LANDEGGER | BARON | LAVENANT | INGBER

A LAW CORPORATION

MICRO SURVIVAL GUIDE

SB 863

Edition 2.0

Including AD Regulations

By Corey A. Ingber

Contributing Comments by Nona Sachs

Edited by Clifford Weinberg and Ginger Volz

2013 © all rights reserved

Edition No.: 2.0

Revised: 1/3/2013

Color Key

BLUE…………………………………………………………… NEW DEVELOPMENT OR FURTHER ANALYSIS

DARK RED……………………………………………………. AD REGULATION

GREEN………………………………………………………… NEW CASE DECISION

TABLE OF CONTENTS

AWW AND PD RATES	**17 - 24**
• New PD Schedule	**17 - 22**
• New PD Rates 1/1/2013 and 1/1/2014	**23 - 24**
• Current PD Min/Max	**23**
• Illustrations	**24**
BUMP UP/DOWN GONE	
• 4658(2)(2) eliminated for injuries on or after 1/1/2013	**25**
CONSULTING REPORTS	
• Changes to Labor Code §4605	**57**
• Limitations	**57**
• QME or PTP to Address	**57**
• Discussion	**57**

INDEPENDENT BILL REVIEW (IBR) AND IBRO	**52 - 56**
• The 2nd review	**52**
• Timing of Request	**52 - 55**
• Process Explained	**52 - 55**
• Fees	**52 - 55**
• Effect of Determination	**54 - 55**
• Limited Appeal	**55**
• Remand	**55**
• Projected Time Frames	**56**
INDEPENDENT MEDICAL REVIEW (IMR)	
• Effective dates	**41**
• IMR Process Explained	**41 - 45**
• Role of IMRO and Process	**45 - 47**
• Summary of Employer Duties	**43**
• Administrative Penalties	**44**
INDEPENDENT MEDICAL REVIEW ORGANIZATIONS (IMRO)	**45 - 49**
• Role	**45**
• Process	**45**
• Effect of IMRO Determination	**46**
• Limited Grounds for Appeal	**46**
• New AD Penalties for Delay	**46 - 47**
• Costs	**47**
• Summary of IMR/IMRO Timeframes	**48**
	49

LIENS	
• Filing Fee	**59 - 62**
• Lien Activation Fee	**60 - 61**
• Proof of Payment	**59 - 60**
• When Payments Must be Made	**59**
• Dismissal by Operation of Law	**59 - 60**
• Entitlement to Reimbursement	**61**
• Health Care Providers	**61**
• Statute of Limitations	**60 - 62**
• Limitations on Filing	**60 - 61**
• Limitations on Assignments	**62**
	62 - 63
MEDICAL FEE SCHEDULE	
• Changes	**64 - 65**
• RBRVS	**65**
• Home Health Care	**65**
• Attorney Fees	**65**
MEDICAL-LEGAL	
• Interpreters	**63**
• Vocational Experts	**64**
• Explanation of Review (EOR)	**63**
• Copy Services	**64**

MEDICAL PROVIDER NETWORKS (MPN)	
• Changes	**57 - 58**
• Medical Access Assistants	**57**
• ADR Power to Investigate	**58**
• MPN Plan Approval	**58**
• Contesting MPN Validity	**58**
• Schedule of Penalties to $5,000	**58**
• *Valdez*	**59**
• Notice Poster §3550 and Changes	**59**
MEDICAL TREATMENT	
• Labor Code §4600	**34**
• Chiropractors	**34**
• Interpreting Services	**35**
• Home Health Care	**35**
MEDICAL TREATMENT PAYMENT	
• Labor Code §4603.2	**50 - 51**
• Out-of-Network Treatment	**50**
• Consequences	**50**
• Provider Requests	**50**
• Time Changes	**50**
• 2nd Review Process Initiates	**51 - 52**
• Explanation of Review (EOR)	**52**

MISCELLANEOUS	**67 - 68**
• Expedited Hearing	**67**
• Evidence Allowed	**67**
• Attorney Fees	**67**
• Death Benefits/Burial	**67**
• Removal by WCAB	**67**
• Interpreters	**67**
• Financial Interest	**68**
PERMANENT DISABILITY	
• Labor Code § 4660	**17**
• Labor Code § 4660.1	**17**
• 2005 PDRS	**17**
• New 1.4 standard Adjustment	**18**
• New Schedules: Guides for PD and Age and Occupation Adjustment	**18**
• FEC is Gone	**18**
• *Guzman* II: "Quick Refresh"	**19**
• *Ogilvie* III: "Quick Refresh"	**19**
• Limits "Add On" for Psyche, Sleep and Sexual Dysfunction	**19**
• *Guzman* II Still Good	**20**
• Rating Psychiatric Injuries	**20**
• Examples of PD Changes Under SB 863	**20**
	22/24

PD PAYMENTS: TIMING

- Labor Code § 4650(b)(1) and (2) — 33
- No PD Advances Prior to Award if Conditions Met — 33
- Offer at 85% wages and compensation — 33
- Employed @ 100% wages and compensation — 33
- "Trigger Points for Offers" — 34

QME PROCESS

- UR decisions — 30
- Diagnosis and Treatment — 30
- Supplemental Report for Corrections — 30
- UR Disputes to IMR/IMRO — 30 - 31
- Diagnosis and Treatment Disputes to IMR/IMRO — 30 – 31
- 2nd Opinion Surgical Process Eliminated — 31
- "AME Dance Disappears" — 31
- Labor Code § 4060 Requests — 31
- Labor Code § 4061/4062 — 31
- Panel Striking — 31
- Use of AME — 31
- Unrepresented Workers — 32
- Limitation on Offices — 32
- Communications with QME — 32 -33

RETURN TO WORK AND SUPPLEMENTAL FUND

- $120 million fund — 65
- Outside of the WCAB — 66

SJDB	
• Labor Code § 4658.5 **NEW**	**25**
• New Voucher	**25**
• When Voucher Obligation Arises	**25**
• Mandatory Form	**27**
• New Amount to $6,000	**28**
• $500 Advance	**28 - 29**
• Computer Equipment	**28 - 29**
• Statute of Limitations	**29**
• No Settlement/Commutation	**29**
• Schools	**30**
UTILIZATION REVIEW	
• Change	**29-34**
WHAT TAKES EFFECT WHEN?	**9-16**

WHAT TAKES EFFECT WHEN?

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

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
QME PROCESS	▪ Elimination of "AME" Dance ▪ 2nd Opinion Surgery process gone ▪ Relaxation of communications		**X** **X** **X**	
IMR and IMRO	▪ Medical Necessity Disputes Taken Away from QME and to IMR	**X** Until 7/1/2013 – effective for all decisions after that date regardless of DOI		
TREATMENT BILLS **SECOND REVIEW** **EOR** **IBR AND IBRO**	▪ Explanation of Review ▪ Request for 2nd Review ▪ IBR and IBRO process ▪ Deemed Final		**X** **X** **X** **X**	

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
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**

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
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 ▪ Statute of Limitations—18 months from date of services provided ▪ Restriction on Assignments		**X** **X** **X** Paid at time of filing of DOR, at Lien Conference if not filing DOR but no later than 1/1/2014 **X** **7/1/2013** **X**	**X** This the drop date time for payment of activation fee or liens are dismissed
MEDICAL LEGAL	▪ Qualified interpreters --exams		**X**	

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
VOCATIONAL EXPERTS **FEE SCHEDULES:** **COPY SERVICES'** **VOC EXPERTS;** **INTERPRETERS:**	▪ 2nd Review and IBR added ▪ IBR Covers Medical-Legal Expenses ▪ Fee Schedule for Voc Experts ▪ Fee Schedule for Copy Services ▪ Fee Schedule for Interpreters During Treatment		**X** **X** **X** **X** **X**	
MEDICAL TREATMENT UNDER 4600: **FEE SCHEDULES:** **HOME HEALTH CARE**	▪ For treatment after 1/1/14 based upon RBRVS ▪ Home Health Care: Adopt Fee Schedule ▪ Home Health Care: Limitations and Prescriptions For: (14 days) ▪ Limitations on "Chiropractic Visits" ▪ Interpreters During Treatment		On or before 7/1/2013 **X** **X** **X** **X**	**X**

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
UTILIZATION REVIEW	▪ Not Needed if Disputing Injury/Body part ▪ Effective for 12 months ▪ All Disputes over UR Decisions go to IMR and not Through QME Process	 **X (and on or after 7/1/2013 regardless of DOI**	**X** **X**	
	▪ UR decisions tied to MTUS ▪ Approval for Retroactive Decisions No Longer Need to be Communicated ▪ Retrospective UR deferred and Timing of Resumption	 **X** And for all UR decisions on or after 7/1/2013 regardless of DOI	**X** **X** **X**	

