The California Commission on Health and Safety and Workers' Compensation

DRAFT Liens Report *for Public Comment*

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Table of Contents

Figures and Tables iv
Table of Recommendations v
Acknowledgements vii
Executive Summary 1
The Scale of the Lien Problem 4
Number of Liens Filed 4
Impact on Costs 7
Impact on the Court System 8
Impact on Public Policy 10
General Recommendations to Manage Lien Volume 11
Background: What is a Lien in Workers' Compensation 13
Counting Liens 13
Types of Liens 13
CHSWC Lien Research 16
Data Sources 16
E-filings 16
Paper Liens from Selected District Offices 17
Survey 18
Combining the Data to Create an Overall Profile 18
Selection of Data Sources 20
General Findings: Types of Liens 21
Medical Lien Disputes 24
Fee Schedule Disputes 24
Authorization Disputes 25
Treatment by Out-of-Network Providers is a Leading Reason for Lien Disputes. 27
Prolonged Unauthorized Treatment 29
When Liens Are Filed 30
Premature Liens 30
Stale Liens 33
Zombie Liens and the Phantom Statute of Limitations 33
Policy Implications of Unlimited Time for Filing 35
Both Bills and Payment Explanations Must Be Improved 37
Medical Insurers Require Exception 38

Liens Filed by Assignees or Representatives 40
Copy Services and Interpreters: Small But Frequent Liens Reflect Deficiencies in Fee Schedules 43
Copy Services and Interpreters: Small But Frequent Liens Reflect Deficiencies in Fee Schedules 43
Copy Service Liens 43
Interpreter Liens 44
Frequent Flyers 47
"Garbage In" from Lien Filers 50
Conclusion 52
Appendix 1. DWC Form 6, Notice and Request for Allowance of Lien 53
Appendix 2. Additional Considerations for Filing Fees 56
Figure A2-1. Effect of Filing Fee on Number of Medical and Medical-Legal Liens 56
Additional Recommendations Relating to Filing Fees: 58
Appendix 3, Adjusting the Estimates for Duplicates and Amended Liens 59
Appendix 4. Table of Number of Liens Filed Yearly at Each WCAB Office 61
Appendix 5. WorkCompCentral.com article on Statute of Limitations 62

Figures and Tables

Figure 1. Number of Liens Filed per Month 4
Figure 2. Growth in Lien Counts as Backlogs are Processed 6
Figure 3. Number of E-Filings per Month 16
Figure 4. Number of Liens Filed Yearly at Each WCAB Office 17
Figure 5. Distribution of Lien Types in Survey Resembles DWC Composite Profile 19
Figure 6. Distribution of Lien Types 21
Figure 7. Medical Lien Provider Types Distribution 23
Figure 8. Treatment Authorization Issues in Medical Liens. 26
Figure 9. MPN Status and Reasons for Denied Authorization for Treatment 27
Figure 10. Medical Liens Submitted Within 90 Days of Date of Services 30
Figure 11. Time from Date of Medical Service to Date of Lien Filing 33
Figure 12. How Long After First Date of Service until Liens Are Filed by Owner or by Assignee 40

Table 1. Average amount claimed per lien 19

Table 2. Duration of Unauthorized Medical Treatment 29

Table of Recommendations

Recommendation 1: Reinstate a filing fee for medical and medical-legal liens. 11

Recommendation 2: Require frequent lien filers to file their liens electronically. 11

Recommendation 3: Prohibit filing of amended liens prior to Declaration of Readiness. 12

Recommendation 4: Until the volume of liens is substantially reduced by other measures such as recommended in this report, equip the WCAB District Office with sufficient resources to meet workloads. 12

Recommendation 5: Adopt medical fee schedules to cover those services that are often disputed due to gaps or ambiguities in the existing fee schedules. 25

Recommendation 6: Establish an administrative system for fee schedule determinations, subject to limited judicial review. 25

Recommendation 7: The boundaries of MPN control over medical treatment should be more clearly defined to minimize the potential for disputes over rights to select medical providers. 29

Recommendation 8: Disputes over assertions of MPN control over medical treatment should be brought to adjudication promptly. 30

Recommendation 9: Sanctions should be imposed on providers and claims administrators alike for repeated patterns of incorrectly asserting or denying the status of an authorized medical provider. 30

Recommendation 10: Consider establishing a maximum duration for treatment that can be claimed by lien in the absence of a Declaration of Readiness by the worker to seek authorization for the worker's chosen provider. 30

Recommendation 11: Labor Code Section 4903.6 should be amended to forbid filing a medical or medical-legal lien until the bill is genuinely in dispute. 32

Recommendation 12: Labor Code Section 4903.6 and Rule 10770.5 should be amended to provide consequences for violation that can be effective deterrents to premature filings. 32

Recommendation 13: Enact a statute of limitations, effective prospectively based on date of services to bar any lien unless the service is billed in accordance with regulations and the lien is filed within a defined time following that service. 37

Recommendation 14: Enact a statute of limitations to bar any lien for service, regardless of date of service, that is not filed within three years of the date of medical service. 37

Recommendation 15: Eliminate implied liens for medical treatment or medical-legal expenses. 38

Recommendation 16: Impose automatic dismissal by operation of law for any lien which is not activated for hearing within finite time. 38

Recommendation 17: Allow additional time for medical insurers to file liens for reimbursement of sums paid for covered treatment. 39

Recommendation 18: A lien claimant should be required to disclose its relationship to the original provider of goods or services and produce documentation on demand. 41

Recommendation 19: A lien representative should be required to provide documentation of the representative's authority upon demand. 41

Recommendation 20: Misrepresentations of ownership of a lien or the authority of a representative should be punished as contempt and should be grounds for dismissal of the lien or for barring the representative from appearing in any proceedings before the Appeals Board. 41

Recommendation 21: Payments in satisfaction or settlement of liens should be made only to the original provider of goods or services unless a bona fide assignment is documented. 42

Recommendation 22: The Administrative Director should adopt a fee schedule and ground rules for payment of copy services. 44

Recommendation 23: The Form 6 "Notice and Request for Allowance of Lien" should be revised to identify liens for document copying services as well as the ground for claiming the lien. 44

Recommendation 24: Either regulation or statute should be adopted to clearly prescribe the events for which interpreter services are payable. 47

Recommendation 25: Either the interpreters' fee schedule should provide for apportioned billing when an interpreter serves multiple cases concurrently, or the WCAB should contract for interpreters to attend hearings and proportionately bill the defendants in each in which they participate. 47

Recommendation 26: The Administrative Director should amend the fee schedule for interpreter services to promote uniformity and to make the fees generally commensurate with the fair market value of the services. 47

Recommendation 27: One or more independent organizations should be identified whose accreditation can serve as an alternative to SPB certification for medical examination and administrative hearing interpreters. 47

Recommendation 28: The subjects of liens should be monitored, and the subjects that arise most frequently should be considered as candidates for improved guidance by the medical treatment utilization schedule and/or applicable fee schedules. 49

Recommendation 29: Liens by frequent filers that state incorrect lien type or make other material misrepresentations should be subject to substantial penalties, ranging from mandatory sanctions to dismissal with prejudice for repeat violations. 51

Recommendation 30: Lien claimants should be required to use EAMS Uniform Assigned Names (UANs), and until UANs are assigned, lien claimants should be required to use correct legal names. 51

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Executive Summary

Liens are both a cause and a result of serious distress in the California workers' compensation system.

As a cause, liens are choking the system. The Presiding Judge of the Los Angeles office estimates that liens consume about 35% of the court's calendar and would consume even more if the calendar slots were not being rationed. Lien hearings take away time for the court to deal with the claims of injured workers. California employers and insurers are spending roughly $200 million per year on loss adjustment expenses to handle medical lien claims. The volume of liens provides an environment where indefensible delays and denials by claims administrators and fraud and abuse by lien claimants can thrive, side by side.

As a symptom, the billions of dollars in dispute reflect both obligations that should have been paid but which may eventually have to be compromised in order to obtain any payment, and claims that should not be paid but which may eventually have to be compromised in order to obtain closure.

The volume of liens forces the courts to encourage settlement, almost to the point of coercion. The necessity of settlement rewards both unjustified claims and unjustified refusals.

The prevalence of liens is unique to California. Other states we have contacted have nothing comparable. One national insurer commented that it writes 22% of its business in California but receives 87% of its liens in this state.[1]

This report attempts to characterize the lien problem so that policymakers can target proposed solutions and to quantify the problem so that the effects of such proposals can be estimated.

This report is based on information furnished by the Division of Workers' Compensation (DWC) about the number of liens filed over time and on three sources of data about individual liens:

- A list of all 37,965 liens filed electronically from 9/22/08 through 1/25/2010.
- Samples drawn from paper liens filed at five high-volume District Offices.
- A survey of incoming liens reported by participating claims administrators.

Key findings:

- Approximately 350,000 liens are being filed in 2010 and over 450,000 are expected in 2011.

[1] CHSWC Minutes of June 24, 2010 meeting

- The volume of filings is sensitive to procedural changes such as the adoption or repeal of a $100 filing fee and the adoption of new filing procedures.
- Medical treatment liens account for more than 60% of the liens filed and 80% of the dollars in dispute.
- $1.5 billion per year is claimed in medical lien disputes (after adjusting for amended liens).
- One-third of medical liens involve disputes over the application of the Official Medical Fee Schedule.
- Authorization for treatment was in dispute in seven out of ten medical liens surveyed.
- Reasons treatment was not authorized were:
    - 37% provider not authorized to treat (mostly out-of-network).
    - 7% denied claims.
    - 6% medical necessity of treatment rejected by utilization review.
    - 1% contested body parts.
    - 20% authorization status unknown or not stated.
- Medical provider networks (MPNs) largely avoid lien disputes arising from in-network providers. Where MPNs exist, the largest share of medical liens arises from out-of-network providers.
- Up to 30% of medical liens are prematurely submitted before the time has elapsed for the claims administrator to pay or object to the provider's bill. Ten percent of medical liens are submitted on the date the service is provided.
- Nearly one-quarter of medical liens are filed more than two years after the last date of services for which payment is claimed, including 6% which are filed five or more years after the last date of services.
- A small percentage of medical liens are filed for services that extended for more than a year by providers who were not authorized to treat, according to claims administrators.

Key Recommendations:

- Reinstate the $100 filing fee on medical liens to discourage frivolous claims and disputes.

- Adopt explicit fee schedules wherever gaps or ambiguities foster frequent disputes.

- Establish an administrative system for fee schedule dispute resolution, with limited judicial review.

- Adjudicate medical treatment authorization disputes expeditiously.

- Amend existing statute and regulation to effectively deter premature lien filings.

- Enact a statute of limitations requiring that medical liens be filed with the Workers' Compensation Appeals Board within a fixed time from the date a medical bill is contested, but in no event later than 18 months from the date of service. (See text for full set of recommendations regarding statute of limitations.)

- Require lien filers to accurately identify themselves and their relationship to the original owner of the alleged debt and to provide documentation of that relationship upon demand.

- Require accurate representations of facts in claims filed for liens.

The Scale of the Lien Problem

Liens tell a great deal about the performance of the workers' compensation system. Workers' compensation is intended to be largely self-administering. Benefits should be paid in accordance with the law and relatively few disputes should require intervention by the courts. The large number of liens is a measurement of the failures of the system to function as intended. Some liens necessarily arise when liability for an injury is factually in dispute. The majority, however, arise because the law is unclear on what should be paid, or one party has failed to pay what it should, or another party perceives an opportunity to obtain more than it is entitled to receive. Furthermore, the volume of liens in the California workers' compensation system creates a heavy burden on the State's administrative system, interfering with injured workers' access to the courts, and imposing substantial costs on employers.

Number of Liens Filed

The Division of Workers' Compensation (DWC) records the number of liens filed monthly. The monthly lien filings since 2000 demonstrate two periods of continual growth and two periods where the volume driven down by procedural circumstances.

Figure 1. Number of Liens Filed per Month

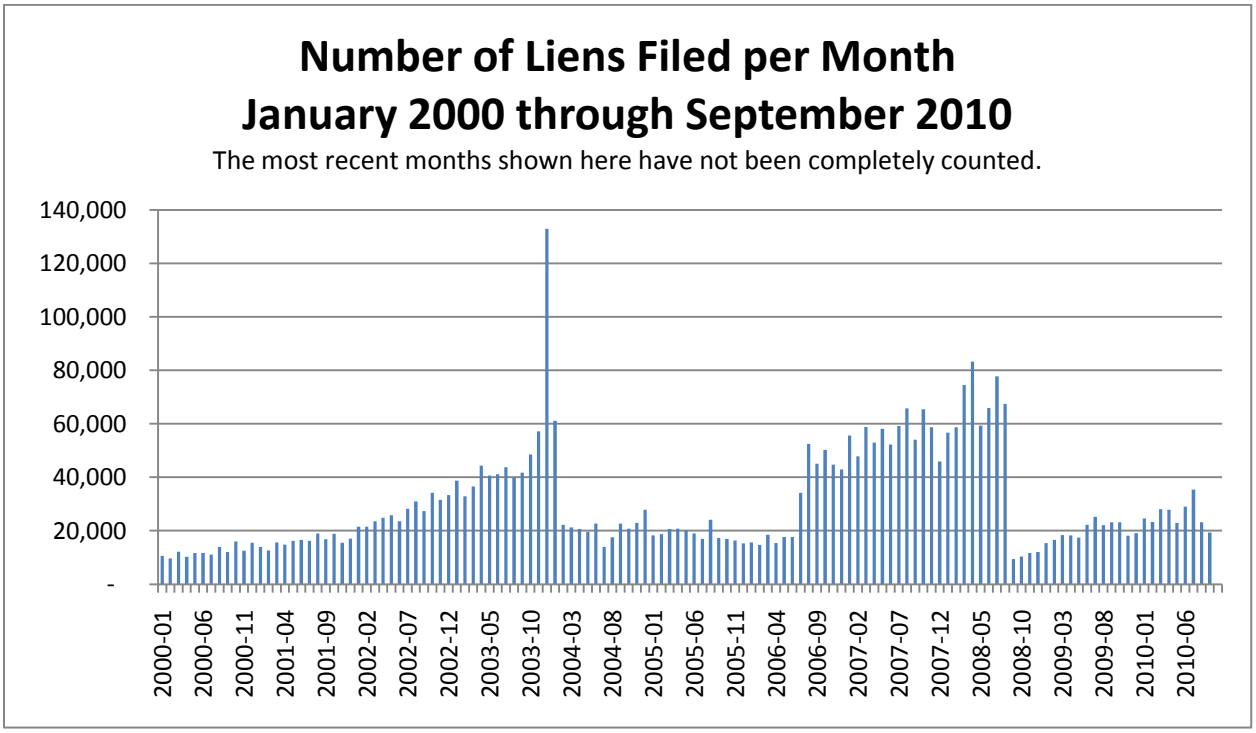


Figure 1 shows the raw count of liens received by DWC each month. Each "Notice and Request for Allowance of Lien" is counted, whether the document is an original lien filed to claim payment for a single medical exam or it is an amended lien filed to add another transaction to a long list. Some of the clerical workload is the same regardless of the reason the document was

filed, but for other purposes, certain adjustments to the raw census numbers may be appropriate. See the section, "Background: What is a Lien in Workers' Compensation," for a more detailed description of the meaning of a lien, what counts as a lien, and how the numbers are affected by amended liens and duplicate liens. Figure 1 depicts the broad pattern in the number of lien documents received each month over a period of more than 11 years.

The rate of lien filing grew steadily to about 500,000 filings per year by 2003. Then a $100 filing fee for medical liens was enacted in September 2003 to become effective 1/1/2004.[2] The enactment of the filing fee produced a one-time spike in filings immediately before it took effect, followed by a sustained reduction. In 2005, total lien filings numbered 224,205.

The filing fee was repealed effective July 12, 2006, and the monthly filings immediately doubled. Nearly 700,000 liens were filed in 2007, and the filings were on pace to exceed 800,000 for 2008 until the Electronic Adjudication Management System (EAMS) was implemented.

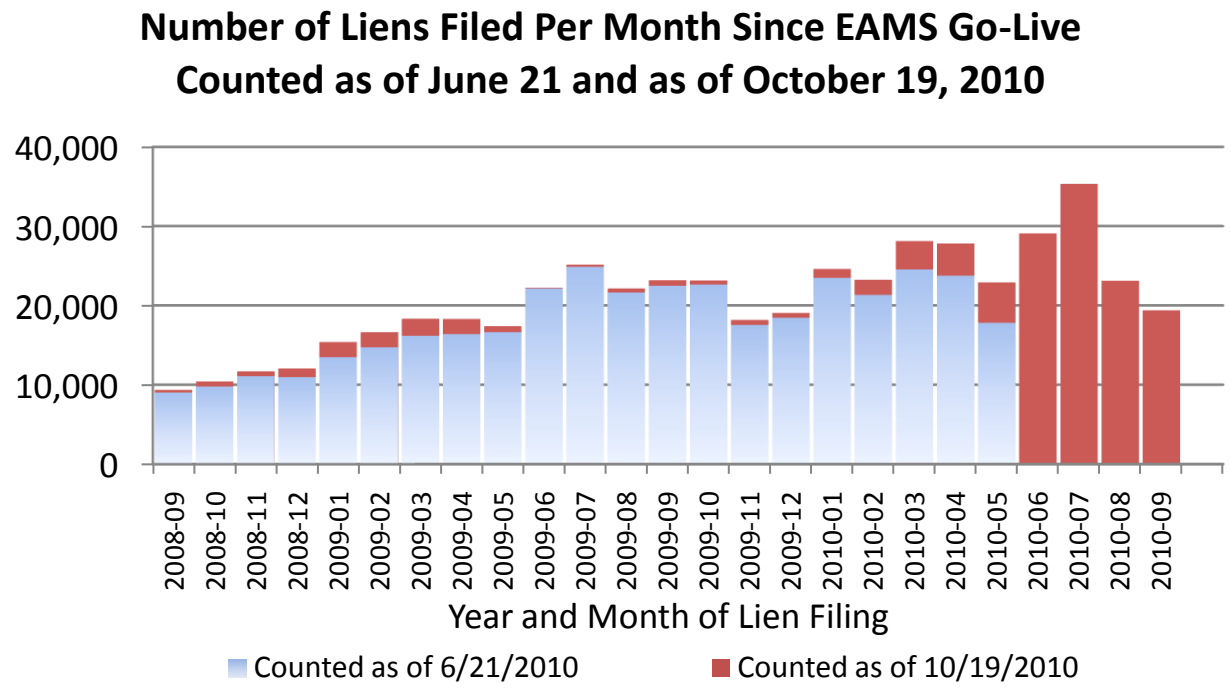
EAMS went live on August 25, 2008, requiring filers to begin using new forms. Figure 1 above shows the filings by the date filed. The number of liens filed per month fell sharply the moment EAMS took effect. The number is recovering slowly. It appears that the transition to EAMS was a stronger deterrent to lien filing than the filing fee, at least in its first two years.

