

SB 863: Assessment of Workers' Compensation Reforms

July 2015

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Introduction

SB 863 was enacted to improve medical care for injured workers and increase compensation for permanent partial disabilities while simultaneously reducing costs for employers. The bill was passed on Aug. 1, 2012, and signed into law by Governor Brown on Sept. 18, 2012. The bill took effect on Jan. 1, 2013.

The Department of Industrial Relations (DIR) and the Division of Workers' Compensation (DWC) have continued to oversee its implementation. The statutory permanent disability benefit increases took effect on Jan. 1, 2013, and Jan. 1, 2014, and the regulations to implement the new Return-to-Work Supplement Program went into effect on April 13, 2015, for dates of injury on or after Jan. 1, 2013.

In addition to increased benefits, one of SB 863's goals is to improve the delivery of medical benefits. By requiring the use of evidence-based medicine to guide treatment decisions and having disputed medical treatment decisions settled by independent medical reviewers, SB 863 addresses that goal. The reforms also improved the Medical Provider Networks (MPNs) by improving injured workers' access to network physicians and giving DWC increased regulatory oversight.

Savings are being realized. On May 7, 2015, the California Insurance Commissioner approved the advisory pure premium rates proposed by the Workers' Compensation Insurance Rating Bureaus (WCIRBs), rates that average \$2.46 per \$100 of payroll, effective July 1, 2015. These rates are, on average, 5% less than the industry average for filed pure premium rates as of Jan. 1, 2015, and 10.2% less than the average of the approved Jan. 1, 2015, advisory pure premium rates of \$2.74. Although insurers are not required to adhere to the Insurance Commissioner's advisory pure premium rates, the WCIRB's recommendation and the Commissioner's decisions demonstrate a substantial reduction in costs to employers as the effects of SB 863 continue to play out.

This report updates last year's analysis of the impacts of SB 863 and is intended to report on the changes, the accomplishments, the opportunities for improvement, and the ongoing challenges of the reforms.

Key Points

- SB 863 increased permanent disability (PD) benefits approximately 30% in two steps. Prior to SB 863, the minimum weekly PD benefit was \$130 and the maximum was \$270. For dates of injuries on or after Jan. 1, 2013, the new minimum weekly PD benefit is \$160. The new maximum weekly PD rate for

injuries on or after Jan. 1, 2013 ranges from \$230 to \$290 depending on the PD rating, and for all injuries on or after Jan. 1, 2014, the maximum weekly PD rate is \$290.

- The Return-to-Work Supplemental benefits are in effect and being disbursed.
- More than 12 sets of regulations were enacted to implement SB 863. Additional sets of regulations covering home healthcare and interpreters are in process
- The IMR process and revisions to the Medical Treatment Utilization Schedule (MTUS) show the renewed focus on evidence-based medicine.
- IMR decisions are issued well within the statutory timeframe from receipt of medical records.
- MPNs with increased accountability are being approved.
- After SB 863, lien filings went down by approximately 60% but have increased in the first quarter of 2015.
- The change in the Ambulatory Surgical Centers (ASC) fee schedule generates approximately \$30 million in annual industry savings.
- The WCIRB announced a 3.3% reduction in medical costs for 2014.
- Insurance Commissioner Jones issued an advisory 10% reduction in premiums, effective July 2015, compared to the advisory premiums effective just six months earlier.

Accomplishments

Evidence-Based Medicine: Using the Best Available Evidence to Guide Treatment Decisions

California is a leader in advocating that medical treatment in the workers' compensation system be guided by evidence-based decisions, having established the principle with the passage of SB 228 in 2003. In enacting SB 863, the Governor and Legislature declared their continued commitment to evidence-based medicine, stating that its use is necessary to provide injured workers the highest quality of medical care. SB 863 further solidified the societal goal of providing optimal medical care to workers by creating an Independent Medical Review (IMR) program in which medical experts, not legal experts, ultimately determine the necessity of requested treatment using evidence-based medicine.

Evidence-based medicine is a systematic method of making clinical decisions which involves applying the best available scientific evidence to recommend the most appropriate treatment for individual patients. By encouraging practices that have been proven to work and discouraging those that are ineffective or harmful, evidence-based

medicine results in better care, which translates to better health outcomes and fewer wasted resources. Without the proper application of evidence to guide healthcare decisions, patients may receive treatment of little or no value if it is based on profit, habitual practice, misinformation, or fraud. While science is continually expanding the number of available treatment options, the latest development is not necessarily the best approach. Evidence-based medicine requires doctors to apply a standardized process to evaluate the available treatment options and to consider the possible outcomes before making a recommendation to individual patients.

Evidence-based guidelines assist individual physicians in evaluating the medical evidence. Qualified professional organizations conduct systematic reviews of the medical literature, summarize the findings, and produce medical treatment guidelines containing recommendations supported by scientific evidence. Examples of evidence-based recommendations include the following¹:

- Opioids (narcotics) should not be first-line medications for mild or chronic pain. Opioids can be helpful for severe, short term pain—like pain after surgery for a broken bone. They can also help manage pain from cancer. However, opioids have serious side effect and risks, and other pain treatments may work better and entail fewer risks.
- Bed rest for lower back pain should be limited to one to two days. Longer bed rest can lead to slower recovery. Physical therapy and activities such as walking will result in faster recovery.
- X-rays are not necessary for mild low-back pain. X-rays result in unwanted radiation exposure and do not help in managing most low-back pain.

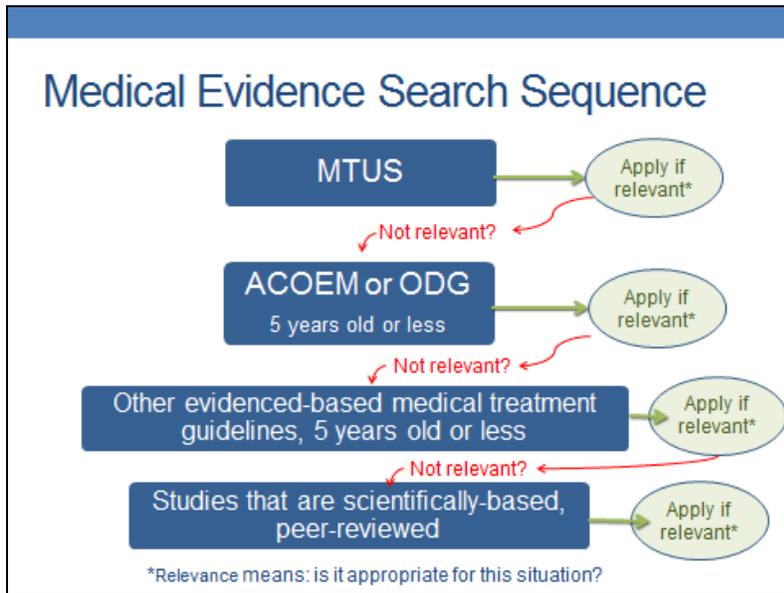
In 2003, the Legislature provided for a Medical Treatment Utilization Schedule (MTUS), a set of evidence-based medical treatment guidelines to be applied when treating injured workers. The DWC administrative director is charged with incorporating the MTUS into regulation (Labor Code sections 5307.27 and 4604.5; sections 9792.20 et seq. of Title 8, California Code of Regulations). The MTUS helps medical providers understand which evidenced-based treatments are most effective in providing better medical outcomes for workers.

The MTUS is presumed to be correct regarding the most appropriate medical treatment for common conditions among injured workers. Nonetheless, since no treatment guideline can address all individual patients or all possible medical conditions and as scientific understanding of the best medical treatment is constantly evolving, allowances

¹ Choosing Wisely. American Board of Internal Medicine Foundation. Things Providers and Patients Should Question. <http://www.choosingwisely.org/clinician-lists/>

are made for when treatment can be based on guidance other than the MTUS. The MTUS describes a Medical Evidence Search Sequence that must be followed to make the best evidence-based clinical decisions for injured workers. A schematic of this methodology is shown on the next page.

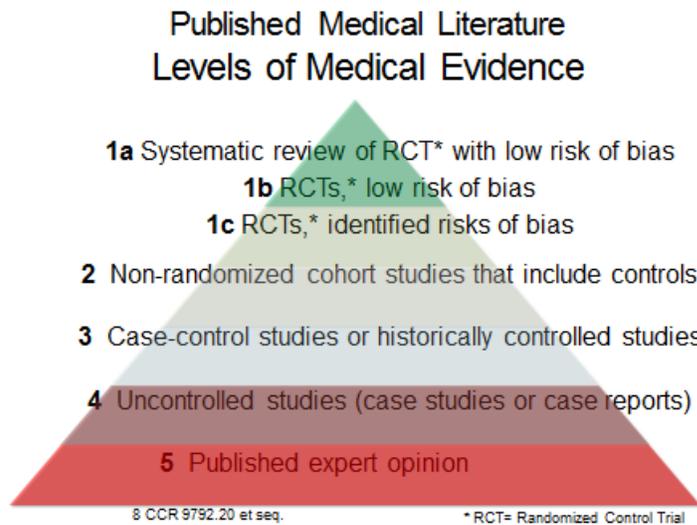
Figure 1: Recommended sequence for medical evidence searches



ACOEM: American College of Occupational and Environmental Medicine
ODG: Official Disability Guidelines

Furthermore, the MTUS specifies the methodology necessary for evaluating published scientific evidence. It ranks high-quality scientific studies without bias at the top of the hierarchy of evidence and published expert opinion at the bottom. Information that is not published in a peer-reviewed scientific journal is not considered medical evidence. The MTUS evidence ranking scheme is shown on the next page.

