



**SULLIVAN**  
ON COMP

## **Special Report: SB 863 Five Years Later**

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# INTRODUCTION

SB 863 was a compromise between employers and employees. It was designed simultaneously to decrease costs to employers and increase benefits to injured employees. Employees received substantial increases in permanent disability benefits, and employers received substantially lower costs as a result of changes in the benefit delivery system designed to eliminate waste, inefficiency and certain loopholes. SB 863 was passed by the Legislature Aug. 1, 2012, and signed by Gov. Jerry Brown Sept. 18, 2012. Most of the changes went into effect Jan. 1, 2013.

This legislation was the most significant overhaul ever of the California workers' compensation system. It changed permanent disability by increasing its benefits, simplifying the formula for calculating it and, in most cases, eliminating add-on claims of permanent disability for sleep disorders, sexual disorders and psychological issues. It changed medical treatment by strengthening medical provider networks, placing restrictions on home health care and establishing a new independent medical review process to resolve treatment disputes. It created fee schedules for home health-care services, copy services, interpreters and vocational experts, and it established an independent bill review process to resolve bill payment disputes. It strengthened the statute of limitations for filing a lien and it implemented lien activation and lien filing fees. Furthermore, it simplified the supplemental job displacement benefit, and established a new return-to-work supplement for workers whose permanent disability benefits were disproportionately low compared with their earnings loss.

Since SB 863 was enacted, administrative regulations have been promulgated to implement the legislation. Extensive case law also has issued, which has interpreted and shaped the reforms. In addition, new legislation has been passed to complement and strengthen the reforms. Employees and employers have adjusted to the changes, and new practices have been adopted.

In a published assessment of SB 863, the Department of Industrial Relations (DIR) concluded, "The goals of SB 863 are being realized."<sup>1</sup> It explained that increased permanent disability benefits and the return-to-work supplement were in effect, and the savings continue to be realized. The WCIRB also published a report estimating the impact of SB 863 to be an annual net savings of \$1.3 billion, or seven percent of total system costs. It estimated that the changes by SB 863 have resulted in an overall 10 percent decline in medical treatment costs.<sup>2</sup>

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<sup>1</sup> Department of Industrial Relations, SB 863: Assessment of Workers' Compensation Reports (July 2016), at p. 24. It is available at: <https://www.dir.ca.gov/dwc/Reports/SB863-Assessment-WC-Reforms-July-2016.pdf>.

<sup>2</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at pp. 2-3. It is available at [http://www.wcirb.com/sites/default/files/documents/sb\\_863\\_cost\\_monitoring\\_report\\_2016.pdf](http://www.wcirb.com/sites/default/files/documents/sb_863_cost_monitoring_report_2016.pdf).

This is not to say that implementation of SB 863 has been painless, or easy. Many of the changes were subject to extensive litigation; some legal battles are being waged, and some SB 863 changes still have not been implemented. For example, fee schedules for home health-care services, interpreters and vocational experts have not been adopted. So the full scope of the changes by SB 863 haven't yet been realized. Nevertheless, with five years of legal development, it's time to reflect on the changes to the workers' compensation system since SB 863.

This booklet will review the specifics of the reform. It will discuss how the law has evolved since SB 863. It will highlight the legal issues that have been decided, the ongoing legal issues and those we anticipate. It will discuss areas that require legal development. When appropriate, it will advise on how to deal with ambiguities in the law.

## LINKS TO SULLIVAN ON COMP

This booklet is a supplement to “Sullivan on Comp,” our comprehensive treatise on the entirety of California workers’ compensation.

It is available in print and as a PDF e-book.

Readers of the e-book version will note that we have linked directly to related sections. If you are a subscriber and *logged in*, clicking on any link in the text will take you directly to that topic in the online edition of “Sullivan on Comp.”

Non-subscribers can learn more at <https://www.SullivanOnComp.com/>.

## **A NOTE ABOUT HYPERLINKS**

This text includes URLs for a wide variety of web resources, including PDF forms.

Because the web is a dynamic, evolutionary creature, its content shifts. Although the hyperlinks in this work were current at the time of publication, it is possible and even likely that some of them won't work when you click them. Generally, the home page addresses are clear, and you might be able to access the information via them. Despite the potential for inoperability of some addresses, we feel that the value of directly referencing most of these resources exceeds the inconvenience you might experience occasionally encountering a broken link.



## **A NOTE ABOUT STATUTORY AND LEGISLATIVE ABBREVIATIONS**

Abbreviations are used throughout the text to reference California legislation, and California and federal legal code statutes. Codes that are less frequently referenced are spelled out. These are the most common abbreviations:

- AB - Assembly Bill
- BPC - Business and Professions Code
- CCR - California Code of Regulations
- CCP - Code of Civil Procedure
- CFR - Code of Federal Regulations
- GC - Government Code
- IC - Insurance Code
- LC - Labor Code
- SB - Senate Bill
- UIC - Unemployment Insurance Code
- U.S.C. - United States Code
- VC - Vehicle Code

# 1. PERMANENT DISABILITY

In 2004, SB 899 changed the permanent disability rating system. The changes were intended to reduce litigation and increase consistency of results. But the reforms did not have as much of an impact on litigation as expected. Because disability was reduced by the new permanent disability schedule, applicant attorneys aggressively sought new ways to increase permanent disability levels. In certain respects, they succeeded: New types of claims were alleged, most notably for sleep dysfunction and sexual dysfunction. Employees also established new methods for rebutting the permanent disability schedule.

In adopting SB 863, the Legislature noted that previous methods of determining permanent disability had become excessively litigious, time consuming, procedurally burdensome and unpredictable. So in exchange for increasing maximum and minimum permanent disability benefits, SB 863 eliminated questionable claims of disability that allegedly were caused by physical injuries. Specifically, for injuries on or after Jan. 1, 2013, SB 863 limited add-on claims of permanent disability for sleep disorders, sexual disorders and psychological issues, while allowing medical treatment for them. SB 863 also changed the formula for rating permanent disability. Diminished future earning capacity no longer is considered, which impacts efforts to rebut the permanent disability schedule under *Ogilvie v. WCAB*.<sup>1</sup> SB 863 also eliminated the 15 percent adjustment for permanent disability for an applicant's return to work under LC 4658(d).

The increases in permanent disability benefits are in effect. But so far, no significant case law has been made interpreting the permanent disability changes made by SB 863. The WCIRB reports that the changes to permanent disability are projected to increase permanent disability ratings by approximately 6 percent, and that the average allocated loss adjustment expense costs per claim have increased. But it also reports that the available data do not suggest any significant post SB-863 increases to permanent disability cost.<sup>2</sup>

## INCREASES IN PERMANENT DISABILITY — CHANGING THE WEEKLY RATE

If an employee has permanent disability after reaching permanent and stationary status, permanent disability indemnity is paid every two weeks for a certain number of weeks at a determined rate. (For a general discussion, see [“Sullivan on Comp” Section 10.61 Compensation Rate](#).) Although SB 863 did not increase the number of weeks permanent disability is payable for an industrial injury, the disability was enhanced by increasing the statutory minimum and maximum wages for purposes of calculating the rate.

SB 863 adopted a two-year phase-in for the increases, which are found in LC 4453(b)(8) and LC 4453(b)(9). The first applies to injuries occurring on or after Jan. 1, 2013, and the second to injuries occurring on or after Jan. 1, 2014.

<sup>1</sup> (2011) 76 CCC 624.

<sup>2</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), p. 2.

Under both statutory provisions, the minimum earnings rate for purposes of calculating permanent disability is \$240 per week. So the minimum rate is \$160 per week — two-thirds of \$240. Previously, for dates of injury on or after Jan. 1, 2006, the minimum permanent disability was \$130 per week.

The maximum earnings rate is a little more complicated. For dates of injury on or after Jan. 1, 2013, the maximum rate is: \$345 for injuries with permanent disability less than 55 percent; \$405 for injuries with permanent disability between 55 percent and 69 percent; and \$435 for injuries with permanent disability between 70 percent and 99 percent. They result in permanent disability rates of \$230, \$270 and \$290 per week respectively.

For dates of injury on or after Jan. 1, 2014, the statutory minimums remain the same, but the maximum earnings are always \$435. So as long as the applicant's wage is sufficient, his or her permanent disability rate is \$290, regardless of the percentage of partial permanent disability.

In conjunction with other changes in the way permanent disability is calculated, these increased weekly rates result in a significant increase in permanent disability benefits.

## COMMENCEMENT OF PERMANENT DISABILITY PAYMENTS

Generally, LC 4650(b) provides that if an injury causes permanent disability, the first payment must be made within 14 days after the date of the last payment of temporary disability. (For a full discussion of the general process, see [“Sullivan on Comp” Section 10.62 Payment of Permanent Disability Indemnity](#).) The employer is required to continue these payments until its reasonable estimate of permanent disability indemnity due has been paid, and if that amount has been determined, until it has been paid.

Even before SB 863, an employer was required to commence payments following the termination of TD.<sup>3</sup> Nevertheless, in *Brower v. David Jones Construction*,<sup>4</sup> the appeals board concluded *en banc* that LC 4650 requires an employer to pay permanent disability indemnity to an employee who might be temporarily disabled, but is not entitled to receive TD based on the statutory TD limits defined in LC 4656(c) (see [“Sullivan on Comp” Section 9.14 Time Limits on Payments on or After April 19, 2004](#)). The board explained that because an employee's level of permanent disability cannot be determined until he or she reaches maximum medical improvement and no longer is temporarily disabled, an employer paying permanent disability indemnity to a temporarily disabled employee is required to pay a reasonable estimate.<sup>5</sup>

## Permanent Disability Delayed for Offer of Work or Return to Work

Effective Jan. 1, 2013, LC 4650(b) was amended to provide that a worker is not entitled automatically to permanent disability indemnity benefits following the last payment of temporary disability. Per LC 4650(b)(2), “Prior to an award of permanent disability indemnity, a permanent disability indemnity payment shall not be required if the employer has offered the employee a position that pays at least 85 percent of the wages and compensation paid to the employee at the time of injury or if the employee is employed in a position that pays at least 100 percent of the wages and compensation paid to the employee at the time of injury.”

So permanent disability payments need not be made if (1) the employer makes the offer of a position that pays at least 85 percent of “wages and compensation,” or (2) the applicant is working at the time the payment

<sup>3</sup> See *Fresno Unified School District v. WCAB (Barajas)* (2012) 77 CCC 566 (writ denied); *Ayer v. WCAB* (1993) 58 CCC 483 (Court of Appeal opinion unpublished in official reports).

<sup>4</sup> (2014) 79 CCC 550 (appeals board *en banc*).

<sup>5</sup> *Brower v. David Jones Construction* (2014) 79 CCC 550 (appeals board *en banc*).

is owed and making what he or she did at the time of injury. Because the language in the first scenario says that only an offer is required, it seems that the employer may delay the payment of permanent disability even if the employee does not accept it. It is unclear how long the employee has to accept the offer. Also, it would seem that the employer may delay to the point of an award regardless of whether the applicant accepts the offer, whether it's for work that is undesirable or even whether it's accepted and the employment ultimately does not work out. There is a money requirement, but no longevity is demanded statutorily.

## Application of New Standard

Section 84 of SB 863 states that its changes, which would include this new rule, apply to all dates of injury as of Jan. 1, 2013 (see [“Sullivan on Comp” Section 1.4 Development of Law](#)). The appeals board, however, has concluded that although LC 4650(b)(3) applies to all dates of injury, it applies only if the injured worker becomes permanent and stationary after Jan. 1, 2013.<sup>6</sup>

Also in one case, the appeals board held that LC 4650(b)(2) did not apply if the employer offered the applicant a position he could not accept. In that case, an applicant was injured while working as a state prison inmate, and the prison offered him work after he was released from incarceration. The appeals board concluded that the qualifying job offer did not preclude permanent disability advances under LC 4650 because the job required him to be re-incarcerated.<sup>7</sup>

## Other Issues

There are several other unsettled issues related to LC 4650(b)(2). There is no clear guidance on what, exactly, the offer must look like. Must it be in writing, or is an oral offer sufficient? Presumably, the offer must be made in good faith. Certainly a written offer is easier to prove in court. Standards for written offers are required to avoid liability for a voucher<sup>8</sup> or a 15 percent increase under LC 4658,<sup>9</sup> and of course no employer wants to violate the FEHA requirements,<sup>10</sup> so employers should be motivated to provide solid offers of work.

Also, the employer is not required to commence permanent disability indemnity if the employee is working at a job that pays at least 100 percent of the wages and compensation at the time of injury. This is so even if that job is with another employer. It does not matter how long the applicant has been off work, or whether wage rates have changed over that time.

It is not clear, however, what happens if the applicant's employment situation changes before an award issues. Must the employer commence advances if circumstances change? Suppose an employed applicant is on permanent and stationary status, and initially is returned to his old job. Permanent disability advances are not made. Later, he becomes unemployed, or makes less money. Or he might be able to move in and out of a status in which he is entitled to weekly payments.

Understanding what, exactly, constitutes “wages and compensation” will be another challenge. What is included in that language and what is not? The courts probably will turn for guidance to the body of law on what may and may not be used to calculate the average weekly earnings for purposes of figuring indemnity benefits. The law is discussed in depth in [“Sullivan on Comp” Section 8.2 Benefits Included in Calculation of Average Weekly Earnings](#).

<sup>6</sup> See *Salles v. Valley State Prison*, 2015 Cal. Wrk. Comp. P.D. LEXIS 267. See also *Chase v. Contra Costa Mosquito & Vector Control District*, 2013 Cal. Wrk. Comp. P.D. LEXIS 101.

<sup>7</sup> *Santos v. California Department of Corrections & Rehabilitation*, 2014 Cal. Wrk. Comp. P.D. LEXIS 731.

<sup>8</sup> See sections commencing with [“Sullivan on Comp” Section 11.3 Supplemental Job Displacement Benefit — Injuries Before Jan. 1, 2013](#).

<sup>9</sup> See [“Sullivan on Comp” Section 11.6 Adjustment of Permanent Disability Payments for Offer of Work](#).

<sup>10</sup> See [“Sullivan on Comp” Chapter 11: Return To Work](#).

The payment of permanent disability is not required to be made in such return-to-work cases except on the issuance of an award. LC 4650(b) adds that “when an award of permanent disability is made, the amount then due shall be calculated from the last date for which temporary disability indemnity was paid, or the date the employee’s disability became permanent and stationary, whichever is earlier.” So, once the award issues, permanent disability is paid retroactively to the applicant’s last payment of temporary disability or permanent and stationary date, whichever is earlier.

It is quite common in workers’ compensation cases for an award to issue only after the parties have worked through the issues and settled the case. Because of LC 4650(b), a lump sum will be common when an employee has returned to work. This should have some broad effects.

Applicants who are in *proper* will be more motivated financially to consent to claims adjusters’ requests that they sign a stipulation. Sometimes PD advances can be a barrier to settlement, and this rule might help with that problem. Perhaps applicants will be more motivated to resolve cases more quickly if no payments are being made along the way.

## **ELIMINATION OF 15 PERCENT ADJUSTMENT FOR RETURN TO WORK**

LC 4658(d) contains an incentive program to return injured workers to their job, or to a modified or alternative position. LC 4658(d)(2) specifies that permanent disability benefits must be increased by 15 percent if the employer does not offer the injured employee regular, modified or alternative work within 60 days of the disability becoming permanent and stationary. Alternatively, LC 4658(d)(3) requires PD benefits to be decreased by 15 percent if the employer does offer the injured employee regular, modified or alternative work within 60 days of the disability becoming P&S. The only exception to the 15 percent increase defined by the statute is if the employer has fewer than 50 employees.<sup>11</sup> This rule is discussed in depth in [“Sullivan on Comp” Section 11.6 Adjustment of Permanent Disability Payments for Offer of Work.](#)

LC 4658(e), which applies to injuries occurring on or after Jan. 1, 2013, contains no provision allowing for an adjustment of permanent disability benefits based on the employer’s ability to return an injured employee to work. So the 15 percent permanent disability adjustment has been eliminated for injuries occurring on or after Jan. 1, 2013. This is a boon for employers because the finances usually worked against them, and because of the difficulties administering this part of the benefit.

## **THE 2013 PERMANENT DISABILITY SCHEDULE**

LC 4660.1 establishes the permanent disability schedule for injuries occurring on or after Jan. 1, 2013. The 2013 Schedule is similar to, but fundamentally different from, its predecessor. Under LC 4660.1, only three components are used to determine an employee’s permanent disability: (1) the nature of the physical injury or disfigurement; (2) the occupation of the injured employee; and (3) the employee’s age at the time of injury.

The 2013 Schedule expressly applies in determining the percentages of permanent partial and permanent total disability. More significant, LC 4660.1(c) provides that “there shall be no increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, arising out of a compensable physical injury.”

## **Components of Rating**

Like the 2005 Schedule, the 2013 Schedule under LC 4660.1(b) requires the “nature of the physical injury or disfigurement” to incorporate “the descriptions and measurements of physical impairment and the

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<sup>11</sup> *Granite Construction, Inc. v. WCAB (Black)* (2009) 74 CCC 1507 (writ denied).

corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition).” The AMA guides express disability in terms of whole person impairment (WPI). The impairment is no longer adjusted for future earning capacity as in the 2005 PD schedule.<sup>12</sup> Instead, the WPI value is multiplied by an adjustment factor of 1.4, which is equal to the maximum adjustment under the 2005 PD schedule, increasing the employee’s disability by 40 percent. The disability is adjusted further by the employee’s occupation and age at the time of injury.

Until the schedule of age and occupational modifiers is amended for injuries occurring on or after Jan. 1, 2013, permanent disability will be rated using the age and occupational modifiers in the 2005 Schedule. Those modifiers are described in depth in [“Sullivan on Comp” Section 10.15 Use of 2005 Permanent Disability Schedule](#). The process at this time for rating permanent disability for dates of injury on or after Jan. 1, 2013, is:

1. Determine the impairment percentage under the AMA guides.
2. Multiply the percentage by 1.4 (or increase by 40 percent).
3. Modify the percentage using the age and occupational tables of the 2005 Schedule.

The 40 percent adjustment has the potential to increase a permanent disability award significantly. For example, in one case, the appeals board rescinded an award of 97 percent PD, and awarded permanent total disability when the WCJ erroneously calculated the applicant’s permanent disability as if the injury had occurred in 2011, rather than using the 2013 DFEC multiplier of 1.4 that was applicable to all injuries on or after Jan. 1, 2013.<sup>13</sup>

The roles of the various parties in the rating process, including raters, doctors, lawyers and judges, were discussed in the seminal *en banc* decision of *Blackledge v. Bank of America*.<sup>14</sup> There appears to be no reason to think that the roles of the parties in the rating process have changed.

### **Schedule Applies to Both Permanent Partial and Permanent Total Disability**

Per LC 4660.1(a), the 2013 Schedule must be used “[i]n determining the percentages of permanent partial or permanent total disability.” This change eliminates any interpretation that the 2013 Schedule applies only to cases of permanent partial disability, and not to cases of permanent total disability.

Why is this important? As discussed in [“Sullivan on Comp” Section 10.19 Rebutting Schedule Under Ogilvie](#), some cases have held that the 2005 Schedule adopted under LC 4660 applies only to permanent partial disability. Those cases reasoned that because LC 4660 is used for determining “the percentages of permanent disability,” and LC 4662 allows the appeals board to determine permanent total disability “in accordance with the fact,” LC 4660 applies only to cases involving permanent partial disability, and that LC 4662 applies to cases involving permanent total disability.<sup>15</sup> This argument is made by some applicants to assert that they are not confined to using the schedule for cases in which total permanent disability is proposed.

Because LC 4660.1(a) provides that the new schedule applies in cases of both permanent partial and permanent total disability, the appeals board may not simply reject the use of the 2013 Schedule to find permanent total disability based on the amorphous standards of LC 4662. But this doesn’t mean that LC 4662 is invalidated in cases in which there is a valid conclusive presumption of total permanent disability. LC

<sup>12</sup> Prior to SB 863, the FEC adjustment ranged from 1.1 to 1.4.

<sup>13</sup> *Robles v. State of California, Department of Corrections & Rehabilitation*, 2015 Cal. Wrk. Comp. P.D. LEXIS 697.

<sup>14</sup> (2010) 75 CCC 613 (appeals board *en banc*).

<sup>15</sup> See e.g., *Edwards v. Caltrans*, 2011 Cal. Wrk. Comp. P.D. LEXIS 429; *Cordova v. Garaventa Enterprises*, 2011 Cal. Wrk. Comp. P.D. LEXIS 523; *Coca-Cola Enterprises, Inc./Coca Cola Bottling Co. v. WCAB (Jaramillo)* (2012) 77 CCC 445 (writ denied).

4660.1(g) states that “Nothing in this section shall preclude a finding of permanent total disability in accordance with Section 4662.”

## **ELIMINATION OF ADD-ON FOR SLEEP DYSFUNCTION, SEXUAL DYSFUNCTION AND PSYCHIATRIC DISORDER**

LC 4660.1(c)(1) states that “there shall be no increases in impairment rating for sleep dysfunction, sexual dysfunction, and compensable psychiatric disorder, or any combination thereof, arising out of a compensable physical injury.” So workers injured on or after Jan. 1, 2013, are generally no longer allowed to add permanent disability for sleep dysfunction, sexual dysfunction and/or a psychiatric disorder that flows from a physical injury.

LC 4660.1(c)(1) was adopted because following the enactment of SB 899 and the 2005 Schedule, applicant attorneys often reacted to the reduction in permanent disability by adding claims of sleep dysfunction, sexual dysfunction and psychiatric disorder in order to increase the permanent disability of injured workers. Section 1 of SB 863 explains that “in enacting subdivision (c) of Section 4660.1 of the Labor Code, the Legislature intends to eliminate questionable claims of disability when alleged to be caused by a disabling physical injury arising out of and in the course of employment.” So it was enacted in recognition that claims of sleep dysfunction, sexual dysfunction and/or a psychiatric disorder arising out of a physical injury are frequently dubious.

But LC 4660.1(c) precludes adding on only permanent disability; it does not preclude an injured employee from receiving other benefits such as medical treatment or temporary disability arising from such conditions. And there are exceptions to this prohibition for psychiatric disorders arising out of violent acts and for catastrophic injuries.

### **Sleep Dysfunction, Sexual Dysfunction and Compensable Psychiatric Disorder Prohibited Only If Arising Out of Physical Injury**

Per the terms of LC 4660.1(c), add-on claims of permanent disability are prohibited only when they arise out of a compensable “physical” injury. Psychological, sleeping or sexual issues can result in permanent disability if they stand on their own — if these conditions arose, for example, from harassment at work. Such conditions also may result in permanent disability if the physical injury is a consequence of one of them — if the harassment, for example, aggravated a high blood pressure condition (hypertension).

What constitutes a compensable physical injury, however, may be debatable. It probably will include orthopedic injuries. But will it include such things as rheumatological claims? These issues probably will need to be clarified by the courts. For further discussion on the case law pertaining to the distinction between psychological and physical injuries, see [“Sullivan on Comp” Section 5.29 Psychiatric Injury — In General](#).

In one case, the appeals board held that an applicant’s claim for sexual dysfunction was not barred by LC 4660.1(c)(1) when he suffered erectile dysfunction as a result of surgery to remove his prostate to treat his industrial prostate cancer. The board found that LC 4660.1(c)(1) was intended to eliminate questionable claims of disability but did not preclude consideration of such impairments when they are directly related to the injury as opposed to being considered a consequence. It found that an injury to the prostate, in terms of sexual dysfunction, could not be considered compensatory.<sup>16</sup> For further discussion of compensable consequence injuries, see [“Sullivan on Comp” Section 5.65 Compensable Consequence Injuries](#).

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<sup>16</sup> *City of Los Angeles v. WCAB (Montenegro)* (2016) 81 CCC 611 (writ denied).

## Prohibition Does Not Apply to Other Benefits

It is clear that LC 4660.1(c) contains a prohibition against permanent disability only. LC 4660.1(c)(1) specifically allows an employee to receive medical treatment for these conditions. It states, “Nothing in this section shall limit the ability of an injured employee to obtain treatment for sleep dysfunction, sexual dysfunction, or psychiatric disorder, if any, that are a consequence of an industrial injury.” Nothing is said about prohibiting other benefits, such as temporary disability, so they aren’t.

For example, in one case, an applicant sustained two injuries in 2014, and both injuries were amended in 2015 to include a claim of injury to the psyche. The applicant had been evaluated by an orthopedic AME, and petitioned for assignment of an additional panel in psychiatry. The defendant challenged the request for that panel, asserting that under LC 4660.1(c)(1), a medical-legal evaluation in the specialty was inappropriate. The appeals board, however, explained that the fact that permanent psychiatric impairment was not available to the applicant did not deprive her of the potential right to medical care or temporary disability indemnity on a psychiatric basis.<sup>17</sup>

Moreover, this prohibition does not appear to alter any rules regarding causation. For example, under LC 3208.3, a psychiatric injury is compensable if the actual events of employment were predominant as to all causes combined, and an employee’s precipitating physical injury may constitute an actual event of employment within the meaning of LC 3208.3.<sup>18</sup> So the physical injury still may be used to establish causation of the psychiatric injury for the purposes of TD and medical treatment, even though an employee would not be allowed to increase his or her PD as a result of the psychiatric injury.

## Exceptions

LC 4660.1(c) establishes two exceptions to the rule that permanent disability may not be increased for a psychiatric disorder arising out of a physical injury. LC 4660.1(c)(2)(A) provides that a compensable psychiatric disorder may increase the impairment rating if it “resulted from being a victim of a violent act or from direct exposure to a significant violent act within the meaning of Section 3208.3.” This language mirrors that of LC 3208.3(b)(2), which states that the “predominant cause” standard required for compensability of psychiatric claims is lowered to a “substantial cause” standard when this sort of violence occurs. For further discussion of the predominant cause requirement, see [“Sullivan on Comp” Section 5.30 Psychiatric Injury — Predominant Cause and Actual Events of Employment](#).

Another exception is laid out in LC 4660.1(c)(2)(B), which allows for an increase to the permanent disability rating in cases of “catastrophic injury, including, but not limited to, loss of a limb, paralysis, severe burn, or severe head injury.” The term “catastrophic injury” appears nowhere in the Labor Code or the regulations, with the singular and unhelpful exception being CCR 9767.9; that regulation simply mentions the term in association with the “serious and chronic condition” exception that applies in cases in which care is transferred into a medical provider network (for a full discussion, see [“Sullivan on Comp” Section 7.57 Medical Provider Network — Transfer of Care](#)).

Note that only a psychiatric disorder resulting from a violent act or catastrophic injury may be excepted from the rule precluding increased permanent disability. LC 4660.1(c)(2) contains no similar exceptions for sleep dysfunction or sexual dysfunction. So it may be that even if a sleep dysfunction or sexual dysfunction arises out of a violent act or catastrophic injury, it could not be added to the injured worker’s permanent disability. But if a sleep disorder or sexual dysfunction were part and parcel of a psychiatric disorder, it is unclear how this issue will be resolved.

<sup>17</sup> *Hernandez v. Fremont Bank*, 2015 Cal. Wrk. Comp. P.D. LEXIS 470.

<sup>18</sup> *Lockheed Martin v. WCAB (McCullough)* (2002) 67 CCC 245.



## Application of Exceptions

So far, there has been little case law interpreting the exceptions defined in LC 4660.1(c)(2). We may look to the exceptions to the two-year restriction on temporary disability; LC 4656(c)(3) (discussed in full in [“Sullivan on Comp” Section 9.14 Time Limits on Payments on or After April 19, 2004](#)) does list severe burns, so the case law there probably will coincide. It also lists an exception for amputations, but LC 4660.1(c)(2)(B) specifies that a loss of a limb qualifies, not amputation alone. So, by itself, amputation may be insufficient.

In one case, the appeals board held that an applicant’s psychiatric injury from being struck by a car while walking through a parking lot Feb. 21, 2013, was compensable because the injury resulted from a violent act in accordance with LC 4660.1(c). The board rejected the defendant’s argument that a “violent act” was an act of criminal or quasi-criminal violence. It explained that although the Labor Code does not define a violent act, it believed that had the Legislature intended to limit a violent act to criminal or quasi-criminal conduct, it would have included such language in the statute. The board held that a violent act is not limited solely to criminal or quasi-criminal activity, and may include other acts characterized by either strong physical force, extreme or intense force or are vehemently or passionately threatening. Because the evidence established that the applicant was hit by a car from behind with enough force to cause her to fall, hit her head and lose consciousness, the appeals board concluded that the circumstances constituted a violent act.<sup>19</sup>

## Rating of Psychiatric Injuries

As discussed in [“Sullivan on Comp” Section 10.15 Use of 2005 Permanent Disability Schedule, the 2005 Schedule](#) does not use the AMA guides for evaluating psychiatric impairments because they do not provide a WPI for any non-neurologically based psychiatric impairment. Instead, the AMA guides state, “Percentages are not provided to estimate mental impairment in this edition of the *Guides*.”<sup>20</sup> So under the 2005 Schedule, psychiatric impairments are evaluated using the Global Assessment of Functioning (GAF) scale.

Although LC 4660.1 adopts the age and occupational modifiers of the 2005 Schedule until the administrative director generates new modifiers for injuries occurring on or after Jan. 1, 2013, it does not specifically adopt any other portions of the 2005 Schedule. SB 863, however, also did not change the method for rating psychiatric disabilities. So psychiatric orders that fall outside of LC 4660.1(c) are still rated using the GAF scale.

## REBUTTING THE NEW SCHEDULE

Per LC 4660.1(d), “The Schedule for Rating Permanent Disability pursuant to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) and the schedule of occupational modifiers ... shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.” This language has long been interpreted to mean that a permanent disability rating based on the schedule is rebuttable.<sup>21</sup> So the new schedule for injuries on or after Jan. 1, 2013, still will be rebuttable.

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<sup>19</sup> *Larsen v. Securitas Security Services* (2016) 81 CCC 770 (panel decision).

<sup>20</sup> American Medical Association *Guides to the Evaluation of Permanent Impairment* (5th ed.) (2002), p. 361.

<sup>21</sup> See *Universal City Studios, Inc. v. WCAB (Lewis)* (1979) 44 CCC 1133, 1143; *Glass v. WCAB* (1980) 45 CCC 441, 449.

## Rebutting 2013 Schedule Under Almaraz/Guzman

LC 4660.1(h) specifically states that “In enacting the act adding this section, it is not the intent of the Legislature to overrule the holding in *Milpitas Unified School District v. Workers’ Comp. Appeals Bd. (Guzman)* (2010) 187 Cal.App.4th 808.” So SB 863 left undisturbed the *Almaraz/Guzman* cases, which allow the “nature of the physical injury or disfigurement” under the AMA guides to be rebutted by evidence within the “four corners” of the guides.

Accordingly, rebuttal of the first part of the rating string — the assessment of the basic impairment caused by the injury — remains unchanged. Under the *Almaraz/Guzman* cases, a physician may utilize any chapter, table or method in the guides to assess an injured worker’s whole person impairment, provided that his or her opinion is supported by substantial evidence. So the *Almaraz/Guzman* cases will remain in effect. For a detailed discussion on *Almaraz/Guzman*, see Section 10.18 Rebutting Schedule Under Almaraz/Guzman.

## Rebutting 2013 Schedule Under Ogilvie

In contrast, it appears that the method to rebut the schedule outlined in *Ogilvie v. WCAB*<sup>22</sup> is no longer available for injuries on or after Jan. 1, 2013. In *Ogilvie*, the Court of Appeal upheld the ruling in *LeBoeuf* that an employee effectively rebuts the scheduled rating when he or she will have an overall greater loss of future earnings than reflected in a rating because, due to the industrial injury, he or she is not amenable to rehabilitation. But there are problems with applying *Ogilvie* to injuries occurring on or after Jan. 1, 2013.

*Ogilvie* noted that there was no meaningful difference between the terms “diminished future earning capacity” and “ability to compete in an open labor market,” and held that the 2005 Schedule may be rebutted by showing that the employee is not amenable to rehabilitation and therefore has suffered a greater loss of future earning capacity than reflected in the scheduled rating. But unlike LC 4660, which considers “diminished future earning capacity,” or former LC 4660, which considered the ability to “compete in an open labor market,” no such considerations are given under LC 4660.1.

In fact, the history of SB 863 states that it “[e]liminates the diminished future earning capacity from the determination of permanent disability, and limits the definition of permanent disability to include only a consideration of how age and occupation affects [sic] the overall classification of employment of the injured workers’ ability to compete in the open labor market or reduction of future earnings.”<sup>23</sup> So the 2013 Schedule cannot be rebutted simply by showing a greater loss of future earnings than reflected in a rating or an inability to return to the open labor market.

