

SB 863: Assessment of Workers' Compensation Reforms

July 17, 2014

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Introduction

Purpose of this report

The 2012 workers' compensation reform, SB 863, initiated fundamental changes in certain components of the workers' compensation system that had become dysfunctional. The largest cost driver was and still is within the category of medical treatment, and this is where the most dramatic changes were made. Changes in the management of medical treatment, such as the advent of independent medical review, and significant changes in the resolution of secondary claims of medical service providers, such as the requirement of filing fees for liens, are intended to make the system more efficient. Labor and employers are asking whether the reforms have delivered the expected improvements. This report is intended to survey the changes, the accomplishments, the shortcomings, and the ongoing challenges.

Overall purpose of workers' compensation

The essential features of the workers' compensation system as it exists today were enacted in California in 1914. The two primary stakeholders are employers and employees. The social bargain is for employees to receive compensation and medical care for injuries and illnesses arising from the job, and for employers to pay for the cost, under a system that limited the amount of their liability so that the cost of work-related injuries could be incorporated into the cost of goods and services produced.

Systemic risks

If not managed appropriately, workers' compensation can deliver too little for injured workers, cost too much due to inefficiency and mis-targeting the benefits, promote non-constructive behaviors, and ultimately reduce opportunities for profitable employment in California.

Why SB 863?

The problem:

- Employees were aggrieved that permanent disability (PD) benefits had been cut by more than 50% as a result of SB 899, the 2004 reform that replaced an often-subjective disability rating system with permanent disability ratings based on the more objective American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment* (5th edition) .
- Both employees and employers were dissatisfied with the delivery of medical treatment, and employees complained of delays and denials of care, while employers complained of runaway cost and the inability to block unnecessary medical treatments.
- Both employees and employers were dissatisfied with the delays in dispute resolution.
- Employers complained that costs in California remained among the highest in the nation and were once again heading toward the #1 spot among all 50 states.

Major goals of the 2012 reform bill:

- Improve compensation for permanent partial disabilities

- Improve access to appropriate medical care. Anecdotes of delayed or denied care were often reported, despite studies showing patient satisfaction and access to care in workers' compensation comparable to the private health insurance environment.
- Reduce costs to employers
 - The Commission on Health and Safety and Workers' Compensation (CHSWC) Liens Report (January 2011) identified avoidable litigation costs.
 - The RAND evaluation of medical care identified avoidable medical costs and opportunities for improvement in delivery of treatment.
 - Employers found the return-to-work incentives of the "bump-up/bump-down" on PD benefits to be unworkable.

Specifics of SB 863

- Increase PD benefits overall by 30% over two years by
 - increasing minimum and maximum weekly amount payable for permanent partial disability, and
 - increasing the ratings for most permanent partial disabilities by using a 1.4 multiplier in the rating calculation, in place of the multipliers of 1.1 to 1.4 according to the type of injury.
- Eliminate cost of Ogilvie -type litigation over PD ratings claiming multipliers in excess of the multiplier assigned for the type of injury or in excess of 1.4.
- Simplify PD awards by eliminating a well-intentioned but impractical attempt to target benefits to injured workers who cannot return to their former employers. The three-tiered disability program was known as "bump-up/bump-down." The program produced a small net increase in PD benefits, so its elimination in SB 863 was offset by a simple increase in overall benefits without the pitfalls of the attempt at individual targeting.
- Eliminate cost of litigating add-on disability ratings for psych, sex, and sleep disorders allegedly arising as consequences of physical injuries. Instead of continuing to allow enhanced awards for the individual injured workers who successfully litigated these secondary effects, the bill raised compensation for all injured workers without the need to prove these consequences of their underlying injuries.
- Improve medical treatment decisions by adopting independent medical review (IMR) to resolve disputes over the medical appropriateness of treatment recommended by a physician, instead of deferring such disputes to medical-legal examiners and ultimately to workers' compensation judges.
- Improve employers' and insurers' ability to contain medical treatment within established medical provider networks (MPNs).
 - CHSWC study had found the majority of medical liens arose from out-of-network physicians.
- Improve patient access to physicians within MPNs, since workers had complained of inability to find a network doctor who would take them. The reform will do so by requiring that insurance carriers
 - post full provider list online,
 - remove doctors from the list who do not acknowledge their membership, and
 - provide medical access assistants.

- Reduce unnecessary cost and reduce inappropriate incentives by changing fee schedules for spinal hardware and ambulatory surgical centers (ASCs), and by updating the physician fee schedule to the resource-based relative value scale (RBRVS) maintained by Medicare.
 - The overpayment for spinal surgical hardware was placed into statute when Labor Code section 5718 was added by AB 1177 (Calderon), Stats 2001 ch 252, and the statutory protection for this payment was preserved as the section was later amended. After a CHSWC study identified the additional payment for spinal hardware as an unnecessary expense, efforts to reduce the payment or repeal it entirely were impeded until it was finally repealed as part of SB 863 in 2012.
 - ASCs have lower costs than hospital outpatient departments and receive lower reimbursements under Medicare and other payment systems, but they were paid the same rates as hospital outpatient departments under workers' compensation. SB 863 reduced their facility fees from 120% to 80% of Medicare's hospital outpatient fee schedule.
 - A physician fee schedule based on Medicare's RBRVS replaced an arbitrary fee schedule that overcompensated (and thus promoted) some services such as surgery and radiology while undercompensating primary care physician services.
- Reduce disputes and litigation costs by establishing fee schedules for copy services, interpreters, vocational experts, and home care services.
 - Copy services and interpreters had been identified by the CHSWC Liens Report as subjects in need of fee schedules to reduce litigation. In addition, vocational expert fees and home care services were concerns for employers negotiating the reforms.
- Eliminate frivolous lien disputes by requiring a filing fee on new medical liens and an activation fee on already-filed medical liens. Projected savings were primarily based on the deterrent effect of the filing fee on parties who file unwarranted liens and the resultant savings in litigation costs for employers and insurers. It was also expected that removing the financial incentive for medical providers to furnish unnecessary medical goods and services would lead to unquantified savings for employers and insurance carriers.
- Give the Department of Industrial Relations (DIR) and the Self-Insurers' Security Fund increased oversight over self-insured employers to prevent avoidable defaults from occurring and thereby reduce costs to other self-insurers.

Key Findings

- SB 863 successfully trimmed three percentage points off the rate increase, employers still had to endure an increase of more than 10% in their workers' compensation costs. As a result, even though an increase in workers' compensation costs has been projected for 2013 and 2014, it is estimated that costs would have risen even more without SB 863. Insurance prices had already begun to rise in 2012. After SB 863 was passed, the Department of Insurance adopted an advisory pure premium rate for January 1, 2013, which was up 11.3% from the rate one year earlier. If SB 863 had not been enacted, indications are that the increase would have been 14.3%.
- Permanent disability (PD) benefits increases are now in effect. It is too soon to determine the net effects, primarily because it takes up to two years or more for permanent disability to be determined.
- SB 863 reduced Ambulatory Surgery Center (ASC) facility fees from 120% to 80% of Medicare's hospital outpatient fee schedule. The average amount paid per ASC episode in the first six months after the change in fee schedules was 26% lower than in the year before the change took effect.
- SB 863 amended the inpatient fee schedule by repealing the separate reimbursement for spinal hardware. The average amount paid per episode of the spinal surgery involving implantable hardware declined by 56% after the separate reimbursement (duplicate payment) for spinal hardware was repealed.
- The lien filing fee halved the number of new liens being filed. In the first year the filing fee was in effect, 213,092 liens were filed, down from 469,190 in 2011, a greater than 50% reduction.
- Medical costs appear to be down: Preliminary data from WCIRB indicate that the estimated ultimate medical loss per lost-time claim is down 1.3% from calendar year 2012 to 2013. However, because the estimate is based on historical trends and adjusters' predictions of what their cases will cost over the lifetime of the case, it is a weak indicator of the performance of the system after the extensive reforms brought about by SB 863.
- The Independent Medical Review (IMR) process is heavily used: approximately 185,000 IMR applications have been filed to date. The QME process that IMR replaces costs on average \$1,653 per QME request, at least three times higher than the administrative cost of an IMR. An IMR costs \$420 to process, down from \$560 initially, and the cost will go down further starting in 2015.

- More than eighty percent of IMR determinations uphold the UR finding that the treatment request is not medically necessary. Pharmaceuticals are the most common IMR request, and narcotics are the most common type of pharmaceutical requested.
- Ten sets of cost-saving regulations have been enacted, and additional regulations are in process.