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
CONSULTING REPORTS	▪ Limitations on §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		

SUBJECT	PROVISION	INJURIES ON OR AFTER 1/1/2013	1/1/2013 –REGARDLESS OF DATE OF INJURY	1/1/2014
MISCELLEANOUS				
$120 MIL FUND	▪ 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	
ATTORNEY FEES	▪ Attorney Fees: filing Application for Non-represented Workers eliminated		X	
	▪ Attorney Fees Permitted for Home Health Care Issues		X	
REMOVAL	▪ WCAB Power Expands to Remove Non-Attorneys		X	
FINANCIAL	▪ More Limitations on Financial Interests		X	

SUMMARY OF SB 863
And the New AD Regulations

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

LABOR CODE	SUBJECT	ADDITIONS/CHANGES[ii]/ + REGULATIONS + DEVELOPING CASE LAW
§4660 §4660.1 (NEW)	**PERMANENT DISABILITY**	• Labor Code **§4660** is left intact for injuries prior to 1/1/2013 • **For injuries on or after 1/1/2013**, new **§4660.1 applies** • The 2005 *PDRS* ***does not apply*** to injuries on and after 1/1/2013. Instead the 2005 PDRS is effectively being *replaced* by two schedules; the first being the "**The Schedule for Rating Permanent Disabilities Pursuant to the AMA Guides**" and the other being the "**Schedule of Age and Occupational Modifiers.**" Therefore, when reference is made to the "Schedule" or the "PDRS," it now means *both* the AMA Guides and the Schedule of Age and Occupational Modifiers[iii]

	PERMANENT DISABILITY	• Under current §4660, the FEC ranking is established within ratios of earning losses by body parts across eight rankings ranging in an FEC adjustment factors from 10% to a maximum of 40%. While the FEC is technically "gone" for injuries on or after 1/1/2013, it is being replaced by a **standard 1.40 upward adjustment factor against the impairment standard FOR ALL BODY PARTS**. So, before going to the new schedule (AMA Guides + Schedule of Age and Occupational Modifiers) you will multiply the Guides based impairment by **1.40** then adjust for age and occupation in order to determine the percentage of PD • The new "**Schedule for Rating Permanent Disabilities Pursuant to the AMA Guides**" and the "**Schedule of Age and Occupational Modifiers**" will both be considered prima facie evidence and therefore rebuttable. ***[NOTE***: Does this mean that *Ogilvie* is still alive and well? The answer here is likely "yes" since it can still be argued that if both schedules are rebuttable and since *Almarez/Guzman* II is still very much in "play" then *Ogilvie* could be used to support the argument that an injured worker will sustain a *far greater* level of PD because of wage loss as he or she is unable to compete in the open labor market. And that loss is greater than the PD afforded under the Schedule because this injured worker will suffer a much higher PD "loss" resulting from the uniqueness of his or her occupation being impacted on his or her individual future earning capacity] **[*NOTE*:** If you refer to **§139.48**, *Ogilvie* is seemingly very much still alive, since the AD will have a $120 million dollar fund from which eligible workers will be entitled to supplemental payments if PD is found to be "disproportionately low" in comparison to their respective loss of earnings. We don't know what the criteria for eligibility will be, or the basis upon which funds will be distributed, but it is expected that any form of distribution will be based upon some measurable entitlement criteria directly related to the *old FEC* and the issues routinely being raised under *Ogilvie*. Therefore, "*Ogilvie*" ghosts appear to be both alive and well within SB 863. This also appears to be something outside of the WCAB, but who knows right now] • FEC is technically eliminated but we question whether *Ogilvie* really disappears

	PERMANENT DISABILITY	• ***Quick Refresh:*** ***Guzman II: 8/19/2010: Milpitas Unified School District v. WCAB (Guzman) 187 Cal. App 4th 808, 75 CCC 837:*** *Court holds that the AMA Guides 5th should be used as "intended" by its authors and this means taking into account the whole book, including instructions and the use of "clinical judgment." This permits a physician to go beyond the chapters, tables and strict protocols of the Guides. To support a case for "rebuttal" the physician must therefore explain why departure from the impairment percentages is necessary and how it was arrived at. The California Supreme Court denied review on 11/10/2010, so for now this 6th DCA decision is good law until another district decides otherwise.* • ***Quick Refresh:*** ***Ogilvie III:*** *Decided on 7/39/3011 by the 1st DCA: Ogilvie v. WCAB: (197 Cal App 4th 1262); 76 CCC 624: Here, the Court upholds three (3) methods by which to rebut the FEC component of the PDRS: (1) Showing of a factual error in the application of a formula or in the preparation of the PDRS: (2) The injury impairs applicant's rehabilitation or (3) Nature or severity of the injury was not captured within sampling of data used to produce the FEC. The California Supreme Court has granted review, but has neither decertified nor vacated the lower court's opinion, so it stands, for now* • **Adds adjustment factor of 1.4** against the WPI determined under the AMA Guides, 5th, before going to the Schedule of Age and Occupational Modifiers. **Every impairment standard will therefore be upward adjusted by 40% before modifications for occupation and age to determine adjusted PD** • Under the 2005 PDRS, the FEC is determined by an assigned FEC rank across 8 levels, with a range of between a 10% and maximum 40% adjustment. Under SB 863 revisions, the body parts which will be the *most upwardly impacted* are fingers, elbows, knees, ankles, feet, toes and hips

	PERMANENT DISABILITY	• **No increases in impairment ratings for the compensable consequences of a physical injury resulting in psyche, sleep or sexual dysfunction, or any combination thereof**: Exceptions are being a victim of a violent act or direct exposure to a significant violent act, a catastrophic injury which includes, but is not limited to things such as loss of a limb, paralysis, a severe burn or severe head injury. [***NOTE:*** This should hopefully reduce what now appears to be a standard "routine" of many physicians, who report compensable consequences.] ***NOTE FROM COREY*:** I think we will be seeing more CT claims for "straight psychiatric" injuries in order to circumvent this new PD limitation. Or, we may expect some PTP's will simply shift from psyche, sleep and sexual dysfunction to GERD, IBS and hypertension as the new "add-ons" du jour.] • **Nothing herein *is intended to overrule Guzman II*** *[**NOTE:*** If anything, I fully expect that "chapter and table shopping" within the Guides will become the near norm and that we will likely face expansive discussions on why the tables or specific applications of the Guides are not as accurate as "hybrid" and "analogy based" ratings resulting from creative combinations and mixtures using different parts of the Guides, all tied together with the connective tissue being the ADL's.]

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

	PERMANENT DISABILITY	• **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 18% @$220 = $14,410, plus or minus 15%	17.05 15 21 214F 21 22 22% @ $230 = $15,065
35 year old carpenter **Back** **DRE III 13%**	15.03 13[5] 17 380H 21 20 20% @220 = $16,610, plus or minus 15%	15.03 13 18 380H 22 21 21% @ $230 = $18,515
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, plus or minus 15%	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 1/1/2014

	AWW AND PD RATES **Current AWW and PD Rates:**	**Injuries from 1/1/2006 – 12/31/2012**2006 to 12/31/2012 **PD TO 69%** ▪ MINIMUM: AWW $195 minimum = $130 ▪ MAXIMUM: AWW $345 maximum =$230 **PD @ 70% - 99%** ▪ MINIMUM: AWW $195 minimum = $130 ▪ MAXIMUM: AWW $405 maximum =$270
§4453(b)(8)		**§4453(b)(8): Injuries on or after 1/1/2013** **PD TO 54%:** ▪ MINIMUM: AWW $240 minimum = $160 ▪ MAXIMUM: AWW $345 maximum =$230 **PD @ 55 -69:** ▪ MINIMUM: AWW $240= $160 ▪ MAXIMUM: AWW $405 = $270 **PD @70-99:** ▪ MINIMUM: AWW $240 = $160 ▪ MAXIMUM: AWW $435 = $290

	AWW AND PD RATES	***Some Illustrations 1/1/13 @ MAXIMUM vs. 2006***
	Current AWW and PD Rates:	(see table below)
§4453(b)(9)		**§4458(b)(9)" Injuries on or after 1/1/2014:**

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

	2005		SB863	%
15	11,615	230	11.615	SAME
20	17,365	230	17,365	SAME
30	30,130	230	"	"
45	54,280	230	"	"
55	71,587.50	270	84,037.50	+17.4
65	89,987.50	270	105,637.50	+17.4
70	116,977.50	290	125,642.50	+7.4
85	181,777.50	290	195,242.50	+7.4
90	203,377.50	290	218,442.50	+7.4
99	242,257.50	290	260,202.50	+7.4

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)

§4453(b)(9)

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

PD @1-99:

