

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
WORKERS' COMPENSATION APPEALS BOARD  
SUPPLEMENTAL STATEMENT OF REASONS**

**Subject Matter of Proposed Regulations:  
Rules of Practice and Procedure of the Workers' Compensation Appeals Board**

**BACKGROUND:**

By its authority under Labor Code sections 5307 and 5307.4 (see also, Lab. Code, §§ 133, 5309 and 5708), the Workers' Compensation Appeals Board (WCAB) noticed and held a public hearing and accepted written comments on its proposal to adopt and amend certain Rules of Practice and Procedure (Rules) in Title 8, Division 1, Chapter 4.5, subchapters 1.9 (§ 10210 et seq.) and 2 (§ 10300 et seq.), of the California Code of Regulations. The public hearing on the initially proposed Rules modifications was held on April 15, 2013. The written comment period also closed on that date.

The WCAB has considered all of the public hearing testimony and all of the timely written comments. The testimony and written comments have persuaded the WCAB to propose further changes to its Rules. Accordingly, in light of its general rulemaking authority (Lab. Code, §§ 5307, 5307.4, 5309 and 5708) and its "power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it" (Lab. Code, § 133), as well as by analogy to Government Code section 11346.8(c), the WCAB, in its discretion, has elected to give the public 15 days (**i.e., until 5pm on Thursday, July 25, 2013**) to submit written comments regarding the newly proposed modifications to the Rules.<sup>1</sup>

This Supplemental Statement of Reasons (SSOR) has been prepared to comply with the procedural requirements of section 5307.4 and for the convenience of the regulated public to assist it in analyzing and commenting on the newly proposed modifications. By analogy to Government Code Section 11346.9(b), the WCAB incorporates its Initial Statement of Reasons (ISOR), unless otherwise specified.

**1. Section Amended: 10250 (entitled "Declaration of Readiness to Proceed").**

The WCAB intends to adopt the changes to Rule 10250 as initially proposed, with two minor modifications.

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<sup>1</sup> Under Government Code section 11351, the rulemaking provisions of Article 5 (Gov. Code, § 11346 et seq.), Article 6 (*id.* § 11349 et seq.), Article 7 (*id.* § 11349.7 et seq.), and Article 8 (*id.* § 11350 et seq.) of the Administrative Procedure Act (APA) "shall not apply" to the WCAB, with one exception not relevant here. Therefore, when the WCAB makes modifications to its proposed rules following a public hearing, it is not required to utilize the procedure of Government Code section 11346.8(c), which mandates that administrative agencies subject to the APA must give the public 15 days to present written comments (without a further public hearing) regarding an agency's post-hearing modifications to their initially proposed regulations.

However, Labor Code section 133 confers the WCAB with "expansive authority" to do *all things* necessary and convenient in the exercise of its power and jurisdiction, and this authority must be "liberally construed." (Cf. *Consumers Lobby Against Monopolies v. Public Utilities Com.* (1979) 25 Cal.3d 891, 905 [construing the similar authority of the Public Utilities Commission under Public Utilities Code section 701]; accord: *Southern California Edison Co. v. Peevey* (2003) 31 Cal.4th 781, 792; *San Diego Gas & Electric Co. v. Superior Court* (1996) 13 Cal.4th 893, 915.) Moreover, there is nothing in the Labor Code that *precludes* the WCAB from giving notice that it will accept further written comments regarding changes it is proposing to make in light of the public testimony and written comments it received in response to its initially proposed Rules.

Accordingly, in view of the nature of the post-hearing changes the WCAB is considering making to its initially proposed rules, the WCAB deems it appropriate to give the public 15 days to submit written comments on these proposed post-hearing changes, by analogy to section 11346.8(c). These additional comments will assist the WCAB in analyzing the post-hearing changes it is considering.

First, the WCAB intends to add a new subdivision (b) to proposed Rule 10250. It would require that, where a declaration of readiness (DOR) requests a lien conference or lien trial, the DOR shall be served on all parties and lien claimants “listed on the official participant record in EAMS at the time of service and, if represented, on their attorney(s) or nonattorney(s) representative(s) of record.”<sup>2</sup> The reason for this provision is that, in some instances, DORs for lien conferences and trials are not being served on all lien claimants. Accordingly, some lien claimants are unaware of a lien conference or lien trial until they receive the notice of hearing, which often gives them insufficient time to prepare. This results in unnecessary continuances. Similarly, the DORs are sometimes served on the defendants and lien claimants, but not on their attorneys or non-attorney representatives of record. This again sometimes results in unnecessary continuances.

Second, in his written comments Mark Gerlach of the California Applicants’ Attorneys Association (CAAA) correctly points out that there is a drafting error in proposed Rule 10250(b)(1), i.e., the reference to section 10301(dd)(4) should be a reference to section 10301(dd).<sup>3</sup>

At the April 16, 2013 public hearing, Danielle Carter of Landmark Medical Management (Landmark) complained that, if a paper-filed lien claim has not yet been scanned into the Electronic Adjudication Management System (EAMS), proposed Rule 10250(b) (now, proposed Rule 10250(c)) would prohibit a lien claimant from filing a DOR even if it has become a “party” under proposed Rule 10301(dd). The WCAB disagrees. Preliminarily, as explained in the ISOR, the provision of proposed Rule 10250 that only a “party” as defined by Rule 10301 may file a DOR is *not* a substantive change in the WCAB’s Rules. In any event, the WCAB anticipates that this will be an increasingly diminishing problem because most lien claims are now filed electronically, either through JET-filing or e-forms (<http://www.dir.ca.gov/DWC/EAMS/EAMS.htm>) and, as of January 1, 2013, all medical treatment liens and claims of costs filed in the form of a lien *must* be filed electronically (Lab. Code, § 4903.05(b)). Therefore, to the extent that some district offices might currently have a scanning backlog, they should be caught up soon.

Ms. Carter of Landmark also complained that proposed Rule 10250 would require a party filing the DOR to declare under penalty of perjury that they have completed discovery, which she asserts would be unfair because “between [Rules] 10582.5 and 10770.1, lien claimants have only a 90-day period to exercise discovery.” The WCAB disagrees. First, although non-physician lien claimants now have limits on the discovery of “medical information” (Lab. Code, § 4903.6(d); see also proposed Rules 10538 & 10608), lien claimants are not otherwise limited in conducting informal or formal discovery before they become a “party” under Rule 10301. Second, all that proposed Rule 10250(c) would require is that a declarant state under penalty of perjury that it has completed discovery “*on the issues specified* in the declaration of readiness.” (Italics added.) Therefore, for example, if the issue on which the DOR is filed relates to a dispute over discovery, then the lien claimant or other party filing the DOR obviously will not have completed its discovery on the underlying issues.

## **2. Section Amended: 10260 (entitled “Consolidation Procedures”).**

The WCAB intends to adopt the changes to Rule 10260 as initially proposed, with the exception of a minor non-substantive modification for clarity.

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<sup>2</sup> The official participant record is available through the public information case search function of EAMS. It can be used to identify all currently active parties, lien claimants, attorneys, and non-attorney representatives. Also, it can be used to obtain their addresses, except that residence addresses are confidential (see Lab. Code, § 138.7(b)(5)(C)).

<sup>3</sup> This SSOR will make periodic references to some specific public comments, but for the most part the SSOR is a general, non-specific response to the public testimony and written comments offered. Nevertheless, all of the public hearing testimony and timely written comments were reviewed and analyzed by the WCAB, even if no specific reference is made to individualized testimony or comments.

**3. Section Amended: 10300 (entitled “Adoption, Amendment or Rescission of Rules”).**

The WCAB intends to adopt the changes to Rule 10300 as initially proposed.

**4. Section Amended: 10301 (entitled “Definitions”).**

The WCAB intends to largely adopted changes to Rule 10301 as initially proposed, except as stated below.

The WCAB intends to modify the initially proposed language of Rule 10301(h) defining “cost.”

Rule 10301(h), as originally proposed, stated that costs “include, but are not limited to” certain specified items, but the specified items did not include medical-legal expenses. Labor Code section 4903.05, however, allows the filing of a claim of costs in the form of the lien, and the WCAB anticipates that many such filings will be for medical-legal expenses. Accordingly, the WCAB concludes that Rule 10301(h) should be modified to expressly state that “costs” include medical-legal expenses, so as to obviate any question about whether medical-legal expenses are subject to a claim of costs filed in the form of a lien.

Nevertheless, as more extensively discussed in the SSOR for newly proposed Rule 10451.3 below, the fact that medical-legal expenses are being expressly deemed “costs” does *not* mean that they can be claimed through a petition for costs. Therefore, the WCAB is also proposing to add a new paragraph to Rule 10301(h) providing that the inclusion of medical-legal expenses within the definition of “cost” does not permit them to be claimed through a petition for costs; however, they may be sought through a claim of costs in the form of a lien.

The WCAB also intends to modify the initially proposed definition of “party” in Rule 10301(dd) (current Rule 10301(x)) to include an interpreter filing a petition for costs in accordance with section 10451.3. This would permit an interpreter to file a DOR when filing, for example, a petition for costs for interpreter services at a WCAB hearing. This proposed modification is again predicated on newly proposed Rule 10451.3 regarding petitions for costs. Under proposed Rule 10451.3, petitions for costs may be filed only by parties to the underlying case-in-chief (i.e., employees, dependents, and defendants), with the exception that interpreters may file petitions for costs for services *other than* those tendered at a medical treatment appointment, medical-legal examination, or medical-legal deposition. (See SSOR discussion of Rule 10451.3.)

The WCAB further intends to modify the initially proposed definition of “section 4903(b) lien” in Rule 10301(ii) to expressly include interpreter services and copying and related services rendered in connection with medical treatment. (See SSOR discussion of Rule 10451.2.)

**5. Section Amended: 10408 (entitled “Pleadings and Forms”).**

The WCAB intends to adopt Rule 10408 as initially proposed, without further changes.

In the public comments, it was suggested that multiple additional “forms prescribed and approved by the Appeals Board” be added to the forms expressly enumerated in subdivision (a), subparts (1) through (9). The proposal to specifically list other forms was largely related to the many new petitions and other documents that would be required to be filed under the WCAB’s proposed SB 863 rules.

The WCAB concludes it is unnecessary to specify any additional forms because: (1) proposed Rule 10408(a)(10) includes the catchall of “any other form the Appeals Board, in its discretion, determines should be uniform and standardized; and (2) proposed Rule 10408(b) states that any form for WCAB proceedings created by the Division of Workers’ Compensation (DWC) “shall be presumed to have been prescribed and approved by the Appeals Board,” unless the Appeals Board states to the contrary.

Furthermore, it is premature to specify any additional forms because they have not yet been created by DWC. Forms creation requires time and resources that are not always readily available. This is particularly true if the

creation of the form requires programming so that EAMS can read its text fields to properly gather and store the information.

It has also been suggested that the provision in subdivision (b) that DWC “may” create these forms be changed to “shall.” The WCAB rejects this suggestion for the reasons just stated.

**6. Section Newly Amended: 10450 (entitled “Petitions and Answers”).**

In the original round of rulemaking, several of the initially proposed Rules contained the same or similar requirements for the filing of various petitions. Rather than stating these requirements in each separate Rule, the Appeals Board is now proposing to incorporate these requirements into Rule 10450, the generic rule on petitions. The generic rule on petitions has also been extended to apply to answers.

These proposed amendments include provisions that, unless otherwise provided by statute or rule: (1) an answer may be filed within 10 days after the filing of the petition; (2) the time for filing a petition or answer is extended by sections 10507 (extending the time when service is made other than personally) and 10508 (extending the time when the last day for filing falls on a weekend or holiday); (3) all petitions and answers shall be verified and a failure to verify constitutes a valid ground for summarily dismissing or denying a petition or summarily rejecting an answer; (4) service of any petition or answer shall be made on specified persons and entities and a failure to concurrently file a proof of service constitutes a valid ground for summarily dismissing or denying a petition or summarily rejecting an answer; and (5) a document cover sheet and document separator sheet shall accompany each petition or answer, with the appropriate title entered into the title field. The proposed amendments also merge into a single rule specified requirements about where and how a petition is to be filed.

In discussing the proposed Petition to Enforce rule, Jeremy Merz of the California Chamber of Commerce (CalChamber) essentially suggested a limitation that a petition shall be filed only by a person or entity allegedly entitled to relief. The WCAB is not aware of any significant problem of petitions being filed by persons or entities not entitled to the relief sought and, if any such petitions are filed, the WCAB believes that the sanctions and other remedies afforded by Labor Code section 5813 and Rule 10561 are a sufficient deterrent. Therefore, the WCAB rejects the CalChamber’s suggestion.

**7. Proposed Section Renumbered: 10451 (entitled “Petition for Costs”).**

The WCAB intends to delete Rule 10451, as initially proposed. Instead, the WCAB intends to re-number it as proposed Rule 10451.3 and make various modifications to it. The reasons the modifications are discussed in the SSOR regarding Rule 10451.3.

