Steve Cattolica October 31, 2017
Advocal

The Division has proposed the following additional language:

> (i) Notice Denying Liability for All Compensation Benefits. If the claims administrator denies liability for the payment of all workers' compensation benefits for any claim except a claim for death benefits, including medical-only claims, the claims administrator shall advise the employee of the denial and the reasons for it.
>
> The notice shall contain the following statement:
>
> > Although your claim has been denied, if you believe that you still need medical treatment for your injury or illness, you have the right to obtain treatment outside the workers' compensation system.
> >
> > If you have your own health insurance, or are eligible to be treated by someone else's health insurance, you can use that insurance to get medical care. You should advise your physician that you believe that your injury or illness is work related, so the health insurer can seek reimbursement from the claims administrator.
> >
> > If you do not have health insurance available, there are doctors, clinics, or hospitals that will treat you without immediate payment. You should advise any doctor, clinic, or hospital that agrees to treat you that you believe that your injury or illness is work related so they can seek payment from the claims administrator through the workers' compensation system.

First, CSIMS supports the additions and changes to this regulation as submitted by the California Applicants Attorney Association. However, from our members' perspective as both treating physicians and evaluators, the current proposal is both misleading and erroneous. This proposal does very little to provide accurate guidance to the injured worker regarding what he/she should expect when seeking care while a dispute about liability for the injured worker's claim or an additional body part/system is being resolved. The added confusion and stress is counterproductive to the healing process. Therefore, we make the following suggestions:

1) We understand that it is considered fraud to <u>not</u> tell a treating physician that an injury may be work related. In both places where the phrase "should advise," appears, it must be replace by "must advise." The current language is dangerously misleading.

2) Reading the second and third paragraphs the reader is lead to believe that care "will" be provided. Under some health insurance policies, that might be true, but without insurance, it is virtually always not true without providing more guidance. Additionally, the second sentence of the second paragraph uses the phrase, "...any doctor, clinic, or hospital *that agrees to treat you*...." (emphasis added). Initial use of the word "will" and later use of the reference, "agrees to treat you" are materially different. "Will" infers the provider will provide the care; whereas "agrees to treat you" infers that the physician may not agree. In many cases this latter outcome is much more realistic and truthful. No claimant would understand or perceive the critical difference, yet both sentences set up the injured worker with a misleading, albeit positive expectancy. The injured worker has a right to know that the burden lies on him/her to get the provider to agree.

3) As mentioned by other commentators, nowhere does the disclosure inform the injured worker of their potential liability for costs. This is an egregious omission. Although the statute does not require this notice to so state, it is extremely misleading and not in the public's best interest to omit the fact, if the I/W losses the liability question, the cost of care will come out of the I/W's pocket.

We look forward to improvements in this proposal that will better protect and inform this vulnerable segment of consumers.

Denise Niber, Claims and Medical Director — October 31, 2017
California Workers' Compensation Institute

Recommended revisions to the proposed regulation are indicated by underscore and ~~strikeout~~. Comments and discussion by the Institute are identified by *italicized text.*

Forum Comment:

Labor Code section 138.4(f), as amended by Senate Bill 1160, states:

> On or before January 1, 2018, the administrative director shall adopt regulations to provide employees with notice that they may access medical treatment outside of the workers' compensation system following the denial of their claim.

The Division has chosen to fulfill this mandate by simply modifying the DWC Denial notice, and the Institute wholeheartedly supports this approach. This is the most cost-effective solution -- with the least administrative burden -- to effectuate the requirement of Labor Code section 138.4(f) as enacted by Senate Bill 1160. However, the Institute is concerned that the amended

language as currently drafted will be misinterpreted by employees and providers in such a way as to cause increased administrative burden in the form of unnecessary and untenable liens.

