

SB 863: Assessment of Workers' Compensation Reforms

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Introduction

SB 863 was enacted to improve medical care for injured workers and increase compensation for permanent partial disabilities while simultaneously reducing costs for employers. The bill was passed on August 1, 2012, and signed into law by Governor Brown on September 18, 2012. The bill took effect on January 1, 2013.

The Department of Industrial Relations (DIR) and the Division of Workers' Compensation (DWC) have continued to oversee its implementation. The statutory permanent disability benefit increases took effect on January 1, 2013, and January 1, 2014, and the regulations to implement the new Return-to-Work Supplement (RTWS) Program went into effect on April 13, 2015, for dates of injury on or after January 1, 2013. The Department conducted a public hearing on a petition to amend the RTWS application deadline and decided to proceed with rulemaking to amend the application deadline.

In addition to increasing benefits, one of SB 863's goals is to improve the delivery of medical benefits. By requiring the use of evidence-based medicine to guide treatment decisions and having disputed medical treatment decisions settled by independent medical reviewers, SB 863 works toward that goal. The reforms also improved the Medical Provider Networks (MPNs) by improving injured workers' access to network physicians and giving the DWC increased regulatory oversight.

Savings from SB 863 continue to be realized. Updated annual estimates of savings from reforms by the Workers' Compensation Insurance Rating Bureau (WCIRB) are about \$600 million greater than initially estimated. On May 27, 2016, the California Insurance Commissioner approved the advisory pure premium rates proposed by the WCIRB, rates that average \$2.30 per \$100 of payroll, effective July 1, 2016. These rates are, on average, 5 percent less than the industry average for filed pure premium rates as of January 1, 2016, and 10.4 percent less than the average of the approved January 1, 2016, advisory pure premium rates of \$2.57. This is the second mid-year rate filing approved by the WCIRB since 2012. Although insurers are not required to adhere to the Insurance Commissioner's advisory pure premium rates, the WCIRB's recommendation and the Commissioner's decisions demonstrate a substantial reduction in costs to employers.

National concerns about the increasing use and detrimental effects of opioid abuse have prompted several states to adopt drug formularies. This trend, coupled with the evidence of increased opioid use in California that the Independent Medical Review (IMR) process has brought to light, prompted the passage of Assembly Bill 1124

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(Statutes 2015, Chapter 525). This legislation requires the adoption of an evidence-based workers' compensation drug formulary by July 1, 2017. The goal is to adopt an evidence-based drug formulary that will promote the provision of timely high-quality medical care and maximize health and work-related outcomes, while reducing administrative burden and cost. The preliminary criteria used to evaluate potential approaches to the formulary include the following:

- Reliance on evidence-based criteria in determining the drugs and recommendations for the formulary
- An established process for regular updates to the formulary drugs and recommendations
- Transparency in the decision-making process used to establish and maintain the formulary drug list and recommendations
- Compatibility with the medical treatment utilization guidelines
- Accessibility and ease of use

The DWC has been considering a variety of approaches to the formulary in light of the goals and preliminary criteria. Together with the RAND Corporation, the contractor providing technical expertise, the DWC has been gathering information from workers' compensation system participants, and other jurisdictions and payment systems, in order to identify formulary issues and best practices.

This report updates last year's analysis of the impacts of SB 863 and is intended to report on the changes, the accomplishments, the opportunities for improvement, and the ongoing challenges of the reforms.

Key Points

- SB 863 increased permanent disability (PD) benefits approximately 30% in two steps. Prior to SB 863, the minimum weekly PD benefit was \$130, and the maximum was \$270. For dates of injuries on or after January 1, 2013, the new minimum weekly PD benefit is \$160. The new maximum weekly PD rate for injuries on or after January 1, 2013, ranges from \$230 to \$290, depending on the PD rating, and for all injuries on or after January 1, 2014, the maximum weekly PD rate is \$290.
- The RTWS benefits are in effect and being disbursed; additional rulemaking will amend the RTWS application deadline.
- More than 12 sets of regulations were enacted to implement SB 863. Additional sets of regulations covering home healthcare and interpreters are in process.

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- The IMR process and revisions to the Medical Treatment Utilization Schedule (MTUS) show the continued focus on evidence-based medicine.
- IMR decisions are issued well within the statutory timeframe from receipt of medical records.
- Medical Provider Networks (MPNs) with increased accountability are being approved.
- The number of lien filings fell by approximately 60% after SB 863 was passed, but then increased in the first quarter of 2015.
- The change in the Ambulatory Surgical Centers (ASC) fee schedule generates approximately \$80 million in annual savings.¹
- The elimination of duplicate reimbursement for spinal surgical implants generates approximately \$140 million in annual savings.²
- The implementation of the resource-based relative value scale (RBRVS) for physician services was initially estimated to increase costs by \$340 million per year. The RBRVS is now estimated to decrease costs by \$10 million per year. This updated estimate is driven in large part by a decline in the number of special services and reports transactions, and that decline has contributed to a 4.8% decrease in physician payments per claim for the 2014 service year, rather than the increase in physician costs previously projected.³
- According to the WCIRB, the projected average medical cost of 2015 indemnity claims is about 8% below the projected average medical cost for 2011, largely a result of medical cost savings arising from SB 863.⁴
- Insurance Commissioner Dave Jones issued an advisory reduction in premiums, effective July 2016, that is 5% lower than the one effective just six months earlier.
- DIR is exploring options to streamline the utilization review process based on empirical analysis of data collected through the IMR system.
- Workers' compensation fraud remains a significant concern, as revealed by data collected through and matched across the IMR and lien filing systems. The DIR and the Department of Insurance (DOI) are convening meetings to gather stakeholder input and help identify viable solutions and formulate a comprehensive strategy to reduce fraud.

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http://www.wcirb.com/sites/default/files/documents/sb_863_cost_monitoring_report_2015_retrospective_evaluation.pdf.

² Ibid.

³ Ibid.

⁴ http://www.wcirb.com/sites/default/files/documents/160412_report_on_12-31-15_insurer_experience-complete.pdf.

Accomplishments

Medical Treatment Utilization Schedule Updates: Focus on Chronic Pain and Opioid Use

California continues to be a leader in advocating that medical treatment in the workers' compensation system be guided by evidence-based decisions. Evidence-based medicine is a systematic method of making clinical decisions that involves applying the best available scientific evidence to recommend the most appropriate treatment for individual patients. By encouraging practices that have been proven to work and discouraging those that are ineffective or harmful, evidence-based medicine results in better care, which translates to better health outcomes and fewer wasted resources. Evidence-based medicine requires doctors to apply a standardized process when evaluating the available treatment options and to consider the possible outcomes before making a recommendation to individual patients.

In 2003, the Legislature provided for a Medical Treatment Utilization Schedule (MTUS), which includes a set of evidence-based medical treatment guidelines to be applied when treating injured workers. The MTUS helps medical providers understand which evidenced-based treatments are most effective in achieving better medical outcomes for workers.

The DWC is engaged in an ongoing process to improve the MTUS to ensure that it reflects current scientific medical knowledge and offers practical, high-quality guidance for the care of injured workers. In 2015, the MTUS was updated to explain and clarify the scientific process underlying evidence-based clinical decisions made for injured workers. These regulations provide a transparent, systematic methodology for evaluating medical evidence and guiding clinical decision making.

In recognition of the significant concern over chronic pain and to address issues that have given rise to a national epidemic of prescription drug misuse, the DWC has updated the MTUS Chronic Pain Medical Treatment Guidelines and produced separate, stand-alone MTUS Opioids Treatment Guidelines. Currently in the final stages of the rulemaking, these guidelines address the need to treat pain adequately while avoiding harmful health impacts and facilitating functional recovery.

The MTUS Opioids Treatment Guidelines are designed to be used starting with the first encounter with the injured worker. The Guidelines have separate sections for addressing opioid use for acute pain (up to four weeks after injury or the onset of pain), subacute pain (one to three months), and chronic pain. Depending on the stage of

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treatment, specific recommendations are made to guide the healthcare provider. These recommendations include alternative treatments, screening for risk factors, patient treatment agreements, the use of California's Controlled Substance Utilization and Evaluation System (CURES), and tapering opioids.

Work has begun to update the remainder of the current MTUS chapters as well as to add additional topic chapters. MTUS updates will continue in 2017.

Anti-Fraud Efforts

Building on the framework of SB 863, efforts are underway to develop and implement an empirically based, systematic strategy to confront fraudulent activity. The Labor and Workforce Development Secretary David Lanier, Chair Tom Daly of the California Assembly Committee on Insurance, and Chair Tony Mendoza of the California Senate Committee on Labor and Industrial Relations called for a concerted effort to identify and curb fraudulent activity in the workers' compensation system.

Collaboration across jurisdictions and data sharing are central to a successful approach, and stakeholders provide the variety of perspectives that need to be considered. As directed by Secretary Lanier, the DIR convened working groups in June 2016 to elicit information and evidence of fraudulent activity in the workers' compensation system. DIR Director Christine Baker served as chair of the steering committee for this effort, and co-chairs were Nettie Hoge, the chief deputy commissioner of the California Department of Insurance; George Parisotto, acting administrative director of the DWC; and Eduardo Enz, executive officer of the Commission on Health and Safety and Workers' Compensation.

The ongoing feedback has helped prioritize efforts, interpret results of initial findings observed in the data patterns, and formulate policy recommendations for consideration. Based on a synthesis of stakeholder input, ongoing departmental efforts to detect and deter fraud, and an independent review of best practices in other health systems conducted by the RAND Corporation, the DIR will be identifying a set of recommendations. A white paper due to the Labor Secretary is being prepared to synthesize the information collected and outline the issues and options for addressing key themes identified.

Electronic Submission of Medical Records

To improve efficiency in California's workers' compensation system, the DWC is exploring options to move their processes to an electronic platform. Particular emphasis is being placed on processes related to the administration of medical care in workers' compensation. Those processes require timely exchanges of substantial, sensitive information by and between a variety of interested parties. Trying to meet those needs using traditional paper-based resources leads to additional frustration, cost and delay – all of which, it is believed, can be reduced or eliminated through the move to a more electronic platform.

A key component of the DWC's process modernization effort will likely involve the use of a web-based "portal" application. At the highest level, the portal could serve as a hub

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for communication related to the provision of medical care in worker's compensation. Ultimately, the portal could offer users a comprehensive, secure, anytime-and-anywhere means to access and engage in the medical treatment process. Some key considerations include the ability to:

- Sign and submit form applications electronically with the click of a button.
- Submit documents and review those submitted by others, all in a role-based system that allows each user to see and touch only those pieces of information to which they have a right.
- Instantly retrieve case status and history.
- Transmit correspondence electronically the moment it is generated.
- Review dashboard reporting on program status that can be tailored to provide the information most useful to each user/participant.

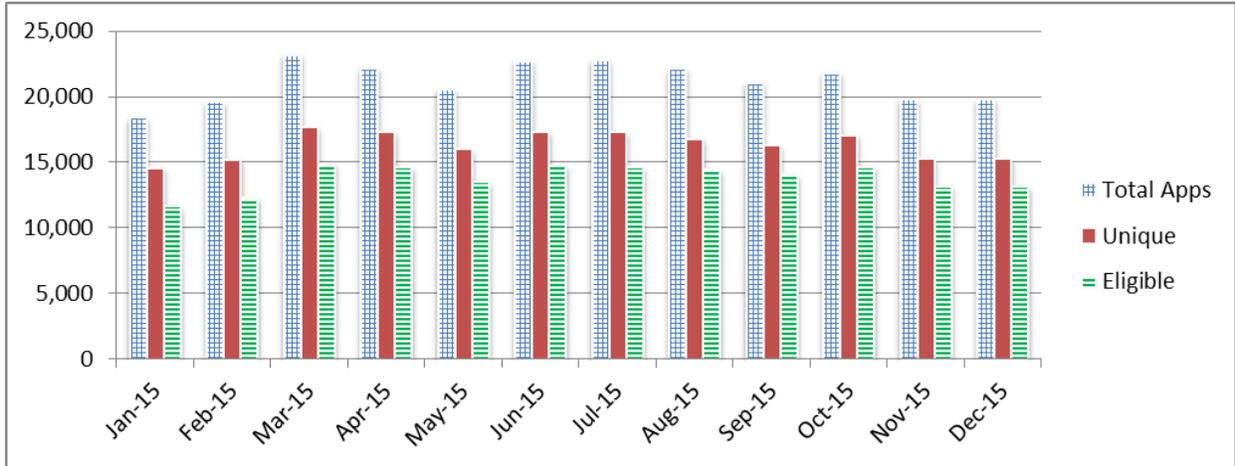
A pilot of the portal is currently underway for the Independent Medical Review program.

Independent Medical Review

Independent Medical Review (IMR) is available to workers who receive a utilization review (UR) decision stating that a physician's treatment request is being denied or modified on the basis of medical necessity. To request IMR, workers must submit a signed IMR application along with a copy of the UR decision within 30 days of the denial or modification. The IMR application and supporting material are submitted to the Independent Medical Review Organization (IMRO). The DWC has contracted with Maximus Federal Services (henceforth, Maximus). Decisions are issued by physician reviewers selected by the IMRO and matched by specialty to the nature of the medical dispute.

In 2015, the IMRO received 253,779 IMR applications, of which 195,685 (77%) were unique (not duplicates) and 165,427 (65%) were eligible to proceed with IMR. The overall inflow of IMR applications to the IMRO in 2015 averaged approximately 20,800 per month (see Figure 1).

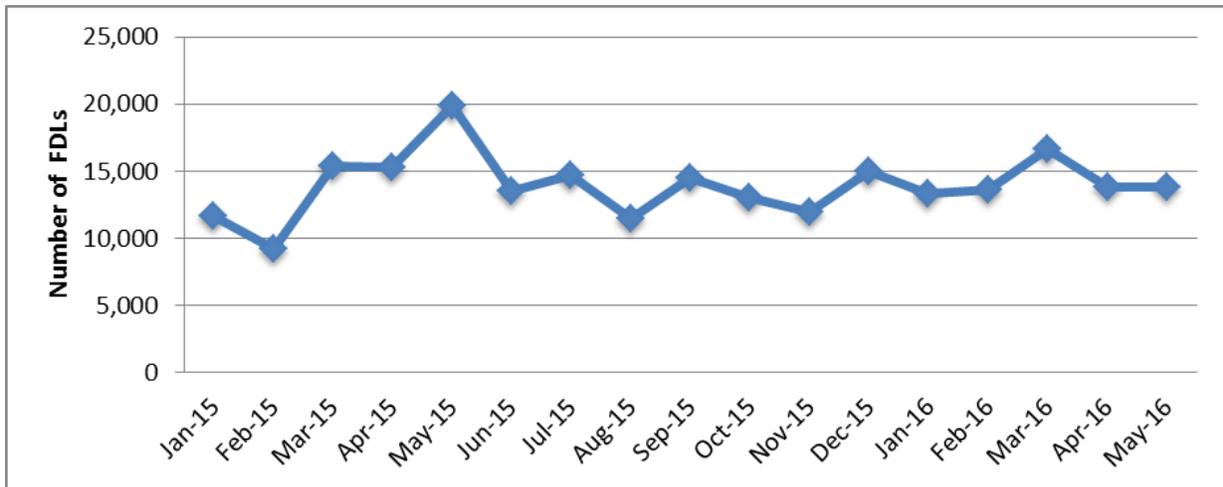
Figure 1. IMR Applications Received, January–December 2015 (N = 253,779)



Source: DWC IMR Database.