One reason that EAMS could be a deterrent is that it required using a new version of Form 6, "Notice and Request for Allowance of Lien." The old lien forms were to be phased out. There were many complaints about the new forms required for EAMS. The new multi-page form may be a daunting replacement for the old single-page form. In addition, the new filing procedure required additional steps for would-be lien claimants. The filing hurdles are presumably the main reason for the drop in filings.

Another possible factor might be failures of DWC staff to enter lien documents in a manner that EAMS can recognize. All new filings, not just liens, had to be scanned into EAMS by DWC staff. This quickly produced a backlog of documents awaiting scanning. Backlogged documents are eventually being put into the system (as demonstrated in Figure 2), so the backlogs themselves cannot account for the observed drop in filings when EAMS went live. Faced with backlogs, however, some staff may have taken shortcuts to scan the documents into EAMS without manually entering the data required for the system to recognize liens. To the extent this may have occurred, some filed liens may never show up in the census.

[2] Labor Code section 4903.05, enacted Stats. 2003 ch. 639, repealed Stats. 2006 ch. 69.

Figure 2. Growth in Lien Counts as Backlogs are Processed



The differences between June 21, 2010 and October 19, 2010 inventories indicate backlogged documents that were entered into EAMS between thes two dates. Recent months are not fully counted yet.

The lien count for any given month continues to grow for several more months before most of the documents have been processed. The darker areas in Figure 2 show the changes in the number of liens that were counted when the census was taken on two dates, four months apart. Naturally, the later count covers four additional months. Furthermore, it includes liens which had been filed in earlier months but which had not been processed in time to be included in the previous census. The difference is the result of the lag in processing the documents. It can be observed that the difference is minimal for some months like June 2009, greater for some others like January 2009, and greatest for the latest three months just before the first count was taken (March, April and May, 2010). Recognizing the lag in developing the full headcount enables us to interpret the most recent data. Although the October 2010 census appears to show a decline for August and September, it is likely that when all the liens filed in those months have been processed, the upward trend will be found to continue unabated. Estimates of future lien filings based on data for recent periods must take account of the lag in counting.

At a minimum, we expect that over 334,000 liens will be filed in 2010. That estimate is based on the numbers through July 2010 (as counted on 10/19/2010) and a continuation for the remaining five months at the same rate as the average rate for the five months up to July. It is more likely that the number of liens will continue to grow, similar to past patterns. At the

maximum, based on linear growth at the same rate seen in the first seven months of 2010, the total for 2010 would approach 370,000, and for 2011, it would exceed 512,000. We consider those to be the lower and upper bounds for estimating the final lien volume for 2010 and the projected volume for 2011.

Based on the rate of growth seen over the two years since EAMS took effect, over 350,000 liens will have been filed by the end of 2010, and over 470,000 will be filed in 2011. These are the estimates we adopt for the purpose of projecting the impact of liens.

Impact on Costs

One measure of the impact of liens is the cost to employers and insurers to handle liens, including the documentation, negotiation, and participation in hearings. Employers and insurers consulted by Commission on Health and Safety and Workers' Compensation (CHSWC) staff have estimated the adjustment expense around $1,000 per lien. The estimates from different sources using different methods arrived at similar conclusions, leading us to accept this as a rough estimate of the employer cost for adjustment expenses for liens.

If even a third of the liens filed this year could have been avoided by a better functioning system, that would mean that $117 million dollars of frictional costs could have been saved.

Employers also bear the cost of administering the workers' compensation system, including DWC and the Workers' Compensation Appeals Board (WCAB) judicial system. For fiscal year 2009/2010, employers were assessed $233,309,000 for the Workers' Compensation Administration Revolving Fund.[3] It is not easy to identify how much of this budget is spent on lien-related issues. The next section of this report describes one large District Office which is devoting over one-third of its calendar time to lien matters.

The cost for a lien claimant to file and pursue a lien is not similar to the cost for a claims administrator to adjust and defend against the lien. Many liens are filed and handled by non-attorney collection representatives who invest much less time and effort into each dispute than the defendant's adjusters and attorneys invest. The reason a $100 filing fee is such an effective deterrent is that it is a proportionately large increase in the investment required of one who would file and pursue collection of a lien. Even though a medical provider's direct cost for lien collection efforts may be small, the write-off of uncollected fees can still be a factor in setting the rates a medical provider will charge for services.

The frictional and administrative costs of liens are separate from the amounts paid in settlement of liens. An employer's cost to litigate a lien is typically greater than the lien

[3] Letter by John Duncan, Director, Department of Industrial Relations, to All Insurers Authorized to Transact Workers' Compensation in California, dated November 19, 2009, announcing user funding assessments.

claimant's cost, so the cost of litigation together with the difficulty of getting a lien case adjudicated gives an employer an incentive to pay to settle a lien even if the employer believes that the lien claim is without merit. At the same time, the difficulty in getting a lien case adjudicated gives a lien claimant an incentive to accept a compromise even if the lien claimant believes that the claim is fully justified. Later in this report, we will discuss the billions of dollars that are in dispute. It is not feasible, however, to estimate how much is being overpaid or underpaid amidst all the conflicting claims.

The cost to workers is indirect. Whatever employers are spending on loss adjustment expenses or on settlement of unjustified lien claims is money coming out of the workers' compensation budget that is not directly going into benefits for injured workers or, more broadly, for payment of wages and benefits, for business development, or for public services. Another impact on injured workers is the potential loss of access to medical providers for whom the difficulties of lien collection make it uneconomical to serve workers' compensation patients.

Impact on the Court System

The courts do not have the capacity to handle all the lien disputes that are filed. The backlog appears in two forms. One is delays in processing the paper lien documents into the court's electronic file in a litigated case. The other is delays in hearing lien disputes. Both backlogs will be illustrated by the current situation of the Los Angeles District Office of the WCAB. As shown later, in Figure 4, Los Angeles has the highest lien volume in the state.

The trial level courts of the California workers' compensation system are the 24 District Offices, ranging from a single-judge office in Eureka to a 22-judge office in Van Nuys. Approximately 30 of those judge positions around the state were vacant as of early October 2010. At that time, the Los Angeles office had 16 authorized judge positions but only 13 full-time judges and one part-time retired annuitant. [4]

The Los Angeles Office currently receives 3,700 to 4,000 paper-filed liens and about 270 electronically filed liens every month. Electronically filed liens require no clerical time at the District Office, but the office cannot keep up with the paper-filed liens. Processing paper liens into EAMS requires an estimated ten minutes of staff time per document. The Los Angeles office has nine clerks, which is insufficient to handle even the filings related to the injured workers' claims, leaving no time to process the lien filings. Judges, secretaries, and court reporters have been pressed into service processing liens. The Presiding Judge personally devoted five hours a day to processing lien filings for over a month, and she continues processing them for an hour a day as of October 2010. Without staff to process the paper liens, the backlog of unprocessed liens grows by 3,700 to 4,000 per month.

[4] The facts in this narrative concerning the Los Angeles office were obtained in conversations and correspondence in October 2010 between CHSWC staff and Jorja Frank, the Presiding Judge of the Los Angeles office. The number of e-filings is from DWC e-filing records through 2009.

Unprocessed liens cause problems for the parties to a case and add to the court's judicial workload. As long as a lien has not been processed into EAMS, the lien claimant will not be listed as a party of record. If the underlying case is set for hearing, the lien claimant may not get notice of hearing, the lien may not be addressed at the hearing, and the hearing may have to be postponed to give notice to the lien claimant or the lien claimant may subsequently be entitled to a separate hearing.

The greater backlog is the sheer number of liens processed into the system but awaiting hearing or disposition. The Los Angeles office has an estimated 800,000 pending liens on the hundreds of thousands of cases that have been filed over the years, according to the Presiding Judge. Even if that estimate is too high, there is not enough time for the judges to hear and decide all of the disputes arriving each month, let alone to work though the accumulated cases.

As of October 2010, 35% of the court's calendar time is devoted to lien calendars. The Presiding Judge has assigned four judges to conduct lien trials and conferences. There are 144 lien trials scheduled per month, with an average of about 8 liens in each case set for trial. About 35% of those liens are being settled on the day of trial; the rest are being submitted and decided by the judges. This is a departure from the past practice of allowing multiple conferences to be held while the parties jockeyed for position or attrition. Parties who fail to appear or who are unprepared to prove their cases are not getting repeated opportunities to take up the court's time or their opponents' time while delaying a disposition of the dispute. Using lien conferences and lien trials, this lien unit is getting liens resolved at a rate approaching 2,000 per month, meaning that every month, another 1,700 to 2,000 liens are added to the 800,000 lien backlog. At a hearing in October 2010, it was remarked that it would take something like 30 years to work through the backlog even if not another lien were filed in Los Angeles.

The Los Angeles office is attempting innovative ways to cope with the workload while keeping the majority of the court's resources available for handling disputes for injured workers. In a "Lien Fiesta" beginning in May 2010, hundreds of cases were set for lien conferences, resulting in many settling or being set for trial. A lien unit was established to focus on disposition of liens. In October 2010, the Presiding Judge began hearings to consider the feasibility of consolidating hundreds of liens involving common issues of law or fact so that even more of these liens could be resolved. As of this writing, the outcome of this initiative remains unknown. Even if the consolidations succeed in bringing a few thousand liens to closure, the court will remain overwhelmed by the avalanche.

Court staffing is one part of the solution to handle the workload and fulfill the Constitutional mandate for "an administrative body with all the requisite governmental functions to determine any dispute or matter arising under such legislation, to the end that the administration of such legislation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character…." (Constitution, Art. XIV, Sec. 4.) The cost of increased staff will likely be more than offset by the savings from quicker and more effective performance of the court's dispute resolution function.

Impact on Public Policy

A court system that is overwhelmed by liens is unable to enforce the law. Instead, the court must encourage or even coerce settlements because it does not have the capacity to adjudicate all the disputes. As a result, parties are not held accountable for their conduct, and business practices that are contrary to law continue to flourish.

Consider two hypothetical lien claims that illustrate this point:

> In one case, a physician who is authorized to treat an injured worker has prescribed physical therapy consistent with the medical treatment utilization schedule, the treatment has been provided by a physical therapist who is in the insurer's medical provider network (MPN) or is otherwise eligible to treat the worker, and an appropriate bill and documentation have been submitted to the insurer, but the insurer, without explanation, has paid the physical therapist either less than the amount of the bill or nothing at all. After exhausting informal efforts to obtain payment, the physical therapist files a lien. The court should order payment with a 15% increase and interest pursuant to Labor Code Section 4603.2.
>
> In another case, an injured worker who is receiving undisputed treatment from a physician within the insurer's MPN goes to another physician who, without authorization and in the absence of an emergency, undertakes treatment and dispenses drugs and devices inconsistent with the medical treatment utilization schedule. The physician files a lien simultaneously with the initial report and bill for the services and the drugs and devices. The insurer denies liability based on a utilization review determination that the treatment was not medically appropriate and based on the insurer's right to retain treatment within the MPN. The court should deny the physician's claim entirely.

If these liens are filed today, in most cases, the misconduct of the parties would be rewarded by a settlement:

> In the first case, the physical therapist will compromise the bill for perhaps 75% of what should have been paid according to the fee schedule, but even if the bill is eventually paid in full, the claimant will likely waive the interest and penalty in order to get the matter resolved without waiting for a trial that may never occur. The insurer will escape its obligation without consequences, and medical providers will continue to shy away from workers' compensation cases because of the reputation for poor payment.
>
> In the second case, the insurer will pay its attorney or claims representative to attend conferences, at which the physician's representative may or may not show up or be prepared, and the insurer will eventually pay perhaps 20% of the lien claim just to avoid the expense of further hearings and to get the case closed. The physician will profit handsomely on the drugs and devices even after paying the lien representative a small

commission. The physician will continue to victimize injured workers by providing inappropriate treatment and to exploit the failures of the judicial system by extracting money from insurers and employers.

Faced with hundreds of thousands of liens and insufficient resources to deal with them, the court has no option but to promote or even force settlements. The Los Angeles Presiding Judge pronounced it a success when all the lien cases set for trial on the first day of the new lien calendar were settled.[5] Settlements have a vital place in the dispute resolution system when parties can reach a reasonable compromise of a good faith dispute. Settlements defeat public policy when they reward and perpetuate bad conduct. The Legislature and the Administrative Director of DWC have enacted statutes and regulations to govern the behaviors of the parties, but an overwhelmed judicial system is unable to enforce these laws.

General Recommendations to Manage Lien Volume

When we measure the scale of the lien problem, we are measuring the dysfunction of a system that is intended to deliver benefits swiftly and economically, but which is bogged down in foot-dragging and abuse. The number of liens has to be reduced and the causes of liens have to be addressed, and these efforts must proceed hand-in-hand. Our first set of recommendations is addressed merely to coping with the volume of liens and the burden they place on the dispute resolution system.

Recommendation 1: Reinstate a filing fee for medical and medical-legal liens.

A filing fee clearly deters filing liens. Presumably, it has greater deterrent effect on unmerited liens and frivolous liens than on liens where the claimant foresees a probability of recovering the amount in dispute as well as the filing fee. See additional discussion in Appendix 2.

Recommendation 2: Require frequent lien filers to file their liens electronically.

Electronic filing eliminates the burden of clerical time required to process liens into EAMS. In addition, it improves the administration of justice by assuring that the lien claimant is promptly added to the case to receive notice of all proceedings. Court personnel observe that the majority of liens are filed by a relatively small number of lien claimants.

[5] Presiding Judge Jorja Frank told WorkCompCentral that the lien unit's first day went well: "All the lien cases set for trial were settled." WorkCompCentral.com, "Attorneys, Reps Welcome Lien Unit With Open Arms," June 8, 2010, reporting on the opening of the Los Angeles Workers' Compensation Appeals Board's new lien unit.

Recommendation 3: Prohibit filing of amended liens prior to Declaration of Readiness.

Amendments of the amount in dispute should be timely served on the parties, but the court has no need for this information until the matter is set for hearing pursuant to a Declaration of Readiness to Proceed. Paperwork for the court should be kept to a minimum. Only changes of address and changes of representatives are needed for the address record, and those can be submitted by letter or, preferably, electronically. It may also be appropriate to allow amended liens to be filed electronically if they do not necessitate any clerical work for the court.

Recommendation 4: Until the volume of liens is substantially reduced by other measures such as recommended in this report, equip the WCAB District Office with sufficient resources to meet workloads.

Although other recommendations in this report are intended to reduce court workloads, there is no substitute for equipping the courts with the resources needed to cope with the incoming paperwork and to work through the accumulated liens.

Background: What is a Lien in Workers' Compensation

Counting Liens

The numbers shown in the Overview section of this report are the numbers of lien claims filed on "Notice and Request for Allowance of Lien" or its equivalent. The term "lien" may refer to an inchoate right or it may refer to a formal assertion of the right. Unless otherwise indicated, we use the term "lien" to mean the document filed with the WCAB which invokes the jurisdiction of the court. For emphasis, we may refer it as a "filed lien" or a "filing."

A single filing ordinarily includes all the claims by one lien claimant in one injured worker's case. For a medical lien, that means one medical provider files one Notice and Request for Allowance of Lien covering all of the billing disputes connected with the treatment of one worker arising out of one injury or several injuries.

An amended lien may be filed if additional payment disputes arise after the original lien filing. For the purpose of measuring the amount in dispute or measuring the volume of the dispute resolution workload, it is still one lien by one lien claimant in one case, albeit an updated lien. For the purpose of measuring clerical workloads, the amended lien requires processing similar to an original lien. DWC census figures count amended liens the same as original liens. In fact EAMS currently requires that amended liens be designated as original liens.

A lien may be duplicated if it is filed in each of several claims for separate injuries. For example, three injuries may arguably contribute to the need for treatment, and a medical provider may file one lien for that treatment in each of the three cases while the defendants argue over which one is liable. In such a case, one medical bill will appear as three liens in a DWC census.

See Appendix for discussion of the adjustments that can be made to the raw data to account for amended and duplicate liens.

Types of Liens

Eleven possible types of liens are listed in section 4903 of the Labor Code,[6] including both medical treatment and medical-legal expense within one subdivision. Several of these possible lien types are rare. To understand the lien problem, one must understand that the majority of liens are actually medical benefit disputes.

Outside of worker's compensation, liens are ordinarily a form of legal notice that secures the payment of an obligation. The lien holder's interest must be satisfied when, for example, the debtor sells a property and a portion of the proceeds is redirected to the lien holder, but the buyer has no direct debt to the lien holder. A minority of workers' compensation liens are of

[6] All section references are to the Labor Code unless otherwise indicated.

this type. These include child support liens, most attorney fee liens, and certain other liens where the lien holder has no direct claim against the defendant. These lien claimants have a right to satisfy an obligation by intercepting benefits that would otherwise be payable to the injured worker. These conventional liens constitute less than 10% of the liens being filed as of spring of 2010. When we consider the volume of lien filings, these may be considered to be the irreducible minimum. These conventional liens are little cause for concern for the worker's compensation system.

The typical workers' compensation lien is a direct claim against the defendant for a benefit which is not otherwise payable to the injured worker. The rationale is that the lien claimant has furnished medical treatment or other service that the employer was required to provide, so the lien claimant is entitled to payment from the employer.[7] A medical provider must accept the payment allowed by workers' compensation and must not collect from the patient unless the claim turns out to be non-compensable.[8] A lien is the medical provider's vehicle for contesting the employer's determination of the amount payable for medical goods or services. Unlike conventional liens, these are not obligations of the injured worker.

We will group the types of liens as follows:

- Medical treatment – these are the predominant type of liens in worker's compensation. Medical treatment includes every benefit required to be provided under section 4600, and it includes claims for reimbursement when treatment for an occupational injury or illness has been paid by a health insurer or health care service plan.

- Medical-Legal Expenses – these are expenses incurred to prove or disprove a contested claim, including such issues as permanent disability or the appropriateness of medical treatments. They are ordinarily payable by the employer or insurer. Medical-legal claims are grouped with medical treatment both in the section 4903 list and for most lien procedure requirements.