As discussed above, in most circumstances, increasing permanent disability based on add-ons such as psyche, sleep or sex disorders is prohibited (LC 4660.1(c)(1)). What if the employee is unable to return to the open labor market as a result of his or her physical injury in addition to a psychological disorder and sleep disorder flowing from the physical injury? Because, in most cases, LC 4660.1(c) prohibits increasing permanent disability for a psychological, sleep or sex disorder, it is unlikely that such an employee would be entitled to an award of permanent total disability. Just as *Ogilvie* concluded that *LeBoeuf* applies only if the employee’s diminished future earnings are attributable directly to the work-related injury, and not to nonindustrial factors such as general economic conditions, illiteracy, lack of English and lack of education, it may be that if *LeBoeuf* applies, it applies only to injuries occurring on or after Jan. 1, 2013, if the employee’s disability is directly related to the physical injury, and not the psyche, sleep or sex disorder.

<sup>22</sup> (2011) 76 CCC 624.

<sup>23</sup> Bill analysis, third reading of SB 863 as amended Aug. 30, 2012, section 28.

Moreover, as discussed in Chapter III: Return-to-Work Program, the Legislature enacted LC 139.48 to create a return-to-work-program for employees “whose permanent disability benefits are disproportionately low in comparison to their earnings loss.” Employees who have a greater loss of future earnings than reflected in a rating or an inability to return to the open labor market may seek a remedy under LC 139.48 rather than against the employer. So although this issue has not been clarified by the courts, it is unlikely that *Ogilvie* can be applied for injuries occurring on or after Jan. 1, 2013. For a detailed discussion on *Ogilvie*, see Section 10.19 Rebutting Schedule Under *Ogilvie*.

## 2. SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

The supplemental job displacement benefit (SJDB) has been available since Jan. 1, 2004. It replaced the vocational rehabilitation benefit. The benefit comes in the form of a nontransferable voucher, and often is referred to by practitioners simply as the “voucher.” But the benefit was not widely used because the trigger for it occurred far too late in the process. Specifically, employers were required to provide the voucher within 25 calendar days from the issuance of the permanent partial disability award by a WCJ or the appeals board. So rather than use the voucher for retraining as intended, the benefit commonly was settled as part of a compromise and release because there was no statutory language precluding settlement of the voucher.

SB 863 sought to reform the voucher to make its promise of retraining more viable. A few changes were made to the rules regarding vouchers for injuries before 2013. Specifically, for injuries before Jan. 1, 2013, per LC 4658.5(d), a voucher issued on or after Jan. 1, 2013, expires two years after the date the voucher is furnished to the employee or five years after the date of injury, whichever is later. SB 863 also added LC 4658.5(e), which states that an employer is not liable for compensation for injuries incurred by the employee while using the voucher. For further discussion of the voucher for injuries before Jan. 1, 2013, see [“Sullivan on Comp” Section 11.3 Supplemental Job Displacement Benefit — Injuries Before Jan. 1, 2013.](#)

LC 4658.7 was adopted and significant changes were made for injuries occurring on or after Jan. 1, 2013. SB 863 changed the conditions under which an employee is eligible for the voucher and the time when the employer must provide it as well as its amount. It expanded the goods and services for which the voucher may be used, and simultaneously placed restrictions on perceived abuses of it. And SB 863 eliminated the ability of the parties to settle an injured worker’s entitlement to the voucher, although the courts have crafted a limited exception to this rule. For a complete discussion of the voucher for injuries on or after Jan. 1, 2013, see [“Sullivan on Comp” Section 11.4 Supplemental Job Displacement Benefit — Injuries on or After Jan. 1, 2013.](#)

Administrative regulations have been adopted to implement the changes by SB 863. The WCIRB reports that as a result of the changes, use of the supplemental job displacement benefit has increased. Some of this growth is driven by an increase in the average SJDB payment. Some of it is the result of the \$120 million return-to-work fund created by SB 863, which makes eligibility for the return-to-work supplement the same as eligibility for the SJDB voucher.<sup>1</sup> For further discussion of the return-to-work supplement, see Chapter III.

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<sup>1</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), pps. 7-8.

## ELIGIBILITY FOR VOUCHER

The conditions under which an injured worker is eligible for the voucher for dates of injury after Jan. 1, 2013, are established in LC 4658.7(b), CCR 10133.31 and CCR 10133.34. A permanently partially disabled worker is entitled to the voucher unless the employer makes an offer of regular, modified or alternative work, per CCR 10133.34, no later than 60 days after receipt by the claims administrator of the physician's return-to-work & voucher report (form DWC-AD 10133.36) indicating the work capacities and activity restrictions relevant to regular work, modified work or alternative work (CCR 10133.31(b)). The offer of work also must be for employment lasting at least 12 months (CCR 10133.34(b)(3)).

Unlike for injuries before Jan. 1, 2013, LC 4658.7(b) allows the employer to offer regular work, in addition to modified or alternative work. LC 4658.1 defines "regular work" as the employee's usual occupation or the position in which he or she was engaged at the time of injury, and offers wages and compensation equivalent to those paid to the employee at the time of injury. "Modified work" is "regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury,..." "Alternative work" is "work that the employee has the ability to perform, that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury,..."

All forms of work must be located within reasonable commuting distance of the employee's residence at the time of injury, unless the employee waives this condition. It will be deemed waived if the employee accepts the regular, modified or alternative work and does not object to the location within 20 days of being informed of the right to object. The condition will be deemed conclusively to be satisfied if the offered work is at the same location and the same shift as the employment at the time of injury (CCR 10133.34(b)(2)).

LC 4658.7(b) changes the conditions that trigger an employer's duty to offer regular, modified or alternative work. In contrast to injuries before Jan. 1, 2013, for which an employer must offer work within 30 days of the termination of temporary disability, for later injuries, the employer has 60 days to offer work following receipt of a report from a PTP, AME or QME finding that the disability from all conditions for which compensation is claimed has become permanent and stationary, and that the injury has caused permanent partial disability. "Receipt" is defined as "the date of actual receipt by electronic delivery, personal service, or five days after the date of deposit in the United States mail" (CCR 10116.9(o)). So the mailbox rule applies to reports sent by mail (see ["Sullivan on Comp" Section 15.15 Service of Documents](#)).

The employer is required to make an offer of regular, modified or alternative work on a specific form — the notice of offer of regular, modified or alternative work for injuries occurring on or after Jan. 1, 2013 (form DWC-AD 10133.35). The statute also requires that the medical report that precipitates the offer must include a specific form created by the administrative director — the physician's return-to-work & voucher report (form DWC-AD 10133.36). The duty to determine whether regular, modified or alternative work is available is not triggered (at least for purposes of the voucher) until the employer receives this form notifying it that the applicant is permanent and stationary for all injuries. Per LC 4658.7(h)(2), the form is required to fully inform "the employer of work capacities and of activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work." This is intended to make it easier for an employer to perform the return-to-work analysis and understand the injured worker's work capacities so that it can make an informed decision. On receipt of the form, the claims examiner is required to forward it to the employer (CCR 10133.31(b)(1)).

If the applicant is timely given a return-to-work offer but is unable to return to work due to other nonindustrial medical conditions, the employer would not be liable for the voucher.<sup>2</sup>

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<sup>2</sup> See *Taro v. Atascadero State Hospital, Department of Mental Health*, 2014 Cal. Wrk. Comp. P.D. LEXIS 82.

### OPTIONAL JOB DESCRIPTION

Under LC 4658.7(b)(1)(A), the employer or claims adjuster has the option of providing the physician with a job description “of the employee’s regular work, proposed modified work, or proposed alternative work.” The form for describing the employee’s job duties is established in CCR 10133.33. The form must be completed jointly by the employer and employee.

If such a form is provided, the physician is to “evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description.” The physician is required to complete the bottom portion of form DWC-AD 10133.36 (CCR 10133.31(b)(2)). Under LC 4658.7(b)(1)(B), the claims adjuster is to send the form to the employer “for the purpose of fully informing the employer of work capacities and activity restrictions resulting from the injury that are relevant to potential regular, modified, or alternative work.” So this process dovetails with the interactive process.

### EXCEPTIONS TO PROVISION OF VOUCHER

LC 4658.7 does not provide any exceptions to provision of the voucher when the employer does not timely make an offer of work. But, per CCR 10133.31(c), “An employee who has lost no time from work or has returned to the same job for the same employer, is deemed to have been offered and accepted regular work in accordance with the criteria set forth in Labor Code section 4658.7(b).” This provision was added to clarify that if an applicant loses no time from work or returns to his or her regular job, no return-to-work offer is required.<sup>3</sup> That is, if an employer fails to make an offer on the appropriate form of regular, modified or alternative work, it is not required to provide a voucher if the applicant has lost no time from work or has returned to work for the same employer.

Also, in one case, the appeals board held that an applicant was not entitled to a voucher when he was terminated for cause (threatening violence to a co-worker) while on modified duty. The board found no case law indicating that an employer must rehire an employee who was terminated for cause, or in the alternative, provide supplemental job displacement benefits to such an employee. It found that because the employer provided substantial periods of modified work, such work would have continued if the applicant hadn’t threatened his co-worker, resulting in the applicant’s termination. It added that per CCR 10133.54, the applicant was required to request that the administrative director resolve the dispute, and he did not pursue or exhaust this administrative remedy.<sup>4</sup>

### OFFER OF WORK TO EMPLOYEE WHO MAY NOT WORK LAWFULLY

Former CCR 10133.34(b)(4) stated, “When the employer offers regular, modified or alternative work to the employee that meets the conditions of this section and subsequently learns that the employee cannot lawfully perform regular, modified or alternative work, the employer is not required to provide the regular, modified or alternative work.” This language, however, was eliminated effective Jan. 1, 2014.

What remains an issue is whether, for the purposes of avoiding the voucher, an employer must offer regular, modified or alternative work to an employee who may not lawfully work. The Court of Appeal has held that an illegal immigrant is not entitled to vocational rehabilitation benefits when the individual is unable to return to work solely because of immigration status, rather than because of an industrial injury (see [“Sullivan on Comp” Section 4.21 Aliens](#)).<sup>5</sup> Furthermore, the California Supreme Court has held that SB 1818, which extends state law employee protections and remedies to all workers regardless of immigration

<sup>3</sup> Final Statement of Reasons (supplemental job displacement regulations, p. 4), available at [http://www.dir.ca.gov/DWC/DWCPropRegs/SJDB\\_Regs/SJDB\\_FSOR.pdf](http://www.dir.ca.gov/DWC/DWCPropRegs/SJDB_Regs/SJDB_FSOR.pdf).

<sup>4</sup> *Barcenas v. Ramco Enterprises*, 2015 Cal. Wrk. Comp. P.D. LEXIS 91.

<sup>5</sup> *Del Taco v. WCAB (Gutierrez)* (2000) 65 CCC 342.

status, is pre-empted by federal immigration law to the extent it authorizes an award of lost pay damages for any period after the employer's discovery of an employee's ineligibility to work in the United States.<sup>6</sup>

So, if an employer discovers that the employee is an illegal immigrant, it might be sufficient to issue a notice of offer of regular, modified or alternative Work (form DWC-AD 10133.35), but simultaneously notify the employee that he or she may not accept the position due to his or her illegal status.

## OFFER OF WORK TO SEASONAL EMPLOYEE

CCR 10133.34(b)(4) establishes the requirements for an offer of regular, modified or alternative work for a seasonal worker. Seasonal work means employment as a daily hire, a project hire or an annual season hire (CCR 10116.9(q)). The offer must reflect that:

- A. The employee was hired for seasonal work prior to injury.
- B. The offer of regular, modified or alternative seasonal work is of reasonably comparable hours and working conditions to the employee's previous employment, and the one-year requirement may be satisfied by cumulative periods of seasonal work.
- C. The work must commence within 12 months of the date of the offer. And
- D. The offer meets the other conditions required for regular, modified or alternative work.

## ISSUANCE AND AMOUNT OF VOUCHER

LC 4658.7(c) and CCR 10133.31(d) require an employer to offer an injured worker the supplemental job displacement nontransferable voucher for injuries occurring on or after Jan. 1, 2013, within 20 days after the window for making an offer of regular, modified or alternative work. So if the employer cannot offer the employee work within the 60-day period, it has 20 days to offer the voucher. The appropriate form for the voucher is form DWC-AD 10133.32.

LC 4658.7(d) and CCR 10133.31(e) provide that the voucher may be redeemed for as much as an aggregate \$6,000. For injuries occurring before Jan. 1, 2013, the amount varied from \$4,000 to \$10,000, depending on the level of disability. For injuries on or after Jan. 1, 2013, all permanently partially disabled workers who are not timely returned to work are entitled to the same \$6,000 for the voucher.

Until the administrative director amends the voucher form (form DWC-AD 10133.32) to include notice of the return-to-work supplement application process, employers have a duty to provide injured workers who receive the voucher with notice of the return-to-work supplement established under LC 139.48. CCR 17303 requires all vouchers issued to be accompanied by a cover sheet, prepared by the claims administrator, with this notice: "Because you have received this Voucher and are unable to return to your usual employment you may be eligible for a Return-to-Work Supplement. You must apply within one year from the date this Voucher was served on you. You should make a copy of the Voucher which you will need to apply for the Return-to-Work Supplement. Details about the Return-to-Work supplement program are available from the Department of Industrial Relations on its web site, [www.dir.ca.gov](http://www.dir.ca.gov), or by calling 510-286-0787." The return-to-work program is discussed further in Chapter III: Return-to-Work Program.

It's not clear whether an employer is required to issue multiple vouchers if an employee has sustained multiple injuries, and nothing in LC 4658.7 speaks to this. For injuries prior to Jan. 1, 2013, the appeals board has held that an employee is entitled to multiple vouchers if he or she sustains multiple injuries.<sup>7</sup>

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<sup>6</sup> *Salas v. Sierra Chemical Co.* (2014) 79 CCC 782.

<sup>7</sup> *Silva v. LSG Sky Chefs*, 2015 Cal. Wrk. Comp. P.D. LEXIS 405.

## USE OF VOUCHER

LC 4658.7(e) expands the expenses for which the voucher may be used. The uses also are outlined in CCR 10133.31(f). A voucher may be applied to:

1. payment for education-related retraining or skill enhancement, or both, at a California public school or with a provider that is certified and on the state's Eligible Training Provider List (ETPL) at <http://etpl.edd.ca.gov>, including payment of tuition, fees, books and other expenses required by the school for retraining or skill enhancement;
2. payment for occupational licensing or professional certification fees, related examination fees and examination preparation course fees;
3. payment for the services of licensed placement agencies, vocational or return-to-work counseling and resume preparation, for a combined limit of \$600;
4. purchase of tools required by a training or educational program in which the employee is enrolled;
5. purchase of computer equipment for as much as \$1,000 payable on submission of a request for purchase of computer equipment (page 4 of form DWC-AD 10133.32) and submitted with appropriate documentation of either a written invoice payable to a computer retailer or itemized receipts showing the purchase(s) of computer equipment. The employer also may give the employee the option to obtain a computer directly from the employer. Computer equipment includes, but is not limited to, monitors, software, networking devices, input devices such as a keyboard and mouse, peripherals such as printers and tablet computers. The employee is not entitled to reimbursement for the purchase of games or any entertainment media;
6. as much as \$500 for miscellaneous expense reimbursement or advance, payable on submission of a request for miscellaneous expenses (page 3 of form DWC-AD 10133.32) and without itemized documentation or accounting. If the employer provides an email address, the employee may submit the request via email or regular mail. The employee is not entitled to any other voucher payment for transportation, travel, telephone or Internet access, clothing, uniforms or incidental expenses.

The last provision may be especially significant. Use of the voucher has been quite rare since its inception. A \$500 incentive may pique interest, especially given the new ease of use. The \$1,000 for computer equipment no doubt will be quite a draw as well.

Per CCR 10133.31(j), the claims administrator must issue the voucher payments to the employee or issue direct payment to the VRTWC, training providers and/or computer retailer within 45 calendar days from receipt of the completed voucher, receipts and documentation. If computer equipment will be provided directly to the employee, the employer must provide it, along with documentation of the cost of the equipment, to the employee within 45 days of receipt of the request for purchase of computer equipment. The appeals board has held that for the purposes of penalties under LC 5814, no benefit or compensation can be determined until a reimbursement request has been made.<sup>8</sup>

## TIME LIMITS FOR USE OF VOUCHER

Time for use of the voucher is limited. Per LC 4658.7(f), it expires two years after the date it is furnished, or five years after the date of injury, whichever is later. A voucher is deemed "furnished" five days after the date of deposit in the U.S. mail or the date of personal service (CCR 10116.9(f)). In addition, an employee is not entitled to payment or reimbursement of any expenses that have not been incurred and submitted to the employer with appropriate documentation before the expiration date (CCR 10133.31(g)). So even if the

<sup>8</sup> *Powell v. Pride Industries, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 692.



employee timely incurred the expenses, the employer is not required to reimburse him or her if they were not timely submitted.

## **NO SETTLEMENT OR COMMUTATION OF VOUCHER**

LC 4658.7(g) and CCR 10133.31(h) preclude settlement or commutation of a claim for the supplemental job displacement benefit for injuries occurring on or after Jan. 1, 2013. So the benefit may be used only for the purposes outlined in the statute.

Nevertheless, the appeals board held that when the parties establish that there is a good-faith dispute that, if resolved against the applicant, would defeat his or her entitlement to all workers' compensation benefits, he or she may settle a claim by a compromise and release agreement that also settles the potential right to the supplemental job displacement benefit voucher. In that case, the settlement agreement included an addendum indicating that the applicant was not entitled to the voucher because the defendant asserted that he suffered no injuries as a result of his employment and that he failed to report the injury prior to termination. The WCJ, however, would not approve a release of the voucher.<sup>9</sup>

The board granted reconsideration and explained that an injured worker's entitlement to the voucher is conditioned on both the acceptance of liability for a claimed industrial injury by the employer and the existence of permanent partial disability, or a determination of these issues after trial. It added that when the trier of fact makes an express finding based on the record that a serious and good-faith issue exists to justify a release, a compromise and release agreement may be approved that will relieve the employer from liability for the voucher. The board found the existence of such a good-faith dispute over the applicant's entitlement to the voucher, and issued an order approving the settlement as presented.<sup>10</sup>

## **NO LIABILITY FOR INJURY WHILE USING VOUCHER**

Per LC 4658.7(i) and CCR 10133.31(i), an employer is not liable for compensation for injuries incurred by the employee while using the voucher. This subsection codifies the *Rodgers*<sup>11</sup> waiver that routinely was seen in settlements before the repeal of vocational rehabilitation.

## **DISPUTE RESOLUTION**

Per CCR 10133.54, when there is a dispute regarding the supplemental job displacement benefit, either the employee or the employer may request that the administrative director resolve it. The party requesting dispute resolution must:

1. complete a request for dispute resolution before the administrative director form (form DWC-AD 10133.55 (SJDB));
2. clearly state the issue(s) and identify supporting information for each issue and position;
3. attach all pertinent documents;
4. submit a copy of the request and all attached documents to the administrative director and serve a copy of the request and all attached documents on all parties; and
5. attach a signed and dated proof of service to form DWC-AD 10133.55 (SJDB).

The opposing party has 20 calendar days from the date of the proof of service of the request to submit the original response and all attached documents to the administrative director and serve a copy of the response

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<sup>9</sup> *Beltran v. Structural Steel Fabricators* (2016) 81 CCC 1224 (panel decision).

<sup>10</sup> *Beltran v. Structural Steel Fabricators* (2016) 81 CCC 1224 (panel decision).

<sup>11</sup> *Rodgers v. WCAB* (1985) 50 CCC 299.

and all attached documents on all parties. The administrative director or that official's designee may request additional information from the parties.

The administrative director or the designee is required to issue a written determination and order based solely on the request, response and any attached documents. The determination and order must be issued within 30 calendar days of the date the opposing party's response and supporting information are due. If additional information is requested, the written determination must be issued within 30 calendar days from the receipt of the additional information. In the event that no decision is issued within 60 calendar days of the date the opposing party's response is due or within 60 calendar days of the administrative director's receipt of the requested additional information, whichever is later, the request shall be deemed to be denied.

Following the receipt of the determination and order, either party may appeal by filing a written petition and a declaration of readiness to proceed within 20 calendar days of the issuance of the decision or within 20 days after a request is deemed denied because of the administrative director's failure to timely issue a decision. The petition must establish the factual and legal basis for the appeal (CCR 10208.11(a)). A copy of the petition must be served concurrently on the administrative director (CCR 10208.11(c)).

If an application for adjudication has been filed previously, the petition must be filed at the district office that has venue. The case number assigned to the application for adjudication will be assigned to the petition. If an application for adjudication has not been filed previously, an application must be filed with the petition, and venue shall be designated and determined in accordance with LC 5501.5 and CCR 10409 (CCR 10208.11(b)).

### **STATE-APPROVED OR ACCREDITED SCHOOL**

Private providers of education-related retraining or skill enhancement selected to provide training as part of a supplemental job displacement benefit, per CCR 10133.58, must meet certain requirements. For injuries between Jan. 1, 2004, and Dec. 31, 2012, private providers must be:

1. approved by the Bureau of Private Postsecondary Education and Vocational Education ([www.bppe.ca.gov](http://www.bppe.ca.gov)), or a California state agency that has an agreement with the bureau for the regulation and oversight of nondegree-granting postsecondary institutions;
2. accredited by one of the regional associations of schools and colleges authorized by the U.S. Department of Education; or
3. approved by a California state agency that has an agreement with the U.S. Department of Education or regional associations of schools and colleges for the regulation and oversight of nondegree-granting private postsecondary providers; or
4. certified by the Federal Aviation Administration.

For injuries after Jan. 1, 2013, private providers of education-related retraining or skill enhancement selected to provide training as part of a supplemental job displacement benefit must be certified and on the state's Eligible Training Provider List (ETPL) at [http://www.edd.ca.gov/Jobs\\_and\\_Training/Eligible\\_Training\\_Provider\\_List.htm](http://www.edd.ca.gov/Jobs_and_Training/Eligible_Training_Provider_List.htm).

### **VOCATIONAL AND RETURN-TO-WORK COUNSELORS**

Under CCR 10133.59, the administrative director is required to maintain a list of vocational and return-to-work counselors who perform the work of assisting injured employees. A VRTWC is a person or entity capable of assisting a person who has a disability by developing a return-to-work strategy and whose regular duties involve the evaluation, counseling and placement of disabled individuals. A VRTWC must have at

least an undergraduate degree in any field and three or more years of full-time experience in conducting vocational evaluations, counseling and the placement of disabled adults (CCR 10116.9(s)).

A VRTWC must apply to the administrative director to be included on the list. The list must be reviewed and revised on a yearly basis, and must be made available on the DIR website or on request. The list is available at: [http://www.dir.ca.gov/dwc/SJDB/VRTWC\\_list.pdf](http://www.dir.ca.gov/dwc/SJDB/VRTWC_list.pdf).

An injured employee may select a VRTWC whenever assistance is needed to facilitate vocational training or return to work in connection with the supplemental job displacement benefit. The injured employee is responsible for providing the VRTWC with any necessary medical reports. But the employer must provide a VRTWC with any medical reports, including permanent and stationary medical reports, on an employee's written request and a signed release waiver. The VRTWC is required to communicate with the injured employee regarding the evaluation.

## 3. RETURN-TO-WORK PROGRAM

In the final hours of negotiating SB 863, concerns remained that some injured workers would not receive adequate permanent disability. In an effort to close this perceived gap, it was agreed that a special fund would be created for these workers.

LC 139.48 was enacted, and a “return-to-work” program was created “for the purpose of making supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss.” Per LC 139.48(c), the return-to-work program applies only to injuries sustained on or after Jan. 1, 2013. This language was added in 2013 by SB 71.

The program is funded by employers to a total annual amount of \$120 million. Per LC 139.48, this money is to come from “non-General Funds of the Workers’ Compensation Administration Revolving Fund.” LC 139.48(a) adds, “Moneys shall remain available for use by the return-to-work program without respect to the fiscal year.”<sup>1</sup>

The return-to-work program is overseen and administered by the director of Industrial Relations, who was given authority to determine eligibility and the amount of payments. The director adopted CCR 17300 - CCR 17310 to implement the return-to-work supplement program.<sup>2</sup> The program went into effect April 13, 2015. Eligible employees receive a supplement to their workers’ compensation benefits directly from the Department of Industrial Relations. Employers have no involvement in the program outside of funding through the annual assessment.

### ELIGIBILITY FOR SUPPLEMENT

To be eligible for the return-to-work supplement, an injured worker must have received the supplemental job displacement benefit (SJDB) voucher for an injury occurring on or after Jan. 1, 2013 (CCR 17302(a)). So eligibility for the return-to-work supplement is the same as eligibility for the SJDB voucher. The voucher is discussed in Chapter II: Supplemental Job Displacement Benefit; it is a benefit issued by the employer to provide educational retraining or skills enhancement for injured employees whose employers are unable to provide work following an industrial injury.

An injured worker who has received a return-to-work supplement may not receive a second or subsequent supplement, except if he or she receives a voucher for an injury that occurs subsequent to receipt of every previous return-to-work supplement (CCR 17302(b)). So it seems that cases with multiple dates of injury will result in only one supplement.

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<sup>1</sup> This language was added in 2013 by SB 71.

<sup>2</sup> The program is based on the findings of studies done by RAND ([http://www.dir.ca.gov/chswc/Reports/2014/Earnings\\_Losses\\_2014.pdf](http://www.dir.ca.gov/chswc/Reports/2014/Earnings_Losses_2014.pdf)).

## **NOTICE OF SUPPLEMENT**

Until the administrative director amends the voucher form (DWC-AD 10133.32) to include notice of the return-to-work supplement application process, employers have a duty to provide injured workers who receive the voucher with notice of the supplement. CCR 17303 requires all vouchers issued to be accompanied by a cover sheet, prepared by the claims administrator, with this notice: “Because you have received this Voucher and are unable to return to your usual employment you may be eligible for a Return-to-Work Supplement. You must apply within one year from the date this Voucher was served on you. You should make a copy of the Voucher which you will need to apply for the Return-to-Work Supplement. Details about the Return-to-Work supplement program are available from the Department of Industrial Relations on its web site, [www.dir.ca.gov](http://www.dir.ca.gov), or by calling 510-286-0787.”

Because receipt of the voucher is the triggering event establishing eligibility of the return-to-work supplement, the Department of Industrial Relations determined that the most effective way to inform injured workers of the new benefit is to provide notice of their potential eligibility within the text of the voucher itself or as an attachment to it. So until the voucher form is amended, claims administrators must provide notice of the benefit through a cover sheet attached to the voucher.

What about injured workers whose cases are closed? The regulations establishing this program have come late in the day, almost 2 1/2 years after the cutoff for eligibility. So the Department of Industrial Relations must reach out to injured workers who have qualified for the benefit but who no longer directly interact with the system. It will publish on its website a notice targeted at eligible persons who received vouchers before the notice was included with them (CCR 17303).

## **TIME LIMIT FOR APPLICATION**

An application for the return-to-work supplement must be received within one year from the date the voucher was served on the individual or within one year from the effective date of the regulations, whichever is later (CCR 17304). Because receipt of the voucher is the triggering event for eligibility of the supplement, an injured worker generally must file an application for it within one year of receipt of the voucher. Some workers with injuries on or after Jan. 1, 2013, received the voucher before the date of the return-to-work supplement regulations. They may apply for the benefit within one year after the effective date of the regulations.

## **METHOD AND CONTENT OF APPLICATION**

Applications for the return-to-work supplement program must be available in English and Spanish (LC 124(b)). By Jan. 1, 2018, the applications also must be available in Chinese, Korean, Tagalog and Vietnamese (LC 124(c)).

An application must be submitted electronically through the Department of Industrial Relations website. The website will be accessible at each I&A office in the state (CCR 17305). The online application is available at <https://www.dir.ca.gov/rtwsp/rtwsp.html>.

One goal in developing the return-to-work supplement program is to keep administrative costs to a minimum and to avoid placing any additional burden on claims administrators. A fully electronic application process was deemed to be the most cost-effective and efficient. Because not all injured workers have internet access in their homes, the DIR set up access kiosks at I&A offices at all WCAB district offices.

The application must include a declaration under penalty of perjury that the information provided is true and correct, and: the individual's first name, last name and middle name; Social Security number or tax ID number; address; telephone number and email address, if available; and the ADJ number of any workers' compensation cases filed. The applicant also must submit a PDF or TIFF document of the voucher as an attachment to the application (CCR 17306). Because the regulations require an electronic copy of the voucher in certain formats, scanning facilities will be available at the access kiosks, and assistance with scanning will be available from I&A officers.

The application requires an applicant to indicate whether he or she is a California resident or not. Residency status is required as part of the DIR's internal practices and has no effect on eligibility for the supplement.

#### **PROCESSING OF APPLICATION AND PAYMENT OF SUPPLEMENT**

A decision on all completed and timely filed applications will be made within 60 days of receipt. Applications satisfying the requirements of the regulations will be approved. The decisions will be issued by mail or email, if available. The decision is a final decision of the director (CCR 17307.)

Each eligible worker who submits a timely and completed application will receive a supplement of \$5,000. Full payment in one sum will be made within 25 days of the date of the decision. Payment will be made directly to the injured worker and is not assignable before payment (CCR 17308).

The amount of the supplement may be adjusted based on further studies conducted by the director in accordance with LC 139.48 (CCR 17308). The \$5,000 amount was set in order to make it available to as many eligible injured workers as possible. To maximize distribution of funds, the director may adjust the amount of the supplement based on the number of individuals who apply for it.

#### **APPEAL OF DECISION**

If an injured worker is dissatisfied with any final decision of the director regarding an application for the return-to-work supplement, he or she has the right to appeal. CCR 17309 covers the appeal process. It provides that an injured worker's appeal initially must be filed at the district office of the WCAB.

The appeal must contain the name of the individual, the ADJ number of the case in which a voucher was provided and a clear and concise statement of the facts constituting the basis for the appeal. A copy of the appeal must be served on the Return-to-Work Program, 1515 Clay St., 17th Floor, Oakland, CA, 94612. Any appeal must be filed within 20 days of the service of the decision. Per CCR 10507, the mailbox rule applies to any decision issued by mail (see Section 15.15 Service of Documents).

In one case, the appeals board held that an *pro per* applicant timely appealed a decision regarding her application for the return-to-work supplement. A notice of benefit ineligibility was issued Oct. 15, 2015, and the applicant sent a letter to the Department of Industrial Relations (DIR) Oct. 27, 2015 appealing the decision. This was an error because the appeal must be filed with the local WCAB office. But the applicant also filed a petition for reconsideration Nov. 10, 2015. The appeals board noted that per CCR 17309, the last day to file an appeal of the ineligibility determination at the appeals board district office was Nov. 9, 2015. Because the applicant filed the appeal with the DIR Oct. 27, 2015, and because of the conflicting information on the DIR website regarding the procedure for appealing an ineligibility determination, the appeals board believed that the applicant should not be disadvantaged by the incorrect information she received about the appeals process.<sup>3</sup>

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<sup>3</sup> *Rodriguez v. North East Valley Health Corp/Quality Comp*, 2016 Cal. Wrk. Comp. P.D. LEXIS 5.

After an appeal has been timely filed, the return-to-work program is given 15 days to amend, modify or rescind the decision and take further action. If the decision is rescinded, further action must be initiated within 30 days from the order of rescission. If there is a new, amended or modified decision, a new period for appeal is triggered.

Per LC 139.48(b), the appeals will be “subject to review at the trial level of the appeals board upon the same grounds as prescribed for petitions for reconsideration” (see Section 16.60 Petition for Reconsideration — Grounds).

## **FALSE CLAIMS FOR SUPPLEMENT**

Although the application for the return-to-work supplement is relatively easy, and the eligibility requirements are fairly broad, CCR 17310 was adopted to prevent injured workers from making false claims for it. It requires the application to include this notice: “WARNING: any person who knowingly makes or uses a false record or statement material to the claim is liable for treble damages plus a civil penalty of not less than \$5,500 and not more than \$11,000 plus the cost of the action pursuant to the False Claims Act, Government Code sections 12650-12656.” It provides that the warning is not a limitation on any penalties that may attach to any action in violation of the law. It probably will be up to the Department of Industrial Relations to investigate and pursue any false claims for benefits.

## 4. MEDICAL TREATMENT LIMITATIONS

Beyond the changes to medical provider networks and the utilization review/independent medical review procedures (which are discussed in the forthcoming chapters), SB 863 made several changes affecting medical treatment for injured workers. The Legislature reinforced the statutory limits on chiropractic care, occupational therapy and physical therapy, and restricted the use of chiropractors as primary treating physicians. Some regulations were amended to clarify the limits on chiropractic visits

Most significant, SB 863 made changes to the availability of home health care. It requires home health care to be prescribed by a licensed physician and places other restrictions on its availability. It also requires the adoption of a home health-care fee schedule (see Chapter VIII: Fee Schedule Changes). As discussed below, however, liberal construction by the appeals board and the administrative director's failure to adopt a fee schedule have minimized the impact of SB 863 changes to home health care.