In 2015, the IMRO completed 165,525 IMR cases, an average of about 13,800 completed cases per month. This trend continued in the first half of 2016, with approximately 14,200 decisions per month from January 2015 to May 2016 (see Figure 2).

Figure 2. IMR Final Determination Letters Issued, January 2015–May 2016 (N = 236,685)



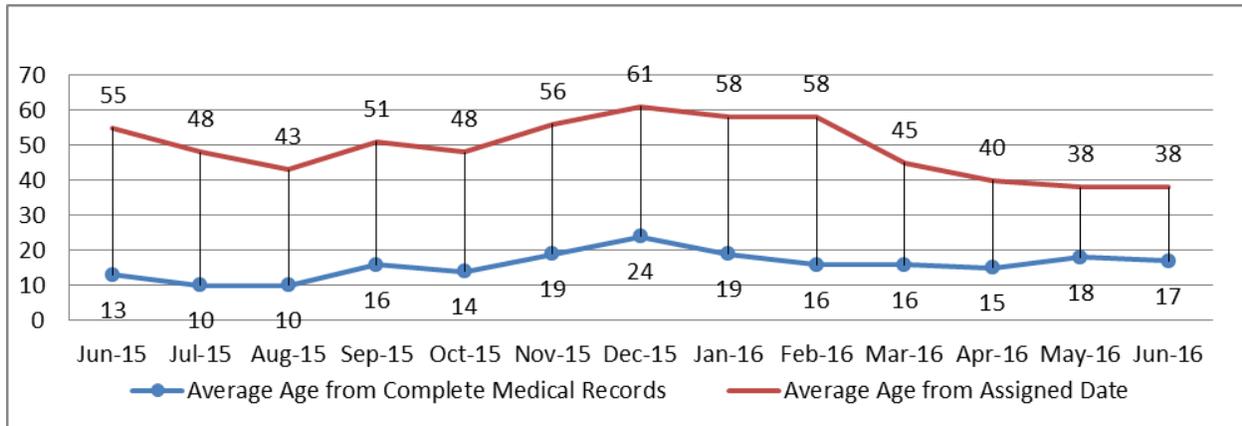
Source: DWC IMR Database.

According to regulation, a standard IMR application must be completed within 30 days from receipt of records and an expedited application within 72 hours. Any delay in the receipt of medical records from the claims administrator also delays this process. The time it takes to issue an IMR final determination letters from the date of assignment and the date of receipt of the complete medical records has improved since the DWC addressed the problem of late record submission by issuing an “Order to Show Cause re Assessment of Administrative Penalties” to claims administrators who have failed to

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provide medical records requested by Maximus in a timely manner. In the first half of 2016, the timeliness of issuing a final decision after receipt of complete medical records improved, as did the timeliness of the decision from date of assignment (see Figure 3).

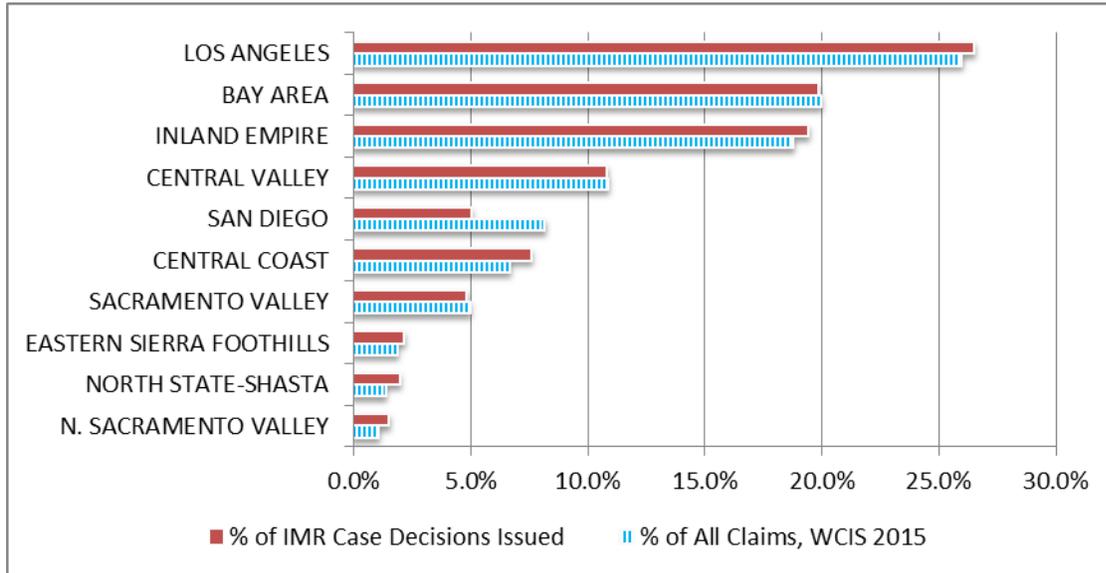
Figure 3. Timeliness (Average Age in Days) of IMR Final Determination Letters from Date of Assignment and Date of Receipt of Complete Medical Records, June 2015–June 21, 2016



Source: DWC IMR Database.

In 2015, Los Angeles had the highest proportion of IMRs (26%), followed by the Bay Area (19.4%), the Inland Empire (19%), the Central Valley (10.6%), the Central Coast (7.5%), and San Diego (5%). The geographic distribution of IMR decisions generally correlates with the distribution of worker' compensation claims filed, although San Diego had 8.2% of all claims but only 5.1% of the total IMR decisions (see Figure 4).

Figure 4. IMR Final Determinations by Geographic Area for Workers Residing in California, January–December 2015 (N = 161,942)



Sources: IMR case decisions: DWC IMR Database; all claims: DIR WCIS Database, WCIS First Reports of Injury filed in 2015.

IMR Case Outcome

The IMRO makes decisions at the case level as well as at the level of the individual treatment request. IMR case outcome describes the overall outcome of the IMR review at the IMR case level. “Treatment request” (referred to as simply “Requests” in the table) refers to the medical treatment that was denied in UR and challenged through the IMR process. IMR cases have at least one treatment or may have more than one. Treatment requests are classified into broad categories (see Table 1).

Table 1. IMR Issues in Dispute with a Final Decision, by Treatment Category, January–December 2015 (N = 282,737)

Treatment Category	Number of Treatment Requests	Percentage of Treatment Requests
Pharmaceuticals	139,355	49.3%
Rehabilitation	41,993	14.9%
Diagnostic Testing	32,669	11.6%
DMEPOS	19,769	7.0%
Injection	17,518	6.2%
Surgery	16,999	6.0%
Evaluation & Management	5,381	1.9%
Psych Services	4,048	1.4%
Programs	3,448	1.2%
Home Health	1,289	0.5%
Transportation	268	0.1%
Total	282,737	100%

Source: DWC IMR Database. IMR treatment requests in 165,525 IMR cases.

Note: DMEPOS refers to durable medical equipment, prosthetics, and supplies.

In 2015, the IMRO reviewed 165,525 cases, with 282,737 individual treatment requests, an average ratio of 1.7 requests per IMR case.

At the case level, an IMR has three possible outcomes:

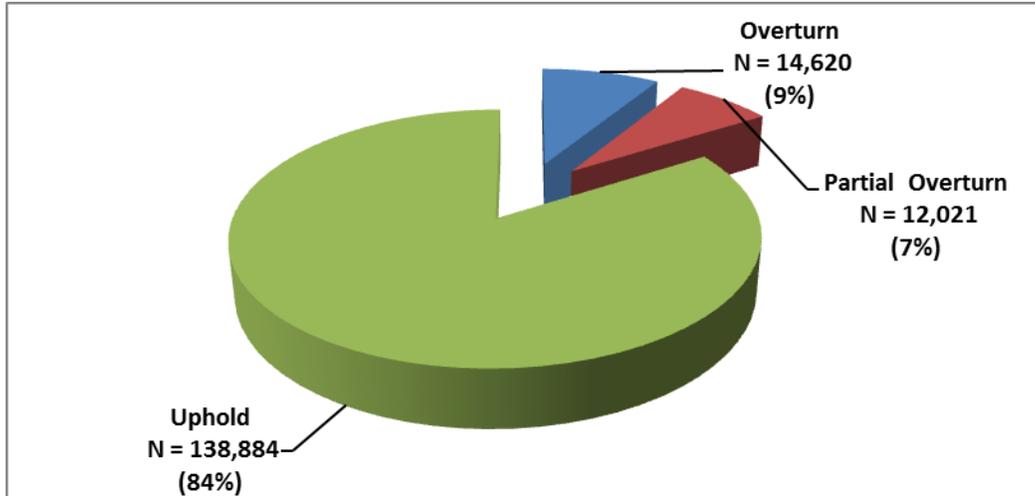
- *Uphold*: None of the disputed items/services are medically necessary and appropriate.
- *Overturn*: All of the disputes items/services are medically necessary and appropriate.
- *Partial Overturn*: Some (but not all) of the disputes items/services are medically necessary and appropriate.

In 2015, of the 165,525 IMR cases with a decision, the IMR upheld the UR decision to deny or modify the request for treatment in 138,884 (84%) cases, overturned the UR

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decision in 14,620 (9%) of the cases, and partially overturned the UR decision in 12,021 (7%) cases (see Figure 5).

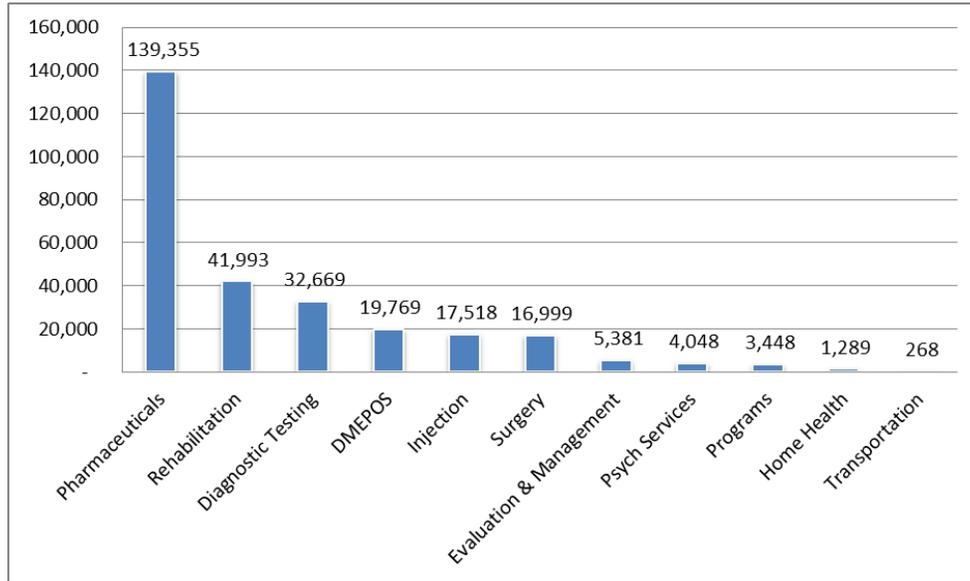
Figure 5. Outcomes of IMR Case-Level Final Determination Letters, January–December 2015 (N = 165,525)



Source: DWC IMR Database.

In 2015, the DWC, in conjunction with the IMRO Maximus, refined the classification system for the individual treatment requests in the IMR cases. The system is still being refined but has improved its ability to classify the types of services in dispute. Pharmaceuticals were the most prevalent issue in dispute, with 139,355 (49.3%) requests in 2015, followed by rehabilitation, which includes physical medicine, chiropractic, and acupuncture services at a distant 41,993 (14.9%) and Diagnostic testing at 32,669 (11.6%) (Table 1, Figure 6).

Figure 6. IMR Issues in Dispute with a Final Decision, by Treatment Category, January–December 2015 (N = 282,737)



Source: DWC IMR Database. IMR treatment requests in 165,525 IMR cases.
 Note: DMEPOS refers to durable medical equipment, prosthetics, and supplies.

Pharmacy

In 2015 the IMRO reviewed 139,355 requests for pharmaceuticals, accounting for nearly half (49.3%) of all treatment requests for the year. Opioids topped the list of the six most frequent categories of pharmaceuticals (44,493, or 32%), followed by muscle relaxants (18,005, or 13%), nonsteroidal anti-inflammatory medications (17,028, or 12%), topical analgesics (10,239, or 7%), and proton pump inhibitors (9,466, or 7%) (see Table 2).

Table 2. Pharmaceutical IMR Requests by Drug Class, 2015 (N = 139,355)

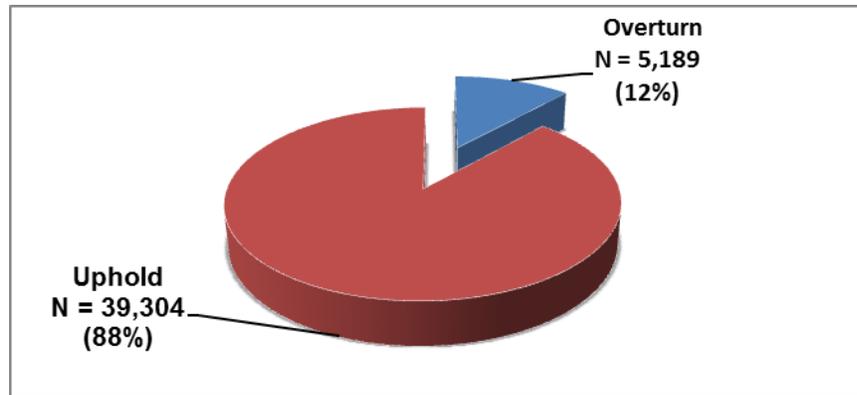
Pharmaceutical Category	Number of Requests	Percentage of Requests
Opioids	44,493	32%
Muscle Relaxant	18,005	13%
NSAID	17,028	12%
Topical Analgesics	10,239	7%
Proton Pump Inhibitors	9,466	7%
Other	40,124	29%
Total	139,355	100%

Source: DWC IMR Database. IMR decisions, treatment classification “Pharmaceuticals.”

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Of the 44,493 requests for opioids, the IMRO overturned the denial in 5,189 requests (12%) and upheld the UR decision in 39,304 requests (88%) (see Figure 7).

Figure 7. Outcomes of Opioid Requests, January–December 2015 (N = 44,493)



Source: DWC IMR Database, IMR final determination letters.