- Interpreters – interpreter liens are not separately listed in section 4903, but may arise within medical treatment, medical-legal, or section 5811 costs. (Section 5811 requires the employer to pay certain litigation costs, including interpreter fees.) Interpreters are separately listed on the Form 6, "Notice and Request for Allowance of Lien."[9] Interpreter liens are numerous and tend to have distinct characteristics justifying their separate categorization.

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[7] We use the term "employer" in the same way as it is used in the Labor Code. Depending on the context, it may mean the actual employer, but more often, it means the employer if the employer is self-insured or uninsured, or it means the employer's insurer if the employer is insured.

[8] Section 3751(b); *Bell* v. *Samaritan Med. Clinic Inc.* (1976) 60 Cal.App.3d 486.

[9] See Appendix for a copy of Form 6, "Notice and Request for Allowance of Lien."

- Copy Services – copy services are not separately listed in section 4903, but may arise within medical treatment, medical-legal, or section 5811 costs. Copy services are not a separate category under the Labor Code or the Form 6, "Notice and Request for Allowance of Lien." We separate them into a category of their own because they are numerous and they have distinct characteristics.

- Attorney fees – these are usually payable out of the injured worker's recovery to the worker's current or former attorney. It is not routinely necessary that an attorney file a lien to secure payment of his or her fee. Defendants must pay for the attorney at the applicant's deposition.

- Living expense and family support – in this category, we combine several types of liens listed in section 4903. These include Employment Development Department (EDD) liens for reimbursement of benefits paid before the employer accepts liability for workers' compensation disability indemnity. These also include family support and child support obligations of the injured worker. These are conventional liens against compensation that would otherwise be payable to the injured worker. Although the amounts tend to be large, these liens are not typically indicative of a dysfunction in the workers' compensation system.

- Other – in addition to the types listed or grouped above, section 4903 recognizes liens for:
    - Burial expense of a deceased employee as allowed by Section 4701.
    - Reimbursement of benefits paid by the Victims of Crime Program.
    - Reimbursement of amounts that have been paid by the Asbestos Workers' Account.

  This is not a complete list of the appropriate uses of the "Other" category. For example, "Other" liens may also be used as a vehicle for one employer to seek contribution from another when responsibility for the payment is shared among two or more employers. All of the appropriate uses are rare, but the "Other" category is frequently checked by lien claimants on the Form 6, "Notice and Request for Allowance of Lien." Usually when the category is checked, the claims actually belong to a specific category. For this study, we have attempted to reclassify "Other" liens to the correct categories.

CHSWC Lien Research

Data Sources

To better understand the nature of the problem and support more focused recommendations, CHSWC collected data from three sources for this project. Each dataset provides a different view of the universe of liens, and together they give us information that no single dataset can provide:

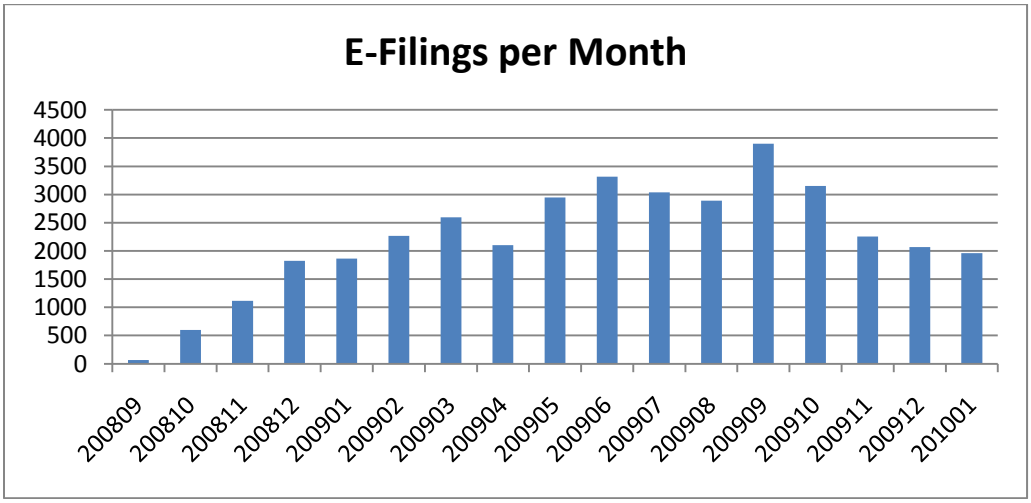
- E-filed liens.
- Sampled paper-filed liens being scanned into EAMS.
- Survey of selected liens being received by selected claims administrators.

These three sources will be described, followed by the findings.

E-filings

DWC received 37,960 liens filed electronically through EAMS between 9/22/2008 and 1/25/2010. E-filing is a voluntary option within EAMS.[10] E-filing data may be skewed by the presence of a few high-volume early adopters of the new technology, so it does not represent a cross-section of all liens. The volume grew as more participants came on board, from 1,862 filings in January 2009 to a peak of 3,902 filings in September 2009.

Figure 3. Number of E-Filings per Month



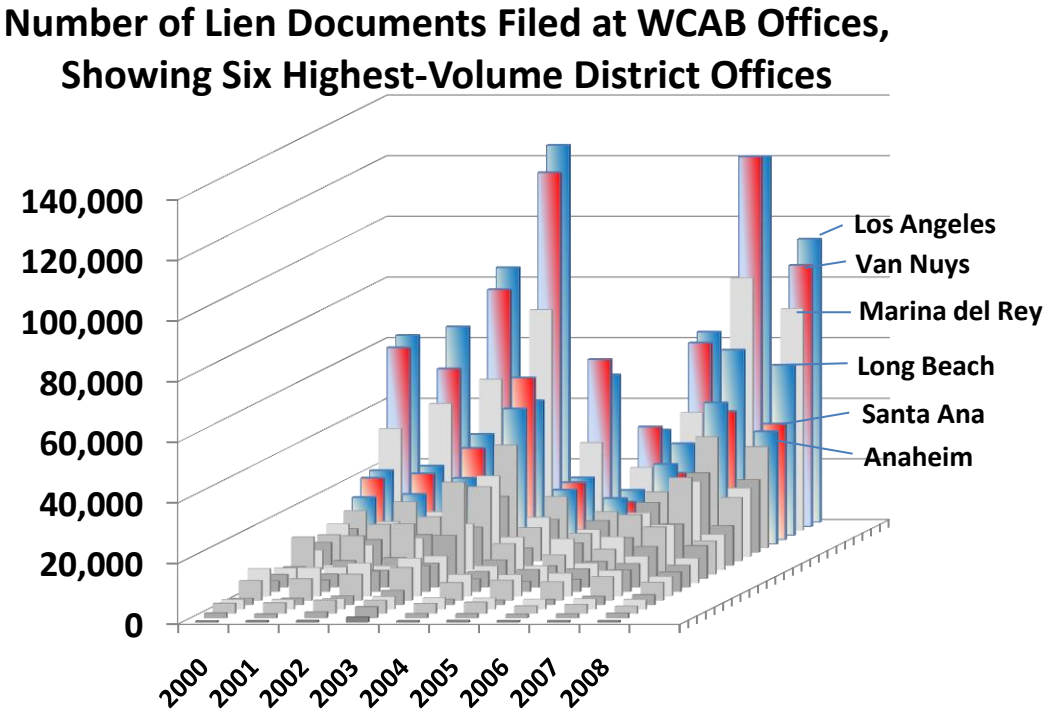
[10] Parties may enroll in e-filing. E-filers agree to file all of their documents electronically. Nevertheless, we identified some names that appeared both as e-filers and paper filers of liens. For descriptions of the e-Filing project, see DWC Newsline No. 81-08, December 23, 2008, and Reference Guide and Instructional Manual for Electronic Filing E-Form Filers revised 6/9/2010.

For reasons we have not determined, the rate of e-filings declined through the fourth quarter to only 2,067 filings in December of 2009. On average, 2,700 liens per month were filed electronically in 2009. Unlike paper filings, e-filings are entered into EAMS immediately, so the drop-off cannot be explained away by EAMS processing backlogs. For 2009, e-filings were about 14% of all lien filings.

Paper Liens from Selected District Offices

The second source is a sample of paper liens that were available at DWC headquarters office in Oakland. These were predominantly documents filed between September 2008 and May 2009 and shipped from backlogged District Offices to DWC headquarters to be input into EAMS. We obtained one box each from the Anaheim, Long Beach, Los Angeles and Santa Ana offices, and two boxes from the Van Nuys office.

Figure 4. Number of Liens Filed Yearly at Each WCAB Office



The chart shows that lien filings are overwhelmingly concentrated in a few high-volume offices, with Los Angeles and Van Nuys towering above the rest. Los Angeles is shown in blue (or medium shaded gray if viewed in black and white), Van Nuys in red (or high contrast shaded gray). The third highest volume was Marina del Rey, shown in pale gray, which we did not sample. See Appendix for a table of the number of lien filings in each office and each year.

CHSWC staff collected structured statistical information by reviewing the first 75 liens in each box. This produced a statistical record of 450 incoming liens drawn from the current workflow of five offices. We expect these records to be generally representative of lien activity in this state. We also collected copies of every 30th lien from each box, for a total of 63 liens, for individual examination.

Survey

Documents filed with the WCAB do not usually answer the question of why a lien has been filed. To learn the issues that generate liens, CHSWC enlisted several claims administrators to participate in a survey. The survey form asked 14 questions about each lien that was received by each claims administrator over a period of approximately four weeks in the spring of 2010. In addition to statistical questions such as date of injury, date(s) of services and date of lien, the survey asked whether the medical services were authorized and if not, why not. The survey also asked about a medical provider's relationship to an MPN and about the existence of billing disputes.

We received data on 1,901 liens. After eliminating duplicates, outliers, and records which omitted essential data, we had a working data set of 1,809 records. The analytic file was further limited to the 1,520 liens filed in the first quarter of 2010. The survey captured 2% of all the liens in the DWC census for that quarter. The survey responses did not include individually identifiable information on workers, lien claimants or employers other than the identities of the survey respondents and optionally, the case number. Those identities were removed when the survey responses were merged into a single database for analysis. These data represent insurers, self-insured self-administered employers, and third-party administrator cases. The participants represent a cross-section of the state both in geographic distribution and in industries. The participants may be more likely than average to have MPNs. Otherwise, we expect these data to be generally representative of the majority of lien activity in the state.

Combining the Data to Create an Overall Profile

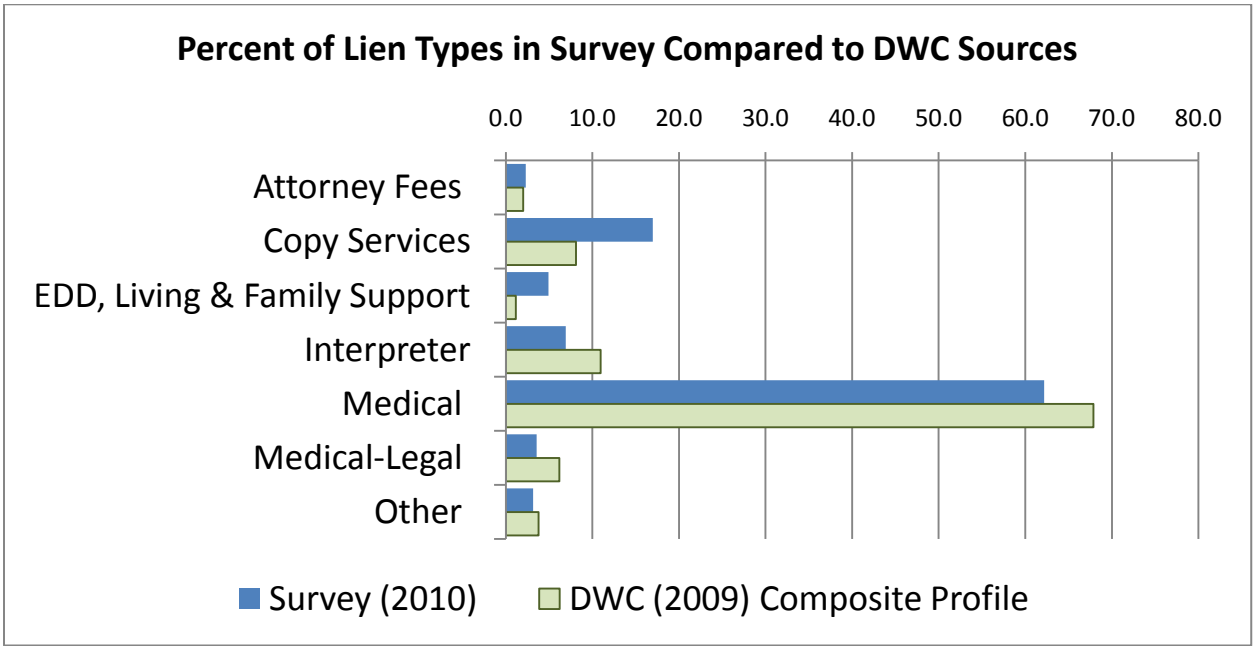
E-filed liens provide a profile of the 14% of liens filed by adopters of that technology, and paper-filed liens provide a sample of the remaining population from five of the six district offices where 54% of all liens are filed. The survey provides more detailed information on a sample of liens being filed during the survey period. Together, these data sources can provide a useful insight into the lien phenomenon.

To construct a composite profile of the entire population of liens from the two DWC data sources, it is necessary to combine the e-filed liens with the paper sample. The paper liens sample must be weighted to reflect the share of the total population which it represents. We use the five-month period from January through May of 2009 to combine these sets because that is the period that the two sets overlap. January 2009 is when e-filings had become a significant share of the total population. May 2009 is the last month for which there were a

significant number of liens in the sampled boxes of paper liens. Within this period, a total of 77,377 liens were filed. E-filings were 11,177 of those, leaving 65,600 paper filings. The sample of paper liens included 285 filed in that period, so there is one record in the sample for every 230 paper liens filed in that period. These two data sets obtained from DWC can be combined to produce a composite profile of the liens being filed in the first five months of 2009.

We can use the survey to make inferences about the whole population of liens if we are convinced that the survey sample is representative of that population. Since we were not able to construct a randomized survey within the resources available for this project, it is necessary to test whether the survey sample resembles the whole population at least in the characteristics that can be measured in both. These comparisons confirm that the survey is generally representative of the whole population.

Figure 5. Distribution of Lien Types in Survey Resembles DWC Composite Profile



In addition, the average amounts per lien among the major liens types are recognizably similar.

Table 1. Average amount claimed per lien

Lien Type	Average per lien in DWC Composite	Average per lien in Survey
Copy Services	$750	$577
Interpreter	$1,038	$1,001
Medical	$5,795	$7,774
Medical-Legal	$3,021	$2,743
Other	$5,643	$7,477

Having confirmed that the survey is generally representative of the population as a whole, we can use the survey data in later sections of this report to infer key characteristics of the whole population.

Selection of Data Sources

The choice of the these three data sources – e-filings, paper samples and survey – is dictated by practicality and opportunity.

Public comments have expressed concern that some of the data are from only five Southern California offices. Although we would have preferred a suitably weighted sample from all District Offices, the fact is that these five offices receive over half (54% for 2008) of all the liens filed in the state. Together, these large offices and the statewide e-filings allow us to construct a profile of the majority of liens in California. We can verify that the survey data satisfactorily reflect that profile. More detailed analysis will be based on the survey data, which were drawn from claims administrators handling claims throughout the state.

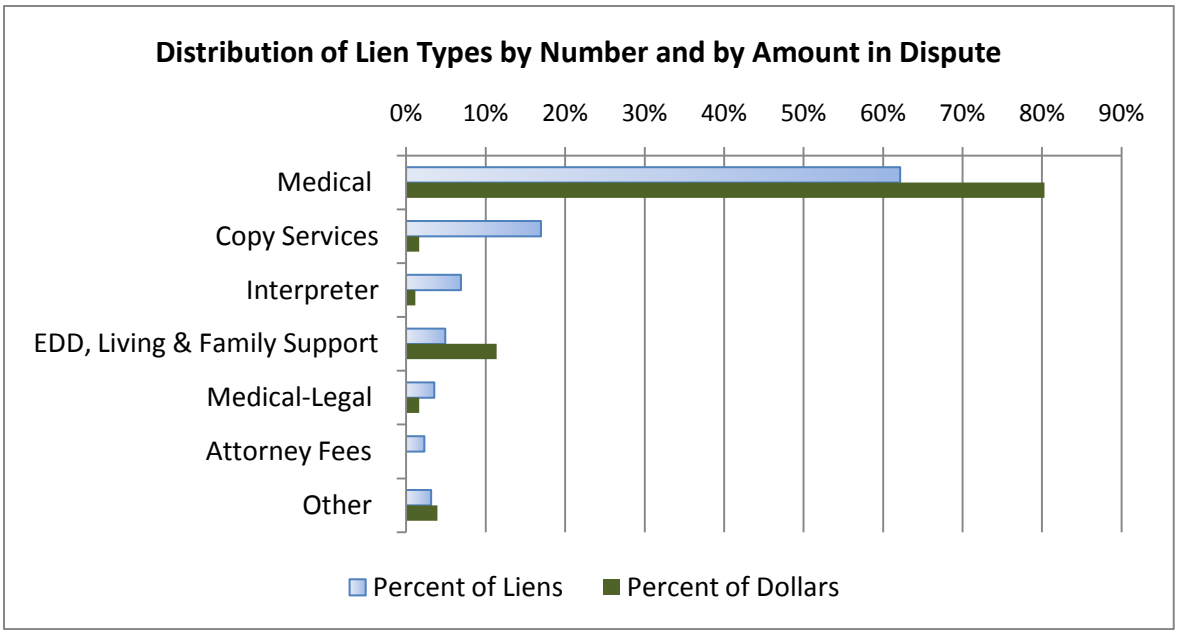
Public comments have also expressed concern that the survey gives only the claims administrators' side of the story in lien disputes. Neither we nor the commentators were able to propose a method for gathering statistically useful information from lien claimants. Unlike the statewide claims administrators participating in the survey, most lien claimants would represent only a particular type of issue and perhaps a particular locality. Discussions with lien claimants were taken into consideration in the interpretation of the data received from the claims administrators.

The types of questions that are addressed in this report can be satisfactorily answered with data from DWC and the survey of claims administrators throughout the state. Despite the need for rough approximations, these analyses provide insights that have not previously been available to California policymakers.