- MINIMUM: AWW $240 = $160
- MAXIMUM: AWW $435= $290.00

§4658(e)	**PERMANENT DISABILITY: WEEKS AND 15% BUMP UP/DOWN: ELIMINATED**	▪ §4658(d)(2) containing the infamous "15% bump up/bump down still applies to injuries prior to 1/1/2013 ▪ For injuries on or after 1/1/2013: new sub-section (e) eliminates **the entire 15% increase or decrease provision** ▪ The number of weeks for 2/3 of AWW allowed for each 1% of PD remains the same for PD from 1-99% (The formula found on Table 15 of the Labor Code remains unchanged)[v]
§4658.5 §4658.7 **NEW**	**SJDB**	▪ **4658.5:** Adds new sub (d) for injuries prior to 1/1/2013 where the SJDB issues after 1/1/2013, it shall expire 2 years from date furnished to employee or 5 years from date of injury, whichever is later ▪ Employee not entitled to payment or reimbursement of expenses that have not been incurred and submitted with appropriate documentation prior to expiration date of voucher ▪ **4658.7: New "Supplemental Job Displacement Nontransferable Voucher" for injuries on or after 1/1/2013:** ▪ Voucher obligation now arises when there **is *any amount of* PPD** and no offer is made within **60 days** of the Claims Administrator **receiving the first report from a PTP, QME or AME** in proper form, finding disability from all conditions for which compensation claimed is permanent and stationary AND injury has caused PPD (see below since the regulation appears to be inconsistent with the timing of the statute)[For injuries between 1/1/04-12/31/12, the "trigger" remains the date upon which TD terminated, so the offer must be made within 30 days from that time, in order to avoid liability for the SJDB]

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

Regulations filed with OAL 12/14/12</td>
<td>

▪ **NEW DWC FORMS:**

§10133.32	**SUPPLEMENTAL JOB DISPLACEMENT NONTRANSFERABLE VOUCHER FORM**	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
§10133.33	**DESCRIPTION OF EMPLOYEE'S JOB DUTIES**	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
§10133.35	**NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK**	All offers are now on one form
§10133.36	**PHYSICIAN'S RETURN-TO-WORK AND VOUCHER REPORT**	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 [§4658.7(h)]
§10133.55	**REQUEST FOR DISPUTE RESOLUTION BEFORE THE ADMINISTRATIVE DIRECTOR**	Same form, same form number, with slight modifications on last page, but nothing substantive

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

	SJDB **Regulations filed with OAL 12/14/12**	▪ **REGULATIONS:** [**§10133.31**] **(new)** The offer is made within 60 days after receipt by the Claims administer 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& S/MMI 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" 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&S/MMI evaluation from all injuries, finds PD but the form is not attached. ▪ **NEW MANDATORY FORM**: **[Form: DWC-AD §10133.36]** Claims Administrator to forward on an AD devised form to employer to inform of work capacities and restrictions which are relevant to potential regular, modified or alternative work. Use of the form is now mandatory per the adopted new regulations ▪ If a physician has been provided a job description [**Form: DWC-AD 10133.33**] the physician shall evaluate and describe in the form whether the capacities and restrictions are compatible with the requirements in the job description. And the physician shall comment on the job description within form AD §1011.33.36, which is attached to the medical report provided to the Claims Administrator ▪ No SJDB entitlement, 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 **Regulations filed with OAL 12/14/12**	▪ 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 other educational providers who are 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) [**NOTE:** 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

	SJDB **Regulations filed with OAL 12/14/12**	▪ **ADVANCE OF $500:** Under the $6,000 aggregate sum, payment to the employee as an advance or reimbursement **up to $500** deemed as a miscellaneous advance without the employee's need to document [***NOTE FROM NONA SACHS:*** Here, the applicant gets an automatic payment of $500 without documentation so expect applicant attorneys to modify their standard transmittal and representation letters to build in automatic demands both for the $500 advance as well as for the computer.] [**§10133.31(e)(6)]:** The regulation is taken "word for word" from the statute, so no further rules here beyond what the statute says. A further change to the regulation permits the employee to make the request by E mail if this is included in the Voucher form ▪ **COMPUTER EQUIPMENT:** Under the $6,000 aggregate sum**, up to $1,000** for the purchase of computer equipment, which will likely include peripherals such as monitors, keyboard, mouse, software and even tablet computers [***NOTE FROM NONA SACHS:*** This could actually become a routine "demand" by applicant attorneys in which for any case where this is likely to be any level of PD, they issue a demand for a computer and its peripherals. According to the statute, the qualifying elements of the SJDB are the existence of any PD and no offer being made within the 60 day time frame. It is the applicant's "choice" as to how to spend the voucher, so it seems as if computer equipment might well become a "routine" thing in any case where there is PD and no timely offer of work] ▪ Voucher expires 2 years from the date it is furnished to employee or 5 years from the date of injury, whichever is later ▪ No payment or reimbursement to employee unless there is submitted documentation prior to voucher expiration date ▪ **No settlement or commutation of SDJB is permitted**

	SJDB **Regulations filed with OAL 12/14/12**	▪ 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 §10133.58(c)**]: the list is now based upon a very wide number of schools. For injuries on or after 1/1/2013, providers of education-related retraining or skill enhancement shall be certified on the ETPL. See; http://etpl.edd.ca.gov ▪ **§10133.31(i):** Claims Administrator to make reimbursement payments within 45 calendar days from receipt of completed voucher, receipts and documentation
§4061	**QME PROCESS**	▪ **§4061** shall not apply to utilization review decisions under §4610 ▪ **§4061** shall not apply to employee disputes of diagnosis or treatment under MPN per §§4616.3 and 4616.4 ▪ For unrepresented employees – Sections (d)(1) and (2) are added which allow an unrepresented employee **or employer** to request one supplemental report from a PQME seeking correction of factual errors in report ▪ PD rating is suspended during this correctional phase of the process ▪ Notice due to employee re: PD replaces "continuing medical care" with "future medical care"
§4062	**QME PROCESS**	▪ **§4062 (b):** For injuries on or after 1/1/2013 and for UR decisions communicated on or after 7/1/2013, regardless of date of injury, all employee objections to utilization review disputes under §4610 are resolved only through independent medical review (IMR) pursuant to §4610.5 *and not through the QME process* ▪ For injuries on or after 1/1/2013 and for objections to diagnosis of treatment recommendations within the 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 §4610.5

	QME PROCESS	▪ Second opinion spinal surgical process under §4062(b) is gone as of 1/1/2013 and for all dates of injury
§4062.2 §139.2	**QME PROCESS** **Regulations filed with OAL 12/20/12**	▪ 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** ▪ **"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] ▪ **§4062.2(b): §4060 requests** -- the 1st working day which is at least 10 days from giving the other side notice of intent to make a PQME request to the DEU Medical Unit ▪ **§4062.2(b): §§4061 or 4062 --** the 1st working day which is at least 10 days from a party making a 20 day objection to the reporting of a treating physician ▪ **§4062.2(c):** Once the panel is assigned, there is no further requirement that the parties then "confer" in an attempt to agree to upon a SPQME from the panel within 10 days and then strike one doctor from the panel within 3 additional days. **Instead, either party may strike one name within 10 days from issuance (plus 5 more days for mailing). If a party fails to strike a name within 10 days (plus 5 for mailing), then the other party can select any of the three as the PQME** ▪ **§4062.2(f):** Parties can agree to AME at any time except as to issues for independent medical review (IBR) under §4610.5 ▪ No QME panel may 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

	QME PROCESS **Regulations filed with OAL 12/20/12**	▪ Preference in assignment of panels given to non-represented employees ▪ QME shall not conduct evaluations at **more than 10 locations.** Changes to regulations: **[8 CCR §§17(b and 31.2]:** On or before 1/1/2013, QME shall notify Medical Director of the street address of the 10 or fewer office locations where the QME will conduct examinations. Between 1/1/2013 and 7/1/2013, no substituted offices without good cause. An individual QME, performing evaluations at more than one office location required to pay additional $100 annual fee per additional office location**.** Each additional office must contain the usual and customary equipment for the type of practice appropriate to the QME specialty ▪ **EFFECT OF FAILURE OF QME TO PROVIDE NOTICE OF OFFICE LOCATIONS TO AD**: New **sub (h)** is added **to 8 CCR §33**, so that if the QME has failed to make the notification of office locations (less than 10) to the AD by 1/1/2013, then the Medical Director "shall" designate the QME to be "unavailable." **This means a replacement panel.** (Another tool to use when reviewing a QME Panel. Have all of the doctors complied with this?)
§4062.3	**COMMUNICATION WITH PQME**	▪ Sub (f) is amended to permit communications with an AME's staff or with the AME as to non-substantial matters such as scheduling of an appointment, missed appointment or furnishing of a record and reports, including availability of report. [***NOTE***: sub (f) refers only to AME's and does not list a PQME so was this a drafting mistake or an omission? This is unclear but it seems the intent was to permit these communications since this has become a problem and there are some cases addressing the issue of contacts with a PQME for non-substantive issues such as "did the applicant show" and "when can we expect the report?" It seems as if the drafters omitted without intent]: ***NOTE FROM COREY:*** Current regulations under 8 CCR §356 and §4062.3 deal with communications to both an AME and QME, so this really appears to be a drafting omission. The same rules should apply to PQME's and AME's.

