

Commission on Health and Safety and Workers' Compensation

SUMMARY OF SB 899, by Labor Code Section

62.5 WC Administration Revolving Fund

- Restores 100% user funding of the Workers' Compensation Administration Revolving Fund, which funds the operation of the Division of Workers' Compensation. (§62.5(b))
- Adds RTW Program (described in Section 139.48) to the operations funded by the WC Admin. Revolving Fund. (§62.5(a))
- Adds that the user assessments shall not exceed the amount necessary to carry out the purposes of this section. (§62.5(e))
- Changes "assessments" to "surcharges".

138.65 Study of Effects of Reform

- Administrative Director is to contract for study of the effects on insurance rates from the 2003-2004 reforms. (Major bills include AB 227, SB 228, and SB 899.)

139.2 QME System and Report Writing

- The process for the Administrative Director to assign a panel of three Qualified Medical Evaluators is amended to reflect the fact that a request for a panel under Section 4062.1 (in cases of unrepresented workers) may come from an employer or from an employee. (§139.2(h)(1))
- The provision for the AD to notify the employee of the assignment of a panel is applicable to panels requested under Section 4062.1 (unrepresented worker) or Section 4062.2 (represented worker). (§139.2(h)(2))
- All physicians are to evaluate permanent disability consistent with the ratable criteria set forth in Section 4660. (§139.2(j)(2))
- Provides that the medical treatment criteria refer to Section 5307.27.

139.48 Return-To-Work Program

- The Return-To-Work program shall be implemented to the extent funds are available. (Its funding source is from Section 5814.6 penalties and from transfers by the AD from the WC Admin Revolving Fund per Section 62.5.)
- The program will reimburse up to \$1,250 of expenses to accommodate a temporarily disabled worker or \$2,500 to accommodate a permanently disabled worker.
- Only private employers with 50 or fewer full-time employees are eligible for reimbursements from the program.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

139.5 Supplemental Job Displacement Benefit and VR

- Repeals the duplicate section for Supplemental Job Displacement Benefit (see Section 4658.5 for second copy of the same provisions enacted by AB 227).
- Re-enacts former Section 139.5 Vocational Rehabilitation benefit for injuries occurring before January 1, 2004, but the VR law is repealed entirely effective January 1, 2009.

2699 "Private Attorneys General" exception

- The right of employees to prosecute for civil penalties for Labor Code violations that could be prosecuted by the state does not extend to civil penalties under WC under Division 4, audit penalties under Section 129.5, or discrimination under Section 132a.

3201.5 Integrated Benefits in Carve-Out (Construction)

- Employer and union may negotiate any aspect of benefit delivery if employees are eligible for group health benefits and nonoccupational disability benefits through the employer.

3201.7 Integrated Benefits in Carve-Out (Non-Construction)

- Employer and union may negotiate any aspect of benefit delivery if employees are eligible for group health benefits and nonoccupational disability benefits through the employer.

3201.9 Data Reporting on Carve-Out

- Corrected cross-reference to Section 3201.7(h) in existing statute requiring reporting on the experience of carve-out programs.

3202.5 Liberal Construction

- The burden of proof by preponderance of evidence applies equally to all parties and lien claimants.

3207 "Compensation" Defined

- Defines compensation as every benefit under this Division 4, deletes Vocational Rehabilitation from the definition.

3823 Fraud Reporting

- Grants civil immunity to the people who are required to report fraud.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

4060 – 4062.5 AME/QME and Medical Dispute Resolution

- The dispute resolution process through an AME or a single QME applies to all disputes including compensability of claim (§4060), permanent disability evaluation (§4061), and all other disputes (§4062).
- There is an exception for medical treatment issues that are subject to utilization review under Section 4610, but if the employee objects to the outcome of utilization review the employee may still request an exam through the AME or single QME process (§4062(a)).
- Existing law is retained regarding 2nd opinion upon employer's objection to spinal surgery. (§4062(b)).
- Unrepresented employee gets a QME exam by requesting a panel to be assigned, then selecting one from the panel. (§4062.1)
- Represented employee gets an AME if parties agree, but if they do not agree on AME, then either side requests a panel, each side strikes one name, and the remaining physician is the QME who will conduct the exam. (§4062.2) The new procedure for represented cases applies to dates of injury on or after January 1, 2005. (§4062.2(a)) (NOTE: The bill leaves a gap in the represented QME process until January 1, 2005.)
- Existing provisions of law regarding communication with AME or QME and the duty of the QME to render a report are recast in Sections 4062.3 and 4062.5.

4062.8 Educational Materials for Treating Physicians

- Existing provisions from Section 4062.9 regarding educational material for treating physicians are moved to new Section 4062.8.

4062.9 Repeal of Treating Physician's Presumption

- The presumption of correctness of opinions of treating physicians has already been restricted, and in this bill it is completely repealed.
- Section 46 of the bill makes the repeal apply to all cases, regardless of date of injury, but shall not constitute good cause to reopen any final decision.