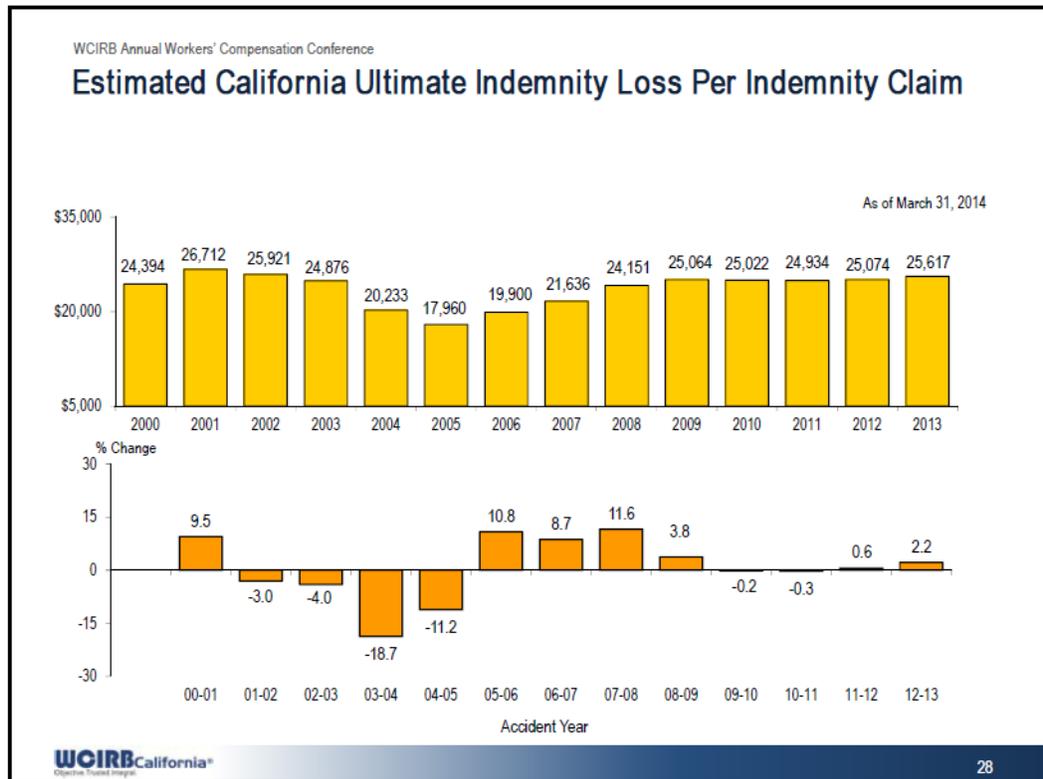
Accomplishments (not limited to SB 863 and its implementation)

Increases in permanent disability benefits

PD benefits increases are now in effect.

- Preliminary data from the Workers' Compensation Insurance Rating Bureau (WCIRB) of California indicate that the estimated ultimate indemnity loss (Temporary Disability [TD] + PD) per lost-time claim is up 2.2% from accident year (AY) 2012 to AY 2013.

Chart 1



Bellusci, Dave. "The California Workers' Compensation System: A WCIRB Perspective" Annual Workers' Compensation Conference, June 12, 2014

- The estimated ultimate indemnity loss per lost-time claim is not a strong measure of the benefit increase, however, for several reasons:
 - Estimated ultimate indemnity is affected by other factors, as well, such as the annually indexed TD rate and the projected impact of system reforms and changes that may prolong or shorten the average duration of TD.
- The net effect of changes to PD cannot actually be observed yet, for several reasons:
 - Along with the higher multiplier incorporated into the rating formula and the higher benefits payable for a given PD rating, SB 863 also reduced certain ratings by eliminating certain enhancements to ratings (enhancements or add-ons that were previously obtained for secondary impairments of psych, sex, or

sleep) and eliminating the three-tiered compensation structure known as “bump-up/bump-down.” The interaction of these changes may be complex.

- The increase in PD benefits was phased in, with about one-third of the increase becoming effective for injuries occurring in 2013, and the remaining two-thirds taking effect for injuries in 2014 or later.
- Claims typically do not reach PD awards until 18 months or later following the date of injury, with more severe cases generally taking longer to reach this point. Therefore, few cases have yet reached PD award, and the ones that can be observed are not a representative sample.

Independent Medical Review

Independent Medical Review (IMR) was launched less than 17 weeks after SB 863 was signed. The Division of Workers’ Compensation (DWC) and staff at the DIR negotiated the contract with the independent review organization, created the organizational structure within DWC, and created the technological infrastructure to operate the program. As prescribed by SB 863, the program underwent a six-month soft launch with only a few eligible cases, until all dates of injury became eligible for IMR beginning in July 2013. Since then, the volume of IMR cases has been an order of magnitude greater than expected, resulting in delays and unexpected costs. The basic premise remains sound, and the program is ramping up to cope with the volume. The program may need further refinements.

Qualified Medical Evaluation backlog

QME backlogs are under control.

- Qualified medical evaluators (QMEs) are assigned when duly requested to resolve medical disputes. SB 863 made relatively minor tweaks in the QME process. The last major change prior to that was SB 899 (Poochigian 2004), which required attorney represented cases to go through a QME process similar to the one already established for non-represented cases. Ever since 2004, there have been perennial backlogs in the DWC responses to parties’ requests for panels of three QMEs from which the evaluator would be selected for each case.
- DIR has applied additional resources to catch up on the backlog and has reorganized the workflow to assure that backlogs do not return.
- DWC received 12,000 to 14,000 initial requests for panel QMEs per month from January through April of 2014. (In 2009, DWC received 9000 panel requests per month, and the request numbers have been increasing each year.) Almost 40% of the requests are from represented injured workers. Working with DIR IT, DWC is developing an online QME panel request process that will allow parties in represented cases to request an initial QME panel online. In May 2014, DWC met with a focus group to make sure that the online program would address users’ concerns. The new program will allow a party to electronically fill out the form 106 online by prompting the needed information depending on whether the request falls under Labor Code sections 4060, 4061 or 4062. The requesting party will then upload necessary documentation. The panel will be

issued immediately and the requesting party will then be required to serve the opposing parties. If a panel was already issued, that information, with the names of the QMEs, will be provided. The program is expected to be ready for the public's use by January 2015.

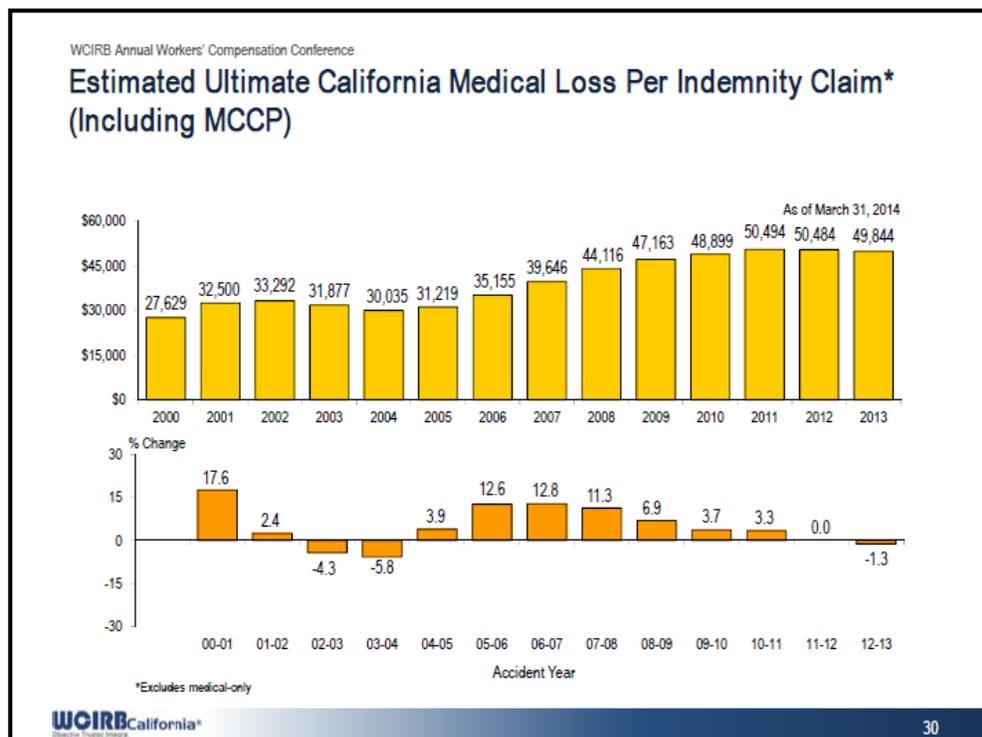
- DWC is now timely in issuing QME requests.

Medical expenses

Medical expenses appear to be under better control, although empirical evidence is still scant, and there is resistance to some of the cost reductions.

- Preliminary data from WCIRB indicate that the estimated ultimate medical loss per lost-time claim is down 1.3% from AY 2012 to AY 2013.

Chart 2:



Bellusci, Dave. "The California Workers' Compensation System: A WCIRB Perspective" Annual Workers' Compensation Conference, June 12, 2014

- "Estimated ultimate loss" is based on historical trends and on adjusters' predictions of what their cases will cost over the lifetime of the case, so it is a weak indicator of the performance of the system after the extensive reforms brought about by SB 863.
- Actual experience data is still very limited at this point, so soon after the changes took effect. Two particular changes have been studied based on the first few months under new fee schedules. (See [Appendix A](#) for a complete list of new fee schedules, including a description of the three described in more detail below.)

