business day is not Monday, 11/10/2014, which would apply if the RFA were for a prospective review. But, here, the 1st business day is 11/7/2014. If the claims administrator sends all of the required medical records to UR by Monday, 11/10/2014, which is now the 2nd business day, then the UR reviewer now has up to 72 hours from the time the items were received. Therefore, we are now dealing with actual "time of receipt" rather than full business and calendar days. But, remember you are still up against the 5 business day deadline, which is Thursday, 11/13/2014, but YOU MAY NOT HAVE THAT WHOLE DAY, BECAUSE OF THE 72 HOUR REQUIREMENT • In the wake of Dubon II, we simply do now know whether there will be any noticeable impact on the practice of challenging UR decisions and trying to side-step IMR at the WCAB, since many applicant attorneys may proceed as if Dubon I were still applicable. You can certainly expect a push-back from some applicant attorneys, who will very aggressively scrutinize every element of the time process associated with UR, including the time that the decision was made and then communicated to the PTP. So be ready • **TIMOTHY BODAM v. SAN BERNARDINO COUNTY DEPARTMENT OF SOCIAL SERVICES** (2014) **WCAB Significant Panel Decision**.[xiii] (A significant panel decision is not binding nor is it controlling precedent, but it is citable as these decisions do reflect that the issue supports a general dissemination.[xiv] Here, the WCAB denied defendant's petition for

		removal, holding that defendant is obligated to comply with "all time requirements in conducting UR, including the time frames for communicating the UR decision; "A UR decision that is timely made but is not timely communicated is untimely." "When a UR decision is untimely and therefore, invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence." Therefore, the WCAB determined that any lateness in the written follow-up after the initial 24 communication to the requesting physician either by E mail or by FAX would still render the entire decision untimely. That the time limits under Lab C 4610 are "mandatory."[xv] Defendant had contended that the effect of a late notice of UR decision was provided for under 8 CCR 9792.10.1(c)(2), *the time limits for requesting IMR are extended and therefore do not run until the notice is provided* • **TIME ELEMENT NOW EXTREMELY IMPORTANT**: Pending further determination by the Courts of Appeal, for now, "time" is the essential element which determines whether or not a UR decision is invalid and hence defaulting to the WCAB for medical necessity decision. This author has suggested that one approach may be to AVOID USING THE TELEPONE to notify the requesting physician but instead sticking with the FAX or E mail, which then takes away the requirement for the further written notice by mail within 2 business days, which was the subject of **Bodam**. This just removes one step in the process and makes proof somewhat easier. This author has also suggested using a *"Template Timeline"* for tracking the dates of the RFA request received, by fax, E mail regular or certified mail, date of referral to UR, date of receipt by UR, date of decision, the date of 5th business day, date of initial communication to physician by telephone, fax or E mail. And, with telephone decisions only, the date of the written follow up post 2 business days **IMR EXPLAINED**
	9792.10.3 IMR **9792.10.4** **9792.10.5** **9792.10.6** **9792.10.7** **9792.10.8** **9792.12**	For all injuries on and after 1/1/2013 as well as for all UR decisions taking place after 7/1/2013, regardless of the date of injury, all disputes over UR decisions to delay, modify or deny medical treatment requests shall be determined through the IMR process and no other, UR decisions which are not reviewed by an IMRO shall otherwise be deemed final ▪ Medical necessity issues are now being taken out of the hands of the QME's and AME's and placed into the realm of an IMRO, whose Reviewer's(s) decision is essentially final,

	IMR **IMR**	except under very limited circumstances ▪ The IMR process pertains only to medical necessity issues. Therefore, if the employer or Claims AD has other grounds upon which to deny a recommendation for medical treatment, then the IMR process is, in effect, deferred until 30 days after the Claims AD serves the employee with a notice showing that the other dispute over liability has been resolved. In cases where there is a combination of both a medical necessity (UR) and a non-UR basis (e.g. disputed body part) then once the AD determines that IMR is appropriate at least in part, the process is deferred unless employer agrees to IMR [9792.10.2(d)] ▪ Per sub (f): Subject to form, content and regulations from the AD, the employer will be required to provide a one page form to the employee: *Regulations Adopted*: [Application for Independent Medical Review, DWC Form IMR-1 with all fields completed and pre-addressed for mailing to the AD; Claims AD may pre-pay postage] together with the regular UR notifications, which among other things, will require the employer to tell the employee that the UR decision is final unless a request for IMR is made within 30 days after service of the UR decision upon the employee. Also, the employee will be informed of what information may be provided to the IMRO to support employee's position on the disputed medical necessity issue. [9792.9.1(e)(5)]. Regulations require Claims AD to serve a notification which lists all of the documents submitted to the IMRO. Documents not previously served shall be provided with this notice ▪ Failure to provide the required AD form (above) suspends the limitations for employee to request IMR and then the time runs from the time that the notice is provided [9792.10.1(c)(2)]: The regulation actually expands the so-called "fails" to include any breach in the notice provisions under 9792.9(1) or 9792.9.1(e) so that any problem with the notification process will suspend the IMR process from going forward until the Claims AD corrects the failures will full notification. *NOTE FROM COREY:* This doesn't make much sense since an error in the timing of the process by the Claims AD would not seem to be correctable so that in effect, any lateness in the UR process would seem to suspend, if not doom the IMR process from going forward

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AD to expeditiously review all IMR requests and to notify whether the request is approved. [9792.10.3]: Upon receipt of the Application DWC Form IMR-1, the AD will look at the completeness of the application, whether a previous application was made, assertions by Claims AD of factual or legal grounds precluding liability, or “other reasons” not specified. AD to make reasonable requests for additional, appropriate information with parties to have 15 days to respond. Following all information received, AD shall immediately inform parties that a disputed medical treatment is not eligible for IMR and reasons
If approved, then assignment is made to the IMRO, which must notice the parties of the assignment within one business day [(9792.10.4)] and employer has 15 days [9792.10.5(a)(1)] following receipt of the notification from the IMRO within which to provide the IMRO with documents and records. NOTE FROM COREY: This has changed from 10 days under the statute to 15 days according to the new regulations. These include the relevant medical records to the medical necessity issue in dispute, including employee’s current medical condition, medical treatment being provided and all information or other relevant documents used in the UR process. The 10 (now 15 days) days changes to 24 hours if there is an imminent or serious threat to the health of the employee. 9792.10.5(a)(1)(A): the “documents” include:

<table>
<tr><th>DOCUMENTS PROVIDED BY CLAIMS AD</th><th>PROVIDED BY EMPLOYEE</th></tr>
<tr><td>All reports of the treating physician within 1 year prior to the RFA</td><td>Treating physician’s recommendation of medical necessity</td></tr>
<tr><td>All reports and records of medical treatment identified in the RFA</td><td>Reasonable information supporting the employee’s position that disputed medical treatment was medically necessary; including all information or “additional material” which the employee deems relevant (is this not an invitation for advocacy?)</td></tr>
<tr><td>Decision to modify or delay</td><td>Information justifying that treatment was</td></tr>
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	necessary on an urgent or emergency basis
All correspondence to employee concerning the UR decision	
All materials supplied by employee to Claims AD in support of the request	
All other relevant documents	
Claims AD response to any additional issues raised in the DWC IMR-1	
Newly discovered or developed records	Same

- Employer to concurrently provide copies to employee and treating physician, unless otherwise previously provided

- Employer is also required to provide a listing of all documents served upon IMRO

- Summary of Employer duties: (1) Serve the 1 page form (4610.5(f), DWC Form IMR-1 to the employee, together with the required UR decision notices on the disputed medical necessity issue; (2) Provide documents to the IMRO within 15 days (or 24 hours) and; (3) provide notification to the employee which lists documents submitted to the IMRO including copies of all documents not previously served

- *NOTE FROM COREY:* Under changes to the utilization review statute, UR decisions shall be in effect for 12 months unless there is some factual change. But, we don't yet know how the IMR issues will be handled. If there are multiple RFA's within a PR-2, will each be the subject of a separate IMR. Or, what happens if the PTP sends in "one RFA" at a time? Will each independently trigger UR and IMR? Should the IMRO not know that the PTP is "dripping" each request separately? It is too soon to know but worth considering as we gear up