**8. Section Newly Added: 10451.1 (entitled “Determination of Medical-Legal Expense Disputes”).**

Preliminarily, Rule 10451.1, as initially proposed, has been re-numbered to proposed Rule 10451.4. (See SSOR discussion of Rule 10451.4.)<sup>4</sup>

Rule 10451.1(a) begins by stating: “The following procedures shall be utilized for the determination of medical-legal expense disputes.” This is because the Appeals Board’s Rules, as initially proposed, had several different provisions relating to medical-legal expenses (i.e., proposed Rules 10451, 10451.1, and 10451.2). As revised, however, Rule 10451.1 merges many of those procedures into a single rule, as well as incorporating some additional procedures into that rule. However, some procedures have not been incorporated — e.g., for the reasons set forth in the discussion below, Rule 10451.1 does not incorporate the provisions of initially proposed Rule 10451(b)(3) that would have allowed a petition for costs to be filed for interpreter services rendered during a medical-legal examination. Further, some new language has been added for clarification purposes.

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<sup>4</sup> All further references to Rule 10451.4 are to the newly proposed version.

Rule 10451.1(b)(1) states that, for purposes of this section, “medical-legal expense” shall mean *any* cost or expense incurred by or on behalf of any party for the purpose of proving or disproving a contested claim, including but not limited to: (A) goods or services expressly specified by Labor Code section 4620(a); (B) services rendered by a non-medical expert witness (e.g., a vocational expert); (C) services rendered by a certified interpreter during a medical-legal examination; and (D) all costs or expenses for copying and related services.<sup>5</sup>

The reason for the “*any* cost or expense” language of Rule 10451.1(b)(1) and for the express inclusion of subdivisions (b)(1)(B) and (b)(1)(D) is found in the language of section 4620(a), which states:

“For purposes of this article, a medical-legal expense means *any* costs and expenses incurred by or on behalf of any party, which expenses *may include* X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter’s fees by a certified interpreter ... for the purpose of proving or disproving a contested claim.” (Italics added.)

“The word ‘any’ means without limit and no matter what kind.” (*Delaney v. Superior Court* (1990) 50 Cal.3d 785, 798; see also, e.g., *Cal. State Auto. Ass’n. Inter-Ins. Bureau v. Warwick* (1976) 17 Cal.3d 190, 195 [“From the earliest days of statehood [the Supreme Court has] interpreted ‘any’ to be broad, general and all embracing”]; *Davidson v. Dallas* (1857) 8 Cal. 227, 239 [“The word ‘any’ means every”]; accord: *People v. Dunbar* (2012) 209 Cal.App.4th 114, 117-118; *Dept. of Cal. Highway Patrol v. Superior Court* (2008) 158 Cal.App.4th 726, 736.)

Similarly, “the word ‘including’ in a statute is ‘ordinarily a term of enlargement rather than limitation.’ ” (*Hassan v. Mercy American River Hosp.* (2003) 31 Cal.4th 709, 717 [quoting from *Ornelas v. Randolph* (1993) 4 Cal.4th 1095, 1101]; accord: *Flanagan v. Flanagan* (2002) 27 Cal.4th 766, 774.)

Accordingly, under section 4620(a), a medical-legal expense is “any” cost or expense incurred for the purpose of proving or disproving a contested claim, regardless of whether that cost or expense “may include” a “medical” component in addition to a “legal” (forensic) component.

Necessarily, therefore, a “medical-legal expense” would include the expense of a non-medical expert (e.g., the report or testimony of a vocational expert, or of a lay person not employed by the Disability Evaluation Unit of DWC who was brought in to rebut a recommended permanent disability rating).

Also, when a legal copy service copies medical, personnel, wage, business, or other records or engages in other services relating to such records, its charges constitute medical-legal expenses. (See *Martinez v. Terrazas* (2013) 78 Cal.Comp.Cases 444, 449 (Appeals Board en banc) (*Martinez*).)

Rule 10451.1(b)(1)(C) specifically emphasizes that “medical-legal expense” includes services rendered by a certified interpreter during a medical-legal examination. This conclusion is mandated by the language of Labor Code section 4620(a), which provides that “a medical-legal expense ... may include ... interpreter’s fees by a certified interpreter ... .” However, this subdivision is being expressly included to lay to rest any confusion that might still exist based on the language of initially proposed Rule 10451(b)(2). (See also *Martinez*, 78 Cal.Comp.Cases at p. 449, fn. 6.)

Rule 10451.1(b)(2) defines “medical-legal provider” to mean any person or entity who seeks payment for or reimbursement of a medical-legal expense, other than an employee or dependent (or the attorney or non-attorney representative of an employee or dependent) who directly paid for medical-legal goods or services. The reason for this provision is that the independent bill review (IBR) provisions of Labor Code sections 4603.2, 4603.6,

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<sup>5</sup> “Related services” might include, for example: (1) subpoenaing, reviewing, organizing, and storing medical, personnel, wage, business, or other records; or (2) travel expenses associated with copying such records.

and 4622 apply only to a “provider.” (See Lab. Code, §§ 4603.2(b)(1), (b)(2)(A) & (B), (e)(1), (e)(2), (e)(4), 4603.3(a)(1) & (6), 4603.6(a), (c), (e), (h), 4622(b)(1), (b)(2), (b)(4), (c), (e)(1); see also Cal. Code Regs., tit. 8, §§ 9792.5.4(i), 9792.5.5, 9792.5.7.) Therefore, the Appeals Board concludes that where, for example, an applicant or an applicant’s attorney advances or otherwise directly pays a medical-legal expense (e.g., paying a physician in advance for a medical-legal deposition or paying a vocational expert in advance for a report or trial testimony), they may file a petition for costs without undertaking IBR.

Rule 10451.1(c)(1) provides that, where applicable, IBR applies solely to medical-legal expense disputes directly related to the amount payable under an official fee schedule. (See Lab. Code, § 4622(c) [referring to situations where the defendant “denies all or a portion of the amount billed for any reason other than the amount to be paid pursuant to the fee schedules in effect on the date of service”].) It then goes on to specify the types of medical-legal expense disputes that are *not* subject to IBR.

Rule 10451.1(c)(1)(A) provides that IBR shall not be used to resolve any threshold issue that would entirely defeat a medical-legal expense claim (e.g., employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction). It further provides, however, that a “threshold issue” shall not include a dispute over whether the employee sustained industrial injury or injury to a particular body part.

“Employment” is among the specific examples of threshold issues included because medical-legal expenses are reimbursable only for the workers’ compensation claim of an “employee.” (Lab. Code, § 4621(a) [“*the employee* ... shall be reimbursed for his or her medical-legal expenses” (emphasis added)]; *Zarate v. Workers’ Comp. Appeals Bd.* (1979) 99 Cal.App.3d 598, 603 [44 Cal.Comp.Cases 1128].)

On the other hand, injury is specifically excepted because medical-legal costs cannot be disputed on the basis that injury was not sustained. (*Subsequent Injuries Fund v. Industrial Acc. Com. (Roberson)* (1963) 59 Cal.2d 842, 844 [28 Cal.Comp.Cases 139]; *Beverly Hills Multispecialty Group, Inc. v. Workers’ Comp. Appeals Bd. (Pinkney)* (1994) 26 Cal.App.4th 789, 802 [59 Cal.Comp.Cases 461]; *Turudich v. Industrial Acc. Com.* (1965) 237 Cal.App.2d 455, 458 [30 Cal.Comp.Cases 316].)<sup>6</sup>

Rule 10451.1(c)(1)(B) provides that IBR shall not apply to medical-legal expenses incurred prior to January 1, 2013 because this is what the Rules of the Administrative Director (AD) provide (see Cal. Code Regs., tit. 8, §§ 9792.5.4, 9792.5.5(a), 9792.5.7(a)). It is the AD who administers IBR (see Lab. Code, §§ 139.5, 4603.6). In addition, Labor Code section 139.5(a)(1) provides that “[t]he [AD] shall contract with one or more independent medical review organizations and one or more *independent bill review organizations* to conduct reviews” (italics added). In turn, section 139.5(a)(2) provides that “[t]o enable the independent review program to go into effect *for injuries occurring on or after January 1, 2013*, ... independent review organizations under contract with the Department of Managed Health Care ... may be designated by the [AD] to conduct reviews” (italics added). When these two provisions are read together, they imply a legislative intent that IBR is inapplicable to injuries prior to January 1, 2013 (see Stats. 2012, ch. 363, § 84 [stating that SB 863 “shall apply to all pending matters, regardless of date of injury, *unless otherwise specified in this act*” (italics added)]).

Rule 10451.1(c)(1)(C) and (D) are included because IBR relates only to disputes over the amount payable under an official fee schedule. (See Lab. Code, §§ 4622(c), 4603.6(a); Cal. Code Regs., tit. 8, §§ 9792.5.4(i), 9792.5.7(a)(1) & (b)(1).) Therefore, IBR does not apply to “contested claim” or “reasonably, actually, and necessarily incurred” disputes. (See Lab. Code, §§ 4620, 4621, 4622(f).)

Rule 10451.1(c)(1)(E) and (F) address the situations where, based on an alleged breach of statutory or regulatory duties, either: (1) a medical-legal provider asserts that a defendant has waived any objection to the amount of its bill; or (2) a defendant asserts that a medical-legal provider has waived any claim to further payment.

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<sup>6</sup> Both *Roberson* and *Turudich* interpreted former Labor Code section 4600, which at the time of those cases covered medical-legal expenses.

In this regard, the law establishes that where a party has a duty to take a particular action to preserve a claim or defense, it must timely undertake that action and cannot bypass it; otherwise, the party waives that claim or defense. (*Elliot v. Workers' Comp. Appeals Bd.* (2010) 182 Cal.App.4th 355 [75 Cal.Comp.Cases 81] [a defendant that breached its duty to timely initiate the spinal surgery second opinion process under former Labor Code section 4062(b) waived its right to object to the surgery]; *J.C. Penney Co. v. Workers' Comp. Appeals Bd. (Edwards)* (2009) 175 Cal.App.4th 818 [74 Cal.Comp.Cases 862] [a defendant that failed to object to a medical determination regarding temporary total disability by a treating physician within the time limit provided by Labor Code section 4062 waived the right to object to determination].) This is consistent with both Labor Code section 4622(b)(2) and section 4622(c). Section 4622(b)(2) states that “[i]f the provider does not request a second review within 90 days, the bill will be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.” Similarly, section 4622(c) states that “[i]f the provider does not object to the denial [on non-IBR grounds] within 90 days [of the service of the explanation of review], neither the employer nor the employee shall be liable for the amount that was denied.”

Rule 10451.1(c)(1)(G) provides that a non-IBR dispute includes an assertion by a defendant that an interpreter at a medical-legal examination did not meet the criteria established by Labor Code sections 4620(d) and 5811(b)(2) and the Rules of the Administrative Director, as applicable.

Rule 10451.1(c)(2) relates to the duty of a defendant to file a “Petition for Determination of Non-IBR Medical-Legal Dispute” and a declaration of readiness (DOR). It derives from the language of Labor Code section 4622(c), which provides that for disputes “other than the amount to be paid pursuant to the fee schedules in effect on the date of service,” where a medical-legal provider objects to a defendant’s final written determination within 90 days of its service, the defendant “shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection.”

Rule 10451.1(c)(3) provides that if a defendant breaches its duty to file a “Petition for Determination of Non-IBR Medical-Legal Dispute” and a DOR, or breaches a duty under the Labor Code and the AD’s Rules at an earlier stage of the medical-legal expense dispute, the medical-legal provider may file a petition and a DOR. This provision will create a disincentive for a defendant to sit on its hands and do nothing, especially when the sanctions, attorney’s fees, and costs provisions of Rule 10451.1(h)(1) are factored in.

Rule 10451.1(c)(4) provides that, even when a DOR is filed in accordance with subdivisions (c)(2) or (c)(3), if there is a threshold issue within the meaning of subdivision (c)(1)(A) the WCAB may defer hearing and determining this issue until: (A) the issue is presented for determination in the employee’s underlying case; or (B) the employee’s underlying claim has been resolved by a compromise and release agreement or has been abandoned.

The reason for this provision is two-fold.

First, unless the employee has settled or abandoned the underlying case, it will be the employee who will have the greater interest in litigating an unresolved threshold issue. This is because the threshold issue could defeat the employee’s *entire* workers’ compensation claim. Concomitantly, the employee will be better positioned to present evidence on that threshold issue. For example, the employee will have more direct knowledge or access to evidence on the issues of whether he or she was an employee or whether the claim is not barred by the statute of limitations because the defendant failed to give notice of the employee’s workers’ compensation rights.