4600 Medical Treatment and Control

- Defines the treatment "reasonably required to cure or relieve" to mean treatment that is based on the guidelines adopted by the Administrative Director pursuant to Section 5307.27 or the ACOEM Guidelines.
- Unless the employer uses a medical treatment network, the basic rule remains that employer has medical control for first 30 days (or longer in an HCO), and then employee gets the right to select treating doctor.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

- An exception to the basic rule is that employee may be treated by a predesignated physician from the date of the injury if all of the requirements for predesignation are met. It is only available if
 - The employer provides group health coverage, and
 - The physician is the employee's primary care MD or DO who has previously directed the employee's treatment and who agrees to be predesignated.
- If the employer establishes a medical treatment network, employees who did not predesignate must receive care only through the network.

4603.2 Medical Billing

- All payments shall be at fee schedule except as contracted.
- The time limit to make payment runs from date of properly itemized billing.

4604.5 Treatment Guidelines

- Guidelines adopted by the Administrative Director can be rebutted in an individual case only by scientific medical evidence.
- Guidelines are to be evidence-based, nationally recognized and peer reviewed.
- For injuries occurring on or after January 1, 2004, imposes limit of 24 visits to occupational therapy, along with 24 chiropractic and 24 physical therapy visits, unless employer authorizes additional visits.

4616 Medical Provider Networks

- Beginning January 1, 2005, employers may establish networks composed of both primarily occupational and primarily nonoccupational treating doctors, with goal of at least 25% primarily nonoccupational.
- Network shall include sufficient number of physicians to provide timely treatment.
- Employer or insurer has exclusive right to decide which providers are in network.
- Physician compensation shall not be structured to achieve goal of reducing, delaying or denying treatment.
- Treatment shall be in accordance with the guidelines per ACOEM (American College of Occupational and Environmental Medicine) or Section 5307.27.
- Only a licensed physician in the appropriate scope of practice may modify, delay or deny a request for authorization for treatment. (This governs any internal utilization review process the network may adopt.)
- AD shall approve plan if it meets requirements of section. Default approval if AD can't act in 60 days.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

- AD shall adopt implementation regulations in consultation with the Department of Managed Health Care (DMHC).
- Section 4616.1 requires that economic profiling of providers must be disclosed.
- Section 4616.2 requires that continuity of care be provided for up to 12 months after provider leaves the network, depending on defined circumstances.

4616.3 Patient Rights in Networks

- After first visit, the employee has the right to choose doctor in network
- If employee disputes diagnosis or treatment prescribed, patient may obtain 2nd and 3rd opinions in appropriate specialty within network.
- Out-of-network specialist treatment may be provided if approved by employer.

4616.4 IMR Resolution of Dispute with Network

- AD to contract with individual physicians or review organizations to conduct Independent Medical Review to be performed by a doctor, with current certification of appropriate specialty board, and no disciplinary history. The statute contains conflicting provisions about whether the doctor must be California-licensed or may be licensed in any state.
- Employee may request this IMR if treatment is still in dispute after 3rd opinion in network.
- Employer sends specified records to IMR doctor.
- IMR doctor performs exam, reviews documents, issues report using the appropriate guidelines for medical necessity, based on ACOEM and Section 5307.27. Report due in 30 days or less if the reviewer says it is urgent.
- AD shall adopt the report of the reviewer and issue a decision to the parties.
- If IMR finds the disputed care is consistent with guidelines, the employee may seek the disputed services from any physician, not limited to network (§4616.4(i))
- No additional exams or reports shall be ordered or admitted by the WCAB on issues of medical treatment under networks. (§4616.6)
- Note: The bill does not specify who will pay for the cost of the Independent Medical Review.

4616.7 Organizations Deemed Approved as Networks

- These organizations are deemed to meet all or specified parts of the eligibility requirements to be networks:
 - Health Care Organization licensed under Labor Code Section 4600.5
 - Health Care Service Plan licensed pursuant to the Knox-Keene Act.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

- Group disability policy for medical expenses under Insurance Code Section 106(b).
- Taft-Harley health and welfare fund
- These organizations will be approved if they have a reasonable numbers of occupational and non-occupational physicians, as determined by the AD.

4650 Timing of Payments

- Requires PD advances to commence upon cessation of TD payments, including termination when statutory TD limit is reached.

4656 TD Limit to 2 Years

- TD benefits are limited to 2 years from date of commencement of payment in most cases.
- TD may extend to 240 weeks aggregate within first 5 years after date of injury for the following injuries: (§4656(c)(2))
 - Acute and chronic hepatitis B.
 - Acute and chronic hepatitis C.
 - Amputations.
 - Severe burns.
 - Human immunodeficiency virus (HIV).
 - High-velocity eye injuries.
 - Chemical burns to the eyes.
 - Pulmonary fibrosis.
 - Chronic lung disease.