- The average amount paid per ASC episode in the first six months after the change in fee schedules was 26% lower than in the year before the change took effect, according to a [study by the California Workers' Compensation Institute \(CWCI\) and WCIRB](#).¹ This is consistent with the 25% reduction that was projected at the time the bill was enacted.

- The average amount paid per episode of the spinal surgery involving implantable hardware declined by 56% after the separate reimbursement (duplicate payment) for spinal hardware was repealed. The following information is from unpublished work by CWCI and WCIRB summarized at a WCIRB conference in June 2014.
 - By reducing the reimbursement amount for spinal implant surgery, the reform is also expected to reduce the incentive for performing these life-threatening procedures.
 - The excessive profit under the former statute was an incentive to perform unnecessary spinal implant surgery and thereby fostered fraud and corruption and endangered patient health.
 - Pacific Hospital of Long Beach was the highest-volume facility for these procedures. In 2014 its former owner pleaded guilty to paying kickbacks for referring patients to the hospital.
 - Michael Drobot, the former owner of Pacific Hospital of Long Beach, has also admitted to bribing Senator Calderon to protect that overpayment against prior efforts to abolish it.
 - Spinal surgery can be fatal, especially when surgeons are rewarded for employing novel materials or devices. The consensus to abolish the overpayment for spinal hardware was built on research by RAND Corporation for CHSWC showing the unnecessary cost, and the move finally crystalized around a Wall Street Journal article describing how the profit-driven use of spinal hardware cost a patient her life.²
 - The fee currently allowed is sufficiently profitable to assure that the treatments will be available to patients who need them, but not so profitable as to promote unnecessary surgery.

- The shift to RBRVS-based physician fee schedule will produce mixed results.
 - The shifts in fee schedules may produce an increase or decrease in aggregate fees payable to physicians, depending on how the mix of services responds to the change in economic incentives.

¹ David, R. and Johnson, G. Ambulatory Surgical Center Cost Outcomes: The Impact of California SB 863 Workers' Compensation Reforms. WCIRB and CWCI Research Report. February 26, 2014. URL: <http://cwci.org/research.html> (Accessed on July 1, 2014)

² Carreyrou, J., Mcginty, T., and Millman J. "In Small California Hospitals, the Marketing of Back Surgery." Wall Street Journal. February 9, 2012.

- More efficient transaction processing under the updated billing codes (the old fee schedule used codes that had not been updated in 15 years) could save administrative costs.
- Reduction of inappropriate economic incentives to perform more profitable procedures and withhold less profitable services should lead to better and more cost-effective medical treatment and better health outcomes, saving money for employers and insurers in the long run.
- Employers and insurers are likely to remain uneasy about the impacts of RBRVS for years because the costs will be more readily recognizable while the benefits will be difficult to identify amidst other changes that are taking place in the California workers' compensation system and in the national healthcare market.
- Physicians threaten to stop taking workers' compensation patients because the fees for their particular services are reduced under the RBRVS. For example, a lobbyist recently asked whether DWC tracks the providers who no longer take new workers' compensation patients because of the changes in the fee schedule.
 - The DWC is conducting a yearly study of medical access, so if inadequate fees ever do impact access to care, the DWC will address the problem based on empirical evidence.
 - Physicians have previously threatened to leave the workers' compensation system; however there has been no diminution of access to necessary services.
 - Providers who are unhappy with workers' compensation reimbursements do not necessarily have greener pastures open to them. "Patients with private insurance have had to pay more out of their own pockets and have therefore sought less care. [C]ash-strapped states have resisted hikes to the fees they pay to doctors and hospitals for treating Medicaid patients. ... Obamacare and the sequester have curbed the growth of Medicare fees.... Health-care prices were up just 0.9% in March from a year earlier, the slowest growth in 50 years."³

Medicare fees are sufficient to maintain adequate access to physicians, except in counties subject to healthcare shortages. California workers' compensation physician fees are designed to be 20% higher than Medicare rates for comparable services. As a result, physicians may find it difficult to actually get higher reimbursement by leaving the workers' compensation system.

³ "The drugs wear off" The Economist. June 14, 2014; 27-28. URL: <http://www.economist.com/news/united-states/21604206-public-and-private-austerity-takes-its-toll-health-care-workers-drugs-wear> (Accessed July, 1 2014)

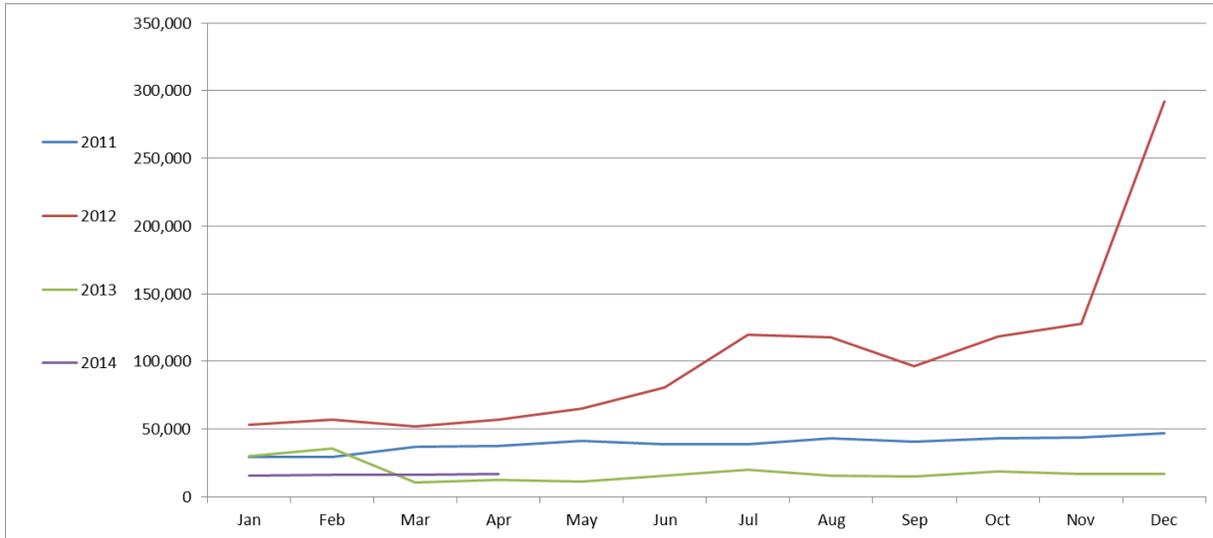
Lien filing and activation fees

The lien filing fee and activation fee systems were built in less than 17 weeks after SB 863 was signed. The DWC developed and adopted regulations, and the DIR Information Services Unit created an award-winning electronic payment and record-keeping system that was deployed throughout the state by January 1, 2013.

- The filing fee was recommended by the January 2011 CHSWC Liens Report as a way to address the problem of liens clogging the workers' compensation judicial system and fostering fraud and abuse. Over 460,000 liens were filed in 2011, mostly for medical services that the insurer or employer either declined to pay or for which they paid less than the billed charges.
- The CHSWC report estimated that the average litigation cost was \$1,000 for every medical or medical-legal lien filed.
- Going a step beyond the CHSWC recommendation, SB 863 not only required a filing fee of \$150 on new medical liens, but also a \$100 activation fee on medical liens already filed. The activation fee would eliminate frivolous liens already on file if the owners did pay the activation fee by the end of 2013.
- The filing fee halved the number of liens being filed. In the first year, the filing fee was in effect, 213,092 liens were filed, down from 469,190 in 2011.
 - While a previous \$100 filing fee was in effect for two and a half years, approximately 220,000 liens were filed in calendar year 2005. The smaller number in 2013 could be a result of a change in the way DWC counts liens where a medical bill is asserted in two or more cases, and it could be a result of the pool of potential liens being depleted by the 2012 rush to file liens before the filing fee took effect. The monthly rate of lien filing spiked during the negotiations for SB 863, when the bill went into print, and again in the last month before the fees took effect.
- The activation fee has been temporarily enjoined by the US District Court in the case of *Angelotti Chiropractic vs. Baker*. Further trial level proceedings are stayed while an appeal to the Ninth Circuit is pending. (See [Appendix B](#) for more information on *Angelotti v. Baker* and a complete list of litigation related to SB 863.)
- If the Ninth Circuit upholds the injunction, the plaintiff will amend the complaint to seek an injunction against the filing fee as well.
- Meanwhile, filing fees are still being collected and the number of liens filed per month remains well under half the number filed per month in 2011. (See **Chart 3** on the next page.)
- In 2011, the CHSWC report estimated that 200,000 liens would be prevented by a filing fee. In 2012, the WCIRB projected a 41% reduction in the number of liens as a result of the filing fee and concurrent changes to the statute of limitations. The actual change from 2011 to 2014, is 270,000 fewer liens, which represent a nearly 60% reduction. (See **Chart 3** on the next page.)

- Besides unclogging the system and removing the environment conducive to fraud and abuse, the lien filing fee is saving California employers and insurers \$270 million per year in litigation costs and untold dollars in nuisance settlement costs.