General Findings: Types of Liens

Medical liens account for 62% of the liens in the survey and 80% of the dollars in dispute. Copy services, which we treated as a distinct lien type, account for 17% of the liens but only 2% of the dollars in dispute. Interpreters account for 7% of the liens and 1% of the dollars in dispute.

Figure 6. Distribution of Lien Types



Medical treatment liens signal the greatest dysfunction in the workers' compensation system as well as the greatest opportunity for systematic improvements. We estimate that $1.5 billion in medical liens will be filed in 2010[11] and $2 billion in 2011. By way of comparison, the total spending on medical benefits statewide in 2009 was nearly $6 billion,[12] so one dollar is in dispute for every four dollars paid.

Copy service liens may appear on the Form 6 as medical treatment, medical-legal, or "other" lien types. We gathered them into a separate lien type to permit analysis of this high-volume issue. In DWC data, we attempted to identify copy service liens according to the name of the lien claimant. In the survey data, the respondents identified the type of service provider based on the documentation that accompanied the liens.

[11] 350,000 liens per year x 62.2% medical liens x $7,774 average medical amount, less 10% to adjust for amended liens = $1.52 billion in medical disputes per year. See Appendix regarding adjustment for amended liens.

[12] "System Costs and Benefits Overview," CHSWC 2010 Annual Report, to be published January 2011.

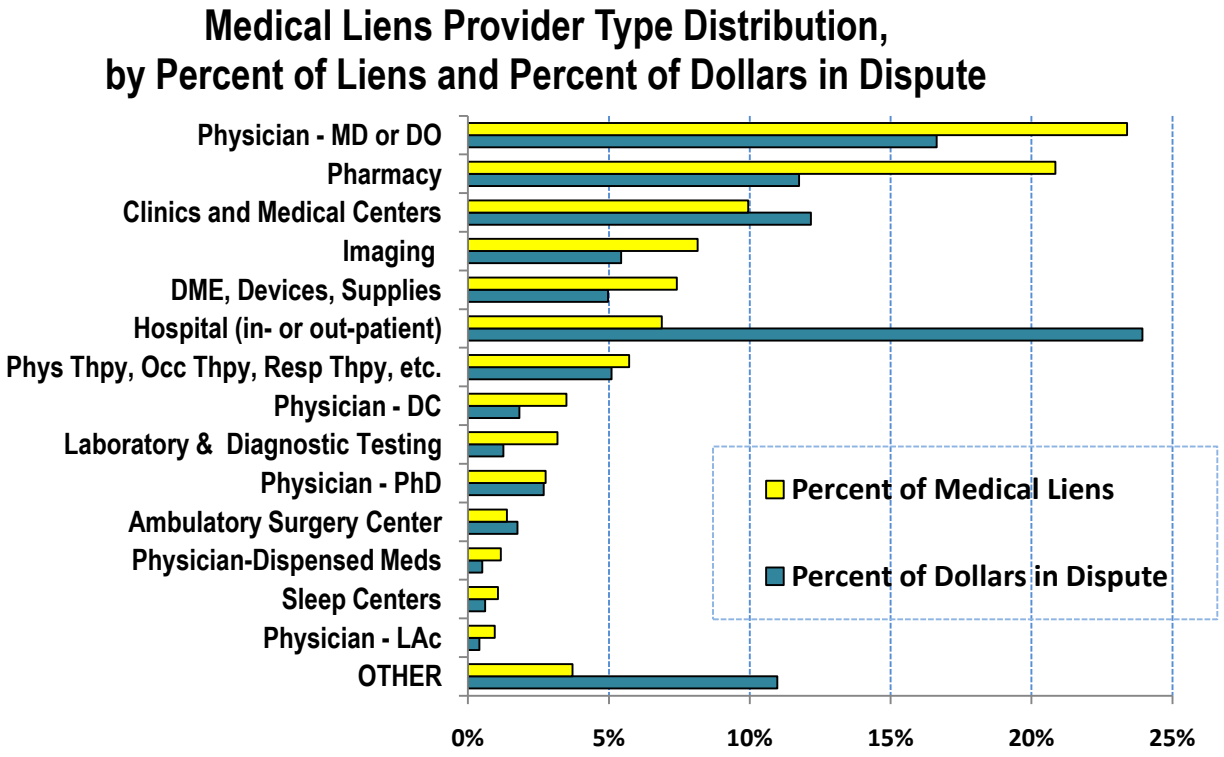
Interpreter liens are noteworthy because they are so numerous for a service that seemingly should be amenable to unambiguous fee schedules.

Transportation services have been the subject of anecdotal reports of problems, but they appear to be a small part of the volume of liens and a small part of the values in dispute. We initially separated transportation liens from the other types, the same as we have done with copy service liens, but we discarded that approach after observing that there was nothing statistically distinctive about them.

The remaining types of liens do not require priority attention from policymakers either because their impact is small or they do not reflect dysfunctions in the system or offer opportunities for improvement. EDD, Family Support, and Living Expenses are all conventional liens against indemnity (temporary disability [TD] or permanent disability [PD]) benefits that would otherwise be payable directly to the employee. Medical-legal liens are relatively small in number and aggregate dollar value. Furthermore, medical-legal liens are often mis-categorized as medical treatment (and vice versa), so any important lessons that could be learned from analysis of medical-legal liens will be gleaned from medical liens. The two types are lumped together in section 4903 and subsequent sections, so recommendations that will be made concerning medical liens can apply to both types. Attorney fee liens are often filed for no specific sum or for arbitrarily large sums, so the amounts claimed have no significance for analysis.

Medical liens were further broken down by type of medical provider. On cursory examination, the provider types do not appear to have significant differences in terms of authorization issues or lien filing timelines. For most provider types, there were too few observations to support fine-grained analysis.

Figure 7. Medical Lien Provider Types Distribution



The following sections will examine issues found in medical treatment liens in more detail, followed by a briefer look at interpreter liens and copy service liens.

Medical Lien Disputes

The survey asked three sets of questions to characterize the disputes that give rise to medical liens. Within each set, only one choice was available.

- Did the lien involve a balance bill after a payment?

- Was the treatment authorized? If not, why not?
  - Yes, treatment was authorized or undisputed
  - Claim denied
  - Body part denied
  - Provider not authorized
  - Rejected Utilization Review
  - Other

- What was the provider's MPN status?
  - In MPN
  - Not in MPN, where an MPN applies
  - MPN not applicable
  - Unknown

The survey also requested the date of injury and date of lien filling. For medical liens, the survey requested the first date of services and, if different, the last date of services. The following sections of this report will describe our analysis of the results.

Fee Schedule Disputes

One out of three medical liens involved a balance bill after a payment had been made. The survey did not delve further into the nature of billing disputes. These could include disagreements over the correct coding for the services rendered and the documentation to substantiate that coding. These could include cases where the bill was paid according to the Official Medical Fee Schedule (OMFS) but, because the claims administrator did not correctly object to the bill, the provider is entitled to be paid the full amount as billed. These could include cases where the bill was paid according to the OMFS but the provider refuses to write off the balance of the charges. In some cases, the OMFS may not prescribe the amount to be paid, leaving the parties to argue over the reasonable value. [13] Until further study is done, we lump all of these together as fee schedule disputes.

[13] A lien representative at an October 6, 2010 hearing in Los Angeles stated that the reasonable reimbursement for the same compounded drug product could differ from one provider to another and from one locale to another depending on the evidence in each case.

Fee schedule disputes are present in 37% of medical liens (315 out of 852 survey records in which the question was answered). Fee schedule disputes are the only issue in 17% of medical liens (145 out of 851 records in which both the fee schedule question and the authorization question were answered).

We estimate that over 37,000 liens filed in 2010 would not be necessary if the amount payable for medical treatment could be swiftly and unequivocally determined.[14] Another 43,000 or more would be a step closer to resolution if fee schedule issues were resolved.[15]

The interpretation and application of fee schedules are technical and specialized. A fee schedule dispute requires documentation, not the testimony of witnesses in most cases. Without technical expertise in the fee schedules, busy workers' compensation judges are understandably inclined to urge settlement rather than offer adjudication on the merits of a fee schedule dispute. As a result, the public policies expressed in the fee schedule are not enforced.

Neutral bill review experts would be more accurate and efficient arbiters of fee schedule disputes. An administrative bill determination system would permit an administrative determination of the reimbursement allowable under the applicable fee schedules based on the documentation exchanged in support of or objection to the amount billed, apart from any other disputed issues. Disputes would be submitted in writing, and decisions would be subject to limited judicial review (requiring the aggrieved party to prove that the administrative determination is not supported by substantial evidence) with strong disincentives for frivolous review. If an administrative bill review process is established, it could improve the resolution of fee schedule disputes, reduce delays in payments, reduce frictional cost, and remove the incentives for unmerited claims or objections.

Recommendation 5: Adopt medical fee schedules to cover those services that are often disputed due to gaps or ambiguities in the existing fee schedules.

Recommendation 6: Establish an administrative system for fee schedule determinations, subject to limited judicial review.

Authorization Disputes

An injured worker may need to obtain medical treatment "on lien" when an employer fails or refuses to furnish treatment. Medical providers treating on lien may not get paid until the employer's liability is admitted or adjudicated, and then they take the risk that an employer may not be found liable and their bills are uncollectible. In a well-functioning system, there would be little need for treatment on lien because liability would be promptly ascertained and

[14] Based on 350,000 expected liens in 2010, with 62.2% of them being medical, and 17% of those being solely for fee disputes.

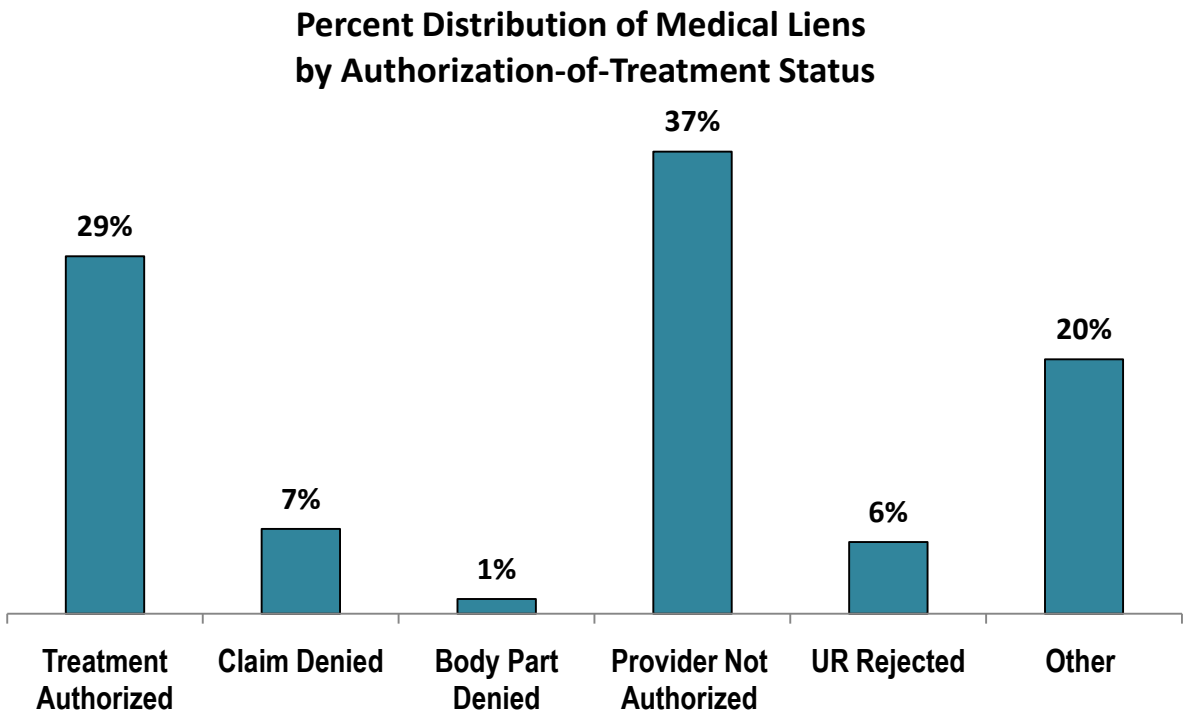
[15] Difference between 37% of medical liens that include fee schedule among other disputes and 17% that have only fee schedule dispute.

employers would furnish all treatment required by law. The survey explored the reasons why employers did not accept liability for treatment.

Treatment was either authorized or undisputed in three out of ten medical liens. When treatment was not authorized, the most common reason was that the provider was not accepted by the employer as an authorized provider. Surprisingly, few liens were observed for treatment in denied claims, treatment of denied body parts,[16] or treatment that was deemed medically unnecessary by utilization review.

The analysis of reasons for authorization disputes must be interpreted cautiously. The survey asked whether treatment was authorized (or undisputed), and if not, why not. Only one answer was permitted, so combinations such as Provider Unauthorized and UR Rejected could not be observed. "Other" was second only to "Provider Unauthorized" as the reason for treatment not being authorized. Subsequent studies might examine the reasons for dispute more thoroughly. The present survey demonstrates that provider authorization is a prominent issue in liens, but other issues may also be more significant than these results suggest.

Figure 8. Treatment Authorization Issues in Medical Liens.



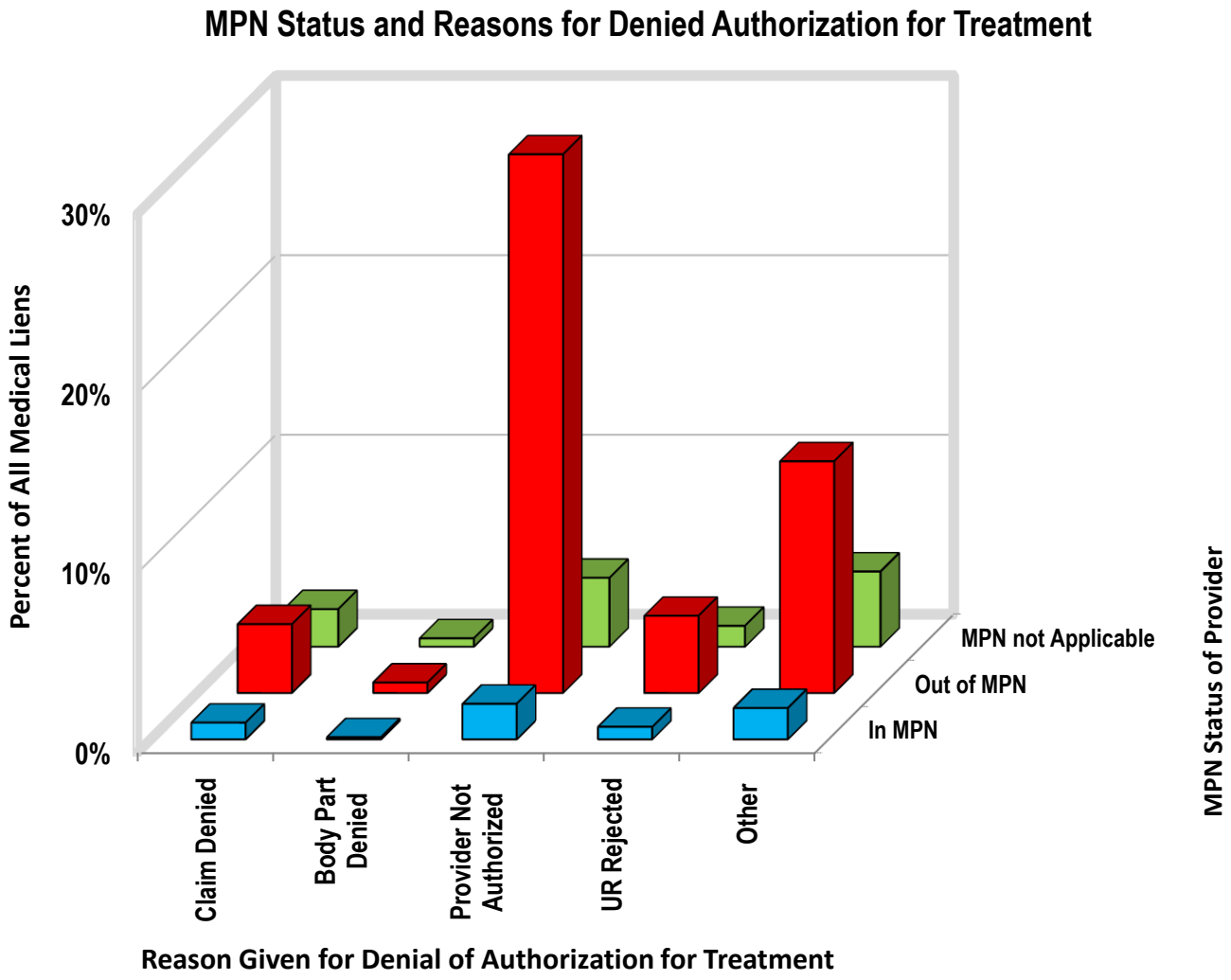
[16] The term "body parts" refers not only to the physical extent of an injury such as a question whether a knee injury also involves an ankle, but also to the associated diagnoses such as whether a back injury also causes a sleep disorder.

The predominance of provider authorization issues warrants further examination into the circumstances for this subset of liens. The following sections will examine the association between authorization issues and MPN status and between authorization issues and duration of treatment.

Treatment by Out-of-Network Providers is a Leading Reason for Lien Disputes.

Predictably, out-of-network providers account for the lion's share of disputes over provider authorization where the employer asserts MPN control. The data also show that out-of-network providers account for the largest share of liens in every category of authorization disputes.

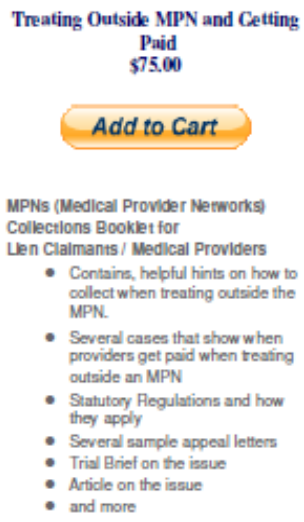
Figure 9. MPN Status and Reasons for Denied Authorization for Treatment



Where MPNs were applicable according to the claims administrators, out-of-network providers filed ten times as many liens as in-network providers for non-authorized treatment.[17] The high rate of liens by out-of-network providers implies that an adversarial relationship exists between these providers and the claims administrators that assert MPN control, and that this adversarial relationship is less common where providers are in the MPN or where claims administrators do not assert MPN control.