### STATUTORY LIMITS ON TREATMENT

As part of SB 863, former LC 4604.5(d) was redesignated as LC 4604.5(c). It still entitles employees injured on or after Jan. 1, 2004, to no more than 24 chiropractic, 24 occupational therapy and 24 physical therapy visits per industrial injury. LC 4604.5(c)(2) still provides that the limits do not apply when the employer authorizes additional visits in writing. (For a full discussion, see [“Sullivan on Comp” Section 7.22 Statutory Limitations on Therapy.](#))

But now, LC 4604.5(c)(2) also states that payment or authorization beyond the 24-visit limits will not be deemed a waiver of them with respect to future requests for authorization. This change was intended to clarify that an insurer or employer may pay for physical medicine treatments in excess of the 24-visit cap without that payment constituting a blanket waiver of it. This change specifically is noted to be declaratory of existing law.

So if an employer either intentionally or unintentionally provides or authorizes more than 24 chiropractic, occupational therapy or physical therapy visits, it does not waive the right to deny further requests for treatment on the grounds that they exceed the statutory limits. Because this amendment is declaratory of existing law, it applies to all injuries occurring on or after Jan. 1, 2004, not just those occurring after the amendment.

The appeals board has held that the treatment limitations of LC 4604.5(d) may be applied even if the employer fails to seek utilization review of the excess visits under LC 4610 as long as the employer does not



authorize the additional visits.<sup>1</sup> Moreover, the administrative director will not impose administrative penalties for failing to conduct utilization review after the treatment limits have been reached (CCR 9792.12(a)(7)). The appeals board, however, has held that if an employer pays for charges related to treatment in excess of the visits permitted under LC 4604.5(d)(1), it may not receive restitution for the excessive payments.<sup>2</sup>

For a full discussion the statutory limits on treatment, see [“Sullivan on Comp” Section 7.22 Statutory Limitations on Therapy.](#))

## LIMITATIONS ON CHIROPRACTORS AS TREATING PHYSICIANS

LC 4600(c) was amended to direct that a chiropractor should not be a treating physician after the employee has received the maximum number of chiropractic visits allowed. This statute was intended to stop chiropractors from lingering as the primary treating physician in a given case.<sup>3</sup> Chiropractors may remain as a primary treating physician only until the applicant has received 24 chiropractic visits.

Effective July 1, 2014, CCR 9785(a)(1) clarifies that a chiropractor may not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. So an employer need not file a petition to terminate a chiropractor as a primary treating physician after the visit limit is reached — the chiropractor automatically loses that status unless the employer provides written authorization for more visits.

CCR 9785(a)(1) adds that the prohibition does not apply to the provision of postsurgical physical medicine prescribed by the employee’s surgeon, or physician designated by the surgeon pursuant to the postsurgical treatment guidelines. This is consistent with LC 4604.5(c)(3) and allows a chiropractor to treat an employee following surgery without those visits being counted toward the 24-visit limit.

CCR 9785(a)(1) defines a “chiropractic visit” as any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. So an injured worker generally is limited to 24 visits with a chiropractor, regardless of whether treatment was provided during the visit.

Nevertheless, in one case, the panel majority held that if a chiropractor was qualified to perform treatment and physical therapy, he or she could be reimbursed for 24 chiropractic visits and 24 physical therapy visits. The majority noted that the applicant could receive a chiropractic visit and a physical therapy visit on the same day and remanded for further development of the record to determine whether one or the other treatment was provided on a particular occasion.<sup>4</sup>

The appeals board also has held that reports from chiropractors after the 24th chiropractic visit are admissible. It explained that after the 24th visit, a chiropractor is not able to continue as an “authorized” treating physician and the defendant’s liability for the treatment is limited. But it found that under LC 4605, the applicant is entitled to continue treating with a chiropractor at his or her own expense. It found such reports admissible under LC 4605, even though the reports could not be the sole basis of an award (see [“Sullivan on Comp” Section 7.59 Employee’s Unreasonable Refusal to Accept Medical Care.](#))<sup>5</sup>

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<sup>1</sup> *Duarte v. Ferguson & Melvin Roofing, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 428.

<sup>2</sup> *Mora v. Steelcase, Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 197.

<sup>3</sup> Previously, case law allowed a chiropractor to continue as the primary treating physician after the visit cap had been reached. *Compton v. Atwater Elementary School District*, 2012 Cal. Wrk. Comp. P.D. LEXIS 16.

<sup>4</sup> *Romero v. California Pizza Kitchen*, 2016 Cal. Wrk. Comp. P.D. LEXIS 20.

<sup>5</sup> *Aguayo v. Grossmont Union High School District*, 2015 Cal. Wrk. Comp. P.D. LEXIS 89.

## LIMITATIONS ON HOME HEALTH CARE

Before SB 863, the law allowed for home care services when an employee needed them as a result of an industrial injury. But the law did not specify rules governing the scope or payment of services. One of the specific purposes of SB 863 was to limit to specific circumstances the provision of home health-care services as medical treatment.

With SB 863, the Legislature sought to prohibit payment for home care services if they were being provided prior to injury. It sought to limit the cases in which home care services were alleged to have been provided, but had not been authorized or ordered by a physician. It sought to limit attorneys' fees for pursuing reimbursement for home health care. The Legislature also required the administrative director to adopt a fee schedule for home health-care services.

Administrative regulations were not adopted to implement the changes to home health care by SB 863, and a fee schedule for home health-care services still has not been adopted, even though that was supposed to have happened by July 1, 2013. Nevertheless, the appeals board has issued an *en banc* decision, *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.*<sup>6</sup> that interpreted the home health-care provisions of SB 863. The board held that the changes made by SB 863 apply to requests for home health care in all cases that were not final as of the effective date of Jan. 1, 2013, regardless of date of injury or dates of service.<sup>7</sup> Home health care is discussed further in [“Sullivan on Comp” Section 7.4 Home Health Care](#).

### Prescription by Licensed Physician

In the past, the appeals board has been liberal regarding the type of evidence that could support an award of home health care.<sup>8</sup> Effective Jan. 1, 2013, LC 4600(h) requires that home health-care services be provided as medical treatment only if the care is prescribed “by a physician and surgeon licensed per Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.” Those references concern practitioners licensed by the Medical Board of California or the Osteopathic Medical Board of California.<sup>9</sup> So a request for home health-care services is appropriate only from an M.D. or D.O. Requests for home health care from chiropractors, psychologists, acupuncturists and nurses needn't be honored.<sup>10</sup>

### Prescription Defined, Provided and Received

LC 4600(h) states that “The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer’s receipt of the physician’s prescription.” So a prescription must exist, and it must have been received by the employer. But what exactly constitutes a prescription? And, how is it established that the employer received it?

<sup>6</sup> (2014) 79 CCC 682 (appeals board *en banc*).

<sup>7</sup> See also *Mulford v. El Toro RV, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 219.

<sup>8</sup> See *Pacific Erectors, Inc. v. WCAB (England)* (2003) 68 CCC 1609 (writ denied) (certified disability management specialist); *American Bridge/Fluor Enterprises v. WCAB (Barragan)* (2012) 77 CCC 901 (writ denied) (nurse case manager).

<sup>9</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 691-692 (appeals board *en banc*). Although LC 4600(h) uses the term “physician and surgeon,” these are not separate requirements. Instead, a “physician and surgeon,” for the purposes of LC 4600(h), is an appropriately licensed M.D. or D.O. under the appropriate sections of the BPC. Per BPC 2050, “The Division of Licensing shall issue one form of certificate to all physicians and surgeons licensed by the board which shall be designated as a ‘physician’s and surgeon’s certificate.’” Per BPC 2453(a), “It is the policy of this state that holders of M.D. degrees and D.O. degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons.”

<sup>10</sup> See *Mulford v. El Toro RV, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 219 (report by occupational nurse could not support an award of home health care).

In *Neri Hernandez*,<sup>11</sup> the appeals board held that the prescription required by LC 4600(h) is either:

1. an oral referral, recommendation or order for home health-care services for an injured worker communicated directly by a physician to an employer and/or its agent; or
2. a signed and dated written referral, recommendation or order by a physician for home health-care services for an injured worker.

The board noted that the Labor Code does not contain a definition of the term “prescription,” and therefore turned to the Business and Professions Code. Under BPC 4040, a “prescription” means an oral or written order that is given for the person and issued by a physician. This is a very broad definition. It allows for both oral and written prescriptions and does not require that a prescription be labeled or written on a particular form. Also, it does not require a detailed description of the recommended services. The board further noted that LC 4600(h) does not specify how an employer must receive the prescription and does not require that it be submitted by an injured worker.

The board concluded that an oral prescription may be made directly by a physician to the employer or the employer’s agent. It is not enough, it seems, for an injured worker to receive an oral prescription from a physician, and then relay that orally to the employer.

The board provided that a proper written prescription may be received from a physician or another source, including from the injured worker, an injured worker’s agent, a third person or another provider. Also, the written prescription may be presented in almost any way. An employer may “receive a prescription” in the form of a request for authorization by a physician, a medical report or a medical record.<sup>12</sup>

In *Neri Hernandez*, the appeals board concluded that a handwritten doctor’s note stating that the applicant needed constant care from his wife was a prescription for home health-care services within the meaning of LC 4600(h). A request for home health care on the DWC RFA form would also qualify as a prescription.<sup>13</sup>

## Overriding Duty to Provide Care

Note that an employer always has an overriding duty to provide care, and to do so in a proactive fashion. Accordingly, the employer also has a general duty when there is a reasonable indication that medical care might be needed to reasonably investigate the possibility. For a fuller discussion of this general idea see [“Sullivan on Comp” Section 7.24 Duty to Provide Care Proactively](#).

It is also true that some statutory requirements limit the liability for care even when there is an established medical need. For example, there are statutory limitations on physical therapy sessions.<sup>14</sup> The appeals board in *Neri Hernandez* described the prescription requirement as a limit on the employer’s duty to provide medical treatment. So the injured worker must prove that the prescription was received by the employer and the date when it was received.<sup>15</sup>

But the appeals board added that the duty to investigate applies if it is unclear whether a prescription exists or has been received. If an employer receives an oral communication or a document that is ambiguous and unclear as to whether the communication or document was actually a prescription sufficient to trigger the liability period, the employer has a duty under LC 4600 to conduct a reasonable and good-faith investigation

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<sup>11</sup> (2014) 79 CCC 682 (appeals board *en banc*).

<sup>12</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 693 (appeals board *en banc*).

<sup>13</sup> See *Esquivel v. Southern California Permanente Medical Group*, 2014 Cal. Wrk. Comp. P.D. LEXIS 405.

<sup>14</sup> [“Sullivan on Comp” Section 7.22 Statutory Limitations on Therapy](#).

<sup>15</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 693 (appeals board *en banc*).

to determine whether benefits are due.<sup>16</sup> This is a point well-taken; as a general matter, an employer must be proactive in providing care and may not turn a blind eye to a possible request.

### Updated Prescription Not Required

One issue that frequently arises is whether a single prescription for home health-care services potentially makes an employer liable for such services indefinitely. Defendants generally argue that home health-care services must be requested continually, as the applicant's condition and need for such services might change over time. But applicants contend that ongoing prescriptions are not required. In one case, the appeals board held that an applicant is not required to obtain renewed or updated prescriptions in order to receive ongoing home health care.

In that case, the defendant agreed at a hearing to provide home health-care services 24 hours a day, seven days a week pursuant to an AME's opinion, but argued that LC 4600(h) requires a new prescription for each period of requested home health-care services. The appeals board explained that under LC 4600(h), an applicant must show receipt of a prescription to commence the liability period for home health-care services. It said, however, that under *Patterson v. The Oaks Farm*,<sup>17</sup> once a defendant authorizes home health-care services, the applicant has no obligation continually to show that the services are reasonable medical treatment. Instead, the defendant is obligated to continue providing the services until they are no longer reasonably required under LC 4600 to cure or relieve from the effects of the injury. The appeals board concluded that the defendant was not entitled unilaterally to terminate the applicant's home health-care services because there was no evidence of a change in her circumstances or condition showing that the services were no longer reasonably required to cure or relieve from the effects of the industrial injury.<sup>18</sup> For further discussion of the duty to continue medical treatment under *Patterson*, see [“Sullivan on Comp” Section 7.2 Scope of Care — Cure or Relieve](#).

### Application of Prescription Requirement

Since *Neri Hernandez*, the appeals board has been quick to explain the type of evidence that will support an award of home health care. In *Gonzalez v. Consolidated Disposal Services/Republic Services*,<sup>19</sup> the applicant sustained a CT injury ending in 2005, and developed a life-threatening lung infection requiring medication for the rest of his life. In 2009, he testified that he could not perform grocery shopping or prepare meals, and that his wife or son helped bathe him, among other things. The wife and son gave similar testimony. On March 29, 2010, the PTP issued a letter reporting that the applicant required 24-hour home care from March 2005 through the present. The letter was served May 18, 2010, and the wife and son later filed a lien for home health-care services. The defendant filed a petition to compel a re-evaluation with the AME in September 2011, but it was denied later. On Jan. 18, 2012, the PTP executed a disclosure and declaration for his letter of March 29, 2010. The defendant sent that report to UR, and UR denied the request for home health care Jan. 30, 2012. The matter proceeded to trial on the home health-care issue.

The appeals board held that substantial evidence supported the need for home health care. It further found that the PTP's letter of March 29, 2010 was a prescription for home health-care services within the meaning of LC 4600(h), and that the defendant's potential liability for home health care began 14 days before the date it received the letter. But the appeals board noted that there was possible evidence in 2009 that the applicant needed home health-care services based on the testimony of the applicant and his wife and son. The board remanded to develop the record on whether the defendant received a prescription at an earlier date. The

<sup>16</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 694 (appeals board *en banc*). See *Acevedo v. Del Mar Die Casting*, 2016 Cal. Wrk. Comp. P.D. LEXIS 82.

<sup>17</sup> (2014) 79 CCC 910 (significant panel decision).

<sup>18</sup> *Warner Brothers, Time Warner Entertainment Co. v. WCAB (Ferrona)* (2015) 80 CCC 831 (writ denied).

<sup>19</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 348.

board rejected the defendant's argument that it was not required to act on receipt of the letter dated March 29, 2010 until 2012, when it received the PTP's declaration. It reiterated that when an employer receives notice that home health-care services may be needed or are being provided, it has a duty to investigate. Because the defendant did not respond to the letter and never investigated the need for home health care, the appeals board imposed a \$10,000 penalty under LC 5814. It further warned that the defendant's breach of its duties could result in audit penalties.<sup>20</sup>

In *Lobo v. County of San Bernardino*,<sup>21</sup> an applicant sustained a CT injury ending in 2010. He contracted a lung infection and pneumonia. Later, he was hospitalized, suffered septic shock, multiple cardiopulmonary arrests and went into a coma. He was hospitalized for eight months, and after discharge was not expected to live. The AME evaluated the applicant May 2, 2011, and reported that he required home care 12 hours a day, seven days a week. But the AME later reviewed a report from Nov. 11, 2010, stating that the applicant was "currently at home with a home health agency ... and had a primary caregiver at home that did the daily dressing change." The applicant later testified that his girlfriend cared for him from Nov. 13, 2010 to Jan. 2, 2012, but was not paid. The girlfriend testified that she cared for the applicant 12 hours a day while also working at her regular job. The adjuster testified that the the girlfriend was not paid because they did not know what services or number of hours were appropriate, and did not pay unless it was requested.

The appeals board concluded that the AME's report of May 2, 2011 was a prescription for home health-care services within the meaning of LC 4600(h). But it noted that the AME's record review indicated that there was a medical record dated Nov. 22, 2010, stating that the applicant was receiving home health care. This record was not in evidence, but the appeals board believed that it could be a prescription for home health care when the applicant was discharged by the hospital. The board deferred on the issue of home health care pending further development as to when liability began. The appeals board then reminded the defendant that it had a regulatory duty to conduct a reasonable and good-faith investigation to determine whether benefits are due. Because the applicant and his girlfriend provided in great detail the life-saving care she provided to the applicant, the defendant was reminded that it could not sit idly by and wait until it receives an official request for treatment before acting, and that it may not refuse to make at least partial payment when it is clear that benefits are owed. The defendant was admonished that unreasonable delays and refusals to provide appropriate and reasonably necessary medical treatment might result in penalties under LC 5814, and told that a bad-faith or frivolous delay in providing medical treatment could result in LC 5813 sanctions as well as audit penalties.<sup>22</sup>

In *Adams v. Little Co. of Mary Hospital*,<sup>23</sup> the appeals board rescinded a WCJ's decision disallowing a lien for home health care and remanded for further proceedings on the prescription requirement. The AME did not recommend home health-care services in his report of Nov. 3, 2008, but testified at his deposition Aug. 5, 2011 that the applicant was in need of home health-care services. The appeals board concluded that the AME's deposition testimony could be construed as an oral prescription that was received Aug. 5, 2011, and because July 22, 2011 was 14 days prior to the deposition, it was the first possible day that his opinion could give rise to liability for home health-care services. The appeals board, however, noted that the AME summarized the report of a licensed clinical social worker (LCSW) dated March 27, 2008, that referred to home health care. Although the LCSW was not a physician within the meaning of LC 4600(h), the board remanded for the WCJ to determine whether a physician contemporaneously recommended services.<sup>24</sup>

<sup>20</sup> *Gonzalez v. Consolidated Disposal Services/Republic Services*, 2014 Cal. Wrk. Comp. P.D. LEXIS 348.

<sup>21</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 353.

<sup>22</sup> *Lobo v. County of San Bernardino*, 2014 Cal. Wrk. Comp. P.D. LEXIS 353. See also *Banuelos v. Nupla Corp.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 485; *Bourgeois v. Vivendi Universal/American Home Assurance Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 518; *Dominguez v. WCAB (Leong)* (2014) 79 CCC 1539 (writ denied); *Acevedo v. Del Mar Die Casting Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 701; *Rodriguez v. Air Eagle, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 3; *Adamson v. Cendant Corp.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 63; *Logudice v. Mimi's Caf*, 2015 Cal. Wrk. Comp. P.D. LEXIS 136; *Williams v. Montgomery Elevator*, 2016 Cal. Wrk. Comp. P.D. LEXIS 362.

<sup>23</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 421.

<sup>24</sup> *Adams v. Little Co. of Mary Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 421. See also *Sims v. Valley Express, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 446 (AME's report prescribing "home support" was a prescription).

In *Griffin v. County of Los Angeles*,<sup>25</sup> the appeals board agreed with a WCJ that the evidence supported that home health-care services were reasonable and necessary, but remanded the case for further proceedings. The applicant suffered a stroke in June 2000, and the appeals board found that a discharge summary of July 26, 2000 signed by a physician stating, “The patient’s wife was taught how to transfer the patient,” and that “The patient is discharged home with home health” was a prescription within the meaning of LC 4600(h). It also concluded that a doctor’s letter dated March 24, 2008 stating that the wife “is physically unable to continue care for her husband, thus assistance in caring for her husband ... is recommended” was a prescription within the meaning of LC 4600(h). But the case was remanded to determine when the defendant received the prescriptions.<sup>26</sup>

The appeals board has shown a willingness to draw a distinction between home health care and attendant services away from the home, at least for purposes of the prescription requirement. In *Mercado v. Park West Enterprises, Inc., dba Co-West Commodities*,<sup>27</sup> the board affirmed an award to the applicant’s wife for payment of attendant care she provided him while he was in the hospital, even though there was no prescription for the wife’s services per LC 4600(h). The board explained that she did not provide home health care because her husband had yet to be discharged home; rather, she provided attendant care at various facilities in lieu of having them charge the defendant for a one-on-one caregiver. The appeals board explained that attendant care, like home health care, was medical treatment a defendant is obligated to provide per LC 4600, and that the defendant was not relieved of the obligation merely because the care was provided by the applicant’s wife. The board, however, reversed an award allowing mileage reimbursement for the wife for travel to the places where treatment was provided. It explained that the cost of mileage incurred in commuting to and from work was not an expense a medical provider was entitled to recover in addition to the fee he or she earns for providing treatment.<sup>28</sup>

### Home Health Care Must be Reasonable and Necessary

LC 4600(h) also provides that home health care will be provided as medical treatment only if it is reasonably required to cure or relieve the injured employee from the effects of his or her industrial injury. In *Neri Hernandez*,<sup>29</sup> the appeals board explained that a prescription is not proof of what are reasonable and necessary home health-care services. Injured workers bear the burden to prove that the services are reasonably required.<sup>30</sup>

In *Neri Hernandez*, the appeals board stated, “[I]n order to obtain an award of home health care services, section 4600(h) requires applicant to show that he had a prescription, that it was received by defendant, and that he met the requirements of section 5307.8. Section 5307.8 requires an injured worker to produce evidence describing the hours of services required and provided, evidence explaining which services may have been provided before an industrial injury, and evidence of a reasonable hourly rate.” The appeals board concluded that any award of reimbursement would be based on an appropriate rate for a similar caregiver, and would not be based on a spouse’s loss of earnings from previous employment.<sup>31</sup> If an applicant fails to

<sup>25</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 429.

<sup>26</sup> *Griffin v. County of Los Angeles*, 2014 Cal. Wrk. Comp. P.D. LEXIS 429. See also *Dolan v. The Gap, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 645 (letter from doctor to nurse case manager was a prescription); *Williams v. Martin Luther King Hospital/County of Los Angeles*, 2014 Cal. Wrk. Comp. P.D. LEXIS 700 (PTP’s report was a prescription, but remanded to determine date of receipt); *Johns v. City of Los Angeles*, 2014 Cal. Wrk. Comp. P.D. LEXIS 718 (doctor’s report was a prescription, but remanded to determine date of receipt); *Williams v. Claire’s Boutiques, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 61 (PTP’s signed report was a prescription); *Andre v. The Pacifica Co.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 700 (PTP issued proper prescription).

<sup>27</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 532.

<sup>28</sup> *Mercado v. Park West Enterprises, Inc., dba Co-West Commodities*, 2014 Cal. Wrk. Comp. P.D. LEXIS 532.

<sup>29</sup> (2014) 79 CCC 682 (appeals board *en banc*).

<sup>30</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 692-693 (appeals board *en banc*).

<sup>31</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 697 (appeals board *en banc*).

show the reasonableness and necessity of attendant care services, he or she may be denied by the appeals board.<sup>32</sup>

In the past, the appeals board has been ready to plow doggedly through the evidence and make the decision it deems correct.<sup>33</sup> But the courts have shown a willingness to hold applicants to a sufficient level of proof. In the seminal case of *State Farm Insurance Co. v. WCAB (Pearson)*,<sup>34</sup> the Court of Appeal rejected an award of \$1,520,640 for 24-hour attendant care services provided by an injured employee's husband. In that case, the employee was found to be 100 percent disabled, but there was a dispute regarding the level of attendant care required. Based on the reporting of an independent medical examiner (IME), the appeals board found that the applicant's husband provided attendant care services 24 hours a day from July 24, 2003, and that he was entitled to compensation for those services at the licensed vocational nursing (LVN) rate of \$30 per hour, or \$720 a day. But the court annulled the decision on two grounds. One, the court found that the applicant and her husband had engaged in improper ex parte communications with the IME, and therefore the IME's opinion supporting attendant care around the clock was invalid.

Two, the court found that the award was not supported by substantial evidence. The court found problems with the evidence that the husband had monitored and assisted the applicant 24 hours per day, seven days per week. It noted that many of the services provided by the husband did not constitute treatment the employer was required to provide. Although the court recognized that care by a family member to monitor and manage an injured worker's health care may qualify as medical care in some cases, it found that the services provided by the husband included numerous categories of caregiver services that did not appear to qualify as reasonably required medical services. (Unfortunately, the court did not explain which services they were.)

The court also concluded that the compensation rate of \$30 per hour was not justified because some of the services provided by the husband were not LVN services. The court instructed that on remand, the appeals board had to redetermine which of the caregiver services the husband provided were medical treatment under LC 4600, and to determine the compensation to be awarded to the husband after appointment of a new IME.<sup>35</sup>

On remand, the appeals board awarded the applicant's husband reimbursement of \$113.50 per day for caring for the applicant 9 1/2 hours per day from July 24, 2003. The board relied on the testimony of the owner of a home-care provider service obtained by the defendant to temporarily provide services to the applicant. He testified that the husband devoted 8 1/2 hours per day of attendant care to the applicant and that his employees were paid \$11 per hour for such services. He also testified that the husband provided one hour per day of services that would be performed by an LVN and paid at \$20 per hour. Based on this testimony, the WCJ awarded \$113.50 per day. The appeals board upheld the award and also found that the husband failed to establish that 24-hour care was required.<sup>36</sup>

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<sup>32</sup> See *Siddiqui v. WCAB* (1997) 63 CCC 224 (writ denied); *Chambers v. California Department of Social Services, Kings County In-Home Services*, 2013 Cal. Wrk. Comp. P.D. LEXIS 39 (AME found conditions that led to applicant's deterioration and need for in-home care were not caused by or related to her industrial injury).

<sup>33</sup> See *Reyes v. Protrades Connections*, 2012 Cal. Wrk. Comp. P.D. LEXIS 691. (2011) 76 CCC 69.

<sup>34</sup> *State Farm Insurance Co. v. WCAB (Pearson)* (2011) 76 CCC 69. See also *Perez v. TK Systems, Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 437 (award of \$508 per day for attendant care provided by siblings was rescinded when there was no medical evidence discussing the applicant's home care needs, including medication administration); *Warwick v. Chartis Insurance Co.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 348 (wife did not provide attendant or nursing care for which she should be reimbursed when she provided home maintenance services — such as cooking, cleaning, general maintenance — that she customarily could be expected to provide for her husband, and applicant had no trouble performing these activities). But see *Better Vision, dba McGuire-Nicholas Manufacturing v. WCAB (Nunez)* (2011) 76 CCC 588 (writ denied) (family member was paid \$45 per hour for providing 24-hour care for applicant when applicant required licensed vocational nurse (LVN), and there was evidence that reasonable rate for required LVN services was \$45 per hour).

<sup>36</sup> *Pearson v. WCAB (Apparicio)* (2012) 77 CCC 1008 (writ denied).

In another case, the appeals board rescinded a decision and held that the applicant had not proved her entitlement to home health-care services. The board acknowledged that, under appropriate circumstances, housekeeping services distinct from nursing services were reimbursable. But it also found that an injured worker was entitled to housekeeping services only if they were reasonably necessary to cure or relieve from the effects of the industrial injury, and that the evidentiary burden of proof is on the injured worker to show that the requested services are reasonable and necessary. In that case, the AME never expressly opined that housekeeping was reasonable and necessary to relieve the applicant from the effects of the industrial injury, and admitted that he had insufficient information to render a valid opinion. So the appeals board found that the applicant had failed to carry her burden.<sup>37</sup>

Again, effective in 2013, disputes regarding the reasonableness and necessity of treatment must be resolved through UR and IMR. If an injury is accepted, and the only dispute is the reasonableness and necessity of the request for home health care, it is important for the employer to refer the request for utilization review.<sup>38</sup> The Supreme Court has stated that UR is an employer's only avenue for resolving an employee's request for treatment.<sup>39</sup> If an employer fails to use the utilization review process, the appeals board still has authority to award the home health care without the matter proceeding to independent medical review, as long as the care either falls within the presumptively correct medical treatment utilization schedule, or the presumption has been rebutted by a preponderance of scientific medical evidence. For further discussion of the utilization review process, see [“Sullivan on Comp” Section 7.36 Utilization Review — Procedures](#). Disputes regarding the reasonable value of services should be directed to the independent bill review process; see the sections commencing with [“Sullivan on Comp” Section 7.69 Independent Bill Review — Scope of Application](#).

### Retroactive Claims for Self-Procured Care

Sometimes the injured worker will self-procure home health care, and submit a bill after the fact. For example, after being discharged from a hospital, an applicant's spouse or other family member may provide care while the applicant is recovering, and then make a claim for retroactive home health care months or even years after the applicant began receiving it.

These cases are often contentious, especially if there is no concurrent medical reporting indicating the need for home health-care services. In the past, the appeals board struggled with whether such care is compensable in these situations. In some cases, the board allowed claims for retroactive home health care without a supporting report by a physician, or based on a physician's report reporting that the care was reasonable and necessary after the fact.<sup>40</sup> In other cases, however, the appeals board refused to award payment based on a medical opinion retroactively recommending the treatment.<sup>41</sup>

SB 863 addressed this problem. Effective Jan. 1, 2013, per LC 4600(h), “The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.” In *Neri Hernandez*,<sup>42</sup> the appeals board found that this language narrows an employer's duty to pay for medical treatment to 14 days before the date that the prescription was received. Liability is not based on the date that the need for services may have begun. So this language prevents claims for retroactive home health care made long after the applicant began receiving it.

<sup>37</sup> *Dunnigan v. WCAB* (2012) 77 CCC 726 (writ denied). See also *Williams v. Claire's Stores, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 497; *Salguero v. Charles Gemeiner Cabinets*, 2013 Cal. Wrk. Comp. P.D. LEXIS 450; *Garcia v. MEK Air Tech*, 2015 Cal. Wrk. Comp. P.D. LEXIS 319; *Reese v. All Saints Health Care*, 2015 Cal. Wrk. Comp. P.D. LEXIS 570.

<sup>38</sup> See *Jagosz v. Hughes Aircraft*, 2013 Cal. Wrk. Comp. P.D. LEXIS 207; *Acevedo v. Spienello Construction Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 400.

<sup>39</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981.

<sup>40</sup> See *Allgreen Landscape v. WCAB (Mota)* (2012) 77 CCC 541 (writ denied); *American Bridge/Fluor Enterprises v. WCAB (Barragan)* (2012) 77 CCC 901 (writ denied).

<sup>41</sup> See *Arana v. Hawthorne School District*, 2011 Cal. Wrk. Comp. P.D. LEXIS 562.

<sup>42</sup> (2014) 79 CCC 682, 693 (appeals board *en banc*).



For example, in one case, an applicant's spouse claimed reimbursement for home health-care services from 1996 to May 31, 2005, when the applicant died of nonindustrial leukemia. The applicant presented a prescription for home health care from a physician dated Aug. 24, 2004, and claimed that it was served Sept. 2, 2004. The defendant claimed that it did not receive the prescription until July 5, 2013. The appeals board denied the spouse's claim for home health care. It explained that there was nothing in the record to establish when the defendant actually received the prescription, and that assuming, for the purposes of argument, that the applicant served the prescription Sept. 2, 2004, and that it was received the same day, the first possible liability period would begin 14 days before Sept. 2, 2004. So most of the spouse's claimed services were barred by LC 4600(h). The appeals board found that the remainder of the claim for home health care could not be supported because there was nothing in evidence establishing that the need for it resulted from the applicant's industrial injury.<sup>43</sup>

## Documentation for Payment

LC 4603.2(b)(1) was amended to clarify that home health-care service providers are subject to the same reporting requirements as other medical services providers if they want to be paid. With a request for payment, home health-care providers must submit an itemization of the services rendered and the charge for each, a copy of all reports showing the services were performed, the prescription or referral from the primary treating physician and any evidence of authorization for the services that may have been received.<sup>44</sup> For further discussion of the documents that must be submitted for payment, see ["Sullivan on Comp" Section 7.67 Submission of Bills and Employer's Response](#).

Nevertheless, in *Neri Hernandez*,<sup>45</sup> the appeals board explained that an injured worker may seek reimbursement for home health-care services or an award of future medical treatment in the form of home health-care services for an injured worker or a provider. It concluded that LC 4603.2(b)(1) was not a part of an injured worker's burden of proof under LC 4600(h) and LC 5307.8 because LC 4603.2(b)(1) concerns payment. The appeals board concluded that "section 4603.2(b)(1) does not impose a separate reporting requirement or a separate procedure for obtaining authorization, but merely shifts the duty to the provider who is seeking payment to include those documents as appropriate."<sup>46</sup>

Because LC 4603.2(b)(1) also states that: "Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600," the appeals board concluded that although a provider of home health-care services must comply with LC 4603.2(b)(1) in order to be paid, an employer also may choose to pay for home health-care services without the required documentation, including a "prescription."<sup>47</sup>

The appeals board added that because LC 4603.2(b)(1) requires a prescription or referral from the primary treating physician, even if a prescription from another physician meets the requirements of LC 4600(h), a referral by a primary treating physician still is required. A report or a request for authorization that is signed by a primary treating physician under LC 4600(h) can be a prescription under both LC 4600(h) and LC 4603.2(b)(1).<sup>48</sup>

<sup>43</sup> *Granados v. Tony Ranch Market*, 2014 Cal. Wrk. Comp. P.D. LEXIS 650.

<sup>44</sup> Previously, the appeals board in one case awarded reimbursement for out-of-pocket attendant care totaling \$228,600 paid by an applicant even though he had failed to provide an itemization for the payments. The appeals board relied on his credible trial testimony, as well as a stipulation that if the attendants who cared for the applicant were called to testify, their testimony would substantiate the applicant's trial testimony. *City of Los Angeles v. WCAB (Lesser)* (1997) 62 CCC 499 (writ denied).

<sup>45</sup> (2014) 79 CCC 682, 695 (appeals board *en banc*).

<sup>46</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 696 (appeals board *en banc*).

<sup>47</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 696 (appeals board *en banc*).

<sup>48</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 696 (appeals board *en banc*).

