

Baker, Christine@DIR

From: Webb, Mark [mwebb@pacificcomp.com]
Sent: Wednesday, December 08, 2010 3:31 PM
To: Baker, Christine@DIR; Taylor, Lachlan@DIR
Subject: Liens
Attachments: 2842.pdf; 2842a.pdf; pw_b125564.pdf

While I understand that your efforts are focused on provider liens, it seems to me that if we are going to say that interpreter services fall under LC 4600 as a reasonably necessary medical benefit (which it seems to me to be) then we can give MPNs the discretion to develop a language assistance program (see attached) and at a minimum have these services available for accepted cases. The rest of the effort is to provide a reasonable reimbursement rate (including reasonable minimums). Take a look at Health & Safety Code Sec. 1367.04 for more information.

As to provider liens, I hope you are not doing anything that would result in unwinding what is happening at the LA Board. (I'm sure you're not but I had to say that.) As these cases move forward, I would think there is a wealth of information that would assist your drafting efforts. I would like to add into the mix that you should require the lien claimant to prove that the service for which the payment is sought is within the scope of the license of the lien claimant. I am hearing that this is a particularly vexing issue with DME suppliers.

I remain skeptical about thinking we can do what we need to do regarding liens solely by statute. That being said, I do feel we need to create a mechanism whereby a provider - especially one who is treating outside the MPN on an accepted case or is treating on a denied claim - must request notice along the lines of what I provided from the Probate Code earlier in this discussion. If we are going to live in the world of EAMS, I think there is every reason to expect a provider to request notice as part of the first visit process. I would like to see this go both to the employer and the Board, but I would be satisfied with this going to the Board and put payers on notice that they need to check things out periodically. I can see exceptions to this where the provider is in an MPN or HCO or where the provider has submitted a request for authorization and that request was approved - but I am not certain these are the scenarios that are generating the bulk of abusive filings. The requirement of filing a request for notice should be jurisdictional and would be a way to trigger the statute of limitations.

As to the factoring companies, while I think that practice is odious I also have an issue with denying a provider the ability to have an agent or assignee pursue the provider's right to reimbursement. That, of course, assumes that the provider still has a right to reimbursement. It also means that the amount to be reimbursed must be per OMFS or contract and not U&C. I think the pleading hurdle needs to be high on these companies but not impossible. This involves s/l issues as well as substantive issues. Similar to the issue identified above, I could see requiring these companies to file something akin to a UCC 1 within 30 days of agreeing with the provide to pursue collection. That would start the clock ticking and could be the first place to start to enforce some evidentiary requirements (like name of provider ,sates of service, etc.)

The issue of prompt pay - and for what - is obviously a critical problem that goes beyond liens. We clearly need to have better incentives for prompt pay. Part of that is having a fee schedule that is capable of more accurate administration by all concerned (I'm leaning toward doing revised CPT Codes rather than RBRVS because of the direction the DWC was going with RBRVS and the uncertainty of how Medicare is going to be funded going forward with the health care reform implementation.) If the data are there to do the revised CPT Codes it seems to me we would be better off doing something that is possible sooner rather than something that may never be resolved later. I do think the MPN regulations should make it clear that an MPN can have a dispute resolution process as part of its provider agreements. [Health & Safety Code Sec. 1367(h)] I fully realize that DMHC just thwacked a number of plans for not administering that process effectively, and that providers have issues with the DMHC contractor who handles billing dispute appeals. However, I also think that it is fundamentally unfair to shift the entire cost of administering the payment mechanism onto the provider. As a practical matter, reimbursements are getting so complicated that asking the provider to bill at fee schedule rather than U&C is not a viable option - especially with a still dysfunctional OMFS and not correspondingly requiring payers to pay at schedule (assuming one of the goals is to limit bill review costs).

This leads us to one of three avenues of discussion: (1) requiring the internal process to be utilized before a lien is filed (tolling the s/l) but correspondingly requiring a higher level of documentation by the provider if a lien is still sought after that process, (2) having a review process at DWC to address appeals from the internal process that must be followed before accessing the WCAB, or (3) establishing an entirely separate process of payment disputes that has no liens and no access to the Board (but still preserving the right to go to the Court of Appeal as required by the Constitution). I know

there are advocates for #2, but I have to say that unless the DWC forum can make a final adjudication of the amount owed then this seems to be an unnecessarily duplicative process. While #3 will produce considerable cardiac moments, there is something to be said for (a) completely delinking the case of the injured worker from billing disputes by providers and (b) taking this burden off the hands of an increasingly overworked and overwrought WCAB. I do not think there is a constitutional impediment to having an alternative forum and I think this can be accomplished without making this a forum for collateral issues.

Anyway, I have attached the two forms from Oregon that are used to address bill disputes. It doesn't have to be all that complicated other than making certain that it is actually used.

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Baker, Christine@DIR

From: Don Balzano [dbalzano@medexhco.com]
Sent: Friday, December 17, 2010 10:11 AM
To: Taylor, Lachlan@DIR
Cc: Baker, Christine@DIR; Lester Sacks M.D.; Geri Plotzke; David Kim
Subject: Report

Hi Lach:

What a great job with the lien report. You are going to really confuse some people with so many objective facts!!!

How about giving me a call at your convenience, or let's set up a time to talk. I want to discuss some comments I wish to make, but I would like your expertise prior to that.

As you know, CAAA has advocated for some time to have EEs treat outside an MPN if the AA's provider-partner or provider of choice is not a member of that particular MPN. They get desired medical reports that way, including TD and PD. Then they can have the providers fight the liens later on, hoping that the payer will eventually cave, or that some loophole (such as claims that the EE was not properly notified, the DWC-7 was not in a conspicuous place, or the hold harmless situation) can be found. Hearing functionally illiterate lien claimants making these arguments at conferences and trials, while pulling around 100 pounds of stale liens, makes me want to blow up the entire system.

As long as self-procured medical reports and retro TD by AMEs are being relied upon by the judges, this problem will continue to fester, even if the other suggested fixes are put into place.

Talk to you soon.

Don

Medex Healthcare, Inc.

Donald P. Balzano, Chief Legal Counsel

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Comment on "Liens Report" -- \$100 lien filing fee

Jon C. Brissman [jonbriss@earthlink.net]

Sent: Sunday, December 19, 2010 3:44 PM

To: CHSWC@DIR

To CHSWC Lien Report Authors:

As an attorney whose practice is entirely focused on representation of lien claimants in WCAB proceedings, I wish to comment on Recommendation #1, the re-establishment of a \$100.00 lien filing fee for medical and medical-legal providers. I submit that it is the wrong approach for several reasons.

First, the approach appears to reflect a bias that the lien backlog has been primarily caused by lien claimants. It recommends nothing to encourage defendants to promptly review, pay, or object to lien claims, and it fails to address the part of the lien backlog caused by workers' compensation judges failing to comply with the requirements of 8 C.C.R. Section 10888. Advocating strict compliance with statutes and regulations by defendants, lien claimants, and judges would go far to reduce the backlog without placing a burden on only one class of participant.

Second, a lien claimant must wait for the case-in-chief to resolve (which could take years) before it has standing to pursue recovery before the WCAB (8 C.C.R. Section 10770.6). The \$100 fee becomes an interest-free loan for the duration of the pendency of the case-in-chief plus whatever post-settlement time elapses before any recovery can be effected.

Third, it can be difficult for an injured worker on a contested claim to find a physician who is willing to treat on a lien basis. The imposition of a \$100.00 lien filing fee increases the risk that physicians willing to treat on a lien basis must take, and potentially convinces some physicians to reject all such patients from their practices. CHSWC should recommend approaches that encourage physicians to provide care to injured workers.

Fourth, Imposing a filing fee will not make the liens go away. Providers will simply send their liens directly to the claims administrators rather than filing them with the WCAB. Labor Code Section 4903.1 requires parties who have been served with liens to file them with the WCAB at the time that settlement documents are submitted for approval. In 2005, when a \$100 lien filing fee requirement was in effect, defendants virtually all ignored the statute -- none, to my knowledge, filed liens with which they had been served. Note that the Labor Code specifies no consequence to defendants' failure to comply with such filing requirements.