In an effort to understand why such a large percentage of liens involve provider authorization disputes, we considered the hypothesis that these may be cases where there was resistance to transferring treatment of existing injuries. MPNs were established beginning in 2005. Existing cases could be transitioned into MPNs at the election of the claims administrator and subject to continuity of care standards. We might expect a large share of provider authorization disputes when pre-MPN cases were being transitioned into MPN control. No such effect was seen in the sample of liens filed in early 2010. In fact, provider authorization issues make up a larger share of all authorization disputes for dates of injury after 2005 than they do for dates of injury before 2005 among liens filed in early 2010 for treatment rendered 2005–2009. The predominance of provider authorization disputes observed in 2010 cannot be attributed to the transition of pre-MPN cases into MPNs.

A remaining hypothesis is that there has been an increase in out-of-network providers choosing to treat without authorization. It is not our purpose to decide when the out-of-network providers are entitled to treat injured workers. There are employers asserting MPN control when they do not have that right. There are attorneys asserting that workers are not confined to treatment within MPNs. There are businesses advising medical providers how to get paid for treating in defiance of MPNs (see accompanying illustration, copied from a website).



"Treating Outside MPN and Getting Paid"
Advertisement for collections guidebook

[17] Out of 619 medical treatment liens for which treatment was not authorized and MPN status was known, 47 were from in-network providers, 471 were from out-of-network providers where the claims administrator asserted an MPN was applicable, and 101 were from providers where the claims administrator said an MPN did not apply to the service.
It may appear puzzling that *any* percentage of provider authorization disputes would involve in-network providers, given the employee's right to free choice within the MPN. Section 4616.3(b) gives the employee free choice of *physician* within the MPN, not free choice of *provider*. Only four in-network unauthorized provider liens were attributed to physicians, and these might have been unjustifiably denied. The rest were pharmaceuticals, labs, physical therapy, and other providers for whom the employee does not have free choice within the MPN.

Regardless of who is right and who is wrong in each case, provider authorization disputes reflect dysfunction in the workers' compensation system. In each case, a provider is asserting a right to treat and be paid for it, and an employer is asserting a right to control the selection of providers, and the worker is in the middle.

Prolonged Unauthorized Treatment

Under 4% of medical liens in the sample from 2010 appear to be for treatment that continued without authorization in excess of one year. The following table shows the number of liens and average amounts in dispute for unauthorized treatment extending for more than one year. In 902 medical liens for which service dates were known, claims administrators stated that the providers were unauthorized in 38% of the cases. The durations shown in Table 1 are the time from the first to the last dates of services for which a claim is made by the provider's lien. The survey was not designed to capture distinctive data from amended liens, so the following table might understate the durations of unauthorized treatment.

Table 2. Duration of Unauthorized Medical Treatment

Time ranges of treatment duration	Number	Percent	Avg $$ amount
From 1 day to 1 year	309	34.3%	5,264
From 1 to 2 years	15	1.7%	4,308
From 2 to 3 years	8	0.9%	8,393
From 3 to 4 years	4	0.4%	12,522
From 4 to 5 years	3	0.3%	11,202
>5 years	1	0.1%	6,671

The number of cases observed with prolonged unauthorized treatment may not appear to require a targeted policy change. Nevertheless, the adversarial relationships surrounding treatment without authorization cannot be beneficial to injured workers, so consideration should be given to resolving authorization disputes before treatment is prolonged. Policy decisions should at least be directed to removing whatever ambiguities generate treatment authorization disputes and then offer swift access to the courts for adjudication of disputes. The current practice of the court is to defer liens until the conclusion of the underlying case and then give the parties little alternative other than to compromise. This practice is not enforcing the law.

The next group of recommendations is aimed at reducing disputes over authorization for medical treatment.

> **Recommendation 7: The boundaries of MPN control over medical treatment should be more clearly defined to minimize the potential for disputes over rights to select medical providers.**

Recommendation 8: Disputes over assertions of MPN control over medical treatment should be brought to adjudication promptly.

Recommendation 9: Sanctions should be imposed on providers and claims administrators alike for repeated patterns of incorrectly asserting or denying the status of an authorized medical provider.

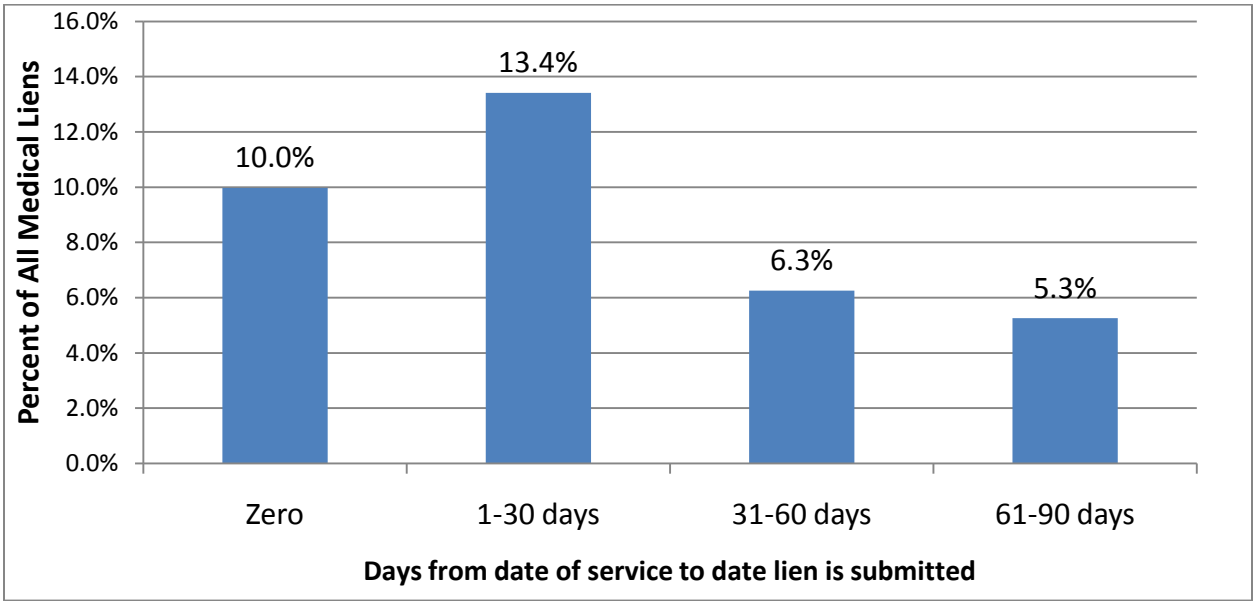
Recommendation 10: Consider establishing a maximum duration for treatment that can be claimed by lien in the absence of a Declaration of Readiness by the worker to seek authorization for the worker's chosen provider.

When Liens Are Filed

Premature Liens

Up to 30 percent of medical liens are filed prematurely. Claims administrators have 30 working days (at least 42 calendar days) to contest a bill and 45 working days (at least 63 calendar days) in which to pay most treatment bills. Thirty percent of medical liens are filed within 60 days of the latest date of the billed services. Most of these are probably filed before the bills have been contested.

Figure 10. Medical Liens Submitted Within 90 Days of Date of Services



Depending on how quickly bills are issued and how quickly claims administrators contest the charges, most of these liens are submitted too early to determine that the bill is contested. Ten percent are filed on the date of services. In these cases, liens are being misused as a billing vehicle rather than correctly used as a vehicle for resolution of disputed bills.

Existing law attempts to prevent the filing of premature liens. Section 4903.6, effective July 12, 2006, and Rule 10770.5, effective November 17, 2008, require that every medical treatment lien or medical-legal lien be filed with a verification that one of three timing requirements has been satisfied:

(1) Sixty days have elapsed since the date of acceptance or rejection of liability for the claim, or the time provided for investigation of liability pursuant to section 5402(b) has elapsed, whichever is earlier.

(2) For a medical treatment lien, the time provided for payment of medical treatment bills pursuant to section 4603.2 has elapsed.

(3) For a medical-legal lien, the time provided for payment of medical-legal expenses pursuant to section 4622 has elapsed.

The statute does not prevent premature liens because it is not properly written to target the problem and because there is little practical consequence for violation. Even if the first condition is satisfied (60 days have elapsed since the date of acceptance or rejection of the underlying claim), a medical lien or medical-legal lien is nevertheless premature if it is filed before either the second or third condition is satisfied (the permissible time for payment has elapsed). Of course, if a bill has actually been contested, then the expiration of the time to pay or contest is moot, and the dispute is ripe for lien filing.

Although 30 percent of medical liens are likely filed before the time for payment of medical treatment bills or medical-legal bills has probably elapsed, five out of six of these hasty liens can comply with the alternative requirement of being filed after the 90-day period for investigation of liability has elapsed. In other words, 25% of liens are probably premature but nevertheless permissible according to the wording of section 4903.6 and Rule 10770.5(a)(1).

Would it make any difference if premature liens were barred, or would the same liens eventually be filed anyway? To answer that question, we analyzed the number of liens filed within 60 days of date of service in which there was no issue of either authorization for service or the fee allowance for the service. Thirteen percent of medical liens fell into this category. Therefore, we estimate that the volume of medical liens could be reduced by approximately 13% if the statute and rule were amended to require that, unless the claims administrator has actually contested a bill, the medical lien cannot be filed until *both* time for the claims administrator to accept or reject the underlying claim *and* time for the claims administrator to pay or object to the bill have elapsed.

The volume of medical liens could also be reduced by enforcing the existing timing requirements. Although 30% of liens are filed within 60 days of the date of services, only five out of six of those are excusable according to the existing language. That leaves 5% of medical liens which are impermissible by any of the three alternatives under the existing language. As

authorized by statute, the rule provides that "failure to attach the verification or an incorrect verification may be a basis for sanctions." In a busy court calendar that is already drowning in liens, there is little incentive for any judge to add to the workload by conducting sanctions proceedings against the violator. The continuing number of violations implies that the existing sanction is ineffective to shape behavior.

To make the prohibition of premature liens effective, it needs to be enforceable without depending on the court to conduct sanctions proceedings. Nor is it feasible for the court to screen all the liens to reject premature filings. Violation on the part of the lien claimant should be an affirmative defense available to the employer or insurer, and consequences should be sufficient to deter violations. For example, the consequence for a zero-day lien or other premature lien could be dismissal with prejudice of the lien claim. Alternatively, the consequence could be a mandatory sanction of at least several hundred dollars or a substantial percentage of the amount of the lien claim, whichever is greater.

Recommendation 11: Labor Code section 4903.6 should be amended to forbid filing a medical or medical-legal lien until the bill is genuinely in dispute.

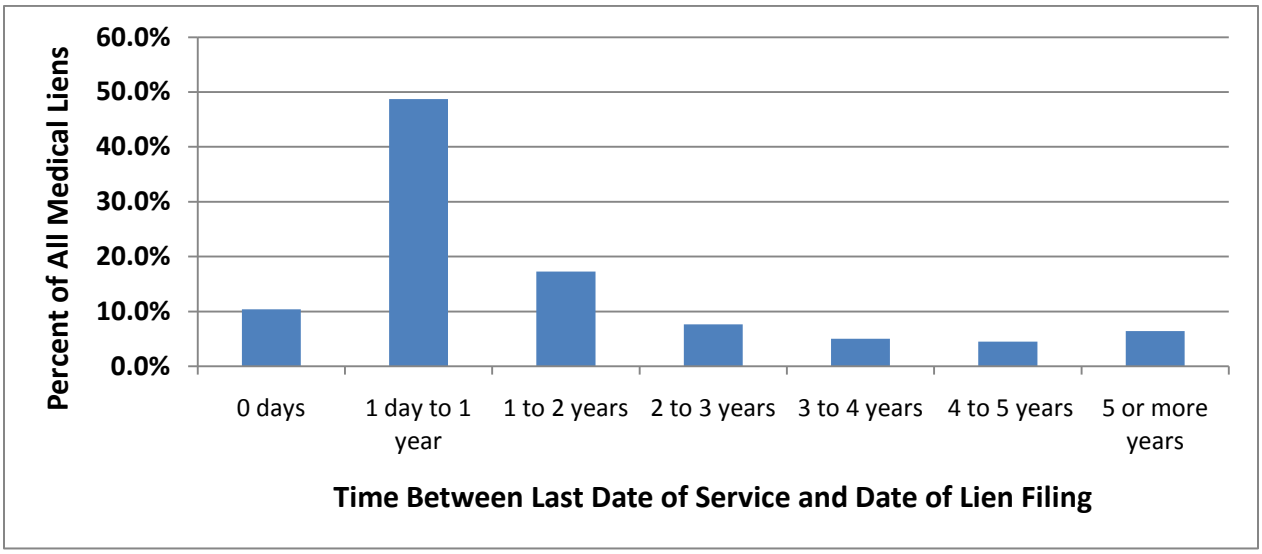
A bill is not genuinely in dispute until either the claims administrator has contested the bill or both (1) liability for the underlying claim is accepted or rejected or the time for disputing liability has passed and (2) the time for paying or contesting the bill has passed.

Recommendation 12: Labor Code section 4903.6 and Rule 10770.5 should be amended to provide consequences for violation that can be effective deterrents to premature filings.

Stale Liens

A substantial number of medical liens are filed years after the date of the medical services. These stale liens create problems, and they are not consistent with the goals of the workers' compensation system.

Figure 11. Time from Date of Medical Service to Date of Lien Filing



The law already prescribes a time limit for an employer to contest a bill and a time limit to pay the uncontested amount, as well as penalty and interest for failing to meet the payment timeline.[18] There are few comparable limits on the time for a medical provider to dispute the employer's action. The public policy of assuring access to care for injured workers by requiring prompt and reasonable payment is not served by allowing medical billing disputes to be raised long after the bill has been either paid or contested. When liens can be filed long after the event, timely and accurate payments are not being rewarded by achieving finality, nor are delayed or inaccurate payments being remedied by prompt dispute resolution.

Zombie Liens and the Phantom Statute of Limitations

In any other civil proceeding, a statute of limitations provides transactional stability for the parties and assures that the proceedings are commenced while evidence is still reasonably available. The injured worker's claim must be filed within one year following the date of injury or the last provision of benefits by the employer. A medical lien claim may have no time limit.

The website of one lien collector proclaims in red capital letters, "STATUTE OF LIMITATIONS DO [*sic.*] NOT APPLY ON WORKERS' COMPENSATION CASES PRIOR TO JAN. 1, 2003." How did it come about that medical lien claimants have even greater rights than injured workers?

[18] Section 4603.2

Until 2003, there was no bar on stale claims for medical bills.[19] It was entirely possible that medical services would be billed at the provider's list price, the employer would pay according to the official medical fee schedule, and the provider would write off the difference without protest, yet the zero-balance account would be resurrected[20] years later and filed as a lien. Some defense attorneys call these "zombie liens" because they were dead and buried only to come back to life.

Section 4903.5 took effect in 2003.[21] This section bars a medical lien unless it is filed within six months of a final decision of the Appeals Board on the underlying claim or five years from the date of injury or one year from the date of services, whichever is latest. Certain lien claimants may file liens within six months after first having knowledge that an industrial injury is being claimed. While this would appear to set outer limits on the time for filing a lien, those limits disappear like phantoms in the light of day.

Stale claims are not necessarily barred by section 4903.5 because a lien is implied any time the claims administrator has written notice of facts sufficient to constitute a lien. Section 4904, which otherwise deals only with Employment Development Department liens, begins with the sentence, "If notice is given in writing to the insurer, or to the employer if uninsured, setting forth the nature and extent of any claim that is allowable as a lien, the claim is a lien against any amount thereafter payable as compensation, subject to the determination of the amount and approval of the lien by the appeals board."

Based on this sentence, it is argued that the employer had written notice of the provider's claim by virtue of the medical bill, so the implied lien arose as soon as the employer paid the lesser amount allowed by the fee schedule. Charged with notice of the implied lien, the employer was obligated to notify the provider of all subsequent proceedings and to file the lien with the Appeals Board when submitting any settlement of the underlying case.[22] An employer who fails to give the required notices cannot later object that the lien claimant waited too long to file its lien in the form and manner required by section 4903.1(c).[23]

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[19] Although this report discusses medical liens, the same timing rules apply to medical-legal liens. Both are included in the list of allowable liens under subdivision (b) of section 4903. Other statutes such as Section 4903.5 may define their scope by reference to section 4903(b).

[20] "Resurrected" is the word used by the lien collector's web page accompanying this discussion.

[21] Statutes of 2002, Chapter 6 (AB 749).

[22] Section 4903.1(b).

[23] See, for example, the noteworthy panel decision of the WCAB in *Loc Tran vs. Viet Nguyen Trucking Co.*, 2007 Cal. Wrk. Comp. P.D. LEXIS 42. In that case, the defendant objected to a doctor's medical-legal bills in 2004 and 2005 and paid a reduced amount on one bill. The worker's claim arising out of an injury in March 2000 was settled in December 2005. The lien was not filed until February 2007. A trial judge disallowed the lien because it was filed beyond the limitations of Section 4903.5. The Appeals Board reversed, saying, "… it appears that notice may have been 'given in writing to the insurer… setting forth the nature and extent' of [the claim] prior to the filing of the Compromise and Release." If that be so, then the lien claimant was entitled to notice of the settlement and could not be barred from asserting

The Appendix contains an article from *WorkCompCentral.com* describing the practical absence of a statute of limitations even after the enactment of section 4903.5. If anything, the statute serves to extend the time in which a lien might otherwise be filed. Even if all the proper notices have been given, the lien claimant has up to five years to file a lien with the WCAB.

On the other hand, a panel decision of the WCAB on September 21, 2010, demonstrates that the limitations prescribed by section 4903.5 may bar some stale claims. In that case, the medical provider did nothing to pursue the disputed portion of its bill for over a year before the underlying case was settled and nothing for a year and half afterwards. The panel held that this lien filed beyond the times permitted by section 4903.5 was barred because "… section 4904(a) does not create an automatic 'notice of lien' every time a defendant pays less than the amount billed by the lien claimant."[24] One might think that this decision shows that the statute of limitations is being applied as intended, except for the fact that this decision was so rare and so remarkable that copies were quickly circulated by e-mail and it made the headlines in the trade press (*WorkCompCentral.com* 11/12/2010, This Week's Top Headlines).

Despite the mixed signals, it can safely be said that there is no clear limitation on the time for filing medical liens, and the limitations that do exist allow for medical liens to be raised in some cases years after the billing questions were apparently laid to rest.

Policy Implications of Unlimited Time for Filing

Stale liens create unmanageable costs without serving the purposes of the workers' compensation system. Existing law creates economic incentives for litigation that is impairing the ability of the system to serve its Constitutional purposes.