In one case, the appeals board found that the applicant was entitled to home health-care services 24 hours a day, seven days a week, at the rate of \$9 per hour. But it found that under LC 5307.8, the defendant was entitled to receive the documentation specified in LC 4603.2(b)(1) before issuing payment, including an itemization of services and charges, copies of all reports showing services performed, a prescription or referral by the primary treating physician and any evidence of authorization.<sup>49</sup> But in another case, the appeals board held that it was sufficient for an applicant's family member home care providers to provide a good-faith estimate of the hours and services provided on the applicant's behalf.<sup>50</sup>

### **Performance of Duties in the Same Manner Prior to Injury**

LC 5307.8 also establishes that no fees will be paid for any services, including those provided by a member of the employee's household, if they had been performed regularly in the same manner and to the same degree before the date of injury. The idea was that there should be no reimbursement for things like cooking for an injured worker if a spouse was doing that before the injury. But the statute prohibits payment only if the services were performed "in the same manner" and "to the same degree" prior to the date of injury.

In *Neri Hernandez*,<sup>51</sup> the appeals board explained that because LC 5307.8 uses the phrase "including" with respect to services provided by a household member, the provision applies to all previously provided services, not just those that were provided by a household member.

In *Gonzalez v. Consolidated Disposal Services/Republic Services*,<sup>52</sup> the appeals board explained, "Where the medical evidence supports a finding that an applicant is in need of twenty four hour supervision, or any part thereof, as a result of an industrial injury, and there is no evidence that the need pre-existed the industrial injury, an award of hours of supervision may be made even where there is no clear evidence of post-injury tasks." In that case, the appeals board found that the applicant was entitled to full-time care, but remanded for him to provide specific descriptions of the tasks performed before and after the injury, and determined that the defendant was not liable for tasks regularly performed before the injury.<sup>53</sup>

In *Lobo v. County of San Bernardino*,<sup>54</sup> the appeals board similarly stated that "an award of hours of supervision may be made where the medical evidence supports a finding that an applicant is in need of twenty four hour supervision, or any part thereof, as a result of an industrial injury and there is no evidence that the need pre-existed the industrial injury." As described above, the applicant's injury resulted in life-threatening medical complications. The appeals board believed that the circumstances of his injury were unusual and the consequences so severe that it was unlikely that there was overlap with the services performed prior to the injury. The applicant, however, was instructed to specify the services performed, and explained which services occurred before and which occurred after the injury. He was further instructed to provide the documentation specified in LC 4603.2(b)(1).

### **Attorneys' Fees for Recovery of Home Health-Care Services**

LC 5307.8(b) establishes that an appropriate attorney's fee for recovery of home health-care fees may be awarded in accordance with LC 4906 and any applicable rules and regulations. LC 4906 pertains to attorneys' fees paid from an injured employee's recovery, so any such fees awarded under LC 5307.8 also would come from an employee's recovery.<sup>55</sup>

<sup>49</sup> *Gonzalez v. Consolidated Disposal Services/Republic Services*, 2014 Cal. Wrk. Comp. P.D. LEXIS 348.

<sup>50</sup> *Acevedo v. Del Mar Die Casting*, 2016 Cal. Wrk. Comp. P.D. LEXIS 82.

<sup>51</sup> (2014) 79 CCC 682, 694 (appeals board *en banc*).

<sup>52</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 348.

<sup>53</sup> See also *Acevedo v. Del Mar Die Casting Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 701.

<sup>54</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 353.

<sup>55</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 695 (appeals board *en banc*). See *Acevedo v. Del Mar Die Casting Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 701 (15 percent fee withheld from home health-care award).

This provision was necessary because the attorneys pursuing claims for home health care usually represented family members, not the injured worker. So the usual attorneys' fees rules did not apply. LC 5307.8 now establishes that fees for recovery of home health-care services are governed by the same rules as those regarding fees for injured workers.

Note, however, in one case, the appeals board upheld a decision that fees for an attorney acting on behalf of a relative, rather than the injured worker, under a retainer agreement may be governed by that agreement rather than LC 5307.8(b). The UEBTF voluntarily paid home health-care benefits to the relative without reserving any amount for attorneys's fees. The board instructed that the attorney should pursue fees under the retainer agreement rather than from the UEBTF.<sup>56</sup>

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<sup>56</sup> *Escobar v. Jimenez*, 2016 Cal. Wrk. Comp. P.D. LEXIS 285.

## 5. MEDICAL PROVIDER NETWORKS

Medical provider networks (MPNs) were authorized initially in 2004 by SB 899. They were intended to grant employers greater control over medical treatment. Before SB 899, employees freely chose a treating physician 30 days after reporting an industrial injury. Employers criticized this right because they believed that injured workers were directed toward physicians who were not using evidence-based treatment, but were engaging in treatment for the purpose of extending temporary disability and increasing permanent disability. MPNs were intended to provide evidenced-based treatment for injured workers with a network of physicians developed by the employer.

But with the use of MPNs, problems developed for employees, employers and even some MPN doctors. Injured workers complained that it was far too difficult or impossible to find MPN physicians to treat them, and claimed it was necessary to treat with non-MPN physicians. Physicians within the MPN complained that they were required to participate in some networks as a condition of participation in other networks, and had no notice of the networks in which they were included. Employers complained that the courts had eroded the intention of the MPN statutes by allowing employees to treat outside of the MPN for minor technical errors that had nothing to do with the delivery of health-care services.

With SB 863, the Legislature sought to correct the deficiencies in the MPN system. SB 863 reforms were intended to improve the quality of MPNs by providing more regulatory oversight. SB 863 made it easier for employees to find physicians within an MPN by requiring online access to MPN rosters and requiring medical access assistants to help injured employees find available MPN physicians. SB 863 adopted changes to ensure that MPN physicians were aware that they were members of the network. SB 863 strengthened employer control by eliminating the ability of injured workers to treat outside of a network based on minor technical deficiencies. It also addressed employer concerns by eliminating incentives for employees to seek treatment outside of the MPN and for non-MPN doctors to provide it.

Administrative regulations went into effect Aug. 27, 2014 to implement many of the reforms of SB 863. Effective Jan. 1, 2016, SB 542 was enacted and made additional changes to the MPN program. Although the MPN rules enacted by SB 863 have prevented some employees from treating outside of a network, others have found ways to treat successfully with non-MPN doctors.

The WCIRB reports that network penetration since 2013 has continued to increase at a rate consistent with that of the immediate prior years. It also reported that the average medical cost per MPN managed claim is approximately \$500, or 4 percent less than a non-network claim.<sup>1</sup>

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<sup>1</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 20.

## SELECTION OF PHYSICIANS WITHIN MEDICAL PROVIDER NETWORK

MPNs present a huge financial incentive for employers to create networks, and for doctors and doctors' groups to be members of the network. Naturally, employers want to choose more conservative doctors for the MPN, and weed out those with an applicant-oriented history. To some extent, this is what has happened. The law says that the administrative director is not allowed to withhold approval based solely on the selection of providers. It is specified that the employer or insurer has the exclusive right to determine the members of the network (LC 4616(d)). This is reinforced in the regulations (CCR 9767.3(c)(5)).

Per CCR 9767.3(c)(4), the MPN also has the right to determine which locations are approved for physicians to provide treatment within the network. Approved locations must be listed in an MPN's provider listing. But an MPN has discretion to approve treatment at nonlisted locations.

Prior to this regulation, the appeals board held that treatment with an MPN physician at a different address still qualified as treatment within the MPN because there was nothing within the MPN contract requiring the doctor to treat at a particular location.<sup>2</sup> Now, not only do defendants have the right to choose the providers within the MPN, they have the right to choose the locations at which they could provide treatment.

In one case issued after the effective date of CCR 9767.3(c)(4), the panel majority held that a doctor could receive payment for services provided at a location other than that listed by the MPN.<sup>3</sup> But the appeals board did not specifically reference CCR 9767.3(c)(4).

## MEDICAL PROVIDER NETWORK APPROVAL PROCESS

LC 4616 allows employers or insurers to establish or modify an MPN for the purpose of providing treatment to industrially injured workers. SB 863 amended that section to alter some of the requirements for MPNs as well as the process for approving them. Per LC 4616(b), the employer, insurer or entity that provides physician network services must submit a plan for the medical provider network to the administrative director for approval. The changes were intended to strengthen the rules to ensure that MPNs are sound and to tighten regulatory oversight. Defendants were given the right to appeal the administrative director's MPN determinations.

### Requirements for an MPN Plan

The requirements for an MPN plan are established in CCR 9767.3. As long as the application for a plan meets the MPN regulations and the requirements of LC 4616 et seq, an employer or insurer may submit for approval MPN applications (CCR 9767.3(a)). The regulations do not preclude an MPN applicant from agreeing to submit for approval an MPN plan that meets the specific needs of an insured employer, the experience of the insured employer, the common injuries experienced by the insured employer, the type of occupation and industry in which the insured employer is engaged and the geographic area where the employees work (CCR 9767.3(b)).

The MPN application must be submitted with the cover page established in CCR 9767.4. Two copies of the completed, signed cover page for the MPN application or plan for re-approval and the complete MPN plan must be submitted to the DWC on compact discs or flash drives in word-searchable PDF format. The hard copy of the completed, signed original cover page and the complete MPN plan must be maintained by the

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<sup>2</sup> *Charter Oak Unified School District v. WCAB (Cerde)* (2011) 76 CCC 1083 (writ denied); *Juarez v. Wm. Bolthouse Farms*, 2009 Cal. Wrk. Comp. P.D. LEXIS 644. *Contra Ayers v. WCAB* (2014) 79 CCC 1334 (writ denied); *Tabak v. San Diego Unified School District*, 2014 Cal. Wrk. Comp. P.D. LEXIS 416.

<sup>3</sup> *The Boeing Co. v. WCAB (Pasquel)* (2015) 80 CCC 1338 (writ denied). The dissent believed the doctor should not receive payment because the contract expressly precluded him from providing services at any other location without prior written consent.

MPN applicant and made available for review by the administrative director on request. Electronic signatures in compliance with GC 16.5 are acceptable (CCR 9767.3(c)).

An MPN applicant must submit the required MPN provider information and ancillary service provider information on compact disc(s) or flash drive(s). Ancillary services are medical services and goods allowed under LC 4600 by a nonphysician including, but not limited to, interpreter services, physical therapy and pharmaceutical services (CCR 9767.1(a)(1)).

The information must be submitted as a Microsoft Excel spread sheet unless an alternative format is approved by the administrative director. If the MPN applicant uses a valid and currently certified health care organization, that must be noted on the application's cover page and only a listing of any additional ancillary service providers is required to be submitted (CCR 9767.3(c)(1)).

The network provider information must be submitted on compact disc(s) or flash drive(s) and must have only these eight columns in this order: (1) physician name; (2) specialty; (3) physical address; (4) city; (5) state; (6) zip code; (7) any MPN medical group affiliations; and (8) an assigned provider code for each physician listed.

If a physician falls under more than one provider code, he or she must be listed separately for each applicable code. These provider codes must be used: primary treating physician (PTP); orthopedic medicine (ORTHO); chiropractic medicine (DC); occupational medicine (OCCM); acupuncture medicine (LAC); psychology (PSYCH); pain specialty medicine (PM); psychiatry (PSY); neurosurgery (NSG); family medicine (GP); neurology (NEURO); internal medicine (IM); physical medicine and rehabilitation (PMR); and podiatry (DPM) (CCR 9767.3(c)(2)).

If the specialty does not fall under any of the listed categories, it must be identified clearly in the specialty column and the code used must be (MISC). By submission of its provider listing, the MPN applicant is affirming that all of the physicians listed have been informed that the medical treatment utilization schedule (MTUS) is presumptively correct on the issue of the extent and scope of medical treatment and diagnostic services and have a valid and current license number to practice in California (CCR 9767.3(c)(2)).

If an MPN chooses to provide ancillary services, that provider file must have only these six columns in this order: (1) the name of each ancillary service provider; (2) specialty or type of service; (3) physical address; (4) city; (5) state; and (6) zip code of each provider. If the ancillary service or provider is mobile, the covered service area within California must be listed. By submission of an ancillary provider listing, the MPN applicant is affirming that the providers listed can provide the requested medical services or goods and have a current valid license number or certification to practice, if they are so required by the state of California. If interpreter services are included as an MPN ancillary service, the interpreters listed must be certified pursuant to CCR 9795.1.6(a)(2)(A)(B) (CCR 9767.3(c)(3)). For further discussion on interpreter certification, see ["Sullivan on Comp" Section 15.111 Interpreters](#).

Per CCR 9767.3(d), a network, entity, administrator or other third party, on agreement with an MPN applicant, may prepare an MPN application on behalf of an eligible applicant. An MPN application must include all of this information:

1. type of eligible MPN applicant (This includes a description of the entity's qualifications to be an eligible MPN applicant and requires proof of MPN eligibility. If the applicant is a self-insured employer or joint powers authority, a copy of the current valid certificate of self-insurance must be attached. For an insurer, a current valid certificate of authority must be attached. For an entity providing physician network services, the application must attach documentation of current legal

status including, but not limited to, legal licenses or certificates and affirm that the entity employs or contracts with physicians and other medical providers or contracts with physician networks.);

2. name of MPN applicant;
3. MPN applicant's taxpayer identification number;
4. name of medical provider network;
5. MPN liaison to DWC (The application must provide the name, title, address, email address and telephone number of the person designated as the liaison for the DWC, who is responsible for receiving compliance and informational communications from the DWC and for disseminating the same within the MPN.); and
6. verification by an officer or employee of the MPN applicant with the authority to act on behalf of the MPN applicant with respect to the MPN. The verification by the authorized individual must state: "I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

An MPN application also must include a description of the MPN plan, including:

1. affirmation that the MPN network is adequate to handle the expected number of claims covered under the MPN and an explanation how this was determined;
2. a description of the MPN geographic service area or areas to be served within California;
3. the toll-free number, email address, fax number and days and times of availability to reach the MPN's medical access assistants;
4. the MPN website address;
5. the web address or URL to the roster of all treating physicians in the MPN, and affirmation that secondary treating physicians who are counted when determining access standards but can be seen only with an approved referral are designated clearly "by referral only";
6. affirmation that each MPN physician or medical group in the network has agreed to treat workers under the MPN and that the written acknowledgments are in accordance with the requirements under "Physician Acknowledgments" (CCR 9767.5.1), described below, and are available for review by the administrative director on request;
7. a listing of the name, specialty and location of each physician as described in LC 3209.3, who will be providing occupational medicine services under the plan (Only individual physicians in the MPN are to be listed, but MPN medical group affiliation(s) may be included with each individual physician listed. By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the physicians, providers or medical group practice in the MPN to provide treatment for injured workers in the workers' compensation system, and that the contractual agreement is in compliance with LC 4609, if applicable.);
8. an electronic copy in Microsoft Excel format of the geocoding results of the MPN provider directory to show estimated compliance with the access standards defined in CCR 9767.5. The geocoding results must include these separate files summarizing data reasonably available at the time of compilation:
  - A. a complete list of all zip codes within the MPN geographic service area;
  - B. a narrative or graphic report that establishes where at least three available primary treating physicians are within the 15-mile access standard from the center of each zip code within the MPN geographic service area;
  - C. a narrative or graphic report that establishes where a hospital or an emergency health-care service provider is within the 15-mile access standard from the center of each zip code within the MPN geographic service area;
  - D. a narrative or graphic report that establishes where at least three available physicians are in each of the specialties commonly required to treat injured workers covered by the

- MPN within the 30-mile access standard from the center of each zip code within the MPN geographic service area;
- E. a list of all zip codes where access standards are not met in the geographic service area or areas to be served by the MPN for primary treating physicians, for acute care hospitals or emergency facilities, and for each specialty listed to treat common injuries experienced by injured workers covered by the MPN, and a narrative report explaining if medical treatment will be provided according to an approved alternative access standard or according to a written policy permitting-out-of-network treatment in those areas; and
  - F. each physician listed in the MPN provider directory listing must be assigned at least one provider code to be used in the geocoding reports.
9. if an MPN chooses to include ancillary services, a listing of the name, specialty or type of service and location of each service, and who will be providing services or goods within the network (By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the ancillary service providers to supply these services under the MPN, and that the services will be available at reasonable times and within a reasonable geographic area to covered employees.);
  10. a description of how the MPN provides ancillary services to its covered employees (The applicant must establish which ancillary services, if any, will be within the MPN. For ancillary services not able to be provided within the MPN per CCR 9767.5(d), there must be an affirmation that referrals will be made to services outside the MPN.);
  11. a description of how the MPN complies with the second and third opinion process established in CCR 9767.7;
  12. a description of how the MPN complies with the access standards established in CCR 9767.5 for all covered employees;
  13. a description of the employee notification process with an English and Spanish copy attached of the required employee notification material and information to be given to covered employees described in CCR 9767.12(a);
  14. a copy of the written continuity of care policy as described in LC 4616.2;
  15. a copy of the written transfer of care policy that complies with CCR 9767.9;
  16. any policy or procedure that is used by the MPN applicant or an entity contracted with the MPN or MPN applicant to conduct “economic profiling of MPN providers” per LC 4616.1, discussed below, and affirmation that a copy of the policy or procedure has been provided to the MPN providers or a statement attached that the MPN applicant does not conduct economic profiling of MPN providers;
  17. an affirmation that the physician compensation is not structured in order to achieve the goal of reducing, delaying or denying medical treatment or restricting access to medical treatment;
  18. a description of how the MPN applicant will ensure that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician’s practice, will modify, delay or deny requests for authorization of medical treatment;
  19. a description of the MPN’s procedures, criteria and how data are used continuously to review quality of care and performance of medical personnel, utilization of services and facilities and costs; and
  20. affirmation that as of Jan. 1, 2013, every contracting agent that sells, leases, assigns, transfers or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer or entity that provides physician network services, or to another contracting agent must, on entering or renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred or conveyed to other insurers, employers, entities providing physician network services or another contracting agent, and specify whether



those insurers, employers, entities providing physician network services or contracting agents include workers' compensation insurers.

If the entity is a health-care service plan, group disability insurance policy or Taft-Hartley Health and Welfare Fund, in addition to the requirements above, an MPN application must establish that the entity has a reasonable number of providers with competency in occupational medicine. The MPN applicant may demonstrate physician competency by confirming that he or she either is board certified or was residency trained in that specialty. Otherwise, the MPN applicant may describe any other relevant procedure or process that assures that providers of medical treatment are competent to provide treatment for occupational injuries and illnesses (CCR 9767.3(e)).

If the MPN applicant is providing for ancillary services within the MPN that are in addition to the services provided by the health-care organization, health-care service plan, group disability insurance policy or Taft-Hartley Health and Welfare Fund, it must enumerate the ancillary services in the application (CCR 9767.3(f)). If a health-care organization, health-care service plan, group disability insurance policy or Taft-Hartley Health and Welfare Fund has been approved as a MPN, and the entity does not maintain its certification, licensure or regulated status, the entity must file a new MPN application (CCR 9767.3(g)). If one of these entities has been modified from its certification, licensure or regulated status, the application must comply with the requirements outlined above (CCR 9767.3(h)).

## **Review of MPN Application**

CCR 9767.2 outlines the process for the administrative director's review of an MPN application. Within 60 days of receipt of a complete new application, the administrative director must approve or disapprove the application based on the MPN regulations and the requirements of LC 4616 et seq. If an application includes correct information for each applicable subdivision of CCR 9767.3, as outlined above, it will be considered complete. Per LC 4616(b), if the administrative director has not acted on a new application plan within 60 days of submittal of a complete plan, it will be deemed approved on the 61st day for a period of four years (CCR 9767.2(a)).

Within 180 days of receipt of a complete plan for re-approval, the administrative director must approve or disapprove the complete plan for re-approval. Again, a plan for re-approval will be considered complete if it includes correct information for each applicable subdivision of CCR 9767.3. If the administrative director has not acted within 180 days of receipt of a complete plan for re-approval, it will be deemed approved on the 181st day for a period of four years (CCR 9767.2(b)).

The administrative director must provide notification(s) to the MPN applicant: (1) citing the date the MPN application or re-approval plan was received; (2) informing the MPN applicant if the application or re-approval plan is not complete and the item(s) necessary to complete it; and (3) if the administrative director is aware that the MPN applicant is not eligible to have an MPN (CCR 9767.2(c)). No additional materials may be submitted by the MPN applicant or considered by the administrative director unless the director issues this notification ((CCR 9767.2(d)).

The decision to approve or disapprove an application is limited to the information provided in the application or re-approval plan (CCR 9767.2(e)). On approval of a new MPN plan, the MPN will be assigned a unique identification number. This number must be used in all correspondence with DWC regarding the MPN, including but not limited to future filings and complaints, and must be included in the complete employee notification, transfer of care notice, continuity of care notice, MPN IMR notice and end of MPN coverage notice (CCR 9767.2(f)).

An MPN applicant may choose to withdraw an approved MPN that has not been implemented by sending a letter signed by the MPN's authorized individual to the administrative director with its name and approval number, and a statement verifying that the MPN has not been used and that the applicant will not use the MPN in the future (CCR 9767.2(g)).

### **Term of MPN Approval and Re-Approval**

LC 4616(b) provides that commencing Jan. 1, 2014, existing, approved plans will be deemed approved for a period of four years from the most recent application or modification approval date. Plans for re-approval must be submitted at least six months before the expiration of the four-year period. CCR 9767.15 was adopted in accordance with this statute.

MPNs approved before Jan. 1, 2014 that are not in compliance with the current MPN regulations must file a modification and update to comply with the current regulations no later than Jan. 1, 2018. If the MPN is required to apply for re-approval before Jan. 1, 2018, based on the four-year approval period, the MPN must update to the current regulations with its re-approval filing, whichever is sooner (CCR 9767.15(a)).

The MPN applicant must file a new complete application for re-approval no later than six months before the expiration of the MPN's four-year date of approval. For MPNs approved before Jan. 1, 2014, the four-year date of approval begins from the most recent approved filing prior to Jan. 1, 2014. For MPNs approved after Jan. 1, 2014, the first four-year date of approval begins from the date the original application is approved. After an MPN has been re-approved, the expiration of re-approval will be four years from the date of the last complete plan re-approval. Each application for re-approval must meet all requirements for a new MPN original application (CCR 9767.15(b)(1)-(4)).

The time frames for the review process for a plan for re-approval are stated above. If such a plan is not filed within the requisite six months before the expiration of approval, the MPN may be subject to penalties or other administrative actions. If an application for re-approval is filed fewer than 60 days before the approval expiration date, the MPN may be subject to penalties. MPN approval will be suspended after the date of expiration if the review is not completed before the expiration of the MPN plan's approval (CCR 9767.15(b)(6)(7)).

### **Denial of MPN Application or Re-Approval**

CCR 9767.13 outlines the procedures for denying an MPN application or application for re-approval. The administrative director must deny approval or re-approval of a plan if the applicant does not satisfy the requirements of the MPN regulations and LC 4616 et seq. If a plan is denied, the administrative director must send a notice by U.S. mail stating the reasons why (CCR 9767.13(a)).

If an MPN application is denied, the applicant may submit a corrected application or plan for re-approval addressing the deficiencies. Alternatively, the MPN applicant may request a re-evaluation by the administrative director (CCR 9767.13(b)).

If an MPN applicant chooses to submit a request for re-evaluation, it must do so within 20 days of the issuance of the notice of disapproval. The applicant must provide a detailed statement explaining why re-evaluation is requested. The request must be accompanied by supporting documents relevant to the specific allegations raised and must be verified under penalty of perjury. The MPN application at issue must not be refiled; it will be made part of the administrative record by incorporation by reference (CCR 9767.13(c)).

Within 45 days of the receipt of the request for a re-evaluation, the administrative director must issue a decision and order affirming or modifying the notice of disapproval, or issue a decision and order rescinding the notice of disapproval and issue an approval of the MPN (CCR 9767.13(d)). The administrative director may extend the 45-day period for 30 days and may order a party to submit additional documents or information (CCR 9767.13(e)).

## Modification of Network

An existing MPN may be modified per CCR 9767.8. To do so, the MPN applicant must complete the notice of medical provider network plan modification form established in CCR 9767.8. It is available from the DWC website at <http://www.dir.ca.gov/dwc/forms.html>.

The MPN applicant must serve the administrative director with two copies of the completed, signed form and any necessary documentation on compact discs or flash drives in word-searchable PDF format. The hard copy of the original signed notice of medical provider network plan modification form and any necessary documentation must be maintained by the MPN applicant and made available for review by the administrative director on request. Electronic signatures in compliance with GC 16.5 are accepted (CCR 9767.8(a)).

The MPN applicant must serve these documents within stated time frames. If no time limit is stated, they must be served before any of these changes occurs:

1. a change in the name of the MPN or the name of the MPN applicant — filing required within 15 business days of the change and accompanied by written documentation reflecting date of change;
2. a change in the eligibility status of the MPN applicant — filing required within 15 business days of written knowledge of a change in eligibility and accompanied by written documentation reflecting date of change;
3. a change of MPN liaison or authorized individual — filing required within 15 business days of change and accompanied by written documentation reflecting date of change;
4. a change in MPN geographic service area within California;
5. a material change in the continuity of care policy;
6. a material change in the transfer of care policy;
7. a change in policy or procedure that is used by the MPN or an entity contracted with the MPN or MPN applicant to conduct “economic profiling of MPN providers” per LC 4616.1;
8. a change in how the MPN complies with the access standards;
9. a material change in any of the employee notification materials, including a change in MPN contact, a change in the MPN medical access assistant’s contact information or a change in provider listing access or MPN website information, required by CCR 9767.12;
10. a change in use of one of these deemed entities: health-care organization (HCO), health-care service plan, group disability insurer or Taft-Hartley Health and Welfare Trust Fund;
11. a revision of any plan section(s) required by CCR 9767.3(d) due to a change of any MPN administrator(s);
12. replacement of the entire MPN plan application; or
13. an update to the current regulations pursuant to CCR 9767.15.

Failure to file a material modification within the requisite time frame might result in administrative actions pursuant to CCR 9767.14 and/or CCR 9767.19 (CCR 9767.8(b)). These are discussed further in Section 7.58 Medical Provider Network — Investigation, Discipline and Administrative Penalties.

The modification must be verified by an officer or employee of the MPN with the authority to act on behalf of the applicant. The verification must state: “I, the undersigned officer or employee of the MPN applicant, have read and signed this notice and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this modification is true and correct” (CCR 9767.8(c)).

Within 60 days of receipt of a notice of MPN plan modification, the administrative director must approve or disapprove it. If the administrative director has not acted on a plan within 60 days, it will be deemed approved. Except as specified, modifications must not be made until the administrative director has approved the plan or until 60 days have passed, whichever occurs first. If the administrative director disapproves of the plan modification, he or she must serve the applicant with such notice within 60 days of its submission (CCR 9767.8(d)).

An MPN applicant denied approval of a plan modification may submit a new request addressing the deficiencies, or request a re-evaluation by the administrative director (CCR 9767.8(e)). Any MPN applicant may request a re-evaluation of the denial by submitting with the division a written request with a detailed statement of explanation. The request must be submitted within 20 days of the issuance of the notice of disapproval. The request for re-evaluation must be accompanied by supporting documents relevant to the specific allegations raised. The request also must be verified under penalty of perjury. The MPN application and modification at issue must not be refiled; they will be made part of the administrative record by incorporation by reference (CCR 9767.8(f)).

Within 45 days of the receipt of the request for a re-evaluation, the administrative director must issue a decision and order affirming or modifying the notice of disapproval, or issue a decision and order rescinding the notice of disapproval and issue an approval of the modification (CCR 9767.8(g)). The administrative director may extend the 45-day limit for 30 days and may order a party to submit additional documents or information (CCR 9767.8(h)).

### **APPEAL OF MEDICAL PROVIDER NETWORK DETERMINATION**

LC 4616(b)(5) states that the administrative director’s determination may be reviewed only by an appeal filed as an original proceeding before the Reconsideration Unit of the appeals board. The appeal must be based on the same grounds and within the same time limits applicable to a petition for reconsideration from a decision of a WCJ.

CCR 9767.13 and CCR 9767.14 also state that if the administrative director denies approval of an MPN or suspends or revokes it, the MPN applicant may request a re-evaluation by the director or may appeal the decision by filing a petition and a DOR.

These rules prompted the adoption of CCR 10959 so that any aggrieved person or entity may file a petition appealing various kinds of MPN determinations. It allows for appeals of determinations to: (1) deny an MPN application; (2) revoke or suspend an MPN plan; (3) place an MPN plan on probation; (4) deny a petition to revoke or suspend an MPN plan; or (5) impose administrative penalties relating to an MPN (CCR 10959(a)).

### **Time Limit and Place for Appeal**

A petition appealing an administrative director’s MPN determination must be filed no later than 20 days after the date of its service. An untimely petition may be summarily dismissed (CCR 10959(b)(1)).

The petition must be filed solely in paper (hard copy) form directly with the Office of the Commissioners of the appeals board at either its P.O. box or street address (CCR 10959(b)(2)). The petition must not be

submitted to any district office of the board, including the San Francisco district office, and it must not be submitted electronically (CCR 10959(b)(3)). A petition that is inappropriately filed will not be accepted for filing nor deemed filed, and will not be acknowledged or returned to the submitting party (CCR 10959(b)(4)).

## Form of Appeal

The appeal form must be a petition appealing the administrative director's medical provider network determination (CCR 10959(c)). Per CCR 10959(d), the caption of the petition must include the:

1. name of the MPN or MPN applicant;
2. identity of the petitioner; and
3. case number assigned by the administrative director to the IMR determination.

The petition must include a copy of the administrative director's determination and proof of service to that determination (CCR 10959(e)). In addition, per CCR 10959(f), the petition may appeal the administrative director's determination on only one or more of these grounds:

1. The determination was without or in excess of the administrative director's powers.
2. The determination was procured by fraud.
3. The evidence does not justify the determination.
4. The petitioner has discovered new evidence material to him or her that, with reasonable diligence, he or she could not have discovered and presented to the administrative director prior to the determination. And/or

The petition must establish specifically and in full detail the factual and/or legal grounds on which the petitioner considers the determination to be unjust or unlawful, and every issue to be considered by the appeals board. The petitioner will be deemed to have waived all objections, irregularities and illegalities concerning the determination other than those established in the petition.

The petition must comply with the requirements of CCR 10842(a)(c), CCR 10846 and CCR 10852. Also, it must comply with the provisions of CCR 10845, including but not limited to the 25-page restriction. For further discussion of these requirements, see ["Sullivan on Comp" Section 16.62 Petition for Reconsideration — Form and Content](#).

Failure to comply with the provisions of this subdivision will constitute valid ground for summarily dismissing or denying the petition.

A copy of the petition must be served concurrently on the DWC Medical Provider Network Unit (MPN Unit) (CCR 10959(g)).

## Action on Filing Petition

On filing, the petition will be assigned to a panel of the appeals board in accordance with LC 115 (CCR 10959(h)). Within 30 days after the filing of an answer or the lapse of the time allowed for filing one, the appeals board must issue a notice for an evidentiary hearing regarding the petition. The hearing must be set for the purposes of specifying the issue(s) in dispute and any stipulations, taking testimony and listing and identifying documentary evidence. The proceedings must be transcribed by a court reporter, whom the appeals board, in its discretion, may order the petitioner to provide. The appeals board also may order the petitioner to pay the costs of the transcript(s) of the evidentiary hearing (CCR 10959(i)).

In its discretion, the appeals board, per CCR 10959(j), may order the evidentiary hearing to be conducted by:

1. one or more commissioners of the appeals board; or
2. a WCJ appointed under LC 5309(b) for the sole purpose of holding hearings and ascertaining facts necessary to enable the appeals board to render a decision on the petition.

If a WCJ is appointed, the judge must not render any factual determinations, but may make a recommendation regarding the credibility of any witnesses presented. The time, date, length and place of the hearing must be determined by the appeals board in its discretion.

The assigned appeals board panel must determine when the petition is submitted for decision. The panel must render a decision within 60 days after submission unless, within that time, the panel orders that the time be extended so that it may study the facts and relevant law further (CCR 10959(k)).

Nothing in CCR 10959 precludes a person or entity aggrieved by an MPN determination from making a timely request to the administrative director to re-evaluate that initial determination in accordance with the relevant regulations. If a request for re-evaluation is made to the administrative director prior to filing a petition with the Office of the Commissioners of the appeals board, the time for filing such a petition is tolled until the administrative director files and serves a decision and order regarding the request for re-evaluation (CCR 10959(l)(1)).

If a request for re-evaluation is made after a petition appealing the administrative director's initial determination is filed, the petitioner must file a copy of the request with the Office of the Commissioners, together with a cover letter requesting that its petition be dismissed without prejudice. A copy of the letter and request for re-evaluation must be served concurrently on the DWC MPN Unit (CCR 10959(l)(2)).

### **MEDICAL ACCESS ASSISTANT**

LC 4616(a)(5) requires every MPN to provide one or more individuals within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, as well as subsequent physicians if necessary. This requirement was adopted as part of SB 863 to address concerns from employees that it was far too difficult or impossible to find MPN physicians to treat them. The administrative director was required to adopt regulations regarding the medical access assistants before July 1, 2013, but finally did so Aug. 27, 2014.