Chart 3: Numbers of liens filed in the same month (January, 2011–April, 2014), processed in EAMS by the 15th of the following month (e.g., April, 2011).



Source: DIR/DWC Research Data

Regulations adopted to implement the reforms

- See [Appendix A](#) for a description of all fee schedules created through rulemaking.
- See [Appendix C](#) for a complete list of regulations adopted.

Self-insured employers

Thanks to the greater oversight that SB 863 allowed the Office of Self-Employed Insurance Plans (OSIP) to have over self-insured employers, the self-insurance marketplace in California is now much stronger: no self-insurers have defaulted since the passage of the law sixteen months ago. This is the first time in the past 30 years that such a long period has passed without defaults occurring. By lowering the rate of defaults, the reform directly reduces costs to all remaining self-insurers.

Challenges

Premium costs

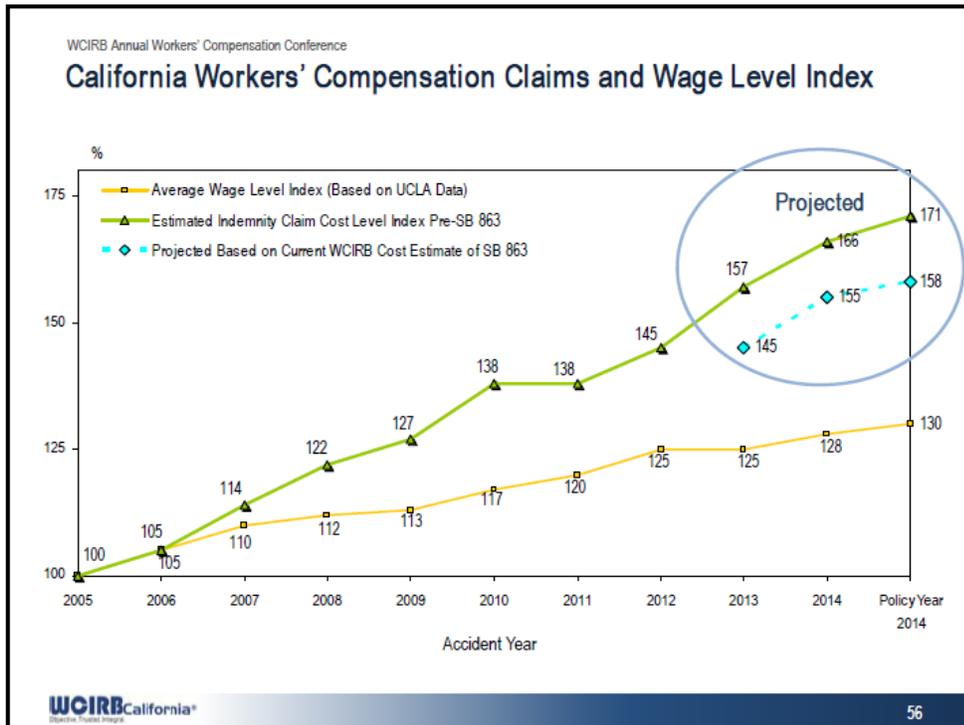
Despite the successes of SB 863, it could not entirely prevent the inevitable rise in premium costs, driven by long-term cost trends that had not been reflected in market prices. Prior to the enactment of SB 863, studies showed costs were increasing.

- The workers' compensation insurance market is slow to recognize and respond to changes in the cost of providing benefits. (Those costs are called "losses" in the parlance of the insurers, but we'll call them "costs" in this report to distinguish them from the profits or losses appearing on an insurer's financial statements). A number of factors may explain this slow response, including the fact that the ultimate costs under a workers' compensation policy are not known until years later and the fact that a company may earn sufficient profits on investments of its reserves to make up for its underwriting loss..
- Since the deregulation of the workers' compensation insurance market in 1995, the combined ratio of the cost for paying the losses and expense divided by the premium income has gone through wide swings. In the last year of rate regulation, the ratio was 95%, which allowed carriers to make an underwriting profit without relying on investment returns. Upon deregulation, prices dropped and the ratio grew to 128% (an underwriting loss that might be acceptable if investment returns were good). Costs grew while prices remained low, driving the ratio up to 190% by 1999, contributing to the insolvency of 31 insurers comprising a quarter of the entire market.⁴ The surviving insurers raised prices, and costs were driven down by legislation enacted between 2002 and 2004, so that by 2004 the ratio was 57%. That ratio allowed an extraordinary profit. Prices then fell, and costs crept up, so that ratios were again at 140% in 2010 and 2011. Under these circumstances, a price increase was inevitable. The SB 863's cost-saving goal was to mitigate the inevitable.
- Insurance prices had already begun to rise in 2012. After SB 863 was passed, the Department of Insurance adopted an advisory pure premium rate for January 1, 2013 that was up 11.3% from the rate one year earlier. If SB 863 had not been enacted, indications are that the rate for 2013 would have increased by 14.3%, three points higher than the actual rise.

⁴ Dixon, et al., "California's Volatile Workers' Compensation Insurance Market: Problems and Recommendations for Change." RAND report for CHSWC. 2009.

- SB 863 successfully trimmed three percentage points off the rate increase. As a result, even though an increase in workers' compensation costs has been projected for 2013 and 2014, it is estimated that costs would have risen even more without SB 863. (See **Chart 4.**)

Chart 4



Bellusci, Dave. "The California Workers' Compensation System: A WCIRB Perspective" Annual Workers' Compensation Conference, June 12, 2014

- In June of 2014, the WCIRB compared the early post-reform data to the projections it made in 2012. **Table 1** summarizes the projected impact of the SB 863 reform in billions of dollars and in percentage of total cost for each major component of the bill, alongside the observed effects so far. (Blank cells indicate that no data is available for comparison.)

Table 1: Projected and Observed Impact of SB 863 Reform on WC Insurance Premiums

| Reform | Projected billion \$ | Projected impact on the cost of premiums | Observed impact | Comparison of observed to projected |
|---------------------------|----------------------|--|-----------------------------|---------------------------------------|
| PD benefit increases | +1.2 | +6.4% | | |
| Elimination of PD add-ons | -0.2 | -0.9% | | |
| Bump-up/down | -0.1 | -0.5% | | |
| Liens | -0.5 | -2.5% | 59% down from the 2011 rate | favorable |
| Spinal hardware | -0.1 | -0.6% | Payments -56% | as projected |
| ASC fees | -0.1 | -0.4% | Payments -26% | as projected |
| IMR | -0.4 | -2.1% | ~200k IMRs/year | too early to measure (see text below) |
| Ogilvie -type litigation | -0.2 | -1.1% | | too early to measure |
| Stronger MPN | -0.2 | -1.0% | | |
| RBRVS | +0.3 | +1.8% | | |
| TOTAL | -0.2 | -0.9 | | |

Sources: Bellusci, Dave. "The California Workers' Compensation System: A WCIRB Perspective" Annual Workers' Compensation Conference, June 12, 2014 (columns 1 and 2, slide 55; column 4, slide 63; column 3, DIR/DWC Research Data).

DIR Director's Return-to-Work program

Return-to-Work (RTW) program not yet finalized.⁵

- Labor Code section 139.48 requires the Director to determine how \$120 million per year will be distributed as supplemental payments to workers whose permanent disability benefits are disproportionately low compared to their earnings loss.
- For more than a year, the Director's staff grappled with methods of ascertaining disproportion between permanent disability and an individual worker's earnings loss. Every solution entailed some combination of unacceptable waiting times for payments, high administrative costs, inappropriate targeting of benefits, or unintended consequences for undocumented workers. Ultimately, it was decided that the individual comparisons are not feasible, and eligibility will be based solely on a single proxy for disproportionately high earnings losses.

⁵ The program is pending clearance as a major regulation by the Department of Finance.

- The resulting design is simple and efficient. While most stakeholders find the design acceptable, some employer representatives contend that the program they agreed to in 2012 was supposed to be a rarely used safety net, not an annual charge of \$120 million.
- It has become urgent to implement the program, since workers with injuries since January 1, 2013, are already reaching the stage where they would be eligible for payments under the streamlined design the Director is adopting.