Fifth, defendants had liability to repay the lien claimant the \$100 lien filing fee if any portion of the lien was found payable (L.C. Section 4903.05). Many defendants refused to voluntarily reimburse the fee when negotiating a lien resolution, thus forcing the lien claimant to litigate or just donate \$100 to the General Fund. Some cases were therefore

added to the WCAB's busy calendar in order to enforce the statutorily-empowered filing fee reimbursement.

Sixth, the report did not clarify whether interpreters whose liens reflect services at medical or medical-legal appointments would also be included in the filing fee requirement. (The recommendation appears to specifically exclude interpreters' "cost" liens.) It could become difficult to find an interpreter for a medical-legal appointment, for instance, if in exchange for the possibility of perhaps collecting eventually on a valid \$90 fee the interpreter has to pay \$100, wait for the case-in-chief to resolve, then endure the gauntlet of litigation. It will be hard to convince that interpreter that the \$100 fee is not a punishment for unluckily encountering a claims administrator or defense counsel who is indifferent, indolent, incompetent, or intransigent.

I sympathize with CHSWC's goal of reducing (or eliminating) frivolous claims or disputes, but I suggest that the \$100 lien filing fee disparately impacts legitimate providers with small-dollar-amount liens. Such lien claimants may lose money by trying to obtain payment to which they are legitimately entitled. The one-size-fits-all approach is not narrowly targeted at the problem lien claimants and will wreak havoc amongst righteous providers.

I am hopeful that CHSWC can devise a strategy other than a lien filing fee to weed out frivolous claims and help reduce the backlog at the WCAB. I submit that defendants' roles in creating the backlog have been ignored or under-reported, and I look forward to see some recommendations to remedy the problems emanating from that quarter.

Jon C. Brissman
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Colton, CA
(909) 512-9205



Comments on CHSWC Draft Liens Report

December 22, 2010

To: The California Commission on Health and Safety and Workers' Compensation

From: Donald Balzano, Legal Counsel

I first wish to commend the Commission staff for accumulating the myriad objective statistics and the excellent recommendations contained within the report. We attempt to grapple with this seemingly overwhelming problem using our individual subjective experiences; now we all have an excellent data base from which we can propose alternatives and solutions.

There are no recommendations with which we would disagree. The purpose of these comments is to expand upon the recommendations that address particularly problematic areas with which I am familiar; it also enables me to add other recommendations, which we want the Commission to consider. While I have witnessed some payments that I felt were being unreasonably withheld by claims payers while at the Board for other reasons, I will leave this subject for others to address because that is not the situation with our employer and insurer program partners.

Filing Fees.

Notwithstanding administrative requirements, the necessity of reinstating a filing fee would appear to be obvious. There have been a number of studies regarding the institution of small and/or tiered copays for pharmacy and clinical utilization, all resulting in the same outcome: a significant decrease in consumption and costs, with no increase in subsequent interventions or office or emergency visits.

These copays, which closely equate to the purpose of lien filing fees, greatly reduce frivolous and unnecessary requests for treatment, just as filing fees would greatly reduce frivolous and non-meritorious liens. A system that allows claims to be made without cost and without penalty for abuse is illogical at best.

Arbitration Process.

Alternatively, perhaps the lien process should be removed from the WCAB entirely; a system of (certified) arbitrators could be instituted in its place. Arbitrators could be mandated, for all filings absent unusual exigent circumstances, to hear and adjudicate cases upon presentation.



Fees could be paid by one party, with the final fee disposition based upon the party who substantially prevails at the arbitration. Perhaps a reconsideration process to the WCAB (similar to the process in DWC-approved ADR carve-outs) might be put into place.

Frequent Flyers.

Something is incredibly wrong with this picture. It appears as though the court and claims personnel are well aware of these filers, and the issues that have created the chasm between demand and payment. Why are these not being specifically addressed to obviate repetitive filings?

MPN Control.

The legislature was clear when they passed Senate Bill 899: "an employer or insurer shall have the exclusive right to determine the members of their network." These networks are to provide all necessary medical treatment to injured employees. Why, then, are so many injured workers instructed to disregard appointments with or treatment regimens ordered by members of MPN networks?

It is because self-procured medical reports are very often allowed into evidence by the WCAB, while the providers of those reports clearly anticipate being paid after filing liens for intentionally self-procured medical treatments. It is considered advantageous by some stakeholders to have the existence of medical reports that address temporary and permanent disability in the most liberal manner, while simultaneously documenting the need for other various and sundry treatment modalities that are often not even tangential to the injury.

Medical reports intentionally procured outside a valid MPN should be inadmissible for all purposes before the WCAB. Only in this manner would the intent of the California Legislature be met. In addition, retroactive temporary disability from AME reports for cases in which the injured worker refuses to treat within the MPN should be denied. There are en banc cases for this proposition.

Filing liens which are denied because they are the result of unauthorized and self-procured treatment outside the MPN should have a substantial penalty attached to them. This penalty could be monetary and/or the inability to file subsequent liens, at least without substantial fees being paid.

Timing for the Filing of Liens.

Recommendations 11 through 17 are excellent. It might be that the filing of a premature lien would bar recovery, while a realistic, understandable, and enforced statute of limitations would be extremely welcome.



Interpreters.

For normal, routine, and the vast majority of medical treatment appointments, payments to certified interpreters should never be necessary; therefore, they should not be allowed. Predominantly, medical provider offices treat patients with specific language requirements, and, if the provider does not speak that language, they must have someone in their office that can do so. This should be a routine cost of conducting a medical practice. Statements have been made that there is a shortage of qualified interpreters; this should alleviate that problem.

Exceptions would include sub-specialists, for example, to whom various and diverse patients are referred for specialized treatment.

Fee Schedule.

There are many fee schedule disputes that regard the correctness or acceptance of the fee schedule modifier (time-based reimbursement). It might be advantageous to have access to medical professionals, e.g., retired physicians, who could readily ascertain the accuracy of billings based upon the diagnostic code and level of severity as evidenced by the history, examination completeness, and medical treatment decision.

Misrepresentation as an Authorized Provider.

The following is an example of one experience pertaining to this issue: one particular provider has been treating Medex HCO enrollees and MPN covered employees on a lien basis and has multiple liens filed at various WCABs in Southern California. All treatment is outside the network, and the provider has been notified on many occasions that he/she is not in the network.

The lien representative files pages from an MPN other than Medex with the court, with the name of the MPN removed, asserting that the provider is indeed a member of the Medex network. If this intentional misrepresentation does not attain an adequate amount of reimbursement, the claimant then refers to a different provider from the actual Medex network with the same name; they then maintain that this is the provider who filed the lien. This is done even though the provider listed in the network holds a different medical degree and designation, as well as a different office address.

Thank you for the opportunity to comment on this timely and outstanding report. The lien situation in California has become not only an embarrassment, but an overwhelmingly difficult challenge that is crippling the WCAB. There are other organizations attempting to address this issue, including a special committee of the Employers' Fraud Task Force, of which I am proud to be a member.

Baker, Christine@DIR

From: Baker, Christine@DIR
Sent: Tuesday, December 21, 2010 3:22 PM
To: 'dpattiz@thezenith.com'
Subject: Re: Lien Report

Thank you. Best wishes in the New Year.

From: Pattiz, Davidson <dpattiz@thezenith.com>
To: Baker, Christine@DIR
Sent: Tue Dec 21 14:28:00 2010
Subject: Lien Report

I wanted to compliment you on the draft lien report. It gathers information in a comprehensive and understandable way, makes some good points and valid recommendations. Our lien staff is reviewing the document now, as is Judge Foust. I hope you are getting positive feedback and that you have a happy holiday.