An MPN medical access assistant is an individual in the United States provided by the MPN to help injured workers with finding available MPN physicians of the injured workers' choice and with scheduling provider appointments (CCR 9767.1(a)(16)). His or her duties include, but are not limited to, contacting provider offices during regular business hours and scheduling medical appointments for covered employees (CCR 9767.5(h)).

MPN medical access assistants must be available at least from Monday through Saturday, 7 a.m. to 8 p.m., Pacific time. Assistance must be available in English and Spanish. There must be at least one MPN medical access assistant to respond at all required times, with the ability for callers to leave a voice message. There must be enough medical access assistants to respond to calls, faxes or messages by the next day, excluding Sundays and holidays (CCR 9767.5(h)(1)).

An MPN medical access assistant is a different position from the MPN contact. The contact is the individual or individuals designated by the employer in the employee notification responsible for responding to

complaints, answering employees' questions about the MPN and assisting the employee in arranging for an MPN independent medical review pursuant to LC 4616.4 (CCR 9767.1(a)(20)).

MPN medical access assistants also have different duties from claims adjusters. MPN medical access assistants work in coordination with the MPN contact and the claims adjuster(s) to ensure timely and appropriate medical treatment is provided to the injured worker. Although their duties are different, if the same person performs both, the MPN medical access assistant's contacts must be separately and accurately logged (CCR 9767.5(h)(2)).

Effective Jan. 1, 2016, SB 542 amended 4616(a)(4) to require every medical provider to post on its website information about how to contact the MPN contact and medical access assistants, and information about how to obtain a copy of the complete employee notification.

## **PHYSICIAN ACKNOWLEDGMENTS**

LC 4616(a)(3) was added as part of SB 863 because physicians objected to being required to participate in some networks as a condition of participation in other networks, and had no notice of the networks in which they were included. Under LC 4616(a)(3), commencing Jan. 1, 2014, a treating physician will be included in an MPN only if, at the time of creating or renewing an agreement to be in the MPN, the physician or an authorized employee provides a separate written acknowledgment that he or she elects to be a member. Copies of the written acknowledgment must be provided to the administrative director on request. In order to implement this statute, CCR 9767.5.1 was adopted.

As part of the MPN application process, an MPN applicant must obtain from each physician participating in the network a written acknowledgment in which he or she affirmatively elects to be a member of the MPN. This requirement does not apply to a physician who is a shareholder, partner or employee of a medical group that elects to participate in the MPN. The requirement, however, applies to the medical group that elects to participate in the MPN (CCR 9767.5.1(a)).

## **Election of Medical Group as Treating Physician**

In one case, the appeals board upheld a WCJ's decision allowing an applicant to designate a physician employed by Casa Colina Transitional Living Center (Casa Colina) to be his primary treating physician within the defendant's MPN. Casa Colina was listed in the MPN, but the physician was not individually listed. Under LC 4616(a)(3) and CCR 9767.5.1, the board found that physicians acting on behalf of a medical group need not acknowledge their membership in the MPN individually, and that medical groups within an MPN may employ the services of physicians who do not register individually with the MPN. The board found that in order for Casa Colina to provide the rehabilitation services as listed on the defendant's MPN, the applicant must be allowed to see the physicians who provide that treatment for Casa Colina.<sup>4</sup>

## **Persons Who May Execute Acknowledgment**

Per CCR 9767.5.1(b)(1), if the acknowledgment is for one or more physicians, it must be executed by one of these:

- A. the physician(s);
- B. an employee of the physician or an employee of the physician's office; or
- C. if authorized by the physician(s), an agent or representative of a medical group.

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<sup>4</sup> *Rivas v. North American Trailer*, 2016 Cal. Wrk. Comp. P.D. LEXIS 572.

If a medical group elects to participate in an MPN, an authorized officer or agent of the medical group must execute the acknowledgment. Unless the acknowledgment is for all physicians who are shareholders, partners or employees of a medical group, or all physicians in a distinct department or unit of the medical group, the acknowledgment must include or refer to a list of the participating physicians. Furthermore, the authorized officer or agent must update the list within 90 days of any additions to or removals from the list.

### Form of Acknowledgment

Per CCR 9767.5.1(c), the written acknowledgment may take several forms, including:

1. a tangible document bearing an original signature, or a facsimile or electronic image of the original document and signature;
2. an electronically signed document in compliance with GC 16.5 or Civil Code 1633.1 et seq, whichever is applicable; or
3. an electronic acknowledgment using generally accepted means of authentication to confirm the identity of the person involved.

The acknowledgment must identify the MPN in which the physician or group participates. Multiple MPNs may be identified in a single acknowledgment, separate acknowledgments or in any combination. Any form that presents more than one MPN for the physician's acknowledgment must enable him or her to opt in or opt out of each MPN. The MPN or MPNs may be identified by reference to a website where a person who is allowed to execute the acknowledgment may see which MPN or MPNs are selected for the physician or group. If permitted by the written acknowledgment, the website listing may be amended without further action by the physician or the group, provided that the website enables the physician or the group to de-select any MPN. If the physician or group is removed from an MPN by anyone other than a person who may execute an acknowledgment, the MPN must give the physician or group notice of that fact in writing or electronically (CCR 9767.5.1(d)).

### Timing of Acknowledgment

Because the regulation went into effect Aug. 27, 2014, if, on or after that date, the physician or medical group entered into a new contract or renewed a contract to participate in the MPN, the acknowledgment must have been obtained at that time. If, on or after Aug. 27, 2014, the physician joined a medical group that had a contract to participate in an MPN or MPNs, the acknowledgment must have been obtained at the time the physician joined.

If, on or after Jan. 1, 2014, but before Aug. 27, 2014, the physician or medical group entered into a new contract or renewed a contract to participate in the MPN, the acknowledgment must have been obtained no later than Jan. 1, 2015. If, on or after Jan. 1, 2014, but before Aug. 27, 2014, the physician joined a medical group that had a contract to participate in an MPN or MPNs, the acknowledgment must have been obtained no later than Jan. 1, 2015.

If a contract entered before Aug. 27, 2014, is continuous or automatically renews without a new execution by or on behalf of the physician, the acknowledgment must have been obtained no later than Jan. 1, 2016, unless:

1. The contract identifies the MPN in which the physician or group is participating. Or
2. The website address is public, and a person authorized to execute the acknowledgment may observe which MPN or MPNs have been selected for the physician or group and may de-select any MPN. The means to authenticate a person to access the website and to de-select any MPN



must be made available on reasonable proof of the requesting person's identity as an authorized person.

## Retention of Acknowledgment

The MPN must retain a copy of the executed acknowledgment for at least three years as long as the MPN remains in force (CCR 9767.5.1(f)). The MPN is responsible for obtaining physician acknowledgments and must ensure that all physician acknowledgments are up to date, meet regulatory requirements and are readily available for review on request by the administrative director (CCR 9767.5.1(g)).

## Internet Posting of Roster

LC 4616(a)(4) provides that commencing Jan. 1, 2014, every MPN must post on its website a roster of all treating physicians within the network, and requires this information to be updated quarterly. Every MPN also must provide to the administrative director the web address of the MPN and its roster of treating physicians. The administrative director will post the web address of every approved MPN on the DIR website.

## PROVING VALIDLY ESTABLISHED MEDICAL PROVIDER NETWORK

What must be shown to establish a valid MPN frequently was contested, and for a long time very little guidance was given. As a result of SB 863, LC 4616(b)(1) states in pertinent part, "Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed." This is a codification and expansion of *Clifton v. Sears Holding Corp. (KMart Corp.)*,<sup>5</sup> the case that defined that rule before SB 863.

In *Clifton*, the appeals board held that a defendant may satisfy its burden of proving it has a properly established and noticed MPN by asserting that it has an approved MPN and requesting judicial notice of the inclusion of its MPN in the list of approved MPNs on the administrative director's website. The list of approved MPNs may be viewed at [http://www.dir.ca.gov/dwc/mpn/dwc\\_mpn\\_main.html](http://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html). Following SB 863, if the defendant establishes that its MPN was approved or deemed approved, it will be conclusively presumed to be validly formed, and is therefore not rebuttable by any evidence.

In fact, the appeals board has instructed that WCJs should take judicial notice of the MPNs listed on the DWC website if the issue of a properly noticed MPN arises. It explained that doing so is consistent with its California constitutional mandate to accomplish substantial justice in all cases expeditiously, inexpensively and without encumbrance of any character.<sup>6</sup> But proving a validly established MPN is not always smooth, so defendants should come to court prepared to show that theirs is valid.

In one case, the appeals board relied on a WCJ's search of the administrative director's list of approved MPNs to find that the employer failed to meet its burden to show that it had a validly established MPN. The appeals board noted that the WCJ could take judicial notice of the publicly available list. The defendant's MPN was not on the list, and the defendant did not offer other evidence, such as a photocopy of the administrative director's authorization letter, or testimony of a knowledgeable person, to support an approved MPN.<sup>7</sup>

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<sup>5</sup> 2012 Cal. Wrk. Comp. P.D. LEXIS 1.

<sup>6</sup> *Morgado v. Powdercoat Services, Inc.* 2014 Cal. Wrk. Comp. P.D. LEXIS 622.

<sup>7</sup> *Castillo v. Tawa Supermarkets, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 554.

In another case, the appeals board affirmed a WCJ's decision that an applicant was allowed to continue treating outside the MPN with her chiropractic treating physician when the defendant could not prove it had a valid MPN. The board noted that it could take judicial notice of a defendant having a validly formed MPN by going to the DWC website, but found the information relating to the defendant's MPN confusing. The appeals board found more than eight MPNs for the defendant carrier Security National Insurance, none of which provided a website address. It also found that none of the documents sent to the applicant and offered by the defendant at trial listed the name Security National Insurance as the carrier, only AmTrust North America, and there was no listing for either AmTrust or employer Newco Foods on the DIR MPN listing. So the appeals board found that the defendant failed to prove the existence of a valid MPN.<sup>8</sup>

In another case, there was a dispute over whether an employer had its own stand-alone MPN, or whether the employer's MPN was part of the CorVel MPN. Because documents supported that the two entities were interrelated, and because the employer failed to present evidence that it had a stand-alone MPN, the appeals board determined that the applicant could treat within the CorVel MPN, and that the lien claimants could recover payment for their services.<sup>9</sup>

### MEDICAL PROVIDER NETWORK NOTICE REQUIREMENTS

LC 4616.3(b) provides that the employer must notify the employee of the existence of the medical provider network, the right to change treating physicians within the network after the first visit and the method by which the list of participating providers may be accessed by the employee. Previously, the MPN notice requirements were defined in former CCR 9767.12 and former CCR 9767.16.<sup>10</sup> Effective Aug. 27, 2014, the MPN notices are enumerated entirely in CCR 9767.12.

The changes were intended to streamline the notice requirement. Now, MPN notices are required only when an employer has knowledge of an injury, when an employee with an existing injury is transferred to an MPN and when the MPN's coverage will end. MPN notices no longer are required when an MPN is implemented or when an employee is hired. Furthermore, MPN notices are not required to be posted at the workplace.

### Time and Method for Providing Notice

Pursuant to CCR 9767.12(a), a complete written MPN notice must be provided to an employee when:

1. an injury is reported;
2. an employer has knowledge of an injury; or
3. an employee with an existing injury is required to transfer treatment to an MPN.

The notification must be provided in English and also in Spanish if the employee primarily speaks Spanish.<sup>11</sup> The appeals board has held that an applicant's illiteracy and inability to read the notices does not vitiate the employer's compliance with the notice requirements.<sup>12</sup>

Generally, the complete MPN notification must be sent by regular mail. But, if the covered employee has regular electronic access to email at work, the notification may be sent electronically instead of by mail at the time of injury or when the employee is being transferred into the MPN. If the employee cannot receive

<sup>8</sup> *Hernandez v. Newco Foods, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 713.

<sup>9</sup> *Aguayo v. Barrett Business Services, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 254.

<sup>10</sup> Those regulations established four different situations in which MPN notification was required. They were: (1) implementation notice — when a network is created or, for one that exists, when an employee is hired; (2) a complete MPN notification — when there is a work-related injury or the applicant begins treating in the network for the first time for another reason; (3) when the employer decides to terminate an MPN; and (4) when the employer switches from one MPN to another.

<sup>11</sup> Former CCR 9767.12(d) required notice in Spanish to "Spanish speaking employees."

<sup>12</sup> *Rodriguez v. Grimmway Enterprises, Inc.* (2011) 39 CWCR 121 [2011 Cal. Wrk. Comp. P.D. LEXIS 93]; *Meza v. Omnia Italian Design, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 439.

this notice electronically at work, the employer must ensure notice is provided to him or her in writing at the time of injury or when he or she is transferred into the MPN.

Note that the regulation establishes that the notice must be given when an injury is reported or when an employer has knowledge of an injury. CCR 9767.12(a), however, does not explicitly specify a time period for providing the MPN notice after the injury is reported. Furthermore, CCR 9767.19 specifies a penalty of \$250 for failure to provide the complete MPN notice, but does not indicate when the notice must be given. So employers should provide the notice within a reasonable time after the injury is reported.

In the same vein, CCR 9767.6(d) requires that the employer “shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.” This notice requirement could be and should be addressed by the complete MPN notification. But, again, the regulation is ambiguous about how long the defense has to send notice, saying only that it must be sent “after the first visit with the MPN physician.” Presumably, a reasonable period will be expected — whatever that is.

## Contents of Notice

Per CCR 9767.12(a)(2), the complete written MPN employee notification must include:

1. the unique MPN identification number;
2. how to contact the person designated by employer as the MPN contact (for covered employees’ questions about the use of MPNs and MPN complaints, including a toll-free telephone number with access to the contact if the MPN geographic service area includes more than one area code);
3. a toll-free number for MPN medical access assistants (with a description of the assistance they provide, including finding available MPN physicians of the injured workers’ choice, scheduling and confirming physician appointments and the times they are available to assist workers);
4. a description of MPN services, the MPN’s web address (for more information about the MPN) and the web address that includes a roster of all treating physicians in the MPN;
5. how to review, receive or access the MPN provider directory (Employees must have access to, at minimum, a regional area listing of MPN providers in addition to maintaining and making available its complete provider directory listing in writing and/or on the MPN’s website. The MPN’s website address must be clearly listed.);<sup>13</sup>
6. how to access initial care and subsequent medical care and how to contact the medical access assistants (if an employee needs help in finding a physician or scheduling an appointment);
7. the mileage, time requirements and alternative access standards required under CCR 9767.5;
8. how to access treatment if:
  - A. the employee is authorized by the employer temporarily to work or travel for work outside the MPN’s geographic service area;
  - B. a former employee whose employer has ongoing workers’ compensation obligations permanently resides outside the MPN geographic service area; and
  - C. an injured employee decides temporarily to reside outside the MPN geographic service area during recovery.
9. how to choose a physician within the MPN;

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<sup>13</sup> Former CCR 9767.12(f)(3) required an employer to make “available its complete provider listing in writing.” So the appeals board upheld a WCJ’s order requiring a defendant to provide in writing a complete medical provider network list in the specialties of orthopedics, internal medicine and psychiatry. *Vargas v. Sears Holdings Corp.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 457. In another case, the appeals board found that former CCR 9767.12(f)(3) did not require a defendant to provide a written list of MPN providers in every case, but that the regulation requires only that a written list be “made available.” In that case, the applicant did not request such a list, so failure to provide it could not serve as a basis for his treatment outside of the MPN. *Brodie v. Carmax*, 2013 Cal. Wrk. Comp. P.D. LEXIS 474.

10. what to do if a covered employee has trouble getting an appointment with a provider within the MPN and how to use the medical access assistants for help;
11. how to change a physician within the MPN;
12. how to obtain a referral to a specialist within the MPN or outside the MPN, if needed;
13. how to use the second and third opinion process;
14. how to request and receive an MPN independent medical review;
15. a description of the standards for the transfer of care policy and a notification that a copy of the policy in English or in Spanish (if the employee speaks Spanish it must be provided on request); and
16. a description of the standards for the continuity of care policy and a notification that a copy of the policy in English or in Spanish (if the employee speaks Spanish it must be provided on request).

If an employee requests an electronic provider directory listing, it must be provided on a CD, flash drive, via email or on a website. The URL address for the provider directory must be listed with any additional information needed to access the directory online including any necessary instructions and passwords.

Employers are responsible for updating an MPN's provider listings at least quarterly with the date of the last update provided on the listing given to the employee. Each provider directory must include a phone number and an email address for reporting listing inaccuracies. If a listed provider dies or no longer treats workers' compensation patients at the listed address, the provider must be removed from the directory within 45 days of notice to the MPN through the contact method stated on the provider directory listing to report inaccuracies (CCR 9767.12(a)(2)(C)).

### **Notice on Termination of Coverage**

A different notice requirement is established in CCR 9767.12(b) concerning the end of MPN coverage. An employer must provide written notice to each injured covered employee treating under an MPN that is ending. It must cite the date he or she no longer will be able to use the network. The notice must be provided in English and in Spanish for employees who speak Spanish.

Before the date MPN coverage ends, the employer must provide this information to every injured, covered employee using its network:

1. the effective date the employee no longer can use the MPN;
2. the unique MPN identification number;
3. whether the MPN still will be used for injuries arising before the date MPN coverage ends;
4. the address(es), telephone number(s) and email address(es) of the MPN contact and MPN medical access assistants who can address MPN questions, and an MPN website;
5. for periods when an employee is not covered by a MPN, that he or she may choose a physician 30 days after the date the employee notified the employer of the injury.

The regulations state that this language may be provided in writing to injured covered employees as required notice of the end of coverage under an MPN: "The [Insert MPN Name] Medical Provider Network (MPN), under the unique MPN Identification number [Insert MPN Identification number] will no longer be used for injuries arising after [Insert Date MPN Coverage Ends]. You will/will not [Select Whichever is Appropriate] continue to use this MPN to obtain care for work injuries occurring before this date. For new injuries that occur when you are not covered by a MPN, you have the right to choose your physician 30 days after you notify your employer of your injury. For more information contact [Insert MPN Contact and Medical Access Assistants toll free number(s), MPN Address(es), MPN Email Address(es), and MPN Website]."

This notice may be provided by mail or included on or with an employee's paystub, paycheck or sent electronically, if the employee has regular access to email at work to receive it before the end of MPN coverage. If the employee cannot receive this notice electronically at work within the required time frame, the employer must ensure the information is provided to the employee in writing before MPN coverage ends. Any pending MPN independent medical review (IMR) will end with the employee's coverage under the MPN. The IMR process is discussed in ["Sullivan on Comp" Section 7.55 Medical Provider Network — Dispute Resolution](#).

## Failure to Provide Notices

SB 863 added LC 4616.3(b) which states, "The employer's failure to provide notice as required by this subdivision or failure to post the notice as required by Section 3550 shall not be a basis for the employee to treat outside the network unless it is shown that the failure to provide notice resulted in a denial of medical care." Although effective Jan. 1, 2013, it applies to any case still pending, except those that were concluded subject only to the appeals board's continuing jurisdiction under LC 5803 and LC 5804.<sup>14</sup>

Before the passage of SB 863, the leading case in the area was the WCAB's *en banc* decision in *Knight v. United Parcel Service*.<sup>15</sup> In that case, the appeals board held that an employer's or insurer's failure to provide the required notice of rights under the MPN that results in a "neglect or refusal" to provide reasonable medical treatment renders the employer or insurer liable for reasonable treatment self-procured by the employee. Accordingly, several decisions from the appeals board determined that a failure to provide the appropriate MPN notices would allow an applicant to treat outside of an MPN only if the failure to notice resulted in a "neglect or refusal to provide reasonable medical care."<sup>16</sup> The appeals board generally allowed treatment outside of an MPN only when it found a neglect or refusal to provide care.<sup>17</sup>

The new statutory language goes even further, requiring an actual "denial of medical care." What constitutes a denial of medical care as opposed to a neglect or refusal? Are the standards the same? Suppose an applicant reports an injury, but the employer does nothing and doesn't send the applicant to a doctor. Is this a denial of care? Perhaps so, despite the fact that the employer did not specifically tell the applicant that he or she could not have medical care. But suppose an applicant reports an injury, and the employer simply refers the applicant to the MPN website. Perhaps this could be seen as a mere neglect of care, because LC 4616.3(a) requires the employer to arrange the initial medical evaluation, but there may not be a refusal. A large body of law discusses the meaning of refusal or neglect to provide care (see ["Sullivan on Comp" Section 7.52 Employer's Neglect or Refusal to Furnish Medical Care](#)), but denial of care is a new standard that must be considered. Defining this standard is the job of the courts, and this is in process, with several panel decisions speaking to the issue.

<sup>14</sup> *Hernandez v. Aramark*, 2013 Cal. Wrk. Comp. P.D. LEXIS 310.

<sup>15</sup> (2006) 71 CCC 1423 (appeals board *en banc*).

<sup>16</sup> See *Santamaria v. Romberg's Landscaping and Tree Service*, 2009 Cal. Wrk. Comp. P.D. LEXIS 604; *Oseguera v. Nakamura*, 2012 Cal. Wrk. Comp. P.D. LEXIS 2. See also *Medrano v. Los Altos Farms*, 2010 Cal. Wrk. Comp. P.D. LEXIS 301; *De Soto v. Foster Farms*, 2010 Cal. Wrk. Comp. P.D. LEXIS 72; *Ochoa v. Bel Aire Window Coverings*, 2012 Cal. Wrk. Comp. P.D. LEXIS 148; *Lopez v. Tri-State Restorations, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 246; *Aban v. Cal Centurian Construction, Inc. dba RWR Construction*, 2012 Cal. Wrk. Comp. P.D. LEXIS 326; *Chavez v. T.D. Hayes Communications*, 2012 Cal. Wrk. Comp. P.D. LEXIS 403; *Sanchez v. Southern Fresh Produce*, 2012 Cal. Wrk. Comp. P.D. LEXIS 438; *Jackson v. Universal Protection Service*, 2011 Cal. Wrk. Comp. P.D. LEXIS 120; *Jackson v. Universal Protection Services*, 2012 Cal. Wrk. Comp. P.D. LEXIS 136; *Quintero v. Adecco*, 2011 Cal. Wrk. Comp. P.D. LEXIS 291; *Espinoza v. Barrett Business Services, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 212; *Guereca v. LSG Sky Chefs*, 2008 Cal. Wrk. Comp. P.D. LEXIS 895; *Gonzalez v. Herman Weisker, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 106; *Mendez-Correa v. Vevoda Dairy*, 2013 Cal. Wrk. Comp. P.D. LEXIS 171; *Figuroa v. AG Force*, 2013 Cal. Wrk. Comp. P.D. LEXIS 201. But see *Canlas v. Victoria Townhouse Apts.*, 2008 Cal. Wrk. Comp. P.D. LEXIS 69 (any breach of the duty to notice entitled applicant to self-procure medical treatment from any physician of her choice).

<sup>17</sup> See *Barrett Business Services, Inc. v. WCAB (Sanchez)* (2007) 72 CCC 834 (writ denied); *Santa Ana Unified School District v. WCAB (Johnson)* (2008) 74 CCC 68 (writ denied); *Alderfer v. BBSI/CI Plumbing, Barrett Business Services, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 410; *Barrett Business Services, Inc. dba Manning Foods v. WCAB (Desiderio)* (2008) 74 CCC 49 (writ denied); *Peterson v. Ralph's Grocery Co.*, 2009 Cal. Wrk. Comp. P.D. LEXIS 241; *Zuniga v. Newstar Fresh Foods, LLC*, 2009 Cal. Wrk. Comp. P.D. LEXIS 560; *Osorio v. Grimmway Enterprises*, 2009 Cal. Wrk. Comp. P.D. LEXIS 174; *Dela Mora v. Wal-Mart Associates, Inc.*, 2009 Cal. Wrk. Comp. P.D. LEXIS 134; *Khosravan v. Walgreen's*, 2011 Cal. Wrk. Comp. P.D. LEXIS 121; *Matancias (Mantancillas) v. Milk Maid Dairy/Tony Dragt*, 2012 Cal. Wrk. Comp. P.D. LEXIS 88; *Zarco v. Alldrin Orchards, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 4; *Galloway v. Riverside County Regional Hospital/County of Riverside*, 2012 Cal. Wrk. Comp. P.D. LEXIS 514; *Sanchez v. County of Fresno*, 2013 Cal. Wrk. Comp. P.D. LEXIS 128.

In one case, the appeals board explained that when an employer establishes the existence of a valid MPN and demonstrates actions designed to give MPN notice to the applicant, the burden shifts to the applicant to show that the notice or some other aspect of the MPN was defective and resulted in a denial of care.<sup>18</sup> In another case, the appeals board also held that the employee has the burden to prove a denial of medical care under LC 4616.3(b); that applicant did not carry this burden. The board found that the defendant had authorized shoulder surgery, and that the applicant offered no evidence why he did not undergo it. He wanted the appeals board to infer that he did not obtain the surgery because the defendant did not have the requisite number of orthopedic surgeons within the time and distance required by CCR 9767.5 (see [“Sullivan on Comp” Section 7.53 Medical Provider Network — Establishment and Maintenance](#)). But there was no evidence about whether the defendant had orthopedic surgeons within the particular time or distance for a specialist from the applicant’s residence or workplace.<sup>19</sup>

In another case, the appeals board held that a defendant’s failure to timely issue MPN notices did not allow an applicant to treat outside the MPN when the failure to notice did not result in a denial of care. The applicant was injured in January 2012 and was provided treatment from the day of the accident. The employer did not issue MPN notices until October 2012. The appeals board nevertheless held that the late notices did not mean the applicant was denied care. It found that the applicant was provided care from the date she reported the injury, so there was no denial of it even though there was a delay in issuing the MPN notice.<sup>20</sup>

In contrast, in one case, the appeals board upheld a determination that an employer’s defective notices resulted in a denial of care when the notices deprived the applicant of the knowledge of how to dispute the findings of her treating MPN physician and to find another one within the network. The applicant was unhappy with her treatment within the MPN, and self-procured treatment with her private doctor. The appeals board explained that if the applicant had been informed of her right to change physicians within the MPN, and of her rights to a referral to a specialist, or of the second and third opinion processes or the IMR process, she would not have had to self-procure the treatment. So the appeals board found that the lack of notice resulted in a denial of care.<sup>21</sup>

If there is an issue about whether the employer provided the appropriate MPN notices, the employer should be prepared to present evidence showing that all of the above information was provided to the applicant. Otherwise, the appeals board may find that it did not provide it.<sup>22</sup>

Note that these considerations apply only if there is a failure to provide notice to the applicant. Independent of this, as described above, is the employer’s general obligation to provide medical care in a proactive fashion. If the employer refuses or neglects to provide care, medical control is lost. So an employer can fail to provide the proper notices, and prove that the failure did not result in a denial of care. But that employer still might lose medical control if, independent of the failure to provide notices, it refuses or neglects to provide care.

<sup>18</sup> *Southland Spine and Rehabilitation Medical Center, Inc. v. WCAB (Salas)* (2015) 81 CCC 88 (writ denied).

<sup>19</sup> *Martinez v. New French Bakery*, 2013 Cal. Wrk. Comp. P.D. LEXIS 438. See also *Cornejo v. Solar Turbines, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 479; *Jimenez v. Sodexho*, 2014 Cal. Wrk. Comp. P.D. LEXIS 683.

<sup>20</sup> *Vasquez v. Target Corp.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 183. See also *Monroy v. AMS Exotic, LLC*, 2014 Cal. Wrk. Comp. P.D. LEXIS 243 (WCAB rejected applicant’s claim that defendant sent MPN notices to the wrong address when they were sent to applicant’s address of record; there was no denial of care because defendant provided treatment three times within a 24-day period before applicant chose to go to a non-MPN provider).

<sup>21</sup> *San Diego Unified School District v. WCAB (Robledo)* (2013) 79 CCC 95 (writ denied). See also *Ovando v. Bodycote International, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 77.

<sup>22</sup> *Cantabrana v. Superior Sod*, 2014 Cal. Wrk. Comp. P.D. LEXIS 47.

## Failure to Post Notices

Per LC 3550 and CCR 9881, the employer is required to post notices regarding employees' workers' compensation rights. The notice must be posted "in a conspicuous location frequented by employees and where such notice may be easily read by employees during the course of the workday." What constitutes a conspicuous location and a discussion of the notice's content are discussed in depth in ["Sullivan on Comp" Section 6.3 Pre-Injury Notices](#). Of special note are the numerous elements required to be posted — they include notice that the applicant has the right to receive medical care and change primary treating physicians, and to receive specific information about how to receive emergency care.

According to the specific language of LC 3550(e), "Failure of the employer to provide the notice required by this section shall automatically permit the employee to be treated by his or her own personal physician with respect to an injury occurring during that failure." But LC 4616.3(b) provides that "a failure to post the notice as required by Section 3550 shall not be a basis for the employee to treat outside the network unless it is shown that the failure to provide notice resulted in a denial of medical care." Although LC 3550 was not amended by SB 863, LC 4616.3(b) is more specific to the issue and should control. The standard is whether the failure to notice resulted in a denial of medical care.<sup>23</sup>

## Failure to Provide Notice of Right to Predesignate

If an applicant has predesignated a treating physician properly under LC 4600(d), he or she is not subject to treatment within an MPN. Per CCR 9782(b), an employer must advise its employees in writing of an employee's right to predesignate under LC 4600(d). CCR 9780.1(e) requires employers to notify their employees of the right to predesignate and provide an optional form for predesignating a personal physician. CCR 9880 requires this information to be provided to every new employee, either at the time of hire or by the end of the first pay period. Does a failure to notify an employee of the right to predesignate allow him or her to treat outside of the MPN?

LC 4616.3(b) applies only if there is a failure to provide MPN notices under that section or a failure to post notice under LC 3550. It does not address whether failure to provide notice of predesignation under LC 4600(d) will allow an applicant to treat outside of an MPN.

In one case preceding SB 863, the appeals board affirmed a decision that an applicant was entitled to treat with her personal physician outside of the defendant's MPN when the defendant failed to establish that the applicant was given notice that she was entitled to predesignate her treating physician. The appeals board believed that the right to predesignate would be meaningless if an applicant were never informed that this right existed. So the appeals board allowed the applicant to continue with her treating physician indefinitely, despite the fact that he was not included within the defendant's MPN.<sup>24</sup>

Since SB 863, the appeals board, without addressing LC 4616.3(b), also held that an applicant could treat outside the MPN with a personal physician if the employer failed to notify the applicant before the injury of his or her right to treat with a personal physician. But the board added that the applicant was entitled to do so provided that all the conditions regarding treating by the personal physician in LC 4600(d) were met. The applicant does not get free choice to treat with any other non-MPN physician.<sup>25</sup>

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<sup>23</sup> For cases discussing whether an applicant could treat outside an MPN for failure to post an LC 3550 notice before the enactment of SB 863, see *Metoyer v. Wilshire West Dental*, 2005 Cal. Wrk. Comp. P.D. LEXIS 48; *Gonzales v. Gilberto Portillo Painting*, 2008 Cal. Wrk. Comp. P.D. LEXIS 545; *Reynoso v. V. Terrazas Contracting*, 2012 Cal. Wrk. Comp. P.D. LEXIS 382.

<sup>24</sup> *Davis v. AC Transit*, 2012 Cal. Wrk. Comp. P.D. LEXIS 567.

<sup>25</sup> *Herrera v. Ameri-Cold Logistics*, 2013 Cal. Wrk. Comp. P.D. LEXIS 51.

## DETERMINATIONS REGARDING WHETHER EMPLOYEE IMPERMISSIBLY TREATED OUTSIDE MEDICAL PROVIDER NETWORK

Following an industrial injury, if an MPN exists, an employer generally will refer an applicant to an MPN doctor for treatment. After receiving this treatment, however, it is not uncommon for an applicant, especially after obtaining an attorney, to designate an out-of-network physician as his or her primary treating physician. The applicant will argue that the new selection is proper due to some defect in the claim to MPN control. The parties may argue about this in court. SB 863 amended LC 4603.2 to describe what happens after the appeals board has decided whether or not an employee's treatment outside the MPN was valid.

### Medical Treatment If Employee Permissibly Treated Outside of MPN

Per LC 4603.2(a)(2), "If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was entitled to select the physician pursuant to Section 4600, the employee shall be entitled to continue treatment with that physician at the employer's expense ..."

What are the reasons an employee could be permitted to treat outside of MPN? Suppose an applicant does so on the grounds of inadequate notice and the appeals board determines that the failure to provide notice resulted in a denial of medical care. In this situation, the employer's objection is still that the physician is not within the MPN. Under LC 4603.2(a)(2), the applicant would be entitled to continue treating with the non-MPN physician after a determination in the applicant's favor.

But what if the employer objects to the applicant's selection of a physician on other grounds? Suppose an employer denies a claim on AOE/COE grounds or because of an affirmative defense. The employer would not be objecting to the physician on the grounds that he or she was not within the MPN, but to the treatment entirely. Is the employee permitted to continue treating with a non-MPN physician if the appeals board determines that the employer denied medical care by denying the claim? LC 4603.2(a)(2) doesn't speak to those situations.