Heavy use of IMRs

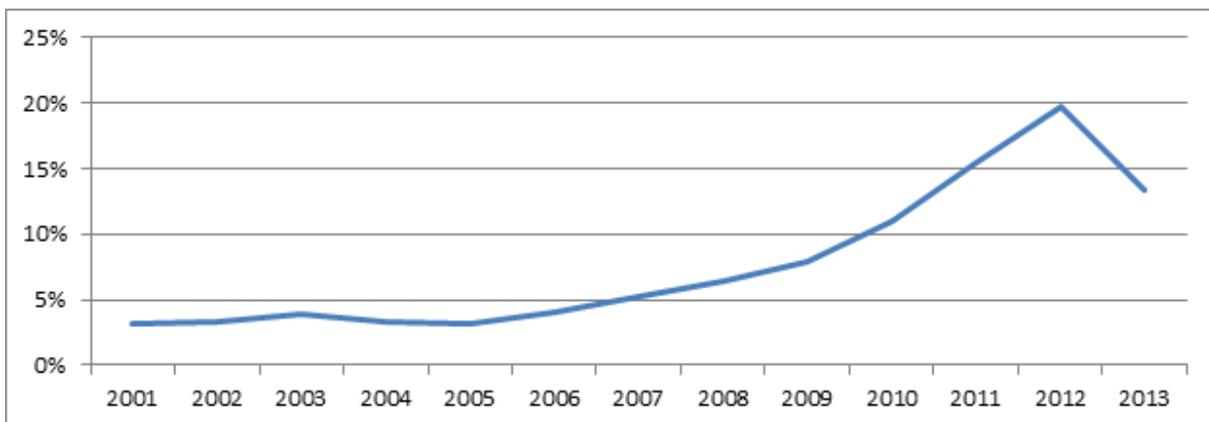
IMR is being heavily used, and it is impairing the efficient delivery of appropriate benefits.

- DIR and DWC projected that IMR would annually divert up to 21,600 medical-necessity disputes from the process of qualified medical evaluators (QMEs) and workers' compensation judges to the new IMR process, and they also projected savings to employers of over \$21 million due to the lower cost of an IMR compared to a QME.⁶
- IMR has to date received approximately 185,000 applications, resulting in adverse consequences for employers and injured workers.
 - The unexpected volume overwhelmed a system that was designed for a tenth as many cases. Months of backlogs are now being cleared out by devoting more resources to the project. Thus the delays will be overcome and decisions will be timely by the end of fall 2014.
 - At a cost of \$560 per review, the unexpected volume of IMRs created unforeseen costs to employers and insurers. As of April 1, 2014, the vendor agreed to reduce the price of a standard review to \$420. The price will be further reduced to an average of \$350 per review beginning in 2015. The current volume of IMR cases will incur additional costs to employers and insurers.
 - The cost of IMR may be offset by savings on unnecessary medical treatment that will be avoided. The data to demonstrate these savings is not yet available.
- The volume was unexpected. IMR is also used for medical treatment dispute resolution under health insurance plans in California, but it is not invoked with nearly the same frequency as in the workers' compensation system.
- Injured workers or their representatives apply for IMR to appeal a decision by an employer or insurer that has denied a treatment recommendation by a treating doctor on the grounds that the treatment is not medically appropriate. IMR is paid for by the insurers and employers.
- Drug management in chronic cases is a "hot button issue" under IMR.

⁶ At \$1,653, the average cost of processing a QME is at least three times higher than the administrative cost of an IMR. An IMR now costs \$420 to process, down from an initial cost of \$560 (and when originally estimating the cost savings, it was believed an IMR would cost \$650). The cost will go down further starting in 2015.

- Elected representatives have received constituent complaints that insurers are cutting off their long-term medications.
- Pharmaceutical management has attracted attention because pharmaceuticals make up an increasing share of medical care costs.
 - A 2010 report by CWCI and its follow-up review found that Schedule II drugs (e.g., morphine, Demerol, OxyContin, and fentanyl patches) grew from 1.6% of all prescriptions and 4.2% of all prescription costs in 2002 to 6.5% of all prescriptions and 18.9% of all prescription costs for calendar year 2009 and 19.6% for 2011.⁷
- Nearly half (46%) of IMR applications are appeals of the employer’s or insurer’s denial of pharmaceuticals such as opioids, non-FDA-approved products or off-label prescriptions. More IMRs are requested in the first year or two of a case than in later years, but the ratio of IMRs that are for pharmaceuticals increases as the cases get older. (See **Chart 5** below.)
- Pharmaceuticals account for only one-fourth of the IMRs on injuries that occurred in 2013, but two-thirds of IMRs on injuries that occurred in 2001. (See **Chart 6** on the next page.)

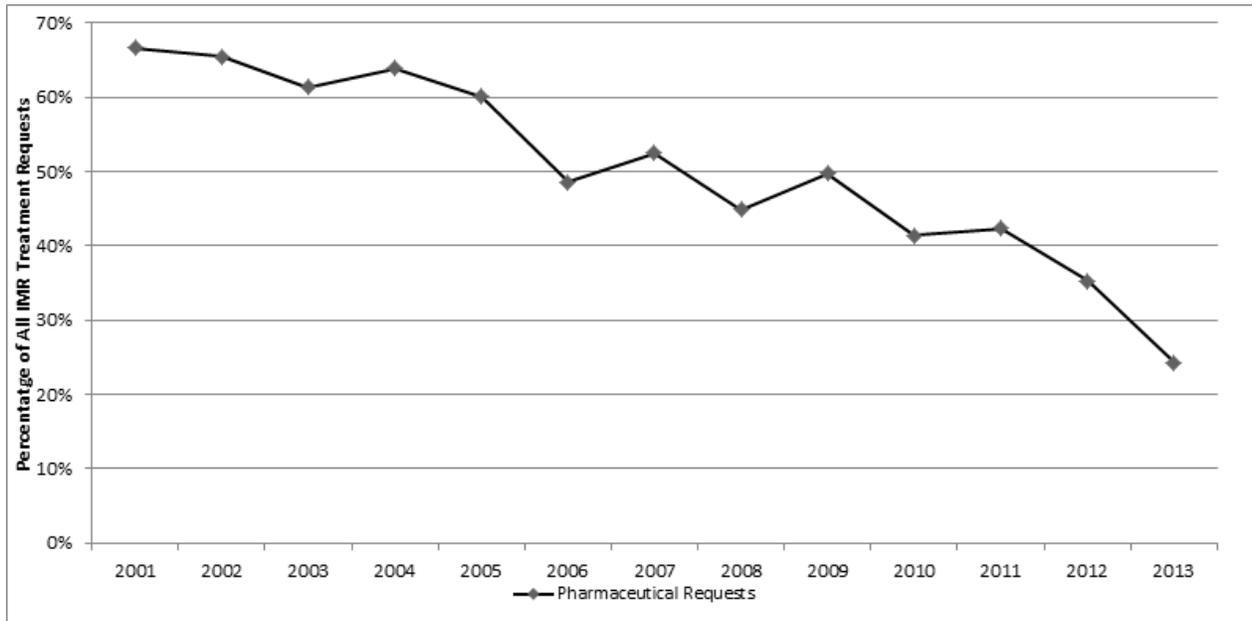
Chart 5: Percent of All IMR Applications by Year of Injury, 2001–2013.



Source: DIR/DWC Research Data

⁷ Swedlow, et al., “Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers’ Compensation System.” CWCI, March 2010.

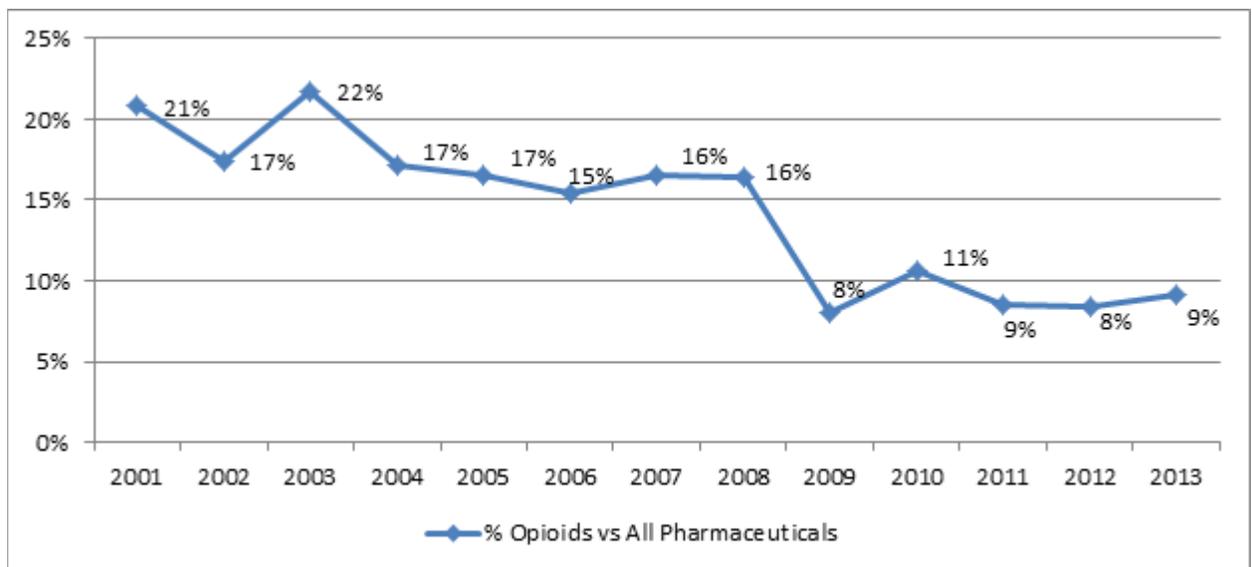
Chart 6: Pharmaceutical versus Non-pharmaceutical IMR Treatment Requests Received from July 1, 2013, to December 31, 2013, by Year of Injury, 2001–2013.