Recommendation:

Modify CCR section 9812(i) text & notice language as follows**:**

> The notice shall contain the following statement:
>
> Although your claim has been denied, if you believe that you still need medical treatment for your injury or illness, you ~~have the right to obtain~~ may access medical treatment outside of the workers' compensation system.
>
> If you have your own health insurance, or are eligible to be treated ~~by~~ under someone else's health insurance, you can use that insurance to get medical care. ~~You should advise your physician that you believe that your injury or illness is work related, so the health insurer can seek reimbursement from the claims administrator.~~
>
> If you do not have health insurance available, there ~~are~~ may be doctors, clinics, or hospitals that will treat you without immediate payment. ~~You should advise any doctor, clinic, or hospital that agrees to treat you that you believe that your injury or illness is work related so they can seek payment from the claims administrator through the workers' compensation system.~~

Discussion:

The Institute's recommended changes are designed to more precisely mirror the statutory language. Labor Code section 138.4(f) as amended by Senate Bill 1160 has not altered anything concerning either medical access or potential rights to reimbursement in denied claims. The legislative intent (as evidenced in the legislative digest of SB 1160) and the plain language of Labor Code section 138.4(f) require only that employees be given ***notice that they may access medical treatment outside the workers' compensation system.*** *Adding additional language is unnecessary, and likely to cause confusion by incorrectly implying that the law concerning medical treatment in the case of a denied claim has changed.*

Abbreviating the regulatory language and limiting it to the specific mandate of Labor Code section 138.4(f) avoids confusion and maximizes clarity. The phrases "right to obtain," "so the health insurer can seek reimbursement," and "so they can seek payment from the claims administrator through the workers' compensation system" could be construed as conferring new benefits or implying that employees' medical treatment outside the workers' compensation system will (or should) be reimbursed through the workers' compensation system. In fact, in the

case of a denied claim, a claimant or lien claimant must prove injury AOE/COE as a prerequisite to entitlement to compensation or reimbursement.

Furthermore, the drafted language does not differentiate between those employees who dispute the denial of their claim and those who do not. Employees often agree with the denial and do not wish to pursue their claims further when, for example, there is a refusal to cooperate in an investigation, a wrong insurer, or a lack of coverage. But the proposed language could be construed as directive, requiring employees to generate medical liens when pursuing treatment outside the workers' compensation system, even if they are not disputing the claim denial -- and even if any such treatment liens are untenable.

The Institute recommends "under" for purposes of accuracy, as a patient is not treated "by" health insurance.

The Institute recommends "may be" for specificity. The phrase "may be" more accurately communicates to the employee that this is a possible option.

In summary, the notice to employees should be precise and focused. Additional language addressing reimbursement and payment is unnecessary, confusing, and should be eliminated to ensure clarity and avoid increased delays and administrative burdens.

Recommendation:
Replace the DWC Denial Notice in the Benefit Notice Instruction Manual with the amended denial notice as recommended above.

Discussion:
In order to avoid confusion and regulatory inconsistency, the Institute also recommends that the Division replace the current DWC Denial notice contained in the Benefit Notice Instruction Manual with the amended denial notice that is to be adopted.

Diane Worley, Director of Policy Implementation October 31, 2017
California Applicants' Attorneys Association

The proposal is to add the following language to the Notice Denying Liability for the Claim:

"Although your claim has been denied, if you believe that you still need medical treatment for your injury or illness, you have the right to obtain treatment outside the workers' compensation system.

"If you have your own health insurance, or are eligible to be treated by someone else's health insurance, you can use that insurance to get medical care. You should advise your physician that you believe that your injury or illness is work related, so the health insurer can seek reimbursement from the claims administrator.

"If you do not have health insurance available, there are doctors, clinics, or hospitals that will treat you without immediate payment. You should advise any doctor, clinic, or hospital that agrees to treat you that you believe that your injury or illness is work related so they can seek payment from the claims administrator through the workers' compensation system.

This proposed amendment to the Benefit Notice regulations is the result of the passage of SB 1160(Mendoza) which was signed into law by the governor in September 2016.

SB 1160 amended Labor Code section 138.4, effective January 1, 2017, to require the AD to adopt regulations, on or before January 1, 2018, "to provide employees with notice that they may access medical treatment outside of the workers' compensation system following the denial of their claim."

Initially, as the DWC Form Notice of Denial set forth in the current Benefit Notice Manual sets forth an **Option 1 FULL DENIAL** and an **Option 2 PARTIAL DENIAL (**where some body parts are admitted and other body parts denied) language should be added to the notice making it clear that accessing medical treatment outside the workers' compensation system for denied body parts(on an otherwise admitted claim) is also allowed.

CAAA recommends the following addition (underlined) to accomplish this:

"Although your claim has been denied or your claimed injury to [body part or body parts] has been denied, if you believe that you still need medical treatment for your injury or illness, you have the right to obtain treatment outside the workers' compensation system."