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Vela, Oliva@DIR

From: CHSWC@DIR
Sent: Thursday, December 23, 2010 10:28 AM
To: Vela, Oliva@DIR
Subject: FW: LIENS CLOGGING THE DWC SYSTEM

From: Karl Moody [karl.moody@lacity.org]
Sent: Tuesday, December 21, 2010 3:58 PM
To: CHSWC@DIR
Subject: LIENS CLOGGING THE DWC SYSTEM

To whom it may concern:

The problem with liens was to be expected in the busy environment of the WCAB Board Offices. As a public entity attorney, it is clear to me that much of the problem is related to simple greed and can be fixed with a simple legislative act along the following lines:

1. The State of California has enacted laws, rules, and mandated procedures for the fair and equitable payment of medical expenses in workers' compensation cases.
2. These laws and rules include statutory limits on medical costs as included in the RVS schedules for all medical treatments, modalities, medications, and durable equipment. The legislature has carefully determined what these costs should be and who should pay them.
3. The legislature must now take action to enforce their rules regarding medical costs in the WCAB system.
4. The current situation demands a draconian rule that will compel the medical community to abide by the previously enacted RVS and related rules by a simple statutory requirement that the Board shall deny in total, any medical lien that exceeds the RVS schedule for any medical services or products included in such lien, by more than 10% (ten percent). When the Board finds as a matter of fact that any lien, contains billings for such services or products that exceed the statutory RVS limits by more than 10%, the WCJ shall disallow the entire lien as a penalty.
5. Any defendant, employer, or carrier who determines that any bill for medical care exceeds the statutory limits by more than 10% may refuse to pay any part of such billing and shall file a Petition to Disallow such bill or a subsequent lien within 30 days of receipt thereof. If the WCAB later finds that such billing or lien was excessive, such bill or lien will be disallowed in its entirety. If found not to be excessive the lien shall be allowed and a 10% penalty thereon assessed against the defendant, employer, or insurance carrier along with costs in the amount of \$250.00 payable to the WCAB.

Since the state legislature has established the RVS schedule as the reasonable and fair value of such services or products, no medical provider should be allowed to bill in excess of such limits and then expect the WCAB to waste hundreds of thousands of hours each year litigating such excessive liens. Those who would intentionally submit bills in excess of the legal limits set by the state, should expect that such conduct will be rejected by the WCAB in the only way the lien claimants will understand. If you overcharge the medical billings by 10% or more, you risk losing the entire billing.

What doctor or medical provider should expect the State of California to defend their right to flaunt the rules of law established by the same state?

A carefully drafted law that makes clear the penalty for overcharging the carriers, employers, the cities and counties and the state of California, will likely end the proliferation of serial lien filers who have found an easy mark in the WCAB system. Choke the cheats and not the WCAB system.

Karl Moody, Esq.
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Vela, Oliva@DIR

From: CHSWC@DIR
Sent: Thursday, December 23, 2010 10:28 AM
To: Vela, Oliva@DIR
Subject: FW: Public Comment on Draft Liens Report

From: Pla, Fernando [Fernando.Pla@sedgwickcms.com]
Sent: Monday, December 20, 2010 7:08 PM
To: CHSWC@DIR
Subject: Public Comment on Draft Liens Report

Dear Members of the CHSWC,

Thank you for the careful research done on this very serious hurdle in our workers' compensation system. I am in agreement with your assessment.

From the perspective of an Operations Manager, I can attest to the fact that our southern California claims professionals are overwhelmed by the volume of liens received weekly. It appears there is a concerted effort in the lien claimant community to deluge the claims offices with duplicative liens. My office has witnessed lien claimants mailing and faxing the same lien every month, followed by collection calls made to the claims examiner, the claims supervisor and the operations manager!

I have observed that many liens are the result of non-MPN physicians treating and referring injured workers on a lien basis, even after being notified more than once that treatment is unauthorized, and requesting that the injured worker be returned to the MPN. Unfortunately, applicant attorneys have made it a customary practice to pull their newly represented clients out of the MPN, without good cause. This results in unnecessary WCAB appearances, and increased legal costs for employers trying to enforce the medical control that the Labor Code clearly grants them. I would submit that whenever applicant's counsel pulls an injured worker out of an employer's MPN, without good cause, they should be sanctioned by the WCAB, with assignment of defense costs to cover the unnecessary appearance. This would ensure that only merited MPN disputes are set on calendar.

In order to reduce the volume of duplicative liens, I would recommend that the legislature amend the Labor Code to allow that lien claimants only submit to the TPA or carrier an initial and a final lien (in the same way that they are required to file with the WCAB). Otherwise, the TPA/carrier should not be required to object to other than the initial and final liens.

Lien claimants should not be permitted to bill in excess of the OMFS without a clear justification attached to their billing, as many liens are nothing more than balance forwards on amounts exceeding the OMFS. Liens exceeding the OMFS without justification should be subject to WCAB sanction, as this is frivolous.

Given the sharp rise of fraudulent liens, I would suggest that all lien claimants be required to undergo a legitimate registration process with the DWC (including a registration fee) providing proof of business ownership (i.e. business license). Also, the WCAB can maintain a current status of any disciplinary action taken against any lien claimant (much like the QME disciplinary list). The registration fee can be used to offset some of the expenses of maintaining such a lien disciplinary list and lien claimant registration.

Thank you for your consideration.

FERNANDO PLA, AIC, WCCP, CPDM | Assistant Vice President | Operations Manager II

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Email Fernando.Pla@sedgwickcms.com

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Vela, Oliva@DIR

From: CHSWC@DIR
Sent: Thursday, December 23, 2010 10:29 AM
To: Vela, Oliva@DIR
Subject: FW: Comments on the CHSWC lien report

From: Spalding, Peter [Peter.Spalding@LibertyMutual.com]
Sent: Monday, December 20, 2010 2:23 PM
To: CHSWC@DIR
Subject: Comments on the CHSWC lien report

I agree with all 30 recommendations set forth in your draft report. I absolutely agree that both claims administrators and lien claimants need to be held more accountable, and that the DWC needs to provide clearer guidance to keep disputes to a minimum.

I would add, however, that Southern CA district offices should model their policies and procedures after the ones used in Northern CA. The reason why liens don't exist in northern venues (at least not to a significant extent) is because the behavior is simply not tolerated.

If a treatment or billing dispute arises in the Bay Area or Sacramento, then applicant's attorneys typically file for an expedited hearing. That is the proper venue for the dispute, whether it's a question of the MPN, utilization review, MTUS, or whatever the case may be. When administrators are found to have mishandled an issue, then they are penalized accordingly; but when requests are in fact found to be unreasonable, then the denials will typically stand. Either way, expedited hearings allow both parties to resolve their disputes quickly and equitably, and in most cases, the issues are resolved for good and do not recur in the future. In other words, this process allows injured workers to get whatever benefits they are rightfully owed, with a minimum of litigation.

That is in stark contrast to the practice in Southern CA, particularly in Los Angeles and Orange Counties. There, applicants' attorneys routinely refer injured workers to providers who will treat on a lien. These providers often make little or no attempt to get authorization under Labor Code section 4610; they simply render treatment and file their liens, sometimes without even issuing reports as required by CCR 9785. This makes it extremely difficult for claims administrators to determine whether treatment is medically appropriate and/or whether the bill should be paid. Moreover, as your report pointed out, lien claimants often make allegations without substantiating evidence; for example, they routinely demand penalties and interest, although they are frequently unable to show unreasonable delays that would trigger penalties under Labor Code 5814.

That being said, I agree with your analysis and conclusions. I encourage you to adopt the report in January, and I sincerely hope that the Legislature and the DWC adopt your recommendations going forward.

Peter J. Spalding
Team Manager
Glendale Commercial Market Claims
Phone: (800) 281-1120, ext. 2013
Fax: (603) 427-1804

Please let my manager know how I am doing. E-mail: Russell.Bledy@LibertyMutual.com

Comments on Draft Lien Report

Bob Achermann [BAchermann@amgroup.us]

Sent: Thursday, December 23, 2010 2:18 PM

To: CHSWC@DIR

Thank you for the opportunity to comment on the recommendations to deal with the volume of medical liens that are being filed and adjudicated. While we can agree with many of the suggestions for improving the current lien resolution problem, notably going to e-filing, we do have a concern with one recommendation and some comments.

First we have major concerns with the prospect of reinstating a \$100 filing fee for all liens. This cost may be disproportionate to some physician charges and could be an unfair disincentive to not pursue appropriate payment for services. In the case of radiology the charge for one imaging procedure could be less than \$200 and the filing fee is a significant barrier. This fee was abandoned some years ago and needs to be carefully analyzed. It may be best to exempt lines under a certain dollar amount or to require the losing party in the lien adjudication to be responsible for the fee.

We also note that the analysis seems to indicate that a fairly small percentage of providers are responsible for as large percentage of the liens that are e-filed. It would appear warranted to implement changes that address the specific abuses. Your chart on page 23 indicates that imaging accounts for about 7% of the liens and about 5% of the total dollar volume. Since radiologists are dependent upon a referral to perform the study and also likely a prior authorization for more expensive modalities, i.e. MRI or CT, it would appear that these limitations would provide necessary documentation as to whether the medical service should have been provided and hence paid. Perhaps these lien claims involve other types of situations that don't have this type of scrutiny, e.g. clinic or other non-radiologist physician does evaluation and imaging for diagnosis within their own facility. We would recommend that you review the ACR Imaging Appropriateness Criteria or other benchmarks that would be good unitization review criteria.