Before SB 863, the appeals board held that employers could transfer an employee into an MPN at any time.<sup>26</sup> (For a full discussion of this topic see ["Sullivan on Comp" Section 7.57 MPN — Transfer of Care.](#)) So an employee could be transferred into an MPN after the employer initially issued a defective MPN notice,<sup>27</sup> or if it initially denied a claim and the employee was forced to self-procure care.<sup>28</sup> But as of 2013, per LC 4603.2(a)(2), an employer no longer is entitled to transfer an applicant into an MPN at any time; it could not do so if it objected on the grounds that the "physician is not within the medical provider network" and lost. But if the employer objects to the treatment on other grounds, then it may be permissible to transfer the applicant back into the MPN. This will need to be clarified by the courts.

LC 4603.2(a)(2) provides that if the appeals board determines that the applicant was entitled to select the physician, the employer must pay from the date of the initial examination if the physician's report was submitted within five working days of it. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee will not be required to pay for any services before the date the physician's report was submitted.

<sup>26</sup> *Babbitt v. Ow Jing dba National Market* (2007) 72 CCC 70 (appeals board *en banc*).

<sup>27</sup> See *O'Leary v. Pinel*, 2012 Cal. Wrk. Comp. P.D. LEXIS 149; *Martin v. Manpower, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 381; *Krause v. WCAB* (2010) 75 CCC 683 (Court of Appeal opinion unpublished in official reports); *Amezcuca v. Westside Produce*, 2013 Cal. Wrk. Comp. P.D. LEXIS 93.

<sup>28</sup> See *Montes v. WCAB* (2008) 73 CCC 709 (writ denied); *Barrett Business Services, Inc., dba Manning Foods v. WCAB (Desiderio)* (2008) 74 CCC 49 (writ denied).



This imposes on non-MPN doctors a duty to notify employers immediately when an applicant commences treatment outside of the MPN. It prevents non-MPN doctors from treating employees for weeks and even months without notifying the employers and then forwarding a massive bill for all of the services performed. It makes sure that if an applicant treats outside the MPN, the defendant immediately may bring the issue of whether that treatment was appropriate to the appeals board. In conjunction with this change, SB 863 amended LC 5502 to allow parties to file a DOR for expedited hearings on MPN issues. An employer may file for an expedited hearing to compel treatment within an MPN even during the 90-day investigation period.<sup>29</sup> This is discussed further in [“Sullivan on Comp” Section 15.32 Expedited Hearing](#).

## **Medical Treatment If Employee Impermissibly Treated Outside of MPN**

Per LC 4603.2(a)(3), “If the employer objects to the employee’s selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer shall have no liability for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.”

So if an employer asserts that the applicant’s physician is not within the MPN and the appeals board determines that the applicant impermissibly treated outside of the network, there are two consequences: (1) the employer is not liable for any treatment provided by or at the direction of that physician; and (2) the employer is not liable for any consequences of the treatment obtained outside of the MPN.

The first consequence has ramifications for the physician who risks not getting paid if the treatment is found to be impermissible. And because LC 4603.2(a)(3) precludes payment “at the direction of that physician,” the employer would not be liable for any referrals made by the non-MPN physician.

The second consequence has potential ramifications for the injured applicant. Generally, as discussed in [“Sullivan on Comp” Section 5.65 Compensable Consequence Injuries](#), an employer is liable for subsequent injuries caused by the original injury. But because LC 4603.2(a)(3) precludes liability for “any consequences” of the treatment obtained outside the MPN, such injuries would not be compensable if the appeals board determines that the applicant impermissibly treated outside the network.

For example, when an applicant sustains an injury traveling to or from a physician’s office for treatment for an industrial injury, generally it’s a compensable consequence of the original injury.<sup>30</sup> If, however, such an accident occurred while an applicant was treating impermissibly outside of an MPN, the applicant would have no remedy against the employer for it. Not only would the employer not be liable for any new medical treatment caused by the accident, it would not be liable for any indemnity, temporary or permanent, that otherwise would be payable.

The diligent defense practitioner no doubt will see almost endless possibilities when it comes to the term “consequences of treatment,” and will strain to tie in as many benefits as possible. Maybe the treatment was unnecessary or went on too long, and as a result the applicant became overweight or addicted to medications. Or maybe there was a surgery that did not go well and the applicant had more permanent disability than he or she otherwise would have had. In short, significant litigation is sure to ensue over the definition of “any consequences.”

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<sup>29</sup> *Kim v. B.C.D. Tofu House, Inc.* (2014) 79 CCC 140 (significant panel decision).

<sup>30</sup> *Laines v. WCAB* (1975) 40 CCC 365.

If a defendant asserts that a doctor is not part of the MPN, it should come to court prepared to make this showing.<sup>31</sup>

## ADMISSIBILITY OF NONMEDICAL PROVIDER NETWORK REPORTS

LC 4603.2(a)(3) specifies that if the appeals board determines that an applicant impermissibly treated outside an MPN, the employer is not liable for the treatment or for any consequences of the treatment. The employer does not have to pay for improper non-MPN reports.

This doesn't mean, however, that non-MPN reports are inadmissible. In *Valdez v. WCAB*,<sup>32</sup> the California Supreme Court held that non-MPN reports under LC 4605 are admissible, but may not support a disability award standing alone. LC 4605 is discussed further in [“Sullivan on Comp” Section 7.59 Employee’s Unreasonable Refusal to Accept Medical Care](#).

Initially, the appeals board issued an *en banc* decision holding that when unauthorized treatment is obtained outside a validly established and properly noticed MPN, reports from the non-MPN doctors are inadmissible and may not be relied on.<sup>33</sup> The appellate court issued an opinion annulling the decision of the appeals board. It found that a rule barring reports from privately retained physicians would eviscerate employees' rights under LC 4605 to consult with any doctor at their own expense.<sup>34</sup> The California Supreme Court decided to review the case, but afterward the Legislature amended LC 4605 as part of SB 863.

LC 4605 has long given an employee the right to a consulting or attending physician at “his own expense.” It was amended to make the language more gender neutral. LC 4605 now states, “Nothing contained in this chapter shall limit the right of the employee to provide, at his or her own expense, a consulting physician or any attending physician whom he or she desires.” When an applicant chooses to self-procure treatment under LC 4605, a defendant is not liable for the costs of the medical treatment.<sup>35</sup>

More significant are new sentences in LC 4605 stating, “Any report prepared by consulting or attending physicians pursuant to this section shall not be the sole basis of an award of compensation. A qualified medical evaluator or authorized treating physician shall address any report procured pursuant to this section and shall indicate whether he or she agrees or disagrees with the findings or opinions stated in the report, and shall identify the bases for this opinion.” So although reports at an employee's “own expense” are admissible in workers' compensation proceedings, they may not be the sole basis of an award, and such reports must be addressed by a QME or “authorized treating physician.”

In *Valdez v. WCAB*,<sup>36</sup> the California Supreme Court found that the subsequent amendment to LC 4605 shed considerable light on the issue before it. The Supreme Court affirmed the Court of Appeal's decision that LC

<sup>31</sup> *Magana v. Koosharem Corp. dba Select Staffing*, 2014 Cal. Wrk. Comp. P.D. LEXIS 531.

<sup>32</sup> (2013) 78 CCC 1209.

<sup>33</sup> *Valdez v. Warehouse Demo Services* (2011) 76 CCC 330 (appeals board *en banc*); *Valdez v. Warehouse Demo Services* (2011) 76 CCC 970 (appeals board *en banc*). See also *Gonzalez v. WCAB* (2012) 77 CCC 449 (writ denied). Cases prior to *Valdez* held that applicants were allowed to treat outside of MPNs at their own expense under LC 4605, and that the reports of these doctors were admissible. *Guerrero v. Davlyn Investments, Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 47; *Salgado v. County of Orange*, 2009 Cal. Wrk. Comp. P.D. LEXIS 279; *Martinez v. Alert Plating Co., Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 108.

<sup>34</sup> *Valdez v. WCAB* (2012) 77 CCC 506.

<sup>35</sup> *Lane v. Big Lots Stores, Inc.*, 2008 Cal. Wrk. Comp. P.D. LEXIS 781; *Salgado v. County of Orange*, 2009 Cal. Wrk. Comp. P.D. LEXIS 279; *Nunez v. Mainstay Business Solutions*, 2010 Cal. Wrk. Comp. P.D. LEXIS 597; *Sanchez v. American Printworks/P & Y T-Shirts and Silk Screenings Co., Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 401; *Arellano v. Ramee Investment Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 459; *Bahena v. De Pinno Roofing*, 2012 Cal. Wrk. Comp. P.D. LEXIS 223; *Madril v. City of Riverside*, 2012 Cal. Wrk. Comp. P.D. LEXIS 247; *Salgado v. County of Orange*, 2009 Cal. Wrk. Comp. P.D. LEXIS 279; *Coghan v. Lange Trucking, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 154; *Moreno v. Harborside Inns of Santa Barbara*, 2010 Cal. Wrk. Comp. P.D. LEXIS 371; *Chavez v. Superior Trailer, Barrett Services, Inc.* 2012 Cal. Wrk. Comp. P.D. LEXIS 60; *Nava v. Barrett Business Services, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 303; *Zuniga v. Barrett Business Services, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 325. In one case, the WCAB held that an employer is not required to pay for treatment outside of a properly established MPN, but added that a defendant was not entitled to “declaratory relief” regarding its potential liability for medical treatment outside the MPN because the issue should be heard at the conclusion of the case. *Evangelista (Evangelista Mejia) v. Sodexo, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 63.

<sup>36</sup> (2013) 78 CCC 1209.

4616.6 (discussed further in [“Sullivan on Comp” Section 7.55 Medical Provider Network — Dispute Resolution](#)) does not prevent employees from seeking treatment at their own expense, or bar those doctors’ reports from disability hearings. The Supreme Court found that under LC 4605, such reports may provide some basis for an award, but not standing alone.<sup>37</sup>

The Supreme Court explained, “Section 4605 has long permitted employees to consult privately retained doctors at their own expense, and the amendments enacted by Senate Bill 863 maintain that right.” It found that the amendments enhanced the effectiveness of MPNs and limited employers’ liability for the costs of out-of-network treatment, but found that “none of the new provisions require MPNs to be exclusive providers of medical treatment.” It added that although the statutory changes “may encourage employees to use MPN services ... they do not foreclose other avenues of treatment, or bar the Board from considering medical reports generated outside of an MPN when it reviews applications for disability benefits.”<sup>38</sup> The case was remanded to the appeals board to consider application of the amendments of SB 863.

So per LC 4605 and *Valdez*, reports at an employee’s “own expense” are admissible in workers’ compensation proceedings, but they will have limited value. They may not support an award on their own and must be reviewed by a QME or authorized treating physician. If the report was not reviewed, it may not be relied on to support an award on its own. The WCAB, however, may not exclude a report for the sole reason that it was prepared by persons not in the MPN.<sup>39</sup>

For example, in one case, the applicant self-procured medical treatment from a non-MPN physician. The reports were admitted into evidence properly, but the WCJ was reversed for making them the basis of an award when they had not been reviewed by the QME.<sup>40</sup>

## DISPUTES OVER MEDICAL PROVIDER NETWORK DOCTOR’S REQUESTS FOR TREATMENT

Following the creation of MPNs, it was widely recognized that an MPN physician’s requests for treatment are subject to the utilization review process established in LC 4610. Utilization review (UR) is the process to “prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and review, treatment recommendations by physicians ...” (LC 4610(a)). It is “the process by which a defendant, through a licensed physician it employs or with whom it contracts, reviews the treatment recommendations of an injured employee’s treating physician and then decides whether to approve, modify, delay, or deny authorization for the treatment based on medical necessity.”<sup>41</sup>

As a result of SB 863, if a utilization review determination denied, delayed or modified a doctor’s request for treatment, the request for treatment was subject to the independent medical review (IMR) process pursuant to LC 4610.5 and LC 4610.6. Under the IMR process, medical treatment decisions are made by one or more independent physicians under contract by the administrative director (LC 139.5).

In 2014, applicants challenged whether the utilization review and independent medical review processes applied to requests for treatment by MPN physicians, and one WCJ even adopted this position. In a trial level decision, the WCJ explained that physicians within the MPN are employed by contract to provide treatment pursuant to the MTUS and ACOEM guidelines. He found nothing within the MPN chapter allowing defendants to challenge the treatment recommendations of the MPN doctor. The WCJ concluded

<sup>37</sup> *Valdez v. WCAB* (2013) 78 CCC 1209, 1216.

<sup>38</sup> *Valdez v. WCAB* (2013) 78 CCC 1209, 1216-17.

<sup>39</sup> See *Garcia v. WCAB* (2014) 79 CCC 619 (Court of Appeal opinion unpublished in official reports).

<sup>40</sup> *Trejo v. Northrup Grumman Corp.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 585.

<sup>41</sup> *Cervantes v. El Aguila Food Products, Inc.* (2009) 74 CCC 1336, 1338, fn. 4 (appeals board *en banc*).

that the MPN scheme precludes the use of UR in disputes over treatment by the employer's MPN physician.<sup>42</sup> The appeals board, however, quickly put an end to this argument.

In *Stock v. Camarillo State Hospital*,<sup>43</sup> the appeals board held that an applicant's participation within the employer's MPN does not prohibit the employer from referring the MPN physician's request for authorization of medical treatment to utilization review and independent medical review. The board explained that by its adoption of the MPN system, the Legislature did not intend to preclude a defendant from seeking utilization review of an MPN physician's request for authorization of medical treatment. It added that the law and the implementing administrative rules provide mechanisms for review of disputed treatment recommendations through UR, whether or not the treating physician is in the employer's MPN. It found that both the UR and MPN provisions of the Labor Code subject a treating physician's request for authorization of medical treatment to review by a physician competent to evaluate the specific clinical issues, whether or not the physician is selected through the MPN. It also found that the definition of a primary treating physician in CCR 9767.1 and CCR 9785(a)(1) includes a physician within an MPN. The appeals board concluded that when a defendant does not approve a treatment request from the applicant's primary treating physician, it must refer the request to a UR physician.<sup>44</sup>

Ultimately, in *Hogenson v. Volkswagen of America*,<sup>45</sup> the appeals board reversed the WCJ's decision and held that medical treatment proposed by an MPN physician is subject to UR and IMR because the Legislature did not exclude MPN treatment from those medical review processes. It explained that although the MPN statute and the UR and IMR statutes were enacted at different times, that did not mean that the UR and IMR processes do not apply to MPN providers. It believed that if the Legislature intended to exempt MPN medical treatment from UR and IMR, it would have expressly excluded MPN providers and treatment from the statutes, but it did not. The board also believed that submitting MPN treatment proposals to UR and IMR is consistent with the legislative goal of assuring that medical treatment is provided by all defendants consistent with uniform evidence-based, peer-reviewed, nationally recognized standards of care.<sup>46</sup>

## **DISPUTES OVER DIAGNOSIS OR TREATMENT PRESCRIBED BY MEDICAL PROVIDER NETWORK DOCTOR**

The Legislature has provided for an exclusive resolution process when an applicant disputes either the diagnosis or the treatment prescribed by the treating physician within the network. The Labor Code allows an applicant to seek an opinion from another physician within the network (LC 4616.3 and CCR 9767.7). A third opinion also may be sought, and if that is not acceptable, one more medical opinion is allowed. The last opinion is performed by a physician called the independent medical reviewer, and is selected by the administrative director per LC 4616.4.

SB 542 amended the Labor Code to distinguish between the MPN independent medical review process and the independent medical review process used to resolve utilization review disputes. The MPN independent medical review process is discussed in detail in [“Sullivan on Comp” Section 7.55 Medical Provider Network — Dispute Resolution](#). The independent medical review and utilization review processes will be further discussed in Chapter VI: Utilization Review and Independent Medical Review.

<sup>42</sup> *Hogenson v. Volkswagen Credit, Inc.* (2014) ADJ2145168 (GOL 0096589).

<sup>43</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 471.

<sup>44</sup> *Stock v. Camarillo State Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 471.

<sup>45</sup> 2016 Cal. Wrk. Comp. P.D. LEXIS 488.

<sup>46</sup> *Hogenson v. Volkswagen of America*, 2016 Cal. Wrk. Comp. P.D. LEXIS 488. Commissioner Sweeney issued a concurring opinion to emphasize that there are two separate and distinct independent medical review processes in the workers' compensation system; one is triggered by the employer's objection to a medical treatment determination and the other is triggered by the employee's objection to an MPN medical treatment determination. See also *Mendoza v. WCAB* (2015) 80 CCC 484 (writ denied); *Parrent v. SBC-Pacific Bell Telephone Co.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 437; *Willoughby v. Hoge, Fenton, Jones & Appel*, 2016 Cal. Wrk. Comp. P.D. LEXIS 512.

## 6. UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

Since 2004, every employer or insurer has been required to establish a medical treatment utilization review process (UR). It determines the reasonableness and necessity of proposed medical treatment. The claims adjuster sends a request for care to a physician who reviews it in accordance with established medical guidelines. Sometimes the review approves the proposed treatment, leaving the employer with no remedy, and a requirement to provide the care. Sometimes the review recommends that the treatment be denied or modified.

Generally, prior to SB 863, if an applicant disputed a utilization review decision to delay, deny or modify a request for authorization of medical treatment, he or she was required to do so in accordance with LC 4062. An applicant was required to notify the employer of the objection, normally within 20 days of receipt of the decision, and obtain a report from a panel QME if he or she was unrepresented, or from an AME or panel QME if he or she was represented. Medical treatment disputes could take months to work their way through this medical-legal process, or longer if supplemental reports and depositions were required of the doctor. More time was consumed bringing the issues through the court system and ultimately to a WCJ who might not fully understand technical medical analysis.

The Legislature found that system to be “costly, time consuming, and [did] not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine.”<sup>1</sup> It believed that the existing process “prolong[ed] disputes and cause[d] delays in medical treatment for injured workers” and also that “the process of selection of qualified medical evaluators [could] bias the outcomes.”<sup>2</sup>

Under SB 863, the Legislature made changes to the UR process and established the independent medical review (IMR) process. Fundamentally, under IMR, medical treatment disputes are submitted to a physician employed by a third party preselected by the state who makes decisions using evidence-based medicine standards. The process bypasses both the medical-legal process and the courts. The process applies to all injuries occurring on or after Jan. 1, 2013, and to all UR decisions communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

The Legislature believed that “having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of care.”<sup>3</sup> It believed that the independent medical review process

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<sup>1</sup> SB 863, Section 1, subdivision (d).

<sup>2</sup> SB 863, Section 1, subdivision (f).

<sup>3</sup> SB 863, Section 1, subdivision (e).

## 6. UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

would be “more expeditious, more economical, and more scientifically sound” than the existing process.<sup>4</sup> The system was designed to ensure that medical experts were used to resolve medical disagreements, and thus decisions from the IMR were final and binding with limited options for appeal. SB 863 requires “that final determinations made pursuant to the ... independent medical review [process] be presumed to be correct and be set aside only as specified.”

To implement the IMR process, the administrative director adopted emergency regulations that went into effect Jan. 1, 2013, and final regulations that were effective Feb. 12, 2014. The WCAB also amended its rules of practice and procedure effective Oct. 23, 2013, to deal with the changes by SB 863. These regulations made changes to the UR process, enacted rules for the IMR process and adopted severe penalties for an employer’s failure to comply with either.

IMR was designed to be efficient and speedy. It was designed to eliminate litigation over medical treatment disputes, and give the parties limited options for appealing an independent medical reviewer’s decision. The reforms were designed to benefit both parties. For workers, the reforms ensured that treatment requests would no longer be modified, delayed or denied except by a physician. Workers also secured a guarantee that UR decisions rendered in their favor could not be challenged by employers on medical-necessity grounds. For employers, the reforms promised to reduce insurance costs by creating uniform medical standards and reducing litigation.<sup>5</sup>

Overall, the IMR process has resulted an overall reduction in system costs. More than 85 percent of IMR decisions have upheld the original utilization review decision.<sup>6</sup> Furthermore, IMR has resulted in speedy resolution of treatment disputes as IMR determinations have generally been completed within 30 days from receipt of records as required by LC 4610.6(d).<sup>7</sup>

Implementation of the IMR process, however, has not been without its difficulties. Injured workers challenged the constitutionality of the IMR statutes, and after a extensive briefing, on Oct. 28, 2015, the 1st District Court of Appeal held that the IMR process is constitutional under the state Constitution.<sup>8</sup> Furthermore, the 2nd District Court of Appeal held that untimely IMR decisions were not invalid and did not give the appeals board jurisdiction over treatment disputes.<sup>9</sup>

Still, the savings from the IMR process have been minimized through judicial decisions. The appeals board has crafted a broad exception that allows it to continue adjudicating medical treatment disputes. Specifically, in *Dubon v. World Restoration, Inc.*,<sup>10</sup> the appeals board *en banc* held that it retains jurisdiction to decide treatment disputes if an employer fails to timely complete a utilization review. Furthermore, in *Bodam v. San Bernardino/Department of Social Services*,<sup>11</sup> the board issued a significant panel decision holding that for a UR decision to be considered timely, it must be both timely made and timely communicated.

As a result, medical treatment disputes continue to be widely litigated. Parties still proceed to trials on the issues of whether a UR decision was timely made, and if not, whether the employee has established the treatment is medically necessary. The WCIRB reported that the number of expedited hearings have actually increased since the enactment of SB 863 and vast majority were related to medical treatment disputes.<sup>12</sup> The WCIRB also reported that the number and costs of medical-legal reports continues to increase.<sup>13</sup> So, although

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<sup>4</sup> SB 863, Section 1, subdivision (f).

<sup>5</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1274.

<sup>6</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 3.

<sup>7</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at pps. 8-9.

<sup>8</sup> *Stevens v. WCAB* (2015) 80 CCC 1262.

<sup>9</sup> *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561.

<sup>10</sup> (2014) 79 CCC 1298 (appeals board *en banc*).

<sup>11</sup> (2014) 79 CCC 1519 (significant panel decision).

<sup>12</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 18.

<sup>13</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 17.

the IMR process has resulted in some savings for employers, it has not reduced litigation over medical treatment disputes.

## STATUTORY AUTHORITY FOR INDEPENDENT MEDICAL REVIEW

SB 863 added LC 139.5 to establish the independent medical review. Per LC 139.5(f), the Legislature finds that the services of independent medical review “are of such a special and unique nature that they must be contracted out.” LC 139.5(a) authorizes the administrative director to contract with one or more IMR organizations to conduct reviews pursuant to the Labor Code sections related to medical treatment, commencing with LC 4600. The organizations must be independent of any workers’ compensation insurer or workers’ compensation claims administrator doing business in the state. The administrative director also is authorized to impose additional requirements an organization must meet to qualify, including conflict-of-interest standards. Currently, independent medical reviews are conducted by Maximus.

Per LC 139.5(b), the independent medical review organization contracted by the administrative director is considered a consultant, and enjoys general protection for communications with that status. The independent medical review organization might be entitled to other privileges or immunity afforded by law, except that nothing in LC 139.5 may be construed to alter the law regarding the confidentiality of medical records.

LC 139.5(c)(d) also establishes several criteria for an independent medical review organization. It must employ a medical director and avoid any conflicts of interest. The requirements for medical professionals selected by the organization are defined in LC 139.5(d)(4). The physicians must be familiar with the guidelines and protocols in the area of treatment under review. The reviewing physician must hold an MD or DO degree and have no history of disciplinary action. As of Jan. 1, 2014, the physician must not hold appointment as a QME pursuant to LC 139.2 — a physician serving as an independent medical reviewer may not be a QME after that date.

For further discussion on the requirements of the independent medical review organization, see [“Sullivan on Comp” Section 7.38 Independent Medical Review — Requirements of Review Organization.](#)

## UTILIZATION REVIEW — DELAY DUE TO THRESHOLD ISSUES

Before 2013, there was no clear guidance on whether utilization review was required for all disputes regarding medical care. In *SCIF v. WCAB (Sandhagen)*,<sup>14</sup> the Supreme Court stated that “... the Legislature intended for the utilization review process to be employers’ only avenue for resolving an employee’s request for treatment.”<sup>15</sup> This language implies that utilization review was mandatory in all cases, on a presentation of a request for medical care.

But complications arose when there were other threshold issues beside the necessity of care, such as when the injury was denied, or a body part was contested. After all, UR is the process used only to approve, modify, or deny a treating physician’s request for authorization for medical treatment. It is used to determine whether or not a request for treatment is medically necessary pursuant to the medical treatment utilization schedule adopted by the administrative director. Utilization review does not determine if the injury or disease is work related (CCR 9792.6(u)).

What if an employer objected to treatment on the grounds that the injury was noncompensable or on the grounds that it was barred by an affirmative defense? Or what if a defendant contested the compensability

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<sup>14</sup> (2008) 73 CCC 981, 992.

<sup>15</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 992.

of certain body parts? These are, after all, different grounds for contesting proposed medical care beyond the reasonableness and necessity of the proposed care.

This landscape presented a tough choice. If the claim was denied, should requests for treatment be sent for utilization review? That seemed like a waste of money, as the services are not cheap. If the employer sent requests for care to utilization review and ultimately proved that there was no injury, then there was no point. In contrast, what if ultimately the applicant won and compensable injury was found? If UR was not performed when medical care was requested, the time limits usually would have passed. In that case, the employer might have to provide the care, as it had lost the opportunity to perform utilization review. This was true even if the care was not necessary or reasonable. What to do?

Effective Jan. 1, 2013, SB 863 amended LC 4610 to clarify that utilization review is not required for denied cases or disputed body parts. It also established procedures for dealing with situations in which medical treatment is disputed on grounds other than medical necessity.

### **Utilization Review in Denied Cases or for Disputed Body Parts**

Per LC 4610(g)(7), “Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.” CCR 9792.9.1(b) adds that UR may be “deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.” So an employer is not required to submit a treatment recommendation to utilization review when a claim is denied or when it is disputing liability for a body part or condition. It can wait for the resolution of the issue.<sup>16</sup>

Note that LC 4610(g)(7) states only that UR is not “required” while the employer is disputing liability for the injury or for the treatment on grounds other than medical necessity. The employer still has the option of sending a treatment request to UR, even if it is disputing the treatment on other grounds. If UR determines that the treatment is medically necessary, the employer still might have grounds to deny authorization of the medical treatment.

The process can continue even to independent medical review, if the employer consents, with all rights reserved. As discussed below, even if the requested medical treatment is found to be reasonable and necessary by the IMR process, an employer is not required to implement the decision if it has disputed liability for any reason besides medical necessity (LC 4610.6(j)). So, if the employer voluntarily has submitted a request for treatment to UR, even though it has denied liability for reasons other than medical necessity, it may not be required to authorize the treatment, despite the UR decision recommending it, until the threshold issue has been resolved. But this will need to be clarified by the courts.<sup>17</sup>

As a matter of practice, it is unlikely that employers will undertake UR while disputing the injury or the treatment on grounds other than medical necessity. It will be far more practical for employers simply to defer UR until the issue giving rise to the denial is resolved in the injured worker’s favor.

### **Notice of Deferral**

If a defendant defers UR because it is disputing liability for the injury or on grounds other than medical necessity, it must give notice of its intent to do so. Per CCR 9792.9.1(b)(1), the defendant must issue a written

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<sup>16</sup> See *Posada v. Long Beach Unified School District*, 2016 Cal. Wrk. Comp. P.D. LEXIS 24.

<sup>17</sup> In *Stevens v. WCAB* (2015) 80 CCC 1262, 1272, the Court of Appeal stated, “A UR decision favoring the worker becomes final, and the employer is not permitted to challenge it.” But the court did not address if a UR decision in favor of the applicant must be authorized if the defendant denied liability for reasons other than medical necessity.



decision deferring UR within five business days of receipt of form DWC RFA (request for authorization), unless the requesting physician has been notified previously of a dispute over liability and an explanation for the deferral of UR for a specific course of treatment.

The decision must be sent to the requesting physician, the applicant and, if the applicant is represented, his or her attorney. The notice must contain:

1. the date form DWC RFA was first received;
2. a description of the specific course of proposed medical treatment for which authorization was requested;
3. a clear, concise and appropriate explanation of the reason for the defendant's dispute of liability for either the injury, claimed body part or parts or the recommended treatment;
4. a plain language statement advising the injured employee that any dispute under this subdivision must be resolved either by agreement of the parties or through the dispute resolution process of the appeals board;
5. the following mandatory language advising the injured employee:
  - A. "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me." And,
  - B. "For information about the workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](http://www.dwc.ca.gov) or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

In one case, the appeals board interpreted CCR 9792.9.1(b)(1)(D) as allowing an applicant to seek WCAB resolution of medical treatment disputes in cases when UR is deferred.<sup>18</sup>

### **Time Limits When Utilization Review Is Deferred**

If the threshold issue supporting an employer's denial of medical treatment is resolved in favor of the injured worker, the employer has a general duty to undertake utilization review for the injury or body parts found to be compensable. This duty applies to both prospective review of new requests for treatment following a decision in the injured worker's favor and to retrospective review of services that have been performed. For example, if a case was denied and the applicant underwent knee surgery, and then the applicant won the case, the employer would have to conduct retrospective utilization review to see if, after the fact, the surgery was necessary. If it was, payment would have to be made. If the knee surgery was not performed, there would be a prospective review situation; utilization review would have to be conducted to determine if the surgery was necessary given the condition.

The rules are complex, but generally, prospective utilization review must be performed within five days of receipt of a request for medical care. Retrospective review must be performed within 30 days. But there are particular rules when utilization review is deferred due to a threshold issue. What gets the clock ticking again on the duty to perform utilization review after there is a deferral?

LC 4610(g)(8) states that "If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer

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<sup>18</sup> 81 *Grand Holdings, Inc., dba California Rehabilitation v. WCAB (Millette)* (2015) 80 CCC 744 (writ denied).

to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability."

So retrospective UR is required when "the employer's liability becomes final." Prospective UR is required after "the determination of the employer's liability." Also, for prospective review, it appears that after the threshold issue is resolved, the applicant must make another request for treatment before the utilization time limits begin to run.

### **Retroactive UR**

CCR 9792.9.1(b)(2) directs that if UR is deferred, the time limit to conduct retrospective UR begins on the date the determination of liability becomes final. But it also directs that the final determination may be "either by decision of the Workers' Compensation Appeals Board or by agreement between the parties." So an agreement by the parties that the defendant is liable for treatment of the condition for which it's recommended also can make the defendant's liability final for the purposes of retrospective UR. Once this final determination is reached, the employer would have 30 days to conduct retrospective UR.

In one case, the appeals board held that a defendant's utilization review determination was untimely when it initially had denied compensable injury, had performed utilization review more than six months after the board found compensable injury and the board had found that the services reviewed were subject to retrospective rather than prospective review. The appeals board explained that although the defendant was not required to conduct UR while it was disputing liability for the applicant's claimed injuries, it was required to either provide care or conduct a UR of the treatment requests immediately on the date the determination of its liability became final. The board found that the defendant took no affirmative steps to meet its legal obligation to provide the applicant with necessary and required treatment following the final determination of compensability, and it warned that this type of affirmative omission could reasonably lead to a referral to the DWC's Audit Unit.<sup>19</sup>

### **Prospective UR**

LC 4610(g)(8) says the time for prospective UR "shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability." CCR 9792.9.1(b)(2) clarifies that the time to conduct prospective UR commences from the date of receipt of a request for treatment "after the final determination of liability."

A decision is considered final only after the appellate process has been exhausted or the time for appeal has expired.<sup>20</sup> So if prospective UR is not required until a final determination of liability, the employer could complete the appeals process before being required to send the requests to UR. This potentially delays an employer's duty to refer requests for treatment to UR for months while the issue works its way through the appeals process.

In any event, under CCR 9792.9.1(b)(2), an agreement by the parties can be a final determination. So, if the parties agree that the defendant is liable for treatment, the defendant must timely conduct prospective UR following receipt of form DWC RFA following the agreement.

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<sup>19</sup> *Belling v. United Parcel Service, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 738.

<sup>20</sup> *Marsh v. WCAB* (2005) 70 CCC 787, 794; *Green v. WCAB* (2005) 70 CCC 294, 306.

## Prospective UR — Second Request Required

It is also significant to note that both LC 4610(g)(8) and CCR 9792.9.1(b)(2) require only the employer to perform prospective UR if form DWC RFA is received after the determination of liability. That is, the time limits begin to run only if there is a determination of the threshold issue and there is a request for care that comes after the determination. The law is silent on whether prior requests for treatment must be sent to UR following a final determination, but there does not appear to be a time limit until the new request is made.

It seems that the Legislature has made a deliberate decision not to force the employer, on an adverse court determination, to review all past requests for care. A second request seems to be required. Perhaps the feeling was that such claims might be old or no longer needed, and that a fresh assessment of the applicant's needs is necessary when the other issues are resolved. Be that as it may, it would seem that the law requires another step to request medical care if the applicant wants the UR clock to start running.

## Objection to Request for Treatment Required

The Labor Code specifies that an employer may defer UR when it is disputing liability for injury or treatment of the condition for which treatment is recommended. The statute also establishes the time limits for an employer to conduct UR after the deferral. But the employer still must act affirmatively in investigating the compensability of injury or disputed body part. The employer may not sit idly by while deferring the request for treatment.