	COMMUNICATION WITH PQME	▪ **Regulations**: changes to **8 CCR §35(b)(1):** Changes this statute to permit the type of clerical communication authorized by §4062.3(f), allowing for oral communications with the AME or staff, relative to non-substantive matters, such as scheduling appointments, missed appointments, furnishing of records and reports and the availability of the pending medical report, unless the WCAB has made a specific finding of an impermissible communications
§§4650(b)(1) and (2)	**TIMING OF PD PAYMENTS**	▪ Adds two sub sections to the statute ▪ **FOR ALL DATES OF INJURY** ▪ NO PD advances if all conditions below are met: ▪ **(b)(1):** advancing PD now subject to (b)(2) ▪ **(b)(2) NEW--No PD advances are payable if prior to an award of PD**, the employer has offered the employee a position paying ***at least 85%*** of the wages and compensation paid at time of injury –or- if employee is employed in a position that pays ***at least 100%*** of the wages and compensation paid at the time of injury ▪ When PD award is made, amount then due will be calculated from the last date upon which TD was paid or the permanent and stationary date, whichever is earlier ▪ Under this statute, if we learn the applicant is working for another employer and earning at least 100% of wages and compensation at time of injury, then no PD advances are required [***NOTE****:* We now have an additional reason to get records from a new employer or the applicant's stipulation as to wages and compensation, otherwise if the compensation is anything lesser, we would have the obligation to advance PD] ▪ PD WILL BE PAID AT THE MINIMUM AND MAXIMUM RATES (ABOVE) AND NOT AT THE TD RATES AS REFLECTED IN EARLIER DRAFTS OF THE BILL

	TIMING OF PD PAYMENTS	▪ ***NOTE FROM COREY:*** We now have 2 trigger points at which offers are to be made: 1) **PRIOR TO AN AWARD TO AVOID PD ADVANCE LIABLITY**; and 2) **WITHNIN 60 DAYS OF RECEIPT OF 1ST REPORT FROM PTP, QME OR AME, FINDING DISABLITY FROM ALL CONDITIONS, THE APPLICANT IS PERMANENT AND STATIONARY AND THERE IS PPD.** *Subject to further regulations, it would be ideal if only one offer can be made, but the criteria for the SJDB offer is more extensive; but if the money and benefits are at the 85% level, and then I presume ONE OFFER WOULD COVER BOTH* ▪ ***NOTE FROM COREY:*** What about existing cases where there is PD? Do we use this statute to discontinue paying PD, if the applicable criteria are there? Can this be done? Undoubtedly, this will be a subject of much discussion and analysis. There is no all-inclusive answer right now, as it may depend upon many factors. However, it is a consideration which should be undertaken with great care, especially with unrepresented injured workers. Stopping PD benefits could induce an applicant to hire a lawyer, so an abundance of caution is recommended for non-represented cases.
§4600	**MEDICAL TREATMENT:** **CHIROPRACTORS §4600(c)**	▪ Under amended §**4600(c),** a chiropractor shall not be a treating physician after the employee has received the maximum "chiropractic" visits under the 24 treatment "hard caps" of §4604.5(d)(1). [***NOTE:*** The statute appears to delimit the chiropractor after the applicant has actually had chiropractic treatment. However "chiropractic visits" are not defined. Does this mean a PTP examination by a chiropractor or does it also pertain to chiropractic adjustments as opposed to physical therapy? But what about a PTP who examines the applicant every 45 days and refers the applicant for physical therapy? This is very likely to be a subject of intense scrutiny, pending regulations, if any.] **NOTE**: If early indications in the regulation drafting are an indication, the regulations will likely define "chiropractic visit" and this would cover both medical management and treatment, so that the caps would apply even to a chiropractor who was not providing care but only acting as the "gatekeeper." It is expected this statutory change will be challenged quickly either on a reconsideration and appeal from a WCAB decision or perhaps even with a direct constitutional attack launched in the Superior Court. ▪ There is also a slight drafting error since the statute refers to the so-called "hard caps" under sub (d) but under the changes in this statute the "hard cap" are actually now contained in sub (c). Stay tuned

	INTERPRETING SERVICES **HOME HEALTH CARE**	▪ **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**: new sub (h) provided only as medical treatment if reasonably required and prescribed by a physician and surgeon ▪ 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 (**new**)	**CHANGES TO UTILIZATION REVIEW** **§9792.1** **§9792.10.1** **RFA**	▪ **CHANGES TO UTILZATION REVIEW STATUTES:** The regulations implementing the statutory changes to UR have been divided between injuries prior to 1/1/2013 and UR decisions before 7/1/2013 vs. those which relate to injuries on or after 1/1/2013 and UR decisions after 7/1/2013.

UTILIZATION REVIEW

Regulations filed with OAL 12/20/12

Side by Side Comparison

	INJURIES PRIOR TO 1/1/2013	INJURIES ON AND AFTER 1/1/2013 AND UR REQUESTS MADE ON OR AFTER 7/1/2013
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 Administrator or UR by FAX or by E mail if there is a receiving "date stamp" ▪ If no receiving date stamp, then date transmitted is deemed date received

	UTILIZATION REVIEW		UR PROCEDURES AND TIME FRAMES	**§9792.9(b)(2)** If liability is finally determined adversely to Claims Administer, then time for conducting retrospective UR begins with the date upon which the liability became final Regulations relating to the communications of UR decisions remain the same, but they change after 7/1/2013 to incorporate the new changes to UR, including use of IMR and mandated notice form language	▪ 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 Administrators shall have fax numbers ▪ All Claims Administrators 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

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

	UTILIZATION REVIEW		**UR DECISIONS** **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 denial 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 Administrator and ***the application shall include an addressed envelope and the postage may be paid for mailing to the AD*** ▪ ***A Clear statement advising that all disputes are to be resolved in accordance with §4610.5 and §4610.6*** and that an objection to the utilization review decision must be communicated by the injured worker or by representative or attorney ***within 30 calendar days from receipt of UR decision.*** ▪ ***Mandatory language also required: re:*** right to disagree with UR decision, please call Claims Examiner @ phone number, or attorney

UTILIZATION REVIEW

DISPUTES	Disputes are resolved through the §4062 QME process until 7/1/2013, 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 must be consistent with the MTUS and may no longer refer to ACOEM Guidelines

- **(g)(6):** UR decisions 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 a 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**
	------------------------------------- **INDEPENDENT MEDICAL REVIEW [IMR]** **§9792.10.3** **§9792.10.4** **§9792.10.5** **§9792.10.6** **§9792.10.7** **§9792.10.8** **§9792.12**	--- ▪ **For all injuries on and after 1/1/2013 as well as for all UR decisions taking place after 7/1/2013, regardless of the date of injury, all disputes over UR decisions to delay, modify or deny medical treatment requests shall be determined through the IMR process and no other, UR decisions which are not reviewed by an IMRO shall otherwise be deemed final** ▪ Medical necessity issues are now being taken out of the hands of the QME's and AME's and placed into the realm of an IMRO, whose Reviewer's(s) decision is essentially final, 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)]**

	IMR **§9792.10.3** **§9792.10.4** **§9792.10.5** **§9792.10.6** **§9792.10.7** **§9792.10.8** **§9792.12**	▪ **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 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 of the documents submitted to the IMRO. Documents not previously served shall be provided with this notice ▪ Failure to provide the required AD form (above) suspends the limitations for employee to request IMR and then the time runs from the time that the notice is provided [**§9792.10.1(c)(2**)]: The regulation actually expands the so-called "fails" to include any breach in the notice provisions under §9792.9(1) or §9792.9.1(e) so that any problem with the notification process will suspend the IMR process from going forward until the Claims AD corrects the failures 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.] ▪ AD to expeditiously review all IMR requests and to notify whether the request is approved**. [§9792.10.3]**: Upon receipt of the Application DWC Form IMR-1, the AD will look at the completeness of the application, whether a previous application was made, assertions by Claims 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 to respond***. Following all information received, AD shall immediately inform parties the reasons that a disputed medical treatment is not eligible for IMR.