We appreciate the opportunity to comment.

Bob Achermann
Executive Director
California Radiological Society

Jorge Shuton [camedmanagementinc2@yahoo.com]

Sent: Thursday, December 23, 2010 2:55 PM

To: CHSWC@DIR

Cc: oti_incesmy@yahoo.com

**To The Commission on Health and Safety and Workers' Compensation
Regarding "Liens Report" for Public Comment.**

I would like my comments to be considered when your offices evaluate this serious issue regarding medical liens in our Workers Compensation System. I have been in this industry since 1989, representing lien claimants. Over these years many laws of been implemented to handle the numerous liens that have been filed, but unfortunately these laws have done little to resolve the issue. I believe the State must now look at what the real problem is, which does not lie with the medical providers. The actual problem lies with the workers compensation carriers. We have numerous laws that require the carriers to pay for the reasonable medical treatment and medical legal charges, but the courts allow them to continue to delay and deny the payable bills, which is the reason for the back log of liens in the courts. The carriers are allowed to deny payment for interpreter liens that were performed in court with no ramifications to the carriers, but a lien claimant. This type of abuse by the carriers goes on and on. For example I also represent AME physician's whose bills are not paid and rejected and yet the courts do very little to help this, we can file a DOR go to court and the bill gets paid but penalties, interest and costs and rarely if ever allowed. An AME is requested by both the parties and yet the carriers fail to pay those bills as well. Something is wrong with this picture, I have example after example of this type of abuse.

Its time for the State, to look at the carriers for the numerous liens that are being filed. Our offices appear on about 100 lien cases a week, wherein we resolve a large sum of them at the board. Had the carriers called or resolved these bills on the phone, all of us would have saved time and expenses. If the carriers are allowed to continue to delay and deny payment of these bills, more liens would be filed. If you have the Workers Compensation Carriers pay the \$100.00 filing fee in order for them them to be allowed to litigate liens at the board, I believe the lien filings would drastically fall. Having the liens claimants and not the carriers pay this bill would be unfair and unjust. The answer is to enforce the laws on the books, which require the carriers to timely pay the medical bills.

Jorge D. Shuton
CA Med Management, Inc.

Interpreting Services - RE: Lien Report

Darrin Altman [darrin@ci-inc.net]

Sent: Thursday, December 23, 2010 4:17 PM**To:** CHSWC@DIR**Cc:** Jackie Foigelman [jackie@ci-inc.net]; Gilbert Calhoun [Gilbert@Christina-Arana.com]; darrinaltman@gmail.com

Thank you for the opportunity to send comments regarding the Lien Report.

As a brief introduction, my name is Darrin Altman and I am the Vice President of Certified Interpreters, Inc. and have worked as an interpreter in the Workers' Compensation community for over 20 years.

- Regarding the amount of liens filed by interpreters, the commission must understand that large amounts are for services provided which are clearly allowed in the Administrative Rules and Labor Code. A great number of liens are filed for interpreting services that are provided at the Workers' Compensation Appeals Board, Agreed Medical Evaluations, Panel Q.M.E. Evaluations and other clearly defined services. The insurance carriers do not automatically provide payment. In fact, my office receives a tremendous amount of groundless objections to the above mentioned services. Most of the objections received do not even reference the service provided. We are therefore forced to file unnecessary liens and eventually Declarations of Readiness to Proceed.

A great number of lien fillings by interpreters would be eliminated if there was some type of consequence to an insurance carrier who objects to clearly legitimate and reasonable services with the intent to simply delay payment. Although there are provisions in the Labor Code for sanctions and in the past penalties and interest, Workers' Compensation judges are reluctant to enforce them when requested by interpreters.

- An interpreter who handles more than one conference at the Workers' Compensation Appeals Board is no different than an attorney who represents more than one applicant or an attorney who defends against various claims for different carriers. In theory, it may seem appropriate to prorate, because I believe the commission is under the assumption that the interpreter simply appears at the appeals board, provides a service and is automatically paid within a reasonable time. Interpreters working at the Workers' Compensation Appeals Board have all of the same types of expenses as attorneys and medical providers; expenses such as offices, utilities, collections, travel, etc. We cannot be treated on one hand as an independent service and on the other hand forced to bill as if we were an employee of the state or insurance industry. If the interpreters were actual employees of the court, provided with benefits and not forced to incur actual expenses, then I could understand the need to prorate the fees amongst the carriers.

- Regarding services provided by interpreters which are not clearly defined in AR 9795.3, specifically medical treatment, the commission must first understand that interpreters are not providing services for common day to day "treatment" visits. Interpreters are not being used or billing for physical therapy sessions or other types of services that the word treatment may entail. Interpreters are providing assistance during medical examinations that generate reports during the course of treatment; the exact services outlined in Labor Code §4600. Labor Code §4600 contains provisions for interpreters and the exact

wording is used in AR 9795.3 (a) 1.

When AR 9795.3 was created, interpreting for the treating physician during the course of treatment or for services recommended by the treating physician was obviously considered, contrary to what many claim. The problem or confusion is caused by the wording used in Labor Code §4600, specifically "When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director." This wording was used as a safeguard to protect against inappropriate billings by unscrupulous parties during the course of treatment. As we know, many times the injured worker is directed to a doctor for treatment at the request of the applicant attorney. With the wording as is, the insurance carrier or the appeals board maintains total control over whether or not an interpreter is paid for treatment related examinations.

However, the insurance carriers and many judges do not understand the true purpose and meaning of the interpreting provision in Labor Code §4600 and which is used in AR 9795.3 (a) 1. To alleviate a lot of unnecessary litigation, the code should be changed and written as "A reasonable and necessary examination by a physician to which an injured employee submits". In support of what I have described I ask the commission to review two recent appeals board decisions, both where an interpreter was denied payment for interpreting for treatment related services, however when proved to be reasonable, received support through the appeals board reconsideration process. In these two cases, the panel of reconsideration judges concurred that interpreters during the course of treatment when reasonable are clearly contemplated in Labor Code §4600, therefore obviously contemplated when creating AR 9795.3, since the exact wording from Labor Code §4600 was utilized. The cases are: [Almalilia Martinez vs. National Fire Insurance of Hartford] ADJ2454787, ADJ4243140 and [Olga Saldana vs. Liberty Mutual] ANA 0372945; 0380241. It is obvious based on the Labor Code, any reference made to an "evaluation" is medical legal in nature and any reference made to an "examination" is treatment in nature. Again, interpreters for medical treatment examinations were clearly contemplated in AR 9795.3.

The current AR 9795.3 lists the fees for interpreting for medical related services at \$11.25 per quarter hour with a two hour minimum or Market Rate. The minimum was set more than 15 years ago I believe. Most insurance carriers will only provide the ancient minimum rate and will not honor Market Rate even when proven. Additionally, the appeals board judges, in my experience do not honor Market Rate even when proven and only allow fees based on the ancient minimum. In the end, we are forced to receive compensation at a rate deemed reasonable many years ago. Understanding the current state of economic affairs it is hard to complain about the fees paid, however the commission must consider the fact that for the most part, interpreters are compensated based on fees set a long time ago.

Regarding the argument that interpreters bill exorbitant fees and many times bill more than the actual doctors to whom they are interpreting for is simply not true. If a doctor's invoice over the course of treatment is compared to the interpreter's invoice, the doctor's invoice will be for a much greater amount. If one particular follow up evaluation is looked at, where a doctor only creates a PR-2, on that one occasion it is possible the interpreter's billing of \$90 may be greater than the doctor's. Again, to say interpreters bill more than doctors

is not true.

I have tried to comment regarding all of the interpreter related issues I found appropriate. I again thank you for this opportunity to comment and I do hope consideration will be given to what I wrote.

CERTIFIEDINTERPRETERS, INC.

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Response to Draft Lien Report

Reid Steinfeld [reid@grantweber.com]

Sent: Tuesday, December 28, 2010 4:23 PM

To: CHSWC@DIR

Cc: Reid Steinfeld [reid@grantweber.com]; richard boggan [richard@workcompliens.com]

Attachments: Response to Cal Commission.doc (97 KB)

To whom it may concern.