IMR Database and Search Tool

An easy-to-use search tool for IMR decisions has been added to the DWC's website. Following a determination by a physician reviewer, information for each IMR case (of the over 300,000 cases that have been decided since the process was implemented on January 1, 2013) is posted on the DWC website. The search tool allows the public to find IMR decisions quickly and efficiently, by case number, date of injury, specialty of reviewer, or category of treatment request. All personally-identifiable information, such as names and addresses, have been redacted (removed) from the public copies. The search tool is available at http://www.dir.ca.gov/dwc/IMR/IMR-Decisions/IMR_Decisions.asp.

Independent Bill Review

Senate Bill (SB) 863 adopted several provisions to provide a quick, efficient way to resolve disputes over medical billing and eliminate litigation at the appeals board over billing disputes. The Independent Bill Review (IBR) process for resolving medical treatment and medical-legal billing disputes is used to decide disputes when a medical provider disagrees with the amount paid by a claims administrator and applies to all services covered by a DWC fee schedule.

The DWC administers the IBR program, which refers applicants to an independent bill review organization (IBRO). The reasonable fees for IBR are paid by the applying physician. If the independent bill reviewer determines that the claims

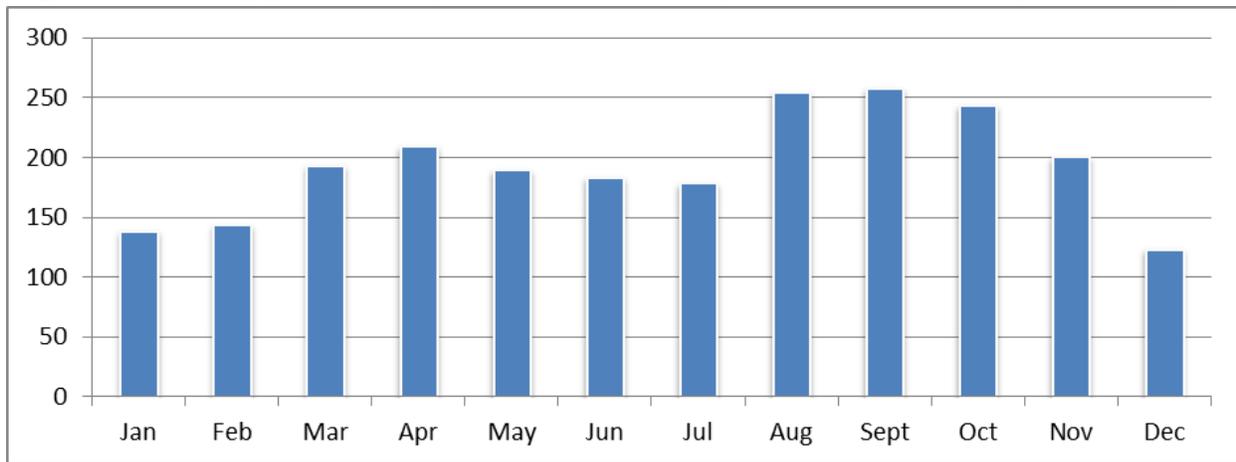
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administrator owes the physician additional payment on the bill, the claims administrator must reimburse the physician for the review fee.

On January 1, 2015, fees for a completed IBR were reduced from \$250 to \$195 per IBR, and the fee for an ineligible IBR that was not sent for review was reduced from \$50 to \$47.50. Sending an IBR to review means assigning and providing the complete file to a certified coding specialist with the expertise necessary to evaluate and render decisions on all line items in dispute.

In 2015, 2,341 IBR applications were filed, an average of about 195 applications per month (see Figure 8).

Figure 8. IBR Applications per Month, January–December 2015 (N = 2,341)



Source: DWC IBR Database.

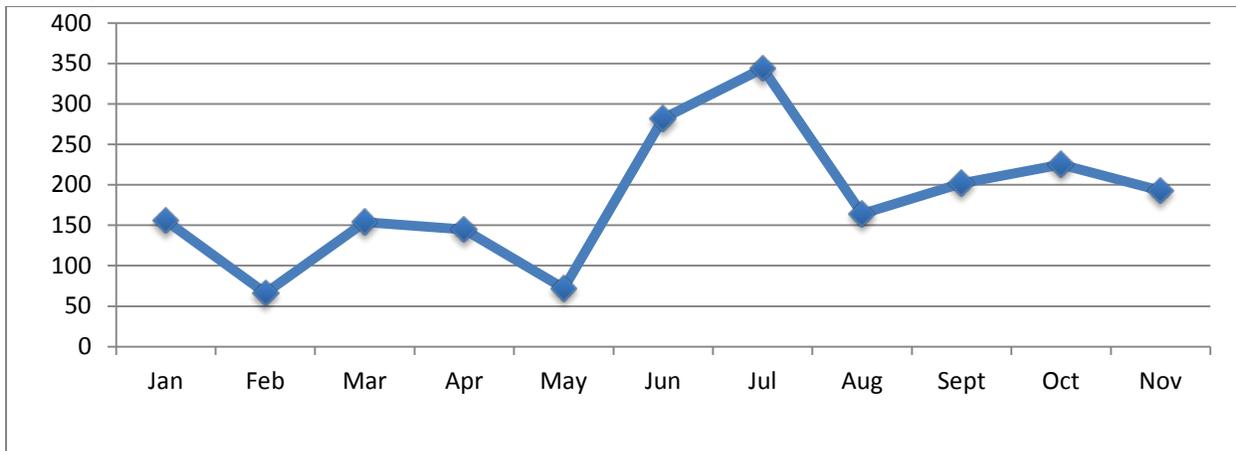
In 2015, the IBRO reviewed and closed 2,732 IBR cases. This included applications received in 2015 and earlier years. Of these, 366 (13%) were found to be ineligible for IBR, and 175 (6%) were withdrawn by the provider (see Table 3), resulting in 2,191 cases that were reviewed and received a final determination by the IBRO. Monthly rates of IBRO decisions fluctuated, with an average of about 180 IBR per month (see Figure 9).

Table 3. Outcomes of IBR Final Determinations, January–December 2015

Disposition	Number of IBR Cases	Percentage
Overtured	1,639	60%
Upheld	552	20%
Ineligible	366	13%
Withdrawn	175	6%
Grand Total	2,732	100%

Source: DWC IBR Database, includes all determinations conducted in 2015, regardless of application year.

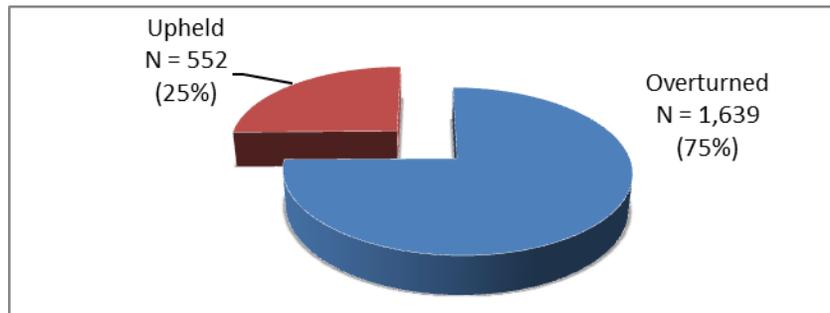
Figure 9. IBR Final Determinations by Month, January–December 2015 (N = 2,191)



Source: DWC. Note final number of determinations 2015 = 2,191.

The IBRO overturned the decision of the claims administrator in 1,639 (75%) of the cases that proceeded to a final decision in 2015, resulting in a payment to the provider. The IBRO upheld the decision of the claims administrator in 552 (25%) of cases, resulting in no payment to the provider (Table 3, Figure 10).

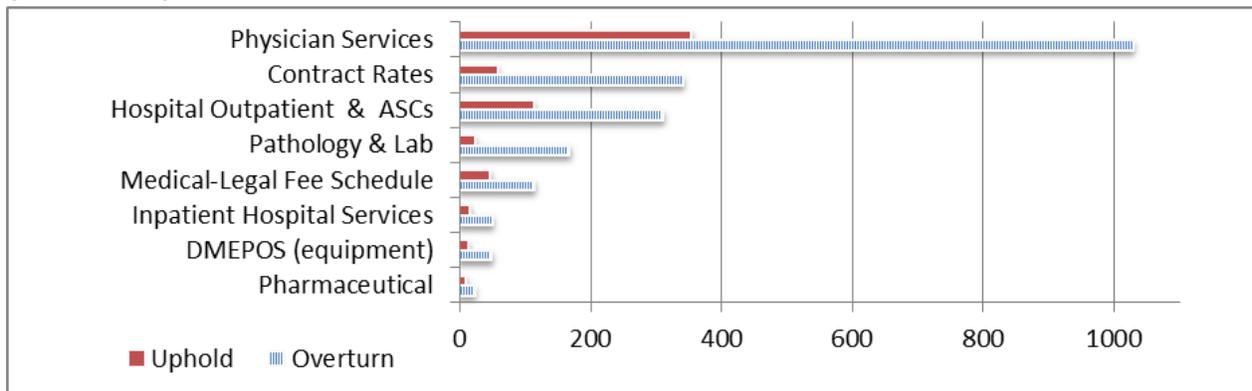
Figure 10. Outcomes of IBR Decisions by the IBRO, January–December 2015 (N = 2,191)



Source: DWC IBR Database

IBR decisions are based on the DWC Official Medical Fee Schedule (OMFS), and IBR cases may contain multiple disputes pertaining to more than one fee schedule. In 2015, the IBRO made 2,191 IBR case-level decisions, comprising 2,739 disputes relating to a fee schedule (see Figure 11). Physician services accounted for over half the disputes (1,385, or 51%), followed by contract rates (426, or 15%), and hospital outpatient and ambulatory surgery centers (401, or 15%). Figure 11 shows the results of IBR decisions by fee schedule and illustrates that 1,030 (74%) of decisions on physician services were overturned, resulting in a payment to the provider.

Figure 11. IBR Decisions by Fee Schedule Category, January–December 2015 (N = 2,739)



Source: DWC IBR Database.

Medical Provider Networks

One of SB 863’s goals was to improve the Medical Provider Network (MPN) program by ensuring injured workers’ access to physicians within MPNs and to provide more regulatory oversight. Regulations implementing SB 863’s revisions to the MPN program

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went into effect on August 27, 2014. The main highlights of the SB 863 MPN regulatory changes for established MPNs include the following:

- As of January 1, 2013, contracting agents are required to inform MPN providers entering or renewing a provider contract that they are part of an MPN, whether their contract is sold, leased, transferred or conveyed to another MPN applicant, contracting agent or WC insurer.
- Medical Access Assistants are required for each MPN to assist workers with finding available MPN physicians and contact physician offices for appointments.
- MPN plans are approved for four years, as of January 1, 2014.
- MPN physicians need to acknowledge that they elect to be part of the MPN, as of January 1, 2014.
- Each MPN must have a website and access to a provider listing on this website, as of January 1, 2014.

SB 863 established administrative oversight, such that:

- The Administrative Director can conduct random audits and investigations of MPNs.
- The Administrative Director can impose penalties, probation, suspension, or revocation with the right to appeal to the Workers' Compensation Appeals Board (WCAB) Reconsideration Unit.
- Anyone who contends that an MPN is not validly constituted may petition the Administrative Director to suspend or revoke the approval of an MPN.

On October 6, 2015, SB 542 was signed into law, and additional changes were made, including the following:

- Distinguishing the MPN independent medical review process from the independent medical review process that resolves UR disputes.
- Requiring every MPN to post on its website information on how to get in touch with the MPN contact person and medical access assistants and how to obtain a copy of any notification regarding the MPN that regulations required MPNs to provide to employees.
- Creating efficiencies for approving MPNs when a modification is made during the four-year approval period.
- Clarifying who provides completion of treatment in the event of a continuity-of-care issue.
- Providing a statutory definition for entities that offer physician network services.

These changes took effect on January 1, 2016.

Medical Expenses

The WCIRB estimates that projected average medical costs per claim (excluding medical cost containment expenses) decreased by about 8% between 2011 and 2015. According to the WCIRB, these declines in medical severity are largely the result of medical cost savings due to SB 863.⁵ The medical changes under SB 863 include the reduction in the ASC fee schedule from 120% of the Medicare outpatient fee schedule to 80% of Medicare's outpatient fee schedule, the elimination of duplicate payment for spinal surgical implants, and the implementation of the RBRVS physician fee schedule. The decreases may also be due to other SB 863 reforms aimed at increasing quality and cost-efficient care.

ASCs account for approximately 7.5% of annual industry medical payments (\$555 million). The WCIRB report,⁶ which is based on Medical Data Call (MDC) information, indicated a 24% drop in the average payment per episode after the enactment of the new fee schedule and no evidence of a shift of services from ASCs to outpatient hospital settings. The change in ASC fees appears to result in approximately \$80 million in annual savings.

The WCIRB report also raised its initial estimates of savings from the elimination of duplicate payment for spinal surgery implants. The report indicates that the average cost of spinal surgery procedures involving spinal implants had decreased by 28% after the reforms enacted by SB 863. This change is now estimated to save about \$140 million annually, an increase in savings of \$30 million over the initial estimates.

In addition, it appears that the new physician fee schedule, which covers approximately 46%⁷ of workers' compensation medical payments, has resulted in medical cost savings of approximately \$10 million per year. The overall reduction in physician fee schedule costs from 2013 to 2014 was largely driven by the 37% decline in payments for Special Services and Reports. Although the Primary Treating Physician's Progress Report (PR-2), the Primary Treating Physician's Permanent and Stationary Report (PR-3 or PR-4), and a Psychiatric Report Requested by the WCAB or the Administrative Director (other than medical-legal report) are separately reimbursable pursuant to CCR, Title 8, section 9789.14, other treating physician reports are no longer reimbursable separately. Under the RBRVS physician fee schedule, the fee for records review and other reports are included in the fee for the underlying evaluation and management service.

⁵ http://www.wcirb.com/sites/default/files/documents/160412_report_on_12-31-15_insurer_experience-complete.pdf.

⁶

http://www.wcirb.com/sites/default/files/documents/sb_863_cost_monitoring_report_2015_retrospective_evaluation.pdf.

⁷ http://www.wcirb.com/sites/default/files/documents/151210_post_sb_863_medical_payment_trends_report.pdf.