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

§9792.10.3
§9792.10.4
§9792.10.5
§9792.10.6
§9792.10.7
§9792.10.8
§9792.12</td>
<td>

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

DOCUMENTS PROVIDED BY CLAIMS ADMINISTRATOR	PROVIDED BY EMPLOYEE
All reports of the treating physician within 1 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 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

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

	IMR **§9792.10.3** **§9792.10.4** **§9792.10.5** **§9792.10.6** **§9792.10.7** **§9792.10.8** **§9792.12**	▪ Employer is also required to provide a listing of all documents served upon IMRO ▪ **Summary of Employer duties**: (1) Serve the 1 page form (§4610.5(f), **DWC Form IMR-1** to the employee, together with the required UR decision notices on the disputed medical necessity issue; (2) Provide documents to the IMRO within 15 days (or 24 hours) and; (3) provide notification to the employee which lists documents submitted to the IMRO including copies of all documents not previously served ▪ ***NOTE FROM COREY:*** Under changes to the utilization review statute, UR decisions shall be in effect for 12 months unless there is some factual change. But, we don't yet know how the IMR issues will be handled. If there are multiple RFA's within a PR-2, will each be the subject of a separate IMR. Or, what happens if the PTP sends in "one RFA" at a time? Will each independently trigger UR and IMR? Should the IMRO not know that the PTP is "dripping" each request separately? It is too soon to know but worth considering as we gear up ▪ **Administrative penalty "not to exceed" $5,000 per day:** *Regulations have now been adopted (see pages 40-42 below) which provide a schedule of administrative penalties under these provisions. The daily amounts are well within the maximum per day, with the maximum actually by 10 times less (maximum per day is $500). But these could change.* Under sub (i) the employer shall not engage "*in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the plan to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be submitted to an administrative penalty…**up to $5,000 per day.**"* [***NOTE:*** This part of the section is loosely written and does not clearly define what the conduct is or what it means by "has the effect of delaying," so is a one-time delay enough to trigger an administrative penalty or does it otherwise require repeated actions over periods of time, equivalent to a business practice? We don't know but I expect the AD will likely establish a schedule of penalties over a range of conduct with the amounts calibrated to the seriousness of the conduct. up with a schedule of penalties over conduct, which will probably scale the fine to the conduct] (See pages 40-42 below)

	IMR	▪ Medical necessity issues will be determined using a ranking or hierarchy of scientific and medical evidence, which in order of priority, beginning with the MTUS under §5307.27 and then providing for lower ranking evidence only if higher ranked evidence is deemed inapplicable to the employee's medical condition
§4610.6 (new)	**INDEPENDENT MEDICAL REVIEW ORGANIZATION [IMRO]** **§9792.10.4** **§9792.10.5** **§9792.10.6** **§9792.10.7** **§9792.10.8** **§9792.12** **Regulations filed with OAL 12/20/12**	▪ IMRO upon assignment shall designate a medical reviewer, to conduct an examination of the submitted documents on the medical necessity issue. May assign more than one reviewer if issue is deemed sufficiently complex such that a single reviewer can't reasonably address all disputed issues. Determination to include whether disputed medical treatment is medically necessary **[(§§9792.10.6(c) and (d)],** using the hierarchy of scientific and medical evidence established under §4610.5(c) and the clinical reasons. A written determination to be made within **30 days or sooner** from date of the DWC Form IMR-1 and supporting documentation **[regular review]**. Upon certification by the AD or treating physician that the condition is imminent and serous, then decision is due in **3 days [expedited review]** from IMR-1, plus supporting documentation ▪ Subject to AD approval, deadlines for regular and expedited may be extended **<u>up to 3 days</u>** in extraordinary circumstances or for good cause **[(§9792.10.6)]** ▪ **§4610.6(e): [§9792.10.6]:** Each IMRO analysis to state whether the disputed health care service is medically necessary and why, citing relevant documents in the record and the relevant findings of the scientific and medical evidence with the hierarchy. If more than one medical professional reviews the issue, then a majority decides. If there is an even split, then the decision shall be in favor *of* ***providing the treatment***. Each reviewer's opinion shall be provided, but shall remain confidential ▪ Determinations of the IMRO are deemed the determinations of the Administrative Director (AD)

	IMRO **§9792.10.4** **§9792.10.5** **§9792.10.6** **§9792.10.7** **§9792.10.8** **§9792.12** **Regulations filed with OAL 12/20/12**	▪ **(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 a 30 day time limit to appeal. The current version does not, but the 30 days is governed by the statute anyway. Limited grounds for appeal, include: The AD acted without or in excess of powers, the final determination was procured by fraud, independent medical reviewer subject to material conflict of interest, in violation of §139.5, determination was result of bias on basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability or determination was based upon plainly erroneous express or implied finding of fact, provided it was a matter or ordinary knowledge based on the information submitted for review and not a matter subject to expert opinion ▪ If AD determination is reversed, the dispute is remanded to a different IMRO, or if a different IMRO is not available, then back to the same IMRO, but with a different reviewer ▪ Neither the WCAB nor a higher court may make a contrary finding of medical necessity ▪ [**§9792.10.7**]: Determinations to approve disputed medical service shall be promptly implemented unless employer has **filed an appeal or has otherwise** disputed liability for other reasons than medical necessity. Otherwise, services not yet authorized will be authorized **within 5 working (business) days.** Employer to reimburse for services already provided **within 20 days** ▪ **ADMINISTRATIVE PENALTIES:** ***NOTE FROM COREY:*** Current regulation 9792.12 provides for administrative penalties for UR. However, the regulation has been amended to now include penalties for IMR as well**. §4620.6(k) and regulation: [§9792.12]: The AD has promulgated nearly 6 pages of lengthy and detailed schedule of penalties:** Here, the AD has left undisturbed the current schedule of penalties associated with UR violations. *However, they have added an additional penalty for the failure to timely communicate a written decision modifying, delaying or denying a treatment authorization @ $250.00 per day, UP TO a MAXIMUM OF $5,000:* **[§9792.12(a)(18)]**

	IMRO §9792.10.4 §9792.10.5 §9792.10.6 §9792.10.7 §9792.10.8 §9792.12 Regulations filed with OAL 12/20/12	▪ **ADMINISTRATIVE PENALTIES FOR IMR:** ***NOTE FROM COREY:*** The AD has made a schedule of administrative penalties which are draconian, because being late can be compounded or conduct can run in multiple fines, so that several delay penalties could attach to each separate act of lateness. However, the AD will not impose the "up to" **$5,000 PER DAY figure which is in the statute. Instead, they have adopted a schedule based upon the conduct and have capped each section.** [***NOTE:*** Here, and unlike §4610.5(i), the penalty process more closely associates the penalty with a specific instance of conduct, so it seems as if this part of the statute would likely pertain to a single act occurring in one claim, but there will likely be a schedule of penalties, so that it is very likely that the number of days delayed will calibrate to a monetary penalty. This will be subject to regulations.] ▪ **SCHEDULE OF PENALTIES: IMR: [§9792.12(A)(19)-(25)]:**

FAILURE TO:	AD PENALTY
Provide DWC IMR-1 with all fields filled out	$2,000
Provide injured worker with clear statement that disputes to be resolved through IMR and objection to UR must be communicated on the DWC Form IMR-1 within 30 calendar days	$2,000
Detail UR internal review appeals process and stating that it is voluntary	$2,000
Timely provide information to the AD	$100 per to maximum of $5,000
Timely provide information to the IMRO	$250.00 per day to maximum of $5,000
Timely implement final determination of IMRO	$500 per day to a maximum of $5,000
Timely pay invoice from IMRO	$250

	IMRO **§9792.10.4** **§9792.10.5** **§9792.10.6** **§9792.10.7** **§9792.10.8** **§9792.12** **Regulations filed with OAL 12/20/12**	▪ 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) Regular Review: MD/DO (2)	**$560.00** **$760.00**	**$550.00** **$740.00**
Regular Review: non MD/DO (1)	**$495.00**	**$475.00**
Regular Review: non MD/DO (2)	**$655.00**	**$635.00**
Expedited Review: MD/DO(1)	**$685.00**	**$645.00**
Expedited Review: MD/DO (2)	**$850.00**	**$830.00**
Expedited Review: non MD/DO (1)	**$595.00**	**$575.00**
Expedited Review: non MD/DO (2)	**$760.00**	**$740.00**
Withdrawn	**$215.00**	**$215.00**
Fees due to IMRO	30 days of billing If not paid within 10 days of due, plus interest @ 10%	