Second, this provision furthers judicial economy. If a medical-legal provider unsuccessfully litigates a threshold issue, then it is questionable whether there will be sufficient privity for the adverse finding against the provider to have *res judicata* or collateral estoppel effect against the employee. However, with respect to a threshold issue, a medical-legal provider stands in the shoes of the injured employee. (E.g., *Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Martin)* (1985) 39 Cal.3d 57, 67-68 [50 Cal.Comp.Cases 411]; *Kunz v. Patterson Floor Coverings* (2002) 67 Cal.Comp.Cases 1588, 1592 (Appeals Board en banc).) Therefore, where

an employee litigates a threshold issue, the WCAB's determination of that issue will apply to the non-employee medical-legal provider.

Rule 10451.1(d)(1) provides that, if a defendant has contested liability for a medical-legal expense for any reason other than the amount payable under an official medical fee schedule, that issue shall be resolved prior to IBR. The requirement that non-IBR issues must be resolved before IBR is mandated by Labor Code section 4603.6(a), which states: "If the employer has contested liability for any issue other than the reasonable amount payable for services, *that issue shall be resolved prior to filing a request for independent bill review*, and the time limit for requesting independent bill review shall not begin to run until resolution of that issue becomes final ... ." (Italics added; see also Lab. Code, § 4603.2(e)(1); Cal. Code Regs., tit. 8, §§ 9792.5.5(b)(2), 9792.5.7(c)(5)). Therefore, IBR is not to be conducted if there is a threshold dispute that would entirely defeat the medical-legal provider's claim. Of course, if the medical-legal provider's claim is defeated based on a threshold issue, then any IBR issue becomes moot.

Whenever a medical-legal provider prevails on the non-IBR issues, the requirement that it must then use IBR to resolve disputes over the amount payable under an official fee schedule is mandated by Labor Code section 4622(b)(4). It states: "[i]f the provider contests the amount paid, after receipt of the second review, the provider *shall request an independent bill review* as provided for in Section 4603.6" (italics added). The WCAB's jurisdiction over an IBR dispute is restricted to determining appeals to the limited extent provided by Labor Code section 4603.6(f).

Rule 10451.1(d)(2) provides that if a non-IBR medical-legal expense dispute is resolved in the medical-legal provider's favor, then any outstanding issue over the amount payable under an official fee schedule shall be resolved through IBR, if applicable. The requirement to use IBR to resolve disputes over the amount payable under an official fee schedule is mandated by Labor Code section 4622(b)(4), which states: "[i]f the provider contests the amount paid, after receipt of the second review, the provider *shall* request an independent bill review as provided for in Section 4603.6" (italics added). Again, the WCAB's jurisdiction over an IBR dispute is restricted to determining appeals to the limited extent provided by Labor Code section 4603.6(f).

Rule 10451.1(d)(3) provides that, when a petition appealing an IBR dispute is filed with the WCAB (see Rule 10957), the medical-legal provider need not file a claim of costs in the form of a lien (see Lab. Code, § 4903.05(b) & (c)) and need not pay a \$150 filing fee (see Lab. Code, § 4903.05(c)). The WCAB adopts this provision because, when interpreting the statutory scheme, the WCAB must choose the construction that comports most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute. (*Torres v. Parkhouse Tire Service, Inc.* (2001) 26 Cal.4th 995, 1003 (*Torres*); *Estate of Griswold* (2001) 25 Cal.4th 904, 911 (*Griswold*)). When an amount payable dispute goes to IBR, the medical-legal provider must pay a fee to the AD (Lab. Code, § 4603.6(c)) and, under the AD's current rules, this fee is \$335. (Cal. Code Regs., tit. 8, § 9792.5.7(d)(1)(A) & (B).) It would be inconsistent with legislative intent to require that, in order to pursue a petition appealing an IBR determination, a medical-legal provider would have to file a lien and pay an additional \$150 filing fee after having paid a \$335 fee to undertake IBR.

Rule 10451.1(e) requires that medical-legal lien claims filed prior to January 1, 2013 under former Labor Code section 4903(b) are governed by the lien conference and lien trial procedures of section 10770.1 and are subject to the timely payment of a lien activation fee, if applicable. The reason for this provision is two-fold. First, such liens necessarily will be for medical-legal expenses incurred prior to January 1, 2013; therefore, they are not subject to IBR. (Cal. Code Regs., tit. 8, §§ 9792.5.4, 9792.5.5(a), 9792.5.7(a).) Second, while the non-IBR issues for such liens are largely those described in Rule 10451.1(d)(1), the Legislature, with limited exceptions, has required that: (1) these medical-legal lien claimants must pay a \$100 lien activation fee in order to invoke the jurisdiction of the WCAB; and (2) these liens must be the subject of a DOR and a lien conference. (Lab. Code, § 4903.06(a); see also *Martinez*, 78 Cal.Comp.Cases 444; *Figueroa v. B.C. Doering Co.* (2013) 78

Cal.Comp.Cases 439 (Appeals Board en banc); *Mendez v. Le Chef Bakery* (2013) 78 Cal.Comp.Cases 454 (Significant Panel Decision).

Rule 10451.1(f) would allow the filing of a petition to enforce if: (1) the AD has issued an IBR determination and order that requires payment; (2) the determination and order has become final (i.e., either a petition appealing the determination and order is not filed with the WCAB, or the WCAB has issued a final decision affirming the determination and order); and (3) the defendant has not timely paid.

This provision is consistent with: (1) Labor Code section 4603.6(f), which provides that an IBR determination of an independent bill reviewer “shall be deemed a determination and order of the administrative director” and that “[this] determination is *final and binding*” unless an aggrieved party files a verified appeal with the WCAB within 20 days of the service of the determination (italics added); (2) Labor Code section 4603.6(h), which provides that “[o]nce the independent bill reviewer has made a determination regarding additional amounts to be paid to the medical provider, the employer *shall pay* the additional amounts per the timely payment requirements set forth in Sections 4603.2 and 4603.4” (italics added); and (3) Labor Code section 4622(a)(1), which provides that, after a medical-legal expense has been through IBR or an IBR appeal, “payments *shall be made* within 20 days of the service of an order of the appeals board or the administrative director pursuant to Section 4603.6 directing payment” (italics added). Accordingly, if a defendant fails to make payment as required by sections 4603.6(f) and (h) and 4622(a)(1), then a medical-legal provider should have the right to enforce payment before the WCAB.

Rule 10451.1(f) further provides that, under these circumstances, the provider does *not* have to file a section 4903(b) lien or a claim of costs lien and does *not* have to pay a lien filing or activation fee.

Again, this provision is adopted because, when interpreting the statutory scheme, the WCAB must choose the construction that comports most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute and to avoiding an interpretation that would lead to absurd consequences. (*Torres, supra*, 26 Cal.4th at p. 1003; *Griswold, supra*, 25 Cal.4th at p. 911.) Under SB 863, when an amount payable dispute goes to IBR, the medical-legal provider must pay a fee to the AD (Lab. Code, § 4603.6(c)) and, under the AD’s current rules, this fee is \$335. (Cal. Code Regs., tit. 8, § 9792.5.7(d)(1)(A) & (B).) It would be absurd if, after paying the IBR fee and obtaining a final and binding determination that the defendant is required to pay (see Lab. Code, §§ 4603.6(f) & (h), 4622(a)(1)), a provider would have to pay a \$150 lien filing fee (Lab. Code, § 4903.05(c)(1)) or a \$100 activation fee (Lab. Code, § 4903.06(a)(1)) to enforce the binding determination and order against a recalcitrant defendant. This is so even though the defendant might be required to reimburse the medical-legal provider for the \$335 fee. (See Lab. Code, § 4603.6(c).) Presumably, a defendant that has failed to pay after an IBR determination will also have failed to reimburse the IBR administration fee.

Rule 10451.1(g) addresses the situations where, based on an alleged breach of statutory or regulatory duties, a medical-legal provider asserts that a defendant has waived any objection to the amount of its bill or a defendant asserts that a medical-legal provider has waived any claim to further payment. The reasoning for this subdivision has already been discussed in connection with Rule 10451.1(c)(2)(F) and (G), above. However, to briefly reiterate, the law establishes that where a party has a duty to take a particular action to preserve a claim or defense, it must timely undertake that action and cannot bypass it; otherwise, the party waives that claim or defense. (See *Elliot, supra*; *Edwards, supra*; Lab. Code, §§ 4622(b)(2), 4622(c).)

In substance, Rule 10451.1(h) provides that, where a defendant or a medical-legal provider engages in bad faith

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actions or tactics, monetary sanctions, attorney's fees, and costs shall be imposed.<sup>7</sup> It further provides that for bad faith actions or tactics occurring on or after the effective date of Rule 10451.1, the monetary sanctions shall not be less than \$500.

Of course, the Board always has the power to impose such sanctions under Labor Code section 5813 and section 10561, even without including an express provision in a particular Rule. However, in addition to the general rulemaking authority that the Legislature has vested in the Appeals Board (Lab. Code, §§ 133, 5307, 5309, 5708), Labor Code section 4622(e)(2) also expressly declares: "The appeals board shall promulgate all necessary and reasonable rules and regulations *to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced.*" (Italics added.) Similarly, section 4627 expressly states: "The board... may promulgate such reasonable rules and regulations as may be necessary to interpret this article *and compel compliance with its provisions.*" (Italics added.) It appears, therefore, that the Legislature has a special concern about enforcing compliance with all medical-legal expense procedures.

In this regard, in the public comments the Appeals Board received in response to its latest rulemaking, as well as those received in response to its prior rulemaking relating to the lien rules (i.e., Cal. Code Regs., tit. 8, §§ 10582.5, 10770, 10770.1), the Appeals Board received numerous complaints about failures by defendants to comply with statutory and regulatory medical-legal procedures. For example, there were complaints by medical-legal providers that sometimes no payments at all are made on medical-legal bills, even with bills from agreed medical evaluators (AMEs) and qualified medical evaluators (QMEs).<sup>8</sup> Based on these complaints, as well as many cases the Board has adjudicated and anecdotal reports from WCJs, it appears that, in a not insignificant percentage of cases, the penalty and interest provisions of Labor Code section 4622(a) do not provide a sufficient incentive for some defendants to comply with the law. Accordingly, consistent with the language of sections 4622(e)(2) and 4627, we conclude that specific sanctions provisions are needed to help insure compliance with the requirements of Labor Code sections 4622, 4603.3, and 4603.6, and the related Rules of the Administrative Director (e.g., Cal. Code Regs., tit. 8, §§ 9792.5.1 et seq., 9793 et seq.). In particular, the imposition of a minimum monetary sanction of \$500 for bad faith actions or tactics occurring after the effective date of this Rule will help enforce the requirements of those statutory and regulatory provisions.

On the other hand, there were also complaints by the defense community regarding the failure of medical-legal providers to follow correct medical-legal procedures. Yet, section 4622 does not impose monetary penalties against medical-legal providers who violate applicable laws (although, of course, they run the risk of waiving their claim). Moreover, the Appeals Board concludes that there should be some significant disincentive to dissuade medical-legal providers from potentially making frivolous claims of non-compliance by a defendant in an attempt to bypass IBR. Therefore, again, consistent with sections 4622(e)(2) and 4627, the Appeals Board believes a specific rule providing for the imposition of monetary sanctions, attorney's fees, and costs against

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<sup>7</sup> In some instances, Rule 10451.1(h) indicates that a determination of a "bad faith" action or tactic can be based on a failure to act in "good faith." This is because "bad faith" and "not in good faith" are legally equivalent terms. (*Corbett v. Hayward Dodge, Inc.* (2004) 119 Cal.App.4th 915, 920-921, 923; see also *Shisler v. Sanfer Sports Cars, Inc.* (2008) 167 Cal.App.4th 1, 9.)

<sup>8</sup> We also take judicial notice of a recent article in the Workers' Compensation Quarterly of the Workers' Compensation Section of the State Bar of California (Vol. 26, No. 1 (2013)) entitled "*Medical-Legal Charges and Needless Bill Reviews.*" The commentator (Jon C. Brissman), who indicates he is an attorney representing lien claimants, states that he has seen explanation of review (EOR) forms from defendants that have denied payment for AME or QME charges based on reasons such as: (1) the claim is denied; (2) the provider is not in the employer's Medical Provider Network (MPN); (3) utilization review (UR) did not certify the AME or QME services; (4) the underlying claim is still in litigation; and (5) the billing was not on a DWC-approved form. As Mr. Brissman correctly notes, none of these is a valid basis for entirely denying a medical-legal expense claim.

medical-legal providers making such frivolous claims is necessary. (Cf. *Torres v. AJC Sandblasting* (2012) 77 Cal.Comp.Cases 1113, 1115, 1121-1122 (Appeals Board en banc) [proceeding to trial without any evidence or with evidence that is indisputably incapable of establishing a claim or affirmative defense constitutes bad faith within the meaning of section 5813 justifying an award of sanctions, attorney’s fees and costs].) Moreover, the imposition of a minimum monetary sanction of \$500 for bad faith actions or tactics occurring after the effective date of this Rule will help “insure compliance” and “compel compliance” with the medical-legal statutory and regulatory provisions, and help “guarantee that [those laws] are enforced.” (Lab. Code, §§4622(e)(2), 4627.)