Please find attached our Public Comments to the Commission with respect to the Lien Recommendations.

We request that you read and consider our position regarding the Lien Recommendations and contact the undersigned or Richard Boggan if you need any clarification.

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To: California Commission on Health and Safety and Workers Compensation

From: Grant & Weber, Reid L. Steinfeld esq., and Richard J Boggan JD

Re: Response and or comment to the California Commission on Health and Safety and Workers Compensation Draft Liens Report. Released on December 16, 2010, Recommendations response / comments to Recommendations, 1, 6, 7, 8, 9, 10, 13, 14, 16, 18, 19, 20, 21.

Grant & Weber is a Collection Agency with offices in Sacramento and Calabasas California. Reid L. Steinfeld has been General Counsel to the Agency for the past 18 years. Grant & Weber a corporation has been in existence since 1977 and Reid L. Steinfeld has been licensed to practice law in California for more than 30 years. Grant & Weber represents many health care providers throughout the State of California and is responding to the Draft report because it affects its clients as well as medical providers throughout California. Grant & Weber, through Reid Steinfeld has filed thousands of liens over the last several years, with approximately 1180 liens filed in 2009 and 1000 liens filed in 2010 throughout the state of California.

Although the report seems accurate in the assessment of the problem of unnecessary lien filing, some the recommendations if adopted as law would not achieve the desired result and may have the opposite effect in causing more litigated issues and or unjust forfeitures by medical providers. In addition a result of denial of reasonable medical treatment to the injured worker may be the unintended consequence as a result if some the recommendations are adopted.

**RECOMMENDATION 1
RESPONSE / COMMENT AS TO RECOMMENDATION 1:
"REINSTATE A FILING FEE FOR MEDICAL AND MEDICAL-LEGAL LIENS."**

Filing a lien does not ensure payment, nor does it make it easy for reimbursement for reasonable and necessary treatment. The idea behind the lien-filing fee is to do away with meritless liens which is based upon outdated and inaccurate data. During the time that a filing fee was in place, Insurance Companies and or Defense Attorneys who represented them would not settle medical treatment bills or even deal with a medical provider unless a lien was filed. By enacting a filing fee again, there may a reduction of lien filing not based on meritless claims but on valid claims that are now too expensive to pursue.

Therefore, if a filing fee is enacted it has to have determinates to both parties, such as a filing fee for filing a lien and a filing fee for the one contesting the lien. The fact that, insurance companies are in a stronger position to object to claims, must be considered by the Commission. If a fee is to be charged it needs to be borne by both parties. A fee of \$10 to \$25 each would be more reasonable than going from \$0 to \$100.00. This charge represents an unreasonable hardship to medical providers.

To resolve, the issue of a filing fee a recommendation would be to ensure that the employer / insurance company deal with the medical services with dates certain to respond and failure would result in the allowance of the medical bills, which is similar to what is enacted in other states specifically Texas.

RECOMMENDATION 6
RESPONSE / COMMENT AS TO RECOMMENDATION 6:
“ESTABLISH AN ADMINISTRATIVE SYSTEM FOR FEE SCHEDULE
DETERMINATIONS, SUBJECT TO LIMITED JUDICIAL REVIEW.”

We have read the rationale, behind this recommendation and agree in general to its merits. However, in its application it may generate abuse if all possibilities are not addressed. An example would be in admitted industrial injury cases when a carrier pays less than fee schedule. The provider submits the claim as a fee schedule dispute and in return the carrier asserts a PPO discount. This recommendation does not address such a result and therefore may defeat any beneficial results from the adoption of the regulation as an unjustifiable reduction of medical payments below fee schedule.

More than ever in recent years the selling of contract discounts through bill review companies and other methods below fee schedule has risen to the point that one could almost visualize that payment in accordance with the Official Medical Fee Schedule will be an exception and not the rule.

The selling of contract discounts and providers getting paid less than fee schedule has left the Courts split and sometimes at a loss how to handle such reductions which continues to cause litigation. The monies involved for the profit of selling and purchasing contract discounts has resulted in unwarranted profits to network companies and bill review companies in alarming amounts at the expense of medical providers, with frustration to medical providers and increased litigation.

California has enacted Labor Code § 4609 that attempts to address these issues, but most Courts have not construed or allowed its intended results. This abuse is on the rise and is being pushed to all avenues of medical treatment with no end in sight; this has to be addressed if this study is to be considered complete and accurate.

Therefore, it is recommended that if a claim is submitted to an administrative system for fee schedule determinations, subject to limited judicial review”, that if a provider submits a fee schedule dispute and the Defense claims a PPO discount that the Defense has to submit a signed agreement with the providers signature consenting to the discount by the particular payor claiming the discount, clear and concise as reflected in the case of Virginia Woodruff, Applicant v. Greenfield Trucking, State Compensation Insurance Fund, Defendants, (2007) Cal. Wrk. Comp. P.D. LEXIS 93, Opinion Filed September 4, 2007.

“Also, the undersigned WCJ is troubled by the very nature of the extreme discount that SCIF wishes to impose on the provider Good Samaritan. Labor Code 5307.1 provides for reasonable maximum rates to be paid for services provided. In this case, the parties stipulated that the OMFS for the services provided by Good Samaritan was \$21,237.00. Yet, SCIF proposes to pay only less than half this amount and a sum which is only about 13% of the billed amount. It would appear to this WCJ that it is (or should be) against public policy to allow such deeply discounted fees, [*10] unless there are clear and unambiguous facts present that the parties have agreed to such deep discounts. The next "crisis" that appears to be looming in workers compensation will be that of a failure of providers to offer services to injured workers. Already it is getting more and more difficult to find doctors and medical providers willing to provide treatment to injured workers. To allow such deeply discounted rates will only add to this looming crisis. Thus, it would appear that as a matter of public policy, that unless there is an absolutely clear and unambiguous agreement to the contrary, the OMFS amounts should apply. There is no clear and unambiguous agreement between the provider Good Samaritan and SCIF in this case. As such, all else being equal, the OMFS should prevail.”

RECOMMENDATION 7

RESPONSE / COMMENT AS TO 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.”

In Recommendation 7, the data is misplaced. When an injured workers treats outside an MPN it is because the employer failed to provide proper notice and or refused medical treatment. The reason why the data is incorrect is because, when the employer denies injury they are labeling the issue as an MPN in addition to a denied injury and we have adequate law that addresses this issue.

The present law is clear enough; send notice and offer reasonable medical treatment. The abuse is when the issues of MPN's are asserted just to add additional issues to the litigation, which appears standard when the defense is contesting the medical bill. Any further regulation will result in the injured worker going without treatment because the employer refuses to offer treatment within the MPN and medical providers outside the MPN will not treat because the adopted regulation would make it impossible to get paid. En Banc decision of Bruce Knight,

“The Board held that an employer or insurer's failure to provide required notice to an employee of rights under the MPN (medical provider network) that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee.”

RECOMMENDATION 8
RESPONSE / COMMENT AS TO RECOMMENDATION 8:
“DISPUTES OVER ASSERTIONS OF MPN CONTROL OVER MEDICAL TREATMENT SHOULD BE BROUGHT TO ADJUDICATION PROMPTLY.”

8 CCR 9767.9 which is used both to transfer medical treatment into an MPN which was not in existence at the time the injury and case law, has extended this to include transfer of medical treatment after denial of injury and defective notice of MPN, and courts intervention has been used under this regulation which addresses “Recommendation 8.” As shown by the En Banc decision of Babbitt v. Workers' Compensation Appeals Bd., (2007) 72 Cal. Comp. Cas. (MB) 830

“The majority also indicated in relevant part that nothing in the MPN statutes limited MPN transfers to only those employees with injuries or awards occurring after the statutes' January 1, 2005, effective date, that an employer or insurer need not demonstrate a change of condition or defective or incomplete medical treatment before transferring an injured worker into an MPN, and that the four statutory exceptions allowing an employee to continue with his or her current treating physician for a limited time under specified circumstances (i.e., acute conditions, serious chronic conditions, a terminal illness, or certain surgical or other procedures) would be rendered null and void by an additional requirement that employers or insurers prove there had been defective or incomplete medical treatment, or a change in condition, before transferring employees into an authorized MPN.”