IMRO

§9792.10.4
§9792.10.5
§9792.10.6
§9792.10.7
§9792.10.8
§9792.12

Regulations filed with OAL 12/20/12

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

ACTION	TIME FRAME
IMRO issues notice of assignment	1 business day §9792.14
Parties respond to information requested from the AD	15 days following receipt of request §9792.10.3(c)
All documents under §9792.10.5 needed sent to IMRO: Regular	15 calendar days from date of notification if provided by mail 12 calendar days if provided electronically §9792.10.4(e)
All documents under §9792.10.5 needed sent to IMRO: Expedited	24 hours §9792.10.4(f)
IMRO Requests More Information	5 business days: routine case 1 calendar day: expedited case §9792.10.5(c)
IMRO determination is made	Regular: 30 days of receipt of DWC IMR-1 §9792.10.6(d) Expedite: 3 days
Claims AD to Implement determination	5 business days of receipt of final determination 20 days to reimburse provider if services provided §9792.10.7(a)(2)
Appeal by Petition to WCAB	30 days of mailing of final decision (5 more days for mailing per CCP §1013? Probably, but it doesn't say) §9792.10.7(c)

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

	PAYMENT OF TREATMENT BILLS PER §4603.2 SECOND REVIEW **§9792.5.5**	▪ **§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
	New Form: DWC Form SBR-1	▪ The Request: Request for 2nd review for treatment shall be made either on new **DWC Form SBR-1** or on the actual bill if the bill was non-electronic; for medical-legal charges, the request **must be made on the form**. Methods for electronic review depend upon type of service. For pharmacy bills, 2nd review can occur through trading partner agreement or by using the form SBR-1. The request for 2nd review shall include the dates of service and the same itemized services rendered as the original bill. No new dates of service are included here. Also, items in dispute are listed and the amounts and the amount of additional payment being requested and the reasons therefor. If only dispute is money and the provider dos not request a timely 2nd review, the bill is deemed "satisfied." [**(§9792.5.5(e)]** ▪ Any properly documented, itemized services provided and not paid within the **§4603.2** time frames are increased by ***15%, plus interest***
	§9792.5.5	▪ **[§9792.5.5.(f)]:** Employer responds to 2nd review within 14 days with final written determination on each of the amounts in dispute with payment of any balance not in dispute within **21 days** of receipt of 2nd review. Time may be extended by written mutual agreement
	§9794	▪ **[§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

	§9792.5.5	▪ If provider contests final written determination following the 2nd review, then it may request IBR per §4306.3 and [§9792.5.5(h)]
4603.3 (**new**)	**EXPLANATION OF REVIEW** **§9794**	▪ **§4603.2(b)(2): Explanation of Review ("EOR")** now required *upon payment, adjustment or denial* ▪ [§9794 (c)]: EOR is now also required for the payment or objection to medical-legal charges and the objection must also incorporate the use of the EOR. Also, the same rules for 2nd review and IBR also pertain to **medical-legal charges** ▪ EOR includes: statement of items and procedures billed and amounts requested, amounts paid, basis for any adjustment, change or denial of item or procedure, additional information required, times frames involved and the IBR process ▪ This does not appear to apply to a submitted billing item from a provider where the entire bill is being paid, without adjustment, objection, denial or reduction **[*NOTE:*** Unfortunately, this is also unclear. Pending regulations on this section, it is suggested that employers consider an EOR which features a section specifically indicating that the bill is **being paid in full** without adjustment and therefore the rest of the EOR is not being completed on this basis. Therefore, the EOR would be transmitted but with a clear indication that no reduction, change, objection or reduction is being made]
	INDEPENDENT BILL REVIEW (IBR) **§9792.5.7** **Regulations filed with OAL 121/20/12**	▪ Provider may request IBR only if there has been a 2nd review, which did not resolve the issue and the **only dispute is the amount of payment**. If there are other reasons for non-payment other than reasonableness, that issue must be resolved before IBR takes place. Issues which are considered not eligible for IBR include: where the fee is not covered by a fee schedule, contract reimbursement rates, proper selection of an analogous code or formula based on a fee schedule, unless the contract or fee schedule allows for analogous coding **[(§9792.5.7(b)]**

	INDEPENDENT BILL REVIEW ORGANIZATION (IBRO)	▪ **Provider has 30 days from service of 2nd review determination within which to request IBR, otherwise bill is deemed satisfied. [§9792.5.7(c)]:** the 30 days is counted from the date of service of the final written determination under 2nd review if there is a proof of service; or the date of receipt if no proof of service and the Claims Administrator has documentation of date of receipt; if there is no proof of service or not documented date of receipt; then the time is extended by 5 calendar days from date of postmark. Time frames begin if there is an underlying issue contesting liability and not just the bill, in which case it starts from date of WCAB Order or date of resolution in favor of provider.
	New Form: DWC Form IBR-1	▪ 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 must** be made at the time request is made.
	Fee is $335.00	▪ 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 the AD may require electronic only but for now, two methods are permitted to start IBR. Copies of the Form IBR-1 served on employer. Only the request form and the proof of payment are to be submitted to the AD. **Note from Corey:** The regulations change this. They require not only the form but also supporting documents, "that were furnished with the original billing" **+ the EOB + the request for a 2nd review + supporting documents from Claims Administrator + final written determination of 2nd review: Per §9792.5.7(d)(2), the provider required to add documents to the form, including contract for reimbursement rates**
	INDEPENDENT BILL REVIEW ORGANIZATION (IBRO)	▪ **CONSOLIDATION ALLOWED: §§9792.5.7(e) and 9792.5.12: Provider may request that two or more disputes that would constitute a separate request for IBR be consolidated.** ***NOTE FROM COREY:*** The statute (**§4603.2)** is silent on consolidation, so it is neither specifically permitted nor actually disallowed**.** The new regulations permit consolidation under certain conditions requiring a common issue of law and fact. These include: **[1]** multiple dates of medical service involving a single provider, involving one employee, one Claims Administrator and one billing code under a fee schedule or under a contract and

		total amount in dispute does not exceed $4,000; **[2]** Upon a showing of a "possible pattern and practice of underpayment" by a Claims 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 is to conduct a "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 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 or not the request is deemed ineligible. AD makes written determination that the request is ineligible and the reasons. Provider or Claims AD may appeal to the WCAB, by petition, the determination of ineligibility within **30 days of** receipt of determination ▪ If the request is ultimately deemed ineligible then the provider gets a 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
	INDEPENDENT BILL REVIEW ORGANIZATION (IBRO)	

		parties. If requested, the party shall file the documents with the Independent Bill Reviewer within **35 days of the request**, if by mail **or 32 days, if made electronically** with copies to non-filing party. **[§9792.5.13]:** The Independent Bill Reviewer will use the OMFS for treatment services, the contract for reimbursement rates, if applicable, or if for medical-legal, the medical legal fee schedule (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, if any additional money is owed the provider and the reasons. This includes the information received and relied upon ▪ Fee payable by provider. AD to prescribe schedule of fees by regulation. If any additional payment is found owing, employer to reimburse provider for fee paid, in addition to the amount found owing (See fees above) ▪ **[§9792.5.14]**: Determination from IBRO is deemed a determination and order from the AD, binding on the parties and is reviewable on the same grounds as IBR determinations (fraud, conflict of interest, bias, etc.) ***but here the verified appeal must be filed within 20 days of service of the determination*** **[(§9792.5.15(b)]** The same rules apply as those governing appeals to final written IMR determinations ▪ If AD determination is reversed, then dispute is remanded to the AD to submit to a **different** IBRO, or if not available, to the same IBRO but with a different reviewer

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

45 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 (amended)	**CONSULTING REPORTS**	▪ Reports of consulting or attending physicians may not be the sole basis for an award of compensation ▪ QME or authorized PTP **shall address** any report per this section and indicate whether he or she agrees or disagrees with findings or opinions and the basis [***NOTE:*** This doesn't really clear up the *Valdez* issue because out-of-network reports are still admissible and they can now statutorily form the basis of an award so long as there is some supportive opinion either from an "authorized treating physician" or QME.**]** **[*NOTE*:** The statute does not mention an AME, but it would seem as if an AME's opinion would also sustain an award but it does not actually state. Also, by the wording here, it seems as if for an out-of-network report to actually sustain an award, it has to be specifically reviewed and addressed as opposed to an opinion which is in accord but did not specifically review the out-of-network report.**]** ▪ NOTE: Seemingly, the statute presumes the consulting or attending physician is not a QME, PTP or AME but does it also assume the doctor is "out of network."? *Valdez* could impact this statute
§4616 (amended) §4616.3 (amended)	**MPN**	▪ Physicians included in the MPN only if there is a written acknowledgment (1/1/2014) ▪ MPN must place roster of treating physicians on its web site and update at least quarterly **(1/1/2014)** ▪ All approved MPN web sites to be posted by AD **(1/1/2014)** ▪ Every MPN to have 1 or more **medical access assistants** available from 7:00 a.m. to 8:00 p.m., PST, Monday–Saturday by toll free number. Regulations to issue on or before 7/1/2013 **(1/1/2014)** ▪ MPN to establish and follow procedures to continuously review quality of care, performance and utilization of services and facilities