Source: DIR/DWC Research Data

- As **Chart 7** shows, depending on the year, opioids are in dispute in over 15% and up to 22% of the pharmaceutical IMRs on treatment for older injuries for injury dates 2001–2008. By contrast, opioids are in dispute in less than 10% of pharmaceutical IMRs on treatment of injuries that occurred in 2011–2013.

Chart 7: Opioid IMR Treatment Requests as a Percentage of All Pharmaceutical Requests by Year of Injury, 2001–2013.



Source: DIR/DWC Research Data

- These anecdotes and statistics suggest that employers and insurers are utilizing the newly available medical management tools to call a halt to the over-prescribing of medications in chronic cases. As a result, patients are appealing to IMR to retain their accustomed drugs. IMR is then, for the most part, agreeing with the employers and insurers UR decisions that the prescriptions are not medically appropriate.
 - Over-prescribing of opioids is an established pattern⁸ that has drawn scrutiny across the country.⁹
 - The hazards of opioids are now being taken more seriously¹⁰ and the standard of practice is shifting away from the long-term use of opioids for non-cancer pain.¹¹
 - Workers' compensation judges generally ruled in favor of granting the treatment request. As a result, employers and insurers often found it fruitless to attempt to apply evidence-based medical guidelines since the judges would routinely follow the doctors' recommendation. Employers and insurers are now emboldened to apply current medical science because IMR will apply the same medical science to uphold decisions to discontinue inappropriate medications.
 - Doctors who resist the change, as well as their patients who have grown dependent on the prescriptions, are fighting to maintain the status quo.
- More than eighty percent of IMR disputes are decided in favor of the claims administrator's denial of the medical treatment request. In other words, most IMR applications do not change the outcome other than to prolong disputes and to escalate costs to employers and insurers.
- DWC could eliminate about 5% of all IMRs that it is receiving by fixing the statute to eliminate a conflict between two requirements which lead to the submission of IMRs in cases that do not involve a medical treatment dispute.
- One challenge for policy-makers is to find a deterrent to groundless applications for IMR by the representatives of injured workers and the needless costs that these applications impose on employers and insurers.

⁸ Swedlow, et al., "Prescribing Patterns of Schedule II Opioids in California Workers' Compensation." CWCI Research Update. March 2011.

⁹ "Obama Administration Releases Action Plan to Address National Prescription Drug Epidemic." The White House Office of National Drug Control Policy. April 19, 2011. URL: <http://www.whitehouse.gov/ondcp/news-releases-remarks/obama-administration-releases-action-plan> (Accessed July 1, 2014)

¹⁰ Bohnert, et al., "Association between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths." JAMA vol. 304. No. 13. April 5, 2011.

¹¹ CDC weighs in on prescription drug abuse problem" www.riskandinsurance.com/ February 9, 2012. [story link has expired]

Litigation

- IMR Case: The *Francis Stevens v. WCAB* case challenged the constitutionality of the IMR process on the grounds that it denies due process in two ways and is not expeditious. For more details, see Appendix B.
- Lien activation fee case: Lien activation fees have been enjoined by a Federal court, and if the injunction survives the appeal, then injunction against the filing fee may also be sought.

Lien activation fees are no longer being collected, because of the injunction issued in *Angelotti*. Additionally, because of the injunction, liens filed prior to Jan. 1, 2013 that have not paid the activation fee have not been dismissed by operation of law (Labor Code section 4903.06(a)(5)), preventing the expected savings due to reduced friction costs. The lien filing fees are still being collected, as no order has issued prohibiting such collection. In addition, no order presently requires reimbursement of the filing or activation fees collected thus far. If the court holds that the lien filing or activation fees are unconstitutional under the equal protection argument, the statutes could be legislatively revised by deleting the fee exclusions provided in Labor Code sections 4903.05(c)(7) and 4903.06 (b) to health care service plans, group disability insurers, self-insured employee welfare plans, and Taft-Hartley health and welfare funds.

See [Appendix B](#) for more information on this and other lien activation and filing fee cases.

- Post SB 863 WCAB Cases. Since the passage of SB 863, the WCAB has made decisions about home health care, utilization review (UR) / IMR, medical-legal liens, and the lien activation fee. (See [Appendix D](#) for summaries of each decision.)

Interpreters' business model

SB 863 reforms may bring about a change to the workers' compensation interpreters' business model. With the reform in place, unless an interpreter is certified (and many are not), the claims administrators (instead of applicant attorneys and doctors) will be selecting the interpreter. If the claims administrator has not pre-approved a non-certified interpreter in writing, payment for the services is not required. As a result, it is likely that the market will shift away from language service providers that rely on assignments from doctors and attorneys toward larger and more cost-efficient language service providers selected by claims administrators.

Next Steps

Organizational

- Eliminate completion delays for IMR determinations.
 - The IMR vendor, Maximus Federal Services, has increased the number of physician reviewers, improved efficiencies in intake procedures, and is developing electronic applications to reduce the paperwork.
 - Maximus will see substantial decreases in its IMR backlog by August 2014 and expects to be issuing IMR determinations within the 45-day timeframe by November 2014.
- The online system to issue QME panels should be ready for public use by January 2015.

Regulatory

- MPN regulations will be filed with the Office of Administrative Law in July and effective in September 2014.
- The Copy Service Fee Schedule (public hearing July 1, 2014) should be completed by January 2015.
- The Medical Treatment Utilization Schedule (MTUS) will be revised throughout 2014 and 2015.
 - MTUS strength of evidence (public hearing July 1, 2014) should be completed by January 2015.
 - MTUS opioids and chronic pain guidelines should be completed in early 2015.
 - MTUS acupuncture, eye conditions, lower extremity disorders, post-surgical treatment, psychiatry, pulmonary disorders, spinal disorders, stress-related conditions, and upper extremity disorders should all be revised by 2015.
- Interpreter Fee Schedule and Home Health Care Fee Schedule will begin formal rulemaking as soon as the final studies are completed this summer.
- Benefit Notice Regulations will be scheduled for a public hearing this summer.
- WCIS revisions for medical data reporting (public hearing July 14, 2014) will be completed by January 2015.
- WCIS penalty regulations will be scheduled for a public hearing this fall.
- Audit regulations will be scheduled for a public hearing this fall.
- QME Online Panel Request regulations will be scheduled for a public hearing this summer.
- See [Appendix C](#) for the complete list of SB 863 regulations.

Conclusion

It is too early to score the overall effect of SB 863 reforms. The data shows positive changes in the behavior of stakeholders regarding lien filing. Although it is still too early to measure the effects of changes in medical care, physicians and claims administrators can learn from IMR determinations. Injured workers will also have better access to their MPN physicians. The SB 863 revisions to the lien filing procedures, as well as the conflict of interest statute and the fee schedule changes, may help reduce fraudulent behavior in the workers' compensation system, but we recommend more work be done in this area. Finally, pre- and post-SB 863 rate projections indicate that the reform helped slow the inevitable rise in workers' compensation premiums.

Appendix

[A: SB 863 Fee Schedules](#)

[B: Litigation](#)

[C: Complete List of SB 863 Regulations](#)

[D: WCAB Decisions on SB 863 Cases](#)

Appendix A: SB 863 Fee Schedules

1. *Ambulatory Surgery Center (ASC) Fee Schedule:* Per SB 863, the ASC fee was reduced from 120% to 80% of Medicare's Outpatient fee schedule, effective Jan. 1, 2013. The schedule is updated annually to conform to changes in Medicare. The ASC fee schedule was revised recently (effective Sept. 1, 2013) to transition fee allowances that were previously paid under the pre-2014 Official Medical Fee Schedule (OMFS) to be paid under the new RBRVS-based physician fee schedule. Other technical revisions were also made. WCIRB estimated that the fee reduction would save \$80 million per year. They are now projecting a savings of \$100 million per year.
2. *Inpatient (spinal implant):* Per the statute, 14 spinal implant diagnosis-related groups (DRGs) subject to the pass-through were reduced to 7 DRGs and specific amounts were assigned to the procedures. As of January 1, 2014, no additional fees for the spinal implant procedures are allowed. WCIRB estimated a savings of \$110 million.
3. *Physician Fee Schedule (RBRVS):* DWC filed regulations with the Secretary of State on Sept. 24, 2013, and they have an effective date of January 1, 2014. After finalizing the initial regulations, DWC issued another revision to eliminate the use of the Federal Office of Workers' Comp Program (OWCP) relative value units, because the structure of the OWCP data file would result in erroneous fee calculations for 21 procedures. (Instead 81 procedures will be paid 'by report.') On December 23, 2013, DWC posted an update order to adopt 2014 relative value units, 2014 CPT codes, and updated conversion factors. Both of those revisions were in effect by January 1, 2014. Approximately once a month, DWC posts an update.

The new schedule is for services on or after January 1, 2014. There will also be annual updates of procedure codes, relative weights, inflation factor, and the Medicare relative value scale adjustment factor. There is a four-year transition between the pre-2014 OMFS maximum and the 120% of July 1, 2012 Medicare physician fees (before inflation and RVS adjustment). SB 863 required the inclusion of payment ground rules that differ from Medicare as appropriate for workers' compensation.

The adoption of the RBRVS results in general practitioners receiving higher fees and specialists, such as surgeons and radiologists, having reduced fees. DWC has heard concerns that specialists will be refusing to treat workers' compensation patients. However, these statements are usually made by parties who have an economic interest. DWC is monitoring injured workers' medical access via the medical access reports.

4. *Copy Service Fee Schedule:* The proposed regulations provide for a maximum flat fee of \$180 for records up to 500 pages and include all associated services such as pagination, witness fees, and subpoena preparation. For more than 500 pages, an additional per page fee of 20 cents per page is allowed. Certificates indicating that there are no records would be payable at a maximum of \$100. In workers' compensation, the claims administrator pays for the copies requested by both the defense and the applicants. The fee schedule is expected to reduce costs primarily by reducing disputes and allowing parties to utilize IBR instead of filing liens if there are disputes.

Appendix A: SB 863 Fee Schedules

5. *Interpreter Fee Schedule:* DWC is currently waiting for the study and recommendations to be finalized by the Berkeley Research Group. The interpreter fee schedule is separate from the rulemaking regarding the interpreter certification process that is already in effect. The current interpreter fee schedule (8 CCR section 9795.3) provides that for appeals board hearings, arbitration, or deposition, the fee is the greater of a half or full day at Superior Court rate or market rate. For all other events, the fee is \$11.25 per quarter hour with two-hour minimum or market rate. Having a fee schedule that is not tied to “market rate” should reduce costs by reducing disputes and allowing the parties to utilize IBR to resolve fee disputes instead of filing liens.
6. *Home Health Fee Schedule:* DWC has contracted with RAND to provide a study and recommendations. The statute, as written, appears to limit DWC to fee schedules contained in Medicare’s home health agency schedule (which applies to a “60-day episode of care” and is not appropriate) and California’s In-Home Supportive Services (IHHS) (which is limited to “attendant care services,” meaning non-skilled services, and sets inadequate rates). The preliminary RAND study suggests adopting a combination of other schedules, including the Federal Office of Workers’ Compensation Programs and the VA schedule. DWC has suggested language for a legislative change that would allow more flexibility to adopt other governmental fee schedules. (See [Appendix D3](#) for more information.)
7. *Vocational Expert Fee Schedule:* Labor Code section 5307.7 authorizes the Administrative Director to adopt a fee schedule for services provided by vocational experts and expert testimony determined to be reasonable, actual, and necessary by the appeals board.

Please note that [Appendix B](#), the list of all the regulations issuing from SB 863, includes information about the regulations that created these new fee schedules.

Petition for Writ of Mandate on the IMR Process

Francis Stevens v. WCAB; SCIF; & DWC, California Court of Appeals, First Appellate Dist., Division 1 (1st Civ. Case No. A141435)

This petition for writ of mandate/review was filed on April 3, 2014 by Joe Waxman, a San Francisco applicant's attorney. Waxman has also filed an IMR appeal with the San Francisco district office of the WCAB.

The writ challenged the constitutionality of Labor Code section 4610.6 (the IMR process) and asserts the following:

1. allowing an anonymous physician to render a decision adverse to the treating physician with no review by a judge or court is a denial of due process,
2. the inability to cross-examine the anonymous reviewer physician is a denial of due process, and
3. the IMR process is not expeditious¹² and therefore violates the California constitutional requirement for substantial justice in all cases expeditiously and without encumbrance.

In its response, DWC defended the constitutionality of the IMR provisions and argued that the petitioner must first exhaust her administrative remedies. On June 17, 2014, the appellate court denied the petition for writ of mandate. The petitioner did not file an appeal to the State Supreme Court.

The appellate court does not state why it denied the writ. The petitioner failed to exhaust her administrative remedies but now has a petition for reconsideration on file with the WCAB. If the WCAB orders that the injured worker is entitled to a new IMR and the requested treatment is granted, there would be no basis for the writ. Nonetheless, similar cases exist where IMR denied the requested treatment and the injured worker is contending that the statute is unconstitutional, so DWC can expect to see other petition for writs on this matter in the near future.

¹² The petitioner's IMR application was filed on 8/14/13 and the determination did not issue until 2/2/14.

Lien Activation and Filing Fee Cases

(1) *Angelotti Chiropractic v. Christine Baker, et al.*, Ninth Circuit Court of Appeals, Case No. 13-56996

In this case, the plaintiffs, who are providers of medical treatment and medical-legal services, challenged the lien activation fee on the grounds that the fee violates the equal protection, due process, and “takings” protections in the US Constitution.

Defendants filed a petition to dismiss the matter, and the plaintiffs filed a petition for a preliminary injunction to immediately stop collection of the fees, and to stop dismissal of liens based on failure to pay the fee.

The petitions were heard jointly and Judge Wu of the Central District Court in Los Angeles dismissed the due process and “takings” claims, but allowed the equal protection challenge to stand. He also issued a preliminary injunction barring the activation fees and dismissals for failure to pay, as the plaintiffs requested. Accordingly, DWC is no longer collecting or enforcing the activation fee requirement.

Both sides have appealed their respective adverse rulings, and the Ninth Circuit has granted the parties’ joint request to consolidate the appeals.

The appeal is fully briefed and awaiting docketing for oral argument.

(2) *Angelotti Chiropractic v. Christine Baker, et al.*, C.D. Cal., Case No. SA CV 13-01139-GW (JEMx)

Status conference scheduled for August 14, 2014. The parties may stipulate to continue this date given that no decision has been reached on the appeal.

Discovery has been stayed pending the appeal.

The parties agreed that plaintiffs could amend the complaint during the pendency of the stay to assert any new claims that are not likely to be impacted by the Ninth Circuit’s decision in the pending appeal. The parties also agreed that any motion to dismiss such new claims would proceed in the district court without regard to the stay. It is expected that the Plaintiff will amend to seek an injunction against the filing as well as the activation fee. No such amendment has been filed or served as of this date.

(3) *Chorn v. Brown, et al.*, LASC Case No. BC528190

The trial court denied plaintiff’s motion for preliminary injunction on the grounds that it lacked subject matter jurisdiction based on *Greener v. Workers’ Comp. Appeals Bd.* (1993) 6 Cal.4th 1028.

Plaintiff filed a Notice of Appeal on April 21, 2014.

Plaintiff’s counsel also stated that he would be filing a petition for writ of mandate, but no petition has been filed or served as of this date.

(4) *Chorn v. Brown, et al.*, CA Court of Appeal, Second Appellate District, Case No. B255939

On February 24, 2014, the court denied plaintiff’s motion for preliminary injunction on the grounds that it lacked subject matter jurisdiction based on *Greener v. Workers’ Comp. Appeals Bd.* (1993) 6 Cal.4th 1028. This case, also filed by a medical provider, was filed as a class action and raises issues under the California Constitution on essentially the same bases as those

Appendix B: Litigation

asserted in *Angelotti v. Baker*. It also attacks both the lien activation and lien filing fees, seeks reimbursement of all fees paid by all lien claimants to date, and attacks SB 863's limitations on assignments of liens. Plaintiff appealed. The clerk has estimated that the record on appeal will be filed on or about September 5, 2014. Plaintiff's opening brief will be due 40 days after the record on appeal is filed.

(5) *Chorn v. Brown, et al.*, U.S.D.C., C.D. Cal Case No. CV13-06519-GW(JEMx)

Voluntarily dismissed without prejudice on February 3, 2014.

(6) *Kancilia v. Brown, et al.*, U.S.D.C., S.D. Cal Case No. CV13-02737

Voluntarily dismissed without prejudice by the plaintiff on January 24, 2014.

(7) *Kancilia v. Brown, et al.*, San Diego Superior Court Case No. 37-2013-00076513-CU

Voluntarily dismissed without prejudice by the plaintiff on January 22, 2014.

Appendix C: Complete List of SB 863 Regulations

| SB 863 Implementation Completed Regulations | Status | Next Steps | Effective Date Per Labor Code |
|--|---|--|---|
| Ambulatory Surgery Center (ASC) Fee Schedule Non APA rulemaking Labor Code § 5307.1 | Completed, Effective: Jan. 1, 2013 Revised effective date: Sept. 1, 2014 | Completed Revised | Jan. 1, 2013 |
| Spinal Implant (Inpatient Fee Schedule) Non APA rulemaking Labor Code § 5307.1 | Completed, Effective: Jan. 1, 2013 | Completed | Jan. 1, 2013 |
| Interpreter Certification Gov't Code §§ 9795.1, 9795.1.5, 9795.1.6, 9795.3 and 9795.5 Labor Code §§ 4600, 5811 | Completed, Effective: Aug. 13, 2013 (Emergency regulations were in effect 1/1/13) | Certificate of Compliance Completed Final Regulations effective: Aug. 13, 2013 | Jan. 1, 2013 Extended to March 1, 2014 per AB 1376 |
| Qualified Medical Evaluator Regulations and Permanent Disability Rating Determination (QME) Labor Code §§ 139.5, 4610, 4610.5, 4610.6 | Completed, Effective: Sept. 16, 2013 (Emergency regulations were in effect 1/1/13) | Certificate of Compliance Completed Final Regulations effective: Sept. 16, 2013 | For injuries on or after Jan. 1, 2013; For decisions communicated on or after July 1, 2013 |
| Supplemental Job Displacement Benefit (SJDB) Labor Code §§ 4658.5, 4658.6, 4658.7 | Completed, New forms effective: Jan. 1, 2014 (Emergency regulations were in effect 1/1/13) | Certificate of Compliance Completed New forms effective: Jan. 1, 2014 | Jan. 1, 2013 |
| Official Medical Fee Schedule: Physician Fee Schedule (RBRVS) Non-APA Rulemaking Labor Code § 5307.1 | Completed, Effective: Jan. 1, 2014 | Completed Revised | Jan. 1, 2014 |
| Electronic document filing and lien filing fees Labor Code § 4903, 4903.05, 4903.06, and 4903.07 | Completed, Effective: Dec. 16, 2013 (Emergency regulations were in effect 1/1/13) | Certificate of Compliance Completed Final Regulations effective: Dec. 16, 2013 | Jan. 1, 2013 |
| Independent Bill Review; Standardized Paper Billing and Payment; Electronic Billing and Payment Labor Code §§ 139.5, 4603.2, 4603.3, 4603.4, 4603.6, and 4622 | Completed, Effective: Feb. 12, 2014 (Emergency regulations were in effect 1/1/13) | Certificate of Compliance Completed Final Regulations effective: Feb. 12, 2014 | For dates of service on or after Jan. 1, 2013 |

Appendix C: Complete List of SB 863 Regulations

| | | | |
|---|---|---|---|
| | effect 1/1/13) | effective: Feb. 12, 2014 | |
| Independent Medical Review (IMR) Utilization Review (UR) (including Request for Authorization form) and IMR Labor Code §§ 139.5, 4610, 4610.5, and 4610.6 | Completed, Effective: Feb. 12, 2014 (Emergency regulations were in effect 1/1/13) | Certificate of Compliance Completed Final Regulations effective: Feb. 12, 2014 | For injuries on or after Jan. 1, 2013; For decisions communicated on or after July 1, 2013 |
| Predesignation/Chiropractor Primary Treating Physician Regular Rulemaking Labor Code § 4600 | Completed Filed with Sec. of State: Feb. 12, 2014 | Regulations effective: July 1, 2014 | Jan. 1, 2013 |
| SB 863 Implementation Regulations in Progress | Status | Next Steps | Effective Date Per Labor Code |
| Copy Services Fee Schedule Regular rulemaking Labor Code § 5307.9 | Issued Notice of Rulemaking | Public hearing: July 1, 2014 | Dec. 31, 2013 |
| Medical Provider Network (MPN) Regular Rulemaking Labor Code § 4616 | Public hearing: Sept. 30, 2013 1st 15-day comment period: Dec. 26, 2013 2nd 15-day comment period: March 25, 2014 3rd comment period: May 19, 2014 | Review comments, submit to OAL for review | Jan. 1, 2014 |
| Interpreter Fee Schedule Non APA Rulemaking Labor Code § 5811 | Conducting study | Post study | Jan. 1, 2013 |
| Home Health Care Fee Schedule Regular rulemaking Labor Code §§ 4600 and 5307.8 | Working group meeting: Oct. 2, 2012 Conducting study | Post draft regulations on DWC forum | July, 1, 2013 |
| Vocational Expert Fee Schedule Regular rulemaking Labor Code § 5307.7 | Working group meeting: June 28, 2012 | Post draft regulations on DWC forum | |

Appendix D: WCAB Decisions on SB 863 Cases

WCAB En Banc Decisions:

Home Health

Roque Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.; Tower Point National Insurance Company, administered by Tower Select Insurance

June 12, 2014

Case No: ADJ7995806

79 Cal. Comp. Cases

With regard to the SB 863 additions and amendments to the Labor Code regarding home health care services, which became effective January 1, 2013, the Appeals Board held as follows:

1. Sections 4600(h), 4603.2(b)(1), and 5307.8 apply to requests for home health care services in all cases which are not final regardless of date of injury or dates of service.
2. The prescription required by section 4600(h) is either an oral referral, recommendation or order for home health care services for an injured worker communicated directly by a physician to an employer and/or its agent; or, a signed and dated written referral, recommendation or order by a physician for home health care services for an injured worker.
3. Under section 4600(h) to which home health care services are subject, either section 5307.1 or section 5307.8; section 5307.1 applies where an official medical fee schedule or Medicare schedule covers the type of home health care services sought; and otherwise, section 5307.8 applies.

UR/IMR

Jose Dubon v. World Restoration, Inc.; and State Compensation Insurance Fund

May 22, 2014

Case No: ADJ4274323 (ANA 0387677) - ADJ1601669 (ANA 0388466)

79 Cal. Comp. Cases

The Appeals Board granted State Compensation Insurance Fund's petition for reconsideration of the February 27, 2014 Opinion and Decision After Reconsideration (En Banc) wherein the Appeals Board previously held that the Workers' Compensation Appeals Board may determine if a UR decision suffered from material defects that undermine the integrity of the decision, and if so, it may then determine the medical necessity issue based on substantial medical evidence. (See *Dubon v. World Restoration, Inc.* (2014) 79 Cal.Comp.Cases 313 (Appeals Board en banc) (Dubon).) The Appeals Board granted reconsideration in order to allow sufficient opportunity to further study the factual and legal issues, noting that the prior decision remains in effect and binding pending a decision after reconsideration in the present matter.

In the February 27, 2014 *Dubon* decision, the WCAB held that the UR decision was invalid, that the UR decision therefore was not subject to Independent Medical Review (IMR), and that the Workers' Compensation Judge must then determine the medical necessity of the requested treatment based on substantial medical evidence. The Appeals Board specifically held as follows:

1. MR solely resolves disputes over the medical necessity of treatment requests. Issues of timeliness and compliance with statutes and regulations governing UR are legal disputes within the jurisdiction of the WCAB.

Appendix D: WCAB Decisions on SB 863 Cases

2. A UR decision is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the UR decision. Minor technical or immaterial defects are insufficient to invalidate a defendant's UR determination.
3. If a defendant's UR is found invalid, the issue of medical necessity is not subject to IMR but is to be determined by the WCAB based upon substantial medical evidence, with the employee having the burden of proving the treatment is reasonably required.
4. If there is a timely and valid UR, the issue of medical necessity shall be resolved through the IMR process if requested by the employee.

Medical-Legal Liens

Luis Martinez v. Ana Terrazas; Allstate Insurance Co., Administered by Specialty Risk Services

May 7, 2013

Case No: ADJ7613459

78 Cal. Comp. Cases 444

Where a medical-legal lien claim for copy costs was filed before January 1, 2013, and after January 1, 2013, it was withdrawn and re-filed as a petition for costs under Labor Code section 5811, the Appeals Board held as follows:

1. A claim for medical-legal expenses may not be filed as a petition for costs under section 5811.
2. Medical-legal lien claimants who withdrew their liens and filed petitions for costs prior to this decision may pursue recovery through the lien process if they comply with the lien activation fee requirements of section 4903.06 and if their liens have not otherwise been dismissed.

Lien Activation Fee

Eliezer Figueroa v. B.C Doering Co.; Employers Compensation Insurance Fund

April 25, 2013

Case No: ADJ3274228 (AHM 0120365)

78 Cal. Comp. Cases 439

The Appeals Board held that, where a lien claim falls within the lien activation fee requirements of Labor Code section 4903.06:

1. The lien activation fee must be paid prior to the commencement of a lien conference, which is the time that the conference is scheduled to begin, not the time when the case is actually called.
2. If the lien claimant fails to pay the lien activation fee prior to the commencement of a lien conference and/or fails to provide proof of payment at the conference, its lien must be dismissed with prejudice.
3. A breach of the defendant's duty to serve required documents or to engage in settlement negotiations does not excuse a lien claimant's obligation to pay the lien activation fee.
4. A notice of intention is not required prior to dismissing a lien with prejudice for failure to pay the lien activation fee or failure to present proof of payment of the lien activation fee at a lien conference.

Appendix D: WCAB Decisions on SB 863 Cases

WCAB Significant Panel Decision:

Lien Activation Fee

Maria Elena Mendez v. Le Chef Bakery; Pacific Compensation Insurance Co

April 25, 2013

Case No. ADJ6509620 ADJ6509621

78 Cal. Comp. Cases 454

The Appeals Board panel held that under Labor Code section 4903.06, a lien claimant is not required to pay a lien activation fee prior to a 2013 lien trial where: (1) the declaration of readiness (DOR) is filed prior to January 1, 2013; (2) the lien conference takes place prior to January 1, 2013; and (3) the lien trial takes place in 2013, without any intervening 2013 lien conference.