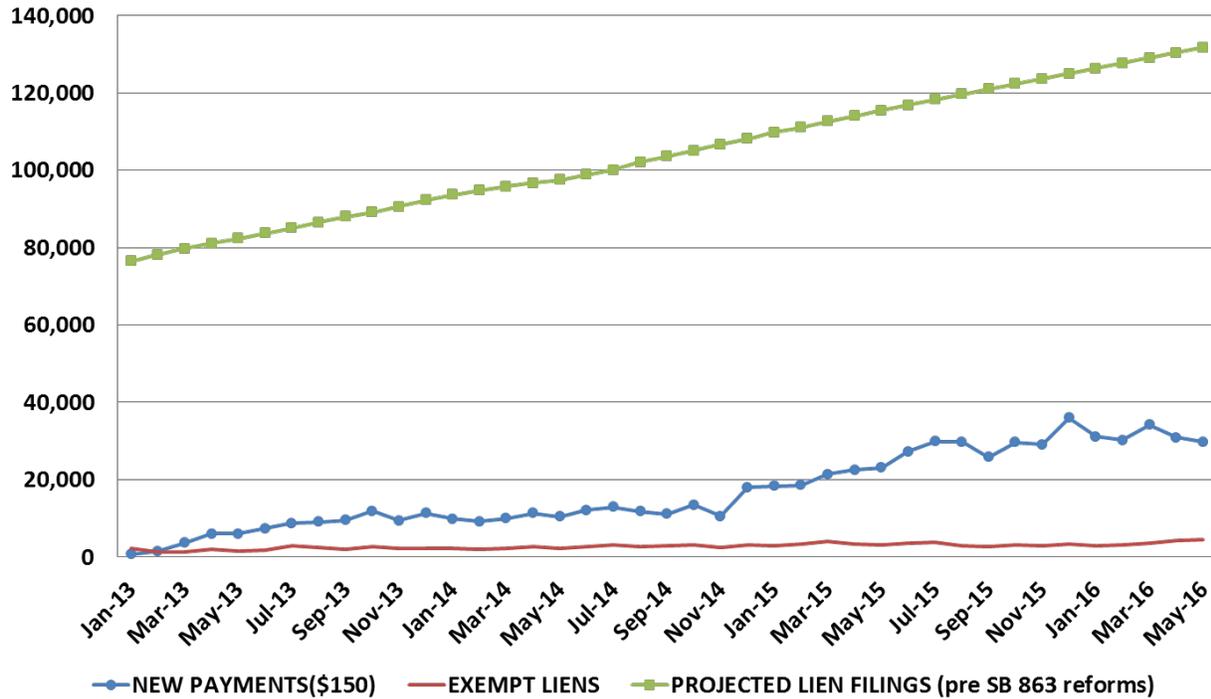
Liens

California's workers' compensation law allows certain claims for payment of services or benefits provided to or on behalf of injured workers to be filed as a lien against the employee's claim for workers' compensation benefits. Payment of those claims can be in the form of settlement between the parties or allowed by order of the WCAB. Liens have always been part of California's workers' compensation system. Lien filings increased dramatically in the early 2000s, prompting legislative action establishing a filing fee for many liens. Filings initially dropped, but in 2006 the filing fee was abolished. Filings increased again, though implementation of the Electronic Adjudication Management System (EAMS) temporarily lowered the rate of lien filings. By 2010 they were high again, and the Commission on Health and Safety and Workers' Compensation (CHSWC) conducted a study of the lien issue and made over 20 recommendations to reduce their number by establishing procedural barriers, creating a statute of limitations, and streamlining the method of dismissing liens. CHSWC also suggested bringing more medical care under MPNs and creating an alternative dispute resolution system for handling fee schedule disputes. SB 863 made wide-ranging changes to California's workers' compensation system, including the introduction of IBR, IMR, and some MPN changes, as well as a partial reintroduction of the lien filing fee effective January 1, 2013.

At the time SB 863 was passed, the WCIRB forecasted that the lien provisions would save \$690 million a year. Anticipating the filing fee, liens filed in the second half of 2012 soared, particularly in Southern California. After the filing fee was implemented, liens dropped dramatically again in 2013. Court challenges were resolved in favor of the DIR's new policies, and in most of 2014, filings numbered approximately 10,000–12,000 per month. In 2015, lien filings rose again and by early 2016 numbered over 30,000 per month (see Figure 12). A WCIRB evaluation of SB 863 in November 2015 opined that the increases "may be a result of temporary increases in lien filings due to the transition of the statute of limitations on filing liens from three years to eighteen months for dates of service on or after July 1, 2013." However, more recent tracking does not uphold that theory.

An analysis of liens filed in the third quarter 2015 revealed that a relatively small number of lien filers submitted the majority of the new liens. These filers are compared across systems, such as IMR/IBR and WCIS databases, to identify patterns of behavior. DIR continues to monitor this trend and submit referrals to the California Department of Insurance and district attorneys based on certain criteria.

Figure 12. New Liens Filed by Month, California, 2013–2016, Paid (\$150) and Exempt



Source: DWC Lien Filing Database.

Return-to-Work Supplement Program

On April 13, 2015, the DIR launched the Return-to-Work Supplement (RTWS) program for injured workers. This \$120 million per year fund, which quickly distributes a \$5,000 payment to each eligible injured worker who has a disproportionate loss of earnings, is an important component of the workers' compensation reforms enacted by SB 863. Injured workers can easily file the application using either an online portal or kiosks that connect to the portal at DWC offices across the state. All completed applications are reviewed for eligibility within 60 days of the date they are filed. Payment to workers are made within 25 days of the eligibility determination.

As of June 27, 2016, the DIR has made supplemental payments totaling \$41.5 million to injured workers. The DIR has received 9,225 applications for the one-time payment of \$5,000, of which 790 were denied either because the person was injured before January 1, 2013, or the application was incomplete or a duplicate. One hundred thirty five applications are in the review process.

Formulary

National concerns about the increasing use and detrimental effects of opioids have prompted several states to adopt drug formularies. This trend, coupled with the evidence of increased opioid use in California that the IMR process has brought to light, prompted the passage of Assembly Bill 1124 (Statutes 2015, Chapter 525). This legislation requires the adoption of an evidence-based workers' compensation drug formulary by July 1, 2017.

The DWC contracted with the independent research firm RAND Corporation through a competitive bidding process to provide consultation on the design, implementation, and economic impact of the formulary and related policies. The DWC has held two public meetings and opened a written comment period to obtain input on development of the formulary. Together with RAND, the DWC has been gathering information from workers' compensation system participants, and other jurisdictions and payment systems, in order to identify formulary issues and best practices. In the near future, the DWC will post draft formulary regulations and the pre-publication RAND formulary report on the DWC Forum webpage for a public review and discussion. Formal rulemaking is anticipated to begin later this year in order to have the formulary adoption completed prior to the statutory deadline of July 1, 2017.

Regulations Adopted to Implement the Reforms

- See [Appendix A](#) for a description of all fee schedules created through rulemaking.
- See [Appendix B](#) for a complete list of regulations adopted.

Challenges

Litigation

- *IMR Constitutional Challenge Case:* The *Francis Stevens v. WCAB* case challenged the constitutionality of the IMR process on the grounds that it denies due process, violates the separation of powers protections, and is not expeditious. On October 28, 2015, after extensive briefing and oral argument, the California Court of Appeal, First Appellate District, issued a decision upholding the constitutionality of the IMR process. For more details, see [Appendix C](#).
- *IMR Timeliness Cases:* The Labor Code sets forth a 30-day time frame for issuing an IMR decision, and a number of injured workers presented challenges

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at the appeals board arguing that the late decisions issued in their cases were invalid, therefore, the workers' compensation judges had jurisdiction to resolve the treatment disputes. WCAB panel decisions regarding the validity and effect of a late IMR decision were split, some finding that a late decision was still valid and binding while others held that an untimely decision was invalid, thereby vesting jurisdiction in the appeals board to decide the issue. Three cases addressing this issue were appealed to the Second and Third Appellate Districts of the California Court of Appeal. The first of these to be decided was *California Highway Patrol v. WCAB (Margaris)*, which held that the statutory time frame to issue a decision was "directory," meaning that a late IMR decision is still valid and binding and does not give the appeals board jurisdiction to decide the treatment dispute. For more details on this case and the other appellate case pending on this issue, see [Appendix C](#).

- *Lien Activation Fee Case*: Collection of lien activation fees was enjoined by the US District Court, Central District of California (Los Angeles), on November 12, 2013, in the *Angelotti* case. On June 29, 2015, the Ninth Circuit Court of Appeals vacated the district court's preliminary injunction, affirmed the dismissal of plaintiffs' constitutional challenges, and reversed the district court's denial of the defendants' motion to dismiss the plaintiff's equal protection claim. The Ninth Circuit denied the plaintiffs' petition for a rehearing on October 18, 2015. The case was sent back to the district court and on November 3, 2015, the judge issued an order vacating the preliminary injunction and giving the lien claimants until December 31, 2015, to pay activation fees required by Labor Code section 4903.06. The plaintiffs filed a petition with the US Supreme Court, challenging the Ninth Circuit's decision, but the petition was denied in May 2016, thereby ending any contention that the lien activation fee is unconstitutional.
- *Lien Activation Fees*: Collection of these activation fees ceased for approximately two years when the district court issued a preliminary injunction in November 2013 in the *Angelotti* case. However, after the Ninth Circuit issued its decision in the case, vacating the preliminary injunction and affirming the dismissal of constitutional challenges to the lien activation fees, the district court issued an order giving the affected lien claimants until December 31, 2015 to pay the required activation fees. Based on that order, the DWC reinstated collection of the statutorily required lien activation fees on November 9, 2015, through December 31, 2015, after which time the fees were no longer accepted. Any affected liens for which activation fees were not paid were dismissed by operation of law pursuant to Labor Code section 4903.06(a)(5). See [Appendix C](#) for more information on this and other lien activation and filing fee cases.

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- *Post-SB-863 WCAB Cases:* Since the passage of SB 863, the WCAB has made decisions about home healthcare, MPNs, UR, IMR, medical-legal liens, and the lien activation fee. See [Appendix D](#) for summaries of each decision.

Next Steps

Physician Education

The DWC has launched its educational project. The first offering, planned for release in fall 2016, will educate healthcare providers on the MTUS and the use of evidence-based medicine. The educational program will be available at no cost and will provide continuing medical educational credits for those who complete the course. Additional courses are planned.

Regulatory

- The MTUS will continue to be revised throughout 2016 and 2017.
 - MTUS opioids and chronic pain guidelines were completed and submitted to the Office of Administrative Law for approval in June 2016. They are expected to go into effect immediately following approval.
- The Home Health Care Fee Schedule should be completed by late 2016.
- The Interpreter Fee Schedule will be completed in 2016.
- The Benefit Notice Regulations were approved by the Office of Administrative Law in August 2015 and became effective for all benefit notices sent on or after January 1, 2016.
- WCIS revisions for medical data reporting were filed with the secretary of state and went into effect on April 1, 2016.
- See [Appendix B](#) for a complete list of SB 863 regulations.

Conclusion

The goals of SB 863 are being realized. While the DIR and the DWC continue to implement the recent workers' compensation reform, increased PD benefits and the RTWS benefit for injured workers are in effect and are being delivered. With the continued emphasis on evidence-based medicine, injured workers will benefit from receiving medically appropriate treatment. In the IMR process, independent medical professionals apply the appropriate evidence-based medical standards within set time frames to resolve treatment disputes. Improvements to the IMR process are ongoing

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and include better systems to reduce delays and increase efficiencies for those submitting the IMR application and medical documentation. The recent reduction in the advisory pure premium rate and the WCIRB studies that indicate medical cost savings show that the SB 863 reform is reducing costs. It is anticipated that costs will continue to decrease with the introduction of the drug formulary and as additional fee schedules go into effect, including the copy service fee, the interpreter fee, and the home healthcare fee schedules.

High on the agenda is a continued focus on empirically identifying and reducing fraud, improving the UR process, and reducing friction in the system.

Appendixes

Appendix A: SB 863 Fee Schedules

Hospital Outpatient Departments and Ambulatory Surgical Centers (HOPD/ASC) Fee Schedule

Per SB 863, the ASC sections of the HOPD/ASC fee were reduced from 120% of Medicare's Hospital Outpatient Departments Prospective Payment System (HOPPS) fee schedule to 80%, effective January 1, 2013. The schedule is updated annually to conform to changes in Medicare. The hospital outpatient departments sections of the HOPD/ASC fee schedule were revised (effective September 1, 2014) such that fee allowances previously paid under the pre-2014 Official Medical Fee Schedule (OMFS) will now be paid under the new resource-based relative value scale (RBRVS)-based physician fee schedule. Other technical revisions were also made. After the HOPD/ASC fee schedule adopted elements of the RBRVS-based physician fee schedule to determine facility fee payment of select hospital outpatient services ("Other Services"), it became apparent that this payment methodology was unsustainable because Medicare will occasionally change its coding practices or payment rules, causing discordance between the RBRVS-based physician fee schedule and the Medicare HOPPS. Rulemaking is currently underway to address this issue. In November 2015, the Workers' Compensation Insurance Rating Bureau (WCIRB) reported that the reduction in maximum ASC facility fee payments shrank those costs by an estimated 25%, which is consistent with the reductions observed based on WCIRB medical transaction data. In addition, the proportion of post-January 1, 2013, services performed in outpatient hospitals rather than ASCs is consistent with pre-reform levels, which suggest that no cost shifting to outpatient hospitals is occurring. The WCIRB report also found that the relative cost per outpatient episode compared to the average ASC cost has increased significantly after SB 863, and, as a result, outpatient hospitals have received a larger share of the total paid amounts since January 1, 2013.

Inpatient (spinal implant)

Per the statute, the number of spinal implant diagnosis-related groups (DRGs) that receive an extra payment for implantable hardware was reduced from 14 to 7 DRGs, and specific amounts were assigned to the procedures. As of January 1, 2014, no additional fees for the spinal implant procedures are allowed. As of November 2015, WCIRB medical data show a decrease of over \$25,000 per procedure, or a reduction in the average cost of these procedures of 28% since 2013.

APPENDIX B: Regulations

Physician Fee Schedule (RBRVS)

The DWC adopted a new physician fee schedule based on the RBRVS used in the Medicare Physician Fee Schedule, effective January 1, 2014.

The new schedule is for services rendered on or after January 1, 2014. The DWC adopts annual updates of procedure codes, relative weights, inflation factor, and the Medicare relative value scale adjustment factor. In addition, midyear updates are posted on a monthly basis. There is a four-year transition between the pre-2014 Official Medical Fee Schedule (OMFS) maximum and the fully implemented Medicare-based physician fee schedule. When fully implemented, the fee schedule is set at 120% of Medicare physician fees. The “120% of Medicare” is determined using the Medicare fee level on July 1, 2012, for the base year, and adjusting for annual inflation and Medicare relative value scale adjustment(s). The transition to “120% of Medicare” will be complete as of January 1, 2017, and thereafter, two conversion factors will be used: anesthesia and other services. SB 863 required the inclusion of a number of payment ground rules that differ from Medicare, as appropriate for workers’ compensation. The adoption of the RBRVS results in higher payments to general practitioners and lower payments to specialists, such as surgeons and radiologists.