	MPN **MPN regulations are in draft--effective date is 1/1/2014**	▪ MPN to submit geocoding of MPN for re-approval ▪ AD has power to investigate at any time **(1/1/2013)** ▪ **(b)(1): MPN plan approval for 4 years (1/1/2013)** ▪ Existing approved MPN plans approved ***for 4 years*** from the most recent application or modification approval date. Re-approval plans must be submitted 6 months before expiration of period **(1/1/2014)** ▪ Any person contending the MPN is not **validly constituted** may petition the AD to suspend or revoke MPN plan approval**. (1/1/2013)** ***COMMENT FROM COREY:*** There is no definition of what they mean by "not validity constituted." Does this mean that a component piece of the MPN is missing or that the MPN is not operating properly or in a case specific example, something was not done correctly? We don't know yet pending regulations. Here, the statute refers to "**not validly constituted**" but **4616(b)(1**) refers to the term **"validly** formed." I don't know if this is significant or simply semantics ▪ AD may promulgate regulations establishing **schedule of administrative penalties** not to **exceed $5,000 per violation**, or probation or both, in lieu of suspension or revocation for less severe violations. Unless suspended or revoked, AD approval of MPN plan is binding on all persons and all courts [***NOTE:*** *It seems uncertain whether the schedule of penalties would relate only to a claimed violation of the validity of the network, commenced either by a petition to the AD or upon the AD's own power to investigate or whether it amounts to a form of "audit penalty" for technical violations which do not rise to the level of "not validly constituted." If we consider the language of sub (b) (5) dealing with "if the medical provider network fails to meet the requirements of this article," then I believe the latter is the sense because they talk about the relative "severity" which seems to imply yet another new penalty system for MPN audits beyond what is already in the regulations for the PARS and compliance audits]*

	VALDEZ **MPN regulations are in draft--effective date is 1/1/2014**	▪ **§4616.3(b) AND *VALDEZ*:** ▪ (b): E**mployer failure either to provide the notice poster per §3550 or provide actual MPN notice shall not become the basis for the employee to treat outside of the MPN**, unless it is shown that the failure to provide notice resulted in a denial of medical care. ***[NOTE***: *it is incumbent to authorize the treatment within 1 working day from filing of claim form (§5402(c) and within 3 business days of receipt of a request for treatment within the MPN (8 CCR §§9767.5(f) and 9767.6) otherwise lateness could doom the viability of the MPN, if the notices were not posted and provided to the employee]*
4903.05 (new)	**LIENS: FILING FEE** **§10207**	▪ **LIEN FILING FEE: of $150**, payable electronically to DWC for all liens filed after 1/1/2013 and must be paid before lien is filed. Payment to be collected electronically. [**§10207]:** NEW: Unless exempted, every lien claimant is responsible for payment of initial filing fee, using form approved by the WCAB. Fee is payable to the Division of Workers' Compensation. Fee to be collected by the AD. While a fee is required for each case, if there are *multiple cases involving the same injured* worker and the same services by same lien claimant, then only one filing fee need be paid ➢ E Filers: Pay electronically following procedures set forth in the *EAMS E-Form Filing Reference Guide.* If liens are being filed in more than 1 case at the same time, then this can be handled in one transaction but claims of two or more cannot be merged ➢ JET filers: follow the EAMS JET File Business Rules Version 4.0 ▪ Any lien submitted after **1/1/2013** shall be invalid unless filed with proof that filing fee was paid and failure to do so does not extend the statute of limitations for filing liens

	LIENS: FILING FEE	▪ Filing of lien shall include proof of payment of filing fee. [**§10207(m)]:** No lien or claim of costs filed as a lien shall be accepted without payment of the full filing fee. Until the fee is paid, the lien shall not be deemed to have been received or filed for any purpose ▪ Filing fee pertains to liens under **§4903(b)** which relate to medical treatment expenses but not subject to IMR or IBR ▪ Per **§4603.6(g),** neither the WCAB nor any court can make a determination of ultimate fact contrary to the determination of the IBRO, so a lien for a contested bill per IBR determination would not be allowable ▪ No merger of claims of two or more providers of goods into a single lien permitted ▪ **No filing fee required for a health care service plan and**: Other liens exempt from a filing fee are liens for group disability insurer, self-insured employee welfare plan, Taft-Hartley Health and Welfare Fund, publicly funded program providing medical benefits on a non-industrial basis, reasonable attorney fees, living expense liens, burial expense liens, spousal and child support liens, EDD, Victims of Violent Crime Liens, defendant filing a DOR to proceed on a lien claim or a party who is not a lien claimant and a companion case
§4903.06 (**new**)	**LIENS: ACTIVATION FEE** **§10208**	▪ **ON OR BEFORE 1/1/2014 --LIEN ACTIVATION FEE: of $100**, payable electronically to DWC required for liens filed prior to 1/1/2013, **including costs filed as a lien**, unless there is proof of prior payment of filing fee ▪ Proof of payment required for filing fee or activation fee with the filing of the DOR, if lien claimant is not the DOR filing party, prior to appearing for a Lien Conference on that case, or 1/1/2014, whichever occurs first. **[§10208]:** Same rules governing filing fee; only 1 activation fee is required, if there are multiple cases involving one worker and one service provider. Same rules also govern manner and method of making payment. All lien claimants who did not file the DOR for a lien conference, but who remain a lien claimant at that time or at time of a consolidated lien conference, shall submit proof of payment at the lien conference

	LIENS: ACTIVATION FEE	▪ Any lien claimant not filing a DOR shall present proof of payment of activation fee at Lien Conference. If not, lien **shall be dismissed with prejudice** ▪ **Lien dismissed by operation of law if either activation fee or filing fee not paid by 1/1/2014** ▪ Same exemptions for activation fee as relate to filing fee **[§10208(a)(1)]** including companion cases ▪ Lien claimants of previously consolidated cases prior to 1/1/2013, required to pay activation fee for each injured worker; payment before or at time of lien conference, but no later than 1/1/2014
§4903.07	**LIENS**	▪ Lien claimant entitled to reimbursement of filing or activation fee, plus interest, upon the proof of 3 conditions: (1) not less than 30 days before DOR or filing of lien, lien claimant has made written demand for settlement for a clear sum stated: (2) Defendant fails to accept the written demand for settlement within 20 days [plus 5 for mailing] (3) Final award by WCAB or arbitrator in favor of lien claimant in a sum equal or greater than the settlement demand
§4903.1 §4903.4 §4903.5 §4903.6	**LIENS**	▪ Liens in favor of health care provider, service plan, group disability policy, of self-insured employee welfare benefit plan not recoverable unless certain conditions occur, including authorization by defendant, expense incurred while employer refused or failed to furnish treatment, or expenses were incurred by emergency ▪ **NEW STATUTE OF LIMITATIONS EFECTIVE 1/1/2013 REGARDLESS OF DATE OF INJURY:** §4903.5((a): For treatment liens under 4§903(b) the limitation is **3 years from the date services were provided prior to 7/1/2013.** For services provided on or after **7/1/2013, the limitation is 18 months** ▪ A more relaxed statute for health care service plans: within 12 months after first knowledge that industrial injury is being claimed but no more than 5 years from date services were provided

	LIENS	▪ Limitations of when liens can be filed (60 days after acceptance or rejection of liability plus either IBR or IMR has taken place) ▪ Lien claimants required to notify employee and his/her representative, employer and representative and WCAB upon hiring, changing or discharging a representative, including attorney or non-attorney. Notice must provide contact information
§4903.8 (new)	**LIENS: LIMITS ON ASSIGNMENTS** ***This section takes effect 1/1/2013 and without regulatory action***	▪ Order or award to issue only in favor of person entitled to payment and not to an assignee, unless the provider has ceased doing business in the capacity held at the time, and has assigned all right, title and interest in the remaining accounts receivable ▪ Assignments must be filed and served ▪ For liens filed on or after 1/1/2013, if assignment occurs before lien filing, a copy of the assignment shall be served at the time lien is filed. If the lien is filed on or after 1/1/2013, but the assignment take place after, then a copy of assignment shall be served within 20 days of assignment date ▪ If lien is filed before 1/1/2013, copy of the assignment is due upon filing of DOR, a lien hearing or by 1/1/2014, whichever is earlier ▪ More than one assignment may cause the WCAB to set the matter for hearing on whether multiple assignments **are bad faith actions or tactics** (sanctions, attorney fees and costs per **§§5811, 5813 and 8 CCR §10561**. These would be awarded against not only lien claimant but also the assignee and their respective attorneys ▪ **§4903.8(d): FOR ALL LIENS FILED ON OR AFTER 1/1/2013 REGARDLESS OF DATE OF INJURY OR SERVICE, NEW DECLARATION UNDER PENALTY OF PERJURY REQUIRED**: (1) services or products described in the bill or products were actually provided; (2) billing statement attached to lien is true and accurate. This declaration is due for liens filed on and after **1/1/2013** and for previously filed liens, at the filing of the DOR, a lien hearing or 1/1/2014, whichever is the earliest