Prior to SB 863, in *Simmons v. State of California, Dept. of Mental Health (Metropolitan State Hospital)*,<sup>21</sup> the appeals board issued an *en banc* decision explaining that when the treating physician either explicitly or implicitly determines for the first time that the injury to the disputed body part is industrial, utilization review is not appropriate. It added, however, that the defendant must timely initiate the AME/QME procedure in accordance with LC 4062(a) if it has not done so, or if the time deadlines of LC 4062(a) have not elapsed.

In one case, the appeals board concluded that *Simmons* was consistent with LC 4610 as amended by SB 863. In that case, the board held that a defendant was liable for right hip replacement surgery, even though the defendant deferred UR on the grounds that it was disputing compensability for the hip, because the defendant did not timely object to a treating physician's request for the surgery by requesting an AME or QME under LC 4062. The board explained that under *Simmons*, if the treatment prescribed relates to a different and disputed body part that the physician explicitly or implicitly has found to be industrial, the defendant must timely initiate the AME/QME procedure under LC 4062(a). It added that if the employer did not dispute a medical determination within the time limit prescribed under LC 4062(a), it could not attack the determination thereafter. The appeals board found substantial evidence supported compensability of the right hip injury. It added, however, that even if the records were not substantial evidence, because the defendant did not object to the treating physician's request within the time prescribed by LC 4062(a), it could not attack the implicit determination of industrial causation later.<sup>22</sup>

So if a defendant disputes whether treatment is related to the industrial injury, it must follow procedures in LC 4062 to resolve the issue.<sup>23</sup> For further discussion on objecting to a treating physician's opinion under LC 4062 as well as the ramifications for failure to object, see [“Sullivan on Comp” Section 14.27 Medical-Legal Process on or After Jan. 1, 2005](#).

<sup>21</sup> (2005) 70 CCC 866 (appeals board *en banc*).

<sup>22</sup> *Robertson v. Bonnano, dba Alpine Cabinets*, 2014 Cal. Wrk. Comp. P.D. LEXIS 443.

<sup>23</sup> *Jarrard v. Calmat Co.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 472.

## **REQUESTS FOR TREATMENT FOR INJURIES ON OR AFTER JAN. 1, 2013, OR FOR ALL INJURIES IF THEIR DECISIONS ARE COMMUNICATED ON OR AFTER JULY 1, 2013**

For injuries on or after Jan. 1, 2013, and for all injuries if the employer's decision on the request for treatment is communicated on or after July 1, 2013, treating physicians generally must request authorization for medical treatment on a specific form. Per CCR 9792.6.1(t), such requests are to be made on a request for authorization (form DWC RFA). This form is established in CCR 9785.5, and is available on the DIR website at <http://www.dir.ca.gov/dwc/forms.html>.

### **Physicians Who May Request Treatment**

The form RFA must be "completed by a treating physician." Normally, such reports are completed by the primary treating physician. But the appeals board has held that a request for authorization from a secondary treating physician also triggers the utilization review process.<sup>24</sup>

The appeals board has explained that the statutory provisions that mandate UR do not specify that the physician requesting authorization must be a designated "primary treating physician." The provisions refer only to treatment recommendations made by "physicians," and provide for communication of UR determinations to the "requesting physician." The board explained that if a secondary physician's opinion is required to determine the proper course of treatment, it is often because the primary treating physician lacks the necessary expertise, and it would be inappropriate to require that the primary treating physician request authorization for treatment that he or she was not qualified to perform or recommend.<sup>25</sup>

An RFA, of course, is needed. The appeals board has held that a report by a consulting physician stating that an applicant "will need surgery" that was not completed on the RFA form was not an appropriate request for treatment sufficient to support an award.<sup>26</sup> Also, even if treatment is recommended by an AME, an employer may request an RFA to decide the medical necessity of the treatment through the UR process.<sup>27</sup> As discussed in ["Sullivan on Comp" Section 14.44 Evaluation Requirements and Rights](#), an AME or QME must not treat, offer to treat or solicit to provide medical treatment, medical supplies or medical devices to the injured worker unless a medical emergency arises. Also, as discussed in ["Sullivan on Comp" Section 14.45 Reporting Requirements](#), per CCR 35.5(g)(2), for an evaluation on or after July 1, 2013, an AME or QME must not provide an opinion on any disputed medical treatment issue, but must provide an opinion about whether the injured worker will need future medical care.

### **Requirements of Request**

A form is considered completed when it identifies both the employee and the provider, identifies a specific, recommended treatment or treatments and is accompanied by documentation substantiating the need for the treatment. The form must be signed by the treating physician and may be mailed, faxed or emailed to the claims administrator. By agreement of the parties, the treating physician may submit the request or authorization with an electronic signature (CCR 9792.6.1(t)).

<sup>24</sup> See *Torres-Ramos v. Marquez*, 2014 Cal. Wrk. Comp. P.D. LEXIS 208; *DeRosa v. Office Solutions*, 2015 Cal. Wrk. Comp. P.D. LEXIS 14; *O'Neal v. Hale Aloha/Mark One Corp.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 80; *Thigpin v. Beacon Oil Co.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 673. *Contra Dugmore v. State of California, Department of Transportation — District 7*, 2014 Cal. Wrk. Comp. P.D. LEXIS 227 (defendant's failure to authorize treatment requested by secondary treating physician did not constitute denial of care when secondary treating physician's reporting was not incorporated by primary treating physician).

<sup>25</sup> *Lopez v. City and County of San Francisco*, 2016 Cal. Wrk. Comp. P.D. LEXIS 206; *Klein v. Warner Bros. Studio*, 2016 Cal. Wrk. Comp. P.D. LEXIS 236.

<sup>26</sup> *Barsoum v. LabCorp*, 2014 Cal. Wrk. Comp. P.D. LEXIS 369.

<sup>27</sup> *Hartson v. American Residential Funding*, 2015 Cal. Wrk. Comp. P.D. LEXIS 40.

The requesting physician should attempt to demonstrate that the requested treatment is consistent with the medical treatment utilization schedule (MTUS). If the medical condition or injury is not addressed in the MTUS, the treating physician should cite and attach guidelines or studies that he or she believes demonstrate the medical necessity of the requested treatment. If the condition or injury is addressed by the MTUS, but the requesting physician is attempting to rebut it, he or she must include: (1) a clear and concise statement that the MTUS' presumption of correctness is being challenged; (2) a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury; and (3) a copy of the entire study or the relevant sections of the guideline containing the recommendation (CCR 9792.21.1(b)(1)). For further discussion on medically reasonable and necessary care under the MTUS, see [“Sullivan on Comp” Section 7.31 Utilization Review — Medical Treatment Utilization Schedule](#).

Per CCR 9792.9.1(c)(2), if the RFA form: does not identify the employee or provider; does not identify a recommended treatment; is not accompanied by documentation substantiating the medical necessity for the requested treatment; or is not signed by the requesting physician, the defendant has a choice. It must treat the form either as complete, and comply with the time limits for UR, or return it to the requesting physician marked “not complete” and specify why it was returned. If the defendant chooses the latter option, it must be done no later than five business days from receipt. If the request for authorization is returned on the grounds that it is incomplete, the time limit for a decision on the returned request will begin on receipt of a completed form RFA.

Alternatively, a defendant may accept a request for authorization for medical treatment that does not utilize the form DWC RFA. But the request must:

1. clearly include “Request for Authorization” at the top of the first page of the document;
2. list all requested medical services, goods or items on the first page; and
3. be accompanied by documentation substantiating the medical necessity for the requested treatment.

The UR regulations do not require a claims administrator to provide a reviewer with any information other than what has been provided with the request for information.<sup>28</sup> For example, in one case, the appeals board rescinded a WCJ's order that a defendant was liable for sanctions under LC 5813 for failing to provide medical reports and records germane to four RFAs to its UR organization for consideration. The board held that it was authorized to impose sanctions for bad-faith tactics or actions that are frivolous or solely intended to cause unnecessary delay even if the underlying process concerns the claims-handling aspects of an RFA for medical treatment. It noted, however, that CCR 9785(g) and CCR 9792.6.1(t)(2) require an RFA to include documentation substantiating the need for the requested treatment. It noted that the primary treating physician, and not a claims adjuster, was the one who knew what medical records substantiated the requested treatment, and that the four RFAs submitted did include documentation that supported the recommended treatment. The board did not believe that the defendant's failure to take the initiative and submit the applicant's complete medical record to the UR doctor was a willful failure to comply with its regulatory and statutory obligations, or an indication of a bad-faith tactic that is frivolous or solely intended to cause delay.<sup>29</sup> For further discussion of sanctions under LC 5813, see [“Sullivan on Comp” Section 13.4 Sanctions Under LC 5813](#).

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<sup>28</sup> *Crawford v. WCAB* (2015) 80 CCC 1344 (writ denied).

<sup>29</sup> *McKinney v. Enterprise Rent-A-Car of San Francisco*, 2016 Cal. Wrk. Comp. P.D. LEXIS 495.

### Request Made on Improper Form

It is not clear if the employer must take any action if it simply receives a medical report requesting medical treatment without the appropriate form. CCR 9792.6.1(y) explains that the utilization review process begins when the completed RFA form, or a request for authorization accepted as complete under CCR 9792.9.1(c)(2), is received by the claims administrator. And CCR 9792.9.1(a) requires that the written request for treatment must be on the form. So the regulations require a defendant to have received an appropriate form before its duty to begin the UR process is triggered.

There's a general duty to provide medical care.<sup>30</sup> Employers have a duty to timely provide reasonably required medical treatment and to investigate whether an applicant's treatment is related to the industrial injury.<sup>31</sup> So a request for treatment should not be ignored just because it is not on the appropriate form. Each request for care must be promptly reviewed and acted on if appropriate.

With that said, the time limits for UR do not commence until an RFA is received. In one case, the appeals board rescinded a WCJ's award of \$13,000 for the applicant's purchase of a walk-in bathtub. The applicant's primary treating physician had not requested authorization for the tub in the form and manner required to trigger the defendant's obligation to conduct utilization review. After the applicant self-procured a walk-in bathtub, the treating physician issued a PR-2 stating that he supported her use of it. The box at the top of the PR-2 that states "Request for Authorization" was not checked, and it was not accompanied by a separate request on a completed RFA form. The treating physician later issued a prescription that suffered from the same deficiencies. The appeals board concluded that the applicant failed to meet her burden that the defendant was required to complete UR on the retrospective request for a walk-in tub.<sup>32</sup>

The appeals board did not believe that the defendant was derelict in its obligation to conduct retrospective UR. It explained that although a defendant should expend an active degree of effort in providing medical treatment, it also believed that the applicant should expend some degree of effort in requesting medical treatment. It was not too much to ask that the form be filled out.<sup>33</sup>

In another case, the appeals board denied payment for services provided by a lien claimant when no requests for authorization were ever submitted. The board explained that because there was no compliance with the mandatory form requirements for requesting treatment, the defendant was under no obligation to conduct utilization review. The appeals board believed that to do allow recovery at the board would mean that a medical provider could essentially circumvent the entire utilization review procedure by deliberately not submitting the RFA forms, thus improperly bestowing jurisdiction on the board.<sup>34</sup>

Also in one case, the appeals board held that it could not find against a defendant based on a tardy utilization review decision when the request for authorization was made on a PR-2 form, and not the appropriate RFA form. The WCAB explained that the applicant could not challenge the timeliness of the defendant's UR decision when the request was not made on a proper form, and reminded the parties that future requests for authorization should be accompanied by the RFA form.<sup>35</sup> But in one case, the appeals board affirmed a

<sup>30</sup> For example, when the employer obtains knowledge of an injury, immediate medical care must be provided (see ["Sullivan on Comp" Section 7.24 Duty to Provide Care Proactively](#)). Also, case law emphasizes that the employer must take responsibility for proactively providing medical care under risk of losing medical control in general (see ["Sullivan on Comp" Section 7.50 Medical Control If There Is No Established Network](#)) and in network cases (see ["Sullivan on Comp" Section 7.56 Medical Provider Network — Escaping the Network](#)).

<sup>31</sup> *Romano v. The Kroger Co. dba Ralph's Grocery Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 125.

<sup>32</sup> *Lechner v. Marin General Hospital*, 2015 Cal. Wrk. Comp. P.D. LEXIS 596.

<sup>33</sup> *Lechner v. Marin General Hospital*, 2015 Cal. Wrk. Comp. P.D. LEXIS 596. See also *Estela v. Exact Staff*, 2016 Cal. Wrk. Comp. P.D. LEXIS 38.

<sup>34</sup> The board alternatively concluded that the lien claimant failed to prove that the treatment was reasonably necessary to cure or relieve from the effects of the industrial injury. *Lopez v. Warner Brothers*, 2015 Cal. Wrk. Comp. P.D. LEXIS 677.

<sup>35</sup> *Torres-Ramos v. Marquez*, 2014 Cal. Wrk. Comp. P.D. LEXIS 208.

decision that a WCJ could decide a treatment dispute even though the request for treatment was not accompanied by an appropriate RFA form when the defendant never raised the issue at trial.<sup>36</sup>

Note that CCR 9792.6.1(y) makes clear that in cases of prior authorization, the utilization review process begins when the treating physician satisfies the conditions described in the UR plan for prior authorization. So utilization review may begin in cases without a completed form RFA if prior authorization has been given to a treating physician.

## Receipt of Request for Authorization

A physician providing treatment under LC 4600 must send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer or other entity (LC 4610(d)).<sup>37</sup> The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director (LC 4610(i)(1)).

A request for authorization must be received by the claims administrator or the claims administrator's UR organization to trigger the UR process (CCR 9792.9.1(a)(1)). A written request for authorization is deemed received by fax or by email on the date received if the fax or email electronically date stamps the transmission.<sup>38</sup> If no such date is recorded, the request is deemed to be received on the date the form was transmitted to the claims administrator or his or her UR organization (CCR 9792.9.1(a)(1)).<sup>39</sup>

If the fax is transmitted after 5:30 p.m., it will be deemed to have been received on the following business day, except in cases of expedited or concurrent review.<sup>40</sup> The copy of the form DWC RFA or the cover sheet accompanying the form transmitted by a fax or by email must include the date, time and place of transmission and the fax number or the email address to which the form was transmitted. Otherwise, the form must be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or email transmission report, which must display either the fax number or email address to which the form was transmitted. The requesting physician must indicate on the form if expedited review is needed. (CCR 9792.9.1(a)(1)). If there is a dispute as to whether the RFA form was transmitted to the defendant, other evidence may be admitted to resolve it.<sup>41</sup>

But if a request for authorization is made by mail, and a proof-of-service by mail exists, absent documentation of receipt, the request will be deemed to have been received five days after the deposit in the mail at a facility regularly maintained by the U.S. Postal Service. If the request for authorization is delivered via certified/return receipt mail, the request will be deemed to have been received on the receipt date entered on the return receipt. In the absence of a proof-of-service by mail, evidence of mailing or a dated return receipt, the request will be deemed to have been received five days after the latest date the sender wrote on the document (CCR 9792.9.1(a)(2)).

Because the regulation specifies that the time runs from the date the claims administrator or UR organization receives the request for authorization, service on a defense attorney alone does not trigger the time limit.<sup>42</sup> But if an RFA form is served on a defense attorney, he or she should make sure that it is forwarded to the claims administrator or UR organization within a reasonable time.

<sup>36</sup> *Vasquez v. United Parcel Service, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 394.

<sup>37</sup> This language was added effective Jan. 1, 2017 by AB 2503. The change was intended to clarify where the RFA and related materials must be sent, so that the time frames specified in statute will be more effective.

<sup>38</sup> See *Ringer v. Restoration Hardware*, 2016 Cal. Wrk. Comp. P.D. LEXIS 220.

<sup>39</sup> Note that this discussion relates to the regulation regarding injuries occurring on or after Jan. 1, 2013, and cases in which the decision is communicated on or after Jan. 1, 2013, for all dates of injury. For dates of injury before Jan. 1, 2013, if the decision is communicated before July 1, 2013, see CCR 9792.9.

<sup>40</sup> See *Green v. WCAB* (2016) 81 CCC 624 (writ denied).

<sup>41</sup> See *Fisher v. Putnam Lexus*, 2016 Cal. Wrk. Comp. P.D. LEXIS 260.

<sup>42</sup> *Castrillo v. Catholic Health Care West dba Marian Medical Center*, 2012 Cal. Wrk. Comp. P.D. LEXIS 454.

For example, in one case, an applicant's attorney wrote to defense counsel Sept. 11, 2015, and attached a PR-2 report from the primary treating physician requesting home assistance eight hours a day, seven days a week. The defense counsel forwarded the request for treatment to the utilization review process established by the defendant. The UR provider received the request Sept. 14, 2015, and the requested treatment was denied Sept. 17, 2015. The appeals board explained that per CCR 9792.9.1(a)(1), the time limit for UR runs from the date the request for authorization "was received by the claims administrator or the claims administrator's utilization review organization." The appeals board concluded that the UR determination was due Sept. 21, 2015, and that the Sept. 17 UR denial was well within the time limits.<sup>43</sup>

In contrast, in another case, the applicant filed a declaration of readiness to proceed to an expedited hearing on the ground that the defendant failed to respond to a request for authorization for treatment. The defendant objected on the ground that it was never provided a request for authorization. The applicant's attorney then faxed the defense counsel a copy of the doctor's report and the request for authorization. The defendant took no action to review the requested medical treatment, and the issue was submitted to a WCJ who awarded the requested treatment. The appeals board upheld the award, explaining that although utilization review is triggered only by either the claims adjuster's or UR organization's receipt of an RFA, a defendant has a continuing duty to conduct a good-faith investigation of the claim and to provide benefits when due under CCR 10109. It instructed that when a dispute exists over whether an RFA was transmitted to the adjuster, the defense attorney alleges that the claims administrator never received a copy of the RFA, and the same attorney then receives a copy of the disputed RFA, that attorney has a duty to transmit a copy of the RFA to the claims administrator within a reasonable time so that the dispute can be resolved as expeditiously as possible. Because the defense attorney's failure to provide the RFA to the claims administrator was unreasonable, the appeals board concluded that the award of treatment was proper.<sup>44</sup>

### Access to Claims Administrator

Per LC 4610(h) and CCR 9792.9.1(a)(3), in order to allow treating physicians to request treatment, every claims administrator must maintain telephone access and have a representative personally available by telephone from 9 a.m. to 5:30 p.m. Pacific time on business days. Also, claims administrators must have a fax number available for physicians to request authorization for medical services.

Claims administrators are required to have a process for receiving communications from doctors requesting authorization for medical services after business hours. To meet this requirement, claims administrators may maintain a voice-mail system, fax number or designated email address.

### UTILIZATION REVIEW — TIME LIMITS

Utilization review "balances the dual interests of speed and accuracy, emphasizing quick resolution of treatment requests, while allowing employers to seek more time if more information is needed to make a decision."<sup>45</sup> So meeting the time limits for utilization review is essential. An employer's failure to comply with the mandatory deadlines established in LC 4610 may preclude it from using the UR process to deny a request for medical treatment.<sup>46</sup> If UR is not performed or is untimely, the applicant may file for an expedited trial on the issue of the requested treatment. In addition, the Labor Code and administrative regulations impose various penalties for failure to comply with the time limits for UR.

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<sup>43</sup> *Bissett-Garcia v. Peace and Joy Center*, 2016 Cal. Wrk. Comp. P.D. LEXIS 174; *Bissett-Garcia v. Peace and Joy Center*, 2016 Cal. Wrk. Comp. P.D. LEXIS 282.

<sup>44</sup> *Czech v. Bank of America* (2016) 81 CCC 856 (panel decision).

<sup>45</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 989.

<sup>46</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 984.



## Types of Review

The utilization review process is divided by law into three categories: concurrent, prospective and retrospective review. The time limits for an employer to conduct each review are different.

“Concurrent review” means UR conducted during an inpatient stay (CCR 9792.6.1(c)). An example would be a request for care while the applicant is in a hospital.

“Prospective review” means any UR conducted before the delivery of the requested medical services, except for utilization review conducted during an inpatient stay (CCR 9792.6.1(s)). An example might be a request for a course of physical therapy.

“Retrospective review” means UR conducted after medical services have been provided and for which approval has not been given (CCR 9792.6.1(u)). So if physical therapy has been provided to an injured worker, retrospective review would be conducted to determine whether the employer should pay for the services, not whether they should be provided to the injured worker.

## General Rules for Applying Time Limits

The limits begin to run from the date the claims examiner or UR organization receives form RFA in writing. This is so despite the ambiguous statutory language that the employer has, per LC 4610(g)(1), “five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.”

One could imagine a scenario in which the recommendation is made but not transmitted to the employer for more than 14 days. The employer, then, would miss the deadline without ever having known it existed. Such an interpretation would not make sense per the statute. If the treating physician makes the recommendation, but it’s not transmitted, the employer cannot reasonably be expected to timely respond. Moreover, the employer probably cannot be held to respond within fewer than five days from notice of the recommendation.<sup>47</sup>

The first day of each time limit is the date after the receipt of the request for authorization. The only exception is when the timeline is measured in hours. In that case, the time for compliance is counted in hours from the time of receipt of form DWC RFA (CCR 9792.9.1(c)(1)).

Generally, the time limits defined in CCR 9792.9.1(c) may be extended only as provided under CCR 9792.9.1(f). For cases of prospective review, if the date or deadline in CCR 9792.9.1(c) to perform any act related to the UR process falls on a weekend or holiday, for the purposes of assessing penalties, the act may be performed on the next normal business day. This rule, however, does not apply to cases involving concurrent or expedited review (CCR 9792.11(o)).

If the date of receipt is disputed, live testimony might be needed.<sup>48</sup> Defendants must be careful to present proof of when the request for authorization was received. In one case, the board found a UR determination untimely when the request for authorization was dated July 8, 2013, but the determination was dated July 22, 2013. Although the defendant claimed on reconsideration that it received the request for authorization July 17, 2013, this evidence was not presented at trial, so the appeals board refused to consider it. Instead, it awarded the requested treatment based on an AME’s opinion, which it found to be substantial evidence.<sup>49</sup>

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<sup>47</sup> See *Creel v. WCAB* (2005) 70 CCC 1154 (writ denied); *Fortuno v. Getz Corp.*, 2009 Cal. Wrk. Comp. P.D. LEXIS 622.

<sup>48</sup> *Ames v. Coinmach Laundry*, 2015 Cal. Wrk. Comp. P.D. LEXIS 336.

<sup>49</sup> *Skillman v. Memory Gardens Cemetery*, 2014 Cal. Wrk. Comp. P.D. LEXIS 390.

### Time Limits for Prospective or Concurrent Review

Per LC 4610(g)(1), prospective or concurrent decisions must be made in “a timely fashion that is appropriate for the nature of the employee’s condition.” The statute is a little tricky about what, exactly, that means; it states that the time for a decision is “not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.” Five working days means five business days — not weekends or holidays.<sup>50</sup>

CCR 9792.9.1(c)(3) also generally requires prospective or concurrent decisions to be made within five business days from the date of receipt of the completed form RFA. But as discussed below, CCR 9792.9.1(f) extends the time for a decision if further information is needed to make a decision. Generally, the defense has at least five working days from receipt of form RFA to complete a utilization review. Within that period, however, the reviewer may request additional appropriate information, and make a decision within 14 calendar days from when the request was received, or deny the request if the additional information is not received.<sup>51</sup>

### Time Limits for Treatment Covered by Drug Formulary

Effective Jan. 1, 2018, LC 4610(g)(1) requires that prospective review regarding requests for treatment covered by the drug formulary be made no more than five working days from the date of receipt of the request for authorization for medical treatment. The statute does not allow additional time to obtain additional information from the requesting physician.

The drug formulary must be developed on or before July 1, 2017 (see Section 7.31 Utilization Review — Medical Treatment Utilization Schedule). It is not clear how employers should handle treatment requests that include both medication and other medical services. This will need to be clarified by regulation or case law.

### Time Limits for Retrospective Review

Per LC 4610(g)(1), in cases in which the review is retrospective, a decision resulting in denial of all or part of the medical treatment service must be communicated within “30 days of receipt of the medical information that is reasonably necessary to make this determination.” CCR 9792.9.1(c)(5) requires retrospective decisions to approve, modify, or deny to be made within the same time period.

CCR 9792.9.1(c)(5), however, adds that the time limit for retrospective decisions is triggered by receipt of the “request for authorization and medical information that is reasonably necessary to make a determination.” CCR 9792.6.1(y) also provides that the utilization review process begins when the completed form RFA is first received by the claims administrator. So the regulations require a request for authorization even before the defendant must conduct a retrospective review.

<sup>50</sup> *Castrillo v. Catholic Health Care West dba Marian Medical Center*, 2012 Cal. Wrk. Comp. P.D. LEXIS 454. LC 4600.4 defines a “normal business day” as a “business day as defined in Section 9 of the Civil Code.” It establishes that all days are considered business days except Sundays and optional bank holiday as defined in Civil Code 7.1, which deems these optional bank holidays: (a) any closing of a bank because of an extraordinary situation, as that term is defined in the Bank Extraordinary Situation Closing Act; (b) every Saturday; (c) every Sunday; (d) Jan. 1; (e) the third Monday in January (Martin Luther King Jr. Day); (f) Feb. 12 (Lincoln Day); (g) the third Monday in February (Presidents Day); (h) the last Monday in May (Memorial Day); (i) July 4; (j) the first Monday in September (Labor Day); (k) Sept. 9 (Admission Day); (l) the second Monday in October (Columbus Day); (m) Nov. 11 (Veterans Day); (n) Dec. 25; (o) Good Friday from 12 p.m. until closing; (p) the fourth Thursday in November (Thanksgiving); (q) any Monday following any Sunday on which Jan. 1, Feb. 12, July 4, Sept. 9, Nov. 11 or Dec. 25 falls; and (r) any Friday preceding any Saturday on which July 4, Sept. 9, or Dec. 25 falls.

<sup>51</sup> In *Hatem v. United Cerebral Palsy*, 2013 Cal. Wrk. Comp. P.D. LEXIS 374, the WCAB found that a UR denial was timely when it was made within 14 days of receipt of the treatment recommendation, without a discussion as to whether a request for additional information was made by the employer. So the case is questionable under the current regulations.

In any event, the medical provider must forward to the defendant the medical information reasonably necessary to make the determination. As discussed in [“Sullivan on Comp” Section 7.67 Submission of Bills and Employer’s Response](#), LC 4603.2 requires medical providers to submit certain documents in order to be paid for their services. Typically, if a defendant disputes the amount of a bill, it would need to undergo a second review and then an independent bill review before the provider would be paid. But these processes are applicable only if the dispute is the amount of payment. If a defendant disputes whether the medical services provided were reasonably necessary to cure or relieve the applicant from the effects of his or her injury, it would be appropriate to refer the medical information to UR.

### **Time Limits for Expedited Review**

In cases of an emergency, LC 4610(g)(2) shortens the period for conducting a utilization review. A decision to approve, modify or deny prospective or concurrent requests must be done on an expedited basis when:

1. the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function; or
2. the normal time limit for the decision-making process would be detrimental to the employee’s life or health or could jeopardize the employee’s ability to regain maximum function.

The Labor Code requires the decision to be made in a timely fashion appropriate to the nature of the employee’s condition, but no more than 72 hours after receipt of the information reasonably necessary to make the determination. CCR 9792.9.1(c)(4) requires the requesting physician to certify in writing and document the need for an expedited review on submission of a request. A request that is not reasonably supported by evidence establishing that the applicant would face an imminent and serious threat to his or her health, or that the normal time frame would be detrimental to the applicant’s condition, may be reviewed by the defendant under the normal time frame.

### **Extensions of Time**

The time limits for making a decision on a request for medical care can be extended if more information is needed. Specifically, CCR 9792.9.1(f) provides that the time for a decision may be extended under one of these circumstances:

1. The claims administrator or review is not in receipt of all the information reasonably necessary to make a determination.
2. The reviewer has asked that an additional examination or test be performed on the injured worker that is reasonable and consistent with professionally recognized standards of medical practice. Or
3. The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

If the defendant has not received all information reasonably necessary to make a determination, the reviewer or nonphysician reviewer must request the information from the treating physician within five business days from the date of receipt of the request for authorization (CCR 9792.9.1(f)(2)(A)). The request for additional information need not be signed by a physician.<sup>52</sup> The UR regulations do not require the claims administrator to provide a reviewer with any information other than what was provided with the request for information. If additional information is needed, the reviewer may request it, but the time is extended.<sup>53</sup>

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<sup>52</sup> *Wells v. WCAB* (2016) 81 CCC 540 (writ denied).

<sup>53</sup> *Crawford v. WCAB* (2015) 80 CCC 1344 (writ denied).

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The request for additional information may be made orally to the requesting physician. For example, in one case, a defendant received the RFA form May 11, 2015. The defendant's UR denial was issued May 19, 2015, six working days after receipt of the RFA form. The appeals board noted, however, that the reviewer documented that additional information was required and attempted peer-to-peer review by leaving two messages with the treating physician May 18, 2015. The appeals board found that the reviewer's request for additional information was made within the five-working day timeline in LC 4610(g)(1), and triggered the alternative 14-day timeline. It noted that the reviewer spoke with the treating physician's nurse May 19, 2015, obtained the additional information requested and told the nurse that his recommendation was to deny the request. Because the UR determination was orally communicated by telephone May 19, 2015, and written confirmation was issued the next day, the appeals board concluded the UR determination was timely, and the applicant's remedy was to appeal the determination through IMR.<sup>54</sup>

If the reviewer requires an additional examination, test or a specialized consultation, the reviewer, within five business days of receipt of the request for authorization, must notify the requesting physician, the applicant and the applicant's attorney, if any, in writing that a decision cannot be made within the required time frame. The reviewer also must request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. Furthermore, the reviewer must provide the anticipated date on which the decision will be rendered.

If the requested information reasonably necessary to make a determination is not received within 14 days from receipt of the completed request for authorization for prospective or concurrent review, or within 30 days of the request for retrospective review, the reviewer must deny the request and state that it will be reconsidered on receipt of the information.<sup>55</sup> If the additional examination, test or specialized consultation is not received within 30 days from the date of the request for authorization, the reviewer must deny the treating physician's request with the stated condition that it will be reconsidered on receipt of the results of the additional procedure or consultation.

On receipt of that information, for prospective or concurrent review, the employer must make a decision within five business days of receipt of the information. For expedited review, the employer must make the decision within 72 hours. For retrospective review, the decision must be made within 30 days (CCR 9792.9.1(f)(4)-(6)).

If an employer does not require additional information, the UR decision must be made within five business days. For example, the appeals board held that a defendant's UR decision was untimely when it received a request for treatment July 21, 2015, but the defendant UR denial was issued July 29, 2015. The board rejected the defendant's argument that the time limit was extended by a letter to the doctor stating, "This request is being delayed to allow time for a peer review. No additional information is needed at this time." The board noted that the defendant did not list one of the exceptions in CCR 9792.9.1(f) necessary to extend the time limit to make a determination. That is, it did not request additional information, an additional examination or test to be performed, or a specialized consultation by an expert reviewer. Because the defendant failed to meet any of the three exceptions in CCR 9792.9.1(f), the board concluded that its UR determination was untimely.<sup>56</sup>

The appeals board has held that a request for additional information extends the time limits for all services requested in an RFA. It also has held that there are not separate timelines for different treatment requests within an RFA. For example, a treating physician requested four treatment modalities, and the UR physician requested additional information pertaining to two of them before issuing a decision within 14 days, as

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<sup>54</sup> *Smith v. Scholle Packaging*, 2015 Cal. Wrk. Comp. P.D. LEXIS 616.

<sup>55</sup> See *Smith v. Plant Construction*, 2014 Cal. Wrk. Comp. P.D. LEXIS 391; *Johnson v. Southwest Airlines*, 2016 Cal. Wrk. Comp. P.D. LEXIS 234.

<sup>56</sup> *Bolton v. County of San Bernardino*, 2016 Cal. Wrk. Comp. P.D. LEXIS 224.

required by LC 4610. The board rejected the WCJ's reasoning that the UR physician should have issued a decision regarding the other two treatment modalities, for which no additional information was required, within five days. It concluded that the UR decision was timely as to all modalities requested.<sup>57</sup>

Similarly, a treating physician requested authorization to perform a two-level artificial disk replacement surgery. The UR nurse sought clarification of the number of inpatient hospital days that were required, then the defendant issued a UR determination denying the requested surgery with an inpatient hospital stay of one day. The appeals board rejected the applicant's argument that the delay to obtain information applied only to the request regarding the length of the applicant's hospital stay following surgery and did not act to delay the five-day period to complete the UR determination of the request for surgery. It explained that CCR 9792.9.1 provides that an RFA triggers the timelines for completing UR and does not make any provision for different timelines for different treatment requests within an RFA. Because the defendant's UR determination was within the timeline provided in LC 4610 and CCR 9792.9.1, the board did not have jurisdiction to address the issue of the medical necessity for the requested medical treatment.<sup>58</sup>

Note, in one case, the appeals board concluded that, provided the 14-day limit is met, "Where a treating physician fails to respond to a request for additional information, ... a defendant's UR denial is timely if it is issued within five days of the last request for additional information." In that case, the board found a defendant's UR timely when it was issued within five days of the last request for information from the treating physician, and 12 days after it received the request for treatment.<sup>59</sup> But the appeals board requirement that a UR determination must be issued within five days of the last request for additional information is found nowhere in the Labor Code or the administrative regulations. The regulations require a request for additional information to be made within five business days of receipt of the request for authorization, but does not mandate that a decision must be made within five days of the request for additional information. It remains to be seen whether this requirement will be imposed by other panels.