**9. Proposed Section Deleted: 10451.2 (formerly entitled “Petition Re: Non-IBR Medical-Legal Disputes”).**

The WCAB intends to delete Rule 10451.2, as initially proposed. Instead, its provisions are now addressed in newly proposed Rule 10451.1, particularly, subdivisions (c)(2) and (3).

**10. Section Newly Added: 10451.2 (entitled “Determination of Medical Treatment Disputes”).**

The WCAB is proposing newly added Rule 10451.2.<sup>9</sup>

Rule 10451.2(a) provides: “The following procedures shall be utilized for the determination of all disputes over medical treatment and related goods and services.”

This provision, when read in conjunction with the balance of Rule 10451.2, recognizes that the Legislature has established special procedures for independent medical review (IMR) and independent bill review (IBR). Concurrently, it recognizes that there are some medical treatment disputes not subject to IMR and/or IBR and that these non-IMR/IBR disputes are governed by other applicable provisions of the Labor Code and of the Rules.

Rule 10451.2(b) provides that “medical treatment” means any goods or services provided in accordance with Labor Code section 4600 et seq., including but not limited to services rendered by an interpreter at a medical treatment appointment.<sup>10</sup> Services rendered by an interpreter at a medical treatment appointment are expressly included because Rule 10450, as it was initially proposed, would have provided that interpreter services at medical treatment appointments could be claimed through a petition for costs. As more extensively discussed in the SSOR for Rule 10451.3, the Appeals Board no longer adheres to this view.

Rule 10451.2(c)(1) provides that IMR, where applicable, applies solely to disputes over the necessity of medical treatment. This provision derives from the language of Labor Code sections 4610.5 and 4610. First, section 4610.5 repeatedly indicates that IMR applies to “medical necessity” or “medically necessary” disputes. (Lab. Code, § 4610.5(c)(2), (c)(3), (f)(2) & (3), (h)(2), (k), (l)(4).) Second, section 4610.5 repeatedly indicates that IMR applies only to disputes over “a utilization review decision” (Lab. Code, § 4610.5(a)(1) & (2) (c)(1) & (3), (d), (e), (f), (h), (j), (k)) and, in turn, section 4610 establishes that UR relates only to review of the “medical necessity” of treatment recommendations by treating physicians (Lab. Code, § 4610(a), (c), (e), (g)(3)(B) & (5)). Accordingly, when read together, these statutory provisions establish that IMR applies only to medical necessity disputes.

Rule 10451.2(c)(1) further provides that IMR also applies only when a defendant has conducted a timely and otherwise procedurally proper UR. This provision is also based on Labor Code sections 4610.5 and 4610.

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<sup>9</sup> All further references to Rule 10451.2 are to the newly proposed version.

<sup>10</sup> Labor Code section 4600(f) and (g) and Labor Code section 5811(b)(2)(C) specifically authorize such services if certain conditions are met. These provisions appear to be a codification of *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228 (Appeals Board en banc) (*Guitron*).

Again, section 4610.5 repeatedly indicates that IMR applies only to disputes over “a utilization review decision.” (Lab. Code, § 4610.5(a)(1) & (2) (c)(1) & (3), (d), (e), (f), (h), (j), (k).) If a defendant never undertakes UR, there obviously will never be a “utilization review decision” to review and, therefore, IMR will not apply.<sup>11</sup>

However, for the following reasons, an untimely or procedurally deficient UR decision is also not subject to IMR.

First, Labor Code section 4610(b) requires that “[e]very employer shall establish a utilization review process *in compliance with this section.*” (Italics added.) In turn, section 4610 requires that, in undertaking UR, defendants shall adhere to various timelines and procedures. In *State Comp. Ins. Fund v. Workers’ Comp. Appeals Bd. (Sandhagen)* (2008) 44 Cal.4th 230, 236-237, 244-245 [73 Cal.Comp.Cases 981] (*Sandhagen*), the Supreme Court held that if a defendant fails to meet the timelines for UR under section 4610, it may not object to the recommended treatment through the procedures of section 4062. Consistent with *Sandhagen*, where a defendant fails to comply with the UR timelines and procedures of section 4610, its UR is not valid. Therefore, in legal effect, there is no “utilization review decision” that can be subject to IMR.

Second, Labor Code section 4604 provides that “[c]ontroversies between employer and employee *arising under this chapter* shall be determined by the appeals board, upon the request of either party, *except as otherwise provided by Section 4610.5.*” (Italics added.) Labor Code section 4610.5(k) gives the AD the authority to approve or disapprove an IMR request. However, there is nothing in the Labor Code or in the AD’s Rules that suggests, in making this determination, the AD (or the IMR organization) may consider whether the underlying UR decision was untimely or otherwise procedurally defective. (Lab. Code, § 4610.5(k); Cal. Code Regs., tit. 8, § 9792.10.3.)<sup>12</sup>

In addition to these provisions regarding IMR, Rule 10451.2(c)(1) also provides that IBR, where applicable, applies solely to disputes directly related to the amount payable to a medical treatment provider under an official fee schedule in effect on the date the medical treatment goods or services were provided. This is consistent with the language of Labor Code section 4603.2(b)(2) which requires that medical treatment payments by a defendant “shall be made at reasonable maximum amounts in the official medical fee schedule ... in effect on the date of service.” (See also Cal. Code Regs., tit. 8, §§ 9792.5.4(a)(1) [indicating that IBR applies to “[m]edical treatment services rendered by a provider or goods supplied in accordance with Labor Code section 4600 that was authorized by Labor Code section 4610, and for which there exists an applicable fee schedule”]; 9792.5.7(b)(1) [stating that “[i]ssues that are not eligible for independent bill review shall include: (1) [t]he determination of a reasonable fee for services where that category of services is not covered by fee schedule”].)

After generally stating the contours of IMR and IBR, Rule 10451.2(c)(1) next goes on to specify some (but not necessarily all) of the disputes that are *not* subject to IMR and/or IBR and that, therefore, are subject to the jurisdiction of the WCAB (see Lab. Code, §§ 4604, 5300, 5304).

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<sup>11</sup> It should be emphasized, however, that UR is not the appropriate mechanism for contesting industrial injury or contesting whether an admitted injury caused or contributed to the need for recommended treatment. (*Simmons v. State of Cal., Dept. of Mental Health* (2005) 70 Cal.Comp.Cases 866, 873-874 (Appeals Board en banc).) Moreover, UR may be deferred if the defendant disputes injury or disputes that the injury was a contributing cause to the need for treatment. (Cal. Code Regs., tit. 8, §§ 9792.9(b), 9792.9.1(b).)

<sup>12</sup> Labor Code section 4610(i) allows the AD to assess administrative penalties if a defendant fails to meet any of the timeframes or other requirements of section 4610. Section 4610(i) further states: “The administrative penalties shall not be deemed an exclusive remedy for the administrative director.” Yet, neither of these provisions gives the AD authority to consider compliance with UR timelines and other procedures when determining whether to approve an IMR request *under section 4610.5.*

Rule 10451.2(c)(1)(A) provides that threshold issues that would entirely defeat a medical treatment claim are non-IMR/IBR issues. Of course, it is axiomatic that a defendant is not liable for medical treatment unless there is a compensable industrial injury over which the WCAB has jurisdiction.

Rule 10451.2(c)(1)(B) provides that a dispute over a UR determination is a non-IMR/IBR issue if the employee's date of injury is prior to January 1, 2013 and the UR decision is communicated to the requesting physician prior to July 1, 2013. This derives from Labor Code section 4610.5(a), which provides that IMR applies to: (1) any dispute over a UR decision regarding treatment for an injury occurring on or after January 1, 2013; and (2) any dispute over a UR decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

Rule 10451.2(c)(1)(C) provides that non-IMR/IBR disputes include an assertion by an employee or a medical treatment provider that IMR is not required because UR was not undertaken or not timely undertaken or was otherwise procedurally deficient; however, if the employee prevails in this assertion, the employee or provider still has the burden of showing entitlement to the recommended treatment.

The provision that IMR does not apply where UR has not been undertaken or not timely undertaken or was otherwise procedurally deficient has already been discussed above.<sup>13</sup>

The provision that, if an employee or medical treatment provider establishes that UR was not timely or was otherwise procedurally deficient, the employee or provider still has the burden of proving entitlement to the recommended treatment, is based on the following.

As stated above, *Sandhagen* held that if a defendant fails to meet the UR timelines of section 4610, it may not use the procedures of section 4062 to object to the recommended treatment. *Sandhagen*, however, did *not* hold that, if a defendant's UR is untimely or otherwise procedurally defective, the employee is relieved of his or her burden of proof (see Lab. Code, §§ 3202.5, 5705). To the contrary, *Sandhagen* held that if a defendant's UR is untimely, the employee "may" utilize Labor Code section 4062 to resolve a medical treatment dispute, which necessarily implies that the employee is not automatically entitled to the recommended treatment. (*Sandhagen*, 44 Cal.4th at pp. 237, 244-245.) More pertinently, *Sandhagen* also expressly declared:

"The Legislature amended section 3202.5 to underscore that all parties, including injured workers, must meet the evidentiary burden of proof on all issues by a preponderance of the evidence. (Stats. 2004, ch. 34, § 9.) Accordingly, *notwithstanding whatever an employer does (or does not do)*, an injured employee must still prove that the sought treatment is medically reasonable and necessary. That means demonstrating that the treatment request is consistent with the uniform guidelines (§ 4600, subd. (b)) or, alternatively, rebutting the application of the guidelines with a preponderance of scientific medical evidence (§ 4604.5)."

(*Sandhagen*, 44 Cal.4th at p. 242 [italics, underlining, and bolding added].)

Accordingly, Appeals Board panel decisions have consistently held that even if UR was untimely or otherwise invalid, the injured employee still has the burden of proving (see Lab. Code, §§ 3202.5, 5705): (1) that the treatment is reasonably required (see Lab. Code, § 4600); and (2) either that the treatment falls within the presumptively correct medical treatment utilization schedule or that this presumption has been rebutted (see Lab. Code, § 4604.5). (E.g., *Flores v. Harbor Rail Transp.* (2013) 2013 Cal. Wrk. Comp. P.D. LEXIS 14, at pp.

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<sup>13</sup> If the WCAB determines that UR was timely and properly undertaken, the issue of medical necessity must then be determined through IMR, if applicable. (Lab. Code, §§ 4610(g)(3)(A) & (B) [disputes over medical necessity "shall be resolved in accordance with Section 4610.5, if applicable"], 4610.5 (d) & (e) ["the employee may request an independent medical review [of a UR decision] as provided by this section" and "a utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section"].)

\*18-\*19; *Chairez v. Cherokee Bindery* (2012) 2012 Cal. Wrk. Comp. P.D. LEXIS 506, at p. \*9.) Moreover, since a medical treatment provider stands in the shoes of the injured employee (e.g., *Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Martin)* (1985) 39 Cal.3d 57, 67-68 [50 Cal.Comp.Cases 411]; *Kunz v. Patterson Floor Coverings* (2002) 67 Cal.Comp.Cases 1588, 1592 (Appeals Board en banc)), the provider has the same burden of proof, even if UR was untimely or otherwise invalid.

Rule 10451.2(c)(1)(D) and (E) address the situations where, based on an alleged breach of statutory or regulatory duties, either: (1) a medical treatment provider asserts that a defendant has waived any objection to the amount of its bill; or (2) a defendant asserts that a medical treatment provider has waived any claim to further payment.<sup>14</sup> These provisions have been included because the law establishes that where a party has a duty to take a particular action to preserve a claim or defense, it must timely undertake that action and cannot bypass it; otherwise, the party waives that claim or defense. (See *Elliot, supra*; *Edwards, supra*; Lab. Code, §§ 4622(b)(2), 4622(c).)

Rule 10451.2(c)(1)(F) provides that non-IMR/IBR disputes include the issue of whether the employee was entitled to select a treating physician not within the defendant's MPN. This provision relates to Labor Code section 4603.2(a)(2) and (3). Subdivision (a)(2) provides that if a defendant objects to an employee's selection of a treating physician on the grounds that the physician is not within defendant's MPN, and there is a final determination that the employee was entitled to select a non-MPN physician, the employee shall be entitled to continue treatment with that physician at the employer's expense "in accordance with this division" (i.e., Division 4 of the Labor Code, which among other things includes IMR and IBR), notwithstanding section 4616.2 (relating to MPNs). Subdivision (a)(3) provides, however, if there is a final determination that the employee was not entitled to select a non-MPN physician, the defendant shall have no liability for the treatment.

Rule 10451.2(c)(1)(G) provides that non-IMR/IBR disputes include an assertion by a defendant that an interpreter who rendered services at a medical treatment appointment did not meet the criteria established by Labor Code sections 4600(f) and (g) and 5811(b)(2) and the AD's Rules. Without going into detail, these provisions generally require that interpreters meet certain qualifications, and there is nothing in the Labor Code or in the AD's Rules which suggests that IMR and/IBR will assess whether an interpreter meets any necessary qualifications.