It is impossible for insurers to determine reasonable reserves for these so-called "zombie liens." Liabilities may arise years after premiums were collected and reserves were established. There is no sound method of calculating an "incurred but not reported" (INBR) factor for these liabilities. The amounts at stake can be large. For example, hospital charges are frequently several times the hospital's actual cost of providing services.[25] The fee schedule reimbursement allows for a reasonable markup on the cost of providing services, but the payment will still be well below the amount charged. A lien collector that recruits a hospital to dig up hundreds of these old zero-balance accounts may present millions of dollars in lien claims on cases that had been closed for years. Depending on the age and the record-keeping practices in use, documentation of the transaction may be irretrievable.

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the lien despite its failure to file a Notice and Request for Allowance of Lien pursuant to Section 493.1(c).

[24] *Maria De Los Angeles Segura vs. Technicolor,* ADJ 964606 and ADJ800629, Opinion and Order Granting Reconsideration and Decision After Reconsideration, September 21, 2010.

[25] See cost-to-charge ratios listed for each hospital in Title 8, Cal. Code Regs. Section 9789.23. Some charge more than ten times their cost, while a few charge less than their cost. Many charge three to four times their cost.

Injured workers' access to care does not depend on the tolerance for stale liens. Most medical providers do not render goods or services without knowing where payment is coming from. Even those who provide treatment in an emergency will promptly seek out a responsible party. No reasonable business model to provide treatment for injured workers relies on the potential to litigate for additional reimbursement years after the fact.

Existing law allows a niche industry to flourish at the expense of employers and, ultimately, workers. One example, provided to CHSWC is this screenshot (redacted) of the website of a collector that "specializes in the recovery of aged, written off, Workers' Compensation accounts dating back to 1991." The company advertises, "Labor Code and PPO discounts recovered."

AGED WORKERS' COMPENSATION RECOVERY EXPERTS

Home Services Features & Benefits How do I get started References

NAVIGATE: Home

specializes in the recovery of aged, written off, Workers' Compensation accounts dating back to 1991.

works with medical providers in California.

is the only company in California that has the technical capabilities to go back to 1991 and resurrect accounts that were not paid appropriately by the Workers' Compensation payers.

provides a new revenue stream that would otherwise remain unrealized without our services.

- Customer Service
  Detailed collection/payment reports
  Always available to our clients
  Quarterly reviews
- Experience
  11 years of success
  Fully trained team members
  Fee schedule experts
  Labor Code experts
  PPO experts
- Results
  No out of pocket start up costs
  Labor code and PPO discounts recovered
  New revenue center for the client

This same organization is reported to have acquired from one hospital over 90,000 zero-balance accounts aged at least three years, creating claims that could easily top $90 million on services for which the hospital already accepted payments based on the fee schedule. According to the collector's website:

> "Our mission is the recovery of aged, written-off receivables for services provided by:
> · Hospitals
> · Surgery Centers
> · Health care systems
> · Orthopaedic groups."

The tolerance for stale liens is a cost to the workers' compensation system that produces windfall revenue for some businesses, but it does not produce benefits for California workers or employers.

Both Bills and Payment Explanations Must Be Improved

Improvements in communications between medical providers and claims administrators can contribute to reducing disputes and fixing clear timelines for dispute resolution. Medical providers report difficulty in identifying what services are being paid, what are contested, and the claims administrator's reasons for contesting some bills. Claims administrators report problematic billing practices such as separate bills for multiple dates of service within a short period of time, re-billing for the same services, and billing without adequate itemization or descriptions of services. All of these problems make it difficult to delineate a dispute and to initiate firm timelines for dispute resolution. Appropriate billing practices and forms, incentives for e-billing or disincentives for paper billing, and genuinely informative explanations of review should be established by regulation. Community input will be required to optimize these procedures. Once those regulations are in effect, then strict limitations on liens can also take effect. Even before new billing and objection procedures are adopted for future medical services, an absolute maximum limitation period should be enacted for all liens, regardless of date of services.

Recommendation 13: Enact a statute of limitations, effective prospectively based on date of services to bar any lien unless the service is billed in accordance with regulations and the lien is filed within a defined time following that service.

We suggest that a statute of limitations should bar a lien for medical treatment unless the provider has billed the claims administrator within 60 days after the date of medical service, and the lien is filed within one year of the bill being contested by the claims administrator, but in no event later than 18 months after the date of medical service.

The effective date of this statute of limitations should allow for adoption of regulations that will prescribe requirements for billing and for contesting bills so that amounts claimed are clearly stated and documented and are not duplicated, and amounts contested are clearly stated with substantive explanations.

Recommendation 14: Enact a statute of limitations to bar any lien for service, regardless of date of service, which is not filed within three years of the date of medical service.

Unlike the statute of limitations tied to standardized billing and objection procedures for newly arising bills for services, this recommendation addresses the universe of old transactions that may yet be resurrected as lien claims. The statute could allow a period for filing any outstanding claims, similar to the limited time allowed for filing outstanding penalty claims under the 2004 amendments of Section 5814.

Recommendation 15: Eliminate implied liens for medical treatment or medical-legal expenses.

Section 4904 should be amended so that an implied lien arises from written notice of a claim only for liens against indemnity benefits in favor of EDD, not for other liens.

Recommendation 16: Impose automatic dismissal by operation of law for any lien which is not activated for hearing within finite time.

One problem reported by courts is the accumulation of filed liens that remain viable indefinitely. In addition to a statute of limitations for filing liens, consideration should be given to establishing a time limit to get a claim ready for hearing and to request a hearing. A potential time limit might be one year from the date of resolution of the underlying case for all cases, including liens already on file.

Medical Insurers Require Exception

Medical insurers stand in a different position than direct providers of medical services and should be allowed more time to submit their claims to workers' compensation payors. A direct provider of medical services has an opportunity to ascertain the source of payment prior to rendering non-emergency services. A medical insurer does not have the same opportunity, so it cannot be held to the same time limits for billing and filing liens in workers' compensation cases.

A medical insurer has a contractual obligation to the patient to pay for treatment of non-occupational conditions without waiting to investigate other potential sources of payment. In this context, "medical insurer" includes a health care service plan, a group disability insurer, an employee benefit plan, or a publicly funded program that pays for non-occupational health care. When occupational liability is in dispute, medical insurers are obligated to pay for treatment until occupational liability is established. Likewise, medical insurers must pay for covered treatment for conditions that might not be identified as industrial at the time services are being provided. Medical insurers must pay on the basis of routine documentation which does not afford an opportunity for them to investigate potential occupational liability before the treatment is rendered or before the direct provider is paid. The relationship between the medical insurer and the direct provider of services makes it impractical for medical insurers to adhere to the same time frames that can reasonably be expected of direct providers.

Medical insurers serve a vital role for workers. When occupational claims are in dispute or when illnesses are not immediately recognized as occupational, it is the non-occupational medical insurer that pays for the worker's necessary medical treatment.

In consideration of the role played by medical insurers and the practical difficulties for medical insurers to meet the same time frames that may be expected of direct providers of treatment,

it is reasonable to provide a longer period for medical insurers to file liens for reimbursement of benefits they have extended to their members and beneficiaries.

This may have been the intent of subdivision (b) of section 4903.5, but the statute was actually written more broadly. Subdivision (b) provides all medical providers the same exception that should logically apply only to medical insurers. In addition to the time frames for filing a lien provided by subdivision (a), which are already quite lax for a direct medical provider, subdivision (b) allows six months after learning that an industrial injury is being claimed. This exception is available to any:

- Health care provider.
- Health care service plan.
- Group disability insurer.
- Employee benefit plan.
- Or other entity providing medical benefits on a nonindustrial basis.

The inclusion of "health care provider" grants the same protection to one who furnishes treatment in knowing defiance of the employer's assertion of MPN control as is granted to a medical insurer who furnishes treatment to a worker whose industrial claim has been disputed. The inclusion of any "other entity" in the existing statute means that a provider may render services under a contract with a health insurer and receive all the payment that was expected at the time of service, then pursue windfall revenue upon subsequently discovering that the patient had a workers' compensation claim. This revenue was not anticipated at the time of rendering service and it was not necessary to protect the worker's access to his or her insured health benefits.

The exact form of the longer limitations period will be determined by policymakers. It could be three years from date of service, or it could be similar to existing section 4903.5, or it could be some other time frame. When it is written, however, it should be narrowly drafted to apply only to medical insurers (as generally defined above) and not to those medical providers who had an opportunity to determine where their payment was coming from before they accepted the patient and provided their services.

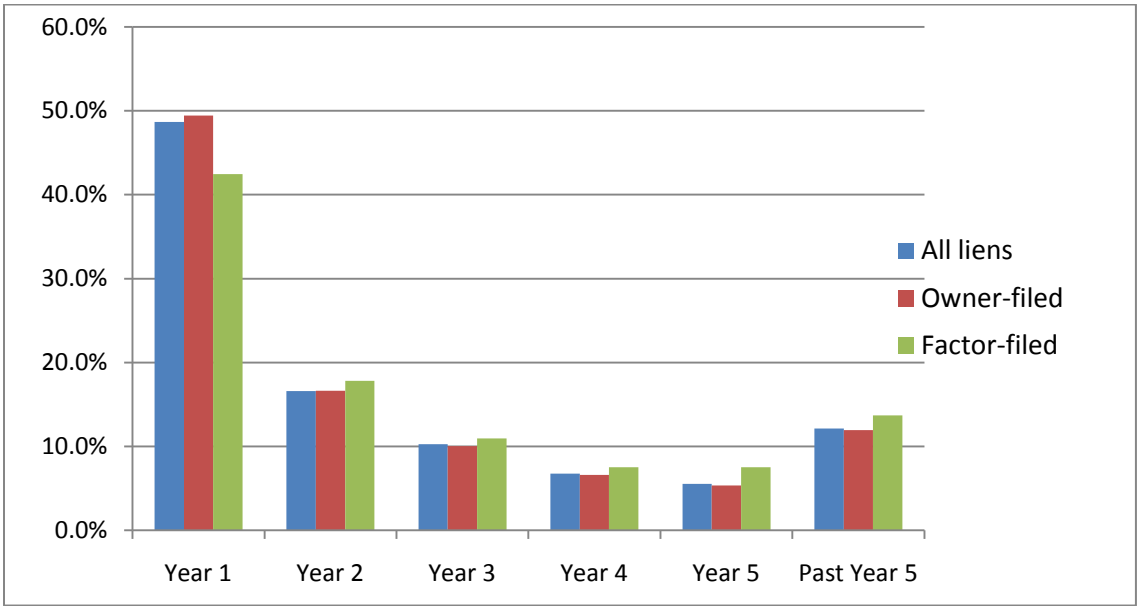
> **Recommendation 17: Allow additional time for medical insurers to file liens for reimbursement of sums paid for covered treatment.**
>
> When a tighter limitations period is enacted for medical liens, an exception should be preserved for nonindustrial medical insurers to have at least an additional six months to a year to identify occupational cases for which covered treatment has been furnished and to submit bills and liens.

Liens Filed by Assignees or Representatives

It has been suggested that assignees are responsible for a large share of stale liens and that assignees should be precluded from filing liens. We examined whether the time from date of service to date of lien filing was different for liens filed by assignees compared to liens filed by the original owners of the claims. We found no evidence of such a disparity, so we make no recommendation to specifically restrict lien filings by assignees.

We asked survey respondents to indicate whether each lien was filed by the original provider. Available answers were "Yes, it looks like the original provider or representative is filing the lien," or "No, it looks like the lien is filed by someone who bought the lien," or "Unknown." We encouraged respondents to give their best guess. The responses showed that owner-filed liens and assignee-filed liens were distributed almost identically.

Figure 12. How Long After First Date of Service until Liens Are Filed by Owner or by Assignee



We conclude that either (a) there is no truth to the hypothesis that assignee-filed liens account for a disproportionate share of stale liens, or else (b) the survey respondents were unable to distinguish between owners and assignees on the basis of the lien documents.

It is possible that the survey respondents could not recognize assignee-filed liens because the documentation is lacking and the relationship of the lien filer to the original owner of the claim can be quite murky. A lien might be filed by the provider's own office staff or by a lien collector acting as a representative for the provider. In both cases, the provider would still own the account receivable. Alternatively, the provider may assign the claim to an assignee. When a business sells all its accounts receivables to a third party to finance its operations, the transaction is called "factoring" and the assignee is a "factor." Regardless of whether the

transaction involves all of the receivables or just certain old accounts, the assignee owns the claim and acts on its own behalf.

Rule 10550(d), effective November 17, 2008, requires a lien claimant to state whether it is the original owner of the alleged debt or if it purchased the alleged debt. So far as we have observed, there does not appear to be any significant practical consequences for disregarding this requirement. Further study would be necessary to determine extent of compliance.

There is evidence, however, that the uncertain role of persons appearing before the courts is causing problems. After years of proceedings on consolidated cases involving the liens of Premier Medical Management Systems, Inc., an order was issued on September 24, 2009, dismissing with prejudice an estimated $70 million dollars of liens of providers for whom Premier provided billing and management services.[26] Almost immediately, providers began to come forward asserting that Premier was not authorized to represent them or that Premier was authorized to represent them for purposes of collection but not dismissal.[27] Another example comes from the Presiding Judge of the Los Angeles District Office, who observed that four or more liens might be filed by different lien collectors for the same services that were furnished by one provider. It becomes all the more challenging to manage litigation and finalize dispositions orders when it is not clear who owns the claim and who has the authority to act on behalf of the owner.

We find no evidence that the practice of assigning lien rights is a problem in and of itself. Nor have we encountered evidence that the practice of employing collection agents is inherently detrimental to the worker's compensation system. We do recognize the court's concern about identifying the lawful claimant or representative who has the authority to bind the owner of the claim. A lien claimant should be deemed to have failed to appear for a hearing if the person appearing does not have the sufficient authority to act on behalf of owner. Misrepresentations should be punished as contempt of court. Documentation of a lien claimant's relationship to the original owner of the claim should be produced upon demand. Unless a transfer of ownership of the debt is documented, payments on awards or settlements of lien claims should be made payable solely to the original providers.

Recommendation 18: A lien claimant should be required to disclose its relationship to the original provider of goods or services and produce documentation on demand.

Recommendation 19: A lien representative should be required to provide documentation of the representative's authority upon demand.

Recommendation 20: Misrepresentations of ownership of a lien or the authority of a representative should be punished as contempt and should be grounds for dismissal

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[26] Stipulation and Order for Disallowance and Dismissal With Prejudice of Requests for the Allowance of Liens, *Idahirma Yero, et al. v. C.I.G.A., et al,* VNO 0406036 et al (Master Consolidation Case).

[27] For example, see "Attorneys Say Premier Lien Dispute Far from Settled," Workers' Comp Executive, Vol. 19 No. 18, October 7, 2009, p. 1.

of the lien or for barring the representative from appearing in any proceedings before the Appeals Board.

Recommendation 21: Payments in satisfaction or settlement of liens should be made only to the original provider of goods or services unless a bona fide assignment is documented.

Copy Services and Interpreters: Small But Frequent Liens Reflect Deficiencies in Fee Schedules.

Two of the three most common and avoidable types of liens are copy services and interpreter liens. This section addresses the broad issues of small but numerous lien disputes that also clog the courts, increase litigation costs, and interfere with the efficient delivery of necessary services for injured workers. Wherever the fee is not clearly prescribed, there will be opportunities both for underpaying and for overcharging, and the judicial process will be burdened with disputes which could have been avoided.

Copy Service Liens

Liens for copy services comprise 17% of the liens reported in the survey. DWC data showed only 7% of liens were for copy services, but this is probably low because we could not reliably recognize copy service liens in DWC data.

The dollar amounts per copy service lien are typically well below $1,000. The cost of pursuing or opposing lien collection is therefore a substantial fraction of the amount in dispute. If copy service bills routinely have to go into lien collections, then the cost of collections and uncollectible accounts must be factored into the price charged for the services.

The price charged for services may be disputed because there is no official fee schedule and no clear fair market value to serve as a yardstick. The level of services may range from simple photocopying to extensive electronic document management, adding further complexity to establishing a fair price. A fair market value is defined as the price a willing buyer pays a willing seller. When the worker's representative can select the service provider without concern for cost and the claims administrator must pay the cost without the opportunity to shop for a competitive price, then there is no open market and the situation promotes billing disputes.

One possible way to reduce disputes would be to allow claims administrators to contract for competitive price schedules for defined levels of service from multiple service providers and then allow a worker's representative to select service providers at the contracted rates. A more familiar way to reduce disputes would be for the Administrative Director to adopt fee schedules that reflect the fair market value of the various service levels and the indications for what service levels are appropriate.

The large number of copy service liens adds to the burden on the courts. The exact number cannot be routinely monitored due to the fact that the Form 6, "Notice and Request for Allowance of Lien," does not provide for the separate identification of copy service liens. Even if the Form 6 were to require separate identification of liens for copy services together with the legal basis for the claim (e.g., section 4621 medical-legal expense, section 5811 cost), some sort of enforcement would be required to overcome the widespread indifference to the accuracy of representations made on the Form 6.

Recommendation 22: The Administrative Director should adopt a fee schedule and ground rules for payment of copy services.

Recommendation 23: The Form 6, "Notice and Request for Allowance of Lien," should be revised to identify liens for document copying services as well as the grounds for claiming the lien.

Interpreter Liens

Interpreter liens are the third most frequent type of liens after medical treatment and copy service liens. The data show interpreter liens at 7% to 11% of all liens.[28] Even this seemingly modest percentage equates to thousands of liens competing for the limited resources of the court, generating litigation expenses for employers, and delaying payments to interpreters. Interpreter liens are one of the subjects under consideration for consolidated proceedings by the WCAB Los Angeles District Office.

The survey did not request information about the causes of interpreter liens. For that, we look to the statements of the Presiding Judge and participants at an October 25, 2010 hearing at the WCAB Los Angeles District Office. The hearing was set by the Judge to invite discussion of the possibility of consolidating cases to more efficiently resolve common issues of law or fact that arise time after time in interpreter liens. Based on a report of the hearing and petitions filed subsequent to the hearing,[29] it appears that these are frequent issues which might be clarified by appropriate statute or regulation:

- When is the defendant liable for the cost of an interpreter other than the events prescribed in Rule 9795.3(a)? Those prescribed events include court proceedings, depositions, medical-legal examinations, and certain other events as provided in section 5811 and Rule 9795.3(a). The responsibility for interpreter expenses for medical treatment is not spelled out by statute or regulation, and it is often subject to dispute.

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[28] Interpreter liens numbered 105 out of 1,520 liens in the survey or 7% of the observations in early 2010. Interpreter liens numbered 1,555 out of 11,771 e-filed liens, or 13% of e-filings in the first five months of 2009. Interpreter liens numbered 30 out of 285 paper liens sampled from five Southern California offices filed in that same period. The weighted composite of e-filings and paper filings was 11% for filing dates from January through May 2009. The decline from 11% in 2009 to 7% in 2010 could reflect sampling error or it could reflect an increase in the numbers of other types of liens causing interpreter liens to become a smaller percentage of the total, even while the number of interpreter liens per month appears to have increased between the five-month sample period in 2009 and the three-month sample period in 2010.

[29] Petitions may be found at http://www.dir.ca.gov/dwc/Liens/InterpreterLiens.pdf and a report is found at http://www.lexisnexis.com/COMMUNITY/WORKERSCOMPENSATIONLAW/blogs/workerscompensationlawblog/archive/2010/10/28/california-presiding-judge-frank-hearing-los-angeles-wcab-district-office-notice-intent-consolidate-interpreting-liens.aspx, both accessed November 23, 2010.

- Is an interpreter entitled to bill each defendant in full for the duration of an engagement, or should an interpreter bill each defendant pro-rata when engaged to appear for multiple cases concurrently, as often occurs at WCAB hearings?

- How is the appropriate rate of payment for an interpreter determined?

- What are the qualifications for an interpreter, and how do the interpreter's qualifications influence the determination of the rate of payment? For example, is the defendant required to pay for interpreting services furnished by a bilingual employee of a medical provider if that person has no recognized credentials as an interpreter?

According to Judge Frank, "Legislation to clarify these common issues of law could relieve the court of a massive number of lien filings and lien hearings." Having the same questions decided in hundreds or thousands of individual cases can produce inconsistent outcomes as well as consume inordinate court time. Where the law is ambiguous, one possible solution is to resolve the issue though consolidated hearings or precedent decisions, but this is still time-consuming and may not produce the ideal public policy. It would be in the best interest of the State as well as workers and employers if the Administrative Director were to adopt interpreter fee schedules and ground rules to resolve these questions.

> "The WCAB is awash in interpreters' liens partly as a result of the absence of guidance that could have been provided by statute or regulation."
>
> California Workers' Compensation Interpreters' Association, argument in opposition to consolidation, December 2, 2010.

We must consider the existing regulations before we can formulate recommendations for improvements. Fees for interpreter services are addressed in Rules 9795.1 through 9795.4.

The regulations are silent as the entitlement to payment for interpreting services outside of the events listed in Rule 9795.3(a). It remains to be determined whether existing statutes give the Administrative Director authority to address this issue.

The regulations define a "qualified" interpreter as one who is certified or provisionally certified, as those terms are defined. By implication, no interpreter fees are payable to an interpreter who is not qualified, but the regulations are not entirely clear. This may require clarification if interpreter services are reimbursable in connection with medical treatment (a question which remains open to debate) and a person who is not "certified" or "provisionally certified" acts as the interpreter.

Rule 9795.1 recognizes a "certified" interpreter as one certified in accordance with either Government Code Section 11513 or Gov. Code section 68562. Section 68562 pertains to Superior Court interpreters. Gov. Code section 11513 has nothing to do with interpreters. The rule should probably be amended to refer to Gov. Code sections 11435.30 and 11435.35. The WCAB is one of 25 state agencies mandated to provide language assistance in adjudicative

proceedings according to Gov. Code section 11435.15(a). Gov. Code section 11435.30 provides for the State Personnel Board (SPB) to certify administrative hearing reporters for this purpose, and section 11435.35 covers medical examination interpreters. The SPB website states that SPB is not conducting testing for Medical Examination or Administrative Hearing Interpreters due to budget constraints. That web page[30] is dated 2008, and we have been told that these tests have been suspended for several years.

Rule 9795.1 recognizes a "provisionally certified" interpreter as one who, when a certified interpreter cannot be present, is deemed qualified by the hearing officer or by agreement of the parties. This regulation is consistent with Gov. Code section 11435.55. Reliance on "provisionally qualified" interpreters may be necessary in light of SPB's suspension of testing for new certifications, but without any meaningful standards, it may erode the integrity of judicial proceedings. It also makes it difficult to evaluate the fair market value of an interpreter's services. A nephew who sits in on a medical exam is probably not entitled to the same payment for services as an SPB-certified Medical Examination interpreter. The Administrative Director, Court Administrator, or the Appeals Board may consider adopting regulations to recognize third-party certification as an alternative to SPB certification so that all persons claiming payment for interpreting services could be held to some standards of interpreting skill and linguistic ability.

Rule 9795.3(b) prescribes fees by the quarter hour for some events and by the half day or full day for others, all based on the supposition that the interpreter is engaged in one event at a time. The regulation does not address the common situation of an interpreter appearing for multiple cases that are set concurrently at WCAB district offices.

Under existing regulations, the payment rate is the greater of the local Superior Court rate or the market rate. The qualifications for Superior Court interpreters differ from SPB-certified Medical Examination Interpreters or Administrative Hearing interpreters, so the Superior Court rate may be an inappropriate starting point. Nevertheless, the rule prescribes that the rate can only go up if the "market rate" is higher. "Market rate" is defined by what an interpreter has been paid recently. (Rule 9795.1(h).) The definition does not give consideration to the amount one would pay to obtain equivalent services in an open market. The "market rate" can be different for each interpreter in the community. It has been reported that some interpreters at medical appointments are charging more than the physicians.

In contrast to the "market value" used in existing regulations, the legal concept of "fair market value" is the price a willing buyer pays a willing seller. If applied to interpreter fees, "fair market value" would promote more uniformity of rates based on the interpreter's qualifications and the supply and demand for a given language service in a given geographic area.

[30] http://www.spb.ca.gov/cmsPrint.aspx?id=5286, accessed December 3, 2010

Along with permitting arbitrary charges by interpreters, the uncertainty engendered by the existing regulations allows claims administrators to underpay or delay payment without consequences. The "market rate" definition in Rule 9795.1 does not reflect free market values, nor does it promote efficient and predictable payment processes.

The Administrative Director could adopt and maintain a fee schedule that reflects the fair market value within each District Office venue or within each county. Different rates may apply depending on the qualifications of the interpreter and the type of event. The Administrative Director may consider recognizing certification by a designated third party as a prerequisite to payment for services or at least as a factor in the determining the fee.

If nothing else, the Administrative Director should allow either party to prove "fair market value" in rebuttal to the Superior Court rate, rather than only allowing an individual's "market rate" to increase the fee above the Superior Court rate.

> **Recommendation 24: Either regulation or statute should be adopted to clearly prescribe the events for which interpreter services are payable.**
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> **Recommendation 25: Either the interpreters' fee schedule should provide for apportioned billing when an interpreter serves multiple cases concurrently, or the WCAB should contract for interpreters to attend hearings and proportionately bill the defendants in each in which they participate.**
>
> **Recommendation 26: The Administrative Director should amend the fee schedule for interpreter services to promote uniformity and to make the fees generally commensurate with the fair market value of the services.**
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> **Recommendation 27: One or more independent organizations should be identified whose accreditation can serve as an alternative to SPB certification for medical examination and administrative hearing interpreters.**

Frequent Flyers

Relatively few lien claimants account for a disproportionately large share of the medical liens filed.

Our ability to identify individual lien filers is limited to the e-filed data set and a small subset of the sample of paper lien claims. The survey data did not identify individual claimants.

In the e-filed data, there were 16,844 medical liens claiming a total of $237,625,019. Twenty-six percent of them (4,467 liens) were filed by one claimant, aggregating $24,709,407, or 10.4% of the dollars claimed in e-filed medical liens. The next largest volume e-filer of medical liens had 5.6% of the total number of e-filed liens. The top ten e-filers of medical liens, by volume, are briefly described below. This list excludes a health care plan that would provide services to

its members regardless of occupational causation. The remaining top e-filers all presumably undertook their services in anticipation of being paid by workers' compensation, and each of them accounts for at least 1.5% of the total volume of e-filed liens. Collectively, these ten enterprises filed 8,833 disputes amounting to more than $59 million in the first 16 months of the e-filing system.[31]

1. Durable medical equipment (DME) provider specializing in electrotherapy devices and cold or heat therapy devices.
2. Provider of computerized ROM testing, muscle testing, and functional capacity evaluations.
3. Provider of functional capacity evaluations.
4. A physician (pain specialist).
5. DME provider specializing in electrotherapy devices.
6. Spinal surgery center.
7. Hospital, apparently general practice, not specializing in workers' compensation cases.
8. Collection service associated with a compounded drugs provider.
9. An orthopedic and cosmetic surgeon, individually and through his corporation.
10. A multi-location chiropractic corporation.

An important caveat in interpreting this information is that the early participants in e-filing do not necessarily reflect the composition of the 86% of liens that are filed on paper. Subject to that caution, we can suggest that at least two types of services are highly susceptible to disputes that result in liens:

- DME, such as electrotherapy devices (TENS units, for example) and hot/cold therapy devices.
- Diagnostic testing and functional capacity testing.

The frequency of these disputes could be reduced if the medical necessity of these goods and services could be more clearly determined by the medical treatment guidelines and the appropriate reimbursement could be more clearly determined by the Official Medical Fee Schedule. DME liens exemplify how incomplete fee schedules and incomplete treatment guidelines foster lien disputes.

[31] In reaching these numbers, each e-filing transaction was regarded as a unique claim for payment for goods or services in the face amount of the claim. No adjustment was made for amendments or duplications. See Appendix regarding amendments observed in paper liens and duplications identified in the survey data. Further examination of the e-filing records might reveal whether amendments and duplications are similar in e-filed liens compared to paper filed liens.

We were able to review the supporting bills in several DME liens because we copied an additional sample of 62 liens randomly drawn from the boxes of paper liens from DWC. Forty-four of the 62 liens were medical, and 6 of those were for DME. One is for hot therapy and cold therapy systems, four are for electrotherapy devices, and one is for both electrotherapy supplies and cold therapy devices. In all of these cases, the devices are identified by codes for the class of device and perhaps a few words of vague description, but not by any further information that would permit comparisons to other devices on the market. Therefore, it is difficult to determine whether the charges in the liens are reasonable when seemingly similar devices are available elsewhere for one-twentieth of the price charged by a lien claimant.

EO236 is a code for a cold therapy system. Cold water is circulated through a pad or wrap that is applied to the affected part of the body. The price to rent the device for 12 weeks in one lien was $5,460. In another case, the price of a water circulating cold pad for 12 weeks was $6,730. Elsewhere, cold therapy devices with code E0236 are advertised for sale for as little as $120 to $130.

E0217 is a code for device that is related to the cold therapy system, except that it circulates hot water. In one lien, a hot therapy system was rented for 12 weeks at a price of $5,880, while a hot water therapy system with the same E0217 code is advertised elsewhere for under $200.

The lien for both hot and cold devices amounted to $11,340 in charges for 12 weeks of home use of these devices. The prescribing physician is one who is also prominently identified with compounded drug prescribing.

Four of the liens are for electrotherapy devices. Codes found in these four liens include E0745, E0769, and E1399. These include transcutaneous nerve stimulators (also called TNS units) and electromuscular stimulators and other variations. That last code is particularly unhelpful for price comparisons, since it is a catch-all for "durable medical equipment, miscellaneous." The prices for the electrotherapy devices in these liens were $1,140, $2,999, $2,995, and $3,200. While comparisons are uncertain because of the limited information available about the particular devices, the prices are far in excess of the $100 to $500 range for TNS units and electromuscular stimulators advertised elsewhere.

Along with the electrotherapy devices, the liens included supplies such as electrodes, lead wires, and batteries. Commonly available electrotherapy devices use conventional 9-volt batteries. The charges for batteries in these liens (battery type not specified) were $50 to $60.

DME liens are a consequence of the lack of guidance in the Official Medical Fee Schedule to determine reasonable prices and the lack of guidance in the medical treatment utilization schedule to evaluate the medical necessity of these devices.

> **Recommendation 28: The subjects of liens should be monitored, and the subjects that arise most frequently should be considered as candidates for improved guidance by the medical treatment utilization schedule and/or applicable fee schedules.**

"Garbage In" from Lien Filers

The information submitted by the parties is often incorrect. A certain degree of confusion is to be expected with the adoption of new EAMS forms, but we observe errors demonstrating that some parties are not even trying. The DWC Form 6, "Notice and Request for Allowance of Lien," requests certain information, but there appears to be no consequence for lien filers who systematically ignore those requirements.

The most glaring example is in the type of lien claim, where the DWC Form 6 offers ten choices. Many lien claimants seem not to know what type of lien they are claiming.

The ninth box is "The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)" Only the Asbestos Workers' Account administered by the Director of the Department of Industrial Relations can be a claimant under that section. Nevertheless, 3% of liens in the District Office samples (13 out of 450) claimed to be filed under this provision. One was an interpreter; the rest were medical providers.

Four of those thirteen "Asbestos Workers' Account" liens were filed by one doctor. This doctor is a qualified medical evaluator (QME) who also shows up in the e-filings with 44 medical treatment liens and 29 medical-legal liens. This is someone who presents himself as being knowledgeable about workers' compensation and has chosen to make it his business to do business in the workers' compensation system, yet does not bother to learn how to complete a standard lien form.

Another sign of indifference is the large percentage of "other" liens checked. In the District Office samples, 15% were marked "other." In the e-forms, 37% of the liens were self-declared "other," but moving just the most frequently occurring names into the categories that obviously fit their names (medical providers to "medical," attorneys to "attorney fee," etc.) would bring the "other" category down to about 2% of the e-filed liens.

Even the names of lien claimants can be inaccurate. The one lien claimant with the largest volume of e-filings misspells its own name so that at least seven different names have to be combined to determine how many this company filed. The second most frequent e-filer used at least ten different spellings. The misspellings amount to only a fraction of a percent of all the liens e-filed by these organizations, but they serve as a reminder that the identity of the lien claimant may not always be clear, especially in the less structured paper liens. Especially with lien collectors, anecdotal reports indicate that it can be very difficult to determine exactly who is the entity asserting the claim.

These are just a few examples of one type of indifference. Repeated over and over, the accumulation of faulty data makes a farce of the entire process. As long as there are no consequences for willful disregard of the accuracy of the information, the lien claim forms

cannot reliably give notice to the parties of the nature of the claims in dispute or even the exact identity of the claimant.

The lax rules of worker's compensation proceedings were intended to make the system accessible for injured workers who are in the system by no choice of their own. There is no justification for allowing the same latitude for enterprises that choose to make their living from the workers' compensation system.

Recommendation 29: Liens by frequent filers that state incorrect lien type or make other material misrepresentations should be subject to substantial penalties, ranging from mandatory sanctions to dismissal with prejudice for repeat violations.

Neither the court nor the parties have the luxury of time to figure out what a claim is really about when an experienced lien claimant is careless with the facts. Mistakes can be tolerated for an inexperienced lien claimant, but not for one in the business of furnishing services in workers' compensation or for any person or entity acting as a collection agent or assignee of the original owner of the claim.

Recommendation 30: Lien claimants should be required to use EAMS Uniform Assigned Names (UANs), and until UANs are assigned, lien claimants should be required to use correct legal names.

EAMS does not currently provide UANs for lien claimants, let alone require their use. Until it does both, lien claimants should at least disclose their true identities. In most cases, this is just a matter of clarifying who the party is. In some cases, it is a matter of unmasking fraudulent misrepresentations.

Conclusion

As representatives of employers and employees, we are not satisfied with a system where millions of the dollars that employers pay for workers' compensation are wasted, providing no benefit to injured workers. We can be outraged by particular situations, but it is not enough to point fingers. Unwanted behaviors – whether they be indefensible delays and denials by payors or exploitative charges and practices by service providers – are occurring because they are being rewarded by the system we have today. Liens show us where the system should be improved.

Wherever there are frequent liens for medical treatment, medical-legal expenses, or other services, there is a need for statutes or regulations to offer clear guidance to inform the parties of their rights and a need for the courts to enforce those rights. Economic incentives should be designed to reward the behaviors that most efficiently apply employers' dollars to produce injured workers' benefits.

Continued monitoring is necessary. This study is just one step toward identifying the problems and framing solutions. Many areas require more in-depth examination than we have given here. Policymakers should remain receptive to other solutions consistent with the overriding goals of delivering appropriate benefits to injured workers while keeping workers' compensation affordable for employers. Ongoing examination of the workers' compensation system can enable policymakers to make informed decisions for the interests of all Californians.

Appendix 1. DWC Form 6, Notice and Request for Allowance of Lien

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien: _____ (MM/DD/YYYY) ☐ Original Lien ☐ Amended Lien

Case No. _____

(Choose only one)

☐ a specific injury on _____ (DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

SSN (Numbers Only) _____ (DATE OF BIRTH: MM/DD/YYYY) _____

Injured Worker:

First Name _____ MI ____

Last Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Attorney/Representative for Injured Worker:

Name _____

Address/PO Box (Please leave blank spaces between numbers , names or words) _____

City _____ State _____ Zip Code _____

Lien Claimant (Completion of this section is required):

Name of Organization filing lien (for individual lien claimants, leave blank) _____

First Name of Individual filing lien(organizational lien claimants, leave blank) _____

Last Name of Individual filing lien(organizational lien claimants, leave blank) _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Phone _____

DWC/ WCAB Form 6 (Page 1) Rev(11/2008)

Lien Claimant's Attorney/Representative, if any

☐ Law Firm/Attorney ☐ Non-Attorney Representative ☐ Lien Claimant not represented

Lien Claimant Law Firm/Representative

First Name

Last Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Employer

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier or Claims Administrator

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

DWC/ WCAB Form 6 (Page 2) Rev(11/2008)

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ _____ against any amount now due or which may hereafter become payable as
Total Lien Amount
compensation to the above-named employee on account of the above-claimed injury.

This request and claim for lien is for (mark appropriate box):

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- ☐ Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The reasonable fee for interpreter's services performed on _____ 20 ___ . (Labor Code § 4600 (f).)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)

☐ Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

_____	_____	_____
(Signature of Attorney/Representative for Lien Claimant)	(Signature of Lien Claimant)	Date (MM/DD/YYYY)

DWC/ WCAB Form 6 (Page 3) Rev(11/2008)

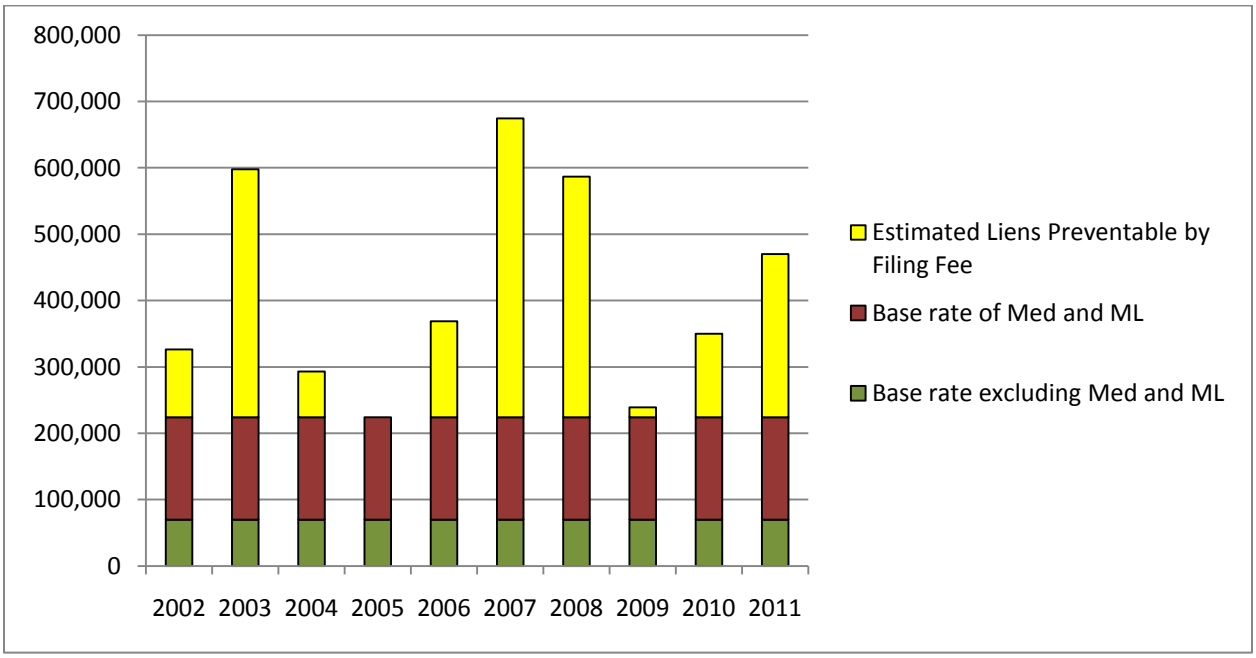
Appendix 2. Additional Considerations for Filing Fees

In view of the fact that the number of liens is a problem in itself and the fact that the number of liens was reduced by the filing fee, policymakers may consider reinstituting a filing fee.

The graphic in Figure 1 clearly demonstrates that the volume of liens was affected by the adoption and subsequent repeal of a $100 filing fee. Unlike EAMS which suppressed lien filings only temporarily, the filing fee continued to hold down the number of lien filings as long as the fee remained in effect.

The number of liens that would be prevented by a filing fee is estimated to be approximately the difference between the number of liens filed in 2005 while the fee was in effect and the number filed in each year since 2005. The base rate established in 2005 includes liens that were not subject the filing fee (liens other than Medical or Medical-Legal) and liens that were filed with payment of the filing fee. The number of liens filed in excess of that base rate is the number that may be eliminated by the re-imposition of a $100 filing fee. The following chart provides a rough illustration of the proportion of liens that may be prevented by a filing fee. The numbers have not been corrected to account for amended liens or for trends that might affect the number of liens that would be filed regardless of the re-imposition of a filing fee.

Figure A2-1. Effect of Filing Fee on Number of Medical and Medical-Legal Liens



A $100 filing fee could prevent the filing of over 200,000 medical and medical-legal liens predicted for 2011.

Ideally, the filing fee would most likely to deter meritless liens. It is not feasible to empirically evaluate that selective effect. Undoubtedly, some meritorious liens were impacted, as well. For example, one health plan has stated that it raised the threshold below which it would not seek recovery by lien. In an effort not to penalize the filers of meritorious liens, the statute provided for the payor to reimburse the lien claimant's filing fee if any part of the lien was found payable. [32] This solution failed because the right to reimbursement was routinely sacrificed to get a claim settled short of trial. Similarly, lien claimants report that to reach settlements, they often have to give up their right to a 15% increase in payment, plus interest, when claims administrators have not timely paid or objected as required by section 4603.2.

In the event that a filing fee is contemplated again, it may help to review the first experience more closely. The $100 filing fee was enacted by Senate Bill (SB) 228 signed into law on September 30, 2003, and becoming effective January 1, 2004.[33] Emergency regulations had to be adopted to implement the filing fee on such short notice. These regulations were subsequently deemed invalid because they were adopted by the Administrative Director rather than the Court Administrator (who had not yet been appointed) as required by statute. An acting Court Administrator was appointed, and permanent regulations were adopted effective June 30, 2004, so that fees were to be collected for liens filed after that date. By that time, SB 899 had amended section 4903.5 to clarify that the fee was applicable to liens on behalf of providers as well as liens filed directly by providers of medical services and medical-legal services. One of the problems experienced by parties while the filing fee was in effect is that defendants questioned whether the filing fees had actually been paid, and the bulk filers were unable to produce individual filing fee receipts.

The filing fee was repealed effective July 12, 2006, by Stats. 2006 ch. 69 (AB 1806). The reasons for the repeal are believed to be a combination of protests by lien filers and the administrative inconvenience of collection. A DWC representative remarked that it cost more to administer than the amount that was collected.

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[32] Section 4603.2(b)(1) provided, *inter alia*, "If any contested itemization is determined payable by the appeals board, the defendant shall be ordered to reimburse the provider for any filing fees paid pursuant to section 4903.5."

[33] Section 4903.05 was added, as follows:
"(a) A filing fee of one hundred dollars ($100) shall be charged for each initial lien filed by providers pursuant to subdivision (b) of Section 4903.
(b) No filing fee shall be required for liens filed by the Veterans Administration, the Medi-Cal program, or public hospitals.
(c) The filing fee shall be collected by the court administrator. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund. Any fees collected from providers that have not been redistributed to providers pursuant to paragraph (2) of subdivision (b) of Section 4603.2, shall be used to offset the amount of fees assessed on employers under Section 62.5.
(d) The court administrator shall adopt reasonable rules and regulations governing the procedure for the collection of the filing fee."

Additional Recommendations Relating to Filing Fees:

1. A filing fee should discourage the filing of inappropriate lien claims:

    a. Filing fees should not be required of certain publicly-funded claimants such as the Veteran's Administration, Medi-Cal or public hospitals.

    b. Filing fees should not be required of liens which are claims against the employee's indemnity benefits, such as EDD liens or Family Support liens.

2. To minimize the adverse impact on meritorious lien claims, streamlined adjudication with limited rights to appeal should be made available for smaller liens.

3. Streamlined adjudication would also enable prevailing lien claimants to collect the additional payments and interest which are prescribed by section 4603.2.

4. DWC can manage the payment of filing fees using available technology including EAMS, so that any interested party can confirm that the fee has been paid.

Appendix 3, Adjusting the Estimates for Duplicates and Amended Liens

A duplicate lien may be filed when the same claim is filed in two or more cases, such as when several injuries contribute to the need for medical treatment. Duplicates may also appear in the data due to multiple copies of the same lien being logged by the survey respondent.

When two or more lien records with identical amounts were found in the raw data of 1,901 records in the survey, the records were flagged as potential duplicates if they matched on either the date of injury or the date of first services. Any record that was doubly flagged (same amount, same date of injury, and same date of first service) was automatically deemed to be a duplicate. If only one flag was set (same amount and either same date of injury or same date of first service), other fields were manually examined. In most cases, singly flagged records were interpreted as duplicates but in some cases there were sufficient other differences that the similarities were judged to be coincidental. Where a duplicate was found, one record was discarded.

Removing the duplications reduced the total amount in dispute in the survey data by almost 4%, and it reduced the number of liens by 4.6%

An amended lien may be filed to restate the amount in dispute when there are charges for services rendered or credits for payments received after an original lien was filed. The total amount in dispute will be overstated if both the original lien and amended lien are added together. When preliminary results of the survey were presented, one commenter said that the apparent dollar value could be double or triple the true amount in dispute. In this section, we describe how one subsample in our data enabled us to estimate the effect of amended liens in our analysis. We conclude that due to amended liens, the number of medical lien disputes is over-counted by about 8%, and the aggregate dollar sum in dispute is overstated by approximately 10% and possibly as much as 18% or as little as 5%.

Our original data collection did not attempt to identify amended liens, and there is no administrative database to identify amended liens. EAMS does not recognize amended liens, so filers are instructed to always check the box for "Original" even when filing an amended lien One of our data sources was paper liens from five Southern California district offices that had been sent to DWC headquarters for scanning into EAMS. We kept a copy of every 30th lien from each box. This produced a set of 62 liens available for further examination.

If only a small fraction of liens are amended, a sample of 62 liens could easily miss them. The more common they are in the general population, the more certain it is that they will be represented in the sample. These five offices account for over half of all liens being filed in the state, so the sample is representative of at least half the liens in the state. The proportions of medical treatment (44), medical-legal (9), interpreter (8), and attorney fee (1) liens in this sample are similar to the proportions in the survey of claims administrators handling claims

statewide. That similarity confirms that this small sample can detect patterns that occur frequently in the general population.

One limitation of this sample of paper liens is that it does not include EDD liens or copy service liens, each of which is at least 5% of the population in the claims administrator survey. The difference is probably explained by the fact that high-volume filers are more likely to be using electronic filing, which bypasses the paper-scanning process. This is not a significant limitation because we are not analyzing EDD liens and because copy services liens comprise a small percentage of the dollars in dispute.

Out of 53 liens for medical treatment and medical-legal expense, we were able to identify 49 liens as either amended or original. The remaining four liens had too little information to be characterized one way or the other. We combined medical treatment and medical-legal because some of the liens purporting to be medical-legal, including two that were amended, appear likely to be medical treatment claims. The total face amount of these 49 liens was $219,162.

Of these 49 liens that were identifiable as either amended or original, four of them, or 8%, were amended. We individually examined the liens and supporting bills to identify original versus amended liens. A lien was considered to be original if the entire amount of the charges was incurred on a single date of service. A lien was likely to be amended if the amount of the lien claim was substantially larger than the amount of the accompanying charges and the charges appeared to be the latest in an ongoing series. The four amended liens included $20,449 of charges that had been filed in earlier liens and $1,883 in new charges for services added by the amended liens. To avoid overstating the amount placed in dispute by the liens in this sample, we must deduct $20,449 or 9.3% of the total face amount.

A sample of this size does not support precise quantitative analysis. We estimate that the effect of amended liens in the general population could be as little as half or as great as double the effect observed in this sample. Therefore, we estimate that when the scale of the lien problem is being measured by a sample or survey that does not distinguish amended liens from original liens, the total dollar value appearing in dispute should be reduced by a figure in the range of 5% to 18%. For a single point estimate of the required correction, we round our observed value up to 10%.

Appendix 4. Table of Number of Liens Filed Yearly at Each WCAB Office

Figure 4 provided a visual depiction of the predominance of a few offices in the total volume of liens filed each year. The source data furnished by DWC is shown below. We have omitted the 2009 figures because they were incomplete when we obtained the data early in 2010.

	2000	2001	2002	2003	2004	2005	2006	2007	2008
LAO	61,602	64,417	83,939	124,265	48,542	30,387	62,680	120,579	93,302
VNO	58,959	51,972	78,118	116,680	55,118	32,870	60,559	121,956	86,111
MDR	33,630	41,882	49,891	72,843	28,983	20,758	38,926	83,320	73,185
LBO	21,275	22,826	33,303	44,312	18,921	14,828	30,157	61,090	56,068
ANA	20,283	21,705	30,122	53,286	18,809	12,401	21,861	42,254	38,133
AHM	15,312	16,378	21,623	44,541	17,777	14,987	26,219	46,532	36,991
POM	12,271	15,222	20,842	33,964	16,946	11,972	18,506	36,673	33,404
SDO	7,780	8,963	12,930	18,446	10,906	10,491	16,408	26,203	23,971
SBR	10,827	11,579	14,826	26,658	12,982	8,925	14,475	24,810	22,659
RIV	8,667	12,134	14,652	24,559	11,058	9,172	15,312	27,539	20,994
OAK	7,619	8,507	10,189	12,682	5,733	7,471	9,148	13,656	13,121
FRE	6,501	8,151	10,461	15,162	10,766	10,242	10,883	14,850	11,663
OXN	12,303	12,661	16,663	30,382	10,072	6,384	8,238	15,601	10,941
BAK	3,903	5,950	6,899	14,205	6,128	4,221	5,625	10,564	10,858
SFO	4,898	5,237	5,612	8,849	5,642	5,659	6,512	8,790	8,155
SJO	4,253	4,389	5,575	7,997	5,210	5,866	6,115	7,845	7,301
SAL	3,590	3,853	6,780	8,618	4,229	3,443	4,098	7,248	6,486
SAC	9,065	9,394	10,825	12,458	7,130	6,985	7,529	8,424	6,463
STK	6,522	7,137	8,649	10,861	5,875	6,697	6,176	7,800	6,014
GOL	2,150	2,169	2,924	4,757	1,808	1,553	1,765	2,798	3,354
SRO	3,193	3,208	3,463	4,168	3,803	3,660	3,251	3,409	3,204
RDG	3,383	3,560	4,413	4,402	3,343	3,796	2,525	3,027	2,463
GRO	1,655	1,360	2,036	3,726	1,467	1,428	1,318	1,404	1,640
EUR	554	581	642	1,759	589	712	584	635	632

Appendix 5. WorkCompCentral.com article on Statute of Limitations

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Return to : Panels Interpreting 4903.5 in Favor of Lien Claimants, Attorney Says

California -- Panels Interpreting 4903.5 in Favor of Lien Claimants, Attorney Says: ***Top*** **[03/20/08]**

Lien claimants are winning statutes of limitations disputes thanks to a recent trend of panel decisions pertaining to Section 4903.5 of the California Code, according to a Southern California attorney.

California Workers' Compensation panels have been interpreting in favor of lien claimants who failed to file an official lien within the statute of limitations mandated by Section 4903.5 of the California Labor Code, said Jon Brissman, a lien claimants' attorney from Colton, Calif.

He said originally workers' compensation attorneys may have viewed Section 4903.5 as "defense oriented." However, the statute has been benefiting lien claimants because Workers' Compensation Appeals Board (WCAB) panels have been interpreting the section in ways that have made it easier to establish a lien, he said.

Brissman said that recent rulings have held that:

- "Defendant's receipt of a contemporaneous bill establishes a lien regardless of whether a lien was filed with the WCAB [relying on language in 4904].
- Defendant's knowledge of services provided triggers defendant's duties to lien claimants under (WCAB rules) 10886, 10888 and 10890, regardless of whether the lien is listed in the Official Address Record.
- Defendant's failure to serve the settlement documents on a provider tolls the operation of 4903.5."

Brissman added, "Apparently, 4903.5 applies only to medical providers of which defendants have no knowledge at the time the case-in-chief settles. Those stealth providers, who would have had no rights prior to 4903.5, were given specific time frames in which an initial lien filing was permissible."

He cited several panel decisions, which are below (click on the website near each decision's name for the panel opinion):

- *Balcon v. SCIF,* http://www.workcompcentral.com/pdf/2008/misc/Balcon.pdf
- *Loc Tran v. Viet Nguyen Trucking,* http://www.workcompcentral.com/pdf/2008/misc/LocTran.pdf
- *Picos v. SCIF,* http://www.workcompcentral.com/pdf/2008/misc/Picos.pdf
- *Barajas v. Don Steve Chevrolet,* http://www.workcompcentral.com/pdf/2008/misc/Barajas.pdf
- *Chablet v. Staff Management*, http://www.workcompcentral.com/pdf/2008/misc/Chablet.pdf

The panels making these rulings include conservative panelists, Brissman said, before adding, "This isn't a liberal construing of the code."

"As far as I know, no one had ever been able to put them together to be able to show a judge that the board panels are consistent on their rulings on this," he said. Brissman said that these interpretations could lead to defense attorneys presenting less statute of limitations defenses, and potentially increase the use of laches defenses. He added that panels are still strongly encouraging lien claimants to file timely liens in workers' compensation cases.

York McGavin, a durable medical equipment supplier who frequently consults with lien claimants in a variety of court challenges, said that he has "yet to lose on this issue." He noted that out of the five cases Brissman provided, the *Loc Tran* decision describes all of the factors involved in interpreting the statute of limitations.

"When we serve a bill on a defendant, and they object to it, they are aware that we have an outstanding balance," McGavin said. He cited Title 8, Section 10301 of the California Code of Regulations, which defines a lien claimant as "any person claiming payment under the provisions of Labor Code Section 4903 or 4903.1."

"When we serve a bill on a defendant, and they object to it, they are aware that we have an outstanding balance," McGavin said. He cited Title 8, Section 10301 of the California Code of Regulations, which defines a lien claimant as "any person claiming payment under the provisions of Labor Code Section 4903 or 4903.1."

McGavin added, "That means that as soon as we claim payment, we automatically become a lien claimant, just by the virtue of claiming. The statute of limitations doesn't start rolling until all three of the conditions are met. That would mean 12 months from date of service, five years from date of injury, or six months from when the case was resolved. Of course, if we're never apprised of a case being resolved, the statute of limitations is tolled until we are apprised."

He said that he has frequently urged defense attorneys to notify all providers of service in a case.

James Pettibone, a managing partner for the Laughlin, Falbo, Levy & Moresi defense firm, said these cases appear to void the intended effect of Section 4903.5.

"The service of a bill may have the same effect as the filing of a lien," he said. "It gives the lien claimants little or no incentive to file a lien with the WCAB. As a result, the WCAB would have no notice of a lien until the lien claimant decides to have their lien adjudicated. The lien claimant's rights appear to be preserved as long as a bill has been served on the defendants before the compromise and release (agreement) is approved."

Pettibone said these panel decisions undermine the purpose of the statute of limitations, which was created to promote finality.

"This section was established to eliminate situations where a lien claimant demands payment years after a case has been closed," he said. "These decisions may well prevent adjusting agencies from closing their files and force the parties to litigate issues such as notice to defendants, the service date of bills, and the authenticity of documents. This litigation could take place long after the witnesses are available and relevant documents have been destroyed."

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