## Time Limits to Communicate Decision

In *Bodam v. San Bernardino/Department of Social Services*,<sup>60</sup> the appeals board issued a significant panel decision holding that in order for a UR decision to be considered timely, a defendant is obligated to comply with all time requirements in conducting UR, including the time frames for communicating the UR decision.

For prospective, concurrent or expedited review, the requesting physician must be notified by telephone, fax or email within 24 hours of making the decision. A written communication must be issued within 24 hours of the decision for concurrent review, within two business days for prospective review and within 72 hours of receipt of a request for expedited review (LC 4610(g)(3)(A); CCR 9792.9.1(e)(3)). The written decision must include the date the information was received (CCR 9792.9.1(f)(4)(5)). For retrospective review, the decision must include the date it was made (CCR 9792.9.1(f)(6)). The written decision modifying or denying treatment must be provided to the requesting physician, the injured worker and the injured worker's attorney, if any (CCR 9792.9.1(e)(5)).

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<sup>57</sup> *Romero v. Stones and Traditions*, 2016 Cal. Wrk. Comp. P.D. LEXIS 142; *Romero v. Stones and Traditions*, 2016 Cal. Wrk. Comp. P.D. LEXIS 255.

<sup>58</sup> *Favila v. Arcadia Health Care*, 2016 Cal. Wrk. Comp. P.D. LEXIS 181. See also *Powell v. Vietnam Investment*, 2016 Cal. Wrk. Comp. P.D. LEXIS 211.

<sup>59</sup> *Chamberlain v. Humphrey & Giacomuzzi Veterinary Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 343.

<sup>60</sup> (2014) 79 CCC 1519 (significant panel decision).

So, for a prospective review, three time limits must be met:

1. The UR determination must be made no later than five working days from receipt of an RFA form, but UR may request additional appropriate information within that period and make a decision within 14 calendar days.
2. The decision must be communicated to the requesting physician by telephone, fax or email within 24 hours of being made.
3. The initial communication must be followed by written communication within two business days.

The appeals board has stated that the time limit for communicating a decision is not included within the time period for making the decision.<sup>61</sup> But the board explained that LC 4610(g)(3)(A) created a two-step process for timely communication of a UR determination and that both steps must be satisfied in order to comply with the statute. It concluded that a UR decision must be (1) communicated by “telephone or facsimile” to the requesting physician within 24 hours of the decision; and (2) communicated to the physician and employee “in writing” within 24 hours for concurrent review or within two business days for concurrent review. It also held that CCR 9792.9.1(e)(3), which suggests that only a communication by telephone to the requesting physician must be followed by written notice to the requesting physician, was invalid to the extent that it was inconsistent with LC 4610(g)(3)(A).<sup>62</sup>

If these time limits are met, the UR decision will be deemed timely.<sup>63</sup> But failure to comply with any of the requirements will result in a finding that the UR determination was untimely.<sup>64</sup> The consequences of an untimely UR decision are discussed later.

### UTILIZATION REVIEW — PROCEDURES

On receipt of a completed request for authorization for treatment, an employer must timely complete the utilization review process. An insurance carrier or third-party administrator may conduct in-house utilization review, or contract with another company to do so. But there are strict rules for how the UR process is to be conducted.

Although an initial review may be conducted by a nonphysician reviewer, a decision to modify or deny a request for treatment must be made by a licensed physician. Rules govern what the reviewer must do if the requested treatment is authorized, and different rules apply if the requested treatment is modified or denied. There are rules specifying the duration of a decision to modify or deny a treatment recommendation, as well as the consequences of an employer’s failure to timely perform a utilization review.

### Review by Physicians or Nonphysicians

On receiving a request for authorization for treatment, an employer may authorize medical treatment without referring the issue to a UR physician. The treatment simply may be authorized without further ado. The Supreme Court has stated that when the employer reviews a request and determines that treatment is reasonably required, the employer has engaged in utilization review.<sup>65</sup> In some cases, a requested treatment obviously is necessary to the experienced practitioner, and it makes sense simply to approve the request.

<sup>61</sup> *Green v. WCAB* (2016) 81 CCC 624 (writ denied).

<sup>62</sup> *Dallas v. Pan Pacific Petroleum*, 2016 Cal. Wrk. Comp. P.D. LEXIS 116.

<sup>63</sup> See *Newton v. Jack-In-The-Box*, 2014 Cal. Wrk. Comp. P.D. LEXIS 601.

<sup>64</sup> See *Boone v. Dreyer’s Grand Ice Cream*, 2014 Cal. Wrk. Comp. P.D. LEXIS 641; *Allen v. Providence Holy Cross Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 635.

<sup>65</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 991.

But a decision to modify or deny a request for authorization of medical treatment for reasons of medical necessity to cure and relieve must be based on appropriate UR standards. And a decision to modify or deny medical treatment may be made only by a licensed physician who is competent to evaluate the clinical issue involved in the medical treatment services,<sup>66</sup> and only if the services are within the scope of the physician's practice (LC 4610(e); CCR 9792.9.1(e)(1)).<sup>67</sup> The reviewer must be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia (CCR 9792.6.1(v)). The physician reviewer need not be licensed in California.<sup>68</sup>

Initially, a nonphysician reviewer (often a nurse) may apply specified criteria to requests for authorization for medical services, and a nonphysician reviewer may approve requests for authorization of them. A nonphysician reviewer also may discuss applicable criteria with the requesting physician, if the treatment for which authorization is sought appears to be inconsistent with the criteria. In such instances, the requesting physician voluntarily may withdraw a portion or all of the treatment in question and submit an amended request. The nonphysician reviewer may approve the amended request for treatment authorization. In addition, a nonphysician reviewer may reasonably request appropriate additional information necessary to render a decision within the time limits discussed below (CCR 9792.7(b)(3)). If additional medical information from a physician is needed in order to determine whether to approve, modify, or deny requests for authorization, the request should seek only information reasonably necessary to make the determination.

So, "If the treatment request is straightforward and uncontroversial, the employer can quickly approve the request — utilization review is completed without any need for additional medical review of the request. If the request is more complicated, the employer can forward the request to its utilization review doctor for review, since the statute requires that the employer seek a medical opinion before modifying, delaying, or denying an employee's request for medical treatment. This ensures that a physician, rather than a claims adjuster with no medical training, makes the decision to deny, delay, or modify treatment."<sup>69</sup>

## Procedure for Approval of Treatment

Generally, if a UR physician approves a treating physician's request for treatment, the determination becomes final and the employer is not permitted to challenge it.<sup>70</sup> In *Sandhagen*, the Supreme Court concluded that "the Legislature intended for the utilization review process to be employers' only avenue for resolving an employee's request for treatment."<sup>71</sup> Under the UR process, workers may challenge decisions denying requested treatment, but employers may not challenge decisions approving it. A UR decision favoring the worker becomes final, and the employer is not permitted to challenge it.<sup>72</sup> The employer's UR doctor is not permitted "to take a second look."<sup>73</sup>

If the requested treatment is approved by UR, the defendant is required to give notice. A written decision must be issued specifying the date the completed request for authorization was received, the medical treatment requested, the specific medical treatment approved and the date of the decision (LC 4610(g)(4) and CCR 9792.9.1(d)). A decision to approve a physician's request for prospective or concurrent treatment must be communicated to the requesting physician within 24 hours and must be communicated initially by

<sup>66</sup> See *Academy of Arts College v. WCAB (Zedd)* (2011) 76 CCC 352 (writ denied) (UR signed by nurse, not physician, was invalid).

<sup>67</sup> See *Dominguez v. WCAB* (2011) 76 CCC 810, 812 (writ denied) (no evidence that anesthesiologist could not render an opinion on dermatologic condition).

<sup>68</sup> See *Navroth II v. Mervyn's Stores*, 2016 Cal. Wrk. Comp. P.D. LEXIS 297.

<sup>69</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 989.

<sup>70</sup> *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561, 568.

<sup>71</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 992. See also *City of Hayward v. WCAB (Rushworth-McKee)* (2007) 72 CCC 237 (writ denied); *Lithia Motors Support Services v. WCAB (Locke)* (2006) 71 CCC 1517 (writ denied) (Court of Appeal opinion unpublished in official reports); *Dixon v. Phillips Buick, Pontiac & Mazda*, 2010 Cal. Wrk. Comp. P.D. LEXIS 343.

<sup>72</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1272.

<sup>73</sup> *Ortega v. AWHs, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 36.

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telephone, fax or email. If the initial communication is by telephone, it must be followed by written notice within 24 hours of the decision for concurrent review and within two business days for prospective review (CCR 9792.9.1(d)(2)).

Per CCR 9792.9.1(d)(3)(B), payment, or partial payment, of a medical bill for services requested on the form DWC RFA within the 30-day time limit will be deemed a retrospective approval, even if a portion of the bill is contested, denied or considered incomplete. LC 4610(g)(1) provides that if payment for the medical service is made within the time prescribed by LC 4603.2, a retrospective decision to approve the service need not be communicated. But CCR 9792.9.1(d)(3)(A) requires a written decision to approve to be communicated to the requesting physician who provided the medical service, the individual who received it and the individual's attorney/designee, if applicable. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

As discussed earlier, however, an employer is not required to submit a request for treatment to utilization review if it has disputed liability for any reason other than medical necessity, but may do so voluntarily. Moreover, even if the requested medical treatment is found to be reasonable and necessary by the independent medical review process, an employer is not required to implement the decision if it has disputed liability for any reason besides medical necessity (LC 4610.6(j)). So if the employer voluntarily has submitted a request for treatment to UR, even though it has denied liability for reasons other than medical necessity, it may not be required to authorize the treatment, despite the UR decision recommending it, until the threshold issue has been resolved. No case, however, has specifically addressed this issue, so it will require further legal development.

### **Procedure for Modifying or Denying Treatment**

An employer must comply with certain requirements in order to deny or modify requests for medical treatment. A request is denied if the requested medical service is not authorized (CCR 9792.6.1(f)). A requested treatment is deemed modified if the physician reviewer determines that part of the requested treatment or service is not medically necessary (CCR 9792.6.1(r)).

For prospective, concurrent or expedited review, decisions to modify or deny must be communicated to the requesting physician within 24 hours of the decision. The initial decision must be communicated by telephone, fax or email. But the telephone communication must be followed by written notice to the requesting physician, the injured worker and the injured worker's attorney. The written communication must be issued within 24 hours of the decision for concurrent review, within two business days for prospective review and within 72 hours of receipt of a request for expedited review (LC 4610(g)(3)(A); CCR 9792.9.1(e)(3)). The written decision must be provided to the requesting physician, the applicant and the applicant's attorney, if applicable (CCR 9792.9.1(e)(5)).

For retrospective review, a written decision to deny all or part of the requested medical treatment must be communicated within 30 days of receipt of the request for authorization and information that is reasonably necessary to make the determination. The decision must be given to the physician who provided the medical services and to the applicant, and his or her attorney/designee, if applicable (CCR 9792.9.1(e)(4)).

Per LC 4610(g)(4) and CCR 9792.9.1(e)(5), a decision modifying or denying treatment must be provided to the requesting physician, the injured worker and the injured worker's attorney. A utilization review decision



may be considered defective if it is not properly communicated to all of them.<sup>74</sup> It must be signed by either the claims administrator or the reviewer. It must take the form of a report containing:

1. the date the form DWC RFA was first received;
2. the date the decision is made;
3. a description of the specific course of proposed medical treatment for which authorization was requested;
4. a specific description of the medical treatment service approved, if any;
5. a list of all medical records reviewed;
6. a clear and concise explanation of the reasons for the decision;
7. a description of the medical criteria or guidelines used, and, per CCR 9792.8, the relevant portions of the criteria or guidelines themselves;
8. the clinical reasons for medical necessity;
9. the application for independent medical review, form DWC IMR, with all fields, except the employee's signature, completed by the claims administrator, and an addressed envelope, which may be postage paid, for mailing to the administrative director;
10. a clear statement that any dispute must be resolved in accordance with the independent medical review provisions of LC 4610.5 and LC 4610.6, and that an objection to the UR decision must be communicated by the injured worker, the worker's representative or the worker's attorney on behalf of the injured worker on the enclosed form IMR within 30 calendar days after service of the decision;
11. this mandatory language: (1) "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me"; and (2) "For information about the workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](http://www.dwc.ca.gov) or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.";
12. details about the claims administrator's internal UR appeals process, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of LC 4610.5 and LC 4610.6, but may be pursued on an optional basis.

If the request for authorization is modified or denied, the UR physician must provide in the utilization review decision a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

A decision modifying or denying treatment authorization provided to the requesting physician also must contain the name and specialty of the reviewer or expert reviewer, and the telephone number of the reviewer or expert reviewer. The decision must disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision. At minimum, there must be four hours per week during normal business hours, 9 a.m. to 5:30 p.m., or a mutually agreeable scheduled time to discuss the decision with the requesting physician. If the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific

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<sup>74</sup> See *Becerra v. Jack's Bindery, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 451; *Bigham v. Epic Management*, 2014 Cal. Wrk. Comp. P.D. LEXIS 313.

## 6. UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

clinical issues involved in the medical treatment services (CCR 9792.9.1(e)(5)(K)). A denial lacking this information is invalid.<sup>75</sup>

If a UR decision to deny a medical service is due to incomplete or insufficient information, the decision must specify the information that is lacking (LC 4610(g)(4); CCR 9791.9.1(e)(5)(F)). Authorization may not be denied for lack of information without documentation reflecting an attempt to obtain via fax, mail or email the necessary information from the physician (CCR 9792.9.1(g)).

The relevant portions of the criteria or guidelines used to modify or deny the requested treatment must be disclosed in writing to the requesting physician, the applicant and the applicant's attorney. Neither the applicant, the applicant's attorney nor the requesting physician may be charged for a copy of the relevant portion of the criteria or guidelines used to modify or deny the treatment requested (CCR 9792.8(a)(3)). In addition, the nonphysician provider of goods or services identified in the request for authorization must be notified in writing of the decision modifying or denying a request for authorization if the nonphysician provider contact information has been included.<sup>76</sup>

If a request for treatment is not approved, or not approved in full, the dispute must be resolved in accordance with LC 4610.5 and LC 4610.6, which establish the independent medical review process. The independent medical review process gives workers, but not employers, a second chance to obtain a decision in their favor.<sup>77</sup>

Neither the employee nor the employer will have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is modified or denied by a utilization review decision unless that decision is overturned by independent medical review or the appeals board (CCR 9792.10.1(a)). As discussed below, however, if the utilization review determination is untimely, the appeals board has concluded that it retains jurisdiction to decide the disputed treatment issue.

Employers also must make sure that their decisions to modify or deny a request for care are consistent with the MTUS (LC 4610(c)). The appeals board has emphasized that UR is intended to ensure that injured workers receive timely and medically necessary treatment pursuant to objective, evidence-based guidelines, and that it is not intended to be a cost-containment method.

If the board finds that a UR decision is not consistent with the MTUS, it may refer the defendant to the administrative director for review of the defendant's written policies and procedures and potentially assess penalties for abuse of the UR process.<sup>78</sup> Also, the appeals board may impose sanctions under LC 5814 (see ["Sullivan on Comp" Section 13.23 Unreasonable Delay — Failure to Pay Medical Treatment Benefits](#)).<sup>79</sup>

If a defendant has a blanket policy of denying a specific treatment authorized by the MTUS, there could be civil liability.<sup>80</sup> For further discussion on a UR physician's duty to make sure his or her decision is consistent with the MTUS or other evidence based guidelines, see ["Sullivan on Comp" Section 7.31 Utilization Review — Medical Treatment Utilization Schedule](#).

### Voluntary Internal Utilization Review Appeal

Although an applicant normally must employ the independent medical review process to dispute a UR decision to deny or modify a request for treatment, the employer may establish an internal UR appeals

<sup>75</sup> *Billups v. WCAB* (2010) 75 CCC 650 (writ denied).

<sup>76</sup> See *Mayer v. Lodi Unified School District*, 2010 Cal. Wrk. Comp. P.D. LEXIS 427.

<sup>77</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1273; *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561, 568.

<sup>78</sup> See *McCool (Nelson) v. Monterey Bay Medicar*, 2014 Cal. Wrk. Comp. P.D. LEXIS 578.

<sup>79</sup> See *County of Riverside v. WCAB (Salem)* (2014) 79 CCC 946 (writ denied).

<sup>80</sup> See *Electronic Waveform Lab, Inc. v. EK Health Services* (2016) 81 CCC 270.

process as part of its utilization review plan. Again, if it has such a plan, the employer must give notice of it in the decision modifying or denying treatment.

Per CCR 9792.10.1(d), nothing precludes the parties from participating in an internal utilization review appeal process on a voluntary basis if the employee and, if represented by counsel, the employee's attorney, have been notified of the 30-day time limit to file an objection to the UR decision in accordance with LC 4610.5 and LC 4610.6. Any request by the employee, or the treating physician, for an internal utilization review appeal process must be submitted within 10 days after receipt of the utilization review decision. After that, a request for an internal utilization review appeal must be completed, and a determination must be issued, within 30 days after receipt of the request for an internal utilization review appeal. That appeal will be considered complete on the issuance of a final IMR determination that determines the medical necessity of the disputed treatment.

Any determination by the defendant following an internal utilization review appeal that results in a modification of the requested medical treatment must be communicated to the requesting physician, the injured worker and the injured worker's attorney, if any. Also, the application for IMR must indicate that the decision is a modification after appeal.

## **Discontinuing Concurrent Care**

Concurrent care cases are special because the applicant is undergoing care while a request is being made. LC 4610(g)(3)(B) attempts to provide protection for these applicants stating, "[M]edical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee." The statute states that medical care provided during a concurrent review "shall" be care that is medically necessary to cure or relieve, and that the employer "shall" be liable only for services determined to be medically necessary to cure and relieve. Similar language is contained in CCR 9792.9.1(e)(6).

Obviously, the motivation here is protecting against the interruption of hospital care. But one might wonder how well the statute accomplishes this. Recall that concurrent care is provided during an inpatient stay. Imagine an applicant recovering from a back injury in the hospital. A course of physical therapy is requested, and is submitted for utilization review. Under this statute, the applicant's hospital stay would not be interrupted while this was considered. But it is difficult to see why it would be anyway — it is difficult to see hospitalization ending just because further care was being considered for authorization.

If the doctor began the course of physical therapy before the request was made, it could not be interrupted while the UR was performed. So the applicant would get the care while it was being considered. But in that case, the physician would undertake provision of the care at his or her own risk, because it was done without prior authorization. If the employer disputes whether the services offered concurrently with utilization review were medically necessary, the dispute must be resolved by the independent medical review process per LC 4610.5, if applicable, or otherwise per LC 4062.<sup>81</sup>

Also, per CCR 9792.9.1(e)(2), failure to obtain prior authorization will not be an acceptable basis for a refusal to cover medical services to treat and stabilize an injured worker requiring emergency health-care services. "Emergency health care services" are defined as those for a medical condition manifesting by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy (CCR 9792.6.1(i)). Such services, however, are subject to

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<sup>81</sup> Per LC 4610(g)(3)(B), further placing the physician at a disadvantage is this language in the statute: "Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary" requires the defense to report the physician to the appropriate licensing board to guard against abuse of treatment. This puzzling rule should serve to deter the physician from agreeing to anything or, indeed, proceeding with any care before authorization is provided.

retrospective review, and documentation for them must be made available to the claims administrator on request.

### Duration of Utilization Review Decision

LC 4610(g)(6) provides that “[a] utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.” This language is repeated in CCR 9792.9.1(h).

The language was added by SB 863 effective Jan. 1, 2013, for all dates of injury. It addresses the problem of doctors repeatedly requesting a treatment procedure after a utilization review decision has denied it. Previously, there was no guidance on how employers were required to address such requests. In *Sandhagen*,<sup>82</sup> the California Supreme Court stated that the “Legislature intended for employers to use the utilization review process when reviewing and resolving *any and all* requests for medical treatment.” So, arguably, all requests for treatment, even those for treatment previously denied, were subject to utilization review. In fact, some cases suggested that an applicant who did not follow the correct procedure for contesting a UR decision simply could wait for a new recommendation.<sup>83</sup> But it made little sense that employers repeatedly would have to deny requests for the same care. LC 4610(g)(6) was adopted to address this issue.

For example, in one case, the appeals board affirmed a WCJ’s decision that an applicant was not entitled to home care assistance requested by the applicant’s treating physician when the request was timely denied by UR and there was no evidence that there was a change in material fact warranting yet another UR review of a repeat RFA. Although a subsequent UR decision was not timely, the appeals board concluded that this did not invalidate the earlier UR decision because it remained in effect for 12 months per LC 4610(g)(6). So the defendant properly could have disregarded the new RFA and not issued a UR decision at all. The appeals board further found that the initial UR decision was not invalid just because it was not signed. It explained that pursuant to *Dubon II*,<sup>84</sup> failure to sign is not a basis for invalidating a UR decision, and that the applicant’s remedy was to request an independent medical review, which she did.<sup>85</sup> *Dubon II* is discussed later in this Chapter.

In another case, the appeals board held that it had no jurisdiction to decide an applicant’s entitlement for ongoing prescription medications pursuant to a request for authorization Sept. 30, 2014, even though the defendant did not submit the request to UR. Denials for medications had been issued Oct. 9, 2012, Nov. 1, 2013, and Nov. 26, 2013, and the last two were within one year of the 2014 request. The parties agreed that previous UR denials were timely, and because there was no appeal of the 2013 UR denials, the appeals board concluded that the defendant had no duty to have those decisions re-reviewed when the medications were requested again Sept. 20, 2014. It added that the fact that the defendant continued to supply the medications until May 20, 2014, did not override the applicant’s duty to timely appeal the UR decisions.<sup>86</sup>

<sup>82</sup> (2008) 73 CCC 981.

<sup>83</sup> See *Barr v. WCAB* (2006) 71 CCC 411 (writ denied); *Jennings v. WCAB* (2006) 71 CCC 424 (writ denied); *Lafond v. WCAB* (2006) 71 CCC 427 (writ denied); *Simone v. WCAB* (2006) 71 CCC 455 (writ denied); *Wolochuk v. WCAB* (2006) 71 CCC 458 (writ denied). But see *Pena v. C&K Dreams, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 484 (after timely denial, defendant not obligated to perform additional URs for three subsequent requests for authorization to perform the same procedure that were based on the same information).

<sup>84</sup> (2014) 79 CCC 1298 (appeals board *en banc*).

<sup>85</sup> *Reyes v. Target, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 582.

<sup>86</sup> *Apparicio v. State Farm Mutual Auto Insurance Co.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 314.

## Request by Different Physician

The employer is not required to take action on a request for the same treatment only if the recommendation is made by the “same physician.” The statute recognizes that if another physician recommends the treatment, the request still would need to be sent through utilization review.<sup>87</sup> Whether the other physician must be a new primary treating physician, or whether a secondary treating physician may recommend the treatment is not specified. But the appeals board has held that a request for authorization from a secondary treating physician also triggers the utilization review process.<sup>88</sup> So if UR denies a request by a primary treating physician, but a secondary treating physician later makes a request for the same treatment, a defendant should send the later request for another UR. For further discussion on the requirements of a request for authorization.

## Documented Change in Facts

Per LC 4610(g)(6), an employer generally is not required to take any action if the same doctor recommends the same treatment previously denied or modified by utilization review. But an employer is required to undertake UR if the same request is “supported by a documented change in the facts.” What constitutes a documented change sufficient to require another UR is not specified. But the statute places the onus on the physician to explain why a documented change exists.

If there is a documented change in the facts material to the UR decision, the treatment request must be sent to UR. If UR approves the treatment, the defendant must authorize it.<sup>89</sup> If the defendant fails to send a request for treatment to UR despite a documented change in material facts, the appeals board will have jurisdiction to decide the treatment dispute and the defendant may be penalized under LC 5814.

For example, in one case, the treating physician submitted a request for authorization (RFA) for a spinal cord stimulator trial and a psychological evaluation in support of that treatment. Independent medical review (IMR) upheld a UR denial of the stimulator, but overturned a denial of the psychological evaluation. After that evaluation, the treating physician submitted a second RFA for a spinal cord stimulator trial, noting that the psychological evaluation was a changed circumstance from the earlier request. He also noted that the applicant’s condition worsened and that he had a history of failed back surgery syndrome. The defendant did not submit the second RFA to UR. The appeals board found that the change in the applicant’s circumstances and condition between the time of the first RFA and second RFA required the defendant to approve the second request or submit it to UR. Because the defendant did not conduct a timely UR of the second RFA, the board had jurisdiction to decide the treatment dispute. It found substantial evidence to support the use of a spinal cord stimulator, and also found that penalties and attorneys’ fees pursuant to LC 5814 and LC 5814.5 were warranted.<sup>90</sup>

Also, if the employer initially denies a request for treatment through the UR process, but subsequently sends a request to UR approving the requested treatment, the employer may not rely on LC 4610(g)(6) to dispute the treatment. In one case, a defendant issued a UR decision denying Nucynta and Neurontin Nov. 5, 2012. On June 28, 2013, the defendant issued a UR decision authorizing several prescriptions including Neurontin, but the defendant continued to dispute liability for the medications. The appeals board concluded that LC 4610(g)(6) does not apply to authorized treatment. Although the board noted that the defendant could rely on the UR denial for the Nucynta, it found the defendant’s denial of the Neurontin prescriptions unreasonable. So the defendant was liable for penalties under LC 5814 and attorneys’ fees under LC 5814.5.<sup>91</sup>

<sup>87</sup> See *Cabral v. Hal Hays Construction, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 519.

<sup>88</sup> See *Lopez v. City and County of San Francisco*, 2016 Cal. Wrk. Comp. P.D. LEXIS 206; *Klein v. Warner Bros. Studio*, 2016 Cal. Wrk. Comp. P.D. LEXIS 236.

<sup>89</sup> See *Melendez v. Kohl’s Department Store*, 2015 Cal. Wrk. Comp. P.D. LEXIS 535.

<sup>90</sup> *Naus v. Central Coast Village Center*, 2016 Cal. Wrk. Comp. P.D. LEXIS 462.

<sup>91</sup> *Cordova v. Garaventa Enterprises*, 2015 Cal. Wrk. Comp. P.D. LEXIS 1.

## APPEALS BOARD'S JURISDICTION OVER MEDICAL TREATMENT DISPUTES

The Labor Code does not contemplate that the appeals board will lose all jurisdiction over medical treatment issues. LC 4604 states, “Controversies between employer and employee arising under this chapter [which includes medical treatment] shall be determined by the appeals board, except as otherwise provided in Section 4610.5.” LC 5502(b) also provides that an expedited hearing may be requested on an employee’s entitlement to medical treatment, except for treatment issues pursuant to LC 4610 and LC 4610.5 (see Section 15.32 Expedited Hearing). LC 4610.5 relates to the independent medical review process. So, under the Labor Code, the appeals board retains jurisdiction over treatment disputes not subject to the IMR process.

Following SB 863, controversy arose over the types of disputes that should be resolved by IMR, and the disputes that should be resolved by the appeals board. Employers argued that the board had no jurisdiction to resolve treatment disputes following a UR denial of care and that such disputes should be resolved by IMR. But applicants argued that the appeals board had broad jurisdiction to decide treatment disputes when a UR decision was materially defective for failure to comply with the UR statutes and regulations. CCR 10451.2(c)(1)(C) added to the controversy by deeming that disputes over whether UR was timely undertaken or was “procedurally deficient” are not subject to independent medical review.<sup>92</sup>

These issues finally were resolved in the case of *Dubon v. World Restoration, Inc.*, although even that decision is not without controversy. The appeals board initially issued an opinion to which the defense community objected because it gave the board broad jurisdiction to decide issues of medical treatment. The board, however, later issued a modified opinion the applicant community found objectionable as severely limiting applicants’ right to medical treatment. Under the current law, the appeals board retains jurisdiction to resolve the timeliness of a UR decision, and if a UR decision is untimely, the board retains jurisdiction to determine the medical necessity of the disputed treatment. But all other UR disputes must be resolved by IMR.

### Original Dubon Decision

In the initial decision of *Dubon v. World Restoration, Inc.*<sup>93</sup> the appeals board held *en banc*

1. IMR solely resolves disputes over the medical necessity of treatment requests, but issues of timeliness and compliance with statutes and regulations governing UR are legal disputes within the jurisdiction of the appeals board.
2. A UR decision is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the decision, although minor technical or immaterial defects are insufficient to invalidate a defendant’s UR determination.
3. If a defendant’s UR is found invalid, the issue of medical necessity is not subject to IMR but is to be determined by the WCAB based on substantial medical evidence, with the employee having the burden of proving that the treatment is reasonably required.
4. If there is a timely and valid UR, the issue of medical necessity will be resolved through the IMR process if requested by the employee.

In *Dubon*, the appeals board concluded that a defendant’s failure to provide the UR physician with adequate records was a material procedural defect that undermined the integrity of the UR decision. It added that a

<sup>92</sup> Cases prior to SB 863 also gave the appeals board jurisdiction over procedurally deficient UR determinations. See *Becerra v. Jack’s Bindery, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 451 (failure to transmit denial to requesting physician by telephone, fax or otherwise procedurally deficient); *Corona v. Los Aptos Christian Fellowship Childcare*, 2012 Cal. Wrk. Comp. P.D. LEXIS 459 (UR was procedurally deficient because UR physician was not provided with all relevant medical reporting and information that was in defendant’s possession as required by UR process); *Fabillaran v. Meadows of Napa Valley*, 2012 Cal. Wrk. Comp. P.D. LEXIS 511 (UR deficient because applicant was notified that she could object to UR determination by sending written notice to claims administrator).

<sup>93</sup> (2014) 79 CCC 313 (appeals board *en banc*).

defect would exist if the employer or the UR physician did not list the records sent and reviewed.<sup>94</sup> It explained, “The need for a UR physician to be provided with and review sufficient medical records to determine the medical necessity of a treatment request and to disclose what those records are goes to the very core of a UR decision.” It added, “To allow these statutory and regulatory requirements to be inadvertently neglected or deliberately disregarded would render UR decisions unreliable, possibly flawed and ultimately would defeat the purpose of having UR at all, while at the same time adding an extra layer of delay to the medical treatment resolution process.”<sup>95</sup>

## Aftermath and Appeal

Following *Dubon*, there was a great deal of litigation at the appeals board over what constituted a material procedural defect in a UR determination. Applicants challenged UR determinations on practically every conceivable ground. The appeals board generally found UR decisions materially defective when the UR physician failed to review all relevant medical reports,<sup>96</sup> when it found factual mistakes in the UR decision<sup>97</sup> or when it believed the UR physician did not address the requested treatment adequately.<sup>98</sup> It rejected UR decisions when the UR physicians failed to sign their reports.<sup>99</sup> Applicants also challenged UR decisions based on the UR physician’s specialty,<sup>100</sup> and when delays were issued by nurses, as opposed to physicians.<sup>101</sup>

There was a great deal of inconsistency at the appeals board on how to apply *Dubon*. In one case, the board determined that a failure to review medical reports was not a material defect because the additional reporting would not have changed the UR determination, which relied on evidence-based guidelines.<sup>102</sup> Another UR decision was not found to be defective when the UR physician documented attempts to obtain the required information before denying the requested treatment.<sup>103</sup> Also, in one case, the panel majority concluded it was appropriate for a UR physician to reconsider whether requested treatment was medically necessary when the physician’s initial decision may not have been based on an accurate medical history — an idea not supported in the statutory scheme.<sup>104</sup>

Accordingly, following a timely petition for reconsideration of the original decision May 22, 2014, the appeals board granted reconsideration in order to allow for further study of the factual and legal issues of the case.<sup>105</sup>

## Dubon Modified

On Oct. 6, 2014, a divided appeals board issued a new decision that substantially modified its prior decision.<sup>106</sup> In the modified decision, commonly known as *Dubon II*, the appeals board majority held that:

1. A UR decision is invalid and not subject to independent medical review (IMR) only if it is untimely.

<sup>94</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 313, 323 (appeals board *en banc*).

<sup>95</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 313, 324 (appeals board *en banc*).

<sup>96</sup> See *Page v. Barman Transport, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 177; *Tabaracci v. Waste Management*, 2014 Cal. Wrk. Comp. P.D. LEXIS 182; *Weilmann v. United Temporary Service*, 2014 Cal. Wrk. Comp. P.D. LEXIS 163.

<sup>97</sup> *Gomez v. Facilities Support Services*, 2014 Cal. Wrk. Comp. P.D. LEXIS 149; *Andronico v. La Rocca Seafