

DEPARTMENT OF INDUSTRIAL RELATIONS

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January 18, 2017

David M. Lanier, Secretary
California Labor and Workforce Development Agency
800 Capitol Mall, Suite 5000
Sacramento, CA 95814

Dear Secretary Lanier,

In May 2016, you directed the Department of Industrial Relations (DIR) to convene a working group of stakeholders to study and make strategic policy recommendations to strengthen anti-fraud efforts in the California workers' compensation system. I am pleased to provide you with this report detailing the Department's anti-fraud efforts, and in particular our efforts to reduce medical provider fraud and illegitimate liens, which were significantly bolstered by the passage of Assembly Bill 1244 (Gray and Daly) and Senate Bill 1160 (Mendoza). Our report also details the relevant research and data that will direct the next series of significant anti-fraud policies targeting premium fraud.

Senate Bill 863, the landmark reform of 2012, addressed the needs of injured workers and employers – the primary stakeholders in the workers' compensation system – by increasing benefits while lowering premiums through the elimination of friction costs. In particular, Senate Bill 863 took medical treatment and billing disputes out of the litigation system and redirected them into the evidenced-based, more timely, more transparent, and less costly Independent Medical Review and Independent Bill Review systems. While these reforms met the primary objectives of increasing benefits and reducing costs, they also generated new data on liens, which aided in exposing provider fraud schemes and fraudulent practices.

The high-profile provider fraud prosecutions by local district attorneys that were publicized in the past year involved investigative and funding support from the California Department of Insurance (CDI), and the expertise and data analysis provided by the DIR and its Division of Workers' Compensation (DWC). CDI and DWC chose to not publicize their involvement to preserve the integrity of the prosecutions by not revealing investigative methods and techniques. However, these efforts were key to ascertaining patterns of fraud, relationships among participants, the extent of fraudulent treatment and billing schemes, and how the schemes were perpetrated within the context of the workers' compensation system.

As directed, DIR in collaboration with CDI and the Commission on Health and Safety and Workers' Compensation convened meetings of stakeholders across the system to assess workers' compensation fraud. The departments moved quickly to help incorporate anti-fraud measures into Assembly Bill 1244 (Gray and Daly) and Senate Bill 1160 (Mendoza). In particular, these measures expressly require the automatic stay of lien claims of providers criminally charged with fraud, and for DWC to

suspend any medical provider, physician or practitioner convicted of fraud from participation in the workers' compensation system. Lien filing requirements were strengthened to ensure that the lien claimant was actually the provider who rendered the service.

Since the start of this year, the lien claims associated with approximately 75 providers currently facing criminal fraud charges were stayed pursuant to new Labor Code section 4615. More than 200,000 liens with a total claim value of over \$1 billion have been stayed. DWC has adopted provider suspension regulations and now is issuing notices of suspension to convicted providers, who together account for at least another 100,000 liens in the system. Removing fraudulent providers and their lien claims from the workers' compensation system will enable the system to improve services to injured workers by improving the system's efficiency and ultimately reducing costs.

Premium fraud – through which unscrupulous employers seek to lower costs by underreporting payroll, misclassifying employees as independent contractors, or misreporting workers engaged in high-risk occupations as engaged in low-risk occupations – also warrants focused attention. Premium fraud is less impactful on overall system costs than provider fraud since premium costs are mostly redistributed to honest employers in the form of higher premiums.

The cost of the workers' compensation insurance premium is based on an employer's payroll total. By misreporting payroll costs, some employers avoid the higher premiums they would incur with accurate reporting of their payroll. Employers can also misreport total payroll or the number of workers in specific high-risk, high-premium occupation classifications by reporting them in lower-risk, lower-premium occupations. A 2009 study funded by CDI's Fraud Assessment Commission found that between \$15 billion and \$68 billion dollars of payroll is underreported annually.

As you know, DIR's ongoing work to combat workers' compensation fraud includes the creation of an Anti-Fraud Support Unit to share and track data from system participants, and obtaining the resources for the new responsibilities entrusted to DIR under Assembly Bill 1244 and Senate Bill 1160. We are also continuously looking into how we can combat fraud administratively and aid in similar efforts with other enforcement entities. DIR contracted with the Rand Institute for an independent evaluation and recommendations, including a review of fraud-detection in other federal and state health care programs, and we expect that study (which currently is in peer review) to be released this spring. We appreciate the interest the Legislature has shown in this area and look forward to continued cooperation between the Administration and Legislature in this mutual effort.

Sincerely,



Christine Baker, Director
Department of Industrial Relations

cc: Dave Jones, California Insurance Commissioner
Steven Bradford, Chair of Senate Labor and Industrial Relations Committee
Tom Daly, Chair of Assembly Insurance Commission
Eduardo Enz, Executive Officer, Commission on Health and Safety and Workers' Compensation

**State of California
Department of Industrial Relations**

**in collaboration with
California Department of Insurance,
Commission on Health and Safety and Workers' Compensation,
and Division of Workers' Compensation**

**Report on Anti-Fraud Efforts
in the California Workers' Compensation System**

Submitted to

David M. Lanier, Secretary

Labor and Workforce Development Agency

January 2017



**State of California
Edmund G. Brown Jr., Governor**

Introduction

Fraud is an ever-present problem in California's workers' compensation system, and it is perpetrated by individuals and companies from all segments of the workers' compensation community. While some associate the word "fraud" with false or exaggerated claims of injury, it also embraces service provider and premium fraud, which can be far more costly to the system and the California employers who pay for that system. Periodic reform measures have taken aim at fraud and its attendant costs by prohibiting referral and fee-sharing arrangements among attorneys and providers, placing stricter controls on medical evaluations and treatment, establishing fee schedules, requiring specific disclosures by providers, and providing funding for local prosecutors who handle workers' compensation fraud cases.

2012's historic reform measure SB 863 had the twin goals of increasing benefits for workers while controlling costs for employers. To date, it has been successful in meeting these goals, delivering increased monetary benefits and appropriate care while containing expenses across the state.¹ SB 863's reforms included establishing an evidence-based Independent Medical Review (IMR) system to take medical treatment decisions and disputes for accepted claims out of the litigation system; an Independent Bill Review (IBR) system to do likewise for billing disputes over accepted claims; new fee schedules to make costs more certain; and new lien-filing fees and restrictions to reduce the volume of lien claims and lien claim litigation. Along with recent technological upgrades to California's systems for managing workers' compensation claims data and adjudication,² SB 863 has also helped provide a framework for developing and implementing an empirically based, systematic strategy to confront fraudulent activity. This comes at a time when high-profile prosecutions in Southern California have shone a spotlight on provider fraud and its costs to the system. As discussed in this report, collaboration across jurisdictions and data sharing will be central to a successful approach. Success will also depend on the willingness of system participants, including parties, lawyers, and judges, to use the tools provided through legislation and technology for identifying and combating fraud.

Stakeholder Engagement

At the direction of Labor and Workforce Development Secretary David M. Lanier, the Department of Industrial Relations (DIR) convened working groups to elicit information and evidence of fraudulent activity in the workers' compensation system. Director of Industrial Relations Christine Baker chaired the steering committee for this effort together with co-chairs Nettie Hoge and Joel Laucher, respectively the outgoing and incoming Chief Deputy Commissioners of the California Department of Insurance (CDI); George Parisotto, Acting Administrative Director of the Division of Workers' Compensation (DWC); and Eduardo Enz, Executive Officer of the Commission on Health and Safety and Workers' Compensation (CHSWC). The steering committee held a

¹ See Workers Compensation Insurance Rating Bureau of California (WCIRB), *Impact of SB 863 on California Workers' Compensation Medical Costs through June 30, 2015*, released December 10, 2015. at www.wcirb.com/sites/default/files/documents/151210_post_sb_863_medical_payment_trends_report.pdf.