Figure 2: Hierarchy of medical evidence



When a dispute arises regarding the appropriateness of the treatment for an individual worker, it is important to have the final determination made by an independent medical professional trained to understand the science and interpret guidelines. This independent medical reviewer must be free from financial incentives or other biases that may affect either the treating physician or the utilization review physician. Accordingly, SB 863 provides for DWC to contract with an independent medical review organization that is free of biases or conflicts of interest. Independent medical review places the final determination of disputed medical treatments into the hands of the experts most capable of ensuring that patients get the best possible treatment for their injuries.

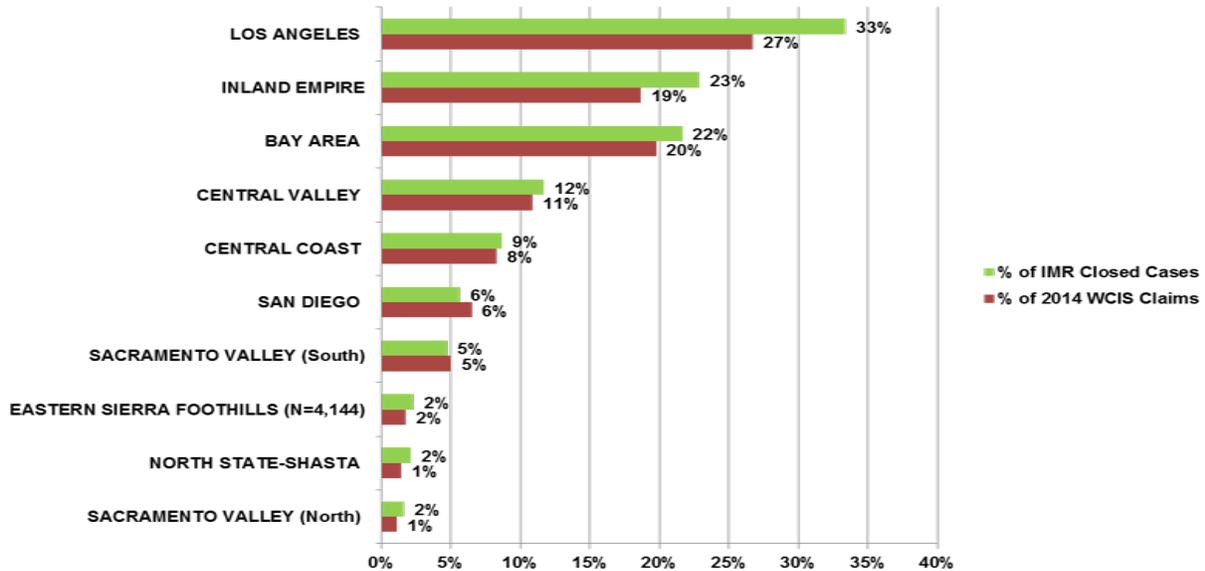
Independent Medical Review

Independent Medical Review (IMR) is available to a worker who receives a utilization review (UR) decision stating that a physician's treatment request is being denied or modified on the basis of medical necessity. To request IMR, the worker must submit a signed IMR application along with a copy of the UR decision within 30 days of the denial or modification. The IMR application and supporting material is submitted to the Independent Medical Review Organization. Pursuant to statute, DWC has contracted with Maximus Federal Services ("Maximus"). Decisions are issued by physician reviewers selected by the IMR organization and matched by specialty to the nature of the medical dispute.

- In 2014, approximately 15,000 IMR applications were filed per month. The following chart indicates the percentage of IMR determinations by geographic area. The chart also indicates that compared to the number of claims filed, a

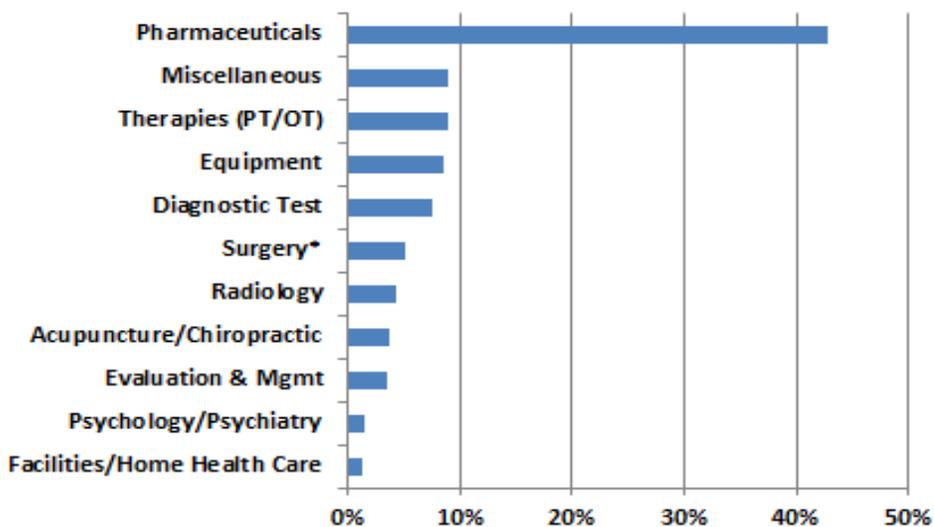
larger proportion of IMR appeals have been filed in Los Angeles and the Inland Empire than in other areas.

Figure 3: IMR determinations by geographic area, 2014



- The largest category of IMR treatment requests were for medications. As shown in the chart below, 42% of 2014 IMR treatment request decisions were for pharmaceuticals.

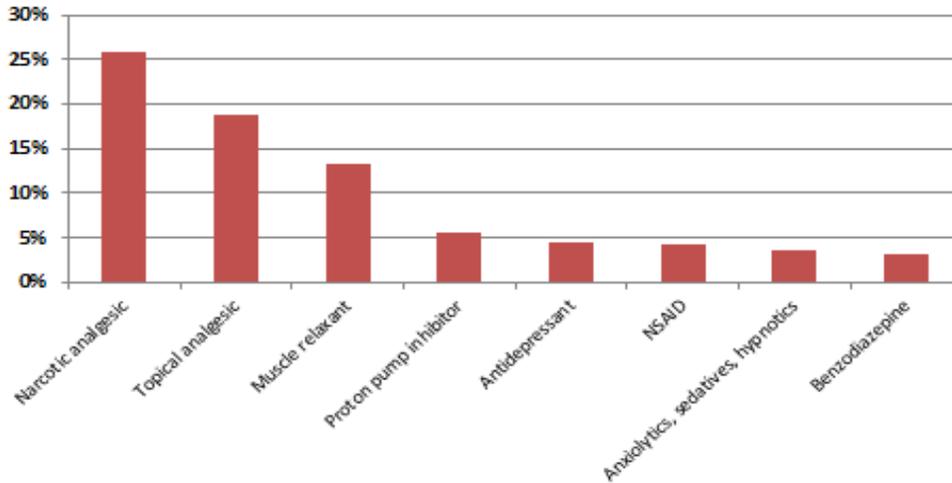
Figure 4: IMR treatment requests organized by treatment category, 2014



% of 339,146 treatment decisions.

- As the chart below shows, treatment requests for narcotic pain medications made up 26% of the pharmaceutical IMR treatment decisions, in other words, a little over 10% of all IMR treatment requests.

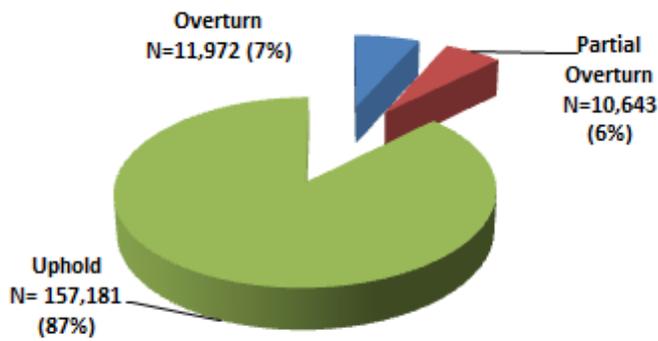
Figure 5: Pharmaceutical IMR treatment requests by subcategory, 2014



Random sample of 780 pharmaceutical IMR decisions from 2014.

- As the chart below shows, independent medical review determinations uphold the UR decisions in 87% of the final determinations.