To put the burden on the medical provider to seek court intervention for continued medical treatment outside the MPN would have the result of the injured worker foregoing necessary medical treatment when the employer does not offer medical treatment and resulting increased litigation.

We recommend that Recommendation #8 not be adopted as there is valid law dealing with this issue as stated above.

RECOMMENDATION 9

RESPONSE / COMMENT AS TO 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

RESPONSE / COMMENT AS TO 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.”

As to Recommendations 9 and 10 their enactment would increase litigation and defeat the entire purpose of these recommendations. In addition the report does not take into consideration the California Supreme Court case of State Comp. Ins. Fund v. Workers’ Comp. Appeals Bd. (Sandhagen) (2008) 44 Cal.4th 230; 73 Cal.Comp.Cases 981 (Sandhagen) which in short clarified that when an employer is faced with deciding whether to approve or deny the treatment recommendation of an injured worker’s physician, it must conduct utilization review pursuant to Labor Code Section 4610. and the En Banc Decision of Simmons v. California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005). If in prescribing treatment for the disputed body part, the treating physician either explicitly or implicitly determines for the first time that the injury to the disputed body part is industrial, the defendant must initiate the AME/QME process within the deadlines established by section 4062(a)."

RECOMMENDATION 13

RESPONSE / COMMENT AS TO 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.”

The time limits suggested by the report of; 60 days, one year and no longer than 18 months has no logical application to any comparable study that demands billing in 60 days. Private insurance allows one year, and Medicare up to one year. Sometimes, the determination that the injury was or not work related by the provider, (especially hospitals), is not clear from the information provided by the injured worker. Medical providers’ bill as fast as possible as it would defeat any profession or business including the medical profession economic stability if billing the responsible party for the medical treatment was habitually delayed past a time period that was necessary to prepare documents, gather information and find the right payor. So if providers are billing past 60 days it is probably with good cause and to try and force them to bill sooner without assessing a motivation for not sending medical bills to the responsible party, would result in medical provider / medical facilities in not treating injured workers.

RECOMMENDATION 14
RESPONSE / COMMENT AS TO 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.”

As to Recommendations 14, the recommendation will increase litigation in that it must be considered that the medical provider is not in possession of all the case information including WCAB#'s, settlement documents and / or the status of the work related injury. Furthermore Claims Adjusters do not give out the necessary information freely and because of this an increase in lien filing will result if Recommendation 14 is adopted.

The effects of such a proposal are both severe and significant.

Every medical provider who treats an injured worker would have to create a policy that whenever they receive an EOB or objection by the insurance carrier they would have to file a lien if the bill is not properly paid, regardless of the additional amount owed -- whether it be \$10.00 or \$100,000.00 -- to protect its interest, regardless of the potential for settlement. This would result in a floodgate of liens filed and mass confusion at the WCAB, and may break down and defeat the intent of the Recommendation. Therefore, the lien process at the WCAB would increase tenfold, taking away resources allocated to the injured worker.

The Commission should not find fault of the medical providers when old outstanding lien claims are being filed years after the case is resolved. It has been the responsibility by law for the Defendants to serve medical providers with the settlement documents, which they do not always provide. So the proposed recommendation, in fact, rewards the wrongful conduct of the insurance companies.

The proposal in effect creates an organizational nightmare for hospitals, clinics and other medical providers in that they would have to train their staff and set up a system that would allow them to protect the medical bills. By complicating the collection of medical bills in workers' compensation and making it so difficult that even the most diligent of medical providers would forego treating industrial injury patients, this would further reduce the number of medical providers willing to treat injured workers. In many instances, at the time of payment to the medical provider, the provider does not know if they have been incorrectly paid under the fee schedule. We presently have statutory limitations on lien filing enacted by the legislature in 2004.

RECOMMENDATION 16
RESPONSE / COMMENT AS TO RECOMMENDATION 16:
“IMPOSE AUTOMATIC DISMISSAL BY OPERATION OF LAW FOR ANY LIEN
WHICH IS NOT ACTIVATED FOR HEARING WITHIN FINITE TIME.”

Recommendation 16 proposes to dismiss liens that are not activated within a certain amount of time. First, there is a process used in the California Workers Compensation Courts where a party may seek dismissal of a lien for failure to pursue / prosecute a lien claim. A party may also directly seek dismissal of the lien by filing such a petition. However to make a lien dismissed by operation of law within a specified time because the Lien Claimant failed to file a Declaration of Readiness (DOR) carries a double edged sword. Lien Claimants, in the present system are hit with sanctions if they file a DOR before the Case in Chief is resolved unfortunately, finding out if the Case in Chief is resolved is not a simple task. The Claims Adjuster's do not give case information to medical providers freely or in the spirit of cooperation and if this recommendation is adopted it may encourage Claims Adjuster's to hold back information, as the reward would be a dismissal of liens. In addition, this would increase the filing of DORs which defeats the purpose of this study to lessen the Courts burden in hearing lien claims

RECOMMENDATION 18

RESPONSE / COMMENT AS TO 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 18 is presently required by 8 CCR §10550 Proper Identification of the Parties and Lien Claimants. We would recommended that as part of the lien filing, a notice of representation along with a statement of whether the claim has been referred, assigned and or purchased, filed under penalty of perjury.

RECOMMENDATION 19

RESPONSE / COMMENT AS TO RECOMMENDATION 19:

“A LIEN REPRESENTATIVE SHOULD BE REQUIRED TO PROVIDE DOCUMENTATION OF THE REPRESENTATIVE'S AUTHORITY UPON DEMAND.”

See response to Recommendation 18.

RECOMMENDATION 20

RESPONSE / COMMENT AS TO 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.”**

This is not a sincere proposal but a threat in the form of a Recommendation that will have only negative consequences, because the Defense will seek privileged contracts, assert that the Lien Claimant is lying, refuse to negotiate medical bills, resulting in causing unnecessary delay and repeated hearings and continued litigation. If the DWC wants to regulate companies that purchase medical provider liens than they should do so directly. It is already law that a Lien Claimant Representative must divulge information if the claims were purchased (see # 18 above). But to try and accomplish it by frustrating the litigation process and or threatening unreasonable sanctions or penalties for such arraignments will only increase litigation for those who purchased medical liens and in addition to those who have not. As set forth the simplest would be that at the time the lien claimant files its lien it discloses under penalty of perjury its relationship to the provider of services and / or goods and if its purchased same.

**RECOMMENDATION 21
RESPONSE / COMMENT AS TO 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.**

This Recommendation clearly appears to be a result of CIGA's basis for not paying for medical services when the relationship between the "Collection Company" and the medical provider has an assignment contract for collections of its medical bills. This assertion has caused increased litigation, unnecessary lien filing and increased hearings. In relation to Recommendation 21 we assert without hesitation it is bound to increase litigation, delay hearings, increase the number of hearing per case and force lien filings. The distinction should be between a purchaser of the claim verses an assignee of the claim. By adopting this Recommendation every representative of medical providers will be denied payment. CIGA is presently not paying nor negotiating any medical bills presented by Collections Companies and / or represented by anyone other than the original provider. As a way of seeing how litigation will increase, CIGA is relying upon Insurance Code section 1063.1 et seq which was originally enacted when an automobile insurance company went out of business and these individuals were left with no recourse and had to pay for automobile damages. CIGA has a misguided use of the word "assignment" as most medical providers retain ownership interest in their claims and have "assigned" their claims to collection companies to assist in the recovery of medical bills because medical providers are in business treating patients not collecting money (see article below, that discusses the law and cases in this area)

Does CIGA Have to Pay Medical Providers When They're "Assigned" to a Collection Company?

Posted by **Reid L. Steinfeld**

There has been a great deal of litigation as to when CIGA is responsible for payment of benefits after taking over from an insolvent insurer. Now, with a recent panel decision, a question that has arisen is: When a medical provider assigns its rights and title to a collection account, is CIGA responsible for payment of that "assigned claim"?

Purpose of CIGA in regards to paying benefits from an insolvent insurer

California Insurance Guarantee Associations' (CIGA) general purpose is to pay the obligations of an insolvent insurer. When an insurance company becomes insolvent, CIGA takes over the claim and pays benefits that the insolvent insurance carrier was obligated to pay, which includes medical liens.

CIGA primarily receives its funding from Member Insurers, distributions from the estates of insolvent Member Insurers, and investment income.