Rule 10451.2(c)(2)(A) and (B) simply provide that: (1) if a non-IMR/IBR dispute is between an employee and a defendant, the procedures for claims for ordinary benefits shall be utilized (including expedited hearings, if applicable); and (2) if the dispute is between a medical treatment provider and a defendant, the procedures applicable to lien claims shall be utilized (including the filing of a section 4903(b) lien and the payment of the lien filing fee or lien activation fee, if applicable).

Rule 10451.2(c)(3)(A) and (B) simply provide that, if a non-IMR/IBR dispute is resolved in favor of the employee or medical treatment provider, then any applicable IMR and/or IBR procedures established by the

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<sup>14</sup> Rule 10451.2(c)(1) does *not* provide that a defendant's assertion that an employee's IMR request was not timely under Labor Code section 4610.5(h) is a non-IMR/IBR issue. This is because: (1) section 4610.5(k) provides that the AD "shall expeditiously review [IMR] requests and immediately notify the employee and the employer in writing as to whether the request for [IMR] has been approved"; (2) AD Rule 9792.10.3(a)(1) provides that the AD shall consider timeliness in determining whether a disputed medical treatment is eligible for IMR (Cal. Code Regs., tit. 8, § 9792.10.3(a)(1)); and (3) AD Rule 9792.10.7 provides that, after a dispute deemed eligible for IMR results in a final determination, the parties may appeal that determination — which would include a determination that the initial IMR request was timely — by filing a petition with the WCAB under section 4610.6(h) (Cal. Code Regs., tit. 8, § 9792.10.7). Therefore, the WCAB has jurisdiction to consider a defendant's challenge to the timeliness of IMR only if the defendant files an IMR appeal. [NOTE: AD Rule 9792.10.3(e) also provides that the parties may appeal an AD determination of ineligibility for IMR — which would include a determination of untimeliness of the initial IMR request — by filing a petition with the WCAB. (Cal. Code Regs., tit. 8, § 9792.10.3(e).)]

Labor Code and the AD's Rules shall be followed,<sup>15</sup> except that IMR appeals shall comply with Rule 10957.1 and IBR appeals shall comply with Rule 10957.

#### **11. Proposed Section Newly Renumbered: 10451.3 (entitled "Petition for Costs").**

As discussed above, the WCAB intends to withdraw its "Petition for Costs" rule as initially proposed (i.e., initially proposed Rule 10451) and instead replace it with proposed Rule 10451.3, with modifications.<sup>16</sup>

Rule 10451.3(a) provides that a petition for costs may be filed only by (1) an employee or the dependent of a deceased employee, (2) a defendant, (3) a qualified interpreter for services other than those rendered at a medical treatment appointment, a medical-legal examination, or medical-legal deposition; or (4) the attorney or non-attorney representative of one of those persons or entities. Any other petition for costs shall be deemed dismissed by operation of law.

The provision of Rule 10451.3(a)(1) and (2) that petitions for costs may be filed by employees, dependents, and defendants (or, under (4), by their attorney or non-attorney representatives) derives from the language of Labor Code section 5811(a). It provides: "In all proceedings under this division before the appeals board, costs *as between the parties* may be allowed by the appeals board." (Italics added.) The "parties" to which section 5811(a) refers are the parties to the case-in-chief (*Martinez v. Terrazas* (2013) 78 Cal.Comp.Cases 444, 447 (Appeals Board en banc) (*Martinez*)), i.e., employees, dependents, and defendants. Although proposed Rule 10301(dd) [see current Rule 10301(x)] provides that lien claimants and certain other persons and entities become "parties" after the underlying case-in-chief has been resolved or abandoned, section 5811 does not permit these lien claimants and others to claim section 5811 costs for the expenses of litigating their liens or other claims. (Cf. Lab. Code, § 4621(a) [only "the employee, or the dependents of a deceased employee, shall be reimbursed for his or her medical-legal expenses"].)

Rule 10451.3(a)(4) further provides, however, that a petition for costs may be filed by a qualified interpreter for services other than those rendered at a medical treatment appointment, medical-legal examination, or medical-legal deposition. As stated in the SSOR regarding proposed Rules 10451.1 and 10451.2, above, interpreter services rendered in the medical treatment context must go through IBR and/or IMR and those rendered in the medical-legal context must go through IBR. Therefore, such interpreter services are not subject to a petition for costs. However, there are certain interpreter services, such as those rendered at a WCAB hearing, that do not constitute medical treatment or a medical-legal expense. And, even though an interpreter is not a "party" under such circumstances, the WCAB concludes that an interpreter may file a petition for costs for services rendered outside a medical treatment or medical-legal context. (See Lab. Code, § 5811(b)(2).)

Rule 10451.3(b)(1) provides that a petition for costs shall not be filed for any medical treatment cost. Rule 10451.3(b)(2) provides, in part, that a medical-legal provider cannot file a petition for costs.

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<sup>15</sup> Labor Code section 4610.5(h)(2) states: "If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved." (See also Cal. Code Regs., tit. 8, §§ 9792.10.3(d), 9792.10.1(c)(1), 9792.10.3(d).)

Labor Code section 4603.6(a) states: "If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until resolution of that issue becomes final ... ." (See also Lab. Code, § 4603.2(e)(1) ["If the provider disputes the amount paid, the provider may request a second review within 90 days of service of ... an order of the appeals board resolving the threshold issue as stated in the explanation of review"]; Cal. Code Regs., tit. 8, §§ 9792.5.5(b)(2), 9792.5.7(c)(5).)

<sup>16</sup> All further references to Rule 10451.3 are to the newly proposed version.

The reason for these provisions is that, as held in the en banc decision in *Martinez*, “[s]ection 5811 ‘costs’ do not include costs and expenses that are governed by other specific statutory schemes.” (78 Cal.Comp.Cases at p. 447; see also *Costa v. Hardy Diagnostic* (2006) 72 Cal.Comp.Cases 1492, 1497, fn. 3 (Appeals Board en banc) (*Costa II*).)

Therefore, in *Martinez*, the Appeals Board determined that a copy service’s claim for medical-legal expenses may not be filed as a petition for costs under section 5811. We adopt and incorporate the rationale of the *Martinez* en banc and will not reiterate it here.

We recognize that *Costa v. Hardy Diagnostic* (2006) 71 Cal.Comp.Cases 1797 (Appeals Board en banc) (*Costa I*) stated: “We believe that [the vocational expert who testified on applicant’s behalf in rebuttal to the permanent disability rating] is entitled to be reimbursed by [defendant] for the reasonable costs associated with her testimony *under section 5811*.” (71 Cal.Comp.Cases at p. 1819 [italics added].) Subsequently, *Costa II* reiterated that the costs of evidence on and/or in rebuttal to a permanent disability rating are properly allowable under section 5811, although among other things *Costa II* concluded that such costs must be reasonable and necessary at the time they were incurred. (72 Cal.Comp.Cases at pp. 1498-1499.) The holding of *Costa II* that expert witness fees incurred by one of the parties in the case-in-chief are allowable under section 5811 was also followed in the Appeals Board’s en banc decision in *Martinez*. (78 Cal.Comp.Cases at p. 447.)

Rule 10451.3(b)(2) abrogates *Costa I*, *Costa II*, and *Martinez*, to the extent they can be read as holding that an expert witness may file a petition for costs under section 5811. As explained in greater detail in the discussion of Rule 10451.1, Labor Code section 4620(a) defines “a medical-legal expense” to mean “*any* costs and expenses incurred by or in behalf of any party ... for the purpose of proving or disproving a contested claim.” (Italics added.) This would include expert witness fees. A provider of medical-legal goods or services may seek payment only by utilizing one of the procedures described in Rule 10451.1.

For essentially the same reasons set out in *Martinez*, we also conclude that a provider of medical treatment goods or services may not file a petition for costs under section 5811. As with the medical-legal expenses discussed in *Martinez*, there is an extensive specific statutory scheme established by the Legislature by which a provider may seek payment of expenses related to medical treatment. (Lab. Code, §§ 4603.2, 4603.3, 4603.6, 4610, 4610.5, 4610.6, 4903(b), 4903.05, 4903.06.)

Proposed Rule 10451, as it was initially noticed for public hearing and comment, would have allowed a petition for costs for *interpreter services* rendered during a medical treatment appointment or a medical-legal examination. The Appeals Board received extensive comments about this proposed provision and, upon further consideration, the Board is persuaded that interpreters should not be excepted from the general rule barring providers from filing petitions for costs for medical treatment and medical-legal expenses.

With respect to interpreter services during medical treatment appointments, section 4600(f) and (g) establish

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that such services constitute a medical treatment expense.<sup>17</sup> In turn, section 4603.2(b)(1) provides “Any provider of services provided pursuant to Section 4600, *including, but not limited to ... interpreters ... shall* submit its request [to the defendant] for payment with an itemization of services provided.” (Italics added.) Therefore, “any provider[s]” of services relating to medical treatment, including “interpreters,” are subject to the billing submission requirements of section 4603.2(b)(1).

Next: (1) section 4603.2(b)(2) provides that “[p]ayments shall be made by the employer with an explanation of review pursuant to Section 4603.3”; (2) section 4603.2(e)(1) states that “[i]f the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review”; (3) section 4603.2(e)(3) states that “[w]ithin 14 days of a request for second review, the employer shall respond with a final written determination”; and (4) finally, section 4603.2(e)(4) requires that “[i]f the provider contests the amount paid, after receipt of the second review, *the provider shall request an independent bill review as provided for in Section 4603.6*” (italics added).

Therefore, sections 4600, 4603.2, and 4603.6 expressly contemplate that, where an amount payable dispute still exists after the defendant’s initial EOR and its final written determination, a “provider” of services under section 4600, including an “interpreter[,],” “shall request” IBR. “Shall” is mandatory language. (Lab. Code, § 15; *Long Beach Police Officers Assn. v. City of Long Beach* (1988) 46 Cal.3d 736, 743 [“the ordinary meaning of ‘shall’ or ‘must’ is of mandatory effect” (internal quotation marks omitted)].) The WCAB’s jurisdiction over IBR disputes is restricted to the very limited appeal rights established by section 4603.6(f).

Of course, where a dispute over interpreter services at a medical treatment appointment does not relate to the amount payable under an official fee schedule, IBR does not apply. But, as stated above, interpreter services during medical treatment appointments constitute a medical treatment expense. (Lab. Code, § 4600(f) & (g).) Therefore, for non-IBR disputes, an interpreter’s recourse is to file a Labor Code section 4903(b) lien and to pay any applicable lien filing or activation fee, as discussed in the SSOR relating to Rule 10451.2 above.

Our conclusion is the same with respect to interpreter services during medical-legal evaluations. Section 4620(a) provides that “a medical-legal expense means any cost and expenses incurred by or in behalf of any party, ... which expenses may include ... *interpreter’s fees* ... for the purpose of proving or disproving a contested claim.” (Italics added; see also Lab. Code, § 4620(d) [“[i]f the injured employee cannot effectively communicate with an examining physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during the medical examination”].) Therefore, interpreter services at medical-legal examinations are a medical-legal expense.

In turn, section 4622 states that “*all* medical-legal expenses ... *shall* ... be paid ... as follows.” (Italics added.) Section 4622(a) and (b) then provide that, preliminarily, the medical-legal provider submits a billing, the defendant issues an EOR, the provider may request second review, and the defendant issues a final written determination. Then, if a dispute over the “amount billed” under a fee schedule in effect on the date of service

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<sup>17</sup> Section 4600(f) states: “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. These services shall be provided by the employer. For purposes of this section, ‘qualified interpreter’ means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.”

Section 4600(g) states, in part: “If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code.”

still remains, “the provider *shall* request an independent bill review as provided for in Section 4603.6.” (Italics added.) Again, this is mandatory language. The only jurisdiction the WCAB has over IBR disputes are the very limited appeal rights established by section 4603.6(f).

Accordingly, sections 4620, 4622, and 4603.6 expressly contemplate that, for “*all* medical-legal expenses,” “includ[ing] ... interpreter’s fees,” a provider’s amount payable dispute shall go through the procedure that ultimately culminates in IBR and very limited appeal rights before the WCAB.

In issuing Rule 10451, as initially proposed, the Appeals Board relied in large part on the following language of section 5811:

“Interpreter fees that are reasonably, actually, and necessarily incurred shall be paid by the employer under this section, provided they are in accordance with the fee schedule adopted by the administrative director.

A qualified interpreter may render services during the following:

(A) A deposition.

(B) An appeals board hearing.

(C) *A medical treatment appointment or medical-legal examination.*

(D) During those settings which the administrative director determines are reasonably necessary to ascertain the validity or extent of injury to an employee who does not proficiently speak or understand the English language.”

(Italics added.)

The Board essentially concluded that, when SB 863 added the italicized language to section 5811, the Legislature intended to allow an interpreter to file a petition for costs for services at a medical treatment appointment or a medical-legal examination.