² These systems are known respectively as the Workers' Compensation Information System (WCIS) and the Electronic Adjudication Management System (EAMS).

series of meetings in June 2016 with representatives of insurers, employers, labor, prosecutors, medical providers, third-party administrators, and attorneys. A plenary follow-up session was held in mid-September to discuss recommendations and next steps.

Participants offered a variety of observations on factors that facilitate fraud and strategies to combat it. Though groups met separately according to their roles in the system and have different priorities in terms of what they want that system to deliver, there was considerable consensus on what the problems are and how they might be solved. Proposed solutions included not only statutory and regulatory fixes, but also better enforcement of existing rules and procedural requirements, more information sharing and coordination among agencies, greater vigilance by insurers to identify and combat provider and premium fraud, more and better use of existing data, making examples of bad actors, greater education and transparency for the workers' compensation system and system participants, and reviewing strategies used in other health-care systems. Stakeholder input helped inform our understanding of the scope of fraud, as well as helping us to prioritize efforts, interpret results of initial findings observed in the data patterns, and formulate policy recommendations. 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-care systems conducted by the RAND Corporation, DIR is now pleased to present the set of recommendations detailed in this report.

Overview of Workers' Compensation Fraud

Fraud within the workers' compensation system comes in many forms, including fraud by applicants (workers claiming injury), premium fraud by employers, staffing companies and professional employer organizations, claim and billing fraud by medical and ancillary service providers, and more elaborate capping and treatment or kickback schemes by providers working in collaboration with legal staff or one another.³ Victims include injured workers, employers, insurers, and taxpayers. DIR has been examining all these areas, with a particular focus on provider fraud and lien abuse.

California's workers' compensation is funded through insurance premiums paid by employers to cover claim costs, plus premium surcharges, also paid by employers, to cover the public costs of administering the system.⁴ Workers' compensation insurance premiums are calculated based on a percentage of the payroll reported for each employee, with rates varying according to occupational risk and the employer's prior claims experience. Reforms such as SB 863's cost containment measures help to lower premiums. However, premium fraud through the intentional underreporting of payroll has the opposite effect. According to a 2009 study conducted on behalf of

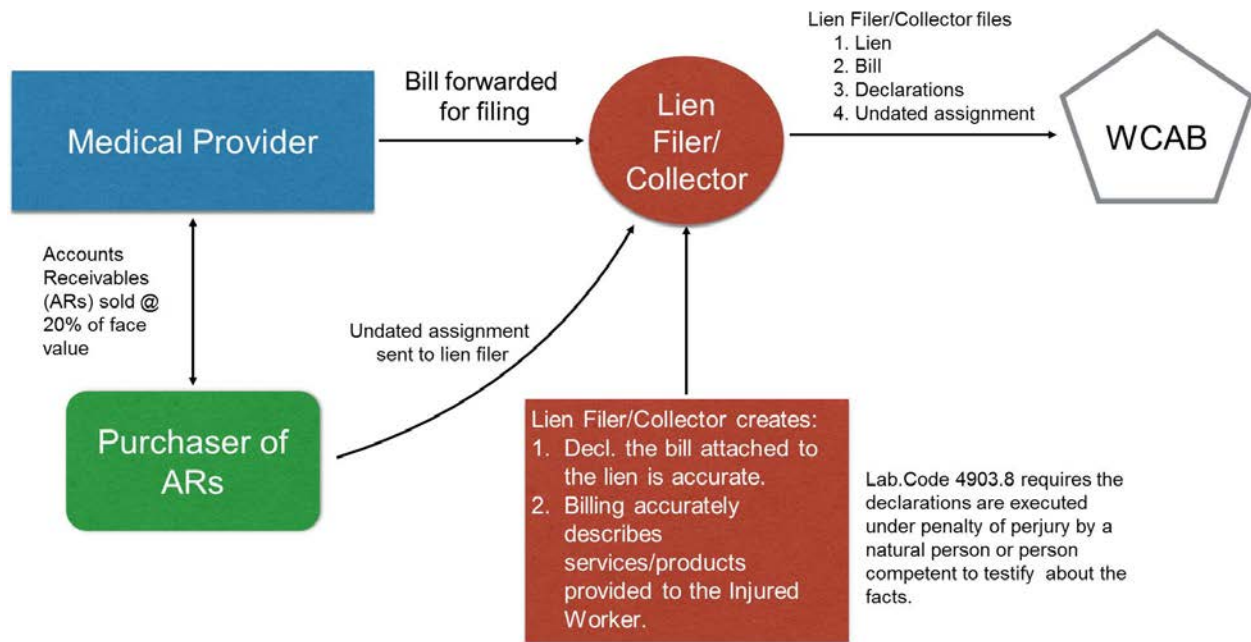
³ See attached list describing various fraud types.

⁴ Claim costs include monetary benefits paid to injured workers (which include fees paid to their attorneys), the cost of medical evaluations and treatment for injured workers (which are paid separately to providers and may greatly exceed the worker's monetary benefits), ancillary services such as interpreters, and all claim evaluation and adjudication costs, including the cost of the insurer's own lawyer. Public costs include assessments to fund DWC, the Workers' Compensation Appeals Board (WCAB), the Uninsured Employers and Subsequent Injuries Benefits Trust Funds, the California Insurance Guarantee Association (to pay claims against insolvent insurers), and CDI's Fraud Assessment Commission (discussed below).

CHSWC,⁵ underreported payroll in 1997 through 2005 ranged from \$4 billion to \$15 billion annually in years of low premium rates to \$55 billion–\$68 billion annually in years of high premium rates. The inevitable consequence is higher rates for everyone, including the honest employers, so that all the risks and costs of workplace illnesses and injuries will remain covered.

Provider fraud has garnered special attention lately through high-profile criminal prosecutions of medical providers involved in referral, treatment, and kickback schemes designed to generate billings for unnecessary or sometimes nonexistent evaluations and treatment. In some schemes, workers are solicited to present dubious claims (*e.g.*, for a different body part supposedly affected by a previously resolved injury claim), then referred for evaluation and treatment outside the insurer’s Medical Provider Network and without the insurer’s knowledge, thereby eluding the Utilization Review and IMR processes and ultimately resulting in the filing of lien claims with the WCAB.⁶ Additional liens may be filed for drugs and for ancillary services such as interpreters, and the liens may be bundled and assigned to others to file, making the service provider more difficult to identify. **Figure 1** depicts how liens have been generated, assigned, and filed despite the anti-assignment provisions of SB 863.

Figure 1. Schematic of Lien Generation



⁵ Frank Neuhauser and Colleen Donovan, “Fraud in Workers’ Compensation Payroll Reporting: How Much Employer Fraud Exists? How are Honest Employers Affected?” University of California at Berkeley (2009), www.dir.ca.gov/chswc/Reports/2011/Final_Report_FAC_Premium_Avoidance.pdf.

⁶ Historically, California law has authorized providers of medical treatment and evaluations to file lien claims in association with an employee’s claim for workers’ compensation benefits. These are not liens against the employee’s benefits in the traditional sense, but instead are an asserted right to be paid directly by the employer or insurer for services provided to an injured worker in connection with a work-related illness or injury.

These cases also put a spotlight on lien-filing abuses that have continued despite SB 863's reforms. A lien filer's ability to get one foot inside the courthouse door creates tremendous pressure on the insurer to pay something in settlement, rather than taking on the expense of fighting or disproving a clearly invalid claim. A recent internal analysis showed that 10% of the state's lien filers were responsible for 75% of the lien claims filed between 2013 and 2015. The top 1%, comprising 68 businesses, filed more than 273,000 liens, totaling \$2.5 billion, and included five individuals who were being prosecuted or had already pled guilty to fraud. However, it remained possible to continue filing and settling liens notwithstanding fraud prosecutions and other lien-filing restrictions. A DIR [issue brief](#) written last August on this topic provides additional detail.

The CDI Fraud Division is the lead state agency for criminal investigations of insurance fraud. CDI's Fraud Assessment Commission allocates funds collected from insurance premium surcharges (see note 5) to support workers' compensation fraud investigations by the CDI's Fraud Division as well as investigations and prosecutions of workers' compensation fraud by local district attorneys.⁷ From an aggregate assessment of \$58.9 million for fiscal year 2016-17, the Commission allocated approximately \$24 million to the Fraud Division and \$35 million to local prosecutors who were pursuing cases of "chargeable fraud" with an estimated overall value of nearly \$900 million statewide. The program supports county prosecutors throughout the state, pursuing all forms of workers' compensation fraud, but the highest value cases involve medical provider fraud, and the district attorneys' offices in Kern, Orange, Riverside, and San Diego counties have distinguished themselves in prosecuting this type of case.

Though unsupported by premium assessments, federal prosecutors have also undertaken some major medical fraud cases against participants in the workers' compensation system, including the successful investigation and prosecution of Long Beach hospital owner Michael Drobot that was aided by the investigative work of CDI's Fraud Division and also led to the prosecution and conviction of State Senator Ron Calderon for political corruption. Another significant resource for the battle against provider fraud are the expert attorneys and research analysts within DWC who can identify and explain aberrational and illegal conduct and can use accumulated data to ascertain the scope and extent of illegal capping, referral, and treatment schemes.

Data Monitoring

The EAMS and WCIS case management and data storage systems, together with the IMR and IBR systems, developed under SB 863 have greatly enhanced DIR's ability to detect fraud. By cross-referencing filings, we are now able to see patterns of behavior and billing among individual providers or groups of providers as well as relationships among providers that were not readily detectable in the past. As the ability to match data and parties across systems becomes more robust, so will the ability to detect fraud.

Data analytics helped DIR ascertain the extent of potentially fraudulent activity associated with a physician (referred to here as "Dr. X") who had been criminally charged in a kickback scheme. In 2006 through 2015, Dr. X's practice, with patients in 50 of the state's 58 counties, was found to have billed and been paid about \$46 million through the workers' compensation system. The practice had billed for more than 1.4 million services,

⁷ By law, at least 40% of the funds must be allocated to the Bureau of Fraud and at least 40% to district attorneys through a competitive grant program.

plus \$500,000 in physician-dispensed drugs and an additional \$160,000 in pharmacy-dispensed drugs. Claims associated with this practice were denied at three times the average rate for medical providers as a whole and included 3 times the average number of cumulative injury claims and 2.5 times the average number of claims for multiple body parts. In 2011-15, Dr. X's practice submitted over 5,000 lien claims requesting payments in excess of \$21 million (an average of \$4,200 per lien). Since 2013, 6,000 IMR requests were filed for treatments proposed by Dr. X's practice but rejected in utilization review (UR). Egregious examples like this led to the incorporation of immediate measures in AB 1244 and SB 1160 to get practitioners such as Dr. X out of the system and prevent them from litigating or collecting on liens associated with their fraudulent activity.

DIR also conducts ongoing monitoring in the following areas:

Illegal Referrals

Since 1993, physicians in the workers' compensation have been prohibited, except under very limited circumstances, from referring workers for evaluation or treatment by another office or facility in which the physician has an ownership interest. They are also prohibited from having cross-referral or referral fee arrangements and from seeking payment for any services provided in violation of these prohibitions. Using ownership information available from sources such as DWC's Qualified Medical Evaluator (QME) licensing files, other medical licensing board files, and corporate records available from the Secretary of State, and cross-checking that information against filings in the EAMS database make it possible to discern referral patterns and interrelationships among providers that are not apparent from individual claim documents, particularly when claims have been assigned to third parties for collection. DIR continually reviews the list of lien filers to determine the ownership of businesses that file liens and will expand the reviews to the IMR and IBR programs to determine whether patterns of abuse or fraud appear in those filings.

DIR will be drafting financial interest disclosure rules to improve the transparency and tracking of ownership interests and referrals. DIR will then serve as a repository of information available for use by the workers' compensation community, medical licensing boards, and other oversight agencies.

Improper Billings and Unnecessary Tests

DIR is currently looking at filing data to identify physicians who consistently overbill for certain services, including through the use of incorrect billing codes, inflating the extent of time spent on an evaluation or treatment, and the "unbundling" of combined services (i.e., making separate claims for each element of service in order to increase the total amount charged). Data analysis can also be used to determine whether physicians are performing tests that either are unnecessary or that duplicate tests already performed.

Corporate Practice of Medicine

Reviewing ownership information for medical groups can lead to evidence of nonmedical professionals who are operating clinics and controlling medical treatment. In addition to DIR's information sources, gaining access to information collected by the Franchise Tax Board would bolster these efforts.

Supplemental Job Displacement Benefits (SJDB)

DIR has recently become aware and is investigating schemes in which the names of injured workers are sold to or

otherwise obtained by counselors and schools, who then submit SJDB voucher forms to obtain payment for services never sought by or provided to the workers.

Recommendations

Administrative

1. Participants need more guidance and education on the workers' compensation system, including in the following areas.
 - How to use the Medical Treatment Utilization Standards (MTUS) guidelines
 - How to bill according to the Official Medical Fee Schedule (OMFS)
 - Nuances of upcoding
 - The appropriateness of CPT billing codes such as 99080 ("Special Reports") and 99199 ("Other Medicine Services and Procedures")
 - The bundling and unbundling of liens and general medical-legal billing rules overall
 - Indications of self-referral violations prohibited by Labor Code section 139.3

Increased knowledge in these areas will enhance the ability of insurers to detect behavior patterns that should be reported. Providers should be aware of the rules associated with each element as well as the sanctions or penalties resulting from noncompliance.

DWC has created an online physician training program that will focus on these and other topics. Additional training modules are under consideration.

2. Workers' Compensation Judges need to be aware of and apply applicable anti-fraud provisions, as well as following protocols for reporting and referring incidents of fraud.

Updates to the fraud protocol along with judges' training are in progress.

3. Increase transparency in reporting of system usage by lien claimants.

DIR continues to report on lien claimant system usage, including liens filed by or on behalf of providers who have been criminally charged or convicted of fraud in relation to the workers' compensation system or the Medi-Cal or Medicare programs.

4. Standardize forms to increase the ability to monitor and match data across systems. Require the National Provider Identifier (NPI) number, which is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services, on all filings.

DIR is reviewing technical options to enhance the features of EAMS for greater accuracy and speed of fraud identification, and the WCAB is in the process of revising its lien forms to correspond with recent legislation and update data requirements.

5. Enforce threshold lien-filing requirements by rejecting incomplete or unsigned documents at the time of attempted submission.

SB 1160 implementation appears to be addressing this issue in part. DWC will continue to monitor to see if additional reforms are necessary.

6. Publicize the CDI's hotline (1-800-927-HELP) and website (www.insurance.ca.gov) to facilitate the reporting of workers' compensation fraud.

This is in progress.

7. Create an Anti-Fraud Support Unit within DIR and maintain a centralized data-intake system for transparency and expedited sharing of information among system participants. The function and purposes would be:

- Serve as DIR's central point of contact with other agencies and stakeholders on fraud issues, both for the sharing of data and information and making referrals for criminal investigation.
- Research fraud within the workers' compensation system, track data, etc.
- Coordinate and advance DIR's anti-fraud activities.

DIR is in the process of developing this team and related program protocols.

8. Create a data sharing process with the CDI's Fraud Division to facilitate investigation of DIR's data analysis indications.

A new memorandum of understanding between the DIR and the CDI focuses on the sharing of information.

Legislation Completed

1. Liens filed by or on behalf of medical service providers who are criminally charged (or by sworn complaint) with workers' compensation fraud, medical billing fraud, insurance fraud, or Medicare or Medi-Cal fraud, should be automatically stayed, pending disposition of the criminal case.

Enacted through [SB 1160](#) (new Labor Code section 4615, effective 1/1/2017).

2. Anti-assignment of lien provisions of SB 863 should be strengthened to preclude all assignments except in cases where the provider has ceased doing business and invalidate any lien assigned in violation of this provision by operation of law.

Enacted through [SB 1160](#).

3. Provide for consolidation and expedited dismissal or disposition of liens upon criminal conviction of provider for fraud involving the workers' compensation, Medicare, or Medi-Cal programs, patient abuse, and other crimes.

Enacted through [AB 1244](#) (new Labor Code section 139.21, effective 1/1/2017).

4. Provide for automatic suspension from the workers' compensation system of any provider upon conviction for fraud, suspension from the Medicare or Medicaid/Medi-Cal programs, or loss of professional license.

Enacted through [AB 1244](#) (new Labor Code section 139.21, effective 1/1/2017).

Recommended Legislation - Significant

1. Formalize an Anti-Fraud Support Unit within DIR (see Administrative Item No. 7 above).
2. Amend relevant provisions of the Insurance Code, Labor Code, and Unemployment Insurance Code to combat premium fraud and related issues as follows.
 - a. Require insurers at least annually to obtain copies of Employment Development Department (EDD) payroll reports and compare them to payroll reported to the insurer by the employer, with appropriate sanctions against employers who fail to supply their EDD payroll reports and insurers who fail to make the required annual comparison.
 - b. Clarify the purposes for which the Labor Commissioner has access to EDD payroll data and provide workers' compensation carriers with access to employer payroll report data (to the extent permitted by federal law) so that data can be compared to payroll data reported directly to the carriers by their policyholders.
 - c. Extend Labor Commissioner's authority to cite employers for failure to secure workers' compensation coverage to include employers who under-report payroll or misclassify workers for the purpose of reducing insurance premiums.
 - d. Create a master business application in an electronic portal that would allow businesses to quickly and easily make updates, as recommended in a [March 2015 Little Hoover Commission Report](#). Include information about employees that insurers can cross-reference with workers' compensation claims.
3. Consider changes to the statute of limitations, with appropriate exceptions, to address the proliferation of post-termination cumulative trauma claims and curb abuse.⁸

Recommended Legislation - Technical

1. Amend the new lien stay statute (Labor Code section 4615, effective 1/1/2017) to bring the definitions and coverage into alignment with the broader definitions and coverage of related lien provisions in new Labor Code section 139.21 [AB 1244] and to extend the stay of liens from the date of a conviction until the institution of lien consolidation proceedings under section 139.21.

Other Proposed Items for Study and Follow-Up Recommendations

⁸ A [December 2016 California Workers' Compensation Institute study](#) showed that a disproportionate share of cumulative trauma claims is filed in the Los Angeles Basin.

1. Have prosecutors report the filing of charges and convictions in workers' compensation fraud cases (including misdemeanors) directly to DIR and the CDI—this could be required by statute (amendment to Business & Professions Code section 803.5), by regulation in conjunction with the Fraud Assessment Commission grant program, or by interagency agreement..
2. Increase funding for fraud prosecutions and determine whether a mechanism or incentive is needed that encourages prosecutors to take on cases that are regional or statewide in scope.
3. Determine whether there are any unnecessary restrictions on the sharing of information among insurers and between insurers and enforcement agencies in cases of suspected workers' compensation fraud.
4. Examine the issues surrounding private employment organizations (PEOs) and their legal liability for workers' compensation. Acquire a better understanding of the impact of staffing companies, employee leasing arrangements, professional employer organizations, and similar types of companies and arrangements, on the workers' compensation system. Examine ways to address and clarify misclassification of employees as independent contractors, as this is the core of the confusion regarding liability among these staffing entities.
5. Prohibit the improper marketing of QME services and improve the quality control review and background checks on physicians applying for new or renewed appointments as QMEs. Review any statutory limitations on the authority to discipline QMEs for violating fee schedule and other requirements.

Appendices

- I. Types of Fraud in the Workers' Compensation System
- II. Issue Brief: Issues and Impact of Lien Filing in California Workers' Compensation System [8.19.2016]
- III. Text of Anti-Fraud Legislation (AB 1244 and SB 1160) enacted in 2016

APPENDIX I – Types of Fraud in the Workers’ Compensation System

- Premium fraud: Workers’ compensation insurance premiums are calculated based on a percentage of the payroll reported for each employee. Higher risk occupations require higher percentage payments, and the employer’s past experience with workers’ compensation claims is also factored into the rate. Premium fraud involves the intentional misreporting of information in order to obtain lower premiums (*i.e.* be charged less) for insurance coverage. Premium fraud includes reporting lower wages than were actually paid, reporting that employees work in occupations with lower risk ratings than their actual jobs, and leaving workers off of payroll reports. It can also include misrepresenting claims histories or even reorganizing as a new company with no claims history in order to obtain lower premiums.
- Misclassification: Misclassification of workers is one way to commit premium fraud. Employers may misclassify employee occupations (*e.g.* classifying roofers as clerical workers) in order to obtain lower premiums, or they may misclassify employees as independent contractors in order to avoid providing any workers’ compensation coverage (or other mandated job protections) for those workers.
- Uninsured Employers: Some employers avoid their legal obligation to provide workers’ compensation coverage either by misclassifying employees as independent contractors (*see* “misclassification” above) or just deciding not to obtain coverage and hoping not to get caught. Employers may also misrepresent facts to avoid liability for individual claims.
- Applicant (Injured Worker) Fraud: Injured workers are commonly referred to as “applicants” in California’s workers’ compensation system, and may bring fraudulent claims for nonexistent illnesses or injuries or by misrepresenting facts in order to increase compensation or obtain benefits and treatment for illnesses or injuries that were not work-related. Applicant fraud can be abetted by attorneys and medical providers who refer workers for tests and treatment for nonexistent or noncompensable illnesses and injuries and provide documentation to support fraudulent claims.

- Billing fraud:** Billing fraud occurs when a service provider intentionally overcharges for services provided, including by using improper billing codes or overstating the extent of service provided, or charges for services that were not provided or are not compensable through the workers' compensation system. Billing fraud can be committed by medical service providers, pharmacies, and ancillary service providers such as interpreters and copy services. Billing fraud may include the use of billing services or shell companies to conceal the identity of the actual provider or billing source.
- Treatment abuse:** Treatment abuse occurs when workers are given tests and treatments that are not needed to cure or relieve a work injury or illness or that may be unrelated to any reported signs or symptoms or diagnosed illness or injury. The primary purpose of these tests and treatments may be to generate billings to insurers.
- Capping and treating:** Capping and treating schemes involve a "capper" who solicits workers to make workers' compensation claims through a clinic or advocacy group which in turn refers workers for unnecessary tests or treatment (*see* "treatment abuse" above) in order to substantiate the claims and bill insurers for the tests and treatment.
- Kickback schemes:** Kickback schemes involve an obligation or agreement to share or "kick back" some part of the compensation due to the person who provides goods or services (or who bills for goods or services not provided). It includes agreements to pay referral fees prohibited by Labor Code §§ 139.3 and 4906 (g). A capping and treating scheme (*see* "capping and treating" above) may include an agreement to share in any payments obtained for claims, tests, or treatment.

APPENDIX II

Department of Industrial Relations

Issue Brief: Issues and Impact of Lien Filing in California Workers' Compensation System

August 19, 2016

Purpose

The purpose of this issue brief is to outline key issues and options involved in lien filing and cost reductions that could be achieved through improvements to the Labor Code's lien statutes.

Background Summary

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 an employer in an employee's claim for workers' compensation benefits.¹ California is unique in this regard—no other state supports lien filing in its workers' compensation system. The filing of a lien generates collateral litigation between the lien filer and the defendant (insurer or employer) over the validity of the claim and the necessity, extent, and value of any services provided. The parties may then settle on an amount due or adjudicate the dispute in a "lien trial" before the Workers' Compensation Appeals Board (WCAB).

The landmark 2012 workers' compensation reform legislation SB 863 included a number of provisions to reduce costs by reducing the volume of lien claims and lien claim litigation in the workers' compensation system, including through the reestablishment of lien filing fees, the creation of an Independent Bill Review system that takes most billing disputes out of the litigation system, and restrictions on the ability of third parties to collect on assigned lien claims. Opponents of these measures, as with much of SB 863, have challenged them in court or argued that they did not really change preexisting ways of doing business. These measures still have not been fully effective in stemming lien filings or the pursuit of fraudulent lien claims, and further reforms may be appropriate.

History

The number of lien filings increased dramatically in the early 2000s, from about 12,000 per month in 2000 to about 40,000 per month in 2003. That year, the legislature established a filing fee of \$100 for liens for medical treatment and medical-legal expenses, expecting that it would curtail routine filings in cases where the right to payment was not in doubt. However, significant administrative resources had to be devoted to processing the fees, and they proved to be less of a deterrent than hoped. The legislature repealed the fee in 2006 and instead adopted new lien filing standards in Labor Code section 4903.6, with the intention of preventing frivolous lien filings.² Nevertheless, after a temporary drop

¹ Two types of claims are denominated as "liens" in the workers' compensation system. First, some liens are for money paid to a worker, such as State Disability Insurance benefits paid by the Employment Development Department (EDD) while the workers' compensation claim is pending, which can be deducted from the monetary benefits that are payable to the worker. Second, some liens are for services that cannot be charged to workers or deducted from their benefits but are charged to and paid directly by the employer or insurer. This brief concerns the second category of liens, which are in addition to the benefits paid directly to workers.

² http://www.dir.ca.gov/dwc/dwc_newsline/2006/Newsline_33-06.pdf.

following the introduction of the Electronic Adjudication Management System (EAMS) online filing system in 2008, lien filings again rose through the end of the decade to as many as 34,000 per month. In 2010, the California Commission on Health and Safety and Workers' Compensation (CHSWC) revisited the issue of why the number of liens was increasing again despite the reforms passed by the legislature in SB 899 (2004). In its 2011 "Liens Report," CHSWC found that "liens are both a cause and a result of serious distress in the California workers' compensation system." The Commission found that in at least one WCAB district office, liens consumed 35% of the court calendar and estimated that employers and insurers were expending \$200 million per year on loss adjustment expenses to handle medical liens. Further, it found that the "volume of liens forces the courts to encourage settlement, almost to the point of coercion. The necessity of settlement rewards both unjustified claims and unjustified refusals."³ CHSWC documented a series of recommendations that were the basis for many of the lien-related adjustments included in the historic SB 863 reforms of 2012.

SB 863 reinstated the lien filing fee and also enacted a new Labor Code section 4903.8 to address the assignment of liens by service providers to others in the business of filing and collecting on liens. Assigned liens were a particular problem in the system and fertile ground for presenting fraudulent claims because they removed the dispute from the persons who actually provided or received the services in question. They are especially prevalent in "denied claims," that is, claims that an insurer has already rejected. In such cases, bills for treatment (real or imaginary) may be run up by a provider with no expectation of direct payment by the insurer, but then bundled and sold to a third party, who files liens in an existing workers' compensation case, sometimes well after the worker's original case has been resolved.

Section 4903.8 requires that any order or award for payment of a lien be made only to the service provider, unless an enforceable and irrevocable assignment was completed prior to January 1, 2013, or the service provider has ceased doing business and has assigned all right, title, and interest in its accounts receivable to the assignee. Subdivision (b) of this section requires a true and correct copy of the assignment to be filed and served with the lien or within 20 days of the assignment. Subdivision (c) authorizes the WCAB to make a bad faith inquiry when there are multiple assignments of the same bill. Subdivision (d) requires the lien to be supported by a declaration under penalty of perjury by at least one natural person who can attest to the fact that the services or products were provided. Subdivision (e) states: "A lien submitted for filing on or after January 1, 2013, . . . that does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien."

Although these provisions seem clear, they have proven difficult to enforce. Third-party filers have omitted requisite information and paperwork regarding assignments when filing their liens through the EAMS system, effectively getting a foot inside the courthouse door and leaving it to defendants or the

³ California Commission on Health and Safety and Workers' Compensation, "Liens Report," January 5, 2011, accessed February 12, 2016, at https://www.dir.ca.gov/chswc/Reports/2011/CHSWC_LienReport.pdf.

Division of Workers' Compensation (DWC) to determine whether the filing was invalid because the lien was assigned after January 1, 2013, or because the provider in fact was still in business. Tools are available for others to do this, including by reviewing statements and other reports filed with the Secretary of State that document the transfer and securing of accounts receivable; and DIR has been able to find instances in which this occurred, but no record of assignment was included in the documents filed through EAMS.⁴

Case Study

Reshealth Medical Group in Hermosa Beach, established as a corporation with the Secretary of State's office on August 14, 2013 (7½ months after the effective date of SB 863), ranks twelfth among medical lien filers in calendar years 2013 through 2015, with 4,696 medical liens filed for services totaling \$21,479,325. In the case of *Gituku v. Alta Home Care*, WCAB Case No. ADJ 9178612, Javlin Three LLC filed lien claims as the assignee of Reshealth, alleging that Reshealth had gone out of business as of the summer of 2015. In a Decision After Reconsideration just issued on August 9, 2016, a panel of WCAB commissioners found that it was impossible to determine whether Reshealth (and another provider from whom Javlin had purchased accounts receivable) fell within either of the exceptions in Section 4903.8 or whether the assignments in fact covered the subject bills, because the assignment contracts offered into evidence were undated and incomplete. However, rather than rejecting the assigned lien claims as invalid under subdivision (e) of section 4903.8, the WCAB punted the case back to a trial judge for further proceedings to address these issues.⁵

One possible way to eliminate cases such as Reshealth would be to require lien filers to submit a structured standardized form to ensure that the requisite information is provided including: 1. date of assignment; 2. indication that the lien is assigned, if applicable, and, if so; 3. to whom it is assigned and reject incomplete filings.

The Power of Data

Access to data has refined our understanding of the issue. SB 863 has greatly enhanced DIR's ability to detect fraud. Among other provisions, SB 863 instituted an independent medical review (IMR) system to resolve medical treatment disputes within the workers' compensation system and mandated a number of reforms in the lien filing system. By cross-referencing IMR filings with other data sources, including

⁴ DIR is reviewing a sample of high-volume lien filers from 2013-2015 that had filed accounts receivable with the Secretary of State to determine how many also had a record of the assignment in EAMS, as required by Labor Code section 4903.8(b).

⁵ The lien claimants in this case also argued that section 4903.8 was not really a limitation on assignments, but just a requirement to award lien payments only to service providers who would then be free to turn the payment over to an assignee. Though correct in terms of the express requirements of subdivision (a) ("Any order or award . . . shall be made for payment only to the [original service provider]"), the problem underlying this argument, as exemplified in this case, is the seemingly entrenched cultural understanding or belief that concrete proof of an assignment and that services were actually provided is unnecessary unless and until someone presses the point and maybe not even then.

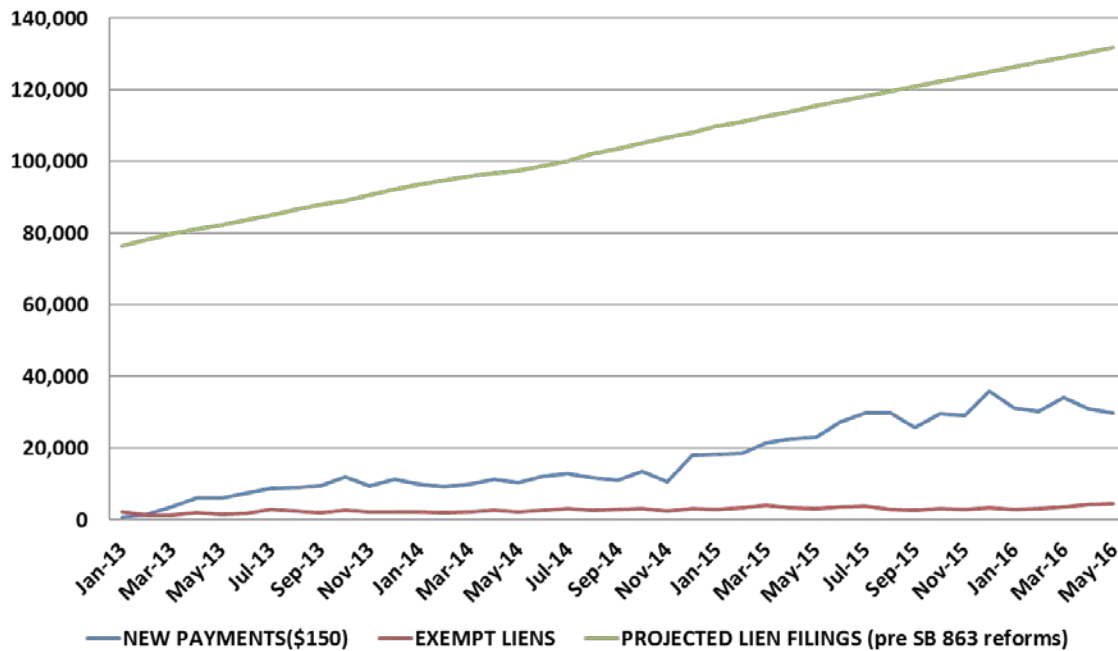
lien filings and provider billing data, we are now able to see patterns of behavior and billing among individual providers or groups of providers that might indicate fraud. This type of information was not so readily detectable in the past. As our ability to capture and to analyze this data obtained through the IMR process, in combination with data available through other DWC, WCAB, and DIR sources, becomes more robust, so, too, will our ability to detect fraud. DIR is evaluating and refining the methodology used to measure outcomes by developing standardized reporting tools and identifying incentives to improve behavior.

DIR is also conducting ongoing data measurements and monitoring/reporting in the following specific areas to evaluate the effectiveness of actions taken.

The top 1% of lien filers by volume on adjudicated cases between 2013 and 2015 discussed above included 68 businesses. Together, these entities filed 273,222 liens totaling \$2.5 billion in accounts receivable. Two of the business owners are currently under indictment, and three others have pled guilty.

As noted in Figure 1, below, between January 2013 and May 2016, nearly 700,000 liens with accompanying filing fees have been filed (for a total of nearly \$104 million in new lien filing fees), as well as nearly 114,000 liens that were exempt from filing fees. In the same period, over 461,000 previously filed liens were activated through payment of a \$100 lien activation fee (for total of \$46 million).

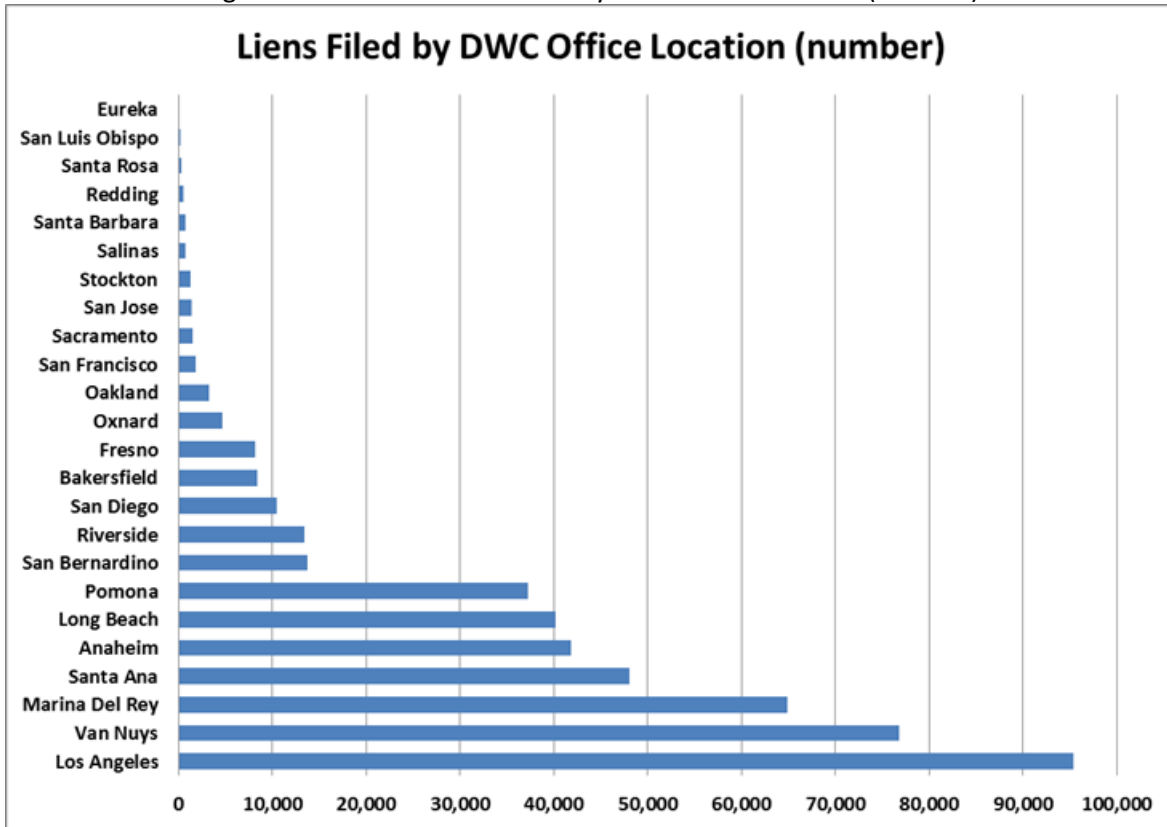
Figure 1. Monthly Lien Filings, 2013-2016



Source: DWC EAMS Lien Filing System.

Further analysis of data in the lien filing system has revealed that 95% of the filings are in Southern California, primarily concentrated (67%) in the Los Angeles basin (see Figure 2).

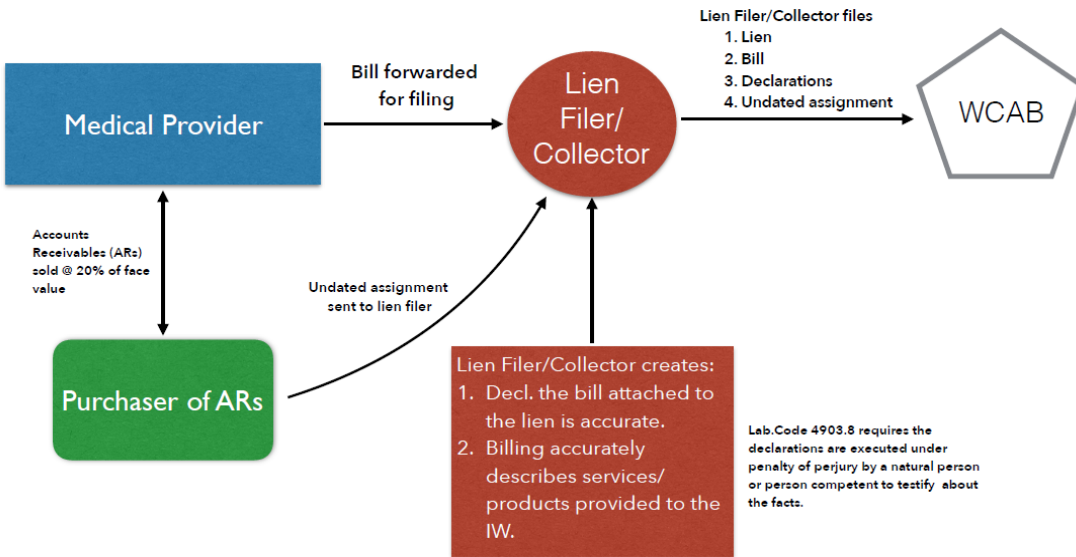
Figure 2. Liens Filed in Q3 2015 by DWC Office Location (number)



Source: DWC EAMS Lien Filing System.

Most liens are filed for denied cases, which are not subject to utilization review to determine whether the treatment is reasonable and necessary. Filing dates suggest that lien claimants tend to wait until after the case-in-chief is settled, rather than seeking early resolution of medical necessity. In current practice, even if lien claimants (particularly those who bundle and buy/sell accounts receivable) only make pennies on the dollar, returns can still be high. Many of these liens are generated despite Labor Code section 4903.8's restrictions on the assignment of lien claims, as shown in Figure 3.

Figure 3. Diagram of Lien Generation



Clear patterns emerge from an examination of lien claim data for the third quarter of 2015. For the period analyzed, 1,232 medical providers filed 76,756 medical and medical-legal liens with charges totaling \$714.6 million. Over 75% of the amount and volume of medical lien claims was attributed to the top 10% of filers, primarily in radiology, pharmacy, and medical groups and centers.

Impact on the Courts

The volume and practices of lien filings have had a considerable impact on the workload and efficacy of the courts in the workers' compensation system. The key issues include:

1. Lien claimant litigation clogs the courts, and the court time devoted to these claims takes away from the time available for injured workers.
2. Injured workers have become a commodity used by medical providers and cappers.⁶
3. Injured workers have been harmed and have even lost their lives due to incorrect and inappropriate treatment.
4. Assignments allow for fraud and for the buying and selling of those injured workers' treatment.
5. Indicted providers use lien collection to finance their defense.

⁶ A capper is someone used to procure clients or patients. Insurance Code section 1871.1(a) states: "It is unlawful to knowingly employ runners, cappers, steerers, or other persons to procure clients or patients to perform or obtain services or benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code or to procure clients or patients to perform or obtain services or benefits under a contract of insurance or that will be the basis for a claim against an insured individual or his or her insurer."

6. Millions of dollars are spent every year on the oversight and regulation of medical treatment because of the high prevalence of fraud in the system.
7. Under our current laws, medical providers who have been convicted may still collect on their liens at the WCAB.
8. Because lien claimant representatives typically are not attorneys and are paid based on the amounts collected, the providers do not have to pay directly for representation. This places defendants who pay their own attorneys to defend these cases at a disadvantage and often makes it more cost effective to pay or settle a fraudulent lien claim than to fight it.

Potential Solutions

DIR has been working with stakeholders to identify potential solutions to these problems. Two ideas have been proposed to curb the nefarious behavior of a few providers that creates exorbitant costs and friction for everyone in the system.

1. Any physician or provider who has pled guilty or no contest to, or who has been convicted of workers' compensation fraud, medical billing fraud, insurance fraud, or Medicare or MediCal fraud shall be barred from pursuing recovery on any workers' compensation bill or lien.
2. Liens filed by a physician or provider who is criminally charged with workers' compensation fraud, medical billing fraud, insurance fraud, or Medicare or Medi-Cal fraud shall be automatically stayed pending the disposition of criminal case.

Estimated Inappropriate Costs to System

If the provisions identified as potential solutions above were to be adopted, the system-wide cost avoidance could be substantial.

Issues and Impact of Lien Filing in California Workers' Compensation System

Table 1. Totals for Liens Filed by Parties Indicted and/or Convicted, 2011-2015, WCAB Cases
 Total Liens: 579,787; Total Lien Amounts: \$4,066,059,795

	Number(#)/Amount(\$)
Number of liens filed by indicted and/or convicted parties	97,079
Number of liens in system filed by indicted parties	80,532
Amount (\$) of liens in system filed by indicted parties	\$508,210,868
Number of liens in system filed by parties that either offered a plea or were convicted	16,547
Amount (\$) of liens in system filed by parties that either offered a plea or were convicted	\$91,107,125
Percent of all liens in system filed by indicted and/or convicted parties	17%
Total amount (\$) liens in system filed by indicted and/or convicted parties	\$599,317,993

Sources: DWC Lien Filing System, data current as of August 11, 2016; various court sources on indictments, pleas, and convictions.

As shown in Table 1, 17% of all liens in the system were filed by indicted or convicted parties to date. Importantly, the dollars tied to these liens totaled \$599,317,993, which, if paid, would be an additional cost to the system.

APPENDIX III – Legislation Completed (2016)

Excerpts of SB 1160 (Stat. 2016, Chap. 868 [Mendoza]) pertaining to lien stays and lien assignments

SECTION 7. Section 4615 is added to the Labor Code, to read:

4615. (a) Any lien filed by or on behalf of a physician or provider of medical treatment services under Section 4600 or medical-legal services under Section 4621, and any accrual of interest related to the lien, shall be automatically stayed upon the filing of criminal charges against that physician or provider for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the Medicare or Medi-Cal programs. The stay shall be in effect from the time of the filing of the charges until the disposition of the criminal proceedings. The administrative director may promulgate rules for the implementation of this section.

(b) The administrative director shall promptly post on the division's Internet Web site the names of any physician or provider of medical treatment services whose liens were stayed pursuant to this section.

* * *

SECTION 9. Section 4903.8 of the Labor Code is amended to read:

4903.8. (a) (1) Any order or award for payment of a lien filed pursuant to subdivision (b) of Section 4903 shall be made for payment only to the person who was entitled to payment for the expenses as provided in subdivision (b) of Section 4903 at the time the expenses were incurred, who is the lien owner, and not to an assignee unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee.

(2) All liens filed pursuant to subdivision (b) of Section 4903 shall be filed in the name of the lien owner only, and no payment shall be made to any lien claimant without evidence that he or she is the owner of that lien.

(3) Paragraph (1) does not apply to an assignment that was completed prior to January 1, 2013, or that was required by a contract that became enforceable and irrevocable prior to January 1, 2013. This paragraph is declarative of existing law.

(4) For liens filed after January 1, 2017, the lien shall not be assigned unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee. The assignment of a lien, in violation of this paragraph is invalid by operation of law.

(b) If there has been an assignment of a lien, either as an assignment of all right, title, and interest in the accounts receivable or as an assignment for collection, a true and correct copy of the assignment shall be filed and served.

(1) If the lien is filed on or after January 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment shall be served at the time the lien is filed.

(2) If the lien is filed on or after January 1, 2013, and the assignment occurs after the filing of the lien, the copy of the assignment shall be served within 20 days of the date of the assignment.

(3) If the lien is filed before January 1, 2013, the copy of the assignment shall be served by January 1, 2014, or with the filing of a declaration of readiness or at the time of a lien hearing, whichever is earliest.

(c) If there has been more than one assignment of the same receivable or bill, the appeals board may set the matter for hearing on whether the multiple assignments constitute bad-faith actions or tactics that are frivolous, harassing, or intended to cause unnecessary delay or expense. If so found by the appeals board, appropriate sanctions, including costs and attorney's fees, may be awarded against the assignor, assignee, and their respective attorneys.

(d) At the time of filing of a lien on or after January 1, 2013, or in the case of a lien filed before January 1, 2013, at the earliest of the filing of a declaration of readiness, a lien hearing, or January 1, 2014, supporting documentation shall be filed including one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring both of the following:

(1) The services or products described in the bill for services or products were actually provided to the injured employee.

(2) The billing statement attached to the lien truly and accurately describes the services or products that were provided to the injured employee.

(e) A lien submitted for filing on or after January 1, 2013, for expenses provided in subdivision (b) of Section 4903, that does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(f) This section shall take effect without regulatory action. The appeals board and the administrative director may promulgate regulations and forms for the implementation of this section.

Excerpts of AB 1244 (Stat. 2016, Chap. 852 [Gray and Daly]) pertaining to provider suspensions and lien consolidation

SECTION 1. Section 139.21 is added to the Labor Code, immediately following Section 139.2, to read:

139.21. (a) (1) The administrative director shall promptly suspend, pursuant to subdivision (b), any physician, practitioner, or provider from participating in the workers' compensation system as a physician, practitioner, or provider if the individual or entity meets any of the following criteria:

(A) The individual has been convicted of any felony or misdemeanor and that crime comes within any of the following descriptions:

(i) It involves fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient.

(ii) It relates to the conduct of the individual's medical practice as it pertains to patient care.

(iii) It is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system.

(iv) It is otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(B) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.

(C) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(2) The administrative director shall exercise due diligence to identify physicians, practitioners, or providers who have been suspended as described in subdivision (a) by accessing the quarterly updates to

the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at <https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>.

(b) (1) The administrative director shall adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the administrative director is required to suspend the physician, practitioner, or provider pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the physician, practitioner, or provider requests a hearing and, in that hearing, the physician, practitioner, or provider provides proof that paragraph (1) of subdivision (a) is not applicable. The physician, practitioner, or provider may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the administrative director finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician, practitioner, or provider.

(3) The administrative director shall have power and jurisdiction to do all things necessary or convenient to conduct the hearings provided for in paragraph (2). The hearings and investigations may be conducted by any designated hearing officer appointed by the administrative director. Any authorized person conducting that hearing or investigation may administer oaths, subpoena and require the attendance of witnesses and the production of books or papers, and cause the depositions of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil cases in the superior court of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure.

(c) The administrative director shall promptly notify the physician's, practitioner's, or provider's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the division's qualified medical evaluator and medical provider network databases, as appropriate.

(d) Upon suspension of a physician, practitioner, or provider pursuant to this section, the administrative director shall give notice of the suspension to the chief judge of the division, and the chief judge shall promptly thereafter provide written notification of the suspension to district offices and all workers' compensation judges. The method of notification to all district offices and to all workers' compensation judges shall be in a manner determined by the chief judge in his or her discretion. The administrative director shall also post notification of the suspension on the department's Internet Web site.

(e) The following procedures shall apply for the adjudication of any liens of a physician, practitioner, or provider suspended pursuant to subparagraph (A) of paragraph (1) of subdivision (a), including any liens filed by or on behalf of the physician, practitioner, or provider or any clinic, group or corporation in which the suspended physician, practitioner, or provider has an ownership interest.

(1) If the disposition of the criminal proceeding provides for or requires, whether by plea agreement or by judgment, dismissal of liens and forfeiture of sums claimed therein, as specified in the criminal disposition, all of those liens shall be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding, and orders notifying of those dismissals may and shall be entered by workers' compensation judges.

(2) If the disposition of the criminal proceeding fails to specify the disposition to be made of lien filings in the workers' compensation system as set forth in paragraph (1), all liens pending in any workers' compensation case in any district office within the state shall be consolidated and adjudicated in a special lien proceeding as described in subdivisions (f) to (i), inclusive.

(f) After notice of suspension, pursuant to subdivision (d), and if subdivision (e) applies, the administrative director shall appoint a special lien proceeding attorney, who shall be an attorney employed by the division or by the department. The special lien proceeding attorney shall, based on the information that is available, identify liens subject to disposition pursuant to subdivision (e), and workers' compensation cases in which those liens are pending, and shall notify the chief judge regarding those liens. Based on this information, the chief judge shall identify a district office for a consolidated special lien proceeding to adjudicate those liens, and shall appoint a workers' compensation judge to preside over that proceeding.

(g) It shall be a presumption affecting the burden of proof that all liens to be adjudicated in the special lien proceeding, and all underlying bills for service and claims for compensation asserted therein, arise from the conduct subjecting the physician, practitioner, or provider to suspension, and that payment is not due and should not be made on those liens because they arise from, or are connected to, criminal, fraudulent, or abusive conduct or activity. A lien claimant shall not have the right to payment unless he or she rebuts that presumption by a preponderance of the evidence.

(h) The special lien proceedings shall be governed by the same laws, regulations, and procedures that govern all other matters before the appeals board. The administrative director shall promulgate regulations for the implementation of this section.

(i) If it is determined in a special lien proceeding that a lien does not arise from the conduct subjecting a physician, practitioner, or provider to suspension, the workers' compensation judge shall have the discretion to adjudicate the lien or transfer the lien back to the district office having venue over the case in which the lien was filed.

(j) At any time following suspension, a physician, practitioner, or provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice, which shall constitute a final disposition of the claim for compensation asserted therein.

(k) The provisions of this section shall not affect, amend, alter, or in any way apply to the provisions of Section 139.2.