Waite v. California Insurance Guarantee Assn., 71 Cal. Comp. Cas. 591 (Cal. App. 2d Dist. 2006)

While CIGA's general purpose is to pay the obligations of an insolvent insurer, it is not itself an insurer. (*R. J. Reynolds Co. v. California Ins. Guarantee Assn.*, *supra*, 235 Cal.App.3d at p. 600.) "CIGA is *not* in the 'business' of insurance CIGA issues no policies, collects no premiums, makes no profits, and assumes no contractual obligations to the insureds." (*Isaacson v. California Ins. Guarantee Assn.*, *supra*, 44 Cal.3d at p. 787.) Rather, it is authorized by statute to pay only covered claims of an insolvent insurer, those determined by the Legislature to be in keeping with the goal of providing protection for the insured public. (*R. J. Reynolds Co. v. California Ins. Guarantee Assn.*, *supra*, at p. 600.)

What is a “covered claim” that makes CIGA liable when it takes over an insolvent insurer?

An issue to be resolved is whether the payment sought is for a “covered claim”.

Insurance Code section 1063.1, subdivision (c)(9) provides: “Covered claims’ *does not include (i) any claim to the extent it is covered by any other insurance ... nor (ii) any claim by any person other than the original claimant under the insurance policy in his or her own name ... and does not include any claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.*”

California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 153 Cal. App. 4th 524, 62 Cal. Rptr. 3d 855, 2007 Cal. App. LEXIS 1196, 72 Cal. Comp. Cas. 910 (Cal. App. 2d Dist. 2007)

“As is relevant here, a “covered claim” means “(1) ... the obligations of an insolvent insurer, including the obligation ... (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; ... (iv) which were incurred prior to the date coverage under the policy terminated ... (vi) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state” (Ins. Code, § 1063.1, subd. (c)(1).)”

Woodliff v. California Ins. Guarantee Assn., 110 Cal. App. 4th 1690, 3 Cal. Rptr. 3d 1, 2003 Cal. App. LEXIS 1207, 2003 Cal. Daily Op. Service 7076 (Cal. App. 2d Dist. 2006)

In regard to the requirement that a “covered claim” be “within the coverage of the insurance policy of the insolvent insurer,” we concluded the latter phrase “to mean within the risks of loss protected against by an insurance policy. Thus the reading of the pertinent portion of subdivision (c)(1) would be: the obligations of an insolvent insurer within the risks of loss protected against by an insurance policy of the insolvent insurer.”

Subdivision (c)(1) of Insurance Code section 1063.1 defines the term “covered claim” to include, “in the case of a policy of workers' compensation insurance,” “the obligations of an insolvent insurer ... to provide workers' compensation benefits under the workers' compensation law of this state.”

Medical services are covered under Insurance Code section 1063.1.

However, recently CIGA has attempted to claim the defense that an assignment of a claim from the original provider is a basis for not paying medical provider liens. According to CIGA an assignment relieves them of their responsibility to pay medical providers claims against insolvent Workers' Compensations Carriers that have been taken over by CIGA.

There are several appellate cases that address the issue of when CIGA is responsible for covered claims. This includes, but is not limited to, another solvent insurance carrier, whether fully liable, partially, liable, or mistakenly pays the claimed benefits. In such instances, CIGA is not responsible for payment or indemnification of those claims.

Furthermore, in the case of California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 153 Cal. App. 4th 524, 62 Cal. Rptr. 3d 855, 2007 Cal. App. LEXIS 1196, 72 Cal. Comp. Cas. (MB) 910 (Cal. App. 2d Dist. 2007)

“The Legislature did not intend CIGA to defray or diminish the responsibility of other carriers. Because other insurance was available, and the insurers were jointly and severally liable to satisfy the employer's responsibility to the worker, CIGA had no liability for any portion of the award. (*Garcia, supra*, 60 Cal.App.4th at p. 559.) Even if Garcia had elected to proceed against only one of the solvent insurers for all his benefits, that insurer would have been obligated to pay the entire award and could not institute proceedings against CIGA for contribution.”

California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 128 Cal. App. 4th 307, 26 Cal. Rptr. 3d 845, 2005 Cal. App. LEXIS 540, 70 Cal. Comp. Cas. (MB) 556, 2005 Cal. Daily Op. Service 3060, 2005 D.A.R. 4123 (Cal. App. 2d Dist. 2005)

“Under the unambiguous language of the statutory scheme, an original claimant can be any person (other than the insurer) instituting a liability claim within the coverage of the policy, provided that he or she does so in his or her own name and not through assignment or by right of subrogation.”

What does the recent panel decision in *Licea* mean?

In a recent Panel Decision of Mirna Licea v. Minson Corporation; California Insurance Guarantee Association for Phico Insurance Company, in liquidation ADJ 1857578 (AHM 0089872) decided June 23, 2009, it appears that the WCAB panel interpreted CIGA's

liability in respect to an assigned claim. The facts of the case are as follows:

Applicant Mirnia Licea, while employed as a laborer by Minson Corporation sustained injury, arising out of and in the course of employment to her back, right leg, right wrist, right hand and right hip. At the time of the injury, the employer's workers' compensation carrier was Phico Insurance Company. CIGA assumed the obligations of Phico Insurance which it became insolvent. The matter resolved by Compromise and Release for \$70,000.00.

Missirian Orthopedic provided treatment to the applicant for charges in the amount of \$39,354.07.

The Trial Judge's Opinion and Recommendation on Petition for Reconsideration, which was incorporated into the Appeals Boards' Denial of Petition for Reconsideration, held that "[KM Financial] did not establish any basis for reimbursement under the Guarantee Act and accordingly, its lien in the amount of \$39,354.07 was correctly disallowed."

The Trial Judge relied on the case of Baxter Healthcare Corp v. California Insurance Guarantee Assn. (2000) 85 Cal. App. 4th 306, 314, wherein the Court held,

"The Guarantee Act excludes from coverage claims asserted by an assignee. That term is not defined or qualified by the act. It must be read in the context of the entire statute and given the meaning it bears in ordinary usage."

It is unclear from the documents reviewed if KM Financial purchased the account of Missirian Orthopedic Medical Group (Missirian) or if they assigned KM Financial for collections (based on wording below it appears the account was purchased), as set forth in the Trial Judge's recommendation and opinion;

"The Notice of Assignment is undated but indicates that Missirian "hereby assigns all title and thereby transfers, without recourse, to KM Financial Services, Inc. "Assignee" or "Buyer" all rights, title interest in the attached Medical Account Receivable' KM in turn appointed Alliance Medical Billing and Collection Services as representative In Fact for the purpose of securing payment of Medical Bills. KM offered no evidence to refute this assignment. Thus the asserted claim here is clearly the claim of the assignee."

In the language of Licea supra, the Judge states that the claim in the case was clearly a claim of assignee in that the provider transferred all interest in the claim without recourse, and, therefore, no dispute of an assignment for the purpose of relieving the original claimant has taken place and would be different if the claim had been assigned for collection purposes only with the original claimant retaining title and ownership interest.

Further in Baxter Healthcare Corp v. California Insurance Guarantee Assn, supra

The Guarantee Act, which created CIGA in 1969, requires CIGA to "pay and discharge covered claims and in connection therewith pay for or furnish loss adjustment services and defenses of claimants when required by policy provisions." (§ 1063.2, subd. (a).) The term "covered claims" means, "the obligations of an insolvent insurer, including the obligation for unearned premiums, (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; (iii) which are presented as a claim to the liquidator in this state or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings; (iv) which were incurred prior to the date coverage under the policy terminated and prior to, on, or within 30 days after the date the liquidator was appointed; (v) for which the assets of the insolvent insurer are insufficient to discharge in full; (vi) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state; and (vii) in the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state." (§ 1063.1, subd. (c)(1).)

Excluded from the definition of "covered claims" is "any claim by any person other than the original claimant under the insurance policy in his or her own name, . . . and . . . any claim asserted by an assignee" (§ 1063.1, subd. (c)(9)(ii).)

KM Financial in its petition for reconsideration cited two cases, the first of which is Richey v. Ziegler (1938) 89 Cal App. 35, in which the Court found that the award to the employee could be assigned legally to the assignee. However, the court dismissed the relevancy of the case as not addressing the Insurance Code 1063.1 issue of assignment.