4658 PD Indemnity Chart, including Tiered PD Benefit

- Return-to-Work adjustment:
 - Tiered PD benefit system provides for 15% decrease or increase in the weekly rate of the payments of the PD award depending on whether or not the employer offers return to work.
 - If terminated before PD is all paid, the remaining weeks of the PD benefit from the time of termination are increased 15% above the base rate.
 - The increase or decrease does not apply to employers with less than 50 employees.
- PD indemnity:
 - Weeks of indemnity for each percentage point of rating are reduced for each percentage point under 15%.
 - Weeks of indemnity for each percentage point of rating are increased for each percentage point of 70% or more.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

- Amendments apply to injuries occurring on or after the date of the revised schedule (§4658(d)(1)), which is due by January 1, 2005, per Section 4660.
- In another paragraph, the section provides that it does not apply to claims arising before April 30, 2004 if
 - There has already been a medical-legal report, or
 - The treating physician has found permanent disability, or
 - The employer has been required to issue a notice under Section 4061 upon the cessation of TD payments. (§4658(d)(4))

4658.1 Definitions

- Definitions of Modified and Alternate work require at least 85% of time-of-injury earnings and location at a reasonable commute distance from residence.

4660 PD Rating Schedule

- One of the basic principles of PD rating, “diminished ability to compete,” is now replaced by “diminished future earning capacity.” Other basic principles remain the nature of the physical injury or disfigurement, age, and occupation.
- The “nature of the physical injury or disfigurement” shall incorporate the AMA Guides for both descriptions and percentage impairments.
- The rating schedule to be developed by the Administrative Director shall adjust from impairment to arrive at diminished earning capacity by a formula based on empirical data of average long term loss of earnings from each type of injury for similarly situated employees, including age and occupation.
- The new schedule is to be adopted by January 1, 2005 (Section 4660(e)) and is also applicable to injuries before January 1, 2005 if there has been no comprehensive report, no treater’s P&S report, and no obligation for employer to issue Labor Code Section 4061 notice (i.e., TD has not ended).

4663 Apportionment

- Apportionment “shall be based on causation.”
- Reports addressing PD must address causation and must determine percentage of PD caused by injury and by other factors, or refer to another doctor to evaluate apportionment.
- Injured employee must disclose previous disabilities or impairments upon request.

4664 Apportionment

- Employer is liable for the percentage of PD directly caused by the injury.
- Any prior awarded disability is conclusively presumed to continue.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

- Accumulation of all PD awards not to exceed 100% for any one region of the body.

4706.5 Death Without Dependents

- Modernization of language, update cross-reference from Section 4750 to Section 4751.

4750, 4750.5 Apportionment Repealed

- All apportionment provisions are now in Sections 4663 and 4664.

4903.05 Lien Filing Fee

- The filing fee is for liens filed on behalf of providers as well as filed by providers.

5402 Early Medical Treatment

- Employer to provide medical after claim form is filed and until accepted or rejected, with \$10,000 limit on liability before the claim is accepted or rejected.

5703 Admissible Evidence

- The list of admissible evidence to the appeals board will also include the medical treatment utilization schedule in effect pursuant to Section 5307.27 or the guidelines in effect pursuant to Section 4604.5.

5814 Penalty for Unreasonable Delay

- Penalty of up to 25% of amount delayed, to maximum of \$10,000, may be imposed, discretionary. (§5814(a))
- Employer can avoid the 25% penalty by paying 10% penalty of the delayed payment within 90 days of discovery if delay is discovered by the employer before the employee makes a claim for penalty. (§5814(b))
- Potential penalties are deemed resolved by Compromise and Release or Stips and Award or by trial of the underlying benefit unless expressly reserved. (§5814(c))
- Any Section 4650(d) no-fault penalty is credited against the 25% penalty. (§4815(d))
- Nothing in this section shall be construed to create a civil cause of action.
- No unreasonable delay in the provision of medical treatment shall be found when the treatment has been authorized by the employer in a timely manner and the only dispute concerns payment of a billing submitted by a physician or medical provider as provided in Section 4603.2.
- There is a two-year statute of limitations from the date the payment of compensation was due.

Commission on Health and Safety and Workers' Compensation
SUMMARY OF SB 899, by Labor Code Section

- New section is effective June 1, 2004, regardless of date of injury. (Section 43 of SB 899 amending §5814(i))

5814.6 Penalty for General Business Practice of Delays

- Up to \$400,000 civil penalty for a general business practice of unreasonable delays or refusals, to be deposited into RTW Fund pursuant to Section 130.48.
- New section is effective June 1, 2004.

6401.7 Injury and Illness Prevention Program

- The requirement for insurers to review their insureds' industrial injury prevention plan (IIPP) only applies to those insured employers with Ex-Mod of 2.0 or greater.
- The review is to be conducted within six months of the commencement of the initial insurance policy term.
- The reviewer need not be "independent."

SB 899 Effective date:

SB 899 provisions apply

- ✍ ***Prospectively from April 19, 2004 (date of enactment)***
- ✍ ***Regardless of date-of-injury, unless otherwise specified.***