However, a statute’s language must not be read in isolation, but instead must be considered with reference to the entire scheme of law of which it is part so that the whole may be harmonized. (*San Leandro Teachers Assn. v. Governing Bd. of San Leandro Unified School Dist.* (2009) 46 Cal.4th 822, 831; *Chevron U.S.A., Inc. v. Workers’ Comp. Appeals Bd. (Steele)* (1999) 19 Cal.4th 1182, 1194 [64 Cal.Comp.Cases 1]; *DuBois v. Workers’ Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 388 [58 Cal.Comp.Cases 286].) As discussed above, for “all” services related medical treatment or medical-legal exams, disputes over the amount payable under an official fee schedule “shall” go through the procedure that ultimately culminates in IBR, with very limited appeals rights to the WCAB. It would be inconsistent with the overall statutory scheme to allow interpreters at medical treatment appointments and medical-legal examinations to bypass that procedure.

This interpretation is consistent with the legislative history of section 4903.06.

First, uncodified section 1(h) states:

“The Legislature finds and declares all of the following: ... (h) That the performance of independent bill review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that independent bill review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code. Existing law provides no method of medical billing dispute resolution short of litigation. Existing law does not provide for medical billing and payment experts to resolve billing disputes, and billing issues are frequently submitted to workers’ compensation judges without the

benefit of independent and unbiased findings on these issues. Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system. The need for independent and unbiased findings and determinations requires that this new function be contracted pursuant to subdivision (b) of Section 19130 of the Government Code.”

Second, legislative committee analyses are subject to judicial notice (*In re J.W.* (2002) 29 Cal.4th 200, 211) and statements in such analyses concerning the statutory objects and purposes which are in accord with a reasonable interpretation of the statute are legitimate aids in determining legislative intent. (*Id.*; e.g., also, *Southern Cal. Gas Co. v. Public Utilities Com.* (1979) 24 Cal.3d 653, 659; *Southern Pac. Co. v. Industrial Acc. Com.* (*Mistretti*) (1942) 19 Cal.2d 271, 275.) According to the August 31, 2012 Senate Floor Analysis, SB 863 was intended to:

“ ... create an ‘independent bill review’ process where expert bill reviewers would make determinations in cases where it is merely a billing, and not a substantive treatment, dispute. This IBR process would relieve substantial congestion in the workers’ compensation courts, provide much faster dispute resolution, and result in better decisions by billing experts as opposed to judges, who have no special training in the arcane world of billing codes and procedures.”

Given the Legislature’s conclusion that bill review determinations should be removed from the ordinary adjudicatory processes of the WCAB, with the exception of a very limited review on appeal, the Appeals Board now concludes the proper view is that, when interpreters render services at medical treatment appointments or medical-legal examinations, any amount payable disputes are subject to IBR, if applicable, and not to a petition for costs under section 5811.

However, for interpreter services rendered at a WCAB hearing, for example, disputes over the amount payable under an official fee schedule are subject to a petition for costs. This is because IBR applies only in the medical treatment and medical-legal contexts. Nevertheless, under section 5811(b)(2), interpreter services outside these contexts are expressly subject to “the fee schedule adopted by the administrative director.”

Rule 10451.3(b)(2) further provides that a petition for costs may be filed by an employee, a dependent, a defendant, or the attorney or non-attorney representative of one of those persons or entities who seeks reimbursement for payment(s) previously made directly to a provider of medical-legal goods or services, subject to any applicable official fee schedule.

The reason for this provision is that, as indicated above, the IBR provisions of Labor Code sections 4603.2, 4603.6, and 4622 apply only to a “provider.” (See Lab. Code, §§ 4603.2(b)(1), (b)(2)(A) & (B), (e)(1), (e)(2), (e)(4), 4603.3(a)(1) & (6), 4603.6(a), (c), (e), (h), 4622(b)(1), (b)(2), (b)(4), (c), (e)(1); see also Cal. Code Regs., tit. 8, §§ 9792.5.4(i), 9792.5.5, 9792.5.7.) Therefore, these IBR provisions do not apply to instances where, for example, an applicant or an applicant’s attorney advances or otherwise directly pays a medical-legal expense (such as a payment to a physician for a medical-legal deposition or a payment to a vocational expert for a report or trial testimony). The Appeals Board concludes, accordingly, that a petition for costs may be filed in this circumstance.

Rule 10451.3(b)(2) also provides, however, that when the party to an underlying case or its attorney files a petition for costs seeking reimbursement for direct payments to medical-legal providers, that petition shall be subject to any applicable fee schedule. Although only “providers” are subject to IBR, there is nothing in the Labor Code to suggest that parties and their attorneys are exempt from any medical-legal fee schedule when they pay a provider directly and then make a claim for reimbursement. (See Lab. Code, §§ 5307.6(a), 5307.7, 5307.9.)

Rule 10451.3(d) provides that no petition for costs shall be filed or served until at least 60 days after a written demand has been sent to the defendant or other person or entity from whom the costs are claimed. Otherwise, the petition may be dismissed (either with or without prejudice, in the discretion of the WCAB).<sup>18</sup> This will encourage the parties to informally resolve any costs issues before presenting them to the WCAB for adjudication, thereby increasing efficiency in the workers' compensation system and reducing the burdens on limited judicial resources. The 60-day delay period for petitions for costs has been adopted by analogy to: (1) Labor Code section 4622(a)(1), which gives a defendant 60 days after receipt of a properly documented medical-legal billing to make payment and issue an explanation of review; and (2) Labor Code section 4603.2(b)(2) and (b)(3), which give a non-governmental defendant 45 days and a governmental defendant 60 days after receipt of a properly documented medical billing to make payment and issue an explanation of review.

In the written comments on Rule 10451, as initially proposed, Stephen J. Cattolica of AdvoCal asked that "written demand" be defined broadly so as to include electronically submitted demands. The WCAB agrees. Therefore, Rule 10451.3(d) provides that, notwithstanding the provisions of AD Rule 10205.6 and WCAB Rule 10505(b), for purposes of this section "written demand" includes a demand served electronically (e.g., by e-mail, by an attachment to an e-mail, or by a fax). Rule 10451.3(d) further provides that, if electronic service is utilized, the proof of service (POS) requirement will be deemed satisfied if the POS substantially conforms to the POS forms of the Judicial Council of California.<sup>19</sup>

As suggested in the written comments of Pam Foust of Zenith Insurance Company, Rule 10451.3(f) provides that, in addition to its general factual allegations, a petition for costs filed by an interpreter must contain: (1) a statement of the name(s) of any interpreter(s) who performed the services; (2) a statement of the certification number of the interpreter(s), or, if not certified, a statement that specifies why a certified interpreter was not used and that sets forth the qualifications of the interpreter; and (3) a statement that the services claimed were actually performed. These provisions are consistent with the Appeals Board's en banc decision in *Guiron*, *supra*, 76 Cal.Comp.Cases 228, which held in substance that an interpreter has the burden of proving that the services were reasonably required, the services were actually provided, the interpreter was qualified to provide the services, and the fees charged were reasonable. These provisions are also consistent with the requirements of Labor Code section 5811(b) for interpreter services rendered at a WCAB hearing or in other circumstances not subject to IBR and/or IMR. The WCAB emphasizes, however, that these provisions of Rule 10451.3(f) do

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<sup>18</sup> Initially proposed Rule 10451(c) had provided that a petition for costs "shall" be dismissed if the petitioner failed to serve a copy of its written demand and of any response from the defendant. Newly proposed Rule 10451.3(d), however, provides that a petition for costs "may" be dismissed. This gives the WCAB the discretion not to dismiss a valid petition for costs merely because there was a procedural failure or oversight. In this regard, the WCAB anticipates that injured employees will file the majority of petitions for costs. Some of these injured employees may be unrepresented and, therefore, may not understand or be aware of the WCAB's Rules of Practice and Procedure.

However, unlike initially proposed Rule 10451(c), newly proposed Rule 10451.3(d) specifically gives the WCAB the discretion to dismiss a petition for costs "with or without prejudice." The WCAB anticipates that the risk of a petition for costs being dismissed with prejudice will increase the incentive to comply with the written demand provisions by those who are or should be aware of the Rule, e.g., represented parties.

<sup>19</sup> Currently, the Judicial Council forms website (<http://courts.ca.gov/forms.htm?filter=POS>) has a proof of electronic service form (i.e., Form POS-050 at <http://courts.ca.gov/documents/pos050.pdf>) with attachments that specify the document(s) served (i.e. Form POS-050(D) at <http://courts.ca.gov/documents/pos050d.pdf>) and the person(s) served (i.e., Form POS-050(P) at <http://courts.ca.gov/documents/pos050p.pdf>).

not affect the burden of proof requirements of *Guitron*.<sup>20</sup>

As with Rule 10451(i) as initially proposed, newly proposed Rule 10451.3(g) again provides that a petition for costs shall not be placed on calendar unless a party to the case-in-chief or petitioning interpreter files a declaration of readiness to proceed (DOR) that lists the petition for costs as an issue. Also, Rule 10451.3(g) would again establish a notice of intention (NIT) procedure by which a petition for costs could be determined without setting a hearing. However, in response to the written comments of Steve Suchil of the American Insurance Association (AIA) and Jeremy Merz of CalChamber regarding Rule 10451(i) as initially proposed, the time for submitting a written response to an NIT has been increased from 10 calendar days to 15 calendar days. We agree that, if the period for responding was 10 calendar days, the delay time in receiving and sending mail would effectively mean that the parties would have only six calendar days to respond, and even less if a three or four-day weekend intervenes.

Rule 10451.3(h) provides that nothing in this Rule precludes the filing of a claim of costs in the form of a lien, but such a lien is not required to file a petition for costs under section 5811. The reason for this provision is that Labor Code section 4903.05(b) allows for the electronic filing of “claims of costs” using a lien claim form. Nothing in section 4903.05(b) precludes a claim of costs under section 5811 from being filed in this manner. On the other hand, nothing in either of those sections suggests that a claim of costs under section 5811 *must* be claimed through a lien form filed electronically under section 4903.05(b). And, for the reasons that follow, the Appeals Board concludes that there cannot be any such requirement.

First, injured employees make the overwhelming majority of section 5811 costs claims. Yet, to make a claim of costs in the form of a lien, a \$150 lien filing fee is required. (Lab. Code, § 4903.05(c) & (c)(1).) The Appeals Board cannot conceive that the Legislature intended to require injured employees to pay \$150 filing fee just recover their litigation costs. Furthermore, claims of costs in the form of a lien “shall” be filed electronically (Lab. Code, § 4903.05(b)), but many self-represented injured employees do not have ready access to a computer.

Second, section 4903.05 is contained in the Chapter of the Labor Code that relates to payments and reimbursements to persons or entities other than injured employees.

Rule 10451.3(i) provides in substance that, where a petition for costs is filed in bad faith or where a defendant fails to promptly make good faith payments on the costs sought by such a petition, monetary sanctions, reasonable attorney’s fees, and costs may be imposed under Labor Code section 5813 and Rule 10561. It further provides that for bad faith actions or tactics occurring on or after the effective date of Rule 10451.3, the monetary sanctions shall not be less than \$500.

Of course, the WCAB has the power to impose such sanctions under Labor Code section 5813 and section 10561, even without including an express provision in this Rule. Nevertheless, there are reasons why an express reference to sanctions should be made in Rule 10451.3 and why, in cases after its effective date, monetary sanctions should not be less than \$500 where bad-faith actions or tactics are found.

First, in the public comments the Appeals Board received in response to its latest rulemaking, as well as those received in response to its prior rulemaking relating to the lien rules (i.e., Cal. Code Regs., tit. 8, §§ 10582.5, 10770, 10770.1), the Appeals Board received numerous complaints about failures by defendants to pay

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<sup>20</sup> The written comments of S. James Tsui of SJT & Associates essentially assert that when a claims adjuster, defense attorney, or applicant’s attorney requests interpreter services, the interpreter should neither be required to request proof or confirmation that the injured worker actually needs an interpreter nor required to conduct an English fluency test. Similarly, when interpreter services are requested, Mr. Tsui asserts the interpreter should not have to ask whether injury has been denied and/or have any burden of proof regarding industrial causation. However, the issue of an interpreter’s burden of proof is not the subject of the WCAB’s current rulemaking. To the extent there might be burden of proof issues unresolved by *Guitron*, those issues should be resolved through further case law.

uncontested costs bills or, at least, to promptly pay a reasonable estimate of the amount due on costs bills. These complaints are substantiated by the Appeals Board's experience in cases that are brought before it.

Second, many costs claims are analogous to medical-legal expense claims, e.g., where a qualified interpreter renders services during a WCAB hearing. (See Lab. Code, §5811(b)(2)(A) & (B).) Indeed, in *Costa II*, the Board specifically recognized that “costs ... under section 5811 [are allowable in a manner] similar to the standards for allowing medical-legal costs under [Labor Code] section 4621(a).” (72 Cal.Comp.Cases at pp. 1498-1499.) And, as discussed in the rationale of Rule 10451.1 relating to the determination of medical-legal expense disputes, the Legislature expressly authorized the Appeals Board to adopt regulations to enforce the medical-legal expense statutory and regulatory provisions and ensure compliance with them. (See Lab. Code, §§ 4622(e)(2), 4627.)

**12. Proposed Section Newly Renumbered: 10451.4 (entitled “Petition to Enforce IBR Determination”).**

As discussed above, Rule 10451.1 as initially proposed has been re-numbered to Rule 10451.4, with some modifications. Except for this re-numbering, the WCAB intends to adopt the Rule as initially proposed, with the following exceptions.

First, proposed Rule 10451.4 would be amended to provide that a petition to enforce may be used not only for enforcing an IBR determination, but also for recovering an IBR fee under Labor Code section 4603.6(c). Section 4603.6(c) provides that a medical provider must pay an administrative fee when it seeks IBR. (See also Cal. Code Regs., tit. 8, § 9792.5.7(d)(1)(A) & (B) [\$335 fee].) However, section 4603.6(c) further provides that, if an IBR determination finds that the defendant owes additional payment to the medical provider, the defendant “shall reimburse the provider for the [IBR] fee in addition to the amount found owing.” Furthermore, AD Rule 9792.5.14(b) states: “If the independent bill reviewer finds any additional amount of money is owed to the provider, the determination shall also order the claims administrator to reimburse the provider the amount of the filing fee in addition to any additional payments for services found owing.” (Cal. Code Regs., tit. 8, § 9792.5.14(b).) Therefore, if a recalcitrant defendant is failing to pay a provider the money due under the IBR determination, the provider should have the right not only to enforce that determination but also to enforce reimbursement of the fee, whether or not the fee reimbursement is actually ordered as part of the determination.

Second, proposed Rule 10451.4(f) now contains a provision that had been contained in Rule 10957(p), as initially proposed. That is, it is now Rule 10451.4(f), and not Rule 10957(b), that would provide that a petition to enforce may include a request for penalties and interest. However, Rule 10451.4(f) makes it clear that the penalties and interest sought would be pursuant to Labor Code section 4603.2(b). Section 4603.2(b) provides that, if certain statutory conditions are met, a medical provider is entitled to have its payment “increased by 15%, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the [provider’s] itemization [of medical services provided].”

Third, consistent with the comments of Mr. Suchil of AIA and Mr. Merz of CalChamber discussed above, the time for responding to an NIT to grant or deny a petition to enforce has been increased from 10 calendar days to 15 calendar days.

There are also some other minor changes, including deleting various procedural provisions that have now been incorporated into the proposed generic petitions and answers rule (i.e., Rule 10450).

**13. Section Added: 10498 (entitled “Special Requirements for Pleadings Filed or Served by Attorneys or by Non-Attorney Employees of an Attorney or Law Firm”).**

The WCAB intends to adopt Rule 10498 as initially proposed.

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**14. Section Added: 10538 (entitled “Subpoenas for Medical Information by Non-Physician Lien Claimants”).**

The WCAB intends to adopt Rule 10538 as initially proposed.

**15. Section Amended: 10582.5 (entitled “Dismissal of Inactive Lien Claims for Lack of Prosecution”).**

Except for some minor non-substantive modifications, the WCAB intends to adopt Rule 10582.5 as initially proposed.

**16. Section Amended: 10606 (entitled “Physicians’ Reports as Evidence”).**

The WCAB intends to modify proposed Rule 10606 to entirely remove proposed subdivision (d) regarding specific circumstances under which the report of an AME or QME will be admissible. The WCAB received some comments essentially asserting that proposed Rule 10606(d) went too far (i.e., the written comments of Norma R. Garner of Landmark Medical Management, LLC (Landmark)) and others essentially asserting that it did not go far enough (i.e., the written comments of Mr. Merz of CalChamber and Michael McClain of the California Workers’ Compensation Institute (CWCI)). Accordingly, for now at least, the WCAB has decided to let the specific issues surrounding the admissibility of an AME or QME be resolved through case law.

**17. Section Added: 10606.5 (entitled “Vocational Experts’ Reports as Evidence”).**

The WCAB intends to modify Rule 10606.5, as initially proposed.

As initially proposed, Rule 10606.5(a) provided that the WCAB favors the production the vocational expert evidence in the form of written reports and that direct examination of a vocational expert witness will not be allowed at trial except upon a showing of good cause. These proposed provisions were derived directly from Labor Code section 5703(j), which states in relevant part: “If vocational expert evidence is otherwise admissible, the evidence shall be produced in the form of written reports. Direct examination of a vocational witness shall not be received at trial except upon a showing of good cause.”

In light of the comments of Mr. McClain of CWCI, the WCAB now proposes to add a sentence to propose Rule 10606.5(a) that good cause shall not be found if the vocational expert has not issued a report and the party offering the vocational expert’s testimony fails to demonstrate that it exercised due diligence in attempting to obtain a report. This is consistent with the mandate of section 5703(j) that vocational expert evidence “shall be produced in the form of written reports.” It is also consistent with the general requirement of Labor Code section 5502(d)(3) that, after the closure of discovery at a mandatory settlement conference (MSC), “[e]vidence ... shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.” Further, the proposed additional sentence will help alleviate waste of the WCAB’s limited calendar time by reducing the number of instances in which an MSC is taken off calendar or continued because a party has not yet obtained a vocational expert report.

**18. Section Amended: 10608 (entitled “Service of Medical Reports, Medical-Legal Reports, and Other Medical Information”).**

The WCAB intends to modify Rule 10608, as initially proposed.

The chief change to proposed Rule 10608 is that the WCAB intends to add provisions to subdivision (c) that: (1) a non-physician lien claimant shall not subpoena any “medical information” and any subpoena that, in whole or in part, requests “medical information” shall be deemed quashed in its entirety by operation of law; and (2) a non-physician lien claimant shall not seek to obtain any medical information using a waiver, release, or other authorization signed by the employee, and any such waiver, release, or other authorization shall be deemed invalid by operation of law. These changes are being made in response to written suggestions from CalChamber

and CWCI. The WCAB concludes that these changes are consistent with Labor Code section 4903.6(d), which provides that no non-physician lien claimant “shall be entitled to any medical information ... about an injured worker without prior written approval of the appeals board.” (Italics added.) Moreover, the first additional provision is essentially a restatement of proposed Rule 10538, whose purpose was discussed in the ISOR.

In addition, the WCAB will remove language from proposed Rule 10608(c) because it is now being incorporated into the generic rule on petitions (i.e., proposed Rule 10450).

The WCAB will now address several of the public comments it received about proposed Rule 10608.

First, there were suggestions that proposed Rule 10608 be broken up into two separate rules, with one of the rules relating only to the entitlement of non-physician lien claimants to medical information. There were also related suggestions that the service requirements be extended to include not just medical and medical-legal reports, but also all documentary evidence. The WCAB does not necessarily disagree with these suggestions. However, the suggestions would require significant re-drafting. Therefore, the WCAB plans to consider these suggestions at a future time. Nevertheless, the WCAB observes that, presently, the mere fact that Rule 10608 does not address the service of non-medical documentary evidence does not preclude a party or lien claimant from obtaining such non-medical documentary evidence through formal or informal discovery.

Second, there were suggestions that all of the references to “10 calendar days” in proposed Rule 10608(b) be changed to “10 business days.” As discussed in the context of other proposed Rules above, the general concern is that when mailing back and forth is taken into account, the parties and the physician lien claimants would effectively have only six calendar days within which to serve documents in response to the filing of an application, DOR, or a request for service of medical and medical-legal reports, and even less if a three or four-day weekend intervenes. However, current Rule 10608 allows only “six days” to respond to requests and, based on the WCAB’s experience and understanding, this six-day time limit has not caused significant problems. Furthermore, under proposed Rule 10608, this six-day limit is being *extended* by an additional four days. Also, proposed Rule 10608.5 would permit service of medical and medical-legal reports to be made by electronic media, including attachments to e-mails. This provision should make it less time consuming and burdensome to respond under Rule 10608. Additionally, the 10-day time period of proposed Rule 10608(b)(3) is triggered by the filing of a DOR. Yet, Labor Code section 5502(a) requires that an MSC be held “not less than 10 days, and not more than 60 days” after a regular DOR, while section 5502(b) provides that an expedited hearing “shall be held and a determination as to the rights of the parties shall be mailed and filed within 30 days” after the filing of an Expedited DOR. Therefore, anything more than the proposed “10 calendar days” provision could cause problems to occur at MSCs and expedited trials.

Third, the WCAB received several complaints about proposed Rule 10608(c), essentially complaining that it violates the due process discovery rights of non-physician lien claimants. However, the provisions of Rule 10608(c) are mandated by Labor Code section 4903.6(d), by which the WCAB is bound. The WCAB lacks the authority to declare a statute unconstitutional. (Cal. Const., art. III, § 3.5; *Greener v. Workers’ Comp. Appeals Bd.* (1993) 6 Cal.4th 1028, 1038–1039 [58 Cal.Comp.Cases 793].) In any event, neither section 4903.6(d) nor Rule 10608(c) prevent a non-physician lien claimant from obtaining confidential medical information regarding an injured employee; they merely require a non-physician lien claimant to demonstrate to the WCAB that the medical information is relevant and obtain an order directing its disclosure.

Fourth, in a similar vein, Landmark specifically complains that proposed Rule 10608(a)(5)’s definition of “physician lien claimant” is too narrow. Landmark agrees that the definition of a “physician lien claimant” properly includes the attorney or non-attorney representative of the physician, but it asserts that an attorney or non-attorney representative should include any person or entity to whom a physician’s lien has been partially or fully assigned. The WCAB disagrees. When a physician lien claimant obtains an attorney or non-attorney, there is merely a principal/agent relationship between them and the physician retains all right, title, and interest in the lien claim. However, as explained in *California Ins. Guarantee Assn. v. Workers’ Comp. Appeals Bd.*

(*Jenkins*) (2012) 203 Cal.App.4th 1328 [77 Cal.Comp.Cases 143] (*Jenkins*), it is different when a physician assigns a lien to an assignee. As held by *Jenkins*, where there has been a complete assignment, legal title passes to the assignee. (*Jenkins*, 203 Cal.App.4th at p. 1335.) Therefore, unless the assignee lien claimant is also a “physician,” it cannot obtain confidential medical information regarding the injured employee except as provided by section 4903.6(d) and Rule 10608(c). Moreover, where there has been a partial assignment, there is some question whether the partial assignee even has standing to pursue recovery. (*Id.*) But, apart from that question, the partial assignee is still a “non-physician” with respect to *its* interest in the lien, unless, again, it is also a physician. Under *Jenkins*, it is a closer question where there has been merely an assignment for collection. *Jenkins* states that, where a physician assigns its lien for collection, the assignee becomes “the administrator or personal representative” of the physician. (*Id.* 203 Cal.App.4th at p 1341.) However, *Jenkins* further states that “[a]n assignment for collection vests legal title in the assignee which is sufficient to enable him to maintain an action in his own name.” (*Id.* 203 Cal.App.4th at p. 1335.) Therefore, because the assignee for collection holds the legal title and is the one actually pursuing the lien claim, it is not a “physician lien claimant.”

**19. Section Added: 10608.5 (entitled “Service by Parties and Lien Claimants of Reports and Records on Other Parties and Lien Claimants”).**

The WCAB intends to adopt Rule 10608.5 as initially proposed. There was a request to have Rule 10608.5 expressly state that service of electronic media may be made by mail. However, Rule 10505 already covers mail service and there is no need to specifically reiterate its provisions in Rule 10608.5.

**20. Section Amended: 10622 (entitled “Failure to Comply”).**

The WCAB intends to adopt Rule 10622 as initially proposed, with the exception of amending the third paragraph to extend its willful suppression provisions to “vocational expert” reports in addition to medical reports. This was an oversight when Rule 10622 was originally re-drafted.

**21. Section Amended: 10770 (entitled “Filing and Service of Lien Claims”).**

The WCAB intends to adopt Rule 10770 as initially proposed, with the following exceptions.

Newly proposed Rule 10770(g) [initially proposed as Rule 10770(f)] already provides that a lien claimant shall provide written notification to the WCAB within five business days after a lien claim has been “resolved or withdrawn.” Proposed Rule 10770(g) would add two new paragraphs.

First, Rule 10770(g) would provide that a lien is not “‘resolved’ unless payment in accordance with an order or an informal agreement has in fact been made and received.” The effect of this provision is that, even where a defendant and a lien claimant have reached a tentative agreement to resolve the lien, *they will both have to appear at any lien conference or trial* unless payment has in fact been made and received or unless the lien claimant for some reason submits a written withdrawal of its lien, notwithstanding its failure to receive payment. Absent one of these circumstances, neither the lien claimant nor the defendant can unilaterally decide not to appear, i.e., permission from the WCJ assigned to the lien conference or lien trial is required. The reason for this provision is it is not uncommon for tentative agreements regarding the resolution of liens to fall through. And, if the defendant and lien claimant then fail to appear at the lien conference or lien trial, it results in a waste of the WCAB’s precious calendar time.<sup>21</sup>

Second, Rule 10770(g) would provide that where a written notification of lien resolution or withdrawal is being filed by a lien claimant, it must serve a copy on its attorney or non-attorney representative, and vice versa if the

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<sup>21</sup> Of course, a non-appearing lien claimant also runs the risk that a notice of intention to dismiss its lien for failure to appear. Or, if it has failed to pay any requisite lien activation or filing fee, it runs the risk that its lien will be dismissed altogether.

lien resolution or withdrawal is being filed by the attorney or non-attorney representative. This cross-service requirement is proposed for adoption because it is not uncommon for the right hand not to know what the left hand is doing because the left hand neglects to notify the right hand. This can cause the lien claimant, or the attorney or non-attorney representative of the lien claimant, to appear at a lien conference or lien trial without knowledge that the lien is resolved. At best, this results in unnecessary confusion. Moreover, regardless of whether it is the lien claimant or its attorney or non-attorney representative that files the written notice of withdrawal, Rule 10770(g) requires that the written notification must include a request to end-date both the lien claimant and the representative as case participants in EAMS. This will reduce the number of unnecessary notices of hearing, thereby saving the resources of DWC and the WCAB.

Third, Rule 10770(h), as initially proposed, will be amended to delete the provision regarding petitions for costs. This provision becomes unnecessary in light of proposed Rule 10451.3, which essentially precludes a petition for costs from being filed for lienable expenses.

Finally, the last subdivision of Rule 10770 will be amended to state that the provisions of subdivision (c)(4)(D) – which requires that the Labor Code section 4903.8(d) declaration under penalty of perjury must be filed with the lien — will not apply to the listed lien claimants, including but not limited to the Employment Development Department (EDD) and any governmental entity pursuing a lien claim for child or spousal support. In substance, section 4903.8(d) mandates that the declaration shall state that “[t]he services or products described in the bill ... were actually provided to the injured employee” and that the billing statement “truly and accurately describes the services or products.” The reality is that EDD, county child support agencies, and the other persons or entities listed do not provide “services or products” within the meaning of section 4903.8(d) and they do not “bill” for them.

## **22. Section Amended: 10770.1 (entitled “Lien Conferences and Lien Trials”).**

The WCAB intends to adopt Rule 10770.1 as initially proposed, with the following exceptions.

First, the WCAB proposes to add a new subdivision (a)(4) providing that: (1) once a DOR for a lien conference has been filed, it cannot be withdrawn; and (2) if the lien of a lien claimant that filed a DOR has been resolved, that lien claimant shall request that its lien be withdrawn in accordance with Rule 10770(g). The reason for this proposal is that, once such a DOR has been filed, it will trigger a lien conference on “*all* unresolved lien claims and lien issues ..., whether or not listed in any DOR.” (See proposed Rule 10770.1(a)(3) [i.e., the second paragraph of current Rule 10770.1(a)].) Therefore, the lien claimant or defendant who filed the DOR should be precluded from withdrawing it, even if the lien or lien issue that led to the DOR’s filing has been resolved. Instead, the lien claimant whose lien has been “resolved” should withdraw its lien using the procedures established by proposed Rule 10770(g) [see current Rule 10770(f)].<sup>22</sup>

Second, the WCAB intends to add new language to Rule 10770.1(c)(3)(B) as initially proposed. The added language provides that where a lien claim is dismissed for failure to present proof of prior timely payment of a required filing fee, the filing of the dismissed lien will not toll, preserve, or extend any applicable statute of limitations. This is consistent with Labor Code section 4903.05(a)(1) and (2), which respectively provide that specified lien claimants must pay a \$150 filing fee and that “a lien submitted for filing that does not [pay the filing fee] shall be invalid, even if lodged with the appeals Board, and shall not operate to preserve or extend any time limit for the filing of the lien.”

Third, the WCAB intends to amend proposed Rule 10770.1(d) [currently, Rule 10770.1(c)] for the purposes of: (1) clarifying that where any conference should have been requested or set as a “lien conference,” then that

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<sup>22</sup> A lien claimant that fails to withdraw its lien as required by proposed Rule 10770(g) will be subject to monetary sanctions, attorney’s fees, and costs. (Lab. Code, § 5813; Cal. Code Regs., tit. 8, § 10561; see also proposed Rule 10770(k) [current Rule 10770(i)].)

conference is a “lien conference” regardless of what other designation may have been given to it; and (2) the WCAB shall not convert, re-set, or continue a “lien conference” to any other type of conference. These changes are being proposed to more strongly emphasize that the lien activation fee provisions of Labor Code section 4903.06 and the discovery closure and other provisions of Rule 10770.1 will apply to all conferences directly relating to a lien claim and that neither a lien claimant nor the WCAB may avoid these consequences by requesting or designating a hearing other than a “lien conference.” This is true notwithstanding whatever other general powers the WCJ might have under any other WCAB Rule, including Rules 10353(b) and 10253(c).

At the public hearing, Landmark Medical Management expressed concern about the provisions of Rule 10770.1(c) requiring that, at a lien conference, a lien claimant must have “proper written proof of prior timely payment” of a lien activation or filing fee. Landmark asserts it does not make any sense to absolutely require a lien claimant to have proof of payment available at the lien conference, given that: (1) the lien representative may simply have forgotten to bring the proof of payment or may not have had access to EAMS before they arrived at the lien conference; and (2) Rule 10770.1(c) also gives a WCJ the discretion to use the Public Search Tool in EAMS to confirm prior timely payment, so the WCJ can easily determine whether payment has been made. The WCAB rejects this assertion.

For one, Landmark’s assertion ignores the statutory language of Labor Code sections 4903.05 and 4903.06. Section 4903.05(c)(1) requires that a lien claimant “shall include proof that the filing fee has been paid” at the time it files its lien, and section 4903.06(a)(2) provides that, if a lien claimant files a DOR, it “shall include proof of payment of the filing fee or lien activation fee with the [DOR].” Since these fees must be paid in conjunction with the filing of the lien or with the DOR, a lien claimant should be readily able to present proof of payment at the lien conference. Similarly, under section 4903.06(a)(4), the lien claimants who did not file a DOR “shall submit proof of payment of the activation fee at the lien conference [and] [i]f ... no proof of payment is available, the lien shall be dismissed with prejudice.” Therefore, section 4903.06(a)(4) clearly puts the onus on all other lien claimants to produce proof of payment at the lien conference.

For another, Landmark ignores the practical realities of being a WCJ. When handling a conference calendar, a WCJ will ordinarily have multiple lien conferences, each with multiple liens. In addition, the WCJ will ordinarily have a number of mandatory settlement conferences (MSCs) and will have to handle a significant number of walk-through documents (see Cal. Code Regs., tit. 8, § 10280). So, while it might not take a WCJ an inordinate amount of time to use the Public Search Tool to look up any particular lien(s) in any particular case(s), a WCJ should not be expected to use the Public Search Tool for every lien at every lien conference. Otherwise, a WCJ would have little or no time to perform his or her judicial functions.

Landmark’s written comments also assert that, at lien conferences before one district office of the WCAB, some WCJs are refusing to sign stipulated orders resolving lien claims. Therefore, it implicitly suggests that a Rule should be adopted requiring such stipulated orders to be executed. However, in discussions with personnel at DWC, the WCAB has been informed that this problem has been resolved.

**23. Section Amended: 10770.5 (entitled “Verification to Filing of Lien Claim or Application by Lien Claimant”).**

The WCAB intends to adopt Rule 10770.5 as initially proposed, except for striking the references to a petition medical-legal costs. This change is being made in light of the changes to the rule on petitions for costs (see Rule 10451.3), which will no longer permit such a petition to be filed for medical-legal costs.

During the public comment period, Mr. Suchil of AIA suggested that Rule 10770.5 applies to all liens, not just medical treatment liens and claims of costs liens for medical-legal expenses. However, it is Labor Code section 4903.6(a) that restricts when an application or lien can be filed, and it refers to a lien “under subdivision (b) of Section 4903.” Given the amendment to Labor Code section 4903(b) by SB 863, this might suggest that the Rule 10770.5 declaration should apply only to medical treatment liens. However, section 4903.6(a)(2)(B) also

refers to “the time provided for payment of medical-legal expenses pursuant to Section 4622.” This indicates that the Rule 10770.5 declaration properly still extends to claims of medical-legal costs filed in the form of a lien. Although the WCAB recognizes that it *could* extend the Rule 10770.5 declaration to other types of liens, the WCAB neither sees nor has been offered a compelling reason for doing so.

**24. Section Amended: 10770.6 (entitled “Verification to Filing of Declaration of Readiness By or on Behalf of Lien Claimant”).**

The WCAB intends to adopt Rule 10770.6 as initially proposed, except for striking the reference to a petition for medical-legal costs. This change is being made in light of the changes to the rule on petitions for costs (see Rule 10451.3), which will no longer permit a petition to be filed for medical-legal costs.

**25. Section Added: 10774.5 (entitled “Notices of Representation, Change of Representation, and Non-Representation for Lien Claimants”).**

The WCAB intends to adopt Rule 10774.5 as initially proposed.

**26. Section Amended: 10845 (entitled “General Requirements for Petitions for Reconsideration, Removal, and Disqualification, and for Answers and Other Documents”).**

The WCAB intends to adopt Rule 10845 as initially proposed.

**27. Section Amended: 10886 (entitled “Service on Lien Claimants”).**

The WCAB intends to adopt Rule 10886 as initially proposed.

In his written comments, Scott Schoenkopf of Rehab Solutions asserts that the proposed amendment to Rule 10886, which would eliminate the requirement to serve settlement documents on lien claimants, is unnecessary. He notes that the Appeals Board’s stated intent in proposing the amendment is to encourage lien claimants to file their liens. He asserts, however, that this concern is already addressed by SB 863’s amendments to the statute of limitations, i.e., Labor Code section 4903.5. The WCAB rejects this assertion. Mr. Schoenkopf fails to recognize that the amended statute of limitations provisions of section 4903.5 apply only to section 4903(b) liens, which under SB 863 are now limited to medical treatment liens. Mr. Schoenkopf further argues that the currently existing provisions of Rule 10886 are now even more necessary with the advent of Labor Code section 4903.6(d), which limits the availability of medical information for non-physician lien claimants. However, as more thoroughly discussed in the SSOR pertaining to Rules 10250 and 10608, there are avenues for non-physician lien claimants to obtain medical information. In any event, the service of settlement documents is unrelated to the service of medical reports.

**28. Section Added: 10957 (entitled “Petition Appealing Independent Bill Review Determination of the Administrative Director”).**

The WCAB intends to adopt Rule 10957 as initially proposed, with two exceptions.

First, proposed Rule 10957(b) will provide that a petition appealing an IBR determination shall be filed with the WCAB no later than 20 days after “the IBR serves the determination” rather than 20 days after the AD serves the determination. Mr. Merz of CalChamber correctly points out that Labor Code section 4603.6(e) provides, “The written determination of the independent bill reviewer shall be sent to the administrative director and provided to both the medical provider and the employer.” Also, AD Rule 9792.5.14(c) provides that “[t]he independent bill reviewer shall serve the determination of the provider, the claims administrator and the Administrative Director” and AD Rule 9792.5.14(d) provides that “the determination issued by the independent bill reviewer shall be deemed to be the determination of the Administrative Director.” Therefore, service of the IBR determination is made by the IBR, not the AD.

Second, some of the procedural provisions of Rule 10957, as initially proposed, are being stricken because they are being incorporated into proposed Rule 10450, the generic rule on petitions and answers.

**29. Section Added: 10957.1 (entitled “Petition Appealing Independent Medical Review Determination of the Administrative Director”).**

The WCAB intends to adopt Rule 10957.1 as initially proposed, with the exception that some of its procedural provisions are being stricken because they are being incorporated into proposed Rule 10450, the generic rule on petitions and answers.

**30. Section Added: 10959 (entitled “Petition Appealing Medical Provider Network Determination of the Administrative Director”).**

The WCAB intends to adopt Rule 10959 as initially proposed, with two exceptions.

First, the second paragraph of subdivision (a) is being amended to clarify that, where it is alleged that the AD should have suspended or revoked a previously approved MPN plan, the allegations must be based on the AD’s failure to act in accordance with the MPN regulations on third-party petitions for suspension or revocation. It is the AD that has the authority to adopt regulations regarding MPN plans (see Lab. Code, § 4616(h) [formerly, § 4616(g)]). Therefore, where the AD denies a petition to revoke or suspend a previously approved MPN plan, any appeal to the WCAB should be based on the AD’s alleged failure to follow or apply regulatory criteria.

Second, the WCAB is striking some of the procedural provisions of Rule 10959, as initially proposed, because they are being incorporated into proposed Rule 10450, the generic rule on petitions and answers.