The second case cited by KM Financial in its petition for reconsideration was the case of Burrow v. Pike (1987) 190 Cal. App. 3d 384, which held that the California Department of Transportation's lien for workers' compensation benefits was not excluded from the definition of a 'covered claim' and found CIGA liable for reimbursement of benefits to the injured worker. However, the Court stated the case had no applicability as the case had to do with the employer failing to file a claim with CIGA regarding the obligations of a third party liability carrier.

It appears in *Licea, supra*, that the WCAB panel stated that an assigned claim cannot be brought forth against CIGA:

Subdivision (c)(1) of Insurance Code section 1063.1 defines the term "covered claim" to include, "in the case of a policy of workers' compensation insurance," "the obligations of an insolvent insurer ... to provide workers' compensation benefits under the workers' compensation law of this state."

Case research

In the workers' compensation system, medical benefits are considered a covered claim, regardless of whether the provider is bringing forth the claim.

California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 136 Cal. App. 4th 1528, 39 Cal. Rptr. 3d 721, 2006 Cal. App. LEXIS 265, 71 Cal. Comp. Cas. (MB) 139, 2006 Cal. Daily Op. Service 1668, 2006 D.A.R. 2296 (Cal. App. 2d Dist.)

"CIGA's authority and liability in discharging 'its statutorily circumscribed duties' are limited to paying the amount of 'covered claims.' [Citations.]" (California Insurance Guarantee Assn. v. Workers' Comp. Appeals Bd., *supra*, 112 Cal.App.4th at p. 363.) With certain exceptions, "covered claims" are "the obligations of an insolvent insurer" (Ins. Code, § 1063.1, subd. (c)(1)), including the obligation "to provide workers compensation benefits under the workers' compensation law of this state." (Ins. Code, § 1063.1, subd. (c)(1)(vi).)"

St. Joseph's Hospital v. Workers' Compensation Appeals Bd., 70 Cal. Comp. Cas. 1612 (Cal. App. 1st Dist. 2005)

"With regard to the lien of St. Joseph's Hospital, the WCAB stated that reasonable charges for treatment that relate to Applicant's

injury would constitute a "covered claim" within the meaning of Insurance Code § 1063.1.”

California Insurance Guarantee Assn. v. Workers' Compensation Appeals Bd., 71 Cal. Comp. Cas. 808 (Cal. App. 1st Dist.2006)

“In addressing CIGA's contention that the WCJ erred in allowing the lien claim of EDD and in ordering CIGA to pay EDD, the WCAB observed that the parties stipulated at trial to defer all liens. The WCAB stated in relevant respects:

"Furthermore, we note that CIGA must generally pay and discharge the "covered claims" of an insolvent insurer. (Ins. Code § 1063.2.) However, "covered claims" do not include "any obligations to any state" government. (Ins. Code § 1063.1(c)(4).) EDD is a "state" agency for purposes of applying Insurance Code section 1063.1(c)(4) (Gov. Code, §§12800, 12803.)”

“In *Viveros, supra*, and in its companion case, *Karaiskos v. Metagenics, Inc.* (2002) 69 Cal.Comp.Cases 900 [Appeals Board en banc opinion], the Appeals Board en banc held that EDD's liens for UCD benefits are not obligations to the state and therefore are "covered claims" for which CIGA is responsible. We explained that when the Appeals Board finds CIGA or its insolvent carrier "liable for compensation against which an EDD lien may be allowed, *whether by Findings & Award, Stipulations & Award, or Order Approving Compromise & Release (OACR)*, the EDD lien is, in essence, an 'obligation' to the injured worker and not to the 'state.' " Therefore, we concluded that Insurance Code section 1063.1(c)(4)] does not exclude EDD's liens from the definition of "covered claims." (Italics added [*by WCAB*]).”

Black Diamond Asphalt, Inc. v. Superior Court, 114 Cal. App. 4th 109, 7 Cal. Rptr. 3d 466, 2003 Cal. App. LEXIS 1827, 2003 Cal. Daily Op. Service 10641, 2003 D.A.R. 13420 (Cal. App. 3d Dist. 2003)

Section 1063.1, subdivision (g), states a “claimant” includes “any insured making a first party claim or any person instituting a liability claim.” . . .Accordingly, the plaintiffs in this action are claimants within the meaning of laws applicable to CIGA since they assert liability claims under third party insurance.

The question must be asked: If it is the obligation of CIGA to pay the claims of the insolvent insurer, is there an obligation of the insolvent insurer to pay the medical bills? If the answer is yes, how could CIGA be relieved from the obligation to pay the medical

benefits? If CIGA is not responsible for paying the medical benefits, then what is the purpose of CIGA?

It is understood that Licea supra was decided because the medical provider no longer retained any legal or financial interest in the claim based on the language of the assignment, and in this writers' opinion, this may have been the justification for the decision.

Claim Assigned to Collection Agency

The question that remains unanswered in Licea supra is what happens when a claim is assigned to a collection company for collection purposes only, where the provider does not assign all right, title, and interest to the claim and is not substituting one claimant for another?

Under the language of the Insurance Code § 1063.1, an original claimant can be any person (other than the insurer) instituting a liability claim within the coverage of the policy, provided that he or she does so in his or her own name and not through assignment or by right of subrogation. As interpreted by the case cited below, subrogation and assignment of a claim is the passing of title of a cause of action. Therefore, when a party transfers a claim and or "assigns" a claim to a representative for the qualified and limited purpose to collect on an account in the name of the medical provider without transferring title, it is not excluded under Insurance Code § 1063.1 as not being a covered claim.

National Union Fire Ins. Co. of Pittsburgh, PA v. Cambridge Integrated Services Group, Inc., 171 Cal. App. 4th 35, 89 Cal. Rptr. 3d 473, 2009 Cal. App. LEXIS 170, 74 Cal. Comp. Cas. (MB) 184 (Cal. App. 1st Dist. 2009)

"Whether the transfer be technically called assignment or subrogation or equitable assignment or assignment by operation of law its ultimate effect is the same, to pass the title to a cause of action from one person to another."

In Licea supra it can be seen that the title and rights to the claim was transferred to KM Financial, with the provider retaining no legal right to the claim of liability..

"The Notice of Assignment is undated but indicates that Missirian "hereby assigns all title and thereby transfers, without recourse, to KM Financial Services, Inc. "Assignee" or "Buyer" all rights, title interest in the attached Medical Account Receivable."

One may argue that this is not a subrogated claim, however, because of the plain language of Insurance Code § 1063.1. It would be hard pressed, if not impossible, to show that the claim was not assigned, as the provider in this case no longer had any rights and/or claim against CIGA. Therefore, the ruling that the claim was not a covered claim seems justified at face value. In addition, as stated by the Trial Judge, KM Financial did not argue the issue of assignment.

Conclusion

This writer contends, even in the strictest interpretation of "Insurance Code § 1063.1, subd. (c)(9)(ii)", the law does not limit the providers' legal right to assign a claim to a Collection Company for collection purposes.

Due to the lack real clarity in Licea supra, we contend that the issue of assignment may cause additional litigation and force medical providers to once again rethink if practicing industrial medicine is financially feasible and viable.

Based upon the case law cited and from a practical standpoint, we contend that CIGA must pay when a claim is assigned for collection purposes only, but may have a valid defense under the Insurance Code if the original provider has divested itself of all interest in the claim.

End of Article

In summary we commend the Commission for the preparation of this draft report in its attempt to address the issue of lien filing, however the Commission seems to have lost their impartiality as we can find no Recommendation that deters the insurance companies from fostering litigation, nor any Recommendation as to regulating Review Companies or 'Silent PPOs' that profit only when reducing payments below fee schedule for valid medical bills. Therefore, the adoption of any of these Recommendations only addresses a partial problem and some even encourage more litigation. For the Recommendations to be fair and achieve there objective deterrents, the Commission needs to put into place rules to dissuade Insurance Companies, Bill Review Companies, and PPO networks from wrongfully denying treatment, reducing medical bills below fee schedule, the selling of contract discounts, and the failure of Claims Adjusters to deal with medical providers until a lien is filed.

Therefore, it is recommended and asserted that the report is incomplete and contains persuasive inaccuracies and should be a starting point for fair and balanced regulations to protect medical providers, injured workers, employers, and insurance companies.

Respectfully Submitted,
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