In a November 2015 report, the WCIRB states that the

changes to convert the physician fee schedule to a Resource-Based Relative Value Scale (RBRVS) basis were estimated to increase physician costs by 2.4% for services provided in 2014 and by 1.6% for services provided in 2015. Estimates of medical payments through the first six months of 2015 suggest a 4.8% decrease in physician payments per claim for the 2014 service year, which is largely being driven by a decline in the number of special services and reports transactions, and a modest increase for the 2015 service year that is generally consistent with the WCIRB’s prospective estimate.

Copy Service Fee Schedule

The copy service fee schedule became effective on July 1, 2015. It provides for a flat fee of \$180 for a set of records of 500 pages or less and includes all associated services, such as pagination, witness fees, and subpoena preparation. For records of more than 500 pages, an additional per-page fee of 10 cents per page is allowed. The flat fee encourages prompt payment and has resulted in fewer billing disputes. Disputes are handled through Independent Bill Review (IBR) rather than through the filing of a lien.

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Interpreter Fee Schedule

In April 2015, the DWC posted draft regulations to its online forum where members of the public may review and comment on the proposals. After posting them, the DWC met with numerous stakeholders regarding the need for requirements to ensure the use of certified interpreters and to protect against interpreter-related fraud; provisions accomplishing those goals have been incorporated into the proposed regulations. The DWC expects to begin formal rulemaking for the interpreter fee schedule in July 2016. The interpreter fee schedule is separate from the rulemaking regarding the interpreter certification process already in effect. The current interpreter fee schedule (8 CCR section 9795.3) indicates that, for Workers' Compensation Appeals Board (WCAB) hearings, arbitration, or deposition, the fee is a half or full day at the Superior Court rate or market rate, whichever is greater. For all other events, the fee is \$11.25 per quarter hour with a two-hour minimum or market rate. Having a fee schedule that is not tied to the "market rate" and that covers so many types of events should reduce costs by reducing disputes and allowing the parties to utilize IBR to resolve fee disputes, instead of filing liens.

Home Health Fee Schedule

The DWC contracted with RAND to provide a study and recommendations, and in May 2015, the DWC posted draft regulations to its online forum where members of the public could review and comment on the proposals. Home health services range from skilled nursing and therapy services provided by home health agencies to unskilled personal care services including bathing, dressing, or grooming, or chore services, such as housework, shopping, or meal preparation, provided by personal care aides. The 2015 RAND study, *Home Health Care for California's Injured Workers—Options for Implementing a Fee Schedule*, identifies options for a single fee schedule that would cover the full range of home health services. The proposed regulations set forth a payment methodology and fees for skilled care by licensed medical professionals and fees for unskilled personal and household services for injured workers. On October 5, 2015, the DWC posted an initial draft of the home healthcare services fee schedule regulations, and a public hearing was held on the draft regulations on November 30, 2015. A second draft of the regulations was released for a second 15-day public comment period, which ended June 8, 2016. The DWC is working on further amendments to the regulations based on the most recent comments received and plans to release a new draft for an additional 15-day comment period by August 2016. The regulations must be finalized with the Office of Administrative Law by October 4, 2016.

APPENDIX B: Regulations

Appendix B: SB 863 Regulations

Division of Workers' Compensation

SB 863 Implementation Division of Workers' Compensation (DWC) regulations	Status	Next Steps	Effective Date per Labor Code
Ambulatory Surgery Center (ASC) Fee Schedule Sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.36, 9789.37, 9789.38, and 9789.39	Completed, Effective: Jan. 1, 2013	Completed	Jan. 1, 2013
Copy Services Fee Schedule Sections 9980, 9981, 9982, 9983, 9984, 9990, 9992, 9994, and 10208.7	Completed, Effective: July 1, 2015	Completed	Dec. 31, 2013
Electronic document filing and lien filing fees Sections 10205, 10205.12, 10206, 10206.1, 10206.2, 10206.3, 10206.4, 10206.5, 10206.14, 10206.15, 10207, 10208, and 10208.1	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Dec. 16, 2013	Completed	Jan. 1, 2013
Home Health Care Fee Schedule Sections 9789.90, 9789.91, 9789.92, and 9789.93.	Posted second draft of regulations on DWC rulemaking page, public comment closed: June 8, 2016	Issue notice of amended rulemaking	July, 1, 2013
Independent Bill Review (IBR); Standardized Paper Billing and Payment; Electronic Billing and Payment Sections 9792.5.1, 9792.5.3, 9792.5.4, 9792.5.5, 9792.5.6, 9792.5.7, 9792.5.8, 9792.5.9, 9792.5.10, 9792.5.11, 9792.5.12, 9792.5.13, 9792.5.14, 9792.5.15, 9793, 9794, and 9795	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Feb. 12, 2014	Completed	For dates of service on or after Jan. 1, 2013

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Independent Medical Review (IMR) Sections 9785, 9785.5, 9792.6, 9792.6.1, 9792.9, 9792.9.1, 9792.10, 9792.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.7, 9792.10.8, 9792.10.9, and 9792.12	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Feb, 12, 2014	Completed	For injuries on or after Jan. 1, 2013; For decisions communicated on or after July 1, 2013
Interpreter Certification Sections 9795.1, 9795.1.5, 9795.1.6, 9795.3, and 9795.5	Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Aug. 13, 2013	Completed	Jan. 1, 2013
Interpreter Fee Schedule Sections 9930 et seq.	Posted draft regulations on DWC forum: May 18, 2015	Issue notice of rulemaking	Jan. 1, 2013
Medical Provider Network (MPN) Sections 9767.5.1 and 9767.16.5-9767.19	Completed, Effective: Aug. 27, 2014	Completed	Jan. 1, 2014
Official Medical Fee Schedule: Physician Fee Schedule Sections 9789.12.1-9789.19	Completed, Effective: Jan. 1, 2014	Completed	Jan. 1, 2014
Official Medical Fee Schedule: Physician Fee Schedule Sections 9789.10-9789.19	Completed, Effective: Jan. 1, 2014	Completed	Jan. 1, 2014
Predesignation/Chiropractor Primary Treating Physician Sections 9780, 9780.1, 9783, 9783.1, and 9785	Completed, Effective July 1, 2014	Completed	Jan. 1, 2013

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<p>Qualified Medical Evaluator (QME) Regulations and Permanent Disability Rating Determination Sections 1, 11, 11.5, 14, 17, 26, 30, 31.2, 31.3, 31.5, 31.7, 32, 33, 34, 35, 35.5, 36, 37, 38, 100, 104, 105, 106, 109, 110, 112, 117, 10159, and 10160</p>	<p>Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Sept. 16, 2013</p>	<p>Completed</p>	<p>For injuries on or after Jan. 1, 2013; For decisions communicated on or after July 1, 2013</p>
<p>Spinal Implant (Inpatient Fee Schedule) Sections 9789.20, 9789.21, 9789.22, and 9789.25</p>	<p>Completed, Effective: Jan. 1, 2013</p>	<p>Completed</p>	<p>Jan. 1, 2013</p>
<p>Supplemental Job Displacement Benefit (SJDB) Sections 9813.1, 10116.9, 10117, 10118, 10133.31-10133.36, 10133.51, 10133.52 10133.53, 10133.55, 10133.56, 10133.57, 10133.58, and 10133.60</p>	<p>Emergency regulations effective: Jan. 1, 2013 Final regulations effective: Jan. 1, 2014 Amended Oct. 1, 2015</p>	<p>Completed</p>	<p>Jan. 1, 2014</p>
<p>Vocational Expert Fee Schedule Regular rulemaking Labor Code section 5307.7</p>	<p>Working group meeting: June 28, 2012</p>	<p>Post draft regulations on DWC forum</p>	<p>Jan. 1, 2013</p>

Appendix C: Litigation

Independent Medical Review (IMR) Process

Francis Stevens v. Outspoken Enterprises et al.

United States Supreme Court Case No. 16-_____

California Court of Appeal, First Appellate District, Case No. A143043

This case, in which the DWC was a party, presented a constitutional challenge to SB 863's Independent Medical Review (IMR) process. After exhausting her administrative remedies, Stevens filed a petition writ of review in California's First District Court of Appeal. The writ challenged the constitutionality of Labor Code sections 4610.5 and 4610.6 (the IMR process), asserting numerous arguments, including: (1) the plenary power of the Legislature to enact workers' compensation statutes was limited by the Separation of Powers Clause in the state constitution; (2) the IMR statutes violate due process protections because they do not provide for meaningful judicial review; (3) the statutes further violate due process by prohibiting the cross-examination of the anonymous IMR physician reviewer; and (4) the IMR process is not expeditious and therefore it violates the California constitutional requirement that substantial justice be accomplished in all case expeditiously and without encumbrance.

The parties filed extensive briefing on the merits, and numerous amicus briefs were filed in support of both the appellant's and respondents' positions. After the amicus briefing was completed, the Court invited the parties and amicus curiae to submit supplemental briefings addressing two questions: (1) Is the plenary power to enact workers' compensation statutes vested in the Legislature by the California constitution limited by its separation of powers clause? and (2) Does the plenary power to enact workers' compensation statutes vested in the Legislature by the California constitution affect our analysis in evaluating petitioner's claims under that due process clause?

In its supplemental brief, the DWC argued that the Legislature's plenary power to adopt workers' compensation statutes is not limited by the separation of powers clause, and the plenary grant of authority to enact a workers' compensation system is key to evaluating any alleged due process violation, as the underlying substantive protected rights that arise in the workers' compensation system are e rights that have been conferred by the Legislature.

The submission of supplemental briefs by all parties was completed by March 9, 2015. The Court heard oral arguments on September 30, 2015. On October 28, 2015, the Court upheld the constitutionality of the IMR process. The Court concluded that the

APPENDIX C: Litigation

Legislature has plenary powers over the workers' compensation system under Article XIV, section 4, of the state constitution, and any exercise of the Legislature's plenary powers over the workers' compensation system is permissible so long as the Legislature finds its action to be necessary to the effectiveness of that system. The Court noted that even if the Legislature's plenary powers were limited, the petitioner's argument that the IMR process violated those limits would fail. The Court concluded that the IMR process did not violate the petitioner's due process rights nor did it violate any provisions of the California constitution.

A petition for rehearing was filed November 12, 2015, and denied by the Supreme Court February 17, 2015. Stevens attempted to file a petition for writ of certiorari with the United States Supreme Court on May 17, 2016, but the filing was not accepted; however, jurisdiction was preserved, and a corrected filing will be allowed if it is filed by July 17, 2016.

Saul Zuniga v. Interactive Trucking, Inc.; State Comp. Ins. Fund (SCIF) California Court of Appeal, First Appellate District, Div. 2, Case No. A143290

This case also involves a challenge to the constitutionality of the IMR process, asserting that the anonymity of the IMR reviewers violates due process and the IMR statute violates the guarantee of a right to appellate review. After successfully appealing an IMR determination and obtaining an order remanding the matter to IMR for review by a different physician reviewer, Zuniga filed a motion for discovery, seeking the disclosure of the IMR reviewers' identities. While the discovery motion was pending, the second IMR decision was issued, authorizing additional, but not all, prescribed medications. Thereafter, over defendant's objections, a trial was set on the issue of the disclosure of the IMR physicians' identities. The workers' compensation judge (WCJ) issued a decision finding that, pursuant to Labor Code section 4610.6(f), he could not release the names of the IMR physicians.

Zuniga filed a petition for reconsideration, which was denied. Zuniga then filed a petition for writ of review, arguing that the anonymity of the IMR reviewers violates due process and that the IMR statutes violate the guarantee of a right to appellate review. The respondent filed its response, arguing that: (1) the petition for review was premature because the petitioner had not exhausted his administrative remedies by filing an appeal of the second determination; (2) the petition had failed to name the DWC, which is an indispensable party; (3) the WCJ was correct in finding that he lacked the authority to order the disclosure of the reviewing doctors; and (4) maintaining the anonymity of the reviewers' identities did not deprive the petitioner of his due process rights.

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The appellate court granted review on February 4, 2016. A request for oral argument was filed May 10, 2016.

IMR Timeliness

CHP v. Workers' Compensation Appeals Board (Margaris)
California Court of Appeal, Second Appellate District, Case No. B269038

In June 2016, the Second District Court of Appeal issued its decision in *Margaris*, deciding the first of three pending appellate cases, all of which are presenting essentially the same issue: whether the statutory time frame for issuing an IMR determination regarding medical necessity is “mandatory” or “directory.” In other words, the appellate courts are deciding whether an IMR decision issued after the 30-day period set forth in Labor Code section 4610.6(d) is invalid and thereby vests jurisdiction in the appeals board to decide whether the proposed treatment is medically necessary and appropriate—that is, “mandatory.” (If the deadline is directory, a late decision would still be valid and binding.) WCAB decisions have gone both ways on this issue, so the appellate courts are being asked to resolve the division of authority. (The other two appellate cases, described more fully below, are currently pending in the Third District Court of Appeal.)

In this case, the WCAB panel found that the timeline for issuing IMR decisions is mandatory and that late IMR decisions vested jurisdiction in the WCAB to determine issues of medical necessity. The Court of Appeal annulled the WCAB decision and remanded, the case to the appeals board with instructions to conduct further proceedings consistent with the Court of Appeal’s opinion.

In its analysis, the Court of Appeal provided a thorough discussion of the legislative history of authorization for medical treatment in workers’ compensation, the implementation of utilization review (UR) of treatment requests, and finally the enactment of the statutory underpinning of IMR. Based on this legislative history, the Court determined that the use of “shall” in Labor Code section 4610.6 was directory, not mandatory.

The Court found significant the lack of a penalty or consequence for noncompliance in the statute as well as the Legislature’s express intent that no WCJ, the appeals board, or other higher court make a determination of medical necessity. In its review of the mandatory vs. directory dichotomy, the Court indicated that statutes that set forth time frames for government actions but do not include a self-executing consequence are

APPENDIX C: Litigation

almost universally construed as directory. The Court noted that construing the 30-day time frame as directory furthers the legislative intent and objectives of SB 863.

Hallmark Marketing v. WCAB (Southard)

California Court of Appeal, Third Appellate District, Case No. C079912

This is the first of two cases on this issue that the Third District Court of Appeal will decide. In this case, the WCAB panel concluded that the time periods in Labor Code section 4610.6(d) are mandatory, and therefore if an IMR determination is not issued in a timely way, the treatment dispute is not resolved via IMR; it may be determined instead by the WCAB under Labor Code section 4604. The defendant employer filed a petition for a writ of review in August 2015, which was granted in October. The California Chamber of Commerce and the California Workers' Compensation Institute have filed amicus curiae briefs in support of the petitioner, and the California Applicants' Attorneys Association filed an amicus brief in support of the respondent. The briefing in this case is complete.

Baker v. WCAB

California Court of Appeal, Third Appellate District, Case No. C080895

This is the second case on this issue pending before the Third District Court of Appeal. In this case, the WCAB panel held that the time frames for issuing an IMR decision are directory. The injured worker, Baker, filed a petition for a writ of review in December 2015, which was granted in April 2016. The Court will be asked to determine whether the timelines are mandatory or directory and whether an untimely IMR determination removes the dispute from the IMR process outlined in Labor Code section 4610.5 and allows it to be determined by the WCAB under Labor Code section 4604. The California Applicants' Attorneys Association has filed an amicus curiae in support of the petitioner, and the California Workers' Compensation Institute filed one in support of the respondent. The case has been fully briefed.

Lien Activation and Filing Fee Cases

Angelotti Chiropractic v. Christine Baker et al.

United States Supreme Court, Case No. 15-873

Ninth Circuit Court of Appeals, Case No. 13-56996

In this case, the plaintiffs, who are providers of medical treatment and medical-legal services, challenged the lien activation fee on the grounds that the fee violates the equal protection, due process, and "takings" protection clauses in the US Constitution.

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The defendants filed a petition to dismiss the matter, and the plaintiffs filed a petition for a preliminary injunction to stop collection of the fees immediately and to stop the dismissal of liens based on failure to pay the fee.

The petitions were heard jointly, and Judge George Wu of the United States District Court, Central District of California (Los Angeles), dismissed the due process and “takings” claims but allowed the equal protection challenge to stand. He also issued a preliminary injunction barring the activation fees and dismissals for failure to pay, as the plaintiffs requested. Accordingly, the DWC stopped enforcing the activation fee requirement.

Both sides appealed their respective adverse rulings, and the case was argued and submitted to the Ninth Circuit November 18, 2014. On June 29, 2015, the Ninth Circuit Court of Appeals issued its decision upholding the constitutionality of the lien activation fees. It held that the lien claimants lacked a “vested property right” in the liens until the underlying workers’ compensation claim was resolved via a final judgment and award. The Ninth Circuit Court rejected the argument that the lien activation fee was an unjust taking of their property by the government. The Court vacated the district court’s preliminary injunction, affirmed the dismissal of plaintiffs’ constitutional challenges, and reversed the district court’s denial of defendants’ motion to dismiss plaintiff’s equal protection claim.

The Ninth Circuit Court denied the plaintiff’s petition for rehearing on October 18, 2015, and sent the case back to Judge Wu to vacate the preliminary injunction and dismiss the case. On November 3, 2015, Judge Wu issued an order vacating the preliminary injunction and permitting lien claimants to pay activation fees required by Labor Code section 4903.06 from 8 a.m., November 9, until December 31, 2015.

Based on this order, the DWC reinstated the collection of the statutorily required lien activation fees. Any affected lien claimant who filed a declaration of readiness or appeared at a lien conference during that period was required to pay the activation fee if it had not been paid previously. The order also stated that lien activation fees had to be paid by December 31, 2015, or the affected liens would be dismissed by operation of law under Labor Code section 4903.06(a)(5). Activation fees are no longer accepted as of midnight on December 31, 2015. Any affected liens for which activation fees were not paid by that cut-off date were dismissed by operation of law pursuant to Labor Code section 4903.06(a)(5).

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The lien claimants filed a petition for a writ of certiorari challenging the Ninth Circuit Court's decision, arguing that the lien activation fees violated the equal protection, due process, and "takings" protections in the US Constitution. On May 23, 2016, the US Supreme Court denied their petition for a writ, which effectively ends any contention that the lien activation fee is unconstitutional.

Chorn v. Brown et. al.

California Court of Appeal, Second Appellate District, Case No. B256117
LASC Case No. BC528190

This case, also filed by a medical provider, was filed as a class action with workers' compensation applicants and raised issues under the California constitution on essentially the same bases as those asserted in *Angelotti v. Baker*. The complaint sought declaratory relief, a preliminary and permanent injunction, and an award of costs, including reasonable attorneys' fees. It attacked both the lien activation fees and lien filing fees, sought reimbursement of all fees paid by all lien claimants to date, and attacked SB 863's limitations on the assignment of liens. On February 24, 2014, the trial court denied the plaintiff's motion for preliminary injunction on the grounds that it lacked subject matter jurisdiction based on Labor Code section 5955 and *Greener v. Workers' Comp. Appeals Bd.* (1993) 6 Cal.4th 1028.

On April 21, 2014, the plaintiff filed an appeal with the Second District Court of Appeal. The Court heard oral arguments on June 11, 2015. On June 17, 2015, in an unpublished opinion, the Court affirmed the superior court's dismissal of the complaint, holding that the superior court lacked jurisdiction to grant an injunction. On June 2, 2015, Chorn also filed a petition for a writ in the same court of appeal with the same allegations (Case No. B264440).

Chorn v. Brown et al.

California Supreme Court, Case No. S234422
California Court of Appeal, Second Appellate District, Case No. B264440

On June 2, 2015, Chorn and a group of workers' compensation applicants filed a petition for a writ of mandate seeking to enjoin the DWC from enforcing the lien activation and lien filing fees, contending that the fees and the limitation on the assignment of liens violated rights in the state constitution to due process, equal protection, and petition for redress of grievances. Chorn also argued that the limitation on the assignment of liens substantially impaired their constitutional contract rights. The injured workers alleged that they were deprived of medical care access as a consequence of SB 863.

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On March 17, 2016, the Court heard oral arguments. On March 28, 2016, the Court held that the workers' compensation applicants lacked standing to obtain the writ relief they sought and dismissed their petition. The court further concluded that the challenged provisions did not violate the constitution and denied Chorn's petition. On April 20, 2016, the Court denied a petition for rehearing.

On May 10, 2016, an appeal was filed with the California Supreme Court.

Chorn v. Brown et al.

United States District Court, Central District, Case No. CV13-16519-GW (JEMx)

On November 18, 2013, Chorn filed a complaint, along with an application for a temporary restraining order (TRO) seeking to enjoin enforcement of the lien filing fee and the provisions precluding the assignment of liens, with the United States District Court, Central District of California. On January 16, 2014, the Court issued a tentative ruling on the defendant's motion to dismiss the complaint and the plaintiff's application for a TRO. The Court denied the TRO application but indicated that it would treat the TRO application as a request for a preliminary injunction and scheduled further dates and proceedings accordingly. The Court presumed that the parties were familiar with the decision in the *Angelotti* case and noted that the plaintiff presented no stronger argument as to the takings clause and due process violations and denied the request for the TRO as to those two claims and granted the defendant's motion to dismiss those claims, without leave to amend the complaint. Before deciding the equal protection claim, the Court gave the plaintiff an opportunity to respond to the defendant's arguments. The Court set the matter for further hearing on the equal protection claim for February 20, 2014. However, the matter was voluntarily dismissed without prejudice on February 3, 2014.

Lien Filing Statute of Limitations Case

Access Mediquip v. WCAB; SCIF

California Court of Appeal, Fourth Appellate District, Div. 1, Case No. D067196

This case involved a challenge to the interpretation and application of the amended statute of limitations for filing medical treatment liens. In this case, the WCJ issued a decision finding that the medical provider's liens were barred by the amended statute of limitations in Labor Code section 4903.5(a). The lien claimant filed a petition for reconsideration, which was denied by the WCAB. The claimant then filed a petition for a writ of review arguing that: (1) the WCAB incorrectly interpreted and applied the amended statute of limitations under Labor Code section 4903.5, improperly dismissing its liens in 11 cases; and (2) the WCAB's retroactive application of the amended statute

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of limitation violates the due process, equal protection, and “taking” clauses of the Fifth and Fourteenth Amendments of the US Constitution and Article I, section 7, of the California constitution.

On February 27, 2015, the Court denied the lien claimant’s petition. The Court stated that the WCAB correctly held that the interpretation of section 4903.5 advanced by the lien claimant would lead to the absurd result that the Legislature intended two limitation periods for the same services. The court also rejected the lien claimant’s constitutional claims, stating, “The disparate treatment of insurers and lien holders is based on the legitimate governmental purpose of eliminating the backlog of liens. Further, a workers’ compensation lien is an entirely statutory right that does not vest until final judgment, and which can be modified or repealed by the Legislature before vesting. . . . [The lien claimant], therefore, did not have a protected property right in its liens.”

Utilization Review (UR) and IMR

Michael Briggs v. WCAB; SCIF

California Supreme Court, Case No. S224671

California Court of Appeal, Fourth Appellate District, Div. 2, Case No. E062825

In the underlying case, the applicant filed for a hearing at the WCAB to challenge a UR decision modifying an opiate prescription. He argued that that UR process interfered with his right to be prescribed opiates due to his severe, chronic, intractable pain under the Health & Safety and Business & Professions Codes. Additionally, he asserted that the UR and IMR statutes conflicted with state and federal laws governing the prescription of controlled substances and that the UR physician violated those laws by modifying the prescribed pain medication without a physical examination. He sought a finding that such decisions could not be made solely under the process created by UR and IMR statutes but, rather, such decisions had to comply with all applicable state and federal laws. The WCJ issued a decision, finding that under *Dubon II*, the WCAB lacked jurisdiction to consider issues of medical treatment unless the UR decision was untimely. The applicant then filed a petition to have the decision reviewed, which was denied by the WCAB.

The applicant then filed a petition for a writ of review with the Court of Appeal, and it was denied. Thereafter the applicant filed a petition for review with the Supreme Court, arguing that the WCAB had erred when it refused to consider the applicant’s asserted right to pain relief and refused to harmonize UR and IMR statutes with state and federal laws regarding the practice of medicine and the administration of controlled substances.

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The defendant filed a response, arguing that: (1) the WCAB's decision that it does not have jurisdiction to look at the substantive issues related to a UR decision if it is rendered in a timely fashion was correct and consistent with statutory and decisional authorities; and (2) the UR and IMR statutes do not conflict with other state and federal statutes regarding the administration of controlled substances. On April 15, 2015, the Supreme Court denied the petition for review.

California Insurance Guarantee Association (CIGA) v. WCAB (Mercado)
California Court of Appeal, Second Appellate District, Div. 2, Case No. B260033

In this case, the Court of Appeal was asked to consider whether the WCAB properly sidestepped IMR when it awarded home modifications as part of the applicant's medical treatment award, based on a UR decision that the WCJ and WCAB found to be "materially defective" pursuant to *Dubon I* (79 Cal.Comp.Cases 313). The WCJ found the UR decision was materially defective because the reviewing physician's specialty was emergency medicine, rather than long-term care, and the physician's modifications and denials were not based on "MTUS, ACOEM Guidelines, or any other identifiable objective criteria as required by Labor Code section 4610." In its decision after reconsideration issued September 30, 2014, the WCAB panel affirmed the WCJ on all issues except medical mileage for the applicant's wife, who provided attendant care.

CIGA filed a petition for a writ of review, arguing that: (1) the UR decision was timely, so the WCAB erred in following *Dubon I*, given its subsequent decision in *Dubon II*; (2) the WCAB erred in awarding penalties for the unreasonable delay or refusal of benefits; (3) the WCAB lacked jurisdiction to allow the applicant's wife's lien for attendant care because she had failed to pay the lien filing fee and to provide the documentation and declarations required by section 4903.8(e); and (4) the WCAB erred in determining that the applicant's wife met her burden of proving that her attendant care of the applicant was reasonable and necessary. On February 5, 2015, the Court, finding good cause, granted the petition. In early March, the petition was dismissed, pursuant to CIGA's request to withdraw it.

This case was featured in an article, "The Fallout of Workers' Comp Reforms: 5 Tales of Harm," by Michael Grabell, ProPublica, as part of a series broadcast in March 2015 based on an investigation of workers' compensation systems conducted by ProPublica and National Public Radio (NPR).

CIGA v. WCAB (Smith)
California Court of Appeal, Third Appellate District, Case No. C077680

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This case is similar to *CIGA v. WCAB (Mercado)* summarized above. In this case, the WCJ issued a decision awarding a home bathroom modification for wheelchair accessibility despite the existence of a timely UR decision denying these modifications. The WCJ determined that the UR decision was invalid because it went beyond the scope of the issue presented. Specifically, the UR reviewer addressed the underlying need for a motorized wheelchair (and concluded it was not necessary), rather than addressing the requested bathroom modification. The WCJ opined that the “the integrity of the review was not just impaired [but a review] did not occur,” and therefore the WCJ took jurisdiction of the issue of reasonableness and necessity and awarded the bathroom modification. The defendant filed a petition for reconsideration, which was denied.

The defendant filed a petition for a writ of review, contending that because the UR decision was stipulated as timely and the WCAB held in *Dubon II* that a UR decision is invalid and not subject to IMR only if it is untimely, the WCAB exceeded its jurisdiction by reversing the timely UR decision and deciding the issue of medical necessity. On January 22, 2015, the Court of Appeal granted the petition for a writ of review. On March 18, 2015, pursuant to the defendant’s request, the Court dismissed the petition for a writ of review.

Jose Dubon v. World Restoration, Inc.; State Comp. Ins. Fund (SCIF)

California Supreme Court, Case No. S224450

California Court of Appeal, Fourth Appellate District, Div. 3, Case No. G051017

The WCAB granted SCIF’s petition for reconsideration of the Opinion and Decision after Reconsideration (en banc) dated February 27, 2014, in which the WCAB held that it could determine whether a UR decision suffered from material defects that may have undermined the integrity of the decision, and, if so, the WCAB could then determine the medical necessity issue based on substantial medical evidence. (See *Dubon v. World Restoration, Inc.* (2014) 79 Cal.Comp.Cases 313 (WCAB en banc) (*Dubon I*)).

After granting reconsideration of its prior en banc decision in order to further review and study the issues, the WCAB issued its decision after reconsideration in which it rescinded its en banc decision of February 27, 2014. In *Dubon II*, the WCAB affirmed the WCJ’s decision, which had determined that the medical necessity of applicant’s requested back surgery must be determined by IMR, notwithstanding any procedural defects in the defendant’s timely UR decision, and held as follows:

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- A UR decision is only invalid and not subject to IMR if it is untimely (but not if it suffered from other types of material defects);
- Legal issues regarding the timeliness of a UR decision must be resolved by the WCAB, not IMR;
- All other disputes regarding a UR decision must be resolved by IMR; and
- If a UR decision is untimely, the determination of medical necessity may be made by the WCAB based on substantial medical evidence consistent with Labor Code section 4604.5.

In November 2014, the applicant filed a petition for a writ of review, arguing that the second en banc decision was inconsistent with the overall statutory scheme for UR and that the WCAB acted unreasonably in finding its jurisdiction had been so limited by the advent of IMR. The Fourth District Court of Appeal, Division 3, summarily denied the applicant's petition on February 5, 2015. Thereafter, the applicant filed a petition for review with the California Supreme Court, which denied the petition for review on April 1, 2015.

Octavio Filippini v. WCAB; Pillsbury, Winthrop, Shaw, Pittman, LLP, et al.
California Court of Appeal, Third Appellate District, Case No. C078193

In this case, the applicant sought a hearing at the WCAB to review UR denials of requests for spinal surgery and address the issue of medical necessity. The WCJ issued his decision, finding that the UR denials were timely but materially deficient and ordering the requested surgery, which was deemed medically necessary. The defendant filed a petition for reconsideration, and the WCAB rescinded the WCJ's findings and award, finding that the WCAB lacked jurisdiction to hear the issue of medical necessity based on the decision in *Dubon II*.

Applicant filed a petition for a writ of review, asserting two main arguments: (1) the IMR process denies an applicant due process; and (2) the WCAB's refusal to address applicant's appeal of the UR decision needlessly delays medical treatment, in violation of Labor Code section 3202. On March 5, 2015, the Court issued an order summarily denying the petition for a writ of review.

Lions Raisins v. WCAB (Miramontes)
California Court of Appeal, First Appellate District, Div. 3, Case No. A144280

In this case, the applicant was found to be 100% disabled, and future medical care was awarded. Although the award did not specify the provision of home health assistance, the defendant had provided home care after the award was issued. Sometime

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thereafter, the claims administrator requested a report from the new treating physician about the need for home care. After not receiving a response from the physician and giving notice to the applicant's counsel, the claims administrator terminated the home healthcare. Afterward the doctor did submit a request for authorization for home care assistance. The request was sent through UR, in which it was denied as inconsistent with the medical treatment guidelines.

After an expedited hearing, the WCJ determined that the UR decision was not valid and ordered the provision of home healthcare. The WCJ did not find that the UR decision was untimely or identify a specific defect. Instead the WCJ opined that the defendant forced the treating physician to provide a prescription so it could perform UR and stop the home healthcare. The WCJ found that the claims administrator had not presented medical evidence showing that the applicant's condition had changed in the period between when care was provided and when it was terminated and had also not presented evidence that the applicant did not need home healthcare. The defendant filed a petition for reconsideration, which was denied by the WCAB.

The defendant filed a petition for a writ of review, arguing, among other things, that: (1) the WCAB lacked the authority to award medical treatment in the absence of a defect in the UR decision; (2) the WCJ's decision was inconsistent with *Dubon II* in that, absent a finding of untimeliness, the WCAB has no jurisdiction to resolve a dispute over the medical appropriateness of treatment; and (3) the WCJ's decision was not supported by substantial evidence and did not comply with medical treatment guidelines. The applicant elected not to file a reply to the petition due to economic hardship. On April 9, 2015, the Court issued an order denying the petition for a writ of review.

Gustavo Mendoza v. WCAB; Professional Security Consultants, et al.
California Court of Appeal, Second Appellate District, Div. 6, Case No. B260240

This case involved the question of whether an employer can use UR to object to treatment requests made by physicians in its medical provider network (MPN). The WCJ found that UR statutes applied to employers both with and without MPNs. Therefore, UR did apply to treatment requests made by MPN physicians and those UR decisions were admissible in medical treatment disputes before the WCAB. The applicant filed a petition for reconsideration, which was denied by the WCAB.

The applicant filed a petition for a writ of review making three key arguments: (1) requests made by MPN physicians are not subject to UR, or, in other words, an employer cannot use UR to object to treatment requests made by providers within its MPN; (2) a UR decision that does not meet the substantial medical evidence standard

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cannot be used to deny care; and (3) the IMR process is a denial of procedural and substantive due process. On April 17, 2015, the Court issued an order summarily denying the petition.

The issue of whether treatment recommendations made by MPN physicians can be submitted to UR is currently pending before the WCAB on reconsideration in the case of *Hogenson v. Volkswagen Credit Inc.* (ADJ2145168). In *Hogenson*, the WCJ held that treatment requests submitted by MPN physicians were not subject to UR and IMR procedures and that UR reports obtained by defendants were inadmissible at trial. The WCJ found that the MPN statutory scheme gives defendants sole control to choose the members of the MPN, provides for a second and third opinion process, and excludes the use of UR reports from consideration in disputes over treatment. The defendant filed a petition for reconsideration, and the WCAB granted the petition in order to allow sufficient opportunity to study the factual and legal issues of the case.

Daniel Ramirez v. WCAB; State Comp. Ins. Fund et al.

California Court of Appeal, Third Appellate District, Case No C078440

In this case, Ramirez requested IMR after a request for acupuncture treatment was denied in UR. The IMR decision upheld the UR denial, and the applicant filed an appeal of the IMR decision at the WCAB, requesting a hearing and an order disclosing the identity of the IMR reviewer, so that the applicant could conduct discovery regarding the reviewer's bias. At the conference, the WCJ advised that the WCAB lacked jurisdiction over all the applicant's arguments and, over the applicant's objection, granted the defendant's request to take the matter off the calendar. Ramirez filed a petition for reconsideration, asserting that the order removing the matter from the calendar was effectively a dismissal of the appeal. The WCAB denied the petition for reconsideration but granted removal to amend the WCJ's order to an actual dismissal of Ramirez's appeal.

Ramirez filed a petition for a writ of review, in which he contends that: (1) the WCAB has jurisdiction to hear medical treatment disputes in cases where an employer fails to conduct UR properly (challenging the holding in *Dubon II*); (2) the IMR statutes are unconstitutional; and (3) the IMR appeals process violates the applicant's due process rights. In its answer, the defendant defended the constitutionality of the IMR statutes and asserted that the WCAB has jurisdiction over treatment disputes only when no UR has been performed or if UR has been performed in an untimely manner.

The Court issued the writ of review in this case on May 7, 2015. The certified record from the WCAB has been filed, and the case is fully briefed. The California Applicants'

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Attorneys Association and the California Society of Industrial Medicine filed amicus curiae briefs in support of the petitioner. The DWC, the California Workers' Compensation Institute, and the California Chamber of Commerce have filed amicus curiae briefs in support of the respondents.

Zurich North America v. WCAB (Dolan)

California Court of Appeal, First Appellate District, Div. 1, Case No. A143976

In this case, the defendant agreed to provide home healthcare services to the applicant for a specified number of hours per month, at a specified rate. The agreement also provided that either party could revisit the amount of home healthcare to be provided. The parties used an agreed medical evaluator (AME) to assist in determining the current need for healthcare, and the AME opined that the applicant needed round-the-clock assistance.

The matter proceeded to an expedited hearing to determine the degree of care required and the period of time in which it was needed. The WCJ awarded the 24/7 care, finding that because UR had not been conducted on the requests for home care, the medical treatment dispute was not subject to IMR, and thus the WCAB had jurisdiction to address the issue of medical necessity. The defendant filed a petition for reconsideration, which was denied by the WCAB.

The defendant filed a petition for a writ of review, arguing that: (1) the WCJ lacked the authority to make a determination regarding a question of medical necessity, including instances when a UR decision is untimely (contrary to the holding of *Dubon II*); (2) the obligation to conduct UR was never triggered because the proper request for authorization was not submitted by the provider; (3) the applicant failed to meet his burden of proof with respect to an entitlement to home healthcare; and (4) the request for home care did not satisfy the requirements of Labor Code section 4600(h). On March 5, 2015, the petition was summarily denied, and the matter was remanded to the WCAB for the purpose of making a supplemental award of attorney fees under Labor Code section 5801 for services rendered in connection with the petition for a writ of review.

King v. CompPartners

California Supreme Court, Case No. S232197

California Court of Appeal, Fourth Appellate District, Case No. E063527

In this case, the Court of Appeal found that (1) the exclusive remedy rule may not preclude a civil claim against a UR physician if the injury "does not meet the conditions

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of compensation” or the alleged negligent act went beyond the claims process of addressing the “medically necessary” question (e.g., failing to communicate a warning to the injured worker); and (2) that there is a doctor-patient relationship between a UR physician and an injured worker that gives rise to a corresponding duty of care.

The case involved UR denials of medications that, prior to their denials, were being provided to the injured worker in connection with his industrial injury. Neither UR reviewer advised of the dangers of an abrupt withdrawal from the medications or provided a weaning protocol in their respective denials of the medications. King alleges that, because of the UR denials, he was required to cease taking the medication immediately. As a result, King alleges he suffered from seizures, which caused additional physical injuries.

The injured worker filed a civil suit against the UR reviewer and the UR company for professional negligence, negligence, intentional infliction of emotional distress, and negligent infliction of emotional distress. King asserted that the UR reviewers owed him a duty of care because his medical treatment was being determined by their decisions. The basis of his suit took issue with the failure to provide either a warning or a weaning regimen in their UR decisions denying the request for medications.

The defendants filed a demurrer to the complaint, asserting that the claims were preempted by the Workers’ Compensation Act. The trial court sustained the defendants’ demurrer without leave to amend. The injured worker filed an appeal, asserting that the Workers’ Compensation Act does not preempt their claims; the defendants owed them a duty of care; and the trial court erred by denying them leave to amend.

In reaching its decision, the Court relied in part upon the decision in *Palmer v. Superior Court* (2002) 103 Cal.App.4th 953, which determined “that the medical director’s [UR] decision amounted to medical care, and was not purely administrative, because the [UR] had to ‘be conducted by medical professionals, and they must carry out these functions by exercising medical judgment and applying clinical standards” (Palmer at p. 972). Citing the *Palmer* decision, the Court of Appeal held that a doctor-patient relationship existed between the UR reviewer and the injured worker, and the UR reviewer owed a duty of care.

The Court, citing *Keene v. Wiggins* (1977) 69 Cal.App.3d 308, advised that the existence of a duty does not mean that the doctor is required to exercise the same degree of skill toward everyone. Rather, the duty to each person varies with the relationship of the parties, the foreseeability of injury or harm that may be expected to flow from his conduct, and the reliance that the person may reasonably be expected to

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place on the opinion received. Determining the scope of the duty depends on the facts of the case. In this case, while the UR reviewer owes a duty, the scope or discharge of that duty will depend on the facts/circumstances of this particular case. The complaint included few factual details, such as the role, if any, that the prescribing doctor played following the UR decision. The Court determined that leave to amend should have been granted as “when more details are provided they could support a conclusion that, under the circumstances, the scope of the [UR reviewer’s] duty included some form of warning injured workers of or protecting injured workers from the risk of seizures.”

The Court held that to the extent the injured worker is faulting the UR reviewer for incorrectly deciding the medical necessity decision because the medication was necessary until the injured worker was weaned from it and the request for authorization should have been modified (i.e., authorize fewer pills for weaning), his claims would be preempted by the Workers’ Compensation Act. However if the complaint is alleging fault against the UR reviewer for the failure to communicate a warning, the claim is not preempted “because that warning would be beyond the ‘medical necessity’ determination made by the [UR reviewer].” The Court of Appeal found that the trial court properly sustained the demurrer due to the uncertainty of the complaint’s allegations but because of the possibility that the causes of action are not preempted, the trial court erred in denying leave to amend, and remanded the case to the trial court to allow for the filing of an amended complaint. The Court’s decision was certified for publication.

After the Court’s decision was issued, numerous requests to withdraw publication of the decision were filed with the California Supreme Court. The defendants also filed a petition for review with the Supreme Court, which was granted April 13, 2016. The Supreme Court’s grant of review caused the automatic retraction of the Appellate Court’s decision.

The Supreme Court characterized the issues on review as including: (1) whether workers’ compensation provided the exclusive remedy to an injured worker who sought medical malpractice damages from a workers’ compensation UR company; (2) whether such a company, in performing UR reviews on behalf of an employer, owes a duty of care to an injured worker; and (3) whether the lower court in this case erred by permitting the worker to amend his complaint. The DWC will be filing an application along with an amicus brief in the case.

Appendix D: SB 863 Case Law

Workers' Compensation Appeals Board (WCAB) en Banc Decisions

HOME HEALTH

Roque Neri Hernandez v. Geneva Staffing, Inc.

June 12, 2014

Case No: ADJ7995806

79 Cal. Comp. Cases 682

Regarding the SB 863 additions and amendments to the Labor Code about home healthcare services, which became effective January 1, 2013, the WCAB held as follows:

- Sections 4600(h), 4603.2(b)(1), and 5307.8 apply to requests for home healthcare services in all cases that are not final, regardless of the date of injury or dates of service.
- The prescription required by section 4600(h) is an oral referral, recommendation, or order for home healthcare services for an injured worker communicated directly by a physician to an employer and/or its agent; or a signed and dated written referral, recommendation, or order by a physician for home healthcare services for an injured worker.
- Under section 4600(h) to which home healthcare services are subject, either section 5307.1 or section 5307.8 applies. Section 5307.1 applies when an official medical fee schedule or Medicare schedule covers the type of home healthcare services sought; otherwise, section 5307.8 applies.

LIEN ACTIVATION AND FILING FEE CASES

Luis Martinez v. Ana Terrazas

May 7, 2013

Case No: ADJ7613459

78 Cal. Comp. Cases 444

In cases where a medical-legal lien claim for copy costs was filed before January 1, 2013, and then it was withdrawn and refiled as a petition for costs under Labor Code section 5811 after January 1, 2013, the WCAB held as follows:

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- A claim for medical-legal expenses may not be filed as a petition for costs under section 5811.
- Medical-legal lien claimants who withdrew their liens and filed petitions for costs prior to this decision may pursue recovery through the lien process if they comply with the lien activation fee requirements of section 4903.06 and if their liens have not otherwise been dismissed.

Eliezer Figueroa v. B.C Doering Co.; Employers Compensation Insurance Fund

April 25, 2013

Case No: ADJ3274228 (AHM 0120365)

78 Cal. Comp. Cases 439

The WCAB held that, when a lien claim falls within the lien activation fee requirements of Labor Code section 4903.06:

- The lien activation fee must be paid prior to the commencement of a lien conference, which is the time that the conference is scheduled to begin, not when the case is actually called.
- If the lien claimant fails to pay the lien activation fee prior to the commencement of a lien conference and/or fails to provide proof of payment at the conference, its lien must be dismissed with prejudice.
- A breach of the defendant's duty to serve required documents or to engage in settlement negotiations does not negate a lien claimant's obligation to pay the lien activation fee.
- A notice of intention is not required prior to dismissing a lien with prejudice for failure to pay the lien activation fee or failure to present proof of payment of the lien activation fee at a lien conference.

UTILIZATION REVIEW (UR) AND INDEPENDENT MEDICAL REVIEW (IMR)

Joann Matute v. Los Angeles Unified School District

August 27, 2015

Case No: ADJ984305 (LBO 0377754)

80 Cal. Comp. Cases 1036

Where Labor Code section 4610.6(h) provides that a verified appeal from an IMR determination must be "filed with the appeals board ... within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer," the Appeals Board held that: (1) the term "mailing" is equivalent to and means "service by

APPENDIX D: SB 863 Case Law

mail,” and (2) the 30-day period to file a timely appeal from an IMR determination is extended by five (5) days pursuant to the provisions of Labor Code section 5316 and Code of Civil Procedure section 1013(a).

WCAB Significant Panel Decisions

IMR

Christopher Torres v. Contra Costa Schools Insurance Group; SCIF

August 28, 2014

Case Nos. ADJ3011154 (SAC 0309784) & ADJ3631113 (SAC 0309785)

79 Cal. Comp. Cases 1181

When the injured worker filed an unverified petition appealing an IMR determination, the WCAB held that the petition is subject to dismissal because Labor Code section 4610.6(h) provides that such a determination “may be reviewed only by a *verified* appeal.” Further, Administrative Director Rule 10450(e) requires that any petition filed with the WCAB “shall be verified under penalty of perjury in the manner required for verified pleadings in courts of record,” and it provides that a unverified petition may be summarily dismissed or denied. While lack of verification does not automatically require dismissal of an unverified petition, an appeal may be dismissed for lack of verification if the appealing party does not, within a reasonable time, cure the defect after receiving notice of it.

LIEN ACTIVATION FEE

Maria Elena Mendez v. Le Chef Bakery; Pacific Compensation Insurance Co.

April 25, 2013

Case No. ADJ6509620 ADJ6509621

78 Cal. Comp. Cases 454

The WCAB panel held that under Labor Code section 4903.06, a lien claimant is not required to pay a lien activation fee prior to a 2013 lien trial when: (1) the declaration of readiness (DOR) was filed prior to January 1, 2013; (2) the lien conference took place prior to January 1, 2013; and (3) the lien trial took place in 2013, without any intervening 2013 lien conference.

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MEDICAL PROVIDER NETWORK (MPN)

Eun Jae Kim v. B.C.D. Tofu House, Inc.; Cypress Insurance Company

February 7, 2014

Case No. ADJ9086333

79 Cal. Comp. Cases 140

The WCAB held that the plain language of Labor Code section 5502(b)(2), amended by SB 863, and Administrative Director Rule 9767.6(c) provide that an expedited hearing may be requested and conducted to determine whether the employee must get treatment within the employer's medical provider network during the 90-day delay period, under Labor Code section 5402(b). The same Labor Code section also states that the employer has to investigate and determine whether to accept or reject the claim. An expedited hearing is available to address the provision of treatment through an MPN even if the employer has not accepted liability for the claim as described in Court Administrator Rule 10252.

MEDICAL TREATMENT

Jennifer Patterson v. The Oaks Farm; California Insurance Guarantee Association for California Compensation Insurance Co., in liquidation

July 24, 2014

Case No. ADJ3905924 (ANA 0339374)

79 Cal. Comp. Cases 910

When the defendant unilaterally terminated nurse case manager services to the injured worker, the WCAB affirmed the WCJ's award reinstating those services, holding as follows:

- The provision of a nurse case manager is a form of medical treatment under Labor Code section 4600;
- An employer may not unilaterally cease to provide approved nurse case manager services when there is no evidence of a change in the employee's circumstances or condition showing that the services are no longer reasonably required to cure or relieve the injured worker from the effects of the industrial injury;
- Use of an expedited hearing to address the medical treatment issue in this case is expressly authorized by Labor Code section 5502(b)(1); and

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- It is not necessary for an injured worker to obtain a request for authorization (RFA) to challenge the unilateral termination of the services of a nurse case manager.

UR

Timothy Bodam v. San Bernardino County/Department of Social Services
November 20, 2014
Case No. ADJ8120989 (SBR 0041910)
79 Cal. Comp. Cases 1519

In affirming the WCJ's finding that the defendant's UR decision was not communicated in a timely fashion to the requesting physician and the employee as required by Labor Code section 4610(g)(3)(A) and Administrative Director's Rule 9792.9.1(e)(3), the WCAB held that: (1) a defendant is obligated to comply with all time requirements in conducting a UR, including the time frames for communicating the UR decision; (2) a UR decision that is made in a timely fashion but is not communicated in a timely way is untimely; and (3) when a UR decision is untimely and, therefore, invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence.

WCAB Noteworthy Panel Decisions

HOME HEALTH

Jesus Rodriguez, Applicant v. Air Eagle, Inc.,
January 9, 2015
2015 Cal. Wrk. Comp. P.D. LEXIS 3

The WCAB, in a split panel opinion, held that applicant was entitled to home healthcare services by a psychiatric technician or licensed vocational nurse beginning October 22, 2013, and continuing indefinitely. The WCAB found that the applicant met his burden to prove that a September 26, 2013, medical report was a prescription under Labor Code section 4600(h). The WCAB concluded that the applicant met his burden of proving with substantial medical evidence that the requested home healthcare services were reasonable and necessary to cure and relieve effects of his industrial injury.

The WCAB concluded that the WCJ's decision was correct, except for finding that the UR was invalid on grounds other than timeliness. The majority pointed out that a UR decision is invalid only if it was untimely, citing *Dubon II*. The WCAB, in amending the

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WCJ's decision, held that defendant's November 6, 2013, UR denial of applicant's request for home healthcare services for 24 hours per day, seven days per week, on a psychiatric basis was untimely and, therefore, invalid. The WCAB found that (1) although the defendant's UR decision was issued nine days after the receipt of a request for authorization (RFA) and was conducted within the time requirements for a *regular* UR decision, the physician checked the box on the RFA for "imminent and serious threat," thereby raising the issue of whether the RFA was subject to timelines for expedited review, requiring a UR decision to be issued within 72 hours of receipt of information reasonably necessary to make a determination; (2) the defendant's claims adjuster and UR reviewer testified that the RFA was filled out correctly and was complete when it was received; (3) the purpose of the check box is to alert the reviewer that a separate timeframe for a decision applies, and there is nothing in 8 CCR section 9792.9.1 as it existed in 2013 that allows a defendant to override the requesting physician's designation of a request as "imminent and serious"; (4) under the circumstances, the RFA should have been treated as an expedited request; and (5) the request for further information regarding the duration of requested home healthcare services sent by the UR reviewer to the defendant on November 1, 2013, did not meet the 72-hour time frame, making the UR denial untimely.

UR

Diane Garibay-Jimenez v. Santa Barbara Medical Foundation Clinic

April 2, 2015

2015 Cal. Wrk. Comp. P.D. LEXIS 130; 43 CWCR 92; ADJ 6552734

This case involves the obligation of employers to forward all relevant medical records to IMR after an application has been accepted and a Notice of Assignment and Request for Information (NOARFI) has issued. The injured worker filed an appeal of an IMR decision upholding a UR decision denying the requested surgery because the IMR reviewer had not reviewed AME reports. The WCJ denied the worker's petition. The injured worker filed a petition for reconsideration. The WCAB granted reconsideration and rescinded the findings and returned the matter to the IMRO for a new IMR.

The WCAB panel held that, according to Labor Code section 4610.5 (l), the employer has an obligation to forward all relevant medical records to IMR. Further, Administrative Director Rule 9792.10.5 mandates that the IMR organization must receive from the claims administrator all reports of the physician relevant to the employer's current medical condition, including reports specifically identified in the request for authorization.

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The WCAB stated that the applicant has no statutory or regulatory obligation to submit medical records to the IMRO. The defendant's failure to provide the relevant medical records to the IMRO constitutes grounds for appeal of the IMR determination under Labor Code section 4610.6 (g) and (h). The WCAB further found that the defendant's failure to comply with its obligation under Labor Code section 4610.5 (l) to provide all relevant medical records to the IMRO rendered its final determination an act without or in excess of the Administrative Director's powers.

Minh Ly, Applicant v. Loral Space Systems, California Ins. Guarantee Ass'n
March 24, 2015
2015 Cal. Wrk. Comp. P.D. LEXIS 138

This case opines on the process to be followed when an injured worker files for an expedited hearing to decide medical treatment decisions after UR has been conducted. In this case, the injured worker requested an expedited hearing regarding the defendant's UR denial of authorization of long-standing prescriptions of medications that had been previously been provided by the defendant. The injured worker further argued that under the *Patterson* case (summarized above), a request for authorization was not necessary, as the prescriptions for medication had been authorized for at least six years, and no change in circumstance had occurred to warrant a modification. The WCJ issued an order taking the matter off the calendar instead of proceeding to expedited hearing.

The WCAB, in a split panel opinion, found that the WCJ erred when, instead of proceeding to an expedited hearing to address applicant's contention that the defendant improperly denied authorization for prescription medication and, without receiving any evidence into the record, she issued a perfunctory order after concluding (1) that defendant's UR denial of treatment was timely (which left her with no jurisdiction to determine the underlying treatment issue) and (2) that the injured worker's reliance upon *Patterson* was misplaced because that case dealt with a nurse case manager (for which no ongoing prescription was needed) and not for medications, as in this case, which do require prescriptions; and each prescription is subject to a request for authorization and UR.

The panel majority held that applicant had a right to an expedited hearing on medical treatment issues under Labor Code section 5502(b)(1), including whether the defendant improperly submitted a prescription to UR pursuant to *Patterson*, and that only after findings on these preliminary issues were made could the issue of the board's jurisdiction be properly decided. The majority found that the WCJ's failure to allow the injured worker to be heard and to create a meaningful evidentiary record was contrary to due process. The dissent opined that the WCJ properly ordered the matter off

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calendar because (1) conducting an expedited hearing in this case was not necessary to determine whether the holding in *Patterson* applies to the request for prescription medication, which, unlike the services at issue in *Patterson*, requires ongoing review and evaluation, and (2) the injured worker did not contend that the UR decision was untimely.

The WCAB granted the injured worker's petition for removal, rescinded the WCJ's order taking the case off the calendar, and returned the case to the trial level for an expedited hearing.

DeRosa v Fremont Compensation

January 30, 2014

43 CWCR 38

This case involves a failure to show timely communication of a UR denial. A unanimous board panel rescinded a WCJ's findings that (1) a secondary treating physician's request for authorization of spinal surgery had not been in compliance with Administrative Director (AD) Rule 9785 (regarding physicians' reporting duties), and (2) the defendant had communicated a UR denial to the physician in a timely fashion. The board found authority for secondary treating physicians to make treatment requests in the Labor Code and the AD Rules. The panel remanded the case to the WCJ for further proceedings, however, concluding that defendant had not shown, but should be permitted to show, timely communication of the UR denial.

The panel concluded that a secondary treating physician's surgical treatment request can be a valid request for treatment triggering UR. The panel reasoned that either a primary or secondary physician may make a request for authorization of treatment. It noted that Labor Code section 4610.5 authorizes either the treating physician or the physician designated by the treating physician to render opinions on all medical issues necessary to determine eligibility for compensation.

With respect to the timeliness of the communication of a UR decision to the requesting physician, the panel indicated that for a UR decision to be timely, it must comply with all time requirements surrounding a UR decision, specifically the requirement in Labor Code section 4610(g)(3) that a UR decision be communicated to the treating physician within 24 hours by telephone, fax, or email and that written notice of the decision be sent to the treating physician and the injured employee (or his/her attorney) within two business days of the time it is issued.

The panel emphasized that, even when a UR decision has been made within a shorter time frame, the Labor Code requires that the communication time requirements of a UR decision start from the date on which the UR decision is actually made.

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Bissett-Garcia v. Peace and Joy Center
April 11, 2016
44 CWCR 112, ADJ1390531

A board panel decision disagreed with the way in which the WCJ determined untimeliness of a UR decision for the purpose of taking jurisdiction to decide the medical treatment dispute under *Dubon II*. At trial, the WCJ invalidated an otherwise timely UR decision because it did not accurately reflect that a phone conversation had taken place between the UR physician and the requesting physician, which involved notice that UR was denying the requested treatment. The WCJ determined that this defect rendered the UR incomplete and therefore untimely. The board panel, in determining that this was not tantamount to an untimely UR, noted that there is no “requirement that a utilization review denial recite the contents of a telephone conference between the reviewer and the treating physician, unless relevant [to the UR decision’s rationale].” Therefore, the WCAB had no jurisdiction under *Dubon II* to decide the medical treatment dispute.

Grijalva v. Care Admin. and Management Professionals
March 18, 2016
ADJ9142464, 44 CWCR 65

This case dealt with an attempt to circumvent the established process for requesting treatment previously denied by UR and IMR. In this case, the applicant requested a supplemental report from the qualified medical evaluator (QME) commenting on treatment that had been previously denied by UR and IMR. The defendant objected and requested a hearing. At the hearing, discovery was closed and the matter was set for trial, with a settlement conference date set for approximately a month before trial.

At the settlement conference, the WCJ issued an order directing the QME to issue a supplemental report commenting on treatment reports from the primary treating physician that addressed treatment previously denied by UR and IMR more than a year earlier. The defendant filed a petition for removal, contending that the WCJ erred by issuing the order, given that discovery closed at the earlier mandatory settlement conference (MSC) and that the authorization for the requested treatment had been denied in valid UR and IMR decisions.

The WCAB panel granted removal and rescinded the WCJ’s order. The panel held that (1) discovery had closed at the MSC held earlier and (2) the request that the QME provide reporting concerning medical treatment determined by UR and IMR to be unnecessary was improper. The panel concluded that any further effort by the applicant to obtain the treatment must be by submission of a new Request for Authorization pursuant to Labor Code section 4610 and not by soliciting an opinion from the QME.

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The panel stated that after valid UR and IMR decisions have been issued denying the treatment, the appropriate course to obtain authorization for the treatment is to submit a new request for authorization by the treating physician with supporting information, as that was the process established by the Legislature to address medical treatment disputes; it is not proper to attempt to circumvent that process by soliciting a report from the QME addressing the denied treatment in the context of expressing an opinion on what future treatment the injured worker may need.

Green v. Elle Placement

March 17, 2016

ADJ9917212, 44 CWCR 88

A divided board panel decision overturned a WCJ's ruling that UR was untimely. The UR determination, dated on the fifth working day after receipt of the request for authorization, had been faxed to the requesting physician after 6:00 p.m. that same day. The panel majority concluded that the UR determination had been made and communicated in a timely fashion; however, the dissent cautioned that the majority's decision would give defendants an additional day to complete their UR determinations, in violation of the five-working-day rule.

Stock v. Camarillo State Hospital

September 12, 2014

ADJ 2426407

Defendants received a medical treatment request from an MPN physician and sent it to UR. The applicant argued that the report should not be admitted because the defendant was not permitted to contest any medical treatment prescribed by MPN physicians or, in other words, that defendants cannot send a treatment request from an MPN physician to UR. At trial, the WCJ found the UR report admissible. The applicant filed for reconsideration.

The WCAB held that the defendant's UR determination of a request submitted by a treating physician in the defendant's MPN was admissible over the applicant's objection. The WCAB found that, contrary to the applicant's argument, the Legislature did not demonstrate an intent to preclude employers from seeking UR of MPN physicians' requests for authorization of medical treatment.

The statutory and regulatory law governing UR and MPN provisions provide that a treating physician's request for authorization of medical treatment must be reviewed by a physician competent to evaluate the specific medical issues, without distinction as to whether the treating physician is selected through an MPN.

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Furthermore, the definition of “primary treating physician” in 8 CCR sections 9767.1 and 9785(a)(1) includes physicians within an MPN. When an employer does not approve a treatment request from an applicant’s “primary treating physician,” the defendant must refer the request to UR. According to the WCAB, further review of the treating physician’s request for a hospital bed to cure or relieve the effects of the applicant’s back injury must occur through IMR.