The above language is straightforward and easily understood.

However, the proposed language continues in paragraphs two and three and may be a bit misleading as to the third paragraph as to who is financially responsible for the treatment when the injured worker does not have private health insurance.

Per 8 CCR §9792.10.1(a), for injuries after 1/1/2013 "Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied…"

Because of this limitation we also recommend the following changes to paragraphs 2 and 3 of the proposed amendments to 8 CCR § 9812(i):

"If you have your own health insurance, or are eligible to be treated by someone else's health insurance, you can use that insurance to get medical care. You also have the right to obtain the treatment through other sources including public healthcare resources. If you believe your injury or illness is work related you should advise your physician that you believe that your injury or illness is work related, so the health insurer or healthcare provider can seek reimbursement from the claims administrator through the workers' compensation system.

"If you do not have health insurance available or you cannot get access to public healthcare resources, there are doctors, clinics, or hospitals that may ~~will~~ treat you without immediate payment. You should have a clear understanding of your financial responsibility for the treatment with your doctor's office when you don't have health insurance. If you believe your injury or illness is work related you should advise any doctor, clinic, or hospital that agrees to treat you ~~that you believe that your injury or illness is work related~~ so ~~they~~ the healthcare provider can seek payment from the claims administrator through the workers' compensation system."

Karen Sims, Assistant Claims Operations Manager October 31, 2017
State Compensation Insurance Fund

Recommended revisions to the proposed regulation are indicated by underscore and strikeout.
8 CCR § 9812(i) Benefit Payment and Notice

Recommendation
The notice shall contain the following statement:

Although your claim has been denied, if you believe that you still need medical treatment for your injury or illness, you ~~have the right to~~ may obtain treatment outside the workers' compensation system.

If you have your own health insurance, or are eligible to be treated by someone else's health insurance, you can use that insurance to get medical care. You should advise your physician that you believe that your injury or illness is work related~~, so the health insurer can seek reimbursement from the claims administrator~~.

If you do not have health insurance available, there are doctors, clinics, or hospitals that will treat you without immediate payment. You should advise any doctor, clinic, or hospital that agrees to treat you that you believe that your injury or illness is work related ~~so they can seek payment from the claims administrator through the workers' compensation system~~.

Discussion

State Fund recommends avoiding language that may be interpreted as creating a right to medical treatment or a right to reimbursement on a denied claim. Use of the term “right” implies entitlement to something. One interpretation could be the entitlement to go “outside the workers’ compensation system.” The other interpretation is the entitlement to “obtain treatment.” Using permissive language such as, “may” or “can” instead of the term “right” avoids the appearance of an entitlement altogether while giving the injured worker a notification of their choice to seek treatment outside the workers compensation system.

State Fund recommends against a declarative statement that there are medical providers that will treat injuries without immediate payment. The denial letters will be used regardless of whether the injured worker lives in urban, suburban, and rural areas. Access to medical providers varies depending on where an injured person lives and there may not be facilities near the injured person that will provide treatment without payment. By using the language of possibility, such as “may be” or “could be,” the injured person is provided information with what to look for, but there is no implied guarantee that there will be such a facility available.

State Fund recommends against including language that medical providers and health insurers can seek payment from the claims administrator in the denial letter. Health insurance providers and medical providers are sophisticated enough to understand the implications of providing treatment on a denied claim once an injured informs them they believe the injury is work related. The risk is in creating a false impression with the injured that they are not responsible for medical bills once a denial has been issued.

Karl Little October 25, 2017

Fantastic! First, we are pushed into using our own Health Care insurance for work injuries. Which, raised the cost to Health Care insurers. Now, you want to trap us into putting it on record with our general practitioners, that the treatment we seek is actually the cause of a work accident. So, neither insurance will cover our medical care. If a WCAB Judge can't make a Workers Comp insurer cover the injured's treatment, neither can a Health Care adjuster. What's the next amendment, convicting the injured for fraud by not specifying the injury happened at work? SB863 is a sham. Created by the Insurance, for the Insurance, to profit the Insurance.

Professor David J. Chetcuti October 24, 2017

Regarding the proposed new language to CCR 9812 concerning seeking medical treatment in a denied workers' compensation claim, the proposed language omits the most obvious option available. An additional sentence is needed:

"You also have the option to seek medical attention with any physician or facility of your choice at your own expense."