- Administrative penalty "not to exceed" $5,000 per day: *Regulations have now been adopted (see pages 40-42 below) which provide a schedule of administrative penalties*

		under these provisions. The daily amounts are well within the maximum per day, with the maximum actually by 10 times less (maximum per day is $500). But these could change. Under sub (i) the employer shall not engage "*in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the plan to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be submitted to an administrative penalty…up to $5,000 per day." [NOTE:* This part of the section is loosely written and does not clearly define what the conduct is or what it means by "has the effect of delaying" so is a one-time delay enough to trigger an administrative penalty or does it otherwise require repeated actions over periods of time, equivalent to a business practice? We don't know but I expect the AD will likely establish a schedule of penalties over a range of conduct with the amounts calibrated to the seriousness of the conduct. up with a schedule of penalties over conduct, which will probably scale the fine to the conduct] (See pages 40-42 below) ▪ Medical necessity issues will be determined using a ranking or hierarchy of scientific and medical evidence, which in order of priority, beginning with the MTUS under Labor Code 5307.27 and then providing for lower ranking evidence only if higher ranked evidence is deemed inapplicable to the employee's medical condition
4610.6 (new)	**INDEPENDENT MEDICAL REVIEW ORGANIZATION [IMRO]** **9792.10.4** **9792.10.5** **9792.10.6** **9792.10.7** **9792.10.8** **9792.12** **Regulations filed with OAL 12/20/12**	▪ IMRO upon assignment shall designate a medical reviewer, to conduct an examination of the submitted documents on the medical necessity issue. May assign more than one reviewer if issue is deemed sufficiently complex such that a single reviewer can't reasonably address all disputed issues. Determination to include whether disputed medical treatment is medically necessary **[(9792.10.6(c) and (d)],** using the hierarchy of scientific and medical evidence established under 4610.5(c) and the clinical reasons. A written determination to be made within **30 days or sooner** from date of the DWC Form IMR-1 and supporting documentation **[regular review]**. Upon certification by the AD or treating physician that the condition is imminent and serous, then decision is due in **3 days [expedited review]** from IMR-1, plus supporting documentation ▪ Subject to AD approval, deadlines for regular and expedited may be extended **up to 3 days** in extraordinary circumstances or for good cause **[(9792.10.6)]**

	IMRO	▪ **4610.6(e): [9792.10.6]:** Each IMRO analysis to state whether the disputed health care service is medically necessary and why, citing relevant documents in the record and the relevant findings of the scientific and medical evidence with the hierarchy. If more than one medical professional reviews the issue, then a majority decides. If there is an event split, then the decision shall be in favor *of* ***providing the treatment***. Each reviewer's opinion shall be provided, but shall remain confidential ▪ Determinations of the IMRO are deemed the determinations of the Administrative Director (AD). ▪ **(h):** Determinations of the AD shall be presumed to be correct and are reviewable only upon verified appeal filed by a petition with the WCAB within **30** days of mailing of determination and copies to all parties, including the AD: [**9792.10.7**]: ***NOTE FROM COREY:*** The earlier version of the regulation contained the 30 days to appeal. The current version does not, but the 30 days is governed by the statute anyway. Limited grounds for appeal, include: The AD acted without or in excess of powers, the final determination was procured by fraud, independent medical reviewer subject to material conflict of interest, in violation of 139.5, determination was result of bias on basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability or determination was based upon plainly erroneous express or implied finding of fact, provided it was a matter or ordinary knowledge based on the information submitted for review and not a matter subject to expert opinion
	IMRO	▪ If AD determination is reversed, the dispute is remanded to a different IMRO, or if a different IMRO is not available, then back to the same IMRO, but with a different reviewer ▪ Neither the WCAB nor a higher court may make a contrary finding of medical necessity ▪ **[9792.10.7]:** Determinations to approve disputed medical service shall be promptly implemented unless employer has **filed an appeal or has otherwise** disputed liability for other reasons than medical necessity. Otherwise, services not yet authorized will be authorized **within 5 working (business) days.** Employer to reimburse for services already

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<td>provided within 20 days

▪ ADMINISTRATIVE PENALTIES: NOTE FROM COREY: Current regulation 9792.12 provides for administrative penalties for UR. However, the regulation has been amended to now include penalties for IMR as well.) 4620.6(k) and regulation: [9792.12]: The AD has promulgated nearly 6 pages of lengthy and detailed schedule of penalties: Here, the AD has left undisturbed the current schedule of penalties associated with UR violations. However, they have added an additional penalty for the failure to timely communicate a written decision modifying, delaying or denying a treatment authorization @ $250.00 per day, UP TO a MAXIMUM OF $5,000: [9792.12(a)(18)]

▪ ADMINISTRATIVE PENALTIES FOR IMR: NOTE FROM COREY: The AD has made a schedule of administrative penalties which are draconian, because being late can be compounded or conduct can run in multiple lines, so that several delay penalties could attach to each separate act of lateness. However, the AD will not impose the “up to” $5,000 PER DAY figure which is in the statute. Instead, they have adopted a schedule based upon the conduct and have capped each section. [NOTE: Here, and unlike 4610.5(i), the penalty process more closely associates the penalty with a specific instance of conduct, so it seems as if this part of the statute would likely pertain to a single act occurring in one claim, but there will likely be a schedule of penalties, so that it is very likely that the number of days delayed will calibrate to a monetary penalty. This will be subject to regulations.]

▪ SCHEDULE OF PENALTIES: IMR: [9792.12(A)(19)-(25)]:

<table>
<tr><th>FAILURE TO:</th><th>AD PENALTY</th></tr>
<tr><td>Provide DWC IMR-1 with all fields filled out</td><td>$2,000</td></tr>
<tr><td>Provide injured worker with clear statement that disputes to be resolved through IMR and objection to UR must be communicated on the DWC Form IMR-1 within 30 calendar days</td><td>$2,000</td></tr>
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IMRO

Detail UR internal review appeals process and stating that it is voluntary	$2,000
Timely provide information to the AD	$100 per to maximum of $5,000
Timely provide information to the IMRO	$250.00 per day to maximum of $5,000
Timely implement final determination of IMRO	$500 per day to a maximum of $5,000
Timely pay invoice from IMRO	$250

- Costs to be borne by employee/Claims AD, subject to an AD developed fee system (below)
- **SCHEDULE OF COSTS PER REGULATIONS: [9792.10.8]:**

TYPE	CALENDAR YEAR 2013	CALENDAR YEAR 2014
Regular Review: MD/DO (1) Regular Review: MD/DO (2)	**560.00** **760.00**	**550.00** **740.00**
Regular Review: non MD/DO (1)	**495.00**	**475.00**
Regular Review: non MD/DO (2)	**655.00**	**635.00**
Expedited Review: MD/DO(1)	**685.00**	**645.00**
Expedited Review: MD/DO (2)	**850.00**	**830.00**
Expedited Review: non MD/DO (1)	**595.00**	**575.00**
Expedited Review: non MD/DO (2)	**760.00**	**740.00**
Withdrawn	**215.00**	**215.00**
Fees due to IMRO	30 days of billing If not paid within 10 days of due, plus interest @ 10%	

- **SUMMARY OF TIME FRAMES FOR THE IMR/IMRO PROCESS:**

ACTION	TIME FRAME
IMRO issues notice of assignment	1 business day 9792.14
Parties respond to information requested from the AD	15 days following receipt of request 9792.10.3(c)
All documents under 9792.10.5 needed sent to IMRO: Regular	15 calendar days from date of notification if provided by mail 12 calendar days if provided electronically 9792.10.4(e)
All documents under 9792.10.5 needed sent to IMRO: Expedited	24 hours 9792.10.4(f)
IMRO Requests More Information	5 business days: routine case 1 calendar day: expedited case 9792.10.5(c)
IMRO determination is made	Regular: 30 days of receipt of DWC IMR-1 9792.10.6(d) Expedite: 3 days

			Claims AD to Implement determination	**5 business days of receipt of final determination** **20 days to reimburse provider if services provided** **9792.10.7(a)(2)**
			Appeal by Petition to WCAB	**30 days of mailing of final decision (5 more days for mailing per CCP 1013? Probably, but it doesn't say)** **9792.10.7(c)**
4603.2 (amended	**PAYMENT OF TREATMENT BILLS PER 4603.2** **EXPLANATION OF REVIEW ["EOR"]** **SECOND REVIEW** **9792.5.5** **9792.5.6** **New Form: DWC Form SBR-1**	▪ Upon final determination that out-of-network treatment was appropriate, requires employer to pay for care from initial examination date if the Doctor's First Report of Injury (due in 5 days) was made on time and if not, at the time the first report was made following initial examination of employee ▪ **(a)(3):** Upon final determination that employee was not entitled to treat out-of-network, then employer has no liability ***or for consequences of the treatment*** *obtained outside of the network." [**NOTE:*** "Consequences" is undefined. Does this mean the defendant is not responsible for aggravation or other exacerbations from out-of-network treatment to which employee is found non-entitled? We don't know at this point. Also, this section should be read in connection with Labor Code **4605**, which is also amended and which permits the non-MPN report to support an award but not the "sole" basis for an award, which means an award must be supported by at least some other concurring medical opinion.] ▪ **(b)(1):** Provider request for payment now required to include **more detail,** including itemization of services, charges, copy of reports showing services performed, prescription or referral from the PTP ▪ **(b)(2):** Payments for medical care + EOR are changed from 45 "working days" to 45 **"days**" after receipt of all required documents under **(b)(1).** [***NOTE:*** The 45 days are	

		linked to a complete submission of all required documents, but the employer is still bound to object to the incompleteness; or a denial of the itemization, within 30 days, together with the Explanation of Review ("EOR" per **4603.3**.) ▪ **(b)(3):** If employer is a governmental entity, the time **is 60** days after receipt of each separate itemization, together with required reports and there is no 15% increase specifically set forth under this sub paragraph ▪ Duplicate submissions to which there was a previously timely response and EOR do not trigger this process ▪ **THE FOLLOWING RULES ARE FOR TREATMENT RENDERED OR MEDICAL-LEGAL EXPENSES INCURRED ON OR AFTER 1/1/2013:** ▪ **4603.2(e)(1): 90 DAYS—Request for Second Review: Treatment services or medical-legal charges: [9794 and 9792.5.5]:** Provider may request a 2nd review **within 90** days of service of EOR by Claims AD by mail with proof of service; if no proof of service, then from the date the Claims AD has documented receipt or if none, then from the date ***5 days later*** than post mark of the EOR or WCAB Order resolving threshold issue ▪ The Request: Request for 2nd review for treatment shall be made either on new **DWC Form SBR-1** or on the actual bill if the bill was non-electronic; for medical-legal charges, the request **must be made on the form**. Methods for electronic review depend upon type of service. For pharmacy bills, 2nd review can occur through trading partner agreement or by using the form SBR-1. The request for 2nd review shall include the dates of service and the same itemized services rendered as the original bill. No new dates of service are included here. Also, items in dispute are listed and the amounts and the amount of additional payment being requested and the reasons therefor. If only dispute is money and the provider dos not request a timely 2nd review, the bill is deemed "satisfied." **[(9792.5.5(e)]** ▪ Any properly documented, itemized services provided and not paid within the **4603.2** time frames are increased by ***15%, plus interest***

		▪ **[9792.5.5.(f)]:** Employer responds to 2nd review within 14 days with final written determination on each of the amounts in dispute with payment of any balance not in dispute within **21 days** of receipt of 2nd review. Time may be extended by written mutual agreement ▪ **[9794(e)]:** Response to request for 2nd review for medical-legal charges on **grounds other than fee schedule**: This revised regulation states that if the Claims AD receives a written objection to the denial of medical-legal charges; Claims AD must file a petition to review the denial and a DOR, because there are "other grounds" and therefore deferring the IBR process until those "other" grounds are determined by the WCAB ▪ If provider contests final written determination following the 2nd review, then it may request IBR per 4306.3 and [9792.5.5(h)]
4603.3 (new)	**EXPLANATION OF REVIEW "EOR"** **9792.5.5.**	▪ **4603.2(b)(2): Explanation of Review ("EOR")** now required *upon payment, adjustment or denial* ▪ [9794 (c)]: EOR is now also required for the payment or objection to medical-legal charges and the objection must also incorporate the use of the EOR. Also, the same rules for 2nd review and IBR also pertain to **medical-legal charges** ▪ EOR includes: statement of items and procedures billed and amounts requested, amounts paid, basis for any adjustment, change or denial of item or procedure, additional information required, times frames involved and the IBR process ▪ This does not appear to apply to a submitted billing item from a provider where the entire bill is being paid, without adjustment, objection, denial or reduction **[*NOTE:*** Unfortunately, this is also unclear. Pending regulations on this section, it is suggested that employers consider an EOR which features a section specifically indicating that the bill is **being paid in full** without adjustment and therefore the rest of the EOR is not being completed on this basis. Therefore, the EOR would be transmitted but with a clear indication that no reduction, change, objection or reduction is being made]

4603.6 (new) 139.5 (new)	**INDEPENDENT BILL REVIEW (IBR)** **9792.5.7** **Regulations filed with OAL 121/20/12** **INDEPENDENT BILL REVIEW ORGANIZATION (IBRO)** **New Form: DWC Form IBR-1** **Fee is $335.00** **As of 10/230/2013, under the new WCAB Rules of Practice and Procedure, for medical-legal expenses, when there are non-IBR foundational issues, the defendant now must file a Petition for Determination of Non-IBR Medical Dispute + DOR, within 60 days**	▪ Provider may request IBR only if there has been a 2nd review, which did not resolve the issue and the **only dispute is the amount of payment**. If there are other reasons for non-payment other than reasonableness, that issue must be resolved before IBR takes place. Issues which are considered not eligible for IBR include: where the fee is not covered by a fee schedule, contract reimbursement rates, proper selection of an analogous code or formula based on a fee schedule, unless the contract or fee schedule allows for analogous coding **[(9792.5.7(b)]** ▪ **New WCAB Rules of Practice and Procedure: 10/23/2013: 8 CCR 10451.1:** Threshold issues which would entirely defeat medical-legal charges must be brought before the WCAB upon a **Petition for Determination of Non-IBR Medical-legal Dispute**, filed by Defendant, together with a DOR. This must be filed within 60 days from the provider's service of objection to our EOR, denying the charges entirely or partially. The same petition may be filed by a provider if defendant breaches its duty to timely file their petition or some other duty under 4622 or the Rules of Practice and Procedure ▪ **New rules also provide for "waiver"** of objections to medical-legal charges if: defendant failed to file the EOR within the required time (60 days) or failed to timely authorize the 2nd review process upon request from the provider or failed to make payment consistent with 2nd review determination. Defendant also waives charges (other than fee schedule – subject to IBR) by failing to file the timely Petition as indicated ▪ **Defendant liable for sanctions, costs and provider's attorney fees:** WCAB finding of bad faith actions may subject defendant to **monetary sanctions of not less than $500,** plus attorney fees to the provider and costs which are in addition to other penalties owing under Lab CF 4622 ▪ **Provider has 30 days from service of 2nd review determination within which to request IBR, otherwise bill is deemed satisfied. [9792.5.7(c)]:** the 30 days is counted from the date of service of the final written determination under 2nd review if there is a proof of service; or the date of receipt if no proof of service and the Claims AD has documentation of date of receipt; if there is no proof of service or not documented date of receipt; then the time is extended by 5 calendar days from date of postmark. Time frames begin if

		there is an underlying issue contesting liability and not just the bill, in which case it starts from date of WCAB Order or date of resolution in favor of provider. ▪ Request for IBR: On Line: [**9792.5.7(d)]:** IBR requests can be made either by mail or electronically (on line). The on line form can be accessed at: http://ww.dir.ca.gov/caibr/htm. Payment of **$335.00 to** be made at the time request is made. ▪ Request for IBR by mail: Mailing Request for Independent Medical Review form, **DWC Form IBR-1 [(9792.5.8)] and paying the fee of $335.00** ▪ Statute provides AD may require electronic only but for now, two methods are permitted to start IBR. Copies of the Form IBR-1 served on employer. Only the request form and the proof of payment are to be submitted to the AD**. Note from Corey:** The regulations change this. They require not only the form but also supporting documents, "that were furnished with the original billing" **+ the EOB + the request for a 2nd review + supporting documents from Claims AD + final written determination of 2nd review: Per 9792.5.7(d)(2), the provider required to add documents to the form, including contract for reimbursement rates** ▪ **CONSOLIDATION ALLOWED: 9792.5.7(e) and 9792.5.12: Provider may request that two or more disputes that would constitute a separate request for IBR be consolidated. *NOTE FROM COREY:*** The statute (**4603.2)** is silent on consolidation, so it is neither specifically permitted nor actually disallowed**.** The new regulations permit consolidation under certain conditions requiring a common issue of law and fact. These include**: [1]** multiple dates of medical service involving a single provider, involving one employee, one Claims AD and one billing code under a fee schedule or under a contract and total amount in dispute does not exceed $4,000; **[2]** Upon a showing of a "possible pattern and practice of underpayment" by a Claims AD for specific billing codes, involving multiple employees with aggregated amounts in dispute not over $4,000; **[3]** Multiple billing codes with a single provider, if involving one employee, one Claims AD and one date of medical service, with no cap

		▪ **[9792.5.9]:** Upon receipt of the DWC Form IBR-1 and attachments, the AD to conduct "preliminary review" to determine whether request is ineligible for review. A checklist of issues is provided. If however, the request is deemed "eligible" for IBR, then the rules under sub (b) apply. AD to assign request to independent medical reviewer **within 30 days** and upon notice of assignment of IBR, the requesting party shall submit required documents to the IBRO within **10 days. The regulations change the statute from 10 days to 15 calendar days if notice by mail or 12 calendar days if notice was provided electronically [(9792.5.9(b)(3)].** Claims AD has the same time within which to submit a statement with supporting documents that the matter is not eligible for IBR ▪ The regulations now install **a 2nd preliminary review** after the running of either the 15 or 12 days above in order to further determine whether or not the request is deemed ineligible. AD makes written determination that the request is ineligible and the reasons. Provider or Claims AD may appeal to the WCAB, by petition, the determination of ineligibility within **30 days of** receipt of determination ▪ If the request is ultimately deemed ineligible then the provider gets partial reimbursement of **$270.00 [(9792.5.((e)(1)]** ▪ Requests for IBR can be withdrawn before determination is made. If the dispute is settled; withdraw occurs by joint written request, but no reimbursement occurs **[(9792.5.11)]** ▪ **[9792.5.9(e)]:** AD assigns for IBRO upon finding of eligibility. Reassignment can occur if it is later determined the IBRO has a prohibited affiliation ▪ **[9792.5.10]:** IBRO reviews materials and may request additional information from the parties. If requested, the party shall file the documents with the Independent Bill Reviewer within **35 days of the request**, if by mail **or 32 days, if made electronically** with copies to non-filing party. [**9792.5.13]:** The Independent Bill Reviewer will use the OMFS for treatment services, the contract for reimbursement rates, if applicable, or if for medical-legal, the MLFS. As such, the reviewer will apply these provisions as if the billing is being reviewed for the first time

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Written determination due within 60 days of assignment: [9792.5.14]: IBRO makes written determination in plain language, if any additional money is owed the provider and the reasons. This includes the information received and relied upon
Fee payable by provider. AD to prescribe schedule of fees by regulation. If any additional payment is found owing, employer to reimburse provider for fee paid, in addition to the amount found owing (See fees above)
[9792.5.14]: Determination from IBRO is deemed a determination and order from the AD, binding on the parties and is reviewable on the same grounds as IBR determinations (fraud, conflict of interest, bias, etc.) but here the verified appeal must be filed within 20 days of service of the determination [(9792.5.15(b)] The same rules apply as those governing appeals to final written IMR determinations
If AD determination is reversed, then dispute is remanded to the AD to submit to a different IBRO, or if not available, to the same IBRO but with a different reviewer
PROJECTED TIME FRAMES: Though subject to regulations, from the statute alone, we have an estimated maximum number of days between the date upon which the bill and report arrive and the final date upon which the IBR becomes final. Using only the maximum number of days, I calculate as follows: BEFORE IBR: 179 maximum days; AFTER initiation of IBR: 120 maximum days or total of 299 = 42.7 weeks! The time frames here are variable because of the method for service which can add 2 days for proof of service if electronically served and 5 days for mailing or the time can be greater if there is no POS and the Claims AD has proof of receipt. So, these times are estimates, but in summary you can see it is a lengthy process:
<table>
<tr><td>45 calendar days</td><td>To pay for authorized, non-contracted medical treatment + EOR</td></tr>
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				governmental entities To pay for proper medical-legal expenses +EOR	
			60 calendar days		
			90 days from EOR or WCAB Order resolving threshold issue	Provider requests 2nd Review on DWC Form SBR-1	
			14 days (or longer by mutual agreement)	Response to 2nd request with final written determination	
			30 days from final determination after 2nd review	Request for IBR on DWC Form IBR-1 + $335 filing fee	
			15/12 days	AD notice of receipt and request for additional information or documents	
			35/32 days	IBRO requires further information from party	
			60 days from assignment by AD to IBRO	IBRO make final. written determination	
			20 days from mailing final determination from IBRO	Verified petition filed with WCAB appealing determination on limited grounds	

4605 (amended)	**CONSULTING REPORTS**	▪ Reports of consulting or attending physicians may not be the sole basis for an award of compensation ▪ QME or authorized PTP **shall address** any report per this section and indicate whether he or she agrees or disagrees with findings or opinions and the basis [***NOTE:*** This doesn't really clear up the Valdez issue because out-of-network reports are still admissible and they can now statutorily form the basis of an award so long as there is some supportive opinion either from an "authorized treating physician" or QME**. [*NOTE:*** The statute does not mention an AME, but it would seem as if an AME's opinion would also sustain but it does not actually state. Also, by the wording here, it seems as if for an out-of-network report to actually sustain an award, it has to be specifically reviewed and addressed as opposed to an opinion which is in accord but did not specifically review the out-of-network report] ▪ **NOTE:** Valdez has now confirmed and clarified that while "out of network" consulting reports are admissible for compensability, the decision also affirms the changes to Lab C 4605 and that such reports cannot be the "sole" basis for a WCAB award. Also, Valdez did not address the costs for the reports, or who is really responsible. Also, it remains unclear as to what standards are met to meet the statutory definition of "addressing" the out of network report ▪ **WCAB Panel Decision**: **Lawrence Lorenz v. Encino Hospital, et. al**. (2014) Cal. Wrk. Comp. P.D. Lexis 410. Applicant brought two cases against two defendants. In one case, the parties went to an AME, Dennis Ainbinder, M.D., who wrote opinions covering both cases. However, in the other case, a CT claim against Prime, defendant neither agreed to Dr. Ainbinder nor obtained their own PQME. Applicant in that case relied upon Dr. Ainbinder. The WCAB held that 4065 did not apply, because Dr. Ainbinder was not deeming a consulting physician. Here, defendant conducted its medical discovery only by participating in the deposition of Dr. Ainbinder. But, the WCAB held this did not bind Prime and they could have gotten a PQME, but they did not exercise the right to do so. Therefore, Prime's waiver did not result in the inadmissibility of Dr. Ainbinder's AME reports
4616	**MPN**	▪ Physicians included in the MPN, only if there is a written acknowledgment. (1/1/2014) In

(amended) 4616.3 (amended)	**VALDEZ** **Since our last publication, the MPN regulations were adopted and took effect 8/27/2014**	the application for approval or re-approval, the MPN applicant must affirm that each MPN physician in the network has agreed, in writing .to treat workers under the MPN and that the "Physician Acknowledgments" under 9767.1, are available for review by the Administrative Director [9767.3 (d)(8)(F)] ▪ MPN must place roster of treating physicians on its web site and update at least quarterly **(1/1/2014)** ▪ All approved MPN web sites to be posted by AD **(1/1/2014)** ▪ Every MPN to have 1 or more **medical access assistants** available from 7:00 a.m. to 8:00 p.m., PST, Monday–Saturday by toll free number. Regulations to issue on or before 7/1/2013 **(1/1/2014)** ▪ MPN to establish and follow procedures to continuously review quality of care, performance and utilization of services and facilities ▪ MPN to submit geocoding of MPN for re-approval ▪ AD has power to investigate at any time **(1/1/2013)** ▪ **(b)(1): MPN plan approval for 4 years (1/1/2013)** ▪ Existing approved MPN plans approved ***for 4 years*** from the most recent application or modification approval date. Re-approval plans must be submitted 6 months before expiration of period **(1/1/2014)** ▪ Any person contending the MPN is not **validly constituted** may petition the AD to suspend or revoke MPN plan approval**. (1/1/2013)** ***COMMENT FROM COREY:*** There is no definition of what they mean by "not validity constituted." Does this mean that a component piece of the MPN is missing or that the MPN is not operating properly or in a case specific example, something was not done correctly? We don't know yet pending regulations. Here, the statute refers to "**not validly constituted**" but **4616(b)(1**) refers to

		the term **"validly** formed." I don't know if this is significant or simply semantics ▪ AD may promulgate regulations establishing **schedule of administrative penalties** not to **exceed $5,000 per violation**, or probation or both, in lieu of suspension or revocation for less severe violations. Unless suspended or revoked, AD approval of MPN plan is binding on all persons and all courts [***NOTE:*** *It seems uncertain whether the schedule of penalties would relate only to a claimed violation of the validity of the network, commenced either by a petition to the AD or upon the AD's own power to investigate or whether it amounts to a form of "audit penalty" for technical violations which do not rise to the level of "not validly constituted." If we consider the language of sub (b) (5) dealing with "if the medical provider network fails to meet the requirements of this article," then I believe the latter is the sense because they talk about the relative "severity" which seems to imply yet another new penalty system for MPN audits beyond what is already in the regulations for the PARS and compliance audits]* ▪ **Changes to Regulations –8/27/2014 Note: There are no material changes to the regulations drafted and now adopted. So the final regulations conform to the prior drafts** ▪ **9767.1 –Definitions**: defines health care shortage, entity and Access Assistant, who must be in the "United States"; also defines probation, provider, MPN Contact and MPN applicant ▪ **9767.3 –Application: "**MPN applicant" is the new term for an applicant. Services under the MPN can only be provided at the listed locations, unless the MPN chooses to allow non-listed locations on case-by-case basis; Sub (c)(6): "An MPN applicant shall have the exclusive right to determine the members of its network" Much more information is required, including: providing electronic copy of geocoded provider list to show compliant with access standards, affirmation that each physician has agreed to treat, and showing how MPN complies with access standards ▪ **9767.5 – Access Standards:** adds the word "available" to the three per specialty requirement and MPN shall meet access standards for the 5 common specialties at "all

		times." For "health care shortage, MPN can propose alternative access in those areas. MPN access assistants shall be located in U.S. and be available Mon-Sat from 7.a.m. -8 p.m. PST. At least one must be available to all required times and enough assistants to respond to calls, faxes or messages by the next day, excluding Sun/holidays ▪ **9767.5.1 – Physician Acknowledgment**: Each physician must sign acknowledgment, unless they are in a group in which case the group can sign a "group acknowledgment," but it must be signed by all members. And, changes in group must be communicated to the MPN. (This could help with a recurring problem involving the "revolving:" door of group practices) ▪ **9767.12 – Employee Notification:** Notification no longer required "pre injury." Now, the notification is required at the time of injury or with an existing injury and required transfer to the MPN. This confirms to the statutory changes that the failure to post notice prior to the date of injury would not otherwise defeat the MPN. Can be sent electronically. Toll-free number must be listed for the MPN Medical Access Assistants, with description of the assistance they might provide and the times they are available. The MPN website shall be "clearly listed." New rules governing notice when MPN coverage ends ▪ **9767.13 – Denial of Approval of Application or Re-approval**: Appeal to an adverse finding by the A.D., is now before the actual WCAB Commissioners in San Francisco, rather than being filed at the local WCAB district office. NOTE: This coincides with new Rule 10959 of the WCAB Rules of Practice and Procedure (drafted) which creates the new Petition Appealing Medical Provider Network Determination of the Administrative Director. This petition actually covers not only the approval/re-approval issues but also probation and the imposition of administrative penalties. The grounds are very similar to reconsideration, including 25 page limits. Once filed, a WCAB panel is assigned, who will then order an evidentiary hearing and shall issue its decision within 60 days of submission ▪ **9767.14 – Probation, Suspension, Revocation:** AD may suspend or revoke or place on suspension, an MPN for certain violations, including failure to meet eligibility for reapproval, Added ground for AD action is MPN failure to respond to at least two or more

		repeated requests or inquiries by the AD ▪ **9767.16 –MPN Complaints:** Complaint regulations replace transfer-of-care regulations under this rule number. A new "form," DWC Medical Provider Complaint Form 9767.16.5. Is created. It requires the details of the complaint, which is then submitted with the MPN Contact. The MPN has 30 calendar days to respond in writing. The response includes disputing complaint, taking remedial action or explaining what actions it intends to take if more than 30 calendar days are needed to address the violation. After the 30 day period (or beyond if reasonable), the complainant can file a written complaint with the DWC against the MPN. (See Form DWC Medical Provider Network Complaint Form 9767.16.5). If AD finds there has been a violation, then it shall notify MPN Contact. NOTE: This kicks in 9767.14(a)(7), which permits the AD to suspend, revoke or place on suspension, any MPN which fails to respond to at least two or more inquiries from the AD, regarding violations ▪ **9767.17 –Petition for Suspension or Revocation of MPN: Form DWC 9767.17.5:** This petition can be filed by "anyone." The grounds include failure to maintain MPN qualifying status or a "systematic failure" to meet access standards. But the failure to retain a *specific provider* in the MPN shall not be grounds to file a petition. Petition is filed with the AD. MPN shall respond within 30 calendar days and within 60 calendar days, AD shall issue order granting or denying petition. ▪ **4616.3(b) AND VALDEZ:** ▪ (b): E**mployer failure either to provide the notice poster per Lab C 3550 or provide actual MPN notice shall not become the basis for the employee to treat outside of the MPN**, unless it is shown that the failure to provide notice resulted in a denial of medical care. **[*NOTE**: it is incumbent to authorize the treatment within 1 working day from filing of claim form (5402(c) and within 3 business days of receipt of a request for treatment within the MPN (8 CCR 9767.5(f) and 9767.6) otherwise lateness could doom the viability of the MPN, if the notices were not posted and provided to the employee]* ▪ **VALDEZ UPDATE:** On 11/14/2013, the Supreme Court filed its decision, holding that "out of network" consulting reports obtained by the applicant, under Lab C 4605, are

		admissible on the issue of compensation, which includes T.D. In its decision, the Court narrowly applied the prohibition against admitting out-of-network consulting reports, under Lab C 4616.16 [this is the MPN statute] to controversies involving "diagnosis" or "treatment," triggered under the IMR provisions of the MPN statute and NOT the IMR process for medical necessity issues, governed under lab C 4610.6. Therefore, if the applicant disputes "diagnosis" and "treatment' under the MPN, he or she gets a 2nd and 3rd opinion and then if it goes to IMR, then the applicant may not go out-of-network and obtain a consulting report under Lab C 4605. But, for regular medical necessity issues, which routinely take place, the decision permits the applicant to go out of network and obtain an admissible consulting report on the issue of compensability, including TD, even though defendant is not liable for the treatment. The Court also affirms that the consulting report cannot be the "sole" basis for an award. The issue of who pays for the report was not addressed by this decision. *NOTE: I don't see this as a major loss for employers, because they will still not be liable for out-of-network treatment, provided proper notice to the IW and timely provision of treatment took place and there is no implication that employers have any liability to pay for these consultative reports. Also, these reports must still be "addressed" by an in-network PTP, QME or AME, and that doctor must agree with the opinion. The other "question" is whether WE get to do the same thing. In theory "yes," but in practice it is a challenge, because remember, Lab C 4605 is the "applicant's statute; ours is Lab C 4050. But the practical challenge is getting the applicant to an examination, let alone having a WCAB order such an examination* ▪ **WCAB Panel Decision**: **Zulema Miranda v. Aramark, PSI** (2014) Cal. Wrk. Comp. P.D. Lexis 533: Here, WCAB reversed the WCJ in finding that defendant neither denied claim to left shoulder nor refused care. (All proper MPN notices were sent) Because the left shoulder was a compensable consequence from the earlier specific admitted injury, then applicant could go out of network but that treatment would be deemed self-procured for which defendant was not held responsible.
4903.05 (new)	**LIENS: FILING FEE** **10207**	▪ **LIEN FILING FEE: of $150**, payable electronically to DWC for all liens filed after 1/1/2013 and must be paid before lien is filed. Payment to be collected electronically. [**10207**]: NEW: Unless exempted, every lien claimant is responsible for payment of initial filing fee, using form approved by the WCAB. Fee is payable to the Division of Workers'

		Compensation. Fee to be collected by the AD. While a fee is required for each case, if there are *multiple cases involving the same injured* worker and the same services by same lien claimant, then only one filing fee need be paid ➢ E Filers: pay electronically following procedures set forth in the *EAMS E-Form Filing Reference Guide.* If liens are being filed in more than 1 case at the same time, then this can be handled in one transaction but claims of two or more cannot be merged ➢ JET filers: follow the EAMS JET File Business Rules Version 4.0 ▪ Any lien submitted after **1/1/2013** shall be invalid unless filed with proof that filing fee was paid and failure to do so does not extend the statute of limitations for filing liens ▪ Filing of lien shall include proof of payment of filing fee. [**10207(m)]:** no lien or claim of costs filed as a lien shall be accepted without payment of the full filing fee. Until the fee is paid, the lien shall not be deemed to have been received or filed for any purpose ▪ Filing fee pertains to liens under **4903(b)** which relate to medical treatment expenses but not subject to IMR or IBR ▪ Per **4603.6(g),** neither the WCAB nor any court can make a determination of ultimate fact contrary to the determination of the IBRO, so a lien for a contested bill per IBR determination would not be allowable ▪ No merger of claims of two or more providers of goods into a single lien permitted ▪ **No filing fee required for a health care service plan and**: Other liens exempt from a filing fee are liens for group disability insurer, self-insured employee welfare plan, Taft-Hartley Health and Welfare Fund, publicly funded program providing medical benefits on a nonindustrial basis, reasonable attorney fees, living expense liens, burial expense liens, spousal and child support liens, EDD, Victims of Violent Crime Liens, defendant filing a DOR to proceed on a lien claim or a party who is not a lien claimant and a companion

		case
4903.06 (new)	**LIENS: ACTIVATION FEE [on hold]** **10208** **-BULLETIN-** **INJUCTION ISSUED BY A FEDERAL JUDGE AGAINST THE LIEN ACTIVATION FEE, EFFECTIVE 11/19/2013**	▪ **ON OR BEFORE 1/1/2014 --LIEN ACTIVATION FEE: of $100**, payable electronically to DWC required for liens filed prior to 1/1/2013, **including costs filed as a lien**, unless there is proof of prior payment of filing fee ▪ **FEDERAL DISTRICT JUDGE ISSUES INJUNCTION AGAINST THE ACTIVATIION FEE EFFECTIVE 11/19/2013. [Angelotti Chiropractic v. Baker]-- Case No. CV 13-cv-01139 GW] –filed 7/29/2013]:** Seven parties as lien claimants representing 33,000 active liens filed before 12/31/2012, have challenged the activation fee and also both the filing fee and the revised statute of limitations, claiming these are unconstitutional on three different grounds: (1) The fees are unlawful takings; (2) The fees violate due process rights; (3) The fees violation equal protections. **NOTE**: The Court has only addressed the activation fee and not the filing fee or the statute of limitations]. Federal Judge George H. Wu rejected (1) and (2) but ruled that plaintiffs had stated a cause of action for equal protection. **NOTE:** The Equal Protection argument is based upon the contention that it was discriminatory for SB 863 to have exempted certain entities from having to pay the retroactive $100 activation fee, including health care plans and hospitals. While Judge Wu has made no ruling on the merits of the challenge, he has concluded that based on the "sliding scale," these plaintiffs have shown a likelihood if irreparable harm, balance of equities and public interest factors all weighing in favor of the preliminary injunction. The injunction pertains to all LIEN providers and enjoins the DWC either from collecting the fee or permitting liens to be dismissed by operation of law, on 1/1/2014. NOTE: On 11/15/2013 the DIR issued a Newsline indicating it will no longer collect the activation fee as of 11/19/2013 and lien claimants will not be required to pay the $100 fee at a hearing or upon the filing of a DOR.[xvi] Also, this injunction appears to have overturned, at least for now, one WCAB En Banc decision: In **Eliezer Figueroa v. B.C. Doering. Co**, (2013) 78 CCC 439, the WCAB held that the lien activation fee had to be paid before the commencement of a lien conference, and not the time the case is called. In another En Ban decision in **Luis Martinez v. Ana Terrazas**, (2013) 78 CCC 444, the WCAB**,** the WCAB ruled that a medical legal expense for copy costs, filed, could not be withdrawn and then refiled as a petition for a "costs" under Lab C 5811 and that the provider had to pursue its lien rights but not by a petition for costs. NOTE: This decision is essentially now moot, because the activation fee is not being collected

		▪ Proof of payment required for filing fee or activation fee with the filing of the DOR of if lien claimant is not the party, prior to appearing for a Lien Conference on that case, or 1/1/2014, whichever occurs first. **[10208]:** Same rules governing filing fee; only 1 activation fee is required, if there are multiple cases involving one worker and one service provider. Same rules also govern manner and method of making payment. All lien claimants who did not file the DOR for a lien conference, but who remain a lien claimant at that time or at time of a consolidated lien conference, shall submit proof of payment at the lien conference ▪ Any lien claimant not filing a DOR shall present proof of payment of activation fee at Lien Conference. If not, lien **shall be dismissed with prejudice** ▪ **Lien dismissed by operation of law if either activation fee or filing fee not paid by 1/1/2014** ▪ Same exemptions for activation fee as relate to filing fee **[10208(a)(1)]** including companion cases ▪ Lien claimants of previously consolidated cases prior to 1/1/2013, required to pay activation fee for each injured worker; payment before or at time of lien conference, but no later than 1/1/2014
4903.07	**LIENS**	▪ Lien claimant entitled to reimbursement of filing or activation fee, plus interest, upon the proof of 3 conditions: (1) not less than 30 days before DOR or filing of lien, lien claimant has made written demand for settlement for a clear sum stated: (2) Defendant fails to accept the written demand for settlement within 20 days [plus 5 for mailing] (3) Final award by WCAB or arbitrator in favor of lien claimant in a sum equal or greater than the settlement demand
4903.1 4903.4 4903.5 4903.6	**LIENS**	▪ Liens in favor of health care provider, service plan, group disability policy, of self-insured employee welfare benefit plan not recoverable unless certain conditions occur, including authorization by defendant, expense incurred while employer refused or failed to furnish treatment, or expenses were incurred by emergency

		▪ **NEW STATUTE OF LIMITATIONS EFECTIVE 1/1/2013 REGARDLESS OF DATE OF INJURY:** 4903.5((a): For treatment liens under 4903(b) the limitation is **3 years from the date services were provided prior to 7/1/2013.** For services provided on or after **7/1/2013, the limitation is 18 months** ▪ A more relaxed statute for health care service plans: within 12 months after first knowledge that industrial injury is being claimed but no more than 5 years from date services were provided ▪ Limitations of when liens can be filed (60 days after acceptance or rejection of liability plus either IBR or IMR has taken place) ▪ Lien claimants required to notify employee and his/her representative, employer and representative and WCAB upon hiring, changing or discharging a representative, including attorney or non-attorney. Notice must provide contact information
4903.8 (new)	**LIENS: LIMITS ON ASSIGNMENTS** ***This section takes effect 1/1/2013 and without regulatory action***	▪ Order or award to issue only in favor of person entitled to payment and not to an assignee, unless the provider has ceased doing business in the capacity held at the time, and has assigned all right, title and interest in the remaining accounts receivable ▪ Assignment must be filed and served ▪ For liens filed on or after 1/1/2013, if assignment occurs before lien filing, a copy of the assignment shall be served at the time lien is filed. If the lien is filed on or after 1/1/2013, but the assignment take place after, then a copy of assignment shall be served within 20 days of assignment date ▪ If lien is filed before 1/1/2013, copy of the assignment is due upon filing of DOR, a lien hearing or by 1/1/2014, whichever is earlier ▪ More than one assignment may cause the WCAB to set the matter for hearing on whether multiple assignments **are bad faith actions or tactics** (sanctions, attorney fees and costs

		per **5811, 5813 and 8 CCR 10561**. These would be awarded against not only lien claimant but also the assignee and their respective attorneys ▪ **4903.8(d): FOR ALL LIENS FILED ON OR AFTER 1/1/2013 REGARDLESS OF DATE OF INJURY OR SERVICE, NEW DECLARATION UNDER PENALTY OF PERJURY REQUIRED**: (1) services or products described in the bill or products were actually provided; (2) billing statement attached to lien is true and accurate. This declaration is due for liens filed on and after **1/1/2013** and for previously filed liens, at the filing of the DOR, a lien hearing or 1/1/2014, whichever is the earliest ▪ Without the declaration, the lien shall be considered invalid if filed on or after **1/1/2013** ***Torres v. Unitech*** (WCAB En Banc:11/15/2012): declaring existing statutes affirm that the lien claimant has the affirmative burden of proving all relevant issues by a preponderance of the evidence and that simply introducing a lien and an unsigned insurance form is not enough. Such conduct therefore exposes the lien claimant and its representative to sanctions, costs and attorney fees, either against one, more or all, under Lab C 5813 and 8 CCR 10561
4620 4622 5307.7 5307.9	**MEDICAL LEGAL COSTS** **INTERPRETERS** **9795.1.5** **9795.1.6**	▪ GENERAL: **4622**: EOR is required when employer responds to medical-legal expenses under 4620 ▪ Adds provision for 2nd review as a condition to permitting same IBR rules for disputed bills for medical treatment ▪ IBR rules also now cover medical-legal expenses in the same manner they pertain to treatment bills ▪ **INTERPRETERS**: **4620: new sub (d**) which permits **qualified interpreters** during medical examinations as part of the definition of medical-legal expenses. [**9795.1.5 and 9795.1.6**]: The prior regulation defined *"qualified interpreter"* as being one who was either certified or provisionally certified. Under **Government Code 68562**, certified interpreters were those who were certified by entities recognized by the Judicial Council as of 7/1/1996 and

	Final regulations filed with Secretary of State on 8/13/2013	who were deemed certified by being on the recommended list of court interpreters. This regulation has been amended ▪ **INTERPRETERS AT HEARINGS, DEPOSITIONS OR ARBITRATIONS: 9795.1.5**: "Qualified" means the interpreter must be certified: This means (1) Being listed on the State Personnel Board webpage or; (2) Being listed on the California Courts webpage [Interpreters who are certified by the Judicial Council are also deemed to be certified for medical examinations too]; (3) or be provisionally certified, meaning deemed to perform services when a certified interpreter cannot be present either by agreement between parties or upon finding from WCAB ▪ **INTERPRETERS FOR MEDICAL TREATMENT APPOINTMENT OR MEDICAL-LEGAL EXAMS: 9795.1.6:** Must be *separately* certified for medical treatment appointments or medical legal exams or provisionally certified. This means: (1) They are listed on the same webpage of the State Personnel Board, but they must have taken the Medical Interpreter Examination; (2) They are listed on the California Courts web page: or: (3) Having passed the Certification Commission for Health Care Interpreters (CCHI) exam. (good for 4 years or; (4) Having passed the National Board of Certification for Medical Interpreters (National Board) exam, which is valid for 5 years
	VOCATIONAL EXPERTS **In draft—due 1/1/2013**	▪ **5307.7:** amended: On or after 1/1/2013, AD to adopt a fee schedule for payment of vocational experts, including vocational evaluations and expert testimony determined to be reasonable. NOTE: There is nothing even in draft form posted on the DWC Rule Making page, so it appears this is not a driving concern and appears to remain on the "back burner." But, the new Rules of Practice and Procedure do contain new provisions governing vocational expert's reports as evidence. **10606.5:** NEW WCAB Rules of Practice and Procedure: (1) Vocational expert reports must disclose qualifications of expert and must further contain declaration to be signed by the expert that the contents of the report are true and correct, the expert prepared the report, etc. (same as 139.2) (2) Must disclose the names and qualifications of others participating in the report; (3) the contents required (similar to medical reports), including all information reviewed, the employee's vocational history, history of injury, reasons for opinion and signature of the

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<td>vocational expert.</td>
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<td>FEE SCHEDULE: COPY SERVICES

The AD has proposed regulations which are currently pending with comment period to 11/8/2014</td>
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Copy Services: AD to adopt on or before 12/1/2013, fee schedule for copy and related services, including records produced in paper or in electronic form. No payment permitted for copy service fees incurred within a 30 period during which applicant requests documents within possession of claims administrator or their representative
9981 – Fee schedule applicable regardless of date of injury
Photocopy service bills: Must provide: (1) professional photocopier registration number: (2) Tax ID No.; (3) date of billing: (4) Claim No.; (5) date of service; (6) Description of services and number of pages produced; (6) Billing Codes may also be included; and (7) the 139.2 declaration is also required
Fee schedule applies if claims administrator fails to provide records within the specified time frames.
No payment of claims administrator provides the records within 30 days of request.
No payment for duplicate records without written good cause
No payment for summaries, tabulations or indexing of documents
Reasonable maximum fees:

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<tr><td>$180.00</td><td>Single set of records from single custodian of records. This includes up to 500 pages as well as mileage, postage, pickup and deliver, phone calls and even repeat visits to the record source, page numbering, witness fees, check fees and preparation, handling and service of SDT.</td></tr>
<tr><td>$75.00</td><td>Cancellation fee after authorization</td></tr>
<tr><td>$20.00`</td><td>Records from EDD</td></tr>
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<tr><td>$30.00</td><td>Records from WCIRB</td></tr>
<tr><td>.10 per page</td><td>For each page above 500 pages</td></tr>
<tr><td>$5.00/30.00</td><td>For each additional set of records in electronic form ordered within 30 days of SDT or 30.00 if ordered after 30 days</td></tr>
<tr><td>$10.26</td><td>For each X-ray or scan per sheet</td></tr>
<tr><td>$3.00</td><td>CD of X rays and scans</td></tr>
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Corey recommends: You send the records by CD Rom to applicant's attorney. That is the fasted and easiest way. You can deal with those attorneys who otherwise demand hard copies.
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<td>5703.1

5307.8 (new)</td>
<td>MEDICAL FEE SCHEDULE CHANGES [OMFS]

9789.12.1 to 9789,19:

New regulations in draft form with public hearing scheduled for 12/12/2013. These are 55 pages of proposed new regulations to take effect 1/1/2014</td>
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Maximum reasonable fees for 2012 based upon estimated annualized aggregate fees of Medicare system for physician services appearing on 7/1/2012. This applies to all treatment to 1/1/2014
THE CURRENT SYSTEM: the OMFS (9789.11) is based upon CPT codes from the AMA, which identifies services actually provided rather than simply a diagnosis. So, there are code numbers assigned for every medical task and service.[xvii] But, it is CMS which applies these codes and makes them resource based applied against their own conversion formula, in order to come up with the resource based relative value scale. The fee is determined by the CPT Code from the AMA but the relative value unit represented is from CMS which is then applied to the conversion factor. (E.g. evaluation and management = $8.50). The Medicare rate for each procedure is derived from the non-facility rate and a weighted geographic adjustment factor of 1.063
FOR TREATMENT ON OR AFTER 1/1/2014:, and until the AD develops a new OMFS based upon the resource-based relative value scale, "RBRVS" maximum fees for physician and non-physician services, including nurses, physical therapy and physician assistants, shall be in accord with Medicare payment system except an average statewide adjustment factor of 1.078 shall apply in lieu of Medicare's locality specific adjustment factors (note these are amounts which are to be factored under sub (g) which means the OMFS is to be adjusted within 60 days to conform to changes in Medicare and Medi-Cal payment systems); NOTE: The following Conversion Factors are based upon the drafted regulations under newly proposed 9790.12.5:

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	HOME HEALTH CARE **In draft—due 7/1/2013. These regulations have not been posted on the DWC website as of this publication**	

	2014	2015	2016	2017
Surgery	51.9750	48.2650	44.5551	40.8451
Radiology	49.9188	46.8943	43.8697	40.8451
Anesthesiology	32.3651	30.1400	27.9148	25.6896
All other	36.0537	37.6509	39.2480	40.8451

- Four year transition to estimated aggregate and the **resource-based relative value scale** at 120 of Medicare conversation factors
- CPT codes are those from AMA 4th Edition
- California specific codes are adopted [9789.12.14]
- California specific modifier for consultation during medical-legal evaluation (-300 [9789.12.15]
- Hospital fees for services performed in outpatient department not to exceed 120 percent of fee paid by Medicare and maximum facility fees for services performed at ambulatory surgical centers not to exceed 80 percent of fees paid by Medicare for same service
- **HOME HEALTH CARE**: **5307.8:** On or before 7/1/2013, AD to adopt fee schedule establishing maximums for service hours and fees for home health care services not covered by Medicare fee schedule. No fees payable to member of employee's household if services had been regularly performed in the same manner and degree prior to the date of injury. **[*NOTE*:** *This will be extremely hard to prove since for the most part, no spouse of an injured employee may be deposed unless the spouse is actually a potential party or is claiming some secondary injury*] The WCAB has not yet promulgated the mandated fee schedule. There have been no posted regulations to date according to the DWC web site
- **Attorney fees may be awardable for recovery of home health care, subject to rules or**

	ATTORNEY FEES	**regulations** ▪ ***COMMENT FROM COREY:*** I see this as a prime opportunity for applicant attorneys to try and generate hourly fees beyond the statutory 15% fees from the cases-in-chief, resulting from their efforts to recover these benefits on behalf of their clients. I see this as a very tempting "target" of opportunity. Also, if you figure that home health care services are a trend in medicine then expect PTP's to prescribe even more of it and applicant attorneys pursuing more of it as well. If the issues are litigated, there could be additional exposure to high fees based upon hourly rates of at least $350.00 and higher. *Hopefully, these issues will be quickly addressed in UR and then in IMR. If so, then potential impact would be blunted because "necessity" medical issues now go to IMR, not to a QME or AME*
139.48	**FOR HIGH EARNING LOSS SUPPLEMENTAL PD PAYMENTS FUNDED TO COMPENSATE** **[THE RETURN-TO-WORK SUPPLEMENTAL PROGRAM OF THE DIR]** **Since our last publication, these reglations are now posted on the DWC website. A public hearing was to be held 12/8/2014. Therefore, these regulations are still in draft form**	▪ Funded by annual $120 million from non-General funds, this would compensate injured workers in a manner unspecified for "supplemental payments" "whose disability benefits are proportionately low in comparison to their earnings loss" Does this not look like Ogilvie? ▪ Eligibility and amounts of these payment are subject to regulations of the AD after findings based on studies of wage loss to be conducted by CHSWC ▪ **POSTED PENDING REGULATIONS IN DRAFT ONLY:** ▪ The Return-to-Work Supplemental Program ▪ Program intended to provide supplemental payments to workers whose PD are disproportionately low in comparison to their earnings loss, based upon RAND study ▪ Eligibility: Applicant must have received the SJDB Voucher for an injury on or after 1/1/2013 ▪ RTWSP eligibility notice required in notice contained in vouchers ▪ Application for RTWSP must be made ELECTRONICALLY, through the DIR web site, within 1 year from date of service of SJDB Voucher. Must be made under penalty of perjury

		▪ All applications to be supported by required information and PDF or Tiff copy of Voucher ▪ All applications to contain warning re; false claims, including treble damages plus a civil penalty of not less than $5,000 up to $11,000, plus costs of action, pursuant to the False Claims Act [Gov. Code 12650-12656] ▪ Applications to be acted upon by DIR within 60 days of receipt ▪ Payment: $5,000 – flat fee, non-assignable lump sum. To be made within 25 days of decision from Director ▪ Appeal may be filed with WCAB District Office within 20 days of service of decision ▪ These supplemental payments are o**utside of the WCAB** but with limited review by the WCAB trial judges; but limited to grounds for petitions for reconsideration (see above) ▪ These regulations do not contain any provision for attorney fees ▪ If this does not change, then perhaps some applicant attorneys might enter into a ***contingency retainer agreement*** with their client for this purpose. Such a fee agreement could presumably entitle the attorney to well more than a 15% fee ▪ ***COMMENT FROM COREY:*** I see this "fund" as a collateral concern because in trying to obtain these benefits, applicant attorneys would have to pursue an Ogilvie issue, which would then likely also be used to rebut the AMA Guides and the Schedule of Age and Occupational Modifiers, so such an effort could have the collateral effect of adversely impacting exposure to PD, using the Ogilvie vehicle as the means. If there are no attorney fees and given the fact that a 15% fee of from $5,000 is only $750.00, I don't know the extent to which applicant attorneys will be motivated to pursue this benefit. It seemingly requires some claim that the PD is disproportionately low compared to the RAND study, which presumably would require some predicate that the RAND study would justify a higher long term wage loss than the 1.4 factor now installed across the board for all

		injuries and body parts ▪ For more information on how workers' compensation is currently user funded, please refer to Labor Code 62.5
	MISCELLANEOUS	
5502	**EXPEDITED HEARING**	• Whether employee is entitled to treat within MPN is now added to the existing issues for expedited hearing ▪ No other issue heard at expedited hearing, until MPN issue is first resolved ▪ Medical treatment issues are heard but not 4610 and IMR issues
5703	**EVIDENCE ALLOWED**	▪ Adds new sub (j) permitting in evidence reports from vocational experts. Evidence in the form of reports preferred over live testimony. Live testimony occurs only upon a showing of good cause. A continuance may be granted for rebuttal testimony if a report was not served sufficiently in advance to permit rebuttal by the opposing party
4066	**ATTORNEY FEES**	▪ Section 4066, permitting attorney fees if employer files application for adjudication of claim in non-litigated cases is now repealed for all dates of injury
4702	**DEATH BENEFITS/BURIAL**	▪ Burial expenses increase up to $10,000 for injuries on or after 1/1/2013
4907	**REMOVAL BY WCAB**	▪ Expands power of WCAB to remove persons other than attorneys from appearing before the WCAB, including hearing representatives and widens the basis for doing so

5811	**INTERPRETERS**	▪ Sets forth duties of an interpreter, which expressly do not include acting as an agent or advocate ▪ Compels non-disclosure to non-immediate participant as to any of the content of conversations or documents except upon court order
139.3 (new)	**FINANCIAL INTEREST**	▪ Interested parties required to disclose financial interests in any entity providing services ▪ Cross-referrals prohibited ▪ Rebates, preferences, patronage, discounts, dividends, commissions, etc., are prohibited by interested parties ▪ Violations are a misdemeanor and subject to civil penalties up to $15,000 per offense

[i] For injuries on or after 1/1/2004 to 12/31/2012, ("old SJDB") for any voucher issued on or after 1/1/2013, the same statute of limitations of 2 years/5 years from DOI shall apply

[ii] Under Section 86 the Act takes effect as to all pending matters, regardless of the date of injury, unless otherwise specified in the act, except nothing shall be deemed a basis upon which to rescind, alter, amend or re-open any final award of compensation benefits

[iii] Until the AD Develops the "Schedule of Occupation and Age Modifiers," we will continue to use the occupational and age adjustment tables from the 2005 PDRS

[iv] Guides to the Evaluation of Permanent Impairment, 5th Edition, American Medical Association, pp. 360

[v] California Compensation Laws of California, 2012 Edition, Lexis/Nexis at pp. 1677

[vi] WCAB panel decisions to not carry decisional or precedential value, but they do possibly "reflect" the thinking of at least those Commissioners and are therefore citable but they are not controlling authority.

[vii] Significant panel decisions are important because they must be issued with the consent of the entire WCAB, but they do not carry the weight or binding authority of an en banc decision. But, they are citable and carry a lot of persuasive value in the industry.

[viii] The writ of mandate was denied but the 1st District Court of Appeals has granted a writ of review in Stevens v. WCAB No. A143043. According to the Appellate Courts Case Information, briefing is occurring and there have been amicus briefs already filed by CWCI, CAAA and the Chamber of Commerce. Arguments took place on 12/3/2014 and a decision is pending.

[ix] Since the issues were procedural, they would take effect currently, regardless of the date of injury.

[x] In Dubon I, applicant contended that the UR Physician Reviewer had not been provided with a number of medical reports from the PTP, consulting surgeon and even the AME, including diagnostic tests, including a discogram, EMG/NCV study and a lumbar MRI.

[xi] Dubon II supra pp 14

[xii] 8 CCR 9792.9.1(c)(4))

[xiii] The author of this Guide is also the author of the petition for removal in Bodam, so I am very thoroughly familiar with the presenting legal issue. Essentially, it was the contention of defendant that a timely "decision" for a prospective UR request was not rendered "late" simply because the 2 business day follow up letter was sent one day late. This is the same thinking in line with the Supreme Court case in Rodriguez, where a defendant made a timely decision to deny a claim the notice of denial was sent later through inadvertence.

[xiv] WCAB "significant panel decisions" defined at http://www.dir.ca.gov/wcab/wcab_dars.htm

[xv] Defendant had maintained that the UR decision was "timely" and that the impact of the late 2 day follow up notice of denial (phone) was dealt with in the regulations, which simply toll the running of the 30 day period during which applicant can request IMR. (8 CCR 9792.10.1(c)(2) until that notice is sent.

[xvi] http://www.dir.ca.gov/dwc/dwc_newslines/2013/Newsline_80-13.pdf

[xvii] CPT means the procedural codes set forth in the American Medical Association's Physician's Current Procedural Terminology (CP) 1997 and maintained by the AMA's Editorial Board.