MICRO SURVIVAL GUIDE

2020

Edition 4.0
Including AD Regulations
SB 1160 & 1244
AB 5
Case Law Updates and When to Use an AME
Special Supplements and Primer
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Edition No.: 4.0

Revised: 01/15/2020

NEW FOR 2020

AB 5 GOES INTO EFFECT [HIGHER BAR FOR ESTABLISHING INDEPENDENT CONTRACTOR] For purposes of wage orders, the effective date is 01/01/2020. For workers' compensation purposes, AB 5 goes into effect only for injuries on or after 07/01/2020. Under AB 5, there is an operative presumption that a worker will be deemed an employee unless the employer can disprove the presumption using the "ABC" test made applicable in the Dynamex decision. Section 2750.3 is added to the Labor Code, incorporating the "ABC" test, which for the most part, replaces the prior standard under the Supreme Court decision in Borrello, which was chiefly a "control of work details test," but also incorporated a number of sub-parts, so that in effect it was a multi-factual test, which has held since 1989

DYNAMEX DECISION

Dynamex is not a workers' compensation case but rather one exclusive to California wage orders. Dynamex involved an attempted certification of class action status for alleged employees, who were performing services for Dynamex involving the delivery of parcels and items. The Dynamex court was very sympathetic to the existence of pervasive abuses in the misclassification of employees. Without going into extensive detail, the Supreme Court has revisited Borello and in a lengthy decision spanning over 40 pages, the Court determined that for the purpose of **wage orders only**, **Borello is no longer the test.** It will be supplanted by a simpler and more easily accommodated test known as "ABC"

AB 5

In specific recognition of the Dynamex decision, the legislature has passed, and the Governor has now signed AB 5. The bill is specifically a codification of the Dynamex decision, which now renders Dynamex applicable to all aspects of the employment relationship, **including workers' compensation,** subject to some exceptions

Under AB 5, there is a presumption that a worker is deemed an employee, **unless** the employer can disprove the presumption by applying the "ABC" test made applicable in Dynamex and now made specifically applicable to workers' compensation. However, the "ABC" test is used first,

unless a “court of law” should rule that the “ABC” test cannot apply within the factual context. The statute also provides specific exceptions where Borello would still otherwise apply

Accordingly, Section 2750.3 is added to the Labor Code, providing that a person providing labor or services for remuneration shall be considered an employee rather than an independent contractor, unless the hiring entity demonstrates that all the following conditions are satisfied:

A. The person is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance and in fact;

B. The person performs work that is outside the usual course of the hiring entities business;

C. The person is customarily engaged in an independently-established trade, occupation or business of the same nature as that involved in the work performed

If we examine the **Borello test versus the “ABC” test**, it is noted that Borello contains more factors but Lab C Section 2750.3 mandates that work performed is “*outside the usual course*” of the hiring entity’s business versus “*distinct occupation or business*” under Borello. I believe that the “outside” criteria makes it more difficult to frame a worker as an independent contractor versus the looser and more generic terms employed by Borello

But the new statute goes on to indicate that “if a court of law rules that the three-part test in Paragraph (1) cannot be applied to a particular context based on grounds other than an expressed exception to employment status as provided under Paragraph (2), then the determination of employee or independent contractor status in that context shall be governed by the California Supreme Court’s decision in S.G. Borello & Sons, Inc. v. Department of Industrial Relations (1989) 48Cal3d 341) Borello”

The statute carves out several exceptions, based upon type of occupation for which Borello would apply. These include the following:

1. Insurance broker or agent;

2. Physician, surgeon, dentist, podiatrist, psychologist or veterinarian;

3. Lawyer, architect, engineer, private investigator or accountant;

4. Securities broker or investment advisor or agents;

5. Direct sales person;

6. Commercial fisherman

The statute then defines specified "professional services" and if the status of the work falls within the purview of "professional services," then **Borello applies**. This only occurs if several conditions are satisfied under this new statute:

A. The individual maintains the business location, which may include the individual's residence, which is separate from the hiring entity. Nothing in the subdivision prohibits an individual from choosing to perform services at the location of the hiring entity;

B. If the work is performed more than 6 months after the effective date of this section, the individual has a business license, in addition to any required professional licenses or permits for the individual to practice in their profession;

C. The individual has the ability to set or negotiate their own rates for the services performed;

D. Outside of project completion dates and reasonable business hours, the individual has the ability to set the individual's own hours;

E. The individual is customarily engaged in the same type of work performed under contract with another hiring entity or holds himself out to other potential customers as available to perform the same type of work;

F. The individual customarily and regularly exercises discretion and independent judgment in the performance of the services.

The term "professional services" means services that meet the criteria, including: marketing, administrator of human resources, travel agent, graphic designer, grant writer, fine artist and services provided by an enrolled agent licensed by the U.S. Department of the Treasury to practice for the IRS, payment processing agent through the independent sales organization, services provided by a still photographer or photo journalist, services provided by a freelance writer, editor or newspaper, cartoonist, who does not provide content submissions, services provided by a licensed esthetician, licensed electrologist, licensed manicurist, licensed barber or licensed cosmetologist. [And under these subsections more conditions are imposed]

The list goes on to include real estate licensees and repossession agencies. Again, for the coverage of these individuals and organizations, **the Borello test is applicable and not Dynamex**

- **PEACE OFFICERS AND FIREFIGHERS: NEW PRESUMPTION ADDED: SENATE BILL 542.** Post-Traumatic Stress Disorder ("PTSD") is now recognized as an actual and separate injury and subject to a rebuttable presumption. The Peace Officer or Firefighter would ordinarily have to have a minimum of 6 months of service, in order to secure the presumption, unless the injury arises from an employment event which is "sudden and extraordinary." This new presumption extends following the termination of employment at the rate of 3 calendar months for each full year of requisite service, not to exceed 60 months. This new presumption, while ostensibly confined only to "PTSD," seems to essentially create a potential new presumption for other psyche injuries, since PTSD is to be diagnosed per the DSM. Will this encourage more psyche claims? I believe that it could motivate some applicant attorneys,

specializing in this area of practice, to take a serious look and yes, it could likely make psyche claims easier to prosecute, even if they only have a component of PTSD

- **MPN ROSTER REQUIREMENTS EXPAND: Lab C 4616(a)(4)(A)(1) added**: Commencing 07/01/2021, MPN's shall post the roster of all participating providers, which includes all physicians and ancillary service providers within the MPN. Every MPN shall provide the AD with a roster of participating providers and each office address and telephone number

- **REQUEST FOR PAYMENT: Lab C 4603.2 (b)(1)(C) added:** Request for payment with itemization of services shall be submitted to employer with the national provider identifier (NPI) for the physician or provider who provided the service. Failure to provide the NPI shall result in request for payment being barred until NPI is submitted. Defendant may request NPI at an earlier date

- **AD EMPOWERED TO INVESTIGATE, REVIEW AND TAKE ACTION AGAINST MPNS: NEW: Lab C 4616 (i) added:** AD has authority and discretion to investigate complaints, conduct random reviews and take enforcement action against MPNs, including any entity that provides ancillary services or an entity which provides servicers on behalf of an MPN, regarding non-compliance with regulations

- **ADDITIONAL DEFINITION OF EMPLOYEE**: [Lab C 3370.1, 3351] Lab C 3351 amended to add as "employee" as of 07/01/2020, any person who is committed to a state mental hospital, while in the course of a vocational rehabilitation program work assignment, including sheltered workshop work assignment, subject to conditions[i]

- **NEW WCAB RULES OF PRACTICE AND PROCEDURE**: The new rules were published on 12/31/2019 and went into effect on 01/01/2020. The new rules can be found here: https://www.dir.ca.gov/wcab/WCABProposedRegulations/Rulemaking-August-2019/Final%20Rulemaking/Final-Text-Of-Regulations.pdf We are studying the new rules now and we will provide a Client Update in the very near future

- **PROPOSED NEW REGULATIONS:** There is nothing on the DIR/WCAB web site, so nothing active is in the actual works

SPECIAL SUPPLEMENT for 2020

The Importance of Tracking all Body Parts in a Claim

For many applicant attorneys, and even for some treating physicians, the admittance of an injury and the provision of medical treatment are often viewed as the equivalent of a carte blanche to other body parts, some of which may not have any realistic, causative connection to the injury. It is therefore essential to good claims handling and for a successful defense, that all body parts should be listed and then tracked throughout the life of an indemnity claim. The impact can be substantial, not only for every day decision-making, but also for achieving maximum impact on discovery, claim settlement, and lien handling. By tracking the "admitted" vs. "disputed" body parts, the claims examiner and counsel can easily dispatch arising issues and make good strategic decisions about medical discovery, litigation, and potential settlement

For practical considerations, this writer keeps an ongoing "chart" for all body parts, so I know exactly which parts are admitted and which are disputed, or as they say, "in play." This helps me critically evaluate a new medical report, conduct an effective deposition, and it helps determine whether the case should settle or go to hearing. Think of the many ways in which disputed body part issues arise:

• **BENEFIT NOTICES:** Providing clear notice to the injured worker as to which body parts are admitted and which are being disputed. This sets the predicate for subsequent non-UR treatment denial decisions

• **NON-UR TREATMENT DECISIONS**: Denials to RFA's from the PTP or secondary treating physician which can be made without having to refer to utilization review. This is exclusive to either denied injuries or denied body parts

• **MPN ISSUES:** Denied body parts can be treated outside of the MPN, but such treatment is self-procured and should be denied on a continuing basis

• **WHETHER TO USE AN AME OR QME**: The presence of and number of so-called "disputed body parts" could have an impact on your decision as to whether to utilize an AME or a PQME. We generally recommend utmost caution in using an AME for disputed body parts, but it still may have a place

• **RED FLAG MEDICAL REPORTING:** How many times have you adjusted an admitted lower back claim, with no reported radiation of pain to the lower extremities, but upon the applicant's selection of a new PTP, you now receive medical reports where the pain is now extending to the hips, knees, legs and feet? Or, what about the neck injury which now straddles to the lower back? The so-called "red flags" can lead to credibility issues and can even form the basis for a later denial of a body part, or even the entire claim

• **SIDE-BY-SIDE ANALYSIS**: We make it a consistent practice to review PTP reports with a healthy dash of skepticism, whether it be a PR-2, a PR-4, or a narrative summary. Specifically, we are looking for "phantom body parts," or simply exaggerated complaints, which have not previously arisen in any medical reporting. An example is an admitted right knee injury, where you start to see the PTP reporting on the left ankle, right hip, and even lower back. Catching these potential inconsistencies early on can impact discovery and can even provide some defense momentum for early case settlement. A lot of applicant attorneys don't want to be involved in litigating claims, where their client is patently exaggerating or outright lying to the physicians

• **COMPENSABLE CONSEQUENCES OR CREDIBILITY ISSUES?** Keeping up with the addition of any new body parts to the claim can help determine whether these may be the legitimate consequences of the admitted injury, the result of the imagination of the applicant, or the creative license of the PTP. Stay aware

• **HELPING DEFENSE COUNSEL WITH THE DEPOSITION**: This is one of the best places to focus attention on the applicant's credibility. This is where, as they used to say, "the rubber meets the road." Here, the applicant can be examined on when the phantom body part complaint arose, whether it was disclosed to a previous PTP, and a lot more. Sometimes, an applicant's listing of complaints barely resembles the reported symptoms to the last PTP. So, this helps make some good decisions on the applicant's credibility

• **SETTLEMENT IMPACT:** Effectively and aggressively handling the disputed body parts can very often result in the achievement of excellent settlements, because it is here where your negotiations can be effectually focused, in order to highlight and illustrate credibility issues, rather than arguing over impairment. Your strongest arguments then focus on the most vulnerable part of the applicant's claim. It also helps to educate opposing counsel on the realistic limits of the case

• **ADJUSTING TREATMENT LIENS:** Disputed body parts make fee schedule arguments essentially moot. Here, you are in a strong position to obtain good results with lien claimants, especially when they have the full burden of proof on an otherwise settled case-in-chief

• **SHAPING AND LIMITING EXPOSURE ON AWARDS:** One of the most overlooked aspects of a stipulated findings and award is the effective limitation for exposure to future medical care by either specifically stipulating to "no injury" for the disputed body parts or shaping an award to deal with those body parts. When drafting a stipulated findings and award, every body part in the record should be dealt with. Do not leave any

body part out. The same advice applies to a compromise and release. With effective tracking and monitoring of all body parts, you stay in control and are on the right path to best claims outcomes

A Few Practice Tips for 2020

- ***APPORTIONMENT:*** *More than a few physicians are still using the "old" pre-reform apportionment analysis in their reports without much regard for Lab C 4663 and Escobedo and really very few seem to really nail it right to "causation." And sometimes the parties are even confused over the issue. This can become the "Achilles Heel" when critically analyzing a medical report. Also, remember if you have a prior stipulated award, it is recommended that you file that award in the pending case, together with a request the WCAB take judicial notice, since the "existence of that prior award" is a burden for the defendant to establish, in order to support apportionment under Lab C 4664. Also, in reviewing medical reports from a PQME or AME, I like to start with the apportionment discussion first. This usually tells me whether the rest of the report is of quality. If the physician fails to address apportionment, other than as a "template," then I have a suspicion about the rest of the report as well. All too often, I see apportionment treated in an overly simplistic fashion. Remember, even if the apportion conclusion is in your favor, it still must be considered substantial medical evidence, so it may become necessary to augment a PQME report with a letter to the physician, asking for a clarification so that the final medical opinion can withstand WCAB scrutiny*

- ***THE MPN IMR:*** *"The Other IMR" Residing within the MPN statutes and Administrative Rules (Lab C 4614.4; 8 CCR 9768.1)) is the so-called "2nd and 3rd opinion provisions, under which applicant can obtain a second and third opinion from another physician, within the MPN, should he/she object to the diagnosis, diagnostic service or treatment recommendation of the MPN PTP. Applicant can request IMR within the MPN system and under 8 CCR 9768.9(d) can also request an* ***actual physical examination****. Remember, this process is entirely separate and apart from the regular UR/IMR system. Some applicant law firms are skipping the objections to the PTP findings, skipping over the 2nd and 3rd opinions and going straight for the actual physical examination. Watch out for this sneaky tactic, since it can appear confusing, based upon their cover letters. Be careful. The objections must take place in proper time and sequence, in order to have the right to request an actual physical examination. They don't get to "pick and choose" the steps in this process. If they haven't followed the steps, then object.*

- ***CHECK EAMS:*** *If there has not been any substantial activity on your litigated claim for months, you might want to check EAMS. That will give you any update on recently filed documents and it may also come up with a new subsequent claim*

- ***COURT CALL:*** *The WCAB permits the use of Court Call, at the sole discretion of each WCAB Judge. Court Call allows defense counsel to call in and then participate in a WCAB matter without having to make a physical appearance. We encourage the selective use of Court Call, especially for Status Conferences and particularly when dealing with the "mill" applicant law firms, who are known for setting multiple*

matters on calendar for the same date and time, so defense counsel is often left waiting for hours, while the applicant's attorney shuttles from hearing room to hearing room. But it should be used very selectively and only on a case-by-case basis. Court Call is generally preferable for Status Conferences. In very rare instances, where the issues are simple and it is our DOR, we might appear for an MSC, typically when we know the matter will likely be continued or taken off calendar. Here is the link to Court Call: https://courtcall.com/

- ***STIPULATED AWARDS AND BODY PARTS:*** *Proper drafting of a stipulated findings and award can be tricky. Always make sure to deal with "every single indicated body part" in every stipulation with request for award. You don't want to "buy" body parts, which should otherwise be rejected; but the stipulated award must specially deal with each and every body part in the record. Make a list of each and every body part and bodily system in the medical record and then either stipulate to "no injury" or list as an admitted body part. And, you need to insert an actual rating for each and every body part producing PD, otherwise you have chaos if there is a subsequent petition seeking new and further disability*

Color Key

BLUE .....NEW DEVELOPMENT AND/ OR FURTHER ANALYSIS
DARK RED.....ADMINISTRATIVE REGULATION
GREEN.....NEW CASE DECISION INCLUDING WCAB PANEL DECISIONS
PURPLE..... UPDATE: 2020

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WHAT TAKES EFFECT WHEN?

SUBJECT	PROVISION	INJURIES ON OR AFTER 01/01/2013	01/01/2013 – REGARDLESS OF DATE OF INJURY	01/01/2014
PD	▪ 1.4 multiplier ▪ No FEC adjustment ▪ Limits on psyche, sleep and sexual dysfunction add on	**X** **X** **X**		
PD RATES	▪ Minimum: to 160 per week ▪ Maximum: to 270 (55%-69%) ▪ Maximum: to 290 (70%-99%) ▪ Maximum: to 290 (1%-99%)	**X** **X** **X**		**X (DOI)**
SJDB	▪ Statute of Limitations: 2yr/5yr ▪ New SJDB to $6,000 ▪ Advance of $500 ▪ Computer Equipment ▪ New form re: work capacities ▪ No settlement of SJDB ▪ No commutation of SJDB	**X** **X** **X** **X** **X** **X** **X**	**X**[ii]	
QME PROCESS	▪ Elimination of "AME" Dance ▪ 2nd Opinion Surgery process gone ▪ Relaxation of communications		**X** **X** **X**	
IMR and IMRO	▪ Medical Necessity Disputes Taken Away from QME and to IMR	**X** Until 7/1/2013 – effective for all decisions after		

		that date, regardless of DOI		
TREATMENT BILLS **SECOND REVIEW** **EOR** **IBR AND IBRO**	▪ Explanation of Review ▪ Request for 2nd Review ▪ IBR and IBRO process ▪ Deemed Final	**DOI 01/01/2013**	**01/01/2013** **X** **X** **X** **X**	**01/01/2014**
MPN	▪ Physicians Included with Written Acknowledgment ▪ MPN Must Place Roster of Physicians on Web Site ▪ All Approved MPN's posted by AD			**X** **X** **X**
	▪ Medical Access Assistants with available hours ▪ AD Powers to Investigate ▪ Plan Approval 4 years ▪ Contesting MPN being "Validly Constituted" ▪ Schedule of Penalties ▪ Notice Poster – Limitations under Valdez		 **X** **X** **X** **X** **X**	**X**
LIENS	▪ $150 Filing Fee Liens filed after: ▪ With Proof of Paid Filing Fee ▪ $100 Activation Fee for all existing and prior liens ▪ Statute of Limitations – 3 years from date of services provided	 **DOI: 01/01/2013**	**X** **X** **X** Paid at time of filing of DOR, at Lien Conference if not filing DOR, but no later than 01/01/2014 **X** **01/01/2013** **07/01/2013**	 **X** This the drop date time for payment of activation fee or liens are dismissed **01/01/2014**

	▪ Statute of Limitations – 18 months from date of services provided ▪ Restriction on Assignments		**X**	
MEDICAL LEGAL	▪ Qualified interpreters – exams		**X**	
VOCATIONAL EXPERTS **FEE SCHEDULES:** **COPY SERVICES'** **VOC EXPERTS;** **INTERPRETERS:**	▪ 2nd Review and IBR added ▪ IBR Covers Medical-Legal Expenses ▪ Fee Schedule for Vocational Experts[iii] ▪ Fee Schedule for Copy Services ▪ Fee Schedule for Interpreters During Treatment		**X** **X** **X** **X** **X**	
MEDICAL TREATMENT UNDER LAB C 4600: **FEE SCHEDULES:** **HOME HEALTH CARE**	▪ For treatment after 01/01/2014 based upon RBRVS ▪ Home Health Care: Adopt Fee Schedule ▪ Home Health Care: Limitations and Prescriptions For: (14 days) ▪ Limitations on "Chiropractic Visits" ▪ Interpreters During Treatment		On or before 07/01/2013 **X** **X** **X**	**X**
UTILIZATION REVIEW	▪ Not Needed if Disputing Injury/Body part ▪ Effective for 12 months ▪ All Disputes over UR Decisions go to IMR and not Through QME Process ▪ UR decisions now tied to MTUS	**X (and on or after 07/01/2013 regardless of DOI)**	**X** **X** **X**	
	▪ Approval for Retroactive Decisions No Longer Need to be Communicated ▪ Retrospective UR deferred and Timing of Resumption	**DOI: 01/01/2013** **X**	**01/01/2013** **X** **X**	**01/01/2014**

		And for all UR decisions on or after 07/01/2013 regardless of DOI		
CONSULTING REPORTS	▪ Limitations on LC 4605 reports		**X**	
PD ADVANCES 4650(b)(2)	▪ No PD advances prior to an Award if all conditions met		**X**	
DEATH BENEFITS	▪ Burial to $10,000	**X**		
MISCELLEANOUS				
120 MIL FUNDS	▪ Return to Work Program and the 120 million Fund under 139.48		**X**	
EXPEDITED HEARING	▪ MPN Issues added To Expedited Hearing		**X**	
INTERPRETERS	▪ Responsibility of Interpreters not to Advocate		**X**	
EVIDENCE ALLOWED	▪ Reports of Vocational Experts permitted and live testimony		**X**	
		DOI: 01/01/2013	**01/01/2013**	**01/01//2014**
ATTORNEY FEES	▪ Attorney Fees: filing Application for Non-represented Workers eliminated ▪ Attorney Fees Permitted for Home Health Care Issues		**X** **X**	
REMOVAL	▪ WCAB Power Expands to Remove Non-Attorneys		**X**	
FINANCIAL			**X**	

	▪ More Limitations on Financial Interests			

SUMMARY OF SB 863
And the New AD Regulations

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

LAB CODE	SUBJECT	ADDITIONS/CHANGES[iv]/ + REGULATIONS + DEVELOPING CASE LAW +NEW FOR 2020
4660 **4660.1**	**PERMANENT DISABILITY**	• Lab C **4660** is left intact for injuries prior to 01/01/2013 • **For injuries on or after 01/01/2013**, new **Lab C 4660.1 applies**

		• The 2005 *PDRS* ***does not apply*** to injuries on and after 01/01/2013. Instead the 2005 PDRS is effectively being *replaced* by two schedules; the first being the "**The Schedule for Rating Permanent Disabilities Pursuant to the AMA Guides**" and the other being the "**Schedule of Age and Occupational Modifiers.**" Therefore, when reference is made to the "Schedule" or the "PDRS," it now means *both* the AMA Guides and the Schedule of Age and Occupational Modifiers[v] • Under current Lab C 4660, the FEC ranking is established within ratios of earning losses by body parts across eight rankings ranging in an FEC adjustment factors from 10% to a maximum of 40%. While the FEC is technically "gone" for injuries on or after 01/01/2013, it is being replaced by a **standard 1.40 upward adjustment factor against the impairment standard FOR ALL BODY PARTS**. So, before going to the new schedule (AMA Guides + Schedule of Age and Occupational Modifiers) you will multiply the Guides based impairment by **1.40** then adjust for age and occupation in order to determine the percentage of PD • The new "**Schedule for Rating Permanent Disabilities Pursuant to the AMA Guides**" and the "**Schedule of Age and Occupational Modifiers**" are both considered as prima facie evidence and therefore rebuttable. ***[NOTE FROM COREY]***: Does this mean that Ogilvie is still alive and well? The answer here is "yes" since it can still be argued that if both schedules are rebuttable and since *Amaras/Guzman* II is still very much in "play" then Ogilvie, subject to further case law limitations, can be used to support the argument that an injured worker will sustain a *far greater* level of PD because of wage loss as he or she is unable to compete in the open labor market. And that loss is greater than the PD afforded under the Schedule because this injured worker will suffer a much higher PD "loss" resulting from the uniqueness of his or her occupation being impacted on his or her individual future earning capacity]. (See below for further discussion on *Ogilvie, Guzman II and Dahl*) • FEC is technically eliminated but Ogilvie and Dahl remain relevant • ***Quick Refresh: Guzman II: 08/19/2010: (Milpitas Unified School District v. WCAB (Guzman)*** *187 Cal. App 4th 808, 75 CCC 837: Court holds that the AMA Guides 5th should be used as "intended" by its authors and this means taking into account the whole book, including instructions and the use of "clinical judgment." This permits a physician to go beyond the chapters, tables and strict protocols of the Guides. To support a case for "rebuttal" the physician must therefore explain why departure from the impairment percentages is necessary and how it was arrived at. The California Supreme Court denied review on 11/10/2010, so for now this 6th DCA decision is good law until another district decides otherwise* • ***Quick Refresh: Ogilvie III:*** *Decided on 07/30/2011 by the 1st DCA: Ogilvie v. WCAB: (197 Cal App 4th 1262); 76 CCC 624: Here, the Court sets forth three (3) distinctly different methods by which to rebut the*

		*FEC component of the PDRS: (1) Proving the existence of a **factual error** in the application of a formula or in the preparation of the PDRS: (2) **The injury impairs applicant's rehabilitation** and; (3) Nature or severity of the injury was not captured within sampling of data used to produce the FEC. The California Supreme Court has granted review but has neither decertified nor vacated the lower court's opinion, so it stands, for now. So, now this holding has essentially reprised the old **LeBoeuf** approach, where evidence from a vocational expert can be used to support a finding that an injured worker is precluded from working in the open labor market and is therefore factually, vocationally, permanently and totally disabled. The burden of rebutting the PDRS was made more difficult for the applicant in the case decision of **Dahl v. Contra Costa County v WCAB** (2015) 240 Cal. App. 4th 746, 80 CCC 1119). Here, the applicant used the 2nd method under Ogilvie, i.e., rehabilitation. But the missing component was the vocational expert's opinion did not specifically state that applicant was not amenable to rehabilitation, but instead the method for determining PD produced a higher rating. This was deemed insufficient. The court ruled that the PDRS may not be rebutted simply by offering an alternative calculation of the diminished earning capacity, but rather the applicant was not amendable to vocational rehabilitation—they did not rule on whether the inability had to be complete or not. **NOTE FROM COREY**: There seems to be a discernible uptick in the use of vocational experts, especially in chronic pain cases, or cases where there are multiple surgeries and claims where there are co-morbid conditions. The use of vocational experts appears to be gaining some traction. This opens a new door and therefore requires some real skill and attention. It becomes critical to secure a good defense vocational expert, who can be expected to critique and rebut the applicant's expert. It also gets you deep into the subject of apportionment since some applicant vocational experts are ignoring apportionment in their own analysis and opinion. Also, defense attorneys may need to challenge these experts by (1) deposition; (2) with a rebuttal from the defense expert; (3) in applicant's deposition, exploring the time frames, the directions provided for testing and the like; and (4) cross examination at trial. Also, watch out for the applicant attorney, who designates a vocational expert, secures a report from that expert and then quickly files a Declaration of Readiness to Proceed. **WCAB Panel Decisions**: **Wright v. Michael's, Gallagher Bassett,** 2015 Cal. Wrk. Comp. P.D. Lexis 455.[vi] Applicant underwent two spinal surgeries, after which she was found to be incontinent. The applicant's vocational rehabilitation expert found she had a total loss of earning capacity based upon a synergistic effect of the functional limitations set forth in the medical reports. She was also taking numerous types of medications and this was one of the factors justifying finding her claim to be 100% PD. **Stephanie Duncan v. EDD/SCIF** 2016 Cal. Wrk. Comp. P.D. Lexis 612.* Applicant contended she was 100% as she was non-feasible for rehabilitation because of her medications. The WCAB panel ordered a remand of the matter back for further development of the record and specifically for the PTP to determine whether applicant's ability to participate in vocational rehabilitation was related to the continued use of the pain medication, Tramadol. Here, the record was deemed insufficiently developed. In a somewhat attenuated approach to LeBoeuf and apportionment, the WCAB issued a panel decision in ***Target Corporation, PSI Admin by Sedgwick v WCAB*** *81 Cal Comp Case 1192, 2016 Cal. Wrk. Comp. LEXIS 131.* Here, the WCJ found the applicant 100% PD based upon applicant's vocational non-feasibility and

		because the PD was not based upon the AMA Guides, the WCAB panel determined that considerations of apportionment should follow a different path – the apportionment analysis should be a "separate, vocational one and should not rely exclusively on each medical cause of impairment criteria under the AMA Guides –that the focus should be on the applicant's "capabilities." [This presents a whole new take on Escobedo] This is also a very ripe area for the scrutiny of applicant's vocational expert report • **Adds adjustment factor of 1.4** against the WPI determined under the AMA Guides, 5th, before going to the Schedule of Age and Occupational Modifiers. Therefore, every impairment standard will be upwardly adjusted by a constant factor of 40%, before further adjustments for occupation and age are made, in order to determine the final PD rating • Under the 2005 PDRS, the FEC had been determined by an assigned FEC rank across 8 levels, with a range of between a 10% and maximum 40% adjustment. Under the revisions of SB 863, the body parts which will be the *most upwardly impacted* are fingers, elbows, knees, ankles, feet and toes • **LIMITING COMPENSABLE CONSEQUENCES FOR PSYCHE, SLEEP AND SEXUAL DYSFUNCTION: LAB C 4660.1 (c)(1): No increases in impairment ratings for the compensable consequences of a physical injury resulting in psyche, sleep or sexual dysfunction, or any combination thereof**: Exceptions are being a victim of a violent act or direct exposure to a significant violent act, a catastrophic injury which includes, but is not limited to things such as loss of a limb, paralysis, a severe burn or severe head injury. (***NOTE:*** This should hopefully reduce what now appears to be a standard "routine" of many physicians, who report compensable consequences. ***NOTE FROM COREY*****:** I think we will be seeing more CT claims for "straight psychiatric" injuries in order to circumvent this new PD limitation. Or, we may expect some PTP's will simply shift from psyche, sleep and sexual dysfunction to GERD, IBS and hypertension as the new "add owns" du jour. ***FURTHER NOTE FROM COREY****: What we are starting to see is a practice where applicants are not formally alleging psychiatric stress but rather non-psychiatric stress, presented in the form of hypertension, Irritable Bowel Syndrome ("IBS") GERD, migraine headaches, chest pain, cardiac issues, heart problems or some other manifestation of stress beyond a formal DSM IV-TR diagnosable mental disorder... This raises the "McCoy" issue. In McCoy, applicant made a psychiatric claim against which defendant raised the "good faith personnel actions under Rolda. Upon prevailing on defending the psyche injury, the court also found that the migraine headaches were also defendable since they were caused by the disputed psyche injury. But, subsequent WCAB panel decisions (see below) have narrowed the target for the defense. In effect, we may be evolving to a point where it becomes much more difficult to tie in "physical manifestations" or "compensable consequential physical injuries" to a Rolda defense. Instead, we could be looking at a "two tracks" system, one for actual psyche claims and the other for non-psychiatric stress claims*

		• ***City of Los Angeles v. WCAB*** **(**2016) 81 CCC 611**. (Writ denied).** Firefighter filed CT claim, among other things suffered prostate cancer. He also suffered resulting sexual dysfunction upon removal of his prostate in the treatment of his industrial prostate cancer, resulting in nerve damage. WCAB held that he was not precluded from having compensable PD because the sexual dysfunction was caused by the treatment for the industrial cancer. This was deemed a "direct injury." **WCAB Panel Decision: *Larsen v. Securitas Security Services, PSI*.** 2016 Cal. Wrk. Comp. P.D... Lexis 237. A security guard was struck by a car while walking through a parking lot. The WCAB held that the statutory definition of "violent act" is not limited to criminal or quasi criminal activity but would also include "other acts" which are characterized by either strong force, extreme or intense force or are vehemently or passionately threatening. **WCAB En Banc Decision: *Wilson v. State of California*** ADJ1011693 (07/15/2019). One of the exceptions to Lab C 4660.1[c] is for "catastrophic injuries." Here, applicant was a state firefighter who sustained serious injuries from exposure to the fires across multiple body systems, which progressed over time. The WCAB determined that the term "catastrophic" does not necessarily relate to the mechanics of injury nor at a specific point in time following injury. Also, numerous factors are involved in determining whether the injury is catastrophic. **WCAB Panel Decision: *Wang v. So. Cal Edison*,** 2015 Cal Wrk. Comp. P.D. Lexis 511. Good faith personnel action defense would not be applicable since the "stress" being alleged was physical stress to the heart and cardiovascular system and therefore not part of the proof required for regular psyche claims. ***Valdes v City of Torrance*** 2019 Cal. Wrk. Comp. P.D. Lexis 456. Applicant injured left shoulder, neck and claimed psyche injury. Applicant received an award of 56% and the WCJ held that 4660.1[c] did not bar recovery for the psyche PD as the psyche injury was directly caused by the injury and not a secondary compensable consequence of the orthopedic injury. • **Nothing herein *is intended to overrule Guzman II* *[NOTE:*** If anything, I fully expect that "chapter and table shopping" within the Guides will become the near norm and that we will likely face expansive discussions on why the tables or specific applications of the Guides are not as accurate as "hybrid" and "analogy based" ratings resulting from creative combinations and mixtures using different parts of the Guides, all tied together with the connective tissue being the ADL's]. **UPDATED NOTE FROM COREY**: Over the past 24 months, I have generally seen a reluctance on the part of most PQME's to venture into the Almaraz Guzman II universe, but it does occur. I see it more frequently in finger, hand, wrist and upper extremities cases than any other • **WHAT ABOUT PSYCHIATRIC INJURIES**? A careful read here will demonstrate that since the 2005 PDRS is technically inapplicable, then seemingly there exists no actual method by which to determine impairment for compensable psychiatric injuries, whether secondary to a physical injury or provable independently. *[**NOTE FROM COREY**]:* In the earlier version, I had envisioned challenges to the GAF since it was never really intended to assess impairment. Instead it was used as a clinical tool in order to assess the capability of patients being treated within a mental health facility. It is found within the DSM-IV-TR. It is a very subjective scale which weights either "symptom severity" or "function" along a numeric scale.

Also, the GAF is not in any way incorporated within the Guides. However, the expected challenges have simply not materialized perhaps because the GAF is easy to apply and simpler to rate than the earlier eight "work function impairments" featured in the 1997 PDRS. Under SB 899, an actual PD rating schedule was mandated ("PDRS"). However, under SB 863 and newly written section Lab C 4660.1, for injuries on and after 01/01/2013, there is no actual PDRS. Instead there are the AMA Guides 5th and the Schedule of Age and Occupational Modifiers. But if you look carefully, there is no actual vehicle with which to come up with a rating for psyche impairment. Turning to the Guides, please note that Chapter 14 specifically does not set forth any actual percentage impairment ratings for emotional disturbance based upon their stated belief that such measures are not accurate. As stated on page 361, *"Percentages are not provided to estimate mental impairment in this edition of the Guides. Unlike cases with some organ systems, there are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist."*[vii] You can expect some physicians may use Table 14-1 on pp. 363 denoting impairments from Class 1 to Class 5 but without percentages. Here, it wouldn't be hard for the physicians to then base estimates of impairment using ADL's as their underlying rationale. This would echo the old "work functions" which were the basis for the 1997 PDRS. Or they may simply continue to use the GAF and then using an Amaras/Guzman discussion, indicate why a GAF based impairment or an impairment improvised by ADL's is "more accurate" then not having a basis upon which to determine psychiatric impairment. I would expect that pending regulations, most physicians will continue to use the old "GAF" method and it seems likely that few might object, in the absence of any further near-term clarification of this issue. ***[NOTE FROM COREY]**: PSYCHIATRIC PD:* Since our first publication, it appears that physicians are generally following the "GAF," with a caveat that some are also using in parallel discussion, the "old" work functions from the 1997 PDRS. But we are also not seeing many Almaraz/Guzman II attempts to enhance the impairment determinations, perhaps in some part since the "GAF" is not a part of the Guides. Also, it appears that Lab C 4660.1 prohibition from "secondary psychiatric PD" is not generating a lot of litigation. However, as explained below, there are some attorneys, who are making strategic decisions to simply bypass the psychiatric claim of stress in favor of launching a "non-psychiatric" claim of stress based upon internal medicine, gastroenterology or neurology

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

EXAMPLE	2005	2013
46-year-old school teacher Right knee Requires use of short brace, Table 17-5 or 15% WPI	17.05 15{2} 17 214F 17 18	17.05 15 21 214F 21 22
35-year-old carpenter Back	15.03 13[5] 17 380H 21 20	15.03 13 18 380H 22 21

		DRE III 13% | | | **46-year-old electrician** **Back: DRE IV 23%** **Neck: DRE IV 28%** **Heart: Class 2 20%** | 15.03 23[5] 29 380H 35 39 15.01 28[5] 36 380H 42 46 3.01 20[5] 25 380H 30 33 46 C 39 C 33 = 78 @270 = 151,537.50 | 15.03 23 32 380H 38 42 15.01 28 39 380H 45 49 3.01 20 28 380H 34 38 49 C 42 C 38 = 81 @290 = 176,682.50 **Remember:** SB 863 increases PD on two levels: (1) The rates go up by increasing minimums and maximum rates for PD over 54% and; (2) Every impairment standard is automatically multiplied by 1.4. (40%). And don't forget that rates go up again for *all PD* for injuries on or after 01/01/2014
4453(b)(8) **4453(b)(9)**	**AWW AND PD RATES** **Current AWW and Rates:** 2006 to 12/31/2012 PD 1-69 | MINIMUM: AWW 195 = 130.00 MAXIMUM: AWW 345 = 230.00 70-99 | MINIMUM: AWW 195 = 130.00 MAXIMUM: AWW 405 = 270.00	**4453(b)(8): Injuries on or after 1/1/2013** **PD @ 01 to 54:** ▪ MINIMUM: AWW 240 minimum = 160.00 ▪ MAXIMUM: AWW 345 maximum =230.00 **PD @ 55 -69:** ▪ MINIMUM: AWW 240= 160.00 ▪ MAXIMUM: AWW 405 = 270.00 **PD @70-99:** ▪ MINIMUM: AWW 240 = 160.00 ▪ MAXIMUM: AWW 435 = 290.00 **4458(b)(9) Injuries on or after 01/01/2014:** **PD @1-99:**

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

Some Illustrations 01/01/13 @ MAXIMUM vs. 2006
<table>
<tr><th></th><th>2005</th><th></th><th>SB863</th><th>%</th></tr>
<tr><td>15</td><td>11,615</td><td>230</td><td>11.615</td><td>SAME</td></tr>
<tr><td>20</td><td>17,365</td><td>230</td><td>17,365</td><td>SAME</td></tr>
<tr><td>30</td><td>30,130</td><td>230</td><td>“</td><td>“</td></tr>
<tr><td>45</td><td>54,280</td><td>230</td><td>“</td><td>“</td></tr>
<tr><td>55</td><td>71,587.50</td><td>270</td><td>84,037.50</td><td>+17.4</td></tr>
<tr><td>65</td><td>89,987.50</td><td>270</td><td>105,637.50</td><td>+17.4</td></tr>
<tr><td>70</td><td>116,977.50</td><td>290</td><td>125,642.50</td><td>+7.4</td></tr>
<tr><td>85</td><td>181,777.50</td><td>290</td><td>195,242.50</td><td>+7.4</td></tr>
<tr><td>90</td><td>203,377.50</td><td>290</td><td>218,442.50</td><td>+7.4</td></tr>
<tr><td>99</td><td>242,257.50</td><td>290</td><td>260,202.50</td><td>+7.4</td></tr>
</table>
The number of weeks is the same as 2006 (the multipliers remain the same) so the difference is the AWW resulting in a higher PD rate from 2006 maximum impacting PD starting at 55-69 (230 to 270) and 70-99 ($270 to $290)
For all injuries on or after 01/01/2014, the PD maximum of $290.00 is applicable for PD from 01 to 99:3 [Lab C 4452(b)(9)
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<td>4658(e)</td>
<td>PERMANENT DISABILITY: WEEKS AND 15% BUMP UP/DOWN: ELIMINATED</td>
<td>

Lab C 4658(d)(2) containing the infamous “15% bump up/bump down still applies to injuries prior to 01/01/2013
For injuries on or after 01/01/2013: new sub-section (e) eliminates the entire 15% increase or decrease provision
The number of weeks for 2/3d of AWW allowed for each 01% of PD remains the same for PD from 1-99% (The formula found on Table 15 of the Labor Code remains unchanged)[viii]

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<tr>
<td>4658.5
4658.7</td>
<td>SJDB</td>
<td>

Lab C 4658.5: Adds new sub (d) for injuries prior to 01/01/2013 where the SJDB issues after 01/01/2013, it shall expire 2 years from date furnished to employee or 5 years from date of injury, whichever is later
Employee not entitled to payment or reimbursement of expenses that have not been incurred and submitted with appropriate documentation prior to expiration date of voucher

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	Regulations became effective 01/01/2014	▪ Slight modifications to Notice of Offer of Modified or Alternative Work for injuries between 1/1/2004 and 12/2012; adding word "inclusive" to clarify time period **Injuries on and after 01/01/2013** ▪ **Lab C 4658.7: New "Supplemental Job Displacement Nontransferable Voucher" for injuries on or after 01/01/2013** ▪ Voucher obligation now arises when there **is *any amount of* PPD** and no offer of work is made within **60 days** of the Claims Administrator **receiving the first report from a PTP, QME or AME** in proper form, finding disability from all conditions for which compensation claimed is permanent and stationary AND injury has caused PPD (see below since the regulation appears to be inconsistent with the timing of the statute) [For injuries between 01/01/04-12/31/12, the "trigger" remains the date upon which TD terminated, so the offer must be made within 30 days from that time, in order to avoid liability for the SJDB] ▪ **AMENDED REGULATIONS: 01/01/2014.** The AD has changed slightly the timing of when the offer of regular, modified or alternative work is to be made. Under prior 8 CCR 10133.31 (b), the offer was due to be made within 60 days of receipt by the Claims Administrator of the Physician's Return-To-Work & Voucher Report [DWC-AD 10133.36]. Now, (b) has been changed to add-- that the offer is to be made within 60 days of the form 10133.36 but adds, "*That indicates the work capacities and activity restrictions that are relevant to regular work, modified work, or alternative work." 8 CCR 10133.3(c): provides that if the employee has lost no time from work or has returned to the same job for the same employer, is deemed to have been offered and accepted regular work in accordance with the criteria set forth under Lab C 4658.(b). Under revised 8 CCR 10133.34(b)(1), the Claims Administrator may serve the offer or work on behalf of the employer* ▪ ***NOTE FROM COREY:*** Remember, the SJDB is essentially for education and training. If an injured worker is deemed illiterate with no formal education, then he or she would obviously not benefit from the education and training services afforded by the voucher. However, that alone DOES NOT necessarily establish the fact that the applicant would not otherwise benefit from the voucher. Your defense vocational expert should be consulted as the services may be based upon direct job placement, predicated on the existence of transferrable job experience or skills. So, be careful here, because the conclusion the applicant would not benefit from services afforded by the SJDB is the potential "flip side" of a LeBoeuf finding, so this issue may tie into an Ogilive attack from applicant's counsel. In other words, finding a way to make the voucher work may turn out to be the best defense against an Ogilvie attack using LeBoeuf

- **NEW DWC FORMS:**

10133.32	**SUPPLEMENTAL JOB DISPLACEMENT NONTRANSFERABLE VOUCHER FORM** **New Voucher Form adopted as of 01/01/2014**	Provides for direct reimbursement to the school or a certified provider. Upon the voluntarily withdrawal from program, employee may not be entitled to full reimbursement **NEW VOUCHER:** Adds that the employer may give the employee the option to obtain computer equipment directly from the employer **NEW VOUCHER:** Ads a page for request for purchase of computer equipment with the option of employer furnished. It also allows the employee to submit bids from retailers by attaching an "invoice" to the request, so the computer need not be paid for, prior to issuance of the payment request. Or, it permits purchase by the employee with receipt of purchase attached to request
10133.33	**DESCRIPTION OF EMPLOYEE'S JOB DUTIES** **NEW FORM: 01/01/2014**	To be developed jointly by the employer and employee. This would be referred to the physician who then prepares form 10133.36. This is prepared jointly between employer and employee[ix] **Form modified to delete reference to Retraining and Return to Work Unit, since that no longer exists**
10133.35	**NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK** **NEW FORM: 01/01/2014**	All offers are now on one form NEW FORM**: Adds that employee may object to the offer (as opposed to only accepting or rejecting) if the offered job location is different than the one held at the time of injury and applicant does not believe the offered job is a reasonable commute from his/her**

					residence. Form also adds a "waiver" of the commuting distance issue. Also, eliminates reference to Retraining and Return to Work Unit, since it does not exist **Adds address of DWC in the event of a dispute**
			10133.36	**PHYSICIAN'S RETURN-TO-WORK AND VOUCHER REPORT** **NEW FORM: 01/01/2014**	This was made mandatory under SB 863, to be forwarded to employer for purposes of fully informing employer of work capacities and of activity restrictions, which are relevant to regular, modified or alternative work (Lab C 4658.7(h)] **This form has changed to more fully conform to the PR-4 and has a "box" for the physician to provide a narrative description of ways in which the impaired activities are limited. Restrictions are rewritten**
			10133.55	**REQUEST FOR DISPUTE RESOLUTION BEFORE THE ADMINISTRATIVE DIRECTOR** **NEW FORM: 01/01/2014**	Same form, same form number, with slight modifications on last page, but nothing substantive Slight changes include the employee "objection" to the offer because of the distance to location. And, they delete reimbursement program as it no longer exists

- **REGULATIONS:** [**10133.31**] The offer is made within 60 days after receipt by the Claims Administrator of the ***Physician's Return-to-Work & Voucher Report***: **DWC-AD 10133.36**) [***NOTE FROM COREY]:*** The "trigger" for the offer here is different than the statute, since the offer is triggered by ***the receipt of the "form***" rather than from the date of the (medical) "report" from the PTP. The "instructions" on the form say it is "mandatory" but what happens if the PTP, QME or AME finds P and S and PPD but does not "attach" the form? This could lead to some mischief, since those dates may not coincide, and the statute would "trump" the regulation. The safer way to go is to ensure that the offer is made timely based upon the date of receipt of the report, since the "form" may not come until several weeks later. Another "twist here" is that the regulations say that if the Claims Administrator furnished a job description to the physician, he/she must fill out the bottom of form 10133.36, but what if they don't? What if the form is then deemed incomplete? What makes sense here is that the "time frame" seems to run at least from the date the Claims Administrator receives the "form" 10133.36, irrespective of whether it is complete or possibly earlier, if the medical report is a P and S evaluation from all injuries, finds PD but the form is not attached

		▪ **MANDATORY FORM**: **[Form: DWC-AD 10133.36]** Claims Administrator is required to forward the required form to the employer, in order to inform of work capacities and restrictions which are relevant to potential regular, modified or alternative work. Use of the form is mandatory per the regulations ▪ If a physician has been provided a job description [**Form: DWC-AD 10133.33**] the physician shall evaluate and describe in the form whether the capacities and restrictions are compatible with the requirements in the job description. And the physician shall comment on the job description within form AD 1011.33.36, which is attached to the medical report provided to the Claims Administrator ▪ No SJDB is required, if a timely offer is made of regular, modified or alternative work lasting at least 12 months. Physician to respond to a job description furnished by the Claims Administrator ▪ SJDB is due 20 calendar days after the 60-day period required to make the offer of work. **SJDB is redeemable in an amount "up to" an aggregate of $6,000 and the benefit is not scaled to any specific level of PD** ▪ Expanded use of voucher, to include occupational licensing, professional certification fees, examination fees, examination preparatory course fees, purchase of tools required by a training or educational program and resume preparation. Under the **$6,000** aggregate sum, payment for resume preparation, services of licensed placement agencies, vocational or return-to-work counseling, all up to a **combined limit of 10%** of the amount of voucher (or not more than $600.00) [**10133.31(e)(1)**]**:** Payment for education-related training or skill enhancement, or both, at California public school or with provide which is certified by the state's Eligible Training Provider List (EPTL) which includes: ▪ Tuition ▪ Fees ▪ Books ▪ Other expenses required of the school ▪ Occupational licensing fee ▪ Professional certification fee ▪ Related examination fees

		▪ Examination preparation course fees ▪ Services of licensed placement agencies (combined limit $600) ▪ Services of vocational or return-to-work counseling (combined limit $600) ▪ Resume preparation (combined limit to $600) ▪ Purchase of required tools ▪ **Computer Equipment** (reimbursable *after cost is incurred and submitted with appropriate documentation* up to $1,000) (including monitors, software, networking devices, input devices, e.g. keyboard and mouse, peripherals (printers) tablet computers. (games or entertainment media are excluded) The regulations do not specifically state that the computer is required as part of the curriculum of the school or training facility. But the entire voucher is linked to education and training, so without some evidence of enrollment, the computer is not allowable ▪ Up to $500 as a miscellaneous expense reimbursement or advance ▪ **ADVANCE OF $500:** Under the $6,000 aggregate sum, payment to the employee as an advance or reimbursement **up to $500** deemed as a miscellaneous advance without the employee's need to document. [**10133.31(e)(6)]:** The regulation is taken "word for word" from the statute, so no further rules here beyond what the statute says. A further change to the regulation permits the employee to make the request by E mail if this is included in the Voucher form ▪ **COMPUTER EQUIPMENT:** Under the $6,000 aggregate sum**, up to $1,000** for the purchase of computer equipment, which will likely include peripherals such as monitors, keyboard, mouse, software and even tablet computers. According to the statute, the qualifying elements of the SJDB are the existence of any PD and no offer being made within the 60-day time frame. It is the applicant's "choice" as to how to spend the voucher, so it seems as if computer equipment might well become a "routine" thing in any case where there is PD and no timely offer of work ▪ **VOUCHER EXPIRES:** 2 years from the date it is furnished to employee or 5 years from the date of injury, whichever is later ▪ No payment or reimbursement to employee unless there is submitted documentation prior to voucher expiration date

		▪ **No settlement or commutation of SDJB is permitted;** Lab C 4658.7(g) and 8 CCR 10133.31(h): **WCAB Panel Decisions*: Beltran v. Structural Steel Fabricators***: 2016 Cal. Wrk. Comp. P.D. Lexis 366—Held that when the parties attempt to resolve (included in C and R) the SJDB and there is a good faith dispute over AOE/COE which might bar recovery, the WCAB may relieve defendant from liability for the SJDB but there has to be a WCAB "finding," in a manner similar to a Thomas finding. ***Roger Pecorino v. PT Gaming, LLC*** 2016 Cal. Wrk. Comp. P.D. Lexis 620: Upholds Beltran, emphasizing that for the SJDB to be settled, the WCAB must make an "express finding" based on record that serious and good faith issue existing to justify release. ***[NOTE FROM COREY]****: In cases where you simply have neither an enough legal nor factual defense in order to obtain a Thomas type finding, one suggestion is to put a stipulation in the C and R agreement that there no PD; without PD there is no entitlement to the SJDB. Or, you can offer language that the applicant remained at work in the same capacity/same wage, so there is no entitlement to the SJDB* ▪ The roster of schools is enhanced as it is now based upon the State of California's Eligible Training Provider List ("ETPL") and this includes a range of programs, featuring classroom education, correspondence, internet and broadcast. The list is based upon the recognition of eligibility to receive funds under the Workforce Investment Act (WIA) of 1998. [**10133.31(e) (1) and 1033.58(c**)]: the list is now based upon a very wide number of schools. For injuries on or after 01/01/2013, providers of education-related retraining or skill enhancement shall be certified on the ETPL. See; http://etpl.edd.ca.gov ▪ **10133.31(l):** Claims Administrator to make reimbursement payments within 45 calendar days from receipt of completed voucher, receipts and documentation ▪ DWC has posted Approved Return to Work Counselors (VRTWC): https://www.dir.ca.gov/dwc/SJDB/VRTWC_list.pdf
4060	**QME PROCESS**	▪ This section applies when no part of the injury is accepted and shall not apply where injury to any part or parts of the body is accepted ▪ Defendant is entitled to request a panel under Lab C 4060 during the 90-day investigative period, in order to determine whether to accept or reject the claim (8 CCR 30(d)(1) ▪ **WCAB Panel Decision: *Sanchez v. Grapevine Catering*** (2016) Cal. Wrk. Comp. P.D. Lexis 126: 8 CCR 30(d)(1) During the 90-day period following service of claim form, the employer may request a QME panel before decision date is due. But this language does not otherwise preclude the injured worker from requesting a QME panel during the same period. Therefore, this decision holds that the applicant can also request a panel during the 90-day period. If the PQME fails to respond to a request for a

		supplemental report, other than for factual corrections (8 CCR 37) then the WCJ has discretion to order a replacement panel, but this is not mandatory. It is subject to some conditions. One WCAB panel decision suggested the conditions are: (1) Length of delay; (2) Prejudice to the party subjected to the delay; (3) The remedy efforts made for the delay (4) The mandate to resolve cases expeditiously [***Vasquez v. Providence Saint Joseph Medical Center*** 2016 44 CWCR 269[x]. ***Martinez v. Avitus*** 2019 Cal. Wrk. Comp. PD. Lexis. While claim was on delay, under Lab C 4060, applicant submitted a request for a chiropractic panel. The next day, defendant requested an orthopedic panel and objected to the chiropractic panel. WCAB determined applicant had first requested and therefore could choose the specialty, subject to defense objection requesting replacement panel in another specialty. Citing ***Ramirez***[xi] this panel upheld applicant's request for the chiropractic panel, noting that a chiropractor may request a referral to other medical specialties and recommend treatment, even in cases involving potential surgery ▪ **NOTE FROM COREY:** We are seeing a rising number of instances where the chosen PTP is a chiropractor, even in hand and wrist cases, so that later medical disputes can be resolved through a chiropractic PQME. It is very important to stay vigilant
4061	**QME PROCESS** **NEW FOR 2020** **HOW TO HANDLE OBJECTIONS TO PQME REPORTS AND DEU SUMMARY RATINGS**	▪ **Lab C 4061** shall not apply to utilization review decisions under Lab C 4610 ▪ **Lab C4061** shall not apply to employee disputes of diagnosis or treatment under MPN per Lab C 4616.3 and Lab C 4616.4 **A PRIMER ON HOW TO HANDLE OBJECTIONS TO PQME REPORTS FOR UNREPRESENTED EMPLOYEES INCLUDING SEEKING CLARIFICATION, SUPPLEMENTAL REPORTS AND DEU RATINGS** ▪ **FACTUAL CORRECTION: UNREPESENTED**: Either the unpresented employee or the Claims AD may request one factual correction, within 30 days of the receipt of the comprehensive medical-legal report from the PQME, pursuant to Lab C 4061.1(d)(1) ▪ **CLAIMS AD REQUESTING**: If Claims AD serves the request for factual correction, must serve copy upon employee, who then has 5 days after service of the request, to respond to the corrections mentioned in the request. The injured workers' response shall be served on the PQME and the Claims AD. (37(b). The time within which the PQME is to respond is now extended by 15 days. Employer

request shall inform employee as to the availability of the Information and Assistance Officer, to assist in responding to the request

- **INJURED WORKER REQUESTING:** If the request for factual correction is filed by the injured worker, the PQME has 10 days after service to the review the corrections requested in the form and determine whether corrections are necessary

- **BOTH PARTIES REQUESTING**: Time extended by 15 days

- **PQME: SUPPLEMENTAL REPORT:** By the end of the appropriate time periods, PQME to prepare supplemental report with the DEU office where the original report was filed, indicating whether the factual correction is necessary, in order to ensure the factual accuracy of the report and, where factual corrections are necessary, if the factual corrections change the opinions of the panel PQME as previously set forth in the report **NOTE:** The time frame for supplemental reports is 60 days (8 CCR 38(i) however the factual correction request triggering a supplemental report is a different time frame

- **PQME REPLACEMENT PANEL?** If the PQME fails to abide by the time frames, a party may request a replacement panel (Lab C 4063.6), 8 CCR 31.5(12). **NOTE:** This would require a party to provide notice of objection to the lateness of the supplemental report, prior in time to the date upon which the supplemental report is issued by the PQME

- **LIMITATIONS:** No party shall be permitted to file documents with the PQME, other than the form; the PQME shall not review any documents, which were not previously provided to the PQME

- **REQUEST FOR SUPPLEMENTAL REPORT OTHER THAN FOR FACTUAL CORRECTIONS**

- This is a broader request than for correction of alleged factual errors and no form of the request is mandated

- No specific time frame is set for a party to request a supplemental report from the

- In a represented case, this is the process used to request consideration of factual errors

- It is good practice to tell the PQME that you are seeking both FACTUAL CORRECTIONS and providing objections and other contentions, so the purposing of the letter is clear and unambiguous

		▪ The request for a supplemental report, other than for factual corrections, shall be accompanied by any new medical records, which were unavailable to the PQME at the time of the original evaluation and which were also properly served on the opposing party ▪ **PRACTICE TIP:** If you know that records and exhibits are to be reviewed by the PQME but are not available prior to the date of the examination, then you need to ensure these are LISTED on your exhibit sheet, so that the other side cannot later contend that these documents were never listed. That way, rights are preserved and therefore getting additional records to the PQME (after the examination0a should not be a problem ▪ An extension of the 60-day time frame of no more than 30 days may be agreed to by the parties without the need to request an extension from the Medical Director ▪ Time frame is **60 days for supplemental report. NOTE:** The failure to provide a timely report can also form the basis upon which to obtain a replacement panel but this gets tricky, especially when you risk starting "all over again" with the time frames for requesting a new panel awaiting a response, possibly having to go the WCAB to obtain an order and then going through the striking and setting process, which probably puts you at least 95 days out. (***Dunn v County of San Bernardino*** (2015) Cal. Wrk. Comp. P.D. LEXIS 520 (WCAB Panel Decision). WCAB determined defendant was entitled to a replacement panel, when the PQME failed to abide by the time frames for a supplemental report ▪ Documents and a letter can be sent to the PQME, without violating the prohibition of ex parte communications (because it is after the initial examination) so long as the other side is copied with the communication, together with any attached documents ▪ **OBJECTIONS TO PQME REPORT: REPRESENTED CLAIMS** ▪ ***QUICK CHECK:*** DID THE PQME RECEIVE AND REVIEW ALL RECORDS AND EXHIBITS? ▪ ***QUICK CHECK:*** ARE THERE MISSING RECORDS OR EXHIBITS? ▪ ***QUICK CHECK:*** ARE THE RECORDS SIMPLY SUMMARIZED OR IS THERE DISCUSSION? ▪ ***QUICK CHECK:*** BODY PART CHECK: Consistent or inconsistent? New body parts? ▪ ***QUICK CHECK:*** FACTUAL CONTINUITY OR DISPARITY?

		▪ ***QUICK CHECK:*** ALL DATES OF INJURY ADDRESSED? ▪ ***QUICK CHECK***: Are other consults or diagnostic tests being recommended? ▪ ***QUICK CHECK***: PSYCHE OR PSYCHOLOGY: What are the validity scores on the MMPI-2? ▪ ***QUICK CHECK PSYCHE***: GOOD FAITH PERSONNEL DEFENSE AND 35-45% CAUSATION? ▪ ***QUICK CHECK:*** BENSON/APPORTIONMENT: Carefully review apportionment discussion. If that is a "fail" then we have a probable "go" for the objection to the PQME report. If they can't figure out apportionment, the PD is therefore legally "incomplete" under Escobedo and the report is arguably not substantial medical evidence ✓ **ANALYSIS:** This is where the time comes in. What are the findings re: AOE/COE, parts of body, TTD/TPD, MMI, impairment and apportionment? Are there errors in the use of the AMA Guides 5th Ed., such as using loss of strength, ROM vs. DRE and chapter and table shopping? ✓ **BASIS UPON WHICH TO OBJECT TO FINDINGS:** • Conclusions based upon conjecture, speculation, surmise and guess • Medical report is not substantial medical evidence • Conclusions not supporting by the facts • Failure to review documents and records or to consider potential contradictory information requiring a critical analysis and associated discussion • Failure to read and consider deposition testimony which contradicted history and/or claims of pain and ADL impacts • Benson not considered • Insufficient and inadequate apportionment discussion • Improper summary of records

		• Failure to disclose other individuals, who help prepare medical report • Body part findings not supported by the record • History provided by applicant alleged as false, incomplete and/or misleading • Insufficient factual analysis supporting medical conclusion(s) • **OBJECTION TO PQME FINDINGS MUST CONTAIN RESERVATION OF INTENT TO CROSS-EXAMINE PHYSICAN.** Practice Tip: Don't wait on this. Get your objection out fast, even if there is no time frame. A/A could transmit out a settlement demand and then file a DOR for an MSC, so make sure you object timely and then go ahead and set the doctor's deposition. This can always be continued or even canceled • **OBJECTION TO PQME REPORT: UNREPRESENTED** • Lab C 4060: Requesting party shall attach claim denial to QME Form 105 • Lab C 4061 and Lab C 4062: CLAIMS ADMINISTRATOR: Attach written objection indicating identity of the PTP, the date of the report subject to the objection and a description of the medical determination that requires a QME to resolve, to the QME Form 105 • Claims AD provides form to injured worker, who then requests a PQME. Once panel is issued, the injured worker has 10 days within which to strike, otherwise the Claims AD can select the PQME • Non-represented employee, who obtains a PQME may not later obtain a medical-legal report if later represented (Lab C 4062.1(e)). • **DEU SUMMARY RATING: UNREPRESENTED** • The rating procedures and processes shall not go forward, during which time either the employer or employee has requested a factual correction (Lab C 4061(d)(2) • PQME sends copy of medical report, together with the summary form (initial) to employee, to the DEU and to the Employer

		• Either the unrepresented employee or the Claims AD may then ask for a rating. DEU shall provide rating within 20 days (plus 5 for mailing) and serve rating on both Employer and Employee (Lab C 4061(e)) • Apportionment issues must be submitted by the AD to a WCJ, who may refer the report back to the POME for clarification or correction, if the WCJ determines the apportionment is inconsistent with the law • **DEU SUMMARY RATING:** Lab C 4061(g); 8 CCR 10164 • **RECONSIDERATION:** Within 30 days of receipt of rating, either the Employer or Employee may request the Administrative Director reconsider the recommended rating or obtain additional information from the PTP or medical evaluator, to address issues not addressed or not completely addressed in the original comprehensive medical evaluation. The request is in writing and shall specify the reasons for the rating reconsideration. The request is set is made using **DEU Form 103.** One or more of the following reasons are set forth and no other reasons will be permitted: • Summary rating was **incorrectly calculated** • Comprehensive medical evaluation **failed to address one or more issues** • Comprehensive medical evaluation **failed to completely address** one or more issues • Comprehensive medical evaluation was not prepared in accordance with required procedures, including compliance with 139.2[xii] • If AD finds the QME report is not complete or not in compliance with required procedures, the AD shall return the report to the PTP or the PQME for appropriate action as the AD instructs. Upon receipt of final report from PTP or PQME, rating is re-calculated • Or the AD can order an additional QME by return to the Medical Director • **IS THE DEFENDANT STUCK WITH A BAD SUMMARY RATING? WHAT TO DO?** • Practice Tip: *Let's be candid. When the claim is not litigated, the "unknowns" can be troubling. So, caution and care should always be exercised*

		• **STEPS:** • Scrutinize the QME report for factual errors; an error can also include an omission. See what the faults are and make a list. This includes reviewing records, getting the right history and comparing histories, physical (or emotional) complaints, implicated body parts against the findings of the PTP. Are there new body parts? Did the PQME address all medical issues? Did the PQME address all alleged/contested body parts? • Request Factual Correction • If the PQME fails to respond timely, ask the Medical Director for **Replacement Panel** • Make an **objection to the QME report with notice of intent to depose** • Provide notice to the employee • If appropriate, ask for a supplemental report (other than for factual correction) if you have a basis, such as new evidence • Prepare a Petition to the AD for Reconsideration of Summary Rating • While this is pending, you can also negotiate a settlement with the injured worker and then arrange for an appointment with the I and An Officer. This can also be handled by defense counsel, who can then coordinate the arrangements at a time when there is a "walk thru" WCJ, who can approve either a stipulated award or compromise and release • File an application for adjudication of claim • Notice the deposition of the PQME. Under 8 CCR 35.5(f), the PQME must be available for deposition within 120 days of deposition notice. There is a least one panel decision suggesting violation of this would not trigger replacement panel, since that isn't once of the listed grounds. (You would have to go to the WCAB and move to strike the report instead) • Yes, this starts the litigation process, but keep in mind, even if Applicant hires counsel, they don't get a new PQME, unless new claims are asserted or they add on new body parts, which is a real risk

		▪ PD rating is suspended during this correctional phase of the process ▪ Notice due to employee re: PD replaces "continuing medical care" with "future medical care"
4062	**QME PROCESS**	▪ **Lab C 4062(b):** For injuries on or after 01/01/2013 and for UR decisions communicated on or after 07/01/2013, regardless of date of injury, all employee objections to utilization review disputes under Lab C 4610 are resolved only through independent medical review (IMR) pursuant to Lab C 4610.5 *and not through the QME process* ▪ For injuries on or after 01/01/2013 and for objections to diagnosis or treatment recommendations within the MPN, regardless of the date of injury, all employee objections to diagnosis or treatment recommendations within the MPN are also resolved only through independent medical review (IMR) pursuant to Lab C 4610.5 ▪ Second opinion spinal surgical process under Lab C 4062(b) is gone as of 01/01/2013 for all dates of injury
4062.2 **139.2**	**QME PROCESS**	▪ The QME process in represented cases is changed. **Gone is the "AME" dance, which means we don't have to propose an AME as a precondition to requesting a PQME from the DEU Medical Unit** ▪ **REVISED REGULATIONS: 09/16/2013: The changes embodied in these revised regulations are minor. Rule 30: AD now permitted to revoke panel: Rule 33: one-year fee period to calendar year: Rule 35: Permitting a letter outlining the "issues" is modified to a letter outlining "the medical determination of the primary treating physician or the compensability issue."** ▪ **"AME DANCE IS GONE" (represented cases): *[NOTE FROM COREY]*:** Modifications to **8 CCR 30**, still require requesting party to attach a copy of the written objection to the PTP opinion and description of the medical dispute but the language regarding proposed AME is removed from the statute. Revised regulations change Rule 30, to permit the Medical Director to revoke a panel due to mistake, misrepresentation or if parties have agreed to resolve dispute using an AME ▪ **4062.2(b): 4060 requests** -- the 1st working day which is at least 10 days from giving the other side notice of intent to make a PQME request to the DWC Medical Unit ▪ **4062.2(b): 4061 or 4062 --** the 1st working day which is at least 10 days from a party making a 20-day objection to the reporting of a treating physician ▪ **4062.2(c):** Once the panel is assigned, gone is the requirement that the parties then "confer" in order to try and agree upon an AME from the panel over a 10-day period and then strike one physician from the panel, within 3 additional days. **Instead, either party may strike one name within 10 days from issuance**

		(plus 5 more days for mailing). If a party fails to strike a name within 10 days (plus 5 for mailing), then the other party can select any of the three as the PQME ▪ **4062.2(f):** In represented cases only, the parties may still agree to utilize an AME at any time, except as to issues now determined exclusively through UR and independent medical review (IBR) under Lab C 4610.5 ▪ No QME panel to be requested on any issue which has been submitted to an AME, unless the agreement has been canceled by mutual written consent ▪ For non-represented injured workers, panel assignments are extended from 15 to 20 working days ▪ Preference in assignment of panels given to non-represented employees ▪ **THIS RULE IS REPEALED:** QME shall not conduct evaluations at **more than 10 locations.** Changes to regulations: **[8 CCR 17(b and 31.2]:** On or before 1/1/2013, QME shall notify Medical Director of the street address of the 10 or fewer office locations where the QME will conduct examinations. Between 1/1/2013 and 7/1/2013, no substituted offices without good cause. An individual QME, performing evaluations at more than one office location required to pay additional $100 annual fee per additional office location**.** Each additional office must contain the usual and customary equipment for the type of practice appropriate to the QME specialty. NOTE: 9/16/2013: [This has been amended to now add that nothing shall prevent a QME from adding additional offices up to the maximum of 10.] ▪ **WCAB En Banc Decision:** ***Navarro v. City of Montebello*** (2014) 79 Cal Comp Cases 328: Labor Code and 8 CCR 35.5(e) do not require that the employee must return to the same QME for an evaluation of a subsequent injury. Therefore, the date of the "filing" or reporting of the injury on the DWC-1 (Claim Form) with the employer will determine which QME must consider which injury. The WCAB therefore made a distinction between returning to the same QME for new medical issues arising from an injury vs. medical issues arising from a different injury, based upon the reporting of that injury. The WCAB also stated in footnote No. 13 that in cases where there are multiple claim forms filed for the same date of injury, the date of the first of those multiple claims would be "significant' in determining which panel QME conducts an evaluation. Finally, the WCAB also stated that it did not appear to make any difference, whether the applicant was or was not represented, since the result would be the same ▪ **WCAB Panel Decisions:**[xiii] ***Weaver v. Univ. of Cal.*** 2014 Cal. Wrk. Com. P.D. Lexis 162: 8 CCR 35.5(f) requires that unless otherwise agreed upon or upon WCAB Order, a PQME must make himself/herself available for deposition within 120 days of deposition notice. Here, the WCAB Panel concluded that defendant not entitled to a new panel due to calendar "inflexibility" when QME first asked for a longer

period but later agreed but defendant sought replacement panel. ***Norwood v. San Francisco Municipal Transportation Agency*** 2014 Cal. Wrk. Comp. P.D. Lexis 176: Applicant not required to go back to prior AME for a new injury claim when parties agreed to use an AME in 3 cases but not the 4th

- **WCAB panel decision:** ***Vasquez vs Providence Medical***. If a QME fails to provide a supplemental report within 60 days of a request to do so (per CCR 38), the board has discretion to order a replacement panel. There is no statutory provision mandating a replacement panel. The board will look at the following circumstances to determine whether a replacement should be issued: 1) length of the delay; 2) prejudice to the party who is subject to the delay; 3) efforts made to remedy the delay; 4) specific facts including potential waiver by the objecting party; 5) constitutional mandate to expeditiously resolve WC cases

- **WCAB panel decision**: ***Gonzalez v. Patin Vineyards*** 2018 Cal. Wrk. Comp PD Lexis 429. Defendant's notice of objection to PTP report in English only was deemed a violation of applicant's due process, when the notice was not also in Spanish. Applicant deemed entitled to a replacement panel[xiv]

- **AD REGULATIONS FOR PQME REQUESTS IN REPRESENTED CASES: 09/02/20015**

- The DWC issued amended regulations, which changed the way we request a PQME, in represented cases.[i] The DWC Medical Unit will neither process nor accept any hard copy panel request with a postmark after 09/03/2015

- If you visit the DWC website, they have a question and answer piece and a demonstration video, both of which we highly recommend

THE REGULATIONS

- Please keep in mind that the "first party to request" is the party who gets to select the specialty of the PQME, and we know many applicant attorneys want a chiropractor. Before we get to that, remember these points about "time" and the proper counting "days"

- Whenever a document is mailed inside California and the "mailing" is the trigger for the start of the day clock, then per CCP 1013(a), if the recipient is in California, the service, while still complete on the date it was mailed, extends the *response time* from the recipient by five (5) calendar days. And, if the recipient is in another state, the time extends to 10 calendar days

- A document which is "mailed" by Express Mail (CCP 1013(c)), facsimile transmission (CCP 1013(e) or electronic service (CCP 1013(g) extends the response time by *two (2) court days*

- In the En Banc decision in ***Messele v. Pitco Foods, Inc.***, (2011) WCAB held that CCP 1013(a) does apply to notice of requests for a PQME and the "triggering event" is the notice by the party so the time does extend by five calendar days[iii]

- Under CCP 12, day one (of the 10 day notice to request a PQME under Lab C 4062.2) is always the next day after the mailing. So, if you mail your notice of intention to obtain a PQME under Lab C 4060 or you make your objection to the PTP under Lab C 4061/4062 on 09/15/2015, "day one" will always be the *next day* or 9/16/2015 for purpose of day counting. But it also includes the last day, extended by the mailing time

- If the last day falls on a Saturday, Sunday or court holiday, then you move to the *next court day*

- Please keep in mind that Lab C 4062.2(b) requires the notice for a PQME to be "mailed," which would seem to rule out personal service

REQUESTS FOR PANELS AND DAY COUNTING

- Requests can be made 24 hours a day

- Requests made on a Saturday, Sunday or a holiday are deemed to have been made at 8:00 a.m. on the next business day

- Requests made Monday-Friday after 5:00 p.m. and before 12:00 a.m. are deemed to have been made at 8:00 a.m. on the next business day

- Requests made Monday-Friday between 12:00 a.m. and 8:00 a.m. are deemed to be made on that same business day

- **10 OR 15 DAYS WITHIN WHICH TO STRIKE:** Prior to this new on-line procedure, there is some authority for the proposition that you **only have 10 days within** which to make your strike, once the panel is assigned. This was discussed in ***Messele***. Don't assume you have 15 days to strike[iv] but for represented cases after 10/01/2015, this clearly changes. Under the new regulations, the requesting party is required to serve opposing party by mail and then 10 days after service of the panel, the strike may take place. Well, it is clear the "service" is the trigger, so yes, the claims administrator would have 5 more days within which to issue a strike, unless otherwise personally served with the panel, as there is no apparent prohibition on this

- **Remember, the day counting is important.** This is important because not only about timing the request against the 10-day notice of intent to request but also knowing when the actual panel request takes place. If the other side requests too soon, *then the validity of the request* is under the jurisdiction of the WCAB, not the Administrative Director ("AD"). The rules governing this are set forth in Rule 30, sub (b)(2). The "Race to the DWC Medical Unit" will be determined by time. If the Claims AD make a request on 09/05/2015, a weekday, at 4:59 p.m. then the request for the PQME is deemed that same business day, or 09/05/2015. But, if applicant's counsel waits until 5:01 p.m., that same date, their request comes the next business day or 09/06/2015, so the defense is deemed first in time. Any week day request from 12:00 a.m. and 8:00 a.m. will be deemed made that same business day

- Time frames for requesting QME and for scheduling an appointment will be tolled ("frozen") if the Medical Director is requesting information from the parties

- **DISPUTES:** Remember, the *validity* of any request for a PQME falls within the sole jurisdiction of the WCAB. However, disputes over the selected *medical specialty* of the PQME remain exclusively within the authority of the AD, subject to appeal before the WCAB

HANDLING QME PANEL STRIKES: LITIGATED CLAIMS

- We expect that some applicant attorneys might try and serve you notice of their intent to request a PQME either by electronic means, fax or by express mail, in which case there is a **12-day time frame** so they could go on line on the 13th day and request a PQME

- You should also expect they will likely initiate their requests before 5:00 p.m. on the first day they can request a PQME, so that the request day starts the 10-day process and day one is deemed the nextday

PRACTICE TIPS ON HANDLING PANEL STRIKES

- **CHECK DATE OF ISSUANCE FOR TIMELY STRIKE**: Under Lab C 4062.2(c) the panel strike must be made within 10 days of assignment of the panel by the DWC-Medical Unit. Check date Medical Unit issued panel (it's on the form) and make sure that you anchor your timely response to that date. If the panel was served by mail [with sender and recipient both in California], the Claims Administrator has 5 additional days [15 total days] within which to act under CCP 1013.[xv] Remember, "day 1" is always the *next day.* If the panel was obtained though in-house by computer or electronically, then there is a 10-day period within which to issue the strike letter[xvi] [if the last day to strike falls on a Saturday, Sunday or court holiday, then the last day is extended to the next court day]

		• **CHECK PANEL SPECIALTY:** You may be seeing a significant number of applicant attorneys directing treatment to a chiropractor, as a precursor to asking for a chiropractic QME panel. Or, you may see an applicant's attorney refer treatment initially to an orthopedist but then ask for a pain management QME panel. So, it is important to carefully examine the practice selection made by opposing counsel. You are permitted to object to the panel specialty; make the objection [meet and confer by e mailing or telephoning A/A] but immediately file your DOR for Expedited Hearing, contesting the specialty but always go through the striking process anyway, in order to preserve your rights, in case the WCAB renders no assistance. When you strike, you can indicate defendant is preserving its rights to contest the specialty in the panel, so the striking process is "without prejudice" • **CHECK OFFICE ADDRESSES OF EACH PHYSICAN:** You may notice that one or more the PQME's are listed out of the same office address. *This may or may not mean something*. Often, QME's are "managed" by so-called medical-legal organizations, who provide various levels of administrative support, including office management. So, you need to know whether the mere sharing of the same address is rises to the level of a "group practice." You will need to call the offices of the two or more shared addresses and find out whether these physicians are merely working out of a third-party office set-up for medical-legal purposes only or they are functioning as a "group practice.?" A group practice is defined as a medical practice, where the physicians, by virtue of a written agreement, share in the costs, profits and otherwise deal with administrative issues; but the bottom line is the concept of sharing or the pooling of expenses and the distribution of profits. The DWC Medical Unit will issue a replacement panel, if it is indicated that one ore more of the physicians is a member of a group practice • **QME DATA BASE:** https://www.dir.ca.gov/databases/dwc/qmestartnew.asp Confirm each of the three physicians is on the QME list. Count the number of office locations. Generally, I like seeing fewer rather than many office locations. A good rule of thumb is I don't like to see more than 6 offices and especially when the number is more than 10. In some cases, it may just come down to striking the physician, who has the most offices. It has been my experience that in general, treating physicians are the ones who are more likely to have a larger number of offices, so these are often "easy red flags" It is hard to imagine one physician practically covering even a half-dozen offices • **DWC MEDICAL UNIT DISCIPLINED PHYSICANS LIST:** Not to be confused with the physicians, who have been charged or convicted of medical wrongdoing, this is the list of QME's who have been disciplined as a physician/PQME. But, a physician, who has been disciplined by having the QME Certificate revoked, is not available as a QME • **CRIMINALLY CHARGED PROVIDERS LIST:** Lab C 4615: This is a list of medical providers, who have been criminally charged and whose liens are automatically stayed, pending the outcome of those charges. Since PQME's do not lodge liens, then technically this doesn't bear on those charges per se, but it does reflect brightly on the physician's reputation, so it goes without saying that you don't want any PQME, who is on the "charged list."

- **SUSPENDED PROVIDERS LIST:** Lab C 139.21(A)(1). This is the list of providers, who have been convicted of a crime involving fraud or abuse of the Medi-Cal or Medicare program, workers' compensation system or any patient. It's doubtful any of the panel doctors are going to be on this list but you need to check. These doctors would be unavailable as a matter of law
- **THE MEDICAL BOARDS: MEDICAL BOARD OF CALIF --ON LINE LICENSE SEARCH:**http://www.mbc.ca.gov/Breeze/License_Verification.aspx**BOARD OF CHIRPORATIC EXAMINERS; LICENSE SEARCH**https://search.dca.ca.gov/?BD=8500&TP=DC**BOARD OF PSYCHOLOGY**https://www.psychology.ca.gov/consumers/index.shtml
- **CHECK WCAB PANEL DECISIONS:** WCAB Panel Decisions are neither citable nor controlling as case determining authority but that doesn't mean they aren't important or reflective. These are the everyday "bread and butter" decisions being made by the WCAB Commissioners, acting in a three-member configuration. These decisions are made after one or both parties to a case files either a reconsideration or removal petition. Here, I am looking at whether the PQME was a PTP, a secondary treating physician, PQME or AME and whether his/her opinions were supported, rejected or whether the record was ordered for further development
- **GOOGLE SERARCH + SOCIAL MEDIA:** This can tell us whether the PQME has published anything, advertises on the internet or has spoken out as an advocate. These searches may also reveal that the PQME is practicing a lot of medicine either at other offices not disclosed in the QME database or perhaps he/she is a member of another group practice, where they are listed on a web page as a treating physician. A lot of these doctors have a veritable web of connections, perhaps in personal injury as well as workers' compensation, so a straight Google search is recommended. A check in with LinkedIn might also reveal where the physician stands on certain workers' compensation issues or perhaps there is a reference to a past or upcoming presentation before CAAA or some other group

WHEN SHOULD I USE AN AME?

- **The decision to use an AME is a critical one, often with great risk. We recommend that a decision to use an AME be made on a case-by-case basis and possibly in consultation with defense counsel**

- We know from our experience, that a majority of the AME reports are generally associated with disappointing and/or incomplete findings or even non-responsive discussions. More often-than-not, we also must endure obtaining further records, referrals for more diagnostic testing, possible referrals to other specialists for consults and of course re-evaluations. This eats up great swaths of time and can cause case reserves to mount

- Always keep in mind that it is just the applicant and the physician "face to face" in the examination room, and the Claims Administrator is not there. You do not get the chance to "explain" your version of the

case facts, other than what is set forth in a cover letter. There is also the subjective reaction factor that an AME may have to an injured worker, such as "I believe him/her," so this mantra can sometimes override the weight of the record and the facts of the case. The examination is therefore often self-serving as the physician may simply take the mechanics of the injury as explained by the applicant as an "article of faith' For CT injuries, the AME's may conclude the job description provided by the applicant or as explained by the applicant is in fact an accurate depiction of the job duties at the time of the injury. In either physical or mental stress cases, the applicant's "charging factual contentions" are laid on the table, so often the AME will find injury, or "leave it up to the trier of fact"

- Consider the "odds." Applicant attorneys know by history and experience, that the most commonly selected, popular AME's, will typically find injury and then some level of impairment. The odds are also high that the permanent and stationary date will conveniently merge with the date of the actual examination. This explains the general willingness, even eagerness, of many applicant attorneys to use AME's. But the odds are also significant that they won't be as eager to resolve a case if the "results" are not to their liking, so a good outcome can have the reverse effect of simply prolonging the case

- **IT OFTEN SIMPLY TAKES TOO MUCH TIME:** At least in Southern California, it can take several months to get into see the AME. And what happens if the applicant misses the appointment, there is a doctor emergency, or the examination cannot be conducted in a single visit? More delays

- **PRO'S, AND CON'S OF USING A PQME?** Unless you have a good, if not compelling reason to use an AME, in most cases, the default decision to use a PQME is probably the right one but you need to do some analysis on a case-by-case basis. A good "rule of thumb" is to avoid using AME's in disputed psychiatric cases, since the tendency may be to establish injury, especially in cases of disputed facts

- **USING AN AME**: **GENERALLY- YES**

Admitted injury, no disputed body parts and reasonable applicant attorney Admitted psyche claim and the issues are impairment and apportionment Admitted hand/wrist injury and issues are impairment and apportionment Exotic or unusual medical issue Applicant is MMI and the issues are continuing or further care Petition to re-open a prior award and the AME is the same as in the prior case Case is going to MSC and there is no PTP or PQME report in your favor PTP reports are outrageous and there are no essential objective findings Sleep apnea Vascular issues

- **USING AN AME: GENERALLY- NO**

Injury denied: legal issue(s) Injury denied: factual issue(s) Disputed body parts Non-exotic medical issue(s) Fibromyalgia or CRPS Disputed psyche injury whether factual, legal or both Difficult or notorious applicant's attorney TTD issue Applicant credibility is in issue Sleep disorders other than apnea General stress causing physical symptoms

- **USING AME: MAYBE**

Admitted Injury: single body part and dispute is MMI, impairment and apportionment Admitted injury: SDT records show strong apportionment basis CT injury: Who is responsible? IBS GERD Hypertension Pulmonary and Respiratory Toxicology

- **SO, WHAT ABOUT USING A PQME?**

USING A PQME: PROS	USING A PQME: CONS
• Appointments usually occur within 60 days vs. what is often a much longer wait for most AME's, but this does vary • Reports are required to be out within 30 days from examination date with no similar requirement for an AME	• It can be a real "crap shoot," especially when you haven't heard of anyone on the panel and can't get any meaningful insights from any sources • Some PQME's are simply not good at forensics, much less, writing reports so there are so many times when the report is not worth much, one

		• Generally, PQME reports are usually shorter in length than AME reports and can be easier to digest but this varies greatly and should not be assumed • Many PQME's are mindful of "reputational" concerns and in many instances, they tend to write modest to moderate reports, which do not aim too far off the center. Some notorious applicant doctors are notably conservative, when functioning as a PQME • The fees are often less than with an AME • It most cases, it seems as if the PQME is more likely to find the applicant at MMI/P and S rather than reflexively recommend more diagnostics and more evaluations	way or the other and a cross-examination is often required • Some PQME's may ignore or give little significance to important SDT medical records and other exhibits, including depositions or they review them with no concern or attention • Apportionment can be a disappointment • Some QME's don't write a lot of workers' compensation reports and despite the certification and writing class, this does not necessarily assure a quality evaluation with an accurate or reasonable impairment assessment • Lots of rules and regulations governing, including what can be sent and when. This can be very frustrating and lead to collateral litigation over what is a "communication vs. what is "information" • A difficult applicant attorney can object to non-medical records proposed to be sent to the PQME thus forcing a hearing before the WCAB
4062.3	**COMMUNICATION WITH PQME**	▪ Sub (f) is amended to permit communications with an AME's staff or with the AME as to non-substantial matters such as scheduling of an appointment, missed appointment or furnishing of a record and reports, including availability of report. ▪ **Regulations**: changes to **8 CCR 35(b)(1):** Change permitting the type of clerical communication authorized by 4062.3(f), allowing for oral communications with the AME or staff, relative to non-substantive matters, such as scheduling appointments, missed appointments, furnishing of records and reports and the availability of the pending medical report, unless the WCAB has made a specific finding of an impermissible communication ▪ 8 CCR 35(a)(3) has been changed from a letter "outlining the issues" to a letter outlining the "medical determination of the primary treating physician or the compensability"	

		▪ **WCAB En Banc Decision 01/23/2017: *Maxim v. SCIF***: This started out as a WCAB Panel Decision. But due to the importance of the issues, it was taken up by the WCAB as a whole. Here, the WCAB explained the distinction between what is considered "information" transmitted to a PQME or AME vs. what is considered a "communication" and how the two are distinct but can also intersect. Information is deemed medical reports from the PTP and other treating physicians, as well as relevant records, which are non-medical in nature. A communication can therefore constitute "information" if it contains references or encloses records of a PTP or medical and non-medical records. An advocacy letter, which would normally be considered a communication can nonetheless "cross the line" and become "information" if it discloses impermissible information or misrepresents facts or law
4650: (b)(1) and (b)(2)	**TIMING OF PD PAYMENTS**	▪ Adds two sub-sections to the statute ▪ **FOR ALL DATES OF INJURY** ▪ NO PD advances if all conditions below are met: ▪ **(b)(1):** advancing PD now subject to (b)(2) ▪ **(b)(2) New--No PD advances are payable if prior to an award of PD**, the employer has offered the employee a position paying ***at least 85%*** of the wages and compensation paid at the time of injury –or- if employee is employed in a position that pays ***at least 100%*** of the wages and compensation paid at the time of injury ▪ When PD award is made, amount then due will be calculated from the last date upon which TD was paid or the permanent and stationary date, whichever is earlier ▪ Under this statute, if we learn the applicant is working for another employer and earning at least 100% of wages and compensation at time of injury, then no PD advances are required *[**NOTE FROM COREY**]:* We now have an additional reason to SDT the employment records from a new employer or the applicant's stipulation as to wages and compensation, otherwise if the compensation is anything lesser, we would have the obligation to advance PD ▪ PD WILL BE PAID AT THE MINIMUM AND MAXIMUM RATES (ABOVE) AND NOT AT THE TD RATES AS REFLECTED IN EARLIER DRAFTS OF THE BILL ▪ ***NOTE FROM COREY:*** We now have 2 trigger points at which offers are to be made: 1) PRIOR TO AN AWARD TO AVOID PD ADVANCE LIABLITY; and 2) WITHNIN 60 DAYS OF RECEIPT OF 1ST REPORT FROM PTP, QME OR AME, FINDING DISABLITY FROM ALL CONDITIONS, THE APPLICANT IS PERMANENT AND STATIONARY AND THERE IS PPD. *Subject to further regulations, it would be ideal if only one offer should*

		be made, but the criteria for the SJDB offer is more extensive; but if the money and benefits are at the 85% level, and then I presume ONE OFFER WOULD COVER BOTH ▪ ***NOTE FROM COREY:*** What about existing cases where there is PPD? Do we use this statute to discontinue paying PD, if the applicable criteria are there? Can this be done? Undoubtedly, this will be a subject of much discussion and analysis. There is no all-inclusive answer right now, as it may depend upon many factors. However, it is a consideration which should be undertaken with great care, especially with unrepresented injured workers. Stopping PD benefits could induce an applicant to go out and hire a lawyer, so an abundance of caution is recommended for non-represented cases ▪ **WCAB En Banc decision: *Brower v. David Jones Construction*** (2014) 79 Cal Comp Cases 550. Applicant's TTD ended under the 104-week cap in 2007 but he was not found permanent and totally disabled [PTD] until 2011, hence there was a gap of four years. The WCAB held that when TTD stops because of the cap before the applicant is determined permanent and stationary, *defendant shall commence PD based on a reasonable estimate of the ultimate level of PD.* And, if the applicant is receiving PPD and then becomes permanent and stationary and deemed 100% PD, then *defendant shall pay PTD retroactive to the date its statutory obligation to pay TTD terminated. And, COLA's will begin on the first date in January, after the injured worker becomes entitled to receive PTD*
4600	**MEDICAL TREATMENT:** **CHIROPRACTORS** **Lab C 4600(c)** **Lab C 4604.5(c)(1)**	▪ **Lab C 4602[C] added:** Request for payment with itemization of services shall be submitted to employer with the national provider identifier (NPI) for the physician or provider who provided service. Failure to provide the NPI shall result in request for payment being barred until NPI is submitted. Defendant may request NPI at an earlier date ▪ Under amended Lab C 4600(c), a chiropractor shall not be deemed a treating physician after the employee has received the maximum "chiropractic" visits under the 24 treatment "hard caps" of Lab C 4604.5(d)(1). [***NOTE FROM COREY]:*** The statute appears to delimit the chiropractor after the applicant has had chiropractic treatment. However, "chiropractic visits" are not defined. Does this mean a PTP examination by a chiropractor or does it also pertain to chiropractic adjustments as opposed to physical therapy? But what about a PTP who examines the applicant every 45 days and refers the applicant for physical therapy? A constitutional attack on this section was rejected by the Court of Appeal in ***Facundo-Guerrero v. WCAB***[xvii] ▪ **WCAB Panel Decision: *Aguayo v. Grossmont Union High School District, PSI by Corvel* 2015 Cal. Wrk. Comp PD. Lexis 89.** After the twenty-fourth chiropractic visit, applicant obtained two more reports from the chiropractor. The panel deemed these were admissible because Lab C 4504.5(d) permits parties to obtain medical consultations at their own expense. And even though Dr. Steinhardt was not permitted to continue as the applicant's PTP under the statute, his reports were permitted because applicant was still entitled to secure treatment with Dr. Steinhardt, at her own expense

CHRONIC PAIN MEDICAL TREATMENT GUIDELINES –OPIODS – 8 CCR 9792.23

- **SERVICE DOG AS MEDICAL TREATMENT**: Applicant's PTP submitted an RFA for service dog in order to assist. Claims AD did not cite basis for denial. Citing a study, the IMR reviewer overturned decision[xviii]

- **MTUS**: **Chronic Pain Medical Treatment Guidelines:** The MTUS for Chronic Pain applies when applicant has pain persisting for three or more months from the onset thereof. These new guidelines replace the prior Opioid Guidelines of 07/2009. The Opioids Treatment Guidelines are in two parts: Part 1 is the Executive Summary; Part 2 contains supplemental information. Among other approaches, functional restoration is favored with a strong focus on regaining ADL's, including returning to work. The global emphasis is upon "patient empowerment and personal responsibility" (Part I, pp 9). The choice of opioid treatment is based upon the type of pain being treated with tailored medications and dosages specific to the individual. Part 2 of the new regulations list the procedures and the correlating summary of supporting medical evidence. Yes, these regulations are very detailed and lengthy

- http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Opioids-ChronicPain/Final-Regulations/CleanCopy/Chronic-Pain-Guidelines.pdf

- **HIGHLIGHTS OF THE NEW OPIODS TREATMENT GUIDELINES:** There are separate guidelines for treatment for: [1] "acute pain" (and sub-acute pain) for the period up to four weeks after injury or from the onset of the pain. Opioids should not be used for the treatment of acute pain, unless the severity thereof so warrants and then only after a determination is made that other non-opioid pain medication or other treatment will not provide an adequate degree of relief: [2] "Chronic" pain is defined as pain lasting three or more months from the time of onset: For the first three months and then for more than three months. [3] More than three months: [4]; Post-operative pain; The following illustrate the guidelines for the ***first three months***

USE OF "C.U.R.E.S."	This is the Controlled Substance Utilization Review System, which is the drug monitoring program in California. It should be accessed with the results documented
EVALUATION AND SCREENING	Performance of a comprehensive assessment, to include the assessment of the relevant history with an examination and the identification of the cause of the pain. This also requires an assessment of the severity of the pain. Medical providers should also determine the existence of any potential comorbidity. Screening is required for potential drug abuse/misuse and alcohol misuse/abuse; and URINE drug testing ("UDT") prior to initiation of opioid trial –establishing a baseline. Periodic urine drug testing verified by a federally certified laboratory on a random basis, two to four times a year during chronic treatment. Screening to take place for patients with a high

				risk of addiction or serious adverse events and psychosocial factors which may contribute to misuse. CURES to be used and tracked. Questionnaires may be utilized. Determine use of current medications which might impact the taking of opioids. Presence of any medical factors which could complicate treatment, including psyche and sleep
			DOSAGES	Provider vigilance for daily doses above 80 mg./day of morphine equivalent dose (MED)
			OTHER TREATMENT	Pain management and functional improvement have not worked with other methods of treatment
			WEANING / TAPERING	Semi-annual attempts to wean from opioids when dosage is 80 mg./day MED or higher
			PATIENT	Discuss benefits and risk of using opioids
			CONSULTING	Considering referral to pain specialist for high risk patients
			MONITORING	For functional improvement; consulting CURES and close monitoring for indications to discontinue, including pain resolution, lack of functional improvement, intolerance and non-compliant patient. Monitoring for effectiveness of therapy by tracking pain and function. The Guides suggest that reliance of observation or physical therapy notes is insufficient. Usage of validated instruments to measure function is recommended and deemed the most reliable
			OPIOID TREATMENT	Using the lowest effective dose of short-acting opioids producing analgesia and improved function; starting with a trial period (not to last more than 60 days) in order to determine if chronic treatment is otherwise required
			AGREEMENT	Patient Treatment Agreement: Applicant understanding of the risks, side effects, potential benefits. Setting of treatment goals with functional improvement and reduction of pain
			VISITS	During titration (base dosing) face-to-face visits every 2-4 weeks. Once a stable dose is established, then face-to-face visits at least every 3 months
	INTERPRETING SERVICES	▪ **Interpreters during treatment:** new sub (g) added: Applicant entitled to services of a qualified interpreter if he or she cannot effectively communicate with the treating physician ▪ AD to adopt fee schedule for qualified interpreter fees in accordance with this section ▪ Employer not required to pay for non-certified or provisionally certified interpreters		
	HOME HEALTH CARE			

	NURSE CASE MANAGER	▪ **Home Health Care ("HHC")**: New Lab C 4600 sub (h): HHC is considered medical treatment if reasonably required and ***prescribed by a physician and surgeon***. The definition of "prescription" was the subject of dispute and the WCAB has issued an en banc decision which changes the meaning of the word "prescribe." **WCAB En banc decision**: ***Hernandez v. Geneva Staffing, Inc.*** (2014) 79 Cal Comp Cases 682: Here, the request for HHC was made by Dr. Lee, who reflected that the applicant would need continuous home care from his wife. His report was signed, but there was no formal prescription for HHC. The WCAB held that the AD regulations governing HHC apply to all pending, non-final cases. More importantly, it was declared a "prescription" for HHC is either **an oral referral communicated directly by a physician to an employer/agent or a signed, dated written referral recommendation or order by a physician. It does not have to be "labelled" or even written in any particular form** ▪ **NURSE CASE MANAGER** ("NCM") For many years, it has been the custom and practice for the claims administrator to essentially decide whether to utilize an NCM and the general practice has also been for the Claims Examiner to select that individual. For the most part, applicant attorneys were not generally engaged in the process, because in most cases, the NCM was assisting the applicant in getting to medical appointments and in the ongoing process of helping to coordinate and facilitate medical treatment, so the feedback would have been generally positive. But there have been instances where applicant attorneys have been demanding a new NCM or one of their own specific choosing. This issue came to the attention of the WCAB, which issued a Significant Panel Decision: **WCAB Significant Panel decision**[xix]: ***Patterson v. The Oaks Farm*** (2014) 79 Cal Comp Cases 910: Here, applicant had sustained serious injuries while training a horse; she was thrown to the ground. She had back surgery but still had ongoing problems. Defendant had appointed but then unilaterally terminated an NCM. Applicant objected and filed a DOR for Expedited Hearing. The WCAB held: (1) Provision of an NCM is considered a form of medical treatment; (2) Employer may not unilaterally cease to provide an NCM when there is no evidence of a change in circumstances or condition(s) showing that the services are no longer reasonably required. Citing the *Pattern* case was a recent WCAB Panel Decision in ***Snow (Deceased) v. SCIF*** (2019) Cal. Work Comp P.D. Lexis 465. Here, the applicant's mother as Guardian ad Litem, was ordered to provided home health care. Later, the son was transferred into a nursing facility. Defendant provided services of an NCM even after the transfer. Defendant did not establish change of circumstances and therefore the NCM services were allowed until the time of death, even though the son was in a facility. **[NOTE FROM COREY]:** By the impact of this decision, defendant would have to consider the NCM issue as "medical necessity" and therefore UR would apply, therefore requiring a timely decision, just like any other medical necessity issue. The WCAB reference to "change in circumstances" would also appear to be squarely a medical necessity issue. But the "sticky" part here is what if the NCM is not performing properly? Would this be deemed a regular medical necessity issue which must be decided by the WCAB or could it be deemed to be non-medical necessity issue? (In which case it would be decided by the WCAB). If you encounter an issue with the NCM, such as failing to communicate or other performance issues, then consider a "meet and confer" with the applicant or if represented, with applicant's counsel.

		Failing that, file a DOR for Expedited Hearing but you need "evidence." This could be a declaration from the examiner or other documentary evidence to detail the performance issues. So long as you admit that an NCM is necessary, then the issue of changing to another (as opposed to termination) would seemingly fall within the WCAB jurisdiction and the NCM should not be unilaterally terminated, pending a hearing. But the "changed circumstances" would go to medical necessity and that would need to be referred timely to UR ▪ Employer not responsible for home health care services that are provided more than 14 days prior to the employer's receipt of the physician's prescription
4610(g) **4610.5**	**CHANGES TO UTILIZATION REVIEW REGULATIONS UNDER SB 1160**	➢ **SB 1160 BRINGS FUTURE CHANGES TO UR**: Present UR statute remained in effect until 01/01/2018 ➢ **01/01/2018: Lab C 4610(b): Prospective UR will not be required within the initial 30 days following injury**, for both emergency treatment and Lab C 4600 medical care for accepted condition(s) or body part(s), provided that: (1) Medical care provided is compliant with the MTUS; (2) Medical care is provided by the MPN, HCO or by the pre-designated applicant's personal physician. Prospective UR is required for noted exceptions, which include surgery, psychological treatment, home health care, imaging and radiology, excluding x-rays, durable medical equipment and pharmaceuticals, unless exempted from UR or not authorized under the drug formulary
	DWC regulations for the Drug Formulary 9792.27.1 and 9792.27.2 UTILIZATION REVIEW	➢ **MTUS DRUG FORMULARY: NO UR FOR DRUGS ON THE FORMULARY**: Applies to drugs dispensed on or after 07/01/2017. Under the administrative regulations, the MTUS Drug Formulary applies to drugs **prescribed by** a physician and dispensed for outpatient use by: (1) A physician; (2) A pharmacy; (3) An inpatient hospital; (4) An outpatient department of a hospital; (5) An emergency department; (6) Ambulatory surgical center; (6) Any other health care provider or health care entity. The MTUS Drug Formulary **does not apply to drugs administered** to the patient by a physician. *These drugs however must go through prospective UR, except for "Special Fill and "Perioperative Fill."* The dispensing of the preferred drug may be subject to retrospective review to determine if the drug treatment was medically necessary. Those drugs which are listed on the Preferred Drug List ("PDL") are pre-authorized and need not go through UR. (The new Drug Formulary is required to be adopted by 07/01/2017 and will contain the Preferred Drug List. No UR shall be required, provided the treating physician is otherwise in compliance with the MTUS. Prospective UR will be required however for drugs on the Non-Preferred List and those not otherwise covered. For a drug identified as "Special Fill," or "Perioperative Fill," the usual requirement to obtain authorization through prospective UR prior to dispensing is altered for the specific circumstances.[xx] Drug treatment which is in conformity with the MTUS Treatment Guidelines is presumed correct on the issue of extent and scope of medical treatment, pursuant to section 8 CCR 9702.21(c) and Lab C 4604.5. While opioids will not be on that list, there will likely be an exception for a "first fill" for no more than 4 days. **Prospective review must occur by no later than 5 working days of**

	UTILIZATION REVIEW	**receipt of the RFA (Lab C 4610. (g)(1).** Off-label use of a drug shall fall within the MTUS Treatment Guidelines and rules and the MTUS Drug Formulary. Authorization through prospective review not required to dispense a Preferred drug for an off-label use if the MTUS Treatment Guideline recommends the off-label use of the drug to treat the condition ➢ Required telephone access during California business hours now includes peer-to-peer ➢ Physician's First Report: Failure to provide a timely report may form the basis upon which to remove the physician's ability to treat the employee –removal from MPN or HCO ➢ 01/01/2018: Retrospective review is permitted to determine whether Lab C 4610(b) treatment is in compliance with the MTUS, including the Drug Formulary. If it is found there is pattern and practice of physician provider failing to provide care in compliance with MTUS, including the Drug Formulary, then employer may remove physician, (pre-designated, MPN, HCO employer-selected) from the ability to treat any employee that is exempt from UR. Employer may file petition for order changing treating physician ➢ On or before 01/01/2018: All UR processes must be **accredited** by an independent, non-profit organization, certifying that all UR processes meet certain indicated criteria ➢ **Prohibition against financial incentives** or consideration to a physician based upon number of modifications or denials ➢ Neither insurer nor third-party administrator shall refer for UR services to an entity in which the referring party has a **financial interest**, unless disclosure is made to the Administrative Director. AD has authority to review underling financial documents, otherwise deemed confidential ➢ UR denial decision based upon **incomplete or insufficient information** shall also specify not only what is needed but also the date(s) and time(s) of attempts made to contact the requesting physician, in order to obtain the necessary information ➢ Final decisions to approve, modify or deny requests (RFA) shall be communicated to requesting physician within 24 hours of the decision by telephone, facsimile or if agreed to by the parties **secure E mail** ➢ 03/01/2019: AD to contact with outside independent research organization to evaluate impact of the first 30 days of medical treatment for claims filed between 01/01/2017 and before 01/01/2019 ➢ AD to develop mandatory system of electronic reporting of documents for every UR performed

UTILIZATION REVIEW

- On or before 01/01/2018, each employer must submit directly or indirectly a description of their UR process to the AD for approval. This must also be disclosed to employees and physicians

- **PRIOR CHANGES FROM SB 863: CHANGES TO UTILZATION REVIEW STATUTES**: The regulations implementing the statutory changes to UR have been divided between injuries prior to 01/01/2013 and UR decisions before 07/01/2013 vs. those which relate to injuries on or after 01/01/2013 and UR decisions after 07/01/2013.

Side by Side Comparison

	INJURIES PRIOR TO 01/01/2013 and 07/01/2013	**INJURIES ON AND AFTER 01/01/2013 AND UR REQUESTS MADE ON OR AFTER 07/01/2013**
DEFINITIONS	9792.6: No changes in definitions to existing regulations	9792.6.1: Minor wording changes to existing definitions. Adds definitions of "denial," "dispute liability, "MTUS," "modification," and redefines UR process as including new DWC Form RFA. UR process begins when the Claims AD receives the RFA.
UR PROCEDURES AND TIME FRAMES	9792.9(b): DEFERRAL: UR deferred if liability for injury disputed or dispute over treatment on grounds other than necessity (b)(1): Dispute must be raised NO Later than 5 business days from RFA. This notice must contain certain elements, including a "clear, concise and appropriate" explanation of the reasons. MANDATORY LANGUAGE under (b)(1)(E) beginning with "You have a right to disagree with decisions affecting your claim…"	New: 9792.9.1: ▪ Request for authorization must be on new DWC Form RFA ▪ The form is an attachment to the treating physician's progress report (PR-2), First Report or any equivalent report which requests authorization ▪ This is mandatory ▪ This initiates the UR process ▪ Provider may use SINGLE REQUEST ▪ Provider can make MULTIPLE REQUESTS on the form ▪ Fax or E mail: Form is deemed received by Claims AD or UR by FAX or by E mail if there is a receiving "date stamp"

	UTILIZATION REVIEW		9792.9(b)(2) If liability is finally determined adversely to Claims AD, then time for conducting retrospective UR begins with the date upon which the liability became final Regulations relating to the communications of UR decisions remain the same, but they change after 07/01/2013 to incorporate the new changes to UR, including use of IMR and mandated notice form language	▪ If no receiving date stamp, then date transmitted is deemed date received ▪ RFA transmitted after 5:30 p.m., Pacific Time, deemed to be received the following business day except for expedited or concurrent review ▪ Requesting physician must indicate whether there is need for expedited review on the form ▪ By mail: absence documented receipt date, RFA deemed received 5 business days after deposit in mail ▪ Certified mail: deemed received on the date entered on returned receipt ▪ Telephone access required from 9:00 a.m. Pacific Time to 5:30 p.m. for health care providers to request authorization ▪ All Claims AD's shall have fax numbers ▪ All Claims AD's must have process for receiving requests after business hours (voice mail, fax or E mail address is okay) ▪ RFA may be deferred if Claims AD disputes liability on grounds other than necessity
		UR DECISIONS	9797.9 (o): effective for 12 months from the date of the decision without further action unless supported by a documented change in the facts material to the basis for the UR decision.	PROSPECTIVE, CONCURRENT AND EXPEDITED REVIEW: 9792.9.1.(c)(3): shall be made within 5 business days from the receipt of the completed DWC + RFA, but no more than 14 calendar days from initial receipt ▪ Expedited: 72 hours ▪ If information necessary but not included in the RFA form, may be requested by reviewer or non-physician reviewer within 5 business days from RFA ▪ RFA may be denied if the additional information sought is not received within 14 days from RFA. The denial must also

	UTILIZATION REVIEW --- **INDEPENDENT MEDICAL REVIEW [IMR]**				state that it will be reconsidered upon request of the required information RETROSPECTIVE: within 30 days of receipt of medical information necessary to make determination. Payment or partial payment within 30 days of the RFA shall be deemed a retrospective approval, even if a portion of the bill is contested, denied or considered incomplete DECISIONS TO APPROVE: The regulations expand what must go into a decision to approve: date of approval, specific treatment requested, and the specific service being approved COMMUNICATING: Decisions for prospective, concurrent and expedited now include E mail as well as telephone and fax DECISIONS TO MODIFY, DELAY OR DENY PROSPECTIVE, CONCURRENT OR EXPEDITED REVIEW: ▪ Within 24 hrs. and by phone, fax or E mail ▪ Followed by written notice: 24 hours for concurrent; 72 hours for expedited and 2 business days for prospective ▪ CONTENTS OF DECISION ARE EXPANDED: (9792.9.1(e): adds language explaining reasons for denying based upon incomplete or insufficient information. Big change: The Application for Independent Medical Review, DWC Form IMR-1 with all fields except signature of the employee, to be completed by Claims AD and *the application shall include an addressed envelope and the postage may be paid for mailing to the AD* ▪ *A Clear statement advising that all disputes are to be resolved in accordance with Lab C 4610.5 and Lab C 4610.6* and that an objection to the utilization review decision must be communicated by the injured worker or by representative or attorney *within 30 calendar days from receipt of UR decision*

				▪ *Mandatory language also required: re:* right to disagree with UR decision, please call Claims Examiner @ phone #, or attorney
		DISPUTES	Disputes are resolved through the Lab C 4062 QME process until 07/01/2013, after which disputes will be resolved exclusively through IMR	Non-UR disputes are guided by: [9792.9.1(b)(1)] ▪ 5 business days to issue written decision deferring UR ▪ Mandatory language under (b)(1)(E) ▪ If deferred issue is finally decided that Claims AD is liable, then time to conduct retrospective UR runs from the date the determination is final ▪ Prospective UR decisions will then run from the date that the Claims AD gets a new RFA after final determination of liability UR disputes: 9792.9.1: are now handled through the IMR and IMRO process of 4610.5 and 4610.6, not through the QME process under 4062
		▪ (g)(7): Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment (body part) for which treatment is recommended ▪ (c): UR decisions are consistent with the MTUS and no longer refer specifically to ACOEM Guidelines ▪ (g)(6): UR decision shall remain effective for 12 months from the date of decision without further action with regard to further recommendation by same physician for same treatment, unless further recommendation is supported by documented change in facts [(9792.9.1 (h)]: UR decisions remains in effect, unless there is a further recommendation which is supported by a documented change in the facts material to the basis of the utilization review decision ▪ (g)(8): If UR is deferred because of (g)(7) but employer is found liable for the injury and treatment, then retrospective UR commences on the date that the employer's liability becomes final. Prospective UR would begin from date of employer's receipt of treatment recommendation after determination of liability ▪ (g)(1): Approval for retroactive UR decisions no longer need to be communicated		

- REGULATIONS: 8 CCR 9792.9.1, 9792.10.1 and DWC Form RFA

THE ATTACKS ON UR AND IMR:
FROM DUBON I TO DUBON II AND BODAM

- The attacks on UR and IMR intensified in 2014, with many applicant attorneys choosing to file DOR's for Expedited Hearings, in order to challenge the validity of an UR decision while simultaneously filing for IMR. This "two tracks" strategy caused a lot of hearings to take place and there was much uncertainty over which body, the WCAB or IMR, had the authority to determine procedural compliance and validity of an UR decision

- **CONSTITUTIONAL AND COLLATERAL CHALLENGES TO IMR:** Since the initial publication of this Guide, there have been several constitutional attacks against the IMR statutes. One challenge was made in ***Stevens v. WCAB (Outspoken Enterprises),*** 241 Cal. App. 4th 1074 in the 1st DCA. The decision held that the IMR process was deemed constitutional. The Court held that the legislature has plenary powers over the worker's compensation system under the Cal. Constitution Art. XIV and that the scheme for UR/IMR is fundamentally fair and so it affords workers with sufficient opportunities to present evidence and be heard. The Supreme Court denied review of this decision. In the same 1st DCA, there is another case pending: ***Zuniga v. WCAB [A143290]*** In this case the writ of review has been granted. Another challenge comes in ***Ramirez v. WCAB [C078440]*** in the 3rd DCA. Does a decision from an improperly conducted UR go through UR or to the WCAB? This case is still pending with oral argument scheduled for 05/02/2017. Another case in the 3rd DCA is ***Hallmark Marketing v. WCAB (Southard)*** Here, Maximus was late in the return of an IMR determination within the established time limits of the statute and does that untimeliness then enable the WCAB to have jurisdiction over the medical dispute? As of this publication, oral argument was pending 04/17/2017. However, the 2nd DCA has issued a published decision in ***California Highway Patrol v WCAB (Margaris)*** (B269038) in which the court considered an IMR Maximus determination taking place after the 30-day period be valid. The court concluded the 30-day time limit on Lab C 4610.6(d) is "directory" and therefore an untimely UR decision is valid and therefore binding on the parties

- **DUBON I: UR DEEMED DEFECTIVE FOR EITHER MATERIAL PROCEDURAL DEFECTS OR UNTIMLINESS**: On 02/27/2014, the WCAB issued its En Banc decision in ***Jose Dubon v. World Restoration, Inc. and SCIF*** (2014) 79 Cal Comp Cases 313 (Dubon I). The applicant had challenged the procedural validity of the underlying utilization review decision, so it was asserted that the WCAB had jurisdiction over the medical necessity dispute, even though that dispute had already gone through the UR process. Essentially, it was maintained that defendant had not sent the requesting physician all the medical reports but only 18 pages were in fact received and it was further alleged that the UR Physician Reviewer did not indicate

		those medical reports upon which he was relying. The WCAB held: [1] that an UR decision is deemed invalid if it suffers from "material procedural defects that undermine the integrity of the UR decision." However, "minor technical or immaterial defects" do not defeat the UR decision and therefore it fully remains within the IMR process." [2] The WCAB has jurisdiction over the underlying issues of material procedural deficiency and timeliness: [3] If the employee prevails on the procedural deficiency or untimeliness argument, then the WCAB has jurisdiction to decide the underlying disputed medical necessity issue, but subject to proof. [4] The right to have UR decisions reviewed through IMR is at the decision of the employee, but it presupposes a valid UR determination • In the aftermath of *Dubon I,* there were continuing efforts to sidetrack and defeat UR and IMR. In one **WCAB Panel Decision** reported by Work Comp Central on 04/04/2014, in ***Weilman v TIG*** (2014) the WCAB determined an UR decision was invalid because the reviewing physicians had *failed to sign their reports*. But this decision was also coupled with the fact that the WCAB stated that the defendant had failed to provide the AME reports to the UR Physician Reviewer and this was enough to undermine the integrity of the UR decision. **And a well-known applicant's attorney even filed a writ of mandate (mandamus) before the 1st District Court of Appeal, claiming that the IMR statute was a violation of Article IV of the California Constitution**.[xxi] From 02/27/2014 to 10/6/2014, it remained unsettled as to what acts were deemed "material defects" compared to those acts which were otherwise deemed immaterial or minor technical defects
	9792.10.3 IMR **9792.10.4** **9792.10.5** **9792.10.6** **9792.10.7** **9792.10.8** **9792.12** **IMR**	• On 05/22/2014, the WCAB granted reconsideration in order to further study both the legal and factual issues raised by SCIF on reconsideration, but it also ordered that Dubon would remain in effect and binding • **DUBON II: WCAB NARROWS DUBON I TO ENCOMPASS ONLY UNTIMLINESS**. On 10/06/2014, the WCAB issued its Opinion and Decision after Reconsideration, or "Dubon II. (2014) 79 Cal Comp Cases 1298.[xxii] ➢ An untimely UR decision is not subject to IMR ➢ Only the WCAB has authority to determine the untimeliness of an UR decision, not IMR. This is because the untimeliness issue is a "legal" dispute, which is within the WCAB's jurisdiction ➢ All other procedural or other disputes over UR will be determined only through IMR, subject to the appeals process as set forth within the statutes and regulations. These disputes would include, among others: (1) The sufficiency of whether the proper or accurate medical records, including physician reports, were ever sent to the Physician Reviewer;[xxiii] (2) Whether the Physician Reviewer considered these records and if so, which ones?; (3) Whether ACOEM or MTUS was properly applied; (4) Incomplete listing of medical records sent to UR; (5) Physician Reviewer fails to state his/her

clinical reasoning, including proper use of medical criteria. ALL OF THESE ISSUES WILL BE DETERMINED ONLY BY IMR, NOT BY THE WCAB

- When an UR decision is timely, then IMR is the "sole vehicle" for reviewing UR expert opinions[xxiv]

- The "bottom line?" Medical decisions, including the use of medical criteria, what documents were referred to UR, and the like, shall be left to the expertise of medical professionals. And, the legal dispute over timeliness shall be left to the expertise of the WCAB

- The WCAB held that defects in procedural compliance can be fixed either in the 2nd appeal process, if any, or in the IMR process (such as furnishing previously unfurnished medical records)

- **NOW WHAT? / MORE RFA'S FOR EXPEDITED REVIEW?** The issue of what is a defective UR decision is decided…for now. But, the Court of Appeal or even the Supreme Court may have the ultimate determination. But it is safe to predict that there will be intensive scrutiny accorded to the TIME LINE AND TIME FRAMES associated with UR decisions under Lab C 4610(g) and the governing regulations. Since we now have **time** as the sole and remaining element, under which an UR decision can be contested and therefore default to the WCAB for the determination of medical necessity, our concern is that more PTP's will be issuing requests for expedited review. This would shorten the time within which to respond and therefore potentially bolster the claim of an untimely UR review

- Perhaps the most important question is what happens when defendant contests whether an RFA is qualified under the expedited review statute and regulations? Who decides this? The regulations indicate that if the request for expedited review is not reasonably supported by the evidence, then the normal five business days is in effect.[xxv] But how is this determined? It could really matter if the sole argument is defendant was late "if" the RFA qualified as an expedited review rather, than a prospective one

- **WATCH FOR THE LATE FAX**: 8 CCR 9792.9.1(a)(1): Normally, an RFA received after 5:30 p.m. Pacific Time, will be deemed to have been "received" the next business day, **except for an expedited review.** ***EXAMPLE:*** A fax for RFA/Expedited Review is received Friday, 11/07/2014 at 7:30 p.m. PST. The first business day is not Monday, 11/10/2014, which would apply if the RFA were for a prospective review. But, here, the 1st business day is 11/7/2014 If the claims administrator sends all the required medical records to UR by Monday, 11/10/2014, which is now the 2nd business day, then the UR Physician Reviewer now has up to 72 hours from the time the items were received. Therefore, we are now dealing with the actual "time of receipt" rather than full business and calendar days. But, remember you are still up against the 5-business day deadline, which is Thursday, 11/13/2014, but YOU MAY NOT HAVE THAT WHOLE DAY, BECAUSE OF THE 72 HOUR REQUIREMENT

- In the wake of *Dubon II,* we simply do now know whether there will be any noticeable impact on the practice of challenging UR decisions and trying to side-step IMR at the WCAB, since many applicant attorneys may proceed as if *Dubon I* were still applicable. You can certainly expect a push-back from some applicant attorneys, who will very aggressively scrutinize every element of the time process associated with UR, including the time that the decision was made and then communicated to the PTP. So be ready

- **Timothy Bodam v. San Bernardino County Dept. of Social Services** (2014) **WCAB Significant Panel Decision**.[xxvi] (A significant panel decision is not binding nor is it controlling precedent, but it is citable as these decisions do reflect that the issue supports a general dissemination.[xxvii] Here, the WCAB denied defendant's petition for removal, holding that defendant is obligated to comply with "all time requirements in conducting UR, including the time frames for communicating the UR decision; "A UR decision that is timely made but is not timely communicated is untimely." "When an UR decision is untimely and therefore, invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence." Therefore, the WCAB determined that any lateness in the written follow-up after the initial 24 communication to the requesting physician either by E mail or by FAX would still render the entire decision untimely. That the time limits under Lab C 4610 are "mandatory."[xxviii] Defendant had contended that the effect of a late notice of UR decision was provided for under 8 CCR 9792.10.1(c)(2), *the time limits for requesting IMR are extended and therefore do not run until the notice is provided*

- **TIME ELEMENT NOW EXTREMELY IMPORTANT**: Pending further determination by the Courts of Appeal, for now, "time" is the essential element which determines whether an UR decision is invalid and hence defaulting to the WCAB for medical necessity decision. This author has suggested that one approach may be to AVOID USING THE TELEPONE to notify the requesting physician but instead sticking with the FAX or E mail, which then takes away the requirement for the further written notice by mail within 2 business days, which was the subject of ***Bodam***. This just removes one step in the process and makes proof of timeliness somewhat easier. This author has also suggested using a *"Template Timeline"* for tracking the dates of the RFA request received, by fax, E mail regular or certified mail, the date of referral to UR, the date of receipt by UR, the date of decision, the date of the 5th business day, the date of initial communication to physician by telephone, fax or E mail. And, with telephone decisions only, the date of the written follow up post 2 business days

IMR EXPLAINED

For all injuries on and after 01/01/2013 as well as for all UR decisions taking place after 07/01/2013, regardless of the date of injury, all disputes over UR decisions to delay, modify or deny medical treatment

		requests shall be determined through the IMR process and no other. UR decisions which are not reviewed by an IMRO shall otherwise be deemed final ▪ Medical necessity issues are now being taken out of the hands of the QME's and AME's and placed into the realm of an IMRO, whose Reviewer's(s) decision is essentially final, except under very limited circumstances ▪ The IMR process pertains only to medical necessity issues. Therefore, if the employer or Claims Administrator has other grounds upon which to deny a recommendation for medical treatment, then the IMR process is, in effect, deferred until 30 days after the Claims Administrator serves the employee with a notice showing that the other dispute over liability has been resolved. In cases where there is a combination of both a medical necessity (UR) and a non-UR basis (e.g. disputed body part) then once the AD determines that IMR is appropriate at least in part, the process is deferred unless employer agrees to IMR [9792.10.2(d)] ▪ Per sub (f): Subject to form, content and regulations from the AD, the employer will be required to provide a one page form to the employee: *Regulations Adopted*: [Application for Independent Medical Review, DWC Form IMR-1 with all fields completed and pre-addressed for mailing to the AD; Claims Administrator may pre-pay postage] together with the regular UR notifications, which among other things, will require the employer to tell the employee that the UR decision is final, unless a request for IMR is made within 30 days after service of the UR decision upon the employee. Also, the employee will be informed of what information may be provided to the IMRO to support the employee's position on the disputed medical necessity issue. [9792.9.1(e)(5)]. Regulations require Claims Administrator to serve a notification which lists all the documents submitted to the IMRO. Documents not previously served shall be provided with this notice ▪ Failure to provide the required AD form (above) suspends the limitations for employee to request IMR and then the time runs from the time that the notice is provided [9792.10.1(c)(2)]: The regulation actually expands the so-called "fails" to include any breach in the notice provisions under 9792.9(1) or 9792.9.1(e) so that any problem with the notification process will suspend the IMR process from going forward until the Claims Administrator corrects the failures with full notification. ***[NOTE FROM COREY]:*** This doesn't make much sense, since an error in the timing of the process by the Claims Administrator would not seem to be correctable so that in effect, any lateness in the UR process would seem to suspend, if not doom, the IMR process from going forward
	IMR	▪ AD to expeditiously review all IMR requests and to notify the parties as to whether the request is approved. [9792.10.3]: Upon receipt of the Application DWC Form IMR-1, the AD will look at the completeness of the application, whether a previous application was made, assertions by Claims

IMR

Administrator of factual or legal grounds precluding liability, or "other reasons" not specified. AD to make reasonable requests for additional, appropriate information with parties to have *15 days within which to respond*. Following all information received, AD shall immediately inform parties that a disputed medical treatment is not eligible for IMR and specifying those reasons

- If application for IMR is approved, then assignment is made to the IMRO, which must notice the parties of the assignment within one business day [(9792.10.4)] and employer has *15 days* [9792.10.5(a)(1)] following receipt of the notification from the IMRO within which to provide the IMRO with documents and records. ***[NOTE FROM COREY]:*** *This has changed from 10 days under the statute to 15 days according to the new regulations*. These include the relevant medical records pertaining to the medical necessity issue in dispute, including the employee's current medical condition, medical treatment being provided, and all information or other relevant documents used in the UR process. The 10 (now 15 days) days changes to 24 hours if there is an imminent or serious threat to the health of the employee. 9792.10.5(a)(1)(A): the "documents" include:

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

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

	IMR	▪ Employer is also required to provide a listing of all documents served upon IMRO ▪ Summary of Employer duties: (1) Serve the 1 page form (Lab C 4610.5(f), DWC Form IMR-1 to the employee, together with the required UR decision notices on the disputed medical necessity issue; (2) Provide documents to the IMRO within 15 days (or 24 hours) and; (3) Provide notification to the employee which lists documents submitted to the IMRO, including copies of all documents not previously served ▪ *[**NOTE FROM COREY**]:* Under changes to the utilization review statute, UR decisions shall be in effect for 12 months, unless there is some factual change in the medical condition. But we don't yet know how the IMR issues will be handled. If there are multiple RFA's within a PR-2, will each be the subject of a separate IMR. Or, what happens if the PTP sends in "one RFA" at a time? Will each independently trigger UR and IMR? Should the IMRO not know that the PTP is "dripping" each request separately? It is too soon to know but worth considering as we gear up ▪ Administrative penalty "not to exceed" $5,000 per day: *Regulations have now been adopted (see pages 40-42 below) which provide a Schedule of Administrative Penalties under these provisions. The daily amounts are well within the maximum per day, with the maximum by 10 times less (maximum per day is $500). But these could change.* Under sub (i) the employer shall not engage "*in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the plan to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be submitted to an administrative penalty…up to $5,000 per day." **[NOTE FROM COREY]:*** This part of the section is loosely written and does not clearly define what the conduct is or what it means by "has the effect of delaying" so is a one-time delay enough to trigger an administrative penalty or does it otherwise require repeated actions over periods of time, equivalent to a business practice? We don't know but I expect the AD will likely establish a Schedule of Penalties over a range of conduct with the amounts calibrated to the seriousness of the conduct ▪ Medical necessity issues will be determined using a ranking or hierarchy of scientific and medical evidence, which in order of priority, ranks as the highest, the MTUS under Labor Code 5307.27 and then providing for lower ranking evidence, only if higher ranked evidence is deemed inapplicable to the employee's medical condition ➢ **CHANGES UNDER SB 1160:** Employee requests for IMR: time shortened to **10 days for formulary disputes** (these will be for non-preferred drugs)

		➢ All other disputes remain at 30 days ➢ Claims Administrator is required to notify Maximus if there is a change in the Claims Administrator responsible for the claim ➢ IMR decisions from Maximus are required within 30 days of receipt of supporting documentation. **For disputes over medication per the Formulary, the time is shortened to five (5) working days from receipt of supporting documentation**
4610.6 **9792.10.4** **9792.10.5** **9792.10.6** **9792.10.7** **9792.10.8** **9792.12**	**INDEPENDENT MEDICAL REVIEW ORGANIZATION [IMRO]** **IMRO**	▪ IMRO upon assignment shall designate a medical reviewer, to conduct an examination of the submitted documents on the medical necessity issue. IMRO may assign more than one reviewer if he medical necessity issue is deemed sufficiently complex such that a single reviewer cannot reasonably address all disputed issues. Determination to include whether disputed medical treatment is medically necessary **[(9792.10.6(c) and (d)],** using the hierarchy of scientific and medical evidence established under Lab C 4610.5(c) and explanation of the supporting clinical reasons. A written determination to be made within **30 days or sooner** from date of the DWC Form IMR-1 and supporting documentation **[regular review]**. Upon certification by the AD or treating physician that the condition is imminent and serous, then decision is due in **3 days [expedited review]** from IMR-1, plus supporting documentation ▪ Subject to AD approval, deadlines for regular and expedited may be extended **up to 3 days** in extraordinary circumstances or for good cause **[(9792.10.6)]** ▪ **Lab C 4610.6(e): [9792.10.6]:** Each IMRO analysis to state whether the disputed health care service is medically necessary and why, citing relevant documents in the record and the relevant findings of the scientific and medical evidence within the hierarchy of evidence. If more than one medical professional reviews the issue, then a majority thereof decides. If there is an even split, then the decision shall be in favor *of **providing the treatment***. Each reviewer's opinion shall be provided, but shall otherwise remain confidential ▪ Determinations of the IMRO are deemed the determinations of the Administrative Director (AD). ▪ **(h):** Determinations of the AD shall be presumed to be correct and are reviewable only upon verified appeal filed by a petition with the WCAB within **30** days of mailing of determination and copies to all parties, including the AD: [**9792.10.7**]: ***[NOTE FROM COREY]:*** The earlier version of the regulation contained the 30 days to appeal. The current version does not, but the 30 days is governed by the statute anyway. The grounds for an appeal are limited and include: [1] The AD acted without or in excess of powers; [2] The final determination was procured by fraud; [3] independent medical reviewer subject to material conflict of interest, in violation of 139.5; [4] Determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability; [5] Determination was based upon plainly erroneous express or implied finding of fact,

provided it was a matter or ordinary knowledge based on the information submitted for review and not a matter subject to expert opinion

- If AD determination is reversed, the dispute is remanded to a different IMRO, or if a different IMRO is not available, then it goes back to the same IMRO, but with to a different reviewer

- Neither the WCAB nor a higher court may make a contrary finding of medical necessity

- **[9792.10.7]:** Determinations to approve disputed medical service shall be promptly implemented unless employer has **filed an appeal or has otherwise** disputed liability for other reasons than medical necessity. Otherwise, services not yet authorized will be authorized **within 5 working (business) days.** Employer to reimburse for services already provided **within 20 days**

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

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

- **SCHEDULE OF PENALTIES: IMR: [9792.12(a):**

FAILURE TO:	AD PENALTY
Provide DWC IMR-1 with all fields filled out	$2,000
Issuance of UR decision where treatment is outside of scope of reviewer's practice	$25,000

Failing to timely communicate request for expedited review	$15,000
Denying treatment solely upon basis that condition not addressed by MTUS	$5000
Failure to discuss or document attempts to discuss reasonable options for care plan	$10,000
Provide injured worker with clear statement that disputes to be resolved through IMR and objection to UR communicated using DWC Form IMR-1 within 30 calendar days	$2,000
Failure to respond to complete RFA or other request in case of non-expedited concurrent review	$2000
Detail UR internal review appeals process and stating that it is voluntary	$2,000
Timely provide information to the AD	$100 per to maximum of $5,000
Timely provide information to the IMRO	$250.00 per day to maximum of $5,000
Timely implement final determination of IMRO	$500 per day to a maximum of $5,000
Failure to respond to complete RFA or other request on a non-expedited prospective review	$500
Failure to disclose or make available the UR criteria to the public	$100
Timely pay invoice from IMRO	$250

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

TYPE	CALENDAR YEAR 2013	CALENDAR YEAR 2014
Regular Review: MD/DO (1)	**560.00**	**550.00**
Regular Review: MD/DO (2)	**760.00**	**740.00**

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

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

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

			Claims AD to Implement determination	**5 business days of receipt of final determination** **20 days to reimburse provider if services provided 9792.10.7(a)(2)**
			Appeal by Petition to WCAB	**30 days of mailing of final decision (5 more days for mailing per CCP 1013? Probably, but it doesn't say) 9792.10.7(c)**
4603.2 (amended)	**PAYMENT OF TREATMENT BILLS PER LAB C 4603.2** **EXPLANATION OF REVIEW ["EOR"]** **SECOND REVIEW** **9792.5.5** **9792.5.6** **Form: DWC Form SBR-1**		▪ Upon final determination that out-of-network treatment was appropriate, requires employer to pay for medical care from the initial examination date if the Doctor's First Report of Injury (due in 5 days) was made on time and if not, at the time the first report was made following initial examination of employee ▪ **(a)(3):** Upon final determination that employee was not entitled to treat out-of-network, then employer has no liability ***or for consequences of the treatment*** *obtained outside of the network." [**NOTE FROM COREY]:*** "Consequences" is undefined. Does this mean the defendant is not responsible for aggravation or other exacerbations from out-of-network treatment to which employee is found non-entitled? We don't know at this point. Also, this section should be read in connection with Lab C 4605, which is also amended, and which permits the non-MPN report to support an award but not as the "sole" basis for an award, which means an award must be supported by another concurring opinion from an AME or PQME ▪ **(b)(1):** Provider request for payment now required to include **more detail,** including itemization of services, charges, copy of reports showing services performed, prescription or referral from the PTP ▪ **(b)(2):** Payments for medical care + EOR are changed from 45 "working days" to 45 **"days**" after receipt of all required documents under **(b)(1).** [***NOTE FROM COREY]:*** The 45 days are linked to a complete submission of all required documents, but the employer is still bound to object to any indicated incompleteness; or a denial of the itemization, within 30 days, together with the Explanation of Review ("EOR" per Lab C 4603.3.) ▪ **(b)(3):** If employer is a governmental entity, the time **is 60** days after receipt of each separate itemization, together with required reports and there is no 15% increase specifically set forth under this sub-paragraph ▪ Duplicate submissions to which there was a previously timely response and EOR do not trigger this process ▪ **THE FOLLOWING RULES ARE FOR TREATMENT RENDERED OR MEDICAL-LEGAL EXPENSES INCURRED ON OR AFTER 01/01/2013:**

		▪ **Lab C 4603.2(e)(1): 90 DAYS—Request for Second Review: Treatment services or medical-legal charges: [9794 and 9792.5.5]:** Provider may request a 2nd review **within 90** days of service of EOR by Claims Administrator by mail with proof of service; if no proof of service, then from the date the Claims Administrator has documented receipt or if none, then from the date ***5 days later*** than post mark of the EOR or WCAB Order resolving threshold issue ▪ The Request: Request for 2nd review for treatment shall be made either on new **DWC Form SBR-1** or on the actual bill if the bill was non-electronic. For medical-legal charges, the request **must be made on the form**. Methods for electronic review depend upon type of service. For pharmacy bills, 2nd review can occur through a trading partner agreement or by using the form SBR-1. The request for 2nd review shall include the dates of service and the same itemized services rendered as set forth in the original bill. No new dates of service are included here. Also, items in dispute are listed and the amounts and the amount of additional payment being requested and the reasons therefor. If the only dispute is money and the provider dos not request a timely 2nd review, the bill is deemed "satisfied." [**(9792.5.5(e)**] ▪ Any properly documented, itemized services provided and not paid within the time frames established by Lab C 4603.2 are increased by ***15%, plus interest*** ▪ **[9792.5.5.(f)]:** Employer responds to 2nd review within 14 days with final written determination on each of the amounts in dispute with payment of any balance not in dispute within **21 days** of receipt of 2nd review. Time frame may be extended by written mutual agreement ▪ **[9794(e)]:** Response to request for 2nd review for medical-legal charges on **grounds other than fee schedule**: This revised regulation states that if the Claims Administrator receives a written objection to the denial of medical-legal charges; Claims Administrator must file a petition to review the denial and a DOR, because there are "other grounds" and therefore deferring the IBR process until those "other" grounds are determined by the WCAB ▪ If provider contests final written determination following the 2nd review, then it may request IBR per Lab C 4306.3 and [9792.5.5(h)]
4603.3	**EXPLANATION OF REVIEW: "EOR"** **9792.5.5.**	▪ **4603.2(b)(2): Explanation of Review ("EOR")** now required *upon payment, adjustment or denial* ▪ [9794 (c)]: EOR is now also required for the payment or objection to medical-legal charges and the objection must also incorporate the use of the EOR. Also, the same rules for 2nd review and IBR also pertain to **medical-legal charges**

		▪ EOR includes: [1] statement of items and procedures billed, and amounts requested; [2] amounts paid; [3] basis for any adjustment, change or denial of item or procedure; [4] additional information required, [5]times frames involved and the IBR process ▪ This does not appear to apply to a submitted billing item from a provider where the entire bill is being paid, without adjustment, objection, denial or reduction. ***[NOTE FROM COREY]:*** Unfortunately, this is also unclear. Pending regulations on this section, it is suggested that employers consider an EOR which features a section specifically indicating that the bill is **being paid in full** without adjustment and therefore the rest of the EOR is not being completed on this basis. Therefore, the EOR would be transmitted but with a clear indication that no reduction, change, objection or reduction is being made
4603.6 **139.5**	**INDEPENDENT BILL REVIEW (IBR)** **9792.5.7** **Regulations filed with OAL 12/20/12** **INDEPENDENT BILL REVIEW ORGANIZATION (IBRO)** **Form: DWC Form IBR-1** **Fee is $335.00** **As of 10/23/2013, under the new WCAB Rules of Practice and Procedure, for medical-legal expenses, when there are non-IBR foundational issues, the defendant now must file a Petition for**	▪ Provider may request IBR only if there has been a 2nd review, which did not resolve the issue and the **only dispute is the amount of payment**. If there are reasons for non-payment other than reasonableness, those issues must be resolved before IBR takes place. Issues which are considered not eligible for IBR include: where the fee is not covered by a fee schedule, contract reimbursement rates, proper selection of an analogous code or formula based on a fee schedule, unless the contract or fee schedule allows for analogous coding **[(9792.5.7(b)]** ▪ **New WCAB Rules of Practice and Procedure: 10/23/2013: 8 CCR 10451.1:** Threshold issues which would entirely defeat medical-legal charges must be brought before the WCAB upon a **Petition for Determination of Non-IBR Medical-legal Dispute**, filed by Defendant, together with a DOR. This must be filed within 60 days from the provider's service of objection to the EOR, denying the charges entirely or partially. The same petition may be filed by a provider if defendant breaches its duty to timely file their petition or some other duty under Lab C 4622 or the Rules of Practice and Procedure ▪ **New WCAB rules also provide for "waiver"** of objections to medical-legal charges if: defendant failed to file the EOR within the required time (60 days) or failed to timely authorize the 2nd review process upon request from the provider or failed to make payment consistent with 2nd review determination. Defendant also waives charges (other than fee schedule–subject to IBR) by failing to file the timely petition as indicated ▪ **Defendant is liable for sanctions, costs and provider's attorney fees:** If the WCAB makes a finding **that** defendant engaged in bad faith actions, this could subject defendant to **monetary sanctions of not less than $500,** plus attorney fees to the provider as well as costs; all of which are in addition to the other penalties owing under Lab C 4622 ▪ **Provider has 30 days from service of 2nd review determination within which to request IBR, otherwise bill is deemed satisfied. [9792.5.7(c)]:** the 30 days is counted from the date of service of the final written determination under 2nd review, if there is a proof of service; or the date of receipt if no proof of service

	Determination of Non-IBR Medical Dispute + DOR, within 60 days	and the Claims Administrator has documentation of the date of receipt. If there is no proof of service or no documented date of receipt, then the time is extended by 5 calendar days from the date of postmark. The time frames begin if there is an underlying issue contesting liability and not just the bill, in which case it starts from date of WCAB Order or date of resolution in favor of provider ▪ Request for IBR: On Line: [**9792.5.7(d)]:** IBR requests can be made either by mail or electronically (on line). The on-line form can be accessed at: http://ww.dir.ca.gov/caibr/htm. Payment of **$335.00 to** be made at the time request is made ▪ Request for IBR by mail: Mailing Request for Independent Medical Review form, **DWC Form IBR-1 [(9792.5.8)] and paying the fee of $335.00** ▪ Statute provides AD may require electronic only but for now, two methods are permitted to start IBR. Copies of the Form IBR-1 served on employer. Only the request form and the proof of payment are to be submitted to the AD**.** ***[NOTE FROM COREY]*****:** The regulations change this. They require not only the form but also the supporting documents, "that were furnished with the original billing" **+ the EOB + the request for a 2nd review + supporting documents from Claims Administrator + final written determination of 2nd review: Per 9792.5.7(d)(2), the provider is required to add documents to the form, including a contract for reimbursement rates** ▪ **CONSOLIDATION ALLOWED: 9792.5.7(e) and 9792.5.12: Provider may request that two or more disputes that would constitute a separate request for IBR be consolidated.** ***[NOTE FROM COREY]:*** The statute (Lab C 4603.2) is silent on consolidation, so it is neither specifically permitted nor disallowed**.** The new regulations permit consolidation under certain conditions, requiring a common issue of law and fact. These conditions include**: [1]** Multiple dates of medical service involving a single provider, involving one employee, one Claims Administrator and one billing code under a fee schedule or under a contract and the total amount in dispute does not exceed $4,000; **[2]** Upon a showing of a "possible pattern and practice of underpayment" by a Claims Administrator for specific billing codes, involving multiple employees with aggregated amounts in dispute not over $4,000; **[3]** Multiple billing codes with a single provider, if involving one employee, one Claims Administrator and one date of medical service, with no cap ▪ **[9792.5.9]:** Upon receipt of the DWC Form IBR-1 and attachments, the AD to conduct "preliminary review" to determine whether the request is ineligible for review. A checklist of issues is provided. If, however, the request is deemed "eligible" for IBR, then the rules under sub (b) apply. AD to assign request to independent medical reviewer **within 30 days** and upon notice of assignment of IBR, the requesting party shall submit all required documents to the IBRO within **10 days. The regulations change the statute from 10 days to 15 calendar days if notice by mail or 12 calendar days if notice was provided**

		electronically [(9792.5.9(b)(3)]. Claims Administrator has the same time within which to submit a statement, with supporting documents, that the matter is not eligible for IBR ▪ The regulations now install **a 2nd preliminary review** after the running of either the 15 or 12 days (above) in order to further determine whether the request is deemed ineligible. AD makes written determination that the request is ineligible and the reasons. Provider or Claims Administrator may appeal to the WCAB, by petition, the determination of ineligibility within **30 days of** receipt of determination ▪ If the request is ultimately deemed ineligible, then the provider gets partial reimbursement of **$270.00 [(9792.5.((e)(1)]** ▪ Requests for IBR can be withdrawn before determination is made. If the dispute is settled. withdraw occurs by joint written request, but no reimbursement occurs **[(9792.5.11)]** ▪ **[9792.5.9(e)]:** AD assigns for IBRO upon finding of eligibility. Reassignment can occur if it is later determined the IBRO has a prohibited affiliation ▪ **[9792.5.10]:** IBRO reviews materials and may request additional information from the parties. If requested, the party shall file the requested documents with the Independent Bill Reviewer within **35 days of the request**, if by mail **or 32 days, if made electronically** with copies to non-filing party. [**9792.5.13]:** The Independent Bill Reviewer will use the OMFS for treatment services, the contract for reimbursement rates, if applicable, or if for medical-legal, the MLFS. As such, the reviewer will apply these provisions as if the billing is being reviewed for the first time ▪ Written determination due within **60 days of assignment:** [**9792.5.14]:** IBRO makes written determination in plain language, whether any additional money is owed the provider and the reasons. This includes the information received and relied upon by the reviewer ▪ Fee payable by provider. AD to prescribe schedule of fees by regulation. If any additional payment is found owing, employer to reimburse provider for fee paid, in addition to the amount found owing (See fees above) ▪ **[9792.5.14]**: Determination from IBRO is deemed a determination and order from the AD, binding on the parties and is reviewable on the same grounds as IMR determinations (fraud, conflict of interest, bias, etc.) ***but here the verified appeal must be filed within 20 days of service of the determination*** **[(9792.5.15(b)]** The same rules apply as those governing appeals to final written IMR determinations

- If AD determination is reversed, then dispute is remanded to the AD to submit to a **different** IBRO, or if not available, to the same IBRO but with a different reviewer

- **SOME CASE LAW:** This is not a "hot" area for litigation. There are less than 25 WCAB Panel decisions to date and most are related to the more technical aspects. But I did find two Panel Decisions of interest. In ***Mario Carrasco v. City of Los Angeles*** (2016) Cal. Wrk. Comp. PD Lexis 225 the lien claimant had filed a reconsideration petition upon an adverse finding by Maximus. But the panel correctly ruled, lien claimant had pursued the wrong remedy. The correct remedy was to file a verified petition for a hearing before the local WCAB office, together with a Declaration of Readiness to proceed. Then, after a trial, lien claimant could have filed a reconsideration petition. Instead, lien claimant simply skipped a step. ***In Santos v. PCW*** (2016) Cal. Wrk. Comp PD Lexis 505, the panel noted that long term facility care is not covered under OMFS. Therefore, IBR does not apply as there could be no dispute over fee schedule

- **PROJECTED TIME FRAMES**: From the regulations, we have an estimated maximum number of days between the date upon which the bill and report arrive and the final date upon which the IBR becomes final. Using only the maximum number of days, I calculate as follows: BEFORE IBR: 179 maximum days; AFTER initiation of IBR: 120 maximum days or total of 299 = 42.7 weeks! The time frames here are variable because of the method for service which can add 2 days for proof of service if electronically served and 5 days for mailing or the time can be greater if there is no POS and the Claims AD has proof of receipt. So, these times are estimates, but in summary you can see it is a lengthy process:

45 calendar days 60 calendar days 60 calendar days	To pay for authorized, non-contracted medical treatment + EOR To pay by governmental entities To pay for proper medical-legal expenses +EOR
90 days from EOR or WCAB Order resolving threshold issue	Provider requests 2nd Review on DWC Form SBR-1
14 days (or longer by mutual agreement)	Response to 2nd request with final written determination
30 days from final determination after 2nd review	Request for IBR on DWC Form IBR-1 + $335 filing fee
15/12 days	AD notice of receipt and request for additional information or documents
35/32 days	IBRO requires further information from party
60 days from assignment by AD to IBRO	IBRO make final. written determination

			20 days from mailing final determination from IBRO	Verified petition filed with WCAB appealing determination on limited grounds
4605	**CONSULTING REPORTS**	▪ Reports of consulting or attending physicians may not be the sole basis for an award of compensation ▪ QME or authorized PTP **shall address** any report per this section and indicate whether he or she agrees or disagrees with findings or opinions and the basis ***[NOTE FOM COREY]:*** This doesn't really clear up the Valdez issue because out-of-network reports are still admissible and they can now statutorily form the basis of an award, so long as there is some supportive opinion either from an "authorized treating physician" or QME**.** The statute does not mention an AME, but it would seem as if an AME's opinion would also sustain but it does not actually state. Also, by the wording here, it seems as if for an out-of-network report to sustain an award, it must be specifically reviewed and addressed as opposed to an opinion which is in accord but did not specifically review the out-of-network report ▪ ***[NOTE FROM COREY]*****:** Valdez has now confirmed and clarified that while "out of network" consulting reports are admissible for compensability, the decision also affirms the changes to Lab C 4605 and that such reports cannot be the "sole" basis for a WCAB award. Also, Valdez did not address the costs for the reports, or who is responsible. Also, it remains unclear as to what standards are require in order to meet the statutory definition of "addressing" the out of network report ▪ **WCAB Panel Decision**: ***Lawrence Lorenz v. Encino Hospital, et. al***. (2014) Cal. Wrk. Comp. P.D. Lexis 410. Applicant brought two cases against two defendants. In one case, the parties went to an AME, Dennis Ainbinder, M.D., who wrote opinions covering both cases. However, in the other case, a CT claim against Prime, defendant neither agreed to Dr. Ainbinder nor obtained their own PQME. Applicant in that case relied upon Dr. Ainbinder. The WCAB held that Lab C 4065 did not apply, because Dr. Ainbinder was not deemed a consulting physician. Here, defendant conducted its medical discovery only by participating in the deposition of Dr. Ainbinder. But, the WCAB held this did not bind Prime and they could have obtained a PQME, but they did not exercise the right to do so. Therefore, Prime's waiver did not result in the inadmissibility of Dr. Ainbinder's AME reports ▪ **WCAB Panel Decision:** ***Marla Harris v. Nordstrom*** (2015) Cal. Wrk. Comp. P.D. Lexis 559. Applicant's PTP recommended right shoulder surgery in the form of rhomboid detachment but the RFA was denied by UR and upheld upon IMR. Applicant went ahead and self-procured the surgery. Applicant made a TTD claim to which defendant raised the issue that there was no established medical necessity. The WCAB panel disagreed with emphasis upon the noted separation between medical treatment resolution (UR and IMR for admitted injuries and body parts) and TTD, each having its own discrete process. The panel distinguished Valdez, declaring that TTD would be addressed "on its own merit"	

	MPN **[Valez]**	▪ Physicians included in the MPN, only if there is a written acknowledgment. (01/01/2014) In the application for approval or re-approval, the MPN applicant must affirm that each MPN physician in the network has agreed, in writing, to treat workers under the MPN and that the "Physician Acknowledgments" under 9767.1, are available for review by the Administrative Director [9767.3 (d)(8)(F)] ▪ MPN must place roster of treating physicians on its web site and update at least quarterly **(01/01/2014)** ▪ **NEW: 4616(a)(4)(A)(1):** Commencing 07/01/2021, MPN's shall post roster of all participating providers, which includes all physicians and ancillary service providers in the MPN. Every MPN shall provide AD with roster of participating providers and each office address and telephone number ▪ Commencing 01/01/2016: Every MPN shall post on its website information on how to contact MPN and Medical Access Assistants and information about how to obtain a copy of any notification regarding the MPN, which is required by regulations ▪ All approved MPN web sites to be posted by AD **(01/01/2014)** ▪ Every MPN to have 1 or more **Medical Access Assistants** available from 7:00 a.m. to 8:00 p.m., PST, Monday–Saturday by toll free number. Regulations to issue on or before 07/01/2013 **(01/01/2014)** ▪ MPN to establish and follow procedures to continuously review quality of care, performance and utilization of services and facilities ▪ MPN to submit geocoding of MPN for re-approval ▪ AD has power to investigate at any time **(01/01/2013)** ▪ **(b)(1): MPN plan approval for 4 years (01/01/2013)** ▪ Existing approved MPN plans approved ***for 4 years*** from the most recent application or modification approval date. Re-approval plans must be submitted 6 months before expiration of period **(01/01/2014): Lab C 4616(b)(1) Commencing 01/01/2016, modification that updates entire MPN plan to bring plan into full compliance shall be deemed approved for four years from date of modification approval. Modification which does not bring into full compliance will not alter existing approval period**

		▪ Any person contending the MPN is not **validly constituted** may petition the AD to suspend or revoke MPN plan approval**. (01/01/2013)** ***[NOTE FROM COREY]:*** There is no definition of what they mean by "not validity constituted." Does this mean that a component piece of the MPN is missing or that the MPN is not operating properly or in a case specific example, something was not done correctly? We don't know yet pending regulations. Here, the statute refers to "**not validly constituted**" but Lab C **4616(b)(1**) refers to the term **"validly** formed." I don't know if this is significant or simply semantics ▪ AD may promulgate regulations establishing a **Schedule of Administrative Penalties** not to **exceed $5,000 per violation**, probation or both, in lieu of suspension or revocation for less severe violations. Unless suspended or revoked, AD approval of MPN plan is binding on all persons and all courts ***[NOTE FROM COREY]:*** *It seems uncertain whether the Schedule of Administrative Penalties would relate only to a claimed violation of the validity of the network, commenced either by a petition to the AD or upon the AD's own power to investigate or whether it amounts to a form of "audit penalty" for technical violations which do not rise to the level of "not validly constituted." If we consider the language of sub (b) (5) dealing with "if the medical provider network fails to meet the requirements of this article," then I believe the latter is the intention because they talk about the relative "severity" which seems to imply yet another new penalty system for MPN audits beyond what is already in the regulations for the PARS and compliance audits]* ▪ **Changes to Regulations –08/27/2014: There are no material changes to the regulations drafted and now adopted. So, the final regulations conform to the prior drafts** ▪ **9767.1 –Definitions**: defines health care shortage, entity and Access Assistant, who must be in the "United States"; also defines probation, provider, MPN Contact and MPN applicant ▪ **9767.3 –Application: "**MPN applicant" is the new term for an applicant. Services under the MPN can only be provided at the listed locations, unless the MPN chooses to allow non-listed locations on case-by-case basis; Sub (c)(6): "An MPN applicant shall have the exclusive right to determine the members of its network" Much more information is required, including: providing electronic copy of geocoded provider list to show compliance with access standards, affirmation that each physician has agreed to treat, and showing how MPN complies with access standards ▪ **9767.5 – Access Standards:** adds the word "available" to the three per specialty requirement and MPN shall meet access standards for the five common specialties at "all times." For "health care shortage, MPN can propose alternative access in those areas. MPN Access Assistants shall be in U.S. and be available Mon-Sat from 7.a.m. -8 p.m. PST. At least one must be available during all required times and there must be a sufficient number of Access Assistants in order respond to calls, faxes or messages by the next day, excluding Sunday and holiday

		▪ **9767.5.1 – Physician Acknowledgment**: Each physician must sign acknowledgment, unless they are in a group practice, in which case the group can sign a "group acknowledgment," but it must be signed by all members. And, changes in the group practice must be communicated to the MPN. (This could help with a recurring problem involving the perceived "revolving" door of some group practices) ▪ **9767.12** – **Employee Notification:** Notification no longer required "pre injury." Now, the notification is required at the time of injury or with an existing injury and required transfer to the MPN. This conforms to the statutory changes that the failure to post notice prior to the date of injury would not otherwise defeat the MPN. Notification may be sent electronically. Toll-free number must be listed for the MPN Medical Access Assistants, with description of the assistance they might provide and the times they are available. The MPN website shall be "clearly listed." New rules governing notice when MPN coverage ends ▪ **9767.13 – Denial of Approval of Application or Re-approval**: Appeal to an adverse finding by the A.D., is now before the actual WCAB Commissioners in San Francisco, rather than being filed at the local WCAB district office. *NOTE:* This coincides with new Rule 10959 of the WCAB Rules of Practice and Procedure which creates the new Petition Appealing Medical Provider Network Determination of the Administrative Director. This petition covers not only the approval/re-approval issues but also probation and the imposition of administrative penalties. The grounds are very similar to reconsideration, including 25-page limits. Once filed, a WCAB panel is assigned, which will then order an evidentiary hearing and shall issue its decision within 60 days of submission ▪ **9767.14 – Probation, Suspension, Revocation:** AD may suspend or revoke or place on suspension, an MPN for certain violations, including failure to meet eligibility for re-approval, an additional ground for AD action is the MPN failure to respond to at least two or more repeated requests or inquiries made by the AD ▪ **9767.16 –MPN Complaints:** Complaint regulations replace transfer-of-care regulations under this rule number. A new "form," is created: DWC Medical Provider Complaint Form 9767.16.5. It requires the setting forth of the details of the complaint, which is then submitted with the MPN contact. The MPN has 30 calendar days within which to respond, in writing. The response includes disputing the complaint, taking remedial action or explaining what actions it intends to take if more than 30 calendar days are needed to address the alleged violation. After the 30-day period (or beyond if reasonable), the complainant can file a written complaint with the DWC against the MPN. (See Form DWC Medical Provider Network Complaint Form 9767.16.5). If AD finds there has been a violation, it shall notify MPN contact. ***[NOTE FROM COREY]:*** This kicks in 9767.14(a)(7), which permits the AD to suspend, revoke or

		place on suspension, any MPN which fails to respond to at least two or more inquiries from the AD, regarding violations ▪ **NEW: Lab C 4616(i) added:** AD has authority and discretion to investigate complaints, conduct random reviews and take enforcement action against MPNs, an entity that provides ancillary services or an entity which provides servicers on behalf of an MPN, regarding non-compliance with regulations ▪ **9767.17 –Petition for Suspension or Revocation of MPN: Form DWC 9767.17.5:** This petition can be filed by "anyone." The grounds include a failure to maintain the MPN's qualifying status or a "systematic failure" to meet access standards. But the failure to retain a *specific provider* in the MPN shall not constitute proper grounds upon which to file a petition. Petition is filed with the AD. MPN shall respond within 30 calendar days and within 60 calendar days, AD shall issue order granting or denying petition ▪ **Lab C 4616.3(b) AND VALDEZ:** ▪ (b): Employer failure either to provide the notice poster per Lab C 3550 or provide actual MPN notice shall not become the basis for the employee to treat outside of the MPN, unless it is shown that the failure to provide notice resulted in a denial of medical care. ***[NOTE FROM COREY]:*** *it is incumbent upon defendant to authorize the treatment within 1 working day from the filing of the Claim Form (Lab C 5402(c) and within 3 business days of receipt of a request for treatment within the MPN (8 CCR 9767.5(f) and 9767.6) otherwise lateness could doom the viability of the MPN, if the notices were not posted and provided to the employee]* ▪ **VALDEZ UPDATE:** On 11/14/2013, the Supreme Court filed its decision, holding that "out of network" consulting reports obtained by the applicant, under Lab C 4605, are admissible on the issue of compensation, which includes T.D. In its decision, the Court narrowly applied the prohibition against admitting out-of-network consulting reports, under Lab C 4616.16 [this is the MPN statute] to controversies involving "diagnosis" or "treatment," triggered under the IMR provisions of the MPN statute and NOT the IMR process for medical necessity issues, governed under lab C 4610.6. Therefore, if the applicant disputes "diagnosis" and "treatment' under the MPN, he or she gets a 2nd and 3rd opinion and then if it goes to IMR, then the applicant may not go out-of-network and obtain a consulting report under Lab C 4605. But, for regular medical necessity issues, which routinely take place, the decision permits the applicant to go out-of-network and obtain an admissible consulting report on the issue of compensability, including TD, even though defendant is not liable for the treatment. The Court also affirms that the consulting report cannot be the "sole" basis for an award. The issue of who pays for the report was not addressed by this decision. *[NOTE FROM COREY]: I don't see this as a major loss for employers, because they will still not be liable for out-of-network treatment, provided proper notice to the injured worker and timely provision of treatment took place and there is no implication that employers*

have any liability to pay for these consultative reports. Also, these reports must still be "addressed" by an in-network PTP, QME or AME, and that physician must agree with the opinion. The other "question" is whether defendants can do the same thing? In theory "yes," but in practice it is a challenge, because remember, Lab C 4605 is the "applicant's statute; ours is Lab C 4050. But the practical challenge is getting the applicant to an examination, let alone being able to obtain an order compelling attendance from the WCJ. Applicant attorneys will routinely object to the evaluation and will therefore instruct their clients not to attend

- **WCAB Panel Decisions**: ***Zulema Miranda v. Aramark, PSI*** (2014) Cal. Wrk. Comp. P.D. Lexis 533: Here, WCAB panel reversed the WCJ in finding that defendant neither denied claim to left shoulder nor refused care. (All proper MPN notices were sent) Because the left shoulder was a compensable consequence from the earlier specific admitted injury, then applicant could go out-of-network, but that treatment would be deemed self-procured, for which defendant was not held responsible. ***Acosta v. Balance Staffing*** (2014) Cal. Wrk. Comp. Lexis PD 480: Where the MPN PTP made a complete release from further care, the appropriate remedy for applicant was to resolve the dispute using the QME process and not by asking for a 2nd opinion. ***Galicia v. Search, Inc. dba Affordable Plumbing***[xxix] 2015 Wrk. Comp P.D. Lexis 710. After being notified applicant was selecting a physician within defendant's MPN, defendant did not schedule appointment, thereby contending the selection was defective because the medical group or address was not indicated. The panel reasoned that defendant should have set the appointment and their failure to do so was tantamount to neglect or refusal to provide care. The following panel decisions were noted from the California Applicant's Attorneys Association 2017 Winter Convention: PP 861-869: ***Joel Rodriguez Luna v. The Home Depot***, ***Helmsman Management*** 2016 Cal. Wrk. Comp. P.D. Lexis 405. Applicant selected an orthopedic surgeon ("specialist") to be his PTP. Therefore, the 15 miles/30-minute access standard did not apply, even though there was only 1 specialist within 15 miles but there were 17 within 30 miles. The panel reasoned that the access standard to be applied was 30 miles/60 minutes, so applicant could not treat out of network. ***Linda Ramirez v, Atria Senior Living, Gallagher Bassett Services*** *2016. Wrk. Comp. P.D. Lexis 164.* Applicant's MPN PTP was a chiropractor who requested authorization for an orthopedic consultation. Dr. Fishman was chosen. The panel held defendant failed to fulfill its duty to provide medical treatment by not providing the written authorization to Dr. Fishman. The applicant was permitted to obtain care outside of the MPN. ***ACCESS STANDARDS***: There are conflicting panel decisions as to whether there must be a specific specialty's availability as the MPN PTP. Some decisions have held that MPN access standards have been met if the MPN provides at least three physicians of any specialty within 15 miles to manage the injury. In ***Elshami v. C & A Restaurants, Inc.,*** 2019 Cal. Wrk. Comp. PD. Lexis 390, the Panel determined that there was no actual legal basis for applicant to challenge MPN access standards by asserting that defendant had to have three PTP's specializing in pain management. Citing ***Souza Puenta vs. Napa Valley United School District***, 2017 Cal. Wrk. Comp. P.D. Lexis 100, this panel concluded that MPN access standards were met, so long as the MPN had a least three PTP's of any specialty. ***Kim v. Elite 4 Print, Inc*** 2019 Cal. Wrk. Comp. P.D. Lexis

		184, a split panel decision where the majority found that in a denied and later accepted claim, applicant was required to transfer care to an MPN PTP, and not outside the MPN, in situations where defendant was exercising its proper right of medical control, after accepting the claim ▪ **Writ denied case: *Bautista v. WCAB*** (2016) 81 Cal Comp Cases 208: Applicant was receiving orthopedic treatment within the MPN. He told the physician he was having anxiety but was not referred to a psychologist or psychiatrist. He sought a 2nd opinion from an MPN psychologist. The WCAB held that he was getting orthopedic care from Dr. Borden and that he had not objected either to his diagnosis or treatment, so the 2nd opinion provisions were inapplicable. Rather, Dr. Borden should have addressed the psyche issues, and then applicant could have asked for a 2nd opinion. The panel held applicant was not entitled to a 2nd opinion when there had been no dispute over either diagnosis or recommendations for treatment ▪ **EMERGING TACTIC BY APPLICANT'S ATTORNEYS**: Second and Third Opinions and IMR [Lab C 4616.3 and 8 CCR 9767.7] As you know, there is a 2nd and 3rd medical opinion process contained with the MPN statute, which until recently, was rarely ever utilized. However, we are seeing more and more applicant attorneys endeavoring to initiate the 2nd/3rd opinion process, in order to provide a potential basis upon which to escape the MPN. Under the statute and guiding regulations, if the injured worker disputes either the diagnosis or the treatment prescribed by the MPN PTP, then the employee may seek a 2nd and 3rd opinion. Under the regulations, once the notice of request is provided (written or oral), then the employer has a set of responsibilities: [1] Providing of a regional listing; [2] Contacting the treating physician and providing copy of all medical records; [3] Notifying the 2nd opinion physician of the selection and the nature of the indicated dispute. If any of obligations do not take place, applicant will allege that he/she has been effectively denied access and that can form the basis upon which to secure out-of-network treatment. This tactic also lends potential confusion, since it has its own internal MPN IMR process, initiated with the Administrative Director. The confusion is probably the purpose of the tactic
4903.05	**LIENS: FILING FEE** **8 CCR 10207**	▪ **LIEN FILING FEE: $150**, payable electronically to DWC for all liens filed after 01/01/2013 and must be paid before lien is filed. Payment to be collected electronically. [**10207**]**:** Unless exempted, every lien claimant is responsible for the payment of the initial filing fee, using a form approved by the WCAB. Fee is payable to the Division of Workers' Compensation. Fee to be collected by the AD. While a fee is required for each case, if there are *multiple cases involving the same injured* worker and the same services by same lien claimant, then only one filing fee need be paid ➢ E Filers: pay electronically following procedures set forth in the *EAMS E-Form Filing Reference Guide.* If liens are being filed in more than 1 case at the same time, then this can be handled in one transaction but claims of two or more cannot be merged

		➢ JET filers: follow the EAMS JET File Business Rules Version 4.0 ▪ Any lien submitted after **01/01/2013** shall be deemed invalid, unless filed with supporting proof that filing fee was paid and failure to do so does not extend the statute of limitations for the filing of a lien ▪ Filing of lien shall include proof of payment of filing fee. [**10207(m)]:** no lien or claim of costs filed as a lien shall be accepted without payment of the full filing fee. Until the fee is paid, the lien shall not be deemed to have been received or filed for any purpose ▪ Filing fee pertains to liens under Lab C 4903(b) which relate to medical treatment expenses but not subject to IMR or IBR ▪ Per Lab C 4603.6(g), neither the WCAB nor any court can make a determination of any ultimate fact, contrary to the determination of the IBRO, so a lien for a contested bill per IBR determination would not be allowable ▪ No merger of claims of two or more providers of goods into a single lien permitted ▪ **No filing fee required for a health care service plan and**: Other liens exempt from a filing fee are liens for group disability insurer, self-insured employee welfare plan, Taft-Hartley Health and Welfare Fund, publicly funded program providing medical benefits on a nonindustrial basis, reasonable attorney fees, living expense liens, burial expense liens, spousal and child support liens, EDD, Victims of Violent Crime Liens, defendant filing a DOR to proceed on a lien claim or a party who is not a lien claimant and a companion case
4903.06	**LIENS: ACTIVATION FEE**	▪ **ON OR BEFORE 01/01/2014 --LIEN ACTIVATION FEE: of $100**, payable electronically to DWC required for liens filed prior to 01/01/2013, **including costs filed as a lien**, unless there is proof of prior payment of filing fee ▪ **FEDERAL DISTRICT JUDGE ISSUES INJUNCTION AGAINST THE ACTIVATIION FEE EFFECTIVE 11/19/2013** ▪ **LIEN ACTIVATION FEES RE-INSTATED**: Following the injunction, the Angelotti plaintiffs, who were fighting the fees, petitioned for a re-hearing and on 08/05/2015, the U.S. Court of Appeals for the 9th Circuit issued and order directing the state to reply to the petition filed for a rehearing in the case of Angelotti. And by the order of Judge George Wu for the Central District of California, all lien activation fees must be paid by 12/31/2015 or the affected liens would be dismissed by operation of law. The activation fees were not being accepted after midnight on 12/31/2015

		Proof of payment required for filing fee or activation fee with the filing of the DOR of if lien claimant is not the party, prior to appearing for a Lien Conference on that case, or 01/01/2014, whichever occurs first. **[10208]:** Same rules governing filing fee; only 1 activation fee is required, if there are multiple cases involving one worker and one service provider. Same rules also govern manner and method of making payment. All lien claimants who did not file the DOR for a lien conference, but who remain a lien claimant at that time or at time of a consolidated lien conference, shall submit proof of payment at the lien conference ▪ Any lien claimant not filing a DOR shall present proof of payment of activation fee at Lien Conference. If not, lien **shall be dismissed with prejudice** ▪ **Lien dismissed by operation of law if either activation fee or filing fee not paid by 01/01/2014** ▪ Same exemptions for activation fee as relate to filing fee **[10208(a)(1)]** including companion cases ▪ Lien claimants of previously consolidated cases prior to 01/01/2013, required to pay activation fee for each injured worker; payment before or at time of lien conference, but no later than 01/01/2014
4903.07	**SB 1160 EFFECTIVE 01/01/2017** **Lab C 4615.5(a) EFFECTIVE**	• Lien claimant entitled to reimbursement of filing or activation fee, plus interest, upon the proof of 3 conditions: (1) Not less than 30 days before DOR or filing of lien, lien claimant has made written demand for settlement for a clear sum stated: (2) Defendant fails to accept the written demand for settlement within 20 days [plus 5 for mailing]: (3) Final award by WCAB or arbitrator in favor of lien claimant in a sum equal or greater than the settlement demand • **LIEN FILING REQUIREMENTS, SUPPORTING DOCUMENTS AND NEW DECLARATION: Lab C 4903.05** Liens filed on or after 01/01/2017: (1) Accompanied by original bill; (2) In addition to either the full statement or itemized voucher supporting the lien; and (3) Medical reports filed if relevant to the issues; and (4) Proof of service with (5) **New declaration**: That dispute is not subject to IBR or IMR and that lien claimant must satisfy one of the following: (A) Is the PTP through an MPN?; (B) Is there an AME or QME?; (C) Has provided treatment per Labor C 4610; (D) After diligent search, no MPN in place; (E) Documentation that medical treatment was neglected or unreasonably refused; (F) Emergency treatment; (G) Is a certified interpreter or copy service. **Lien claimants have until 07/01/2017 to file this declaration for any lien filed before 01/01/2017. Failure to file a signed declaration shall result in dismissal of lien, with prejudice, by operation of law.** Filing of false declaration shall be grounds for dismissal with prejudice, after notice • **ORDERS FOR PAYMENT: Lab C:** Order for payment to lien holder only and not to assignee, unless the person has ceased doing business. All liens to be filed in the name of lien holder only, and no payment

	01/01/2017	to be made without evidence that he or she is owner of lien. This provision does not apply for assignments made prior to 01/01/2013. Assignments made in violation of statute are rendered invalid by operation of law • **LIENS STAYED UPON FILING OF CRIMINAL CHARGES: Labor Code 4615:** 01/01/2017: Any lien filed either for treatment or for medical-legal charges, as well as any accrual of interest related to the lien, will be **automatically stayed upon the filing of criminal charges against the physician or provider** for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the Medicare or Medi-Cal program. The stay remains in effect from the filing of criminal charges until disposition of the criminal proceedings. ***[NOTE FROM COREY]: the statute refers only to filed liens. It does not address present, prospective or ongoing care, or bills and billing statements for which*** liens have not been formally filed. So, some care and caution need to be exercised here because the statute is narrowly worded and pertains only to "filed liens." This means the Claims Administrator or lien handling specialist needs to make a proper distinction between a "filed lien" and the receipt of a billing item for treatment or consultation. Remember, charges for services which are not covered by a "filed lien" are also not covered by the statute. It is recommended that defense counsel be consulted for proper advice, before a decision is made on how to handle ongoing treatment charges, where no lien has been filed. Also, note that this statute does not otherwise prevent the WCAB from inquiring into and determining within a workers' compensation proceeding, whether a lien has been stayed
	Lab C 139.21; 8 CCR 9788.1 EFFECTIVE 01/01/2017	• **CRIMINALLY CHARGED PROVIDERS LIST:** DIR posts list of criminally charged providers, whose liens are stayed. **https://www.dir.ca.gov/Fraud_Prevention/List-of-Criminally-Charged-Providers.pdf**: AD shall be required to post the names of all physicians or providers, whose liens have been stayed, under the statute. ***[NOTE FROM COREY]:*** This on-line list is updated quarterly. However, there may arise an occasion where through a press release from the DWC, a local District Attorney, the California Attorney General's office or the California Department of Insurance, or simply a news story or some other media, that a certain physician or medical provider has been charged. The charging triggers the stay but not the suspension. So, care and caution are urged. It may be safer to simply use the DWC web site as the final reference for those physicians and providers against whom charges have been filed. Otherwise, it would be incumbent to review the charges in written form, before making a conclusion that a physician or providers' liens are now stayed. Also, the list of physicians and providers whose liens are **stayed** is a different list than the list setting forth the physicians or providers who have been **suspended.** The suspension requires a conviction. • **SUSPENDED PROVIDERS AND PROCESS: Lab C 139.21 PROVIDES AS FOLLOWS:**

		• **Administrative Director shall promptly suspend** any physician, practitioner or provider from participating in the workers' compensation system, if the individual or entity meets the following criteria: (A) Conviction of any felony or misdemeanor and the crime(s) which fall within any of the following: (i) Involving fraud or abuse of the Medicare or Medicaid programs, the Medi-Cal program, or the workers' compensation system, or fraud or abuse of any patient; (ii) Relates to the conduct of the individual's medical practice pertaining to patient care; (iii) A financial crime relating to Medicare or Medicaid program, Medi-Cal program, or the workers' compensation system; (iv) It is otherwise substantially related to the qualifications, functions or duties of a provider of services: (B) The individual or entity has been suspended due to fraud or abuse of the federal Medi-Care or Medicaid program, the workers' compensation system or Medi-Cal program: (C) The licensee, certificate or approval to provide health care has been surrendered or revoked: (D) The entity is controlled by an individual, who has been convicted of a felony or misdemeanor described above • AD provides written notice of suspension to physician, practitioner or provider, with notice that suspension is required within 30 days from the date notice is mailed, unless the physician, practitioner or provider requests a hearing within 10 days. A request for hearing stays the suspension. The physician, practitioner or provider must prove that the provisions of the statute are not applicable. The hearing is to take place within 30 days of receipt of request. Due process rights require an evidentiary hearing • AD designates a Hearing Officer, who will conduct the hearing or investigation and will have power to subpoena, administer oaths and require the attendance of witnesses residing within California and the production of records • AD shall provide notice of suspension to state licensing, certifying or registering authorities • AD shall provide notice of suspension to the Chief Judge of the Division, who is charged with the duty to promptly notifying all statewide WCAB district offices and WCJ's of the suspension • **LIST OF PROVIDERS SUSPENDED UNDER LAB C 139.212(a)(1):** https://www.dir.ca.gov/Fraud_Prevention/Suspension-List.htm • Disposition of criminal matter: If the conviction, whether by plea agreement or judgment, requires the dismissal of liens and forfeiture of sums claimed therein, all such liens shall be deemed dismissed with prejudice, by operation of law as of the effective date of the final disposition in the criminal proceeding • If the criminal conviction fails to determine the disposition of the lien(s) then lien(s) go to a specially assigned and consolidated **special lien proceedings**. All liens will be transferred to one WCAB location for this purpose

		• AD appoints a **Special Lien Proceeding Attorney**, employed by the Division, who will identify those liens to be adjudicated and once identified, the Special Lien Proceeding Attorney shall then notify the Chief Judge. The Chief Judge identifies a WCAB district office for consolidated special lien proceedings and appoints a WCJ to preside • There shall be a **presumption affecting the burden of proof**[xxx] that the liens to be adjudicated as well as the underlying billing items for service, arise from the conduct for which there is a conviction. It is the lien claimant, who now has the burden to disprove the presumption that services arose from the conduct for which there is a conviction. [EXAMPLES]: A physician is convicted for a DUI. *Such a conviction would not be relevant, unless the physician was intoxicated, while rendering an examination or in the providing of treatment. Or, the physician was convicted for having written a bad check for an art piece. That would not be covered under the presumption as the conviction would not relate to conduct involving the providing of medical services* • If the physician or provider can produce evidence or argument sufficient to overcome the presumption, then the WCJ has judicial discretion either to continue on and adjudicate the lien as if there existed no conviction or the WCAB may order a transfer of the lien issue back to the WCAB office, where there is proper venue for the case-in-chief
4903.1 **4903.4** **4903.5** **4903.6**	**LIENS**	▪ Liens in favor of health care provider, service plan, group disability policy, of self-insured employee welfare benefit plan are not recoverable, unless certain conditions occur, including authorization by defendant, expense incurred while employer refused or failed to furnish treatment, or expenses were incurred by emergency ▪ **STATUTE OF LIMITATIONS EFECTIVE 01/01/2013 REGARDLESS OF DATE OF INJURY:** Lab C 4903.5(a): For treatment liens under Lab C 4903(b) the limitation is **3 years from the date services were provided prior to 07/01/2013.** For services provided on or after 0**7/01/2013, the limitation is 18 months** ▪ A more relaxed statute for health care service plans: within 12 months after first knowledge that industrial injury is being claimed but no more than 5 years from date services were provided ▪ Limitations of when liens can be filed (60 days after acceptance or rejection of liability plus either IBR or IMR has taken place) ▪ Lien claimants required to notify employee and his/her representative, employer and representative and WCAB upon hiring, changing or discharging a representative, including attorney or non-attorney. Notice must provide contact information

4903.8	**LIENS: LIMITS ON ASSIGNMENTS** ***This section takes effect 01/01/2013 and without regulatory action***	▪ Order or award to issue only in favor of person entitled to payment and not to an assignee, unless the provider has ceased doing business in the capacity held at the time, and has assigned all rights, title and interest in the remaining accounts receivable ▪ Assignment must be filed and served ▪ For liens filed on or after 01/01/2013, if assignment occurs before the date of lien filing, a copy of the assignment shall be served at the time the lien is filed. If the lien is filed on or after 01/01/2013, but the assignment takes place after that date, then a copy of the assignment shall be served within 20 days of assignment date ▪ If lien is filed before 01/01/2013, copy of the assignment is due upon filing of DOR, a lien hearing or by 01/01/2014, whichever is earlier in time ▪ More than one assignment may cause the WCAB to set the matter for hearing on whether multiple assignments **are bad faith actions or tactics** (sanctions, attorney fees and costs per **Lab C 5811, 5813 and 8 CCR 10561**). These may be awarded, not only against the lien claimant but also against the assignee and their respective attorneys ▪ **Lab C 4903.8(d): FOR ALL LIENS FILED ON OR AFTER 01/01/2013 REGARDLESS OF DATE OF INJURY OR SERVICE, DECLARATION UNDER PENALTY OF PERJURY REQUIRED**: (1) Services or products described in the billing were in fact, provided; (2) Billing statement attached to lien is true and accurate. This declaration is due for liens filed on and after **01/01/2013** and for previously filed liens, at the time of the filing of the DOR, at a lien hearing or 01/01/2014, whichever is the earliest in time ▪ Without the declaration, the lien shall be considered invalid if filed on or after **01/01/2013** ***IMPORTANT WCAB EN BANC DECISION: Torres v. AJC Sandblasting and Zurich*** (WCAB En Banc: 11/15/2012, 77 Cal. Comp. Cases 1113): In this case, lien claimant appeared for trial with the only listed evidence being an unsigned health insurance claim form from Unitech to Zurich and two MRI reports. No other evidence was introduced. The WCJ found Unitech had not proven its lien and that having proceeded to trial with only an insurance form as supporting evidence, was found frivolous and therefore ordered sanctions under lab C 5813, plus attorney fees. The WCAB held on reconsideration, that the lien claimant had the full burden of proof on all issues resulting in the lien. The lien claimant "stood in the shoes of the injured employee" and therefore was required to prove, by a preponderance of the evidence, all elements necessary to establish its lien. Also, defendant had not admitted injury so the burden of proving the underlying injury was upon the lien claimant. They also had the burden of proving all other elements of the lien, beyond proving injury. The WCAB noted Unitech had listed exhibits on

		their Pre-Trial Conference Statement, which they did not introduce as evidence at the lien trial. The WCAB also supported the imposition of sanctions under Lab C 5813 and 8 CCR 10561. ***[NOTE FROM COREY]:*** *This is one of the most powerful tools to use, either to help negotiate a very minimal settlement or to attempt to defeat the lien at a Lien Trial. Remember, if there is a denial of the claim AOE/COE, then the lien claimant "steps into the shoes" of the applicant and must be prepared to prove up each and every element of the underlying case-in-chief. This is a major logistical roadblock for most lien claimants.* The same principle was affirmed in a WCAB Panel Decision in ***Powell v. Los Angeles Unified School District****, PSI* 2019 Cal. Wrk. Comp. P.D. Lexis 396. Here, applicant had settled the case by compromise and release. An out-of-network provider filed a lien claim and then asserted the MPN had not complied with the regulations governing access standards by failing to have provided prior notice to the injured worker and therefore demanded payment of the lien for self-procured treatment. The WCAB Panel ruled that the lien claimant "stood in the shoes of applicant" and therefore had the burden of proving that the failure to provide notice resulted in a denial of care
4620 **4622** **5307.7** **5307.9**	**MEDICAL LEGAL COSTS** **INTERPRETERS** **9795.1.5** **9795.1.6**	▪ GENERAL: **Lab C 4622**: Explanation of Review [EOR] is required, when employer responds to requests for payment of medical-legal expenses under Lab C 4620 ▪ Adds provision for 2nd review as a condition to permitting same IBR rules for disputed bills pertaining to medical treatment ▪ IBR rules also now cover medical-legal expenses in the same manner they pertain to treatment bills ▪ **WCAB En Banc Decision**: ***Colamonico v. Secure Transportation*** (2019) 84 CCC; Medical-legal provider has the initial burden of proof that there existed a contested claim at the time expenses were incurred and that the expenses were incurred for the purpose of proving or disproving a contested claim per Lab C 4620 and the medical-legal services were reasonably, actually and necessarily incurred. Defendant did not waive its objections by not setting forth the objections in the EOR ▪ **INTERPRETERS**: Lab C **4620 (d**) which permits **qualified interpreters** during medical examinations as part of the definition of medical-legal expenses. [**9795.1.5 and 9795.1.6]**: The prior regulation defined *"qualified interpreter*" as being one, who was either certified or provisionally certified. Under **Government Code 68562**, certified interpreters are those who are certified by entities recognized by the Judicial Council as of 07/01/1996 or who were deemed certified by being on the Recommended List of Court Interpreters. This regulation has been amended ▪ **INTERPRETERS AT HEARINGS, DEPOSITIONS OR ARBITRATIONS: 9795.1.5**: "Qualified" means the interpreter must be certified: This means: (1) Being listed on the State Personnel Board webpage or; (2) Being listed on the California Courts webpage [Interpreters who are certified by the Judicial Council are

		also deemed to be certified for medical examinations]; (3) Being provisionally certified, meaning they are deemed to perform services, when a certified interpreter cannot be present, either by agreement between the parties or upon a finding from the WCAB ▪ **INTERPRETERS FOR MEDICAL TREATMENT APPOINTMENT OR MEDICAL-LEGAL EXAMS: 9795.1.6:** Interpreters must be *separately* certified for services performed during medical treatment appointments or medical-legal examinations or provisionally certified. This means: (1) They are listed on the same webpage of the State Personnel Board, but they must have also taken the Medical Interpreter Examination; (2) They are listed on the California Courts web page: or: (3) Having passed the Certification Commission for Health Care Interpreters (CCHI) exam. (good for 4 years or; (4) Having passed the National Board of Certification for Medical Interpreters (National Board) exam, which is valid for 5 years ▪ **WCAB Panel Decision**: ***Gonzalez v. Kellermeyer Bergenson Services*** 2016 Cal. Wrk. Comp. PD. Lexis 40. Where the interpreter had sent an invoice for three days of interpreting services and filed a petition for costs, the WCJ found the requested fees were reasonable and there was no viable justification for delay or non-payment. As a consequence, thereof, Lab C 5814 penalties were imposed (25%) together with sanctions of $500 per Lab C 5813
	VOCATIONAL EXPERTS	▪ **Lab C 5307.7:** amended: On or after 01/01/2013: AD to adopt a fee schedule for payment of vocational experts, including vocational evaluations and expert testimony determined to be reasonable. *[NOTE FROM COREY]:* As of 01/02/2020, there is nothing being proposed nor are there any drafted regulations. posted on the DWC Rule Making page, so it appears this is not a driving concern and appears to remain on the "back burner." But, the new Rules of Practice and Procedure do contain new provisions governing vocational expert reports as evidence. **UPDATE: NEW WCAB Rules of Practice and Procedure in effect 01/01/2020, re-numbers this rule from 10606.5 to 10685 but they do not make any changes. WCAB Rules of Practice and Procedure: 10606.5** now re-numbered as **10685:** (1) Vocational expert reports must disclose the qualifications of the expert and must further contain a declaration to be signed by the expert, that the contents of the report are true and correct, the expert prepared the report, etc. (The same declaration as set forth in Lab C 139.2 for a physician signing a medical report); (2) Must disclose the names and qualifications of others participating in the preparation of the report; (3) The contents required (similar to medical reports), including all information reviewed, the employee's vocational history, history of injury, reasons for opinion and signature of the vocational expert
	FEE SCHEDULE: COPY SERVICES **8 CCR 9980**	▪ ***No payment permitted for copy service fees incurred within a 30 period, during which time applicant or his/her representative requests documents, which are within the possession of the Claims Administrator*** ▪ 9981 – Fee Schedule applicable, regardless of the date of injury

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Must be registered professional photocopier
Photocopy service bills: Must provide: (1) Professional photocopier registration number: (2) Tax ID No.; (3) Date of billing: (4) Claim No.; (5) Date of service; (6) Description of services provided and the number of pages produced; (6) Billing Codes may also be included; and (7) The required 139.2 declaration
Fee schedule applies if Claims Administrator fails to provide records within the specified timeframe.
No payment for photocopy fees if the Claims Administrator has provided the records within 30 days of request
No payment due for duplicate records, without written good cause
No payment for summaries, tabulations or indexing of documents
Reasonable maximum fees:

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<tr><td>$180.00</td><td>Single set of records from single custodian of records. Fee includes up to 500 pages, as well as mileage, postage, pickup and delivery, telephone calls and even repeat visits to the record source, page numbering, witness fees, check fees and preparation, handling and service of SDT</td></tr>
<tr><td>$75.00</td><td>Cancellation fee after authorization</td></tr>
<tr><td>$20.00</td><td>Records from EDD</td></tr>
<tr><td>$30.00</td><td>Records from WCIRB</td></tr>
<tr><td>$0.10 per page</td><td>For each page beyond 500 pages</td></tr>
<tr><td>$5.00/30.00</td><td>For each additional set of records in electronic form ordered within 30 days of SDT or $30.00, if ordered after 30 days</td></tr>
<tr><td>$10.26</td><td>For each X-ray or scan per sheet</td></tr>
<tr><td>$3.00</td><td>CD of X rays and scans</td></tr>
</table>
[COREY RECOMMENDS]: Providing the records by CD ROM to applicant’s attorney. That is the fastest and easiest way. You can deal with those attorneys who otherwise demand hard copies
</td>
</tr>
<tr>
<td>5703.1</td>
<td>OFFICIAL MEDICAL FEE SCHEDULE [OMFS]</td>
<td>

Maximum reasonable fees for 2012 based upon estimated annualized aggregate fees of Medicare system for physician services appearing on 07/01/2012. This applies to all treatment on or after01/01/2014

</td>
</tr>
</table>

5307.8

9789.12.1 to 9789,19:

- **THE CURRENT SYSTEM-- PRIOR TO 2014:** The OMFS (9789.11) is based upon CPT codes from the AMA, which identifies services provided rather than simply a diagnosis. So, there are code numbers assigned for every medical task and service.[xxxi] But, it is CMS which applies these codes and makes them resource based applied against their own conversion formula, in order to come up with the resource based relative value scale. The fee is determined by the CPT Code from the AMA, but the relative value unit represented is from CMS, which is then applied to the conversion factor. (E.g. evaluation and management = $8.50). The Medicare rate for each procedure is derived from the non-facility rate and a weighted geographic adjustment factor of 1.063

- **FOR TREATMENT ON OR AFTER 01/01/2014**:, *and until the AD develops a new OMFS based upon* ***the Resource-Based Relative Value Scale, "RBRVS"*** maximum fees for physician and non-physician services, including nurses, physical therapy and physician assistants, shall be in accord with Medicare payment system, except an average statewide adjustment factor of 1.078 shall apply in lieu of Medicare's locality specific adjustment factors (Note: These are amounts which are to be factored under sub (g), which means the OMFS is to be adjusted within 60 days to conform to changes in Medicare and Medi-Cal payment systems)

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

- **UPDATE: AMBULANCE FEE SCHEDULE: 01/01/2020:** Effective for services on or after 01/01/2020, maximum fees not to exceed 120% of the California fees per Medicare Ambulance Fee Schedule

- **UPDATE: DURABLE MEDICAL EQUIPMENT: 01/01/2020:** Effective for services on or after 01/01/2020, maximum fees for DME not to exceed 120% per Medicare fee schedules and tables

- **UPDATE: PATHOLOGY AND CLINICAL LABORATORY:** AD orders fee schedule to be adjusted to conform to the CMS services fee schedule for services on or after 10/01/2019

- Four-year transition to estimated aggregate and the **Resource-Based Relative Value Scale** at 120 percent of Medicare conversation factors

- CPT codes are those from AMA 4th Edition

	HOME HEALTH CARE **ATTORNEY FEES**	▪ California specific codes are adopted [9789.12.14] ▪ California specific modifier for consultation during medical-legal evaluation (-300 [9789.12.15] ▪ Hospital fees for services performed in outpatient department not to exceed 120 percent of fee paid by Medicare and maximum facility fees for services performed at ambulatory surgical centers not to exceed 80 percent of fees paid by Medicare, for the same service ▪ **HOME HEALTH CARE**: **Lab C 5307.8:** On or before 07/01/2013: AD to adopt fee schedule establishing maximums for service hours and fees for home health care services not covered by Medicare Fee Schedule. No fees payable to member of employee's household if services had been regularly performed in the same manner and degree prior to the date of injury. ***[NOTE FROM COREY]:*** *This will be extremely hard to prove since for the most part, no spouse of an injured employee may be deposed unless the spouse is a party or is claiming some secondary injury*] **2020 UPDATE: The WCAB has not yet promulgated the mandated fee schedule. There have been no posted regulations to date according to the DWC web site** ▪ **Attorney fees may be awardable for recovery of home health care, subject to future regulations** ▪ **UPDATE FOR 2017:** It appears that the DWC is delaying the adoption of the new Home Health Care Fee Schedule until presumably this year as they are waiting for guidance both from the federal government as well as from other states. The concern was that under SB 863, the HHCFS was to incorporate Medicare and the state's in house supported program (IHSS). But these two sources combined, do not cover the entire range of services. Therefore, the DWC will also consider the federal program rates. Stay tuned[xxxii] ▪ ***COMMENT FROM COREY:*** I see this as a prime opportunity for applicant attorneys to try and generate hourly fees beyond the statutory 15% fees from the cases-in-chief, resulting from their efforts to recover these benefits on behalf of their clients. I see this as a very tempting "target" of opportunity. Also, if you figure that home health care services are a trend in medicine, then expect PTP's to prescribe even more of it and applicant attorneys pursuing more of it as well. If the issues are litigated, there could be additional exposure to substantial attorney fees, based upon hourly rates of at least $350.00 or higher. *Hopefully, these issues will be quickly addressed in UR and then in IMR. If so, then potential impact would be blunted because medical necessity issues now go to IMR, not to a QME or AME*
139.48	**FOR HIGH EARNING LOSS SUPPLEMENTAL PD PAYMENTS FUNDED TO COMPENSATE**	▪ Funded by annual $120 million from non-General funds, this would compensate injured workers in a manner unspecified for "supplemental payments" "whose disability benefits are proportionately low in comparison to their earnings loss" Does this not look like Ogilvie?

	[THE RETURN-TO-WORK SUPPLEMENTAL PROGRAM OF THE DIR] **THESE REGULATIONS TOOK EFFECT 04/06/2015**	▪ Eligibility and amounts of payment are subject to regulations of by the AD, after findings based on studies of wage loss to be conducted by CHSWC ▪ **2017 REGULATION UPDATE: REGULATIONS FROM DWC: 8 CCR 17300** ▪ **NOTE:** DWC issues Newsline of 03/20/2017 indicating extension of deadline to file for the Return-to-Work Supplemental Program (RTWSP). Amendment to 8 CCR 17304: (a) The application for the Return-to-Work Supplement must be received by the Return-to-Work Supplemental Program within one year from the date the SJDB--Voucher (DWC-AD Form 10133.2 (SJDB) Rev: 10/01/2015 or later version, was served. Notwithstanding sub (a), an application for the Return-to-Work Supplement from any individual, who was issued a Voucher prior to 12/01/2015, for any injury occurring on or after 01/01/2013, must be received by the Return-to-Work Supplement Program, no later than one year from the effective date of this subdivision[xxxiii] ▪ **http://www.dir.ca.gov/ODRegulations/ReturnToWorkRegulations/FinalRegulations/TextOfRegulations.pdf** ▪ The Return-to-Work Supplemental Program ▪ Program is intended to provide supplemental payments to workers whose PD is disproportionately low in comparison to their earnings loss, based upon the RAND study ▪ Eligibility: Applicant must have received the SJDB Voucher for an injury on or after 01/01/2013 ▪ RTWSP eligibility notice is required to be included within the notice contained in vouchers ▪ Application for RTWSP must be made ELECTRONICALLY, through the DIR web site, within 1 year from date of service of SJDB Voucher. Must be made under penalty of perjury. For injured workers with no computer access, they can apply through a computer kiosk at every DWC district office ▪ All applications to be supported by required information and PDF or Tiff copy of Voucher ▪ All applications to contain warning re; false claims, including treble damages plus a civil penalty of not less than $5,000 up to $11,000, plus costs of action, pursuant to the False Claims Act [Gov. Code 12650-12656] ▪ Applications to be acted upon by DIR within 60 days of receipt

		▪ Payment: $5,000 – flat fee, non-assignable lump sum. To be made within 25 days of decision from the AD ▪ Appeal from adverse decision may be filed with WCAB District Office within 20 days of service of decision by AD ▪ The supplemental payment falls o**utside of WCAB jurisdiction, but a Workers' Compensation Judge may review the appeal, subject to the same grounds which support a petition for reconsideration.** ▪ These regulations do not contain any provision for attorney fees ▪ If the regulations remain as they are, then perhaps some applicant attorneys might enter into a ***contingency retainer agreement*** with their client for this purpose. Such a fee agreement could presumably entitle the attorney to well more than a 15% fee ▪ ***[COMMENT FROM COREY]:*** I see this "fund" as a collateral concern because in trying to obtain these benefits, applicant attorneys would have to pursue an Ogilvie issue, which would then likely be used to also support an effort to rebut the AMA Guides and the Schedule of Age and Occupational Modifiers, so such an effort could have the collateral effect of adversely impacting exposure to PD, using the Ogilvie vehicle as the means. If there are no attorney fees and given the fact that a 15% fee of from $5,000 is only $750.00, I don't know the extent to which applicant attorneys will be motivated to pursue this benefit. It seemingly requires some claim that the PD is disproportionately low compared to the RAND study, which presumably would require some predicate that the RAND study would justify a higher, long term wage loss, than the 1.4 factor now installed across the board, for all injuries and body parts ▪ For more information on how workers' compensation is currently user funded, please refer to Lab C 62.5
	MISCELLANEOUS	
5502	**EXPEDITED HEARING**	• Whether employee is entitled to treat within MPN is now added to the existing issues for expedited hearing ▪ No other issue heard at expedited hearing, until MPN issue is first resolved ▪ Medical treatment issues are heard but not Lab C 4610 and IMR issues
5703	**VOCATONAL EXPERTS**	▪ Adds new sub (j) permitting in evidence reports from vocational experts. Evidence in the form of reports preferred over live testimony. Live testimony occurs only upon a showing of good cause. A continuance may be granted for rebuttal testimony, if a vocational expert report was not served sufficiently in

		advance, in order to permit rebuttal by the opposing party. Such reports are admissible under this subdivision, only if the vocational expert has further stated in the body of the report that the contents of the report are true and correct to the best knowledge of the vocational expert
4066	**ATTORNEY FEES**	▪ Lab C 4066, permitting attorney fees if employer files application for adjudication of claim in non-litigated cases is now repealed, for all dates of injury
4702	**DEATH BENEFITS/BURIAL**	▪ Burial expenses increase up to $10,000 for injuries resulting in death on or after 01/01/2013
4907	**REMOVAL BY WCAB**	▪ Expands power of WCAB to remove persons other than attorneys from appearing before the WCAB, including hearing representatives and widens the basis for doing so
5811	**INTERPRETERS**	▪ Sets forth duties of an interpreter, which expressly do not include acting as an agent or advocate ▪ Compels non-disclosure to non-immediate participant as to any of the content of conversations or documents except upon court order
139.3	**FINANCIAL INTEREST**	▪ Interested parties required to disclose financial interests in any entity providing services ▪ Cross-referrals prohibited ▪ Rebates, preferences, patronage, discounts, dividends, commissions, etc., are prohibited by interested parties ▪ Violations are a misdemeanor and subject to civil penalties up to $15,000, per offense
AB 1197	**DEPOSITION NOTICE AFTER 01/01/2016**	▪ **Under AB 1197**, Section 2025.220 of the Code of Civil Procedure has been amended to require that for notices of deposition issued on or after 01/01/2016, we are required to state within the notice: (a) Whether our client "the noticing party" has a contract with a deposition officer or entity furnishing the deposition officer or (b) Whether our client has directed our firm to use a particular deposition officer or entity. This change does not impact the law firm's ability to select a deposition officer or court reporting entity ▪ Please note this new change requires disclosure only, not the details of any actual contract or agreement ▪ If an applicant's attorney wants to make an objection, the Code of Civil Procedure requires a written objection to be made, if at all, by no later than three days prior to the date of the deposition, otherwise

		it is waived. But any objection made must be based upon good grounds. Frivolous objections may be subject to sanctions, attorney fees and cost, per Lab C 5813, 5811 and 8 CCR 10561, so we don't expect much activity with this
	DEPOSITION FEES: LAB C 5710	▪ Before 01/01/2018, the Administrative Director shall adopt a fee schedule for Lab C 5710 fees; amends Lab C 5710(b)(4) ▪ There is currently no fee schedule in place ▪ Currently, applicant attorneys are routinely requesting fees at $400 per hour, though some will go higher and a few lower ▪ WCJ has broad discretion to award fees based upon attorney experience, time involved and location of attorney practice

[i] The conditions are: not the physical aggressor or the result of intentional act; no TTD entitlement during commitment; benefits commence following release. The AWW shall be taken at the minimum. Application for adjudication of claim may be filed during period of commitment. Occupational grouping as a laborer

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

[iii] This has not yet been implemented by the DIR/DWC

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

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

[vi] California Applicant's Attorneys Association 2016 Summer Convention, Marvin Shapiro Memorial: Most Important Cases, pp 435

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

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

[ix] CAVEAT: This form requires some interactivity and that is a good thing, since it would also go to the defense of any potential disability discrimination claim under FEHA. It is very important that the employer know that the process dealing with the employee's job description neither replaces nor supplants the "interactive process for accommodation" mandated by California law.

[x] Cited as Most Important Cases January 2017, California Applicant's Attorney Association 2017 Winter Convention; pp 536

[xi] Ramirez v. Jaguar Farm Labor Contracting Inc. (2018) 84 Cal. Comp. Cases 56

[xii] Presumably reconsider is allowable when PQME has violated 139.2, which includes not having 5 or more evaluations rejected during most recent 2-year period; this requires the WCJ to make a "finding" and sent it to the AD. This would likely result in discipline before-the-fact, so that the QME might be under suspension and therefore would not be active, so I can't see this as a ground. Other grounds here are being terminated, suspended or otherwise disciplined

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

[xiv] Taken from 2019 CAAA Summer Convention Syllabus, "Marvin Shapiro Memorial Most Important Cases" pp 420

[xv] Upheld by WCAB En Banc decision in Matute v. Los Angeles Unified School Dist. (2015) 80 Cal. Comp Cas 1036

[xvi] A WCAB panel decision upholds that electronic service of the panel does not provide another 5 days to strike [Crawford v WCAB (2019)2019 Cal. Wrk. Comp. P.D. Lexis 4

[xvii] Jose-Facundo-Guerrero v. WCAB (2008) 163 Cal App 4th 640, 73 Cal. Comp. Cases 785
[xviii] Appeal of Case #CM18-0138489. Taken from 2019 CAAA Summer Convention Syllabus, "Marvin Shapiro Memorial Most Important Cases" at pp. 417
[xix] Significant panel decisions are important because they must be issued with the consent of the entire WCAB, but they do not carry the weight or binding authority of an en banc decision. But they are citable and carry a lot of persuasive value in the industry.
[xx] 9792.27.11. MTUS List identifies drugs that are subject to the Special Fill policy. These drugs are allowed without prospective review in very limited circumstances and for a short period of time. There are specific conditions listed, including the requirement that the Special Fill drug be prescribed in the initial visit within 7 days of the date of injury; and for a supply not to exceed limit on the MTUS Drug List; FDA approved generic drug or single source brand; (Date after the DOI is "day one."
[xxi] The writ of mandate was denied but the 1st District Court of Appeals has granted a writ of review in Stevens v. WCAB No. A143043. According to the Appellate Courts Case Information, briefing is occurring and there have been amicus briefs already filed by CWCI, CAAA and the Chamber of Commerce. Arguments took place on 12/3/2014 and a decision is pending.
[xxii] Since the issues were procedural, they would take effect currently, regardless of the date of injury.
[xxiii] In Dubon I, applicant contended that the UR Physician Reviewer had not been provided with several medical reports from the PTP, consulting surgeon and even the AME, including diagnostic tests, including a discogram, EMG/NCV study and a lumbar MRI.
[xxiv] Dubon II supra pp14
[xxv] 8 CCR9792.9.1(c)(4))
[xxvi] The author of this Guide is also the author of the petition for removal in Bodam, so I am very thoroughly familiar with the presenting legal issue. Essentially, it was the contention of defendant that a timely "decision" for a prospective UR request was not rendered "late" simply because the 2-business day follow up letter was sent one day late. This is the same thinking in line with the Supreme Court case in Rodriguez, where a defendant made a timely decision to deny a claim the notice of denial was sent later through inadvertence.
[xxvii] WCAB "significant panel decisions" defined at http://www.dir.ca.gov/wcab/wcab_dars.htm
[xxviii] Defendant had maintained that the UR decision was "timely" and that the impact of the late 2 day follow up notice of denial (phone) was dealt with in the regulations, which simply toll the running of the 30-day period during which applicant can request IMR. (8 CCR 9792.10.1(c)(2) until that notice is sent.
[xxix] California Applicant Attorneys Association 2017 Winter Convention "MPN Cases" pp 807
[xxx] A presumption affecting the burden of proof means that the party, against whom the presumption applies, has the burden of essentially disproving the assumed fact by a preponderance of evidence. So, that party now has the affirmative burden of disproving the assumed fact.
[xxxi] CPT means the procedural codes set forth in the American Medical Association's Physician's Current Procedural Terminology (CP) 1997 and maintained by the AMA's Editorial Board.
[xxxii] Work Comp Central News Articles: "Review of OWCP Rates Delaying Home Health Care Fee Schedule" by Greg Jones; 10/18/2016
[xxxiii] Amended regulations at: http://www.dir.ca.gov/ODRegulations/ReturnToWork/ReturnToWork.html