Patricia Ruiz, Workers' Compensation & Labor Compliance Specialist October 23, 2017
Coast Community College District

Because I work for the employer, I'd like to suggest that more information be provided related to the return to work process such as Transitional Return to Work Programs. This is information that is priceless as an employer given that the Interactive process plays such a big part in a claim and there is always the Workers' Comp aspect of it with the Human Resources part of it as well.

Steven Chandler October 23, 2017
Kern Medical

On 10/20/2017, Newsline 2017-95 was received and provides notice of draft benefit regulations along with an opportunity to participate in open comments. As a stakeholder, the following represent my comments and concerns:

The amendment to Labor Code 138.4 is clear, "to provide employees with notice that they may access medical treatment outside of the workers' compensation system following the denial of their claim". What can be more direct and straight-forward than this? Nothing. Why isn't the DIR/DWC simply adding this to the extensive Guidebook already published and from which letters are already referencing? Instead, the DIR wishes to have insurers, self-insureds, TPAs, and other administrators (henceforth, Administrators) again change their standard letters to add an additional 145 words. How does 23 words balloon to 145 words unless, of course, there is a political motive behind this.

It has long been understood that SB899 was created, among other things, to expedite treatment through the development of MPNs. SB863 codified this by strengthening these rules and clarifying the intent that minor errors does not excuse an injured worker from obtaining treatment through such a network. Most agree the system is riddled with issues, especially since liens had been exploding and the new focus is to reduce these liens. This has worked and it continues to do so! In my area, we have few (if any) treaters who provide care on a lien basis. I have providers in my network that often do not give me the 'favorable' opinion I seek; however, the goal of my network is to ensure timely and quality treatment with appropriate reporting.

Where does the law state Administrators have the onus of guiding an employee to seek treatment outside of our network? Yes, I concede this is specific to when claims are denied. This is where the existing notices already direct the employee to the I&A officer as well as to the guidebooks. The health insurers, as many have consolidated, have plenty of attorneys and resources working for them – much, much more than the average employer and in many cases, more than a TPA or these other, smaller insurers. Plus, they are excused from lien filing fees and can petition for costs. Are we now placing the onus on the defendant to *lead* the injured worker on what to say to health insurers so that we face even greater litigation and costs? Now, the Administrators are expected to guide an employee whose claim was denied to Dr's who work on liens? Where is the check and balance that these Dr's will not write an egregiously favorable report to the injured worker in an effort simply to win at a lien trial and get paid? So, in essence – this wording is asking the employer to hand over the checkbook and also provide the pen as well. Again, what political motive is behind taking 23 words and changing them to 145? That's a multiple of 6x!

I have no issues with your initial statement: "*although your claim has been denied, if you believe that you still need medical treatment for your injury or illness, you have the right to obtain treatment outside the workers' compensation system"* provided it is included in the online guidebook. The 2nd and 3rd paragraph is not supported by the amendment to Labor Code 138.4 and, as stated earlier, serves to promote a political agenda. Yes, administrators want to make sure the injured worker receives appropriate and timely care; however, requiring the administrator to add even more language will not produce this result – unless such result includes promoting greater litigation and lien opportunities. I suggest the sentence above providing notice of a right to seek treatment following denial is sufficient to meet the requirements of the law. If even to look for word count, the first paragraph contains 32 words yet the legislature found 23 words to be sufficient.

Let's also look at it this way:
Suppose the DIR requires the letters to be changed. It will need to update the letters manual. Administrators will suffer the need (and cost) to amend the electronic master of these letters and reprogram system defaults to complete it. The extra paragraphs will add an additional page to the letters. Processing of the paperwork to include folding and mailing, including the cost of postage, will increase. An increase in calls and letters will be realized. The WCAB will see an increase in processing, litigation rates will increase, and lien claimants will be given more

opportunities to create opportunities of financial gain (and with it, fraud) on the backs, legs, knees, arms, wrists, and well – lives of the injured worker. Where does it end?

Why is the DIR/DWC unwilling to simply allow one sentence to be added or, this paragraph added to the existing guidebooks? Why will be required to provide additional, unnecessary language, which will serve only to confuse the injured worker even more.