	LIENS: LIMITS ON ASSIGNMENTS ***This section takes effect 1/1/2013 and without regulatory action***	▪ Without the declaration, the lien shall be considered invalid if filed on or after **1/1/2013** ***Torres v. Unitech*** (WCAB En Banc:11/15/2012): declaring existing statutes affirm that the lien claimant has the affirmative burden of proving all relevant issues by a preponderance of the evidence and that simply introducing a lien and an unsigned insurance form is not enough. Such conduct therefore exposes the lien claimant and its representative to sanctions, costs and attorney fees, either against one, more or all, under Lab C 5813 and 8 CCR 10561.
§4620 §4622 §5307.7 §5307.9	**MEDICAL LEGAL** **INTERPRETERS** **§9795.1 (a) and (b)** **Regulations filed with OAL 12/20/12**	▪ **INTERPRETERS**: **§4620: new sub (d**) which permits **qualified interpreters** during medical examinations as part of the definition of medical-legal expenses. [**§9795.1(b)]**: The prior regulation defined *"qualified interpreter"* as being one who was either certified or provisionally certified. Under **Government Code 68562**, certified interpreters were those who were certified by entities recognized by the Judicial Council as of 7/1/1996 and who were deemed certified by being on the recommended list of court interpreters. This regulation has been amended. Now, qualified interpreter is *re-defined*, for purposes of a medical treatment appointment means an interpreter who has a *"documented and demonstrated proficiency in both English and the other language; fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and education and training in interpreting ethics, conduct and confidentiality, which may include standards by the California Healthcare Interpreters* Assoc. or the *National Council on Interpreting in Health care*." It appears that this is entirely satisfied if the interpreter is "certified" by an educational provider in California. But it appears that merely being "certified" under the Government Code, is not currently enough ▪ **§4622**: EOR is required when employer responds to medical-legal expenses under §4620 ▪ Adds provision for 2nd review as a condition to permitting same IBR rules for disputed bills for medical treatment ▪ IBR rules also now cover medical-legal expenses in the same manner they pertain to treatment bills

<table>
<tr><td></td><td>VOCATIONAL EXPERTS
In draft—due 1/1/2013

FEE SCHEDULE: COPY SERVICES
In draft—due 12/31/12</td><td>

- **§5307.7:** amended: On or after 1/1/2013, AD to adopt a fee schedule for payment of vocational experts, including vocational evaluations and expert testimony determined to be reasonable
- **Copy Services:** AD to adopt on or before 12/1/2013, fee schedule for **copy and related services**, including records produced in paper or in electronic form. ***No payment permitted for copy service fees incurred within a 30 period during which applicant requests documents within possession of claims administrator or their representative***

</td></tr>
<tr><td>§5703.1

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

- Maximum reasonable fees for 2012 based upon estimated annualized aggregate fees of Medicare system for physician services appearing on 7/1/2012. This applies to all treatment through 1/1/2014
- For treatment on and after 1/1/2014, *and until the AD develops a new OMFS based upon* ***the resource-based relative value scale, "RBRVS"*** maximum fees for physician and non-physician services, including nurses, physical therapy and physician assistants, shall be in accord with Medicare payment system except an average statewide adjustment factor of 1.078 shall apply in lieu of Medicare's locality specific adjustment factors (note these are amounts which are to be factored under sub (g) which means the OMFS is to be adjusted within 60 days to conform to changes in Medicare and Medi-Cal payment systems)

	2014	**2015**	**2016**
Surgery	49.5313	46.6359	43.7405
Radiology	56.2329	51.1036	45.9744
Anesthesiology	30.0647	28.6067	27.1487
All other	37.1712	38.3958	39.6205

- Four year transition to estimated aggregate and the **resource-based relative value scale** at 120% of Medicare conversation factors

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

	MEDICAL FEE SCHEDULE CHANGES [OMFS] **HOME HEALTH CARE** **In draft—due 7/1/2013** **ATTORNEY FEES**	▪ Hospital fees for services performed in outpatient department not to exceed 120 percent of fee paid by Medicare and maximum facility fees for services performed at ambulatory surgical centers not to exceed 80 percent of fees paid by Medicare for same service ▪ **HOME HEALTH CARE**: **§5307.8:** On or before 7/1/2013, AD to adopt fee schedule establishing maximums for service hours and fees for home health care services not covered by Medicare fee schedule. No fees payable to member of employee's household if services had been regularly performed in the same manner and degree prior to the date of injury. **[*NOTE*:** *This will be extremely hard to prove since for the most part, no spouse of an injured employee may be deposed unless the spouse is actually a potential party or is claiming some secondary injury*] ▪ **Attorney fees may be awardable for recovery of home health care, subject to rules or regulations** ▪ ***COMMENT FROM COREY:*** I see this as a prime opportunity for applicant attorneys to try and generate hourly fees beyond the statutory 15% fees from the cases-in-chief, resulting from their efforts to recover these benefits on behalf of their clients. I see this as a very tempting "target" of opportunity. Also, if you figure that home health care services are a trend in medicine then expect PTP's to prescribe even more of it and applicant attorneys pursuing more of it as well. If the issues are litigated, there could be additional exposure to high fees based upon hourly rates of at least $350.00 and higher. *Hopefully, these issues will be quickly addressed in UR and then in IMR. If so, then potential impact would be blunted because "necessity" medical issues now go to IMR, not to a QME or AME*
§139.48	**FOR HIGH EARNING LOSS SUPPLEMENTAL PD PAYMENTS FUNDED TO COMPENSATE** **Regulations are in draft—due 1/1/2013**	▪ Funded by annual $120 million from non-General funds, this would compensate injured workers in a manner unspecified for "supplemental payments" "whose disability benefits are proportionately low in comparison to their earnings loss" Does this not look like *Ogilvie*? ▪ Eligibility and amounts of these payment are subject to regulations of the AD after findings based on studies of wage loss to be conducted by CHSWC

	FOR HIGH EARNING LOSS SUPPLEMENTAL PD PAYMENTS FUNDED TO COMPENSATE	▪ These supplemental payments appear be **outside of the WCAB** but with limited review by the WCAB trial judges but limited to grounds for petitions for reconsideration ▪ Until there are regulations, comments about this fund would be speculating but what about attorney fees? Would the AD also develop a schedule by which applicant attorneys could get a fee for pursing these benefits? ▪ It is also possible that there will be no fee structure from the AD for attorney fees and that some applicant attorneys might enter into a ***contingency retainer agreement*** with their client for this purpose. Such a fee agreement could presumably entitle the attorney to well more than a 15% fee ▪ ***COMMENT FROM COREY:*** I see this “fund” as a collateral concern because in trying to obtain these benefits, applicant attorneys would have to pursue an Ogilvie issue, which would then likely also be used to rebut the AMA Guides and the Schedule of Age and Occupational Modifiers, so such an effort could have the collateral effect of adversely impacting exposure to PD, using the Ogilvie vehicle as the means ▪ For more information on how workers’ compensation is currently user funded, please refer to Labor Code §62.5

	MISCELLANEOUS	
§5502	EXPEDITED HEARING	• The issue of whether an employer has a validly established MPN is now added to the existing issues for expedited hearing ▪ No other issue heard at expedited hearing, until MPN issue is first resolved ▪ Medical treatment issues are heard but not §4610 and IMR issues
§5703	EVIDENCE ALLOWED	▪ Adds new sub (j) permitting in evidence reports from vocational experts. Evidence in the form of reports preferred over live testimony. Live testimony occurs only upon a showing of good cause. A continuance may be granted for rebuttal testimony if a report was not served sufficiently in advance to permit rebuttal by the opposing party
§4066	ATTORNEY FEES	▪ §4066, permitting attorney fees if employer files application for adjudication of claim in non-litigated cases is now repealed for all dates of injury
§4702	DEATH BENEFITS/BURIAL	▪ Burial expenses increase up to $10,000 for injuries on or after 1/1/2013
§4907	REMOVAL BY WCAB	▪ Expands power of WCAB to remove persons other than attorneys from appearing before the WCAB, including hearing representatives and widens the basis for doing so
§5811	INTERPRETERS	▪ Sets forth duties of an interpreter, which expressly do not include acting as an agent or advocate ▪ Compels non-disclosure to non-immediate participant as to any of the content of conversations or documents except upon court order

§139.3 (**new**)	**FINANCIAL INTEREST**	▪ Interested parties required to disclose financial interests in any entity providing services ▪ Cross-referrals prohibited ▪ Rebates, preferences, patronage, discounts, dividends, commissions, etc., are prohibited by interested parties ▪ Violations are a misdemeanor and subject to civil penalties up to $15,000 per offense

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

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

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

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

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