Figure 6: Outcomes of final determination letters, 2014

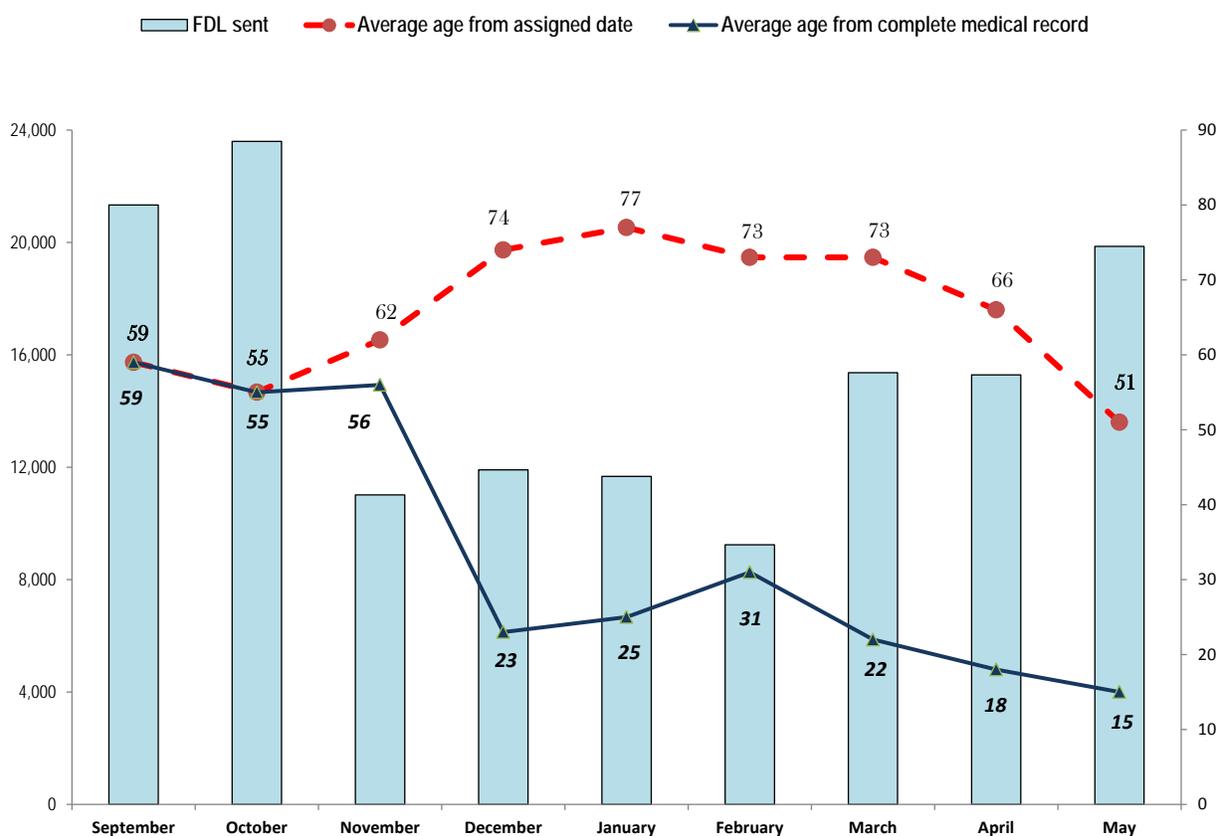


2014 IMR Final Determination Letters: N=179,796.

To maintain transparency, DWC posts determinations on the DWC website, frequently making updated data available to researchers. DWC also prepares an annual IMR analysis. The cost of IMR reviews has been reduced to from the 2013 cost of \$560 per standard IMR to \$390.

Although issues remain regarding the timely submittal of medical records by claim administrators and the proper documentation for appropriate care on behalf of the medical providers, final determination letters are now issued within the statutory time frames from the date of receipt of medical records, as the chart on the next page shows. DWC is addressing the issue of late record submission by issuing Orders to Show Cause re Assessment of Administrative Penalties to claims administrators who have failed to provide medical records requested by Maximus.

Figure 7: Timeliness of IMR final determination letters from date of assignment and date of receipt of complete medical records (September 2014–May 2015)

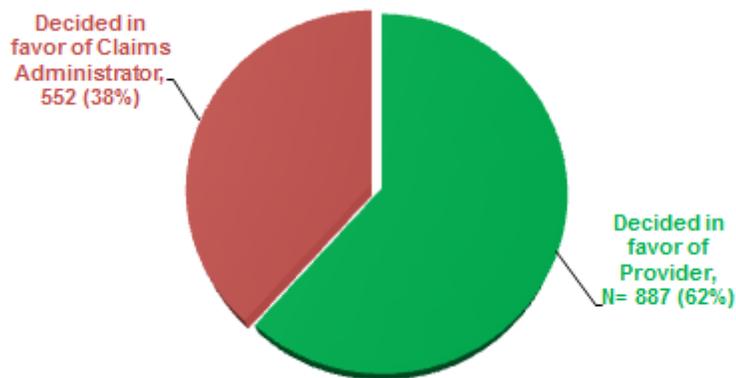


Independent Bill Review

SB 863 created an Independent Bill Review (IBR) program to ensure that disputes regarding payment for medical services are resolved by independent experts using established criteria and fee schedules and result in consistent and transparent decisions.

- Independent bill review is available for medical service providers who dispute the amount of payment following a second review. To request IBR, the provider must provide copies of the original billing, the explanation of review, the request for second review, along with any supporting documentation submitted with that request, and the final explanation of the second review within 30 days of receiving the adverse second review decision. The IBR application and supporting material are submitted to the IBR organization Maximus Federal Services, which has been chosen by DWC pursuant to statute. Decisions are issued by billing and coding experts who are employees of the IBR organization. The cost to process an IBR has also been reduced from \$335 in 2013 to \$195 in 2015.
- In 2014, there were 130 to 239 IBR applications received per month. As shown in the chart below, 62% of the disputes were decided in favor of the provider.

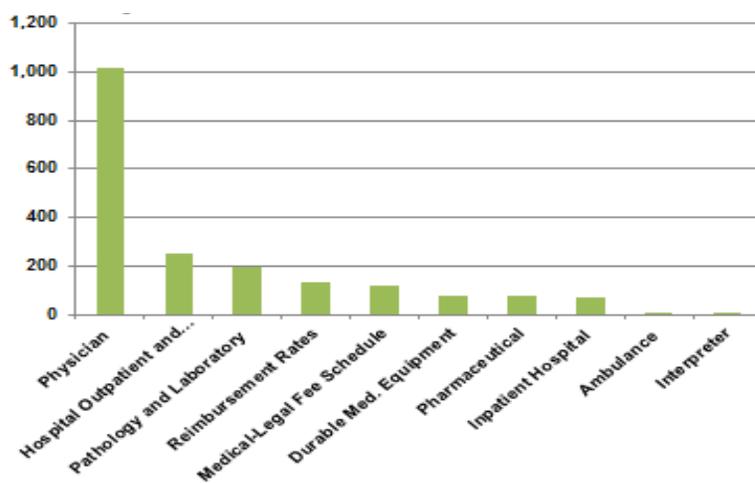
Figure 8: Outcomes of IBR decisions involving a single service



1,439 out of 1,952 IBR decisions through December 2014 disputed payment for a single service.

- The majority of IBR determinations are for physician fee disputes, as the following chart illustrates.

Figure 9: Most common physician services for IBRs



IBR Applications through December 2014: N=2,969.

Medical Treatment Utilization Schedule Updates

The DWC continually improves the Medical Treatment Utilization Schedule (MTUS) to ensure that it reflects current scientific medical knowledge and provides practical, high-quality guidance for the care of injured workers.

Recent regulatory updates to the MTUS (effective April 20, 2015) explain and clarify the scientific process by which evidence-based clinical decisions are made for injured workers. These regulations explain the principles of evidence-based medicine; clarify that the MTUS is the primary source of guidance for treating and reviewing physicians; and provide a transparent, systematic methodology to evaluate medical evidence and guide clinical decision making.

DWC recognizes the continued significant concern over chronic pain among injured workers. In response, updates are being made to the MTUS Chronic Pain Medical Treatment Guidelines. Additionally, to address the national epidemic of prescription drug misuse, DWC has proposed separate, stand-alone MTUS Opioids Treatment Guidelines. These guidelines will address the need to treat pain adequately while at the same time avoiding harmful health impacts. The remainder of the MTUS chapters will be updated in 2015. All proposed changes to the MTUS will go through the rulemaking process, which includes public comment.

Medical Provider Networks

One of SB 863's goals was to improve the Medical Provider Network (MPN) program by ensuring injured workers' access to physicians within MPNs and to provide more regulatory oversight. Regulations implementing SB 863's revisions to the MPN program went into effect on Aug. 27, 2014. The MPN regulations now require unique MPN Identification numbers to be assigned to each MPN. The unique identification number must be included on the notices sent to injured workers so that the injured workers can easily identify their specific MPN.

The MPN regulations provide that when an injury is reported, a complete MPN notification must be provided to the injured worker. The notification must include a description of the MPN services and the MPN's website address. It must also inform the injured worker how to access the MPN provider directory. The URL address for the provider directory must be listed with any additional information needed to access the directory online including any necessary instructions and passcodes.

To ensure that the MPN doctors are available to treat the injured workers, SB 863 requires that the MPN's physician listing must be updated at least quarterly. The regulations also provide that if a listed provider becomes deceased or is no longer treating workers' compensation patients at the listed address, the provider shall be taken off the provider directory within 45 days of notice to the MPN. More importantly, MPNs are now required to have MPN Medical Access Assistants who are available to assist injured workers in finding and scheduling medical appointments with MPN physicians.

The access standards have been clarified to require an MPN to have at least three available physicians from which an injured worker can choose; if the time and location access standards are not met, MPNs shall have a written policy permitting out-of-network treatment. MPN applicants are required to affirm that each MPN physician or medical group in the network has agreed to treat workers under the MPN and that the MPN applicant has obtained written acknowledgements from the physicians in which the physician affirmatively elects to be a member of the MPN.

The regulations also set forth a formal complaint process. If a violation of the regulations or statute exists and the MPN does not remedy the problem within 30 days, a complaint shall be filed with DWC.

Finally, DWC now has greater oversight of MPNs. DWC has the authority to issue penalties for failure to comply with the regulations, as well as place an MPN on

probation, and suspend or revoke an MPN. Not only does DWC now have authority to conduct random reviews of MPNs, but MPN certification must be renewed every four years.

Medical Expenses

The WCIRB estimates medical costs have decreased by 3.3% from 2013 to 2014. According to the WCIRB, this decrease is caused by the SB 863 reduction in the Ambulatory Surgical Center (ASC) fee schedule from 120% of Medicare outpatient fee schedule to 80% of Medicare's outpatient fee schedule and by the implementation of the resource based relative value scale (RBRVS) physician fee schedule. The decreases may also be due to other SB 863 reforms aimed at increasing quality and cost-efficient care.

ASCs account for approximately 5% of all annual industry medical payments (\$120 million). The WCIRB study indicated a 28% drop in payment per episode after the enactment of the new fee schedule and no evidence of a shift of services from ASCs to outpatient hospital settings. The change in ASC fees appears to generate approximately \$30 million in annual insurance savings.

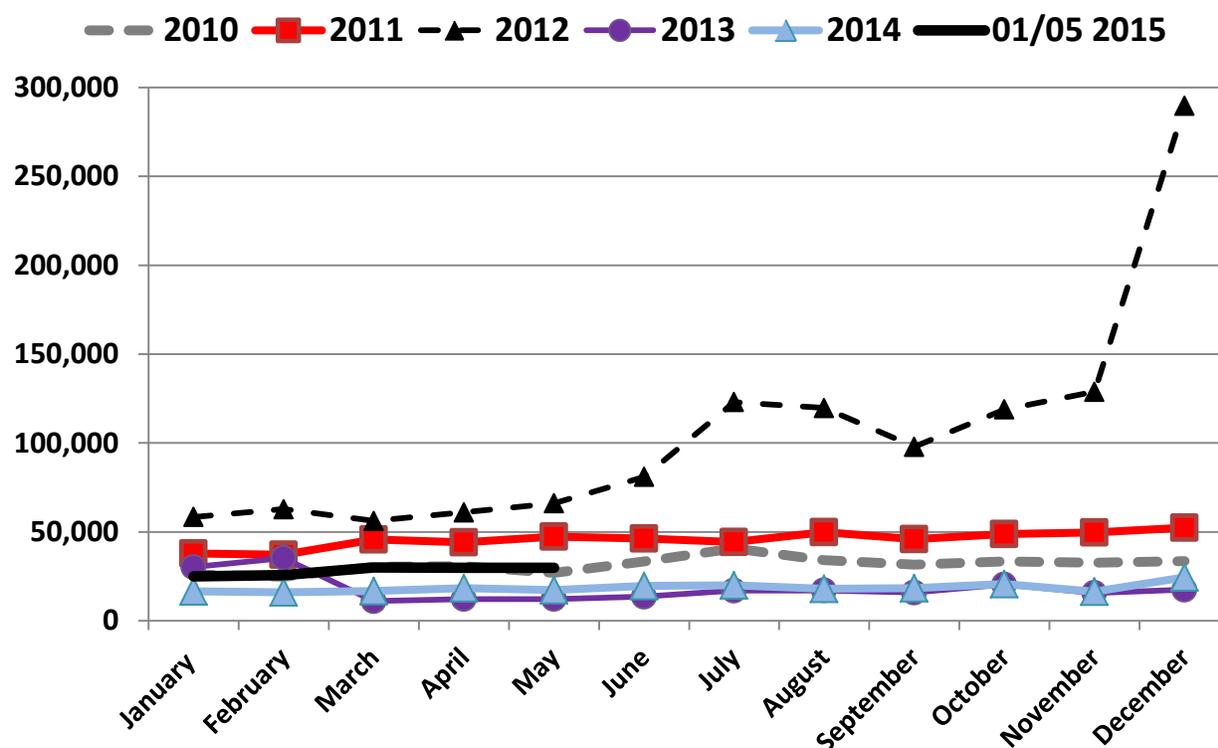
In addition, it appears that the new physician fee schedule, which covers approximately 45% of all workers' compensation medical payments, has resulted in medical cost savings. The overall reduction in physician fee schedule costs from 2013 to 2014 was largely driven by the 37% decline in payments for Special Services and Reports. Although the Primary Treating Physician's Progress Report (PR-2), the Primary Treating Physician's Permanent and Stationary Report (PR-3 or PR-4), and a Psychiatric Report Requested by the WCAB or the Administrative Director (other than medical-legal report) are separately reimbursable pursuant to title 8, CCR §9789.14, other treating physician reports are no longer separately reimbursable. Under the RBRVS physician fee schedule, the fee for record review and other reports are included within the fee for the underlying evaluation and management service.

Liens

SB 863 requires a provider to pay a \$150 filing fee for filing any new lien on or after Jan. 1, 2013. The bill also prohibits filing a lien more than three years after the date of service, or more than 18 months from the date of service if the date of service is on or after July 1, 2013. Lien filings dropped by 60% in 2013 and 2014. (A total of 549,392 liens were filed in 2011; 1,263,571 were filed in 2012; 217,954 in 2013; and 222,163 in 2014.) As a result, the WCIRB forecasts that the lien provisions will save \$690 million a year. However, as indicated in the following chart, lien filing in the first quarter of 2015

(80,664) has increased to the same level as lien filings in 2010 (81,263). The increase may be due to a surge of providers filing liens within the more restrictive 18-month statute of limitations, or it may just be an anomaly.

Figure 10: Number of new liens filed per month, January 2010–May 2015 (as of May 2015)



Return-to-Work Supplement Program

On April 13, 2015, DIR launched the Return-to-Work Supplement Program (RTWSP) for injured workers. This \$120 million per year fund, which will quickly get an additional \$5,000 to each eligible injured worker who has a disproportionate loss of earnings, is an important component of the workers' compensation reforms in SB 863. An online portal and kiosks connect to the portal in DWC offices across the state, allowing injured workers to easily file the application. All completed applications will be reviewed for eligibility within 60 days from the date of filing. Payment to workers will be made within 25 days of the eligibility determination.

As of June 30, 2015, DIR has made supplemental payments totaling \$2,170,000 to injured workers. DIR had received 508 applications for the one-time payment of \$5,000,

of which DIR had completed reviews of 454, and the remaining 54 applications were in the review process. Of the applications reviewed, 388 applications were deemed eligible, and 66 were denied, either because the person was injured before Jan. 1, 2013, or the application was incomplete or a duplicate.

Regulations Adopted to Implement the Reforms

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

Challenges

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 C](#).
- Lien Activation Fee Case: Lien activation fees were enjoined by a Federal court on Nov. 12, 2013, in the *Angelotti* case. On June 29, 2015, the Ninth Circuit Court of Appeals vacated the district court's preliminary injunction, affirmed the dismissal of plaintiffs' constitutional challenges, and reversed the district court's denial of defendants' motion to dismiss plaintiff's Equal Protection Claim. On July 13, the Angelotti plaintiffs filed a petition for rehearing.
- Lien Activation Fees: These fees have not been collected since the preliminary injunction was issued in November 2013 in the *Angelotti* case. Additionally, because of the injunction, liens filed prior to Jan. 1, 2013, for which the activation fee has not been paid have not been dismissed by operation of law (Labor Code section 4903.06(a)(5)), preventing the expected savings due to reduced friction costs. In anticipation that the activation fees will be reinstated, DIR is working to effectuate a transition between the effective date of the district court injunction on November 19, 2013, which prohibited lien claimants from paying the activation fee, and the original law, which would have dismissed all liens for which the lien activation fee had not been paid by January 1, 2014. 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.

See [Appendix C](#) 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, UR / IMR, medical-legal liens, and the lien activation fee.
- (See [Appendix D](#) for summaries of each decision.)

Pharmaceuticals

Pharmaceutical management has attracted attention because pharmaceuticals continue to be the fastest growing component of medical costs. According to the California Workers' Compensation Institute (CWCI), spending on pharmaceuticals comprised one out of every eight dollars spent on medical benefits paid for workers' compensation claims in 2013. WCIRB reports that the medical costs paid for pharmaceuticals increased 235% from accident year 2005 to accident year 2014. A 2010 report by the 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. Nearly half (42%) of the 2014 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. Twenty-six percent (26%) of the pharmaceutical IMR decisions were for narcotic analgesics.

Several factors contribute to high drug expenses, including lack of pricing control for pharmaceuticals, consolidation of pharmaceutical manufacturers, and supply chain and manufacturing inefficiencies. A lack of prescribing guidance provided to physicians compounds the problem. More expensive drugs are sometimes chosen when more cost-effective equivalents may be just as effective. Most importantly, without adequate evidence-based guidance and controls, drugs may be prescribed that are not medically necessary and may even be harmful to patients.

Evidence-based formularies provide the preferred solution to the problem of medically inappropriate pharmaceutical prescriptions and runaway costs. Formularies are widely used by group health insurance, hospitals, and the federal government, among others. A formulary contains a preferred drug list that is continually updated with evidence-based medicine. Formularies specify policies and procedures, (e.g., for dispensing), contain cost-containment strategies, and contain protocols to ensure appropriate medical care, (e.g., for access to non-formulary drugs when medically necessary).

Adoption of an evidence-based formulary involves a two-step process. First, an institution with expertise in evidence evaluation conducts a review of the evidence for medical appropriateness of drugs and drug classes for specific medical conditions and develops an initial list of recommended drugs. As a second step, a separate costs-assessment committee evaluates the initial list and decides the final list of drugs based on cost considerations. This two-step process ensures that scientific evidence is the basis of the formulary and that costs are considered independently. The DWC would be responsible for implementing the final formulary and for conducting education and outreach. An evidence-based formulary would improve care for workers and reduce costs in the workers' compensation system.

Next Steps

Ongoing efforts are being made to improve the workers' compensation system for employers and employees, and to address the delivery of medical treatment. In an effort to continue to reduce delays and confusion, DIR and DWC are working with labor and management and with the Commission on Health and Safety and Workers' Compensation (CHSWC) to find ways to lessen the reliance on a paper driven system.

Qualified Medical Evaluation Online Panel Process

DWC receives approximately 12,000 initial requests for panel Qualified Medical Evaluations (QMEs) per month. Almost 65% 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. DWC met with a focus group to make sure that the online program would address users' concerns and is undergoing rulemaking to implement the online request process. The new program will allow a party to electronically fill out the panel request form (QME 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 the necessary documentation in support of their request. 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, along with the names of the QMEs, will be provided. The regulations are scheduled to go into effect on Sept. 1, 2015, and the use of the online panel request process will be mandatory for represented parties as of Oct. 1, 2015.

Electronic Medical Reports

DIR and DWC are working to facilitate the use of electronic medical records and reports. To increase efficiency and timeliness, DWC will revise the IMR regulations to require electronic IMR applications and electronic medical record submission to the IMR organization. In addition, DWC will conduct public meetings with interested stakeholders to discuss ideas and obstacles regarding electronic health records. Finally, DWC will create a pilot program for an electronic submission of the Doctor's First Report of Occupational Injury or Illness (DLSR Form 5021).

Physician Education

DWC is committed to leading physician education regarding the MTUS and the use of evidence-based medicine. DWC expects that the educational project will launch in February 2016.

Regulatory

- The MTUS will be revised throughout 2015.
 - MTUS opioids and chronic pain guidelines should be completed by mid-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 late 2015.
- The Interpreter Fee Schedule and the Home Health Care Fee Schedule will be completed in 2015.
- Benefit Notice Regulations will be final in July 2015 and will have a Jan. 1, 2016, effective date.
- WCIS revisions for medical data reporting were filed with the secretary of state on April 6, 2015 and will go into effect April 6, 2016.
- Audit regulations will be scheduled for a public hearing this fall.
- See [Appendix B](#) for the complete list of SB 863 regulations.

Conclusion

The goals of SB 863 are being realized. While DIR and DWC continue to implement the recent workers' compensation reform, increased permanent disability benefits and the

return-to-work supplemental benefit for injured workers are in effect and are being delivered. With the continued emphasis on evidence-based medicine, injured workers will benefit from receiving medically appropriate treatment. In the IMR process, independent medical professionals apply the appropriate evidence-based medical standards within set timeframes to resolve treatment disputes. Improvements to the IMR process are ongoing and include better systems to reduce delays and increase efficiencies in submitting the IMR application and medical documentation. The recent reduction in the advisory pure premium rate and the WCIRB studies that show medical cost savings are positive indications that the SB 863 reform is reducing costs. It is anticipated that costs will continue to decrease as additional fee schedules go into effect, including the copy service fee, the interpreter fee, and the home health care fee schedules.

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. In March 2015, the Workers' Compensation Insurance Rating Bureau (WCIRB) reported that the reduction in payments has been slightly greater than the initial predictions, with a 27 % decrease in payments per episode and a 29% decrease in the payments per procedure from the pre-reform to the post-reform period. Additionally, there was no evidence of significant changes in service mix or intensity or shifts away from the ASC to the hospital setting.
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 Jan. 1, 2014, no additional fees for the spinal implant procedures are allowed. As of November 2014, WCIRB's estimate of a savings of \$110 million appears to be correct.
3. *Physician Fee Schedule (RBRVS)*: DWC adopted a new physician fee schedule based on the resource-based relative value scale (RBRVS) used in the Medicare Physician Fee Schedule, effective Jan. 1, 2014. Approximately once a month, the Division of Workers' Compensation (DWC) posts an update.

The new schedule is for services rendered on or after Jan. 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 Official Medical Fee Schedule (OMFS) maximum and the 120% of July 1, 2012, Medicare physician fees (before inflation and RVS adjustment). SB 863 required the inclusion of a number of payment ground rules that differ from Medicare as appropriate for workers' compensation.

The adoption of the RBRVS results in higher payments to general practitioners and lower payments to specialists, such as surgeons and radiologists.

APPENDIX A: SB 863 Fee Schedules

4. *Copy Service Fee Schedule:* The copy service fee schedule is effective July 1, 2015. The 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 10 cents per page is allowed. 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 over copying costs and by requiring parties to utilize Independent Bill Review (IBR) to resolve disputes instead of filing.
5. *Interpreter Fee Schedule:* In April 2015, DWC posted draft regulations to the online forum where members of the public may review and comment on the proposals. DWC expects to begin formal rulemaking for the interpreter fee schedule in July 2015. The interpreter fee schedule is separate from the rulemaking regarding the interpreter certification process already in effect. The current interpreter fee schedule (8 CCR section 9795.3) provides that for Workers' Compensation Appeals Board (WCAB) 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 which is not tied to "market rate" and which covers so many types of events 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 contracted with RAND to provide a study and recommendations, and in May 2015, DWC posted draft regulations to the online forum where members of the public could review and comment on the proposals. Home health services range from skilled nurses and therapy services provided by home health agencies to unskilled personal care or chore services that may be provided by personal care aides. The 2015 RAND study, entitled Home Health Care for California's Injured Workers—Options for Implementing a Fee Schedule, identifies options for a single fee schedule that would cover the full range of home health services. The proposed regulations set forth a payment methodology and fees for skilled care by licensed medical professionals and fees for unskilled personal and household services for injured. DWC expects to begin formal rulemaking for the home health fee schedule in July 2015.
7. *Vocational Expert Fee Schedule:* Labor Code section 5307.7 authorizes the Administrative Director to adopt a fee schedule for services provided by

APPENDIX A: SB 863 Fee Schedules

vocational experts and expert testimony determined to be reasonable, actual, and necessary by the WCAB.

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

APPENDIX B: SB 863 Regulations

Division of Workers' Compensation

SB 863 Implementation Division of Workers' Compensation (DWC) regulations	Status	Next Steps	Effective Date Per Labor Code
Ambulatory Surgery Center (ASC) Fee Schedule Sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.36, 9789.37, 9789.38 and 9789.39	Completed, Effective: Jan. 1, 2013	Completed	Jan. 1, 2013
Copy Services Fee Schedule Sections 9980, 9981, 9982, 9983, 9984, 9990, 9992, 9994, and 10208.7	Completed, Effective: July 1, 2015	Completed	Dec. 31, 2013
Electronic document filing and lien filing fees Sections 10205, 10205.12, 10206, 10206.1, 10206.2, 10206.3, 10206.4, 10206.5, 10206.14, 10206.15, 10207, 10208 and 10208.1	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Dec. 16, 2013	Completed	Jan. 1, 2013
Home Health Care Fee Schedule Labor Code §§ 4600, 5307.8	Posted draft regulations on DWC forum: May 17, 2015	Issue Notice of Rulemaking	July, 1, 2013
Independent Bill Review (IBR); Standardized Paper Billing and Payment; Electronic Billing and Payment Sections 9792.5.1, 9792.5.3, 9792.5.4, 9792.5.5, 9792.5.6, 9792.5.7, 9792.5.8, 9792.5.9, 9792.5.10, 9792.5.11, 9792.5.12 9792.5.13, 9792.5.14, 9792.5.15, 9793, 9794, 9795	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Feb. 12, 2014	Completed	For dates of service on or after Jan. 1, 2013

APPENDIX B: SB 863 Regulations

<p>Independent Medical Review (IMR) Sections 9785, 9785.5, 9792.6, 9792.6.1, 9792.9, 9792.9.1, 9792.10, 9792.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.7, 9792.10.8, 9792.10.9, 9792.12</p>	<p>Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Feb. 12, 2014</p>	<p>Completed</p>	<p>For injuries on or after Jan. 1, 2013; For decisions communicated on or after July 1, 2013</p>
<p>Interpreter Certification Sections 9795.1, 9795.1.5, 9795.1.6, 9795.3 and 9795.5</p>	<p>Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Aug. 13, 2013</p>	<p>Completed</p>	<p>Jan. 1, 2013</p>
<p>Interpreter Fee Schedule Sections 9930 et seq.</p>	<p>Posted draft regulations on DWC forum: May 18, 2015</p>	<p>Issue Notice of Rulemaking</p>	<p>Jan. 1, 2013</p>
<p>Medical Provider Network (MPN) Sections 9767.5.1 and 9767.16.5 - 9767.19</p>	<p>Completed, Effective: Aug. 27, 2014</p>	<p>Completed</p>	<p>Jan. 1, 2014</p>
<p>Official Medical Fee Schedule: Physician Fee Schedule Sections 9789.12.1 - 9789.19</p>	<p>Completed, Effective: Jan. 1, 2014</p>	<p>Completed</p>	<p>Jan. 1, 2014</p>
<p>Official Medical Fee Schedule: Physician Fee Schedule Sections 9789.10 - 9789.19</p>	<p>Completed, Effective: Jan. 1, 2014</p>	<p>Completed</p>	<p>Jan. 1, 2014</p>
<p>Predesignation/Chiropractor Primary Treating Physician</p>	<p>Completed, Effective</p>	<p>Completed</p>	<p>Jan. 1, 2013</p>

APPENDIX B: SB 863 Regulations

Sections 9780, 9780.1, 9783, 9783.1, and 9785	July 1, 2014		
Qualified Medical Evaluator (QME) Regulations and Permanent Disability Rating Determination Sections 1, 11, 11.5, 14, 17, 26, 30, 31.2, 31.3, 31.5, 31.7, 32, 33, 34, 35, 35.5, 36, 37, 38, 100, 104, 105, 106, 109, 110, 112, 117, 10159 and 10160	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Sept. 16, 2013	Completed	For injuries on or after Jan. 1, 2013; For decisions communicated on or after July 1, 2013
Spinal Implant (Inpatient Fee Schedule) Sections 9789.20, 9789.21, 9789.22, and 9789.25	Completed, Effective: Jan. 1, 2013	Completed	Jan. 1, 2013
Supplemental Job Displacement Benefit (SJDB) Sections 9813.1, 10116.9, 10117, 10118, 10133.31 through 10133.36, 10133.51, 10133.52 10133.53, 10133.55, 10133.56, 10133.57, 10133.58 and 10133.60	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Jan. 1, 2014	Completed	Jan. 1, 2014
Vocational Expert Fee Schedule Regular rulemaking Labor Code § 5307.7	Working group meeting: June 28, 2012	Post draft regulations on DWC forum	Jan. 1, 2013

APPENDIX B: SB 863 Regulations

Workers' Compensation Appeals Board (WCAB)

SB 863 Implementation WCAB Regulations	Status	Next Steps	Effective Date Per Labor Code
Rules of Practice and Procedure	Public hearing: April 16, 2013 15 day comment period ends: Jul. 25, 2013 Comment period extended: Aug. 9, 2013 Filed with Secretary of State: Sept. 23, 2013	Complete Certificate of Compliance Regulations effective: Oct. 23, 2013	Oct. 23, 2013

Office of Self-Insurance Plans (OSIP)

SB 863 Implementation SIP Regulations	Status	Next Steps	Effective Date Per Labor Code
Actuarial Reporting and Actuarial Based Security Deposit	Notice of Proposed Emergency Action Issued: Dec. 5, 2012 Filed with Office of Administrative Law: Dec. 19, 2012 Filed with	Certificate of compliance regulations were filed with OAL: July 1, 2013 Certificate of compliance	Jan. 1, 2013

APPENDIX B: SB 863 Regulations

	Secretary of State: Dec. 31, 2012 Public hearings held: June 13, 2013	regulations Effective: Aug. 13, 2013	
Cost of administrating Public sector workers' comp paid from the Workers' Compensation Administration Revolving Fund (WCARF): Labor Code §§3700.1 et seq.	OSIP drafting regulations	Begin rulemaking	Jan. 1, 2013
Self-insured Public agencies must submit data to DIR	OSIP drafting regulations	Begin rulemaking	Jan. 1, 2013

Department of Industrial Relations (DIR)

SB 863 Implementation DIR Regulations	Status	Next Steps	Effective Date Per Labor Code
Return-to-Work Supplement Program Sections 25101 - 25111 Sections 17300-17310	Public hearing: Dec. 8, 2014 - Oakland Dec. 9, 2014 - Los Angeles 1st 15-day comment period: April 1, 2015 Filed with Secretary of State: April 6, 2015	Completed	April 13, 2015

APPENDIX C: Litigation

Independent Medical Review (IMR)

Francis Stevens v. Workers' Compensation Appeals Board (WCAB); State Compensation Insurance Fund (SCIF); & Division of Workers' Compensation (DWC)

California Court of Appeal, 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. The writ challenged the constitutionality of Labor Code section 4610.6 (the IMR process) and asserted 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 expeditious² and therefore violates the California constitutional requirement that substantial justice be accomplished in all cases expeditiously and without encumbrance.

In its response, DWC defended the constitutionality of the IMR provisions and argued that the writ must be denied because the petitioner had not exhausted 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.

Francis Stevens v. WCAB; SCIF; & DWC

California Court of Appeal, First Appellate Dist., Division 1 (1st Civ. Case No. A143043)

The petitioner filed a petition for reconsideration with the WCAB, which was denied. Having now exhausted her administrative remedies, the petitioner filed a second petition for writ of review. In addition to again raising her earlier constitutional challenges, the petitioner also argued that the plenary power of the Legislature to enact workers' compensation statutes was limited by the Separation of Powers Clause in the California Constitution.

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

APPENDIX C: Litigation

In its response to the petition as well as its responses to amicus briefs filed in support of the petitioner, the DWC defended the constitutionality of the IMR statutes, asserted that there were no federal procedural or substantive due process claims in this case, argued that there is no due process claim under the California Constitution, and maintained that the Legislature acted within its plenary powers.

After the amicus briefing was completed, the Court invited the parties and amicus curiae to submit supplemental briefs addressing two questions: (1) Is the plenary power to enact workers' compensation statutes vested in the Legislature by the California Constitution limited by the Separation of Powers Clause of the California Constitution? and (2) Does the plenary power to enact workers' compensation statutes vested in the Legislature by the California Constitution affect our analysis in evaluating the petitioner's claims under the California Constitution's Due Process Clause?

In its supplemental brief, the DWC argued that the Legislature's plenary power to adopt workers' compensation statutes is not limited by the separation of powers clause and the plenary grant of authority to enact a workers' compensation system is key to evaluating any alleged due process violation, as the underlying substantive protected rights that arise in the workers' compensation system are those rights that have been conferred by the Legislature.

The submission of supplemental briefs by all parties was completed by March 9, 2015. The oral argument is scheduled for Sept. 30, 2015.

The *Stevens* case was featured in the article, "The Fallout of Workers' Comp Reforms: 5 Tales of Harm" by Michael Grabell, *ProPublica*, as part of a series run in March 2015 based on an investigation of workers' compensation systems conducted by ProPublica and National Public Radio (NPR).

Saul Zuniga v. Interactive Trucking, Inc.; SCIF
California Court of Appeal, First Appellate District, Div. 2, Case No. A143290

This case also involves a challenge to the constitutionality of the IMR process, asserting that the anonymity of the IMR reviewers violates due process and the IMR statute violates the guarantee of right to appellate review. After successfully appealing an IMR determination and obtaining an order remanding the matter back to IMR for review by a different physician reviewer, the petitioner filed a discovery motion seeking the disclosure of the IMR reviewers' identities. While the discovery motion was pending, the second IMR decision was issued authorizing additional, but not all, of the prescribed medications. Thereafter, over defendant's objections, a trial was set on the issue of the

disclosure of the IMR physicians' identities. The Workers' Compensation Judge (WCJ) issued a decision finding that he could not release the names of the IMR physicians pursuant to Labor Code section 4610.6(f).

The petitioner filed a petition for reconsideration, which was denied. The petitioner then filed a petition for writ of review arguing that the anonymity of the IMR reviewers violates due process and that the IMR statutes violate the guaranteed right to appellate review. SCIF filed its answer arguing: (1) The petitioner lacks standing since he did not exhaust his administrative remedies by filing an appeal of the second determination and therefore the petition for review was premature; (2) the petition failed to name the DWC, which is an indispensable party; (3) the WCJ was correct in finding that he lacked the authority to order the disclosure of the reviewing doctors; and (4) not revealing the reviewers' identities did not deprive the petitioner of his due process rights.

The briefing is complete in this case and it is currently pending.

Lien Activation and Filing Fee Cases

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 stop collection of the fees immediately, 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 enforcing the activation fee requirement.

- Both sides appealed their respective adverse rulings, and the case was argued and submitted to the Ninth Circuit on Nov. 18, 2014. On June 29, 2015, the Ninth Circuit Court of Appeals vacated the district court's preliminary injunction, affirmed the dismissal of plaintiffs' constitutional challenges, and reversed the

APPENDIX C: Litigation

district court's denial of defendants' motion to dismiss plaintiff's Equal Protection Claim. On July 13, the Angelotti plaintiffs filed a petition for rehearing.

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

The parties agreed that the 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, and that any motion to dismiss such new claims would proceed in the district court without regard to the stay. No amendment has been filed or served as of this date. Discovery has been stayed pending the appeal. A Status Conference is scheduled to take place on Aug. 3, 2015.

Chorn v. Brown, et al.
LASC Case No. BC528190

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 asserted in *Angelotti v. Baker*. The complaint seeks declaratory relief, a preliminary and permanent injunction, and an award of costs, including reasonable attorneys' fees. It 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. On Feb. 24, 2014, the trial court denied plaintiff's motion for preliminary injunction on the grounds that it lacked subject matter jurisdiction based on Labor Code section 5955 and *Greener v. Workers' Comp. Appeals Bd.* (1993) 6 Cal.4th 1028. Plaintiff filed a Notice of Appeal on April 21, 2014.

Chorn v. Brown, et al.
California Court of Appeal, Second Appellate District, Case No. B256117

On Feb. 24, 2014, the court denied plaintiff's motion for preliminary injunction on the grounds that it lacked subject matter jurisdiction. Plaintiff filed an appeal on April 21, 2014.

On June 11, 2015 the court heard the oral arguments. On June 17, 2015 the court affirmed the superior court's dismissal of the complaint. However, Chorn recently filed a writ petition in the same court of appeal with the same allegations.

Chorn v. Brown, et al.

U.S.D.C., C.D. Cal Case No. CV13-06519-GW(JEMx)

Voluntarily dismissed without prejudice on Feb. 3, 2014.

Kancilia v. Brown, et al.

U.S.D.C., S.D. Cal Case No. CV13-02737

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

Kancilia v. Brown, et al.

San Diego Superior Court Case No. 37-2013-00076513-CU

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

Lien Filing Statute of Limitations Case

Access Mediquip v. WCAB; SCIF

California Court of Appeal, Fourth Appellate District, Div. 1, Case No. D067196

This case involved a challenge to the interpretation and application of the amended statute of limitations for filing medical treatment liens. In this case, the WCJ issued a decision finding that the medical provider's liens were barred by the amended statute of limitations in Labor Code section 4903.5(a). The lien claimant filed a petition for reconsideration which was denied by the Workers' Compensation Appeals Board (WCAB). The claimant then filed a petition for writ of review arguing: (1) the WCAB incorrectly interpreted and applied the amended statute of limitations under Labor Code section 4903.5, improperly dismissing its liens in 11 cases; and (2) the WCAB's retroactive application of the amended statute of limitation violates the due process, equal protection and "taking" clauses of the 5th and 14th Amendments of the US Constitution and Article I, Section 7, of the California Constitution.

On Feb. 27, 2015, the court denied lien claimant's petition. The court stated that the WCAB correctly held that the interpretation of section 4903.5 advanced by the lien claimant would lead to the absurd result that the Legislature intended two limitation periods for the same services. The court also rejected the lien claimant's constitutional claims stating, "The disparate treatment of insurers and lien holders is based on the legitimate governmental purpose of eliminating the backlog of liens. Further, a workers' compensation lien is an entirely statutory right that does not vest until final judgment,

and which can be modified or repealed by the Legislature before vesting. . . . [the lien claimant], therefore, did not have a protected property right in its liens.”

Utilization Review (UR) and IMR

Michael Briggs v. WCAB; SCIF

California Court of Appeal, Fourth Appellate District, Div. 2, Case No. E062825

California Supreme Court, Case No. S224671

In the underlying case, the applicant filed for a hearing at the WCAB to challenge a timely UR decision modifying an opiate prescription. He argued that that UR process interfered with his right to be prescribed opiates due to his severe, chronic, intractable pain under the Health & Safety and Business & Professions Codes. Additionally, he asserted that the UR and IMR statutes conflicted with state and federal laws governing the prescription of controlled substances and that the UR physician violated those laws by modifying the prescribed pain medication without a physical examination. He sought a finding that such decisions couldn't be made in the vacuum of the process created by UR and IMR statutes, but rather such decisions had to comply with all applicable state and federal laws. The WCJ issued a decision finding that under *Dubon II*, the WCAB lacked jurisdiction to consider issues of medical treatment short of an untimely UR denial. The applicant then filed a petition for removal, which was denied by the WCAB.

The applicant then filed a petition for writ of review with Court of Appeal, which was denied. Thereafter the applicant filed a petition for review with the Supreme Court arguing that the WCAB had erred when it refused to consider the applicant's asserted right to pain relief and refused to harmonize UR and IMR statutes with state and federal laws regarding the practice of medicine and the administration of controlled substances.

Defendant filed an answer arguing: (1) the WCAB's decision that it does not have jurisdiction to look at the substantive issues related to a UR decision if it is timely and that the decision was correct and consistent with statutory and decisional authorities; and (2) the UR and IMR statutes do not conflict with other state and federal statutes regarding the administration of controlled substances. On April 15, 2015, the Supreme Court denied the Petition for Review.

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California Insurance Guarantee Association (CIGA) v. WCAB (Mercado)
California Court of Appeal, Second Appellate District, Div. 2, Case No. B260033

In this case, the Court of Appeal was asked to consider whether the WCAB properly sidestepped IMR when it awarded home modifications as part of the applicant's medical treatment award, based on a UR decision that the WCJ and WCAB found to be "materially defective" pursuant to *Dubon I* (79 Cal.Comp.Cases 313). The WCJ found the UR decision was materially defective because the reviewing physician's specialty was "Emergency Medicine" rather than long-term care, and the physician's modifications and denials were not based on "MTUS, ACOEM Guidelines, or any other identifiable objective criteria as required by Labor Code section 4610." In its Decision After Reconsideration issued Sept. 30, 2014, a WCAB panel affirmed the WCJ on all issues except medical mileage for the applicant's wife who provided attendant care.

CIGA filed a petition for writ of review arguing: (1) the UR decision was timely, so the WCAB erred in following *Dubon I* given its subsequent decision in *Dubon II*; (2) the WCAB erred in awarding 5814 penalties; (3) the WCAB lacked jurisdiction to allow applicant's wife's lien for attendant care due to the fact that she had failed to pay the lien filing fee and to provide the documentation and declarations required by 4903.8(e); and (4) the WCAB erred in determining that applicant's wife met her burden of proving that her attendant care of the applicant was reasonable and necessary. On Feb. 5, 2015, the Court, finding good cause, granted the petition. In early March, the petition was dismissed pursuant to CIGA's request to withdraw its petition.

This case was featured in the article, "The Fallout of Workers' Comp Reforms: 5 Tales of Harm" by Michael Grabell, *ProPublica*, as part of a series run in March 2015 based on an investigation of workers' compensation systems conducted by ProPublica and National Public Radio (NPR).

CIGA v. WCAB (Smith)
California Court of Appeal, Third Appellate District, Case No. C077680

This case is similar to the *CIGA v. WCAB (Mercado)* case referenced above. In this case, the WCJ issued a decision awarding a home bathroom modification for wheelchair accessibility despite the existence of a timely UR decision denying said modifications. The WCJ determined that the UR decision was invalid because it went beyond the scope of the issue presented. Specifically, the utilization reviewer addressed the underlying need for a motorized wheelchair, concluding it wasn't necessary, not the requested bathroom modification. The WCJ opined that the "the integrity of the review was not just impaired [but a review] did not occur," and therefore the WCJ took

jurisdiction of the issue of reasonableness and necessity and awarded the bathroom modification. Defendant filed a petition for reconsideration which was denied.

Defendant filed a petition for writ of review contending that since the UR decision was stipulated as timely and the WCAB held in *Dubon II* that a UR decision is invalid and not subject to IMR only if it is untimely, the WCAB exceeded its jurisdiction by reversing the timely UR decision and deciding the issue of medical necessity. On Jan. 22, 2015, the Court of Appeal granted the petition for writ of review. On March 18, 2015, pursuant to the defendant's request, the Court dismissed the petition for writ of review.

Jose Dubon v. World Restoration, Inc.; SCIF

California Court of Appeal, Fourth Appellate District, Div. 3, Case No. G051017

California Supreme Court, Case No. S224450

The WCAB granted SCIF's petition for reconsideration Opinion and Decision after Reconsideration (En Banc) dated Feb. 27, 2014, wherein the WCAB had held that it could determine whether a UR decision suffered from material defects that may have undermined the integrity of the decision, and if so, the WCAB could then determine the medical necessity issue based on substantial medical evidence. (See *Dubon v. World Restoration, Inc.* (2014) 79 Cal.Comp.Cases 313 (WCAB en banc) (Dubon).)

After granting reconsideration of its prior en banc decision in order to further review and study the issues, the WCAB issued its decision after reconsideration wherein it rescinded its en banc decision of Feb. 27, 2014. In *Dubon II*, the WCAB affirmed the WCJ's decision, which had determined that the medical necessity of applicant's requested back surgery must be determined by independent medical review (IMR), notwithstanding any procedural defects in defendant's timely utilization review (UR) decision, and held as follows:

- 1) A UR decision is invalid and not subject to independent medical review (IMR) only if it is untimely (but not if it suffered from other types of material defects);
- 2) Legal issues regarding the timeliness of a UR decision must be resolved by the WCAB, not IMR;
- 3) All other disputes regarding a UR decision must be resolved by IMR; and
- 4) If a UR decision is untimely, the determination of medical necessity may be made by the WCAB based on substantial medical evidence consistent with Labor Code section 4604.5.

In November 2014, the applicant filed a petition for writ of review arguing that the second en banc decision was inconsistent with the overall statutory scheme for UR and that the WCAB acted unreasonably in finding its jurisdiction had been so limited by the

advent of IMR. The Fourth District Court of Appeal, Division 3, summarily denied the applicant's petition on Feb. 5, 2015. Thereafter, the applicant filed a Petition for Review with the California Supreme Court. On April 1, 2015, the high court denied the petition for review.

Octavio Filippini v. WCAB; Pillsbury, Winthrop, Shaw, Pittman, LLP, et al.
California Court of Appeal, Third Appellate District, Case No. C078193

In this case, Applicant sought a hearing at the WCAB to review UR denials of requests for spinal surgery and address the issue of medical necessity. The WCJ issued his decision finding that the UR denials were timely but materially deficient and ordering the requested surgery, deeming it to be medically necessary. The defendant filed a petition for reconsideration and the WCAB rescinded the WCJ's findings and award, finding that the WCAB lacked jurisdiction to hear the issue of medical necessity based on the decision in *Dubon II*.

Applicant filed a petition for writ of review asserting two main arguments: (1) the IMR process denies applicant due process; and (2) the WCAB's refusal to address applicant's appeal of the UR decision needlessly delays medical treatment in violation of Labor Code section 3202. On March 5, 2015, the court issued an order summarily denying the petition for writ of review.

Lions Raisins v. WCAB (Miramontes)
California Court of Appeal, First Appellate District, Div. 3, Case No. A144280

In this case, the applicant was found to be 100% disabled and future medical care was awarded. Although the award did not specify the provision of home health assistance, defendant had provided home care after the issuance of the award. Sometime thereafter, the claims administrator requested a report from the new treating physician addressing the need for home care. After not receiving a response from the physician and giving notice to the applicant's counsel, the claims administrator terminated the home health care. Afterwards the doctor did submit a request for authorization for home care assistance. The request was sent through UR where it was denied as being inconsistent with the medical treatment guidelines.

After an expedited hearing, the WCJ determined that the UR decision was not valid and ordered the home health care. The WCJ did not find that the UR decision was untimely or identify a specific defect. Instead the WCJ opined that the defendant forced the treating physician to provide a prescription so it could perform UR and stop the home health care. The WCJ found that the claims administrator had not presented medical

APPENDIX C: Litigation

evidence showing that the applicant's condition had changed during the period when care was provided and when it was terminated and had also not presented evidence showing that the applicant was not in need of home health care. The defendant filed a Petition for Reconsideration, which was denied by the WCAB.

Defendant filed a petition for writ of review arguing, among other things,: (1) the WCAB lacked authority to award medical treatment in the absence of a defect in the UR decision; (2) the WCJ's decision was inconsistent with *Dubon II* in that absent a finding of untimeliness, there is no jurisdiction for the WCAB to resolve a dispute as to the medical appropriateness of treatment; and (3) the WCJ's decision was not supported by substantial evidence and did not comply with medical treatment guidelines. Applicant elected not to file a reply to the petition due to economic hardship. On April 9, 2015, the Court issued an order denying the petition for writ of review.

Gustavo Mendoza v. WCAB; Professional Security Consultants, et al.
California Court of Appeal, Second Appellate District, Div. 6, Case No. B260240

This case involved the question of whether an employer can use UR to object to treatment requests made by physicians in its medical provider network (MPN). The WCJ found that UR statutes applied both to employers with MPNs and without MPNs. Therefore, UR did apply to treatment requests made by MPN physicians and those UR decisions were admissible in medical treatment disputes before the WCAB. The applicant filed a petition for reconsideration, which was denied by the WCAB.

The applicant filed a petition for writ of review making three key arguments: (1) requests made by MPN physicians are not subject to UR, In other words, an employer cannot use UR to object to treatment requests made by providers within its MPN; (2) a UR decision that doesn't meet the substantial medical evidence standard cannot be used to deny care; and (3) the IMR process is a denial of procedural and substantive due process. On April 17, 2015, the Court issued an order summarily denying the petition.

The issue of whether treatment recommendations made by MPN physicians can be submitted to UR is currently pending before the WCAB on reconsideration in the case of *Hogenson v. Volkswagen Credit Inc.* (ADJ2145168). In *Hogenson*, the WCJ held that treatment requests submitted by MPN physicians were not subject to UR and IMR procedures, and that UR reports obtained by defendants were inadmissible at trial. The WCJ found that the MPN statutory scheme gives defendants sole control to choose the members of the MPN, provides for a second and third opinion process and excludes the use of UR reports from consideration in disputes over treatment. The defendant filed a

petition for reconsideration and the WCAB granted the petition in order to allow sufficient opportunity to study the factual and legal issues of the case.

Daniel Ramirez v. WCAB; SCIF, et al.

California Court of Appeal, Third Appellate District, Case No C078440

In this case, the applicant requested IMR after a request for acupuncture treatment was denied in UR. The IMR decision upheld the UR denial and the applicant filed an appeal of the IMR decision at the WCAB, requesting a hearing and an order disclosing the identity of the IMR reviewer, so that the applicant could conduct discovery regarding the reviewer's bias. At the conference, the WCJ advised that the WCAB lacked jurisdiction over all of the applicant's arguments and over the applicant's objection, granted the defendant's request to take the matter off the calendar. Applicant filed a petition for reconsideration asserting that the order removing the matter from the calendar was effectively a dismissal of the appeal. The WCAB denied the petition for reconsideration but granted removal to amend the WCJ's order to an actual dismissal of the applicant's appeal.

The applicant filed a petition for writ of review in which the applicant contends: (1) the WCAB has jurisdiction to hear medical treatment disputes in cases where an employer fails to conduct UR properly (challenging the holding in *Dubon II*); (2) the IMR statutes are unconstitutional; and (3) the IMR appeals process violates the applicant's due process rights. In its answer, the defendant defended the constitutionality of the IMR statutes and asserted that the WCAB only has jurisdiction over treatment disputes when no UR has been performed or if UR has been performed in an untimely manner.

The Court issued the writ of review in this case. The certified record from the WCAB has been filed and the case is fully briefed at this time.

Zurich North America v. WCAB (Dolan)

California Court of Appeal, First Appellate District, Div. 1, Case No. A143976

In this case, the defendant stipulated to provide home health care services to the applicant for a specified number of hours per month, at a specified rate. The agreement also provided that either party could revisit the amount of home health care to be provided. The parties used an agreed medical evaluator (AME) to assist in determining the current need for health care and the AME opined that the applicant was in need of 24/7 assistance.

APPENDIX C: Litigation

The matter proceeded to an expedited hearing to determine what degree of care was required and for what period of time it should have been provided. The WCJ awarded the 24/7 care finding that since UR had not been performed on the requests for home care, the medical treatment dispute was not subject to IMR and thus the WCAB had jurisdiction to address the issue of medical necessity. The defendant filed a petition for reconsideration, which was denied by the WCAB.

Defendant filed a petition for writ of review arguing: (1) the WCJ lacked any authority to make a determination regarding a question of medical necessity including those instances when a UR decision is untimely (contrary to the holding of *Dubon II*); (2) the obligation to conduct UR was never triggered because the proper request for authorization was not submitted by the provider; (3) the applicant failed to meet his burden of proof on the issue of entitlement to home health care; and (4) the request for home care did not satisfy the requirements of Labor Code section 4600(h). On March 5, 2015, the petition was summarily denied by order, and the matter was remanded to the WCAB for purposes of making a supplemental award of attorney fees under Labor Code section 5801 for services rendered in connection with the petition for writ of review.

APPENDIX D: SB 863 Case Law

Workers' Compensation Appeals Board (WCAB) en Banc Decisions:

Home Health

Roque Neri Hernandez v. Geneva Staffing, Inc. (doing business as Workforce Outsourcing, Inc.); Tower Point National Insurance Company, administered by Tower Select Insurance

June 12, 2014

Case No: ADJ7995806

79 Cal. Comp. Cases 682

Regarding the SB 863 additions and amendments to the Labor Code regarding home health care services, which became effective Jan. 1, 2013, the WCAB 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 that 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 when an official medical fee schedule or Medicare schedule covers the type of home health care services sought; otherwise, section 5307.8 applies.

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

In cases where a medical-legal lien claim for copy costs was filed before Jan. 1, 2013, and after Jan. 1, 2013, it was withdrawn and re-filed as a petition for costs under Labor Code section 5811, the WCAB 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.

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 WCAB held that, when 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.

Utilization Review (UR) and Independent Medical Review (IMR)

Jose Dubon v. World Restoration, Inc.; State Compensation Insurance Fund (SCIF)
Oct. 6, 2014
Case No: ADJ4274323 (ANA 0387677) - ADJ1601669 (ANA 0388466)
79 Cal. Comp. Cases

The WCAB granted SCIF's petition for reconsideration of the Opinion and Decision after Reconsideration (En Banc), dated Feb. 27, 2014, wherein the WCAB previously held that the WCAB could determine whether a UR decision suffered from material defects that undermine the integrity of the decision, and if so, it could then determine the medical necessity issue based on substantial medical evidence. (See *Dubon v. World Restoration, Inc.* (2014) 79 Cal.Comp.Cases 313 (WCAB en banc) (Dubon).)

After granting reconsideration of its prior en banc decision in order to further review and study the issues, the WCAB rescinded its en banc decision of Feb. 27, 2014. In *Dubon II*, WCAB affirmed the workers' compensation administrative law judge's decision, which determined that the medical necessity of applicant's requested back surgery must be determined by independent medical review (IMR), notwithstanding any procedural defects in defendant's timely utilization review (UR) decision, and held as follows:

- 1) A UR decision is invalid and not subject to independent medical review (IMR) only if it is untimely (but not if it suffered from other types of material defects);
- 2) Legal issues regarding the timeliness of a UR decision must be resolved by WCAB, not IMR;
- 3) All other disputes regarding a UR decision must be resolved by IMR; and
- 4) If a UR decision is untimely, the determination of medical necessity may be made by the WCAB based on substantial medical evidence consistent with Labor Code section 4604.5.

In November 2014, the applicant filed a petition for writ of review arguing that the second en banc decision was inconsistent with the overall statutory scheme for UR and that the WCAB acted unreasonably in finding its jurisdiction had been so limited by the advent of IMR. The Fourth District Court of Appeal, Division 3, summarily denied the applicant's petition on Feb. 5, 2015. Thereafter, the applicant filed a petition for review with the California Supreme Court. On April 1, 2015, the high court denied the petition for review.

WCAB Significant Panel Decisions:

IMR

Christopher Torres v. Contra Costa Schools Insurance Group; SCIF

Aug. 28, 2014

Case No. ADJ3011154 (SAC 0309784) - ADJ3631113 (SAC 0309785)

79 Cal. Comp. Cases 1181

When the injured worker filed an unverified petition appealing an IMR determination, the WCAB held that the petition is subject to dismissal because Labor Code section 4610.6(h) provides that such a determination “may be reviewed only by a *verified* appeal.” Further, Rule 10450(e) requires that any petition filed with the WCAB “shall be verified under penalty of perjury in the manner required for verified pleadings in courts of record,” and it provides that a unverified petition may be summarily dismissed or denied. While lack of verification does not automatically require dismissal of an unverified petition, an appeal may be dismissed for lack of verification if the appealing party does not within a reasonable time cure the defect after receiving notice of the defect.

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 WCAB 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 when: (1) the declaration of readiness (DOR) was filed prior to Jan. 1, 2013; (2) the lien conference took place prior to Jan. 1, 2013; and (3) the lien trial took place in 2013, without any intervening 2013 lien conference.

Medical Provider Network (MPN)

Eun Jae Kim v. B.C.D. Tofu House, Inc.; Cypress Insurance Company
Feb. 7, 2014
Case No. ADJ9086333
79 Cal. Comp. Cases 140

The WCAB held that the plain language of Labor Code section 5502(b)(2), amended by SB 863, and Administrative Director Rule 9767.6(c) provides that an expedited hearing may be requested and conducted to determine whether the employee must get treatment within the employer's medical provider network during the 90-day delay period, under Labor Code section 5402(b). The same Labor Code section also provides that the employer has to investigate and determine whether to accept or reject the claim. An expedited hearing is available to address the provision of treatment through an MPN even if the employer has not accepted liability for the claim as described in Court Administrator Rule 10252.

Medical Treatment

Jennifer Patterson v. The Oaks Farm; California Insurance Guarantee Association for California Compensation Insurance Co., in liquidation
July 24, 2014
Case No. ADJ3905924 (ANA 0339374)
79 Cal. Comp. Cases 910

When the defendant unilaterally terminated nurse case manager services to the injured worker, the WCAB affirmed the WCJ's award reinstating those services, holding as follows:

1. The provision of a nurse case manager is a form of medical treatment under Labor Code section 4600;
2. An employer may not unilaterally cease to provide approved nurse case manager services when there is no evidence of a change in the employee's circumstances or condition showing that the services are no longer reasonably required to cure or relieve the injured worker from the effects of the industrial injury;
3. Use of an expedited hearing to address the medical treatment issue in this case is expressly authorized by Labor Code section 5502(b)(1);

4. It is not necessary for an injured worker to obtain a Request for Authorization (RFA) to challenge the unilateral termination of the services of a nurse case manager.

UR

Timothy Bodam v. San Bernardino County/Department of Social Services
Nov. 20, 2014
Case No. ADJ8120989 (SBR 0041910)
79 Cal. Comp. Cases 1519

In affirming the WCJ's finding that defendant's UR decision was not timely communicated to the requesting physician and the employee as required by Labor Code section 4610(g)(3)(A) and Administrative Director's Rule 9792.9.1(e)(3), the WCAB held: (1) a defendant is obligated to comply with all time requirements in conducting a UR, including the timeframes for communicating the UR decision; (2) a UR decision that is timely made but is not timely communicated is untimely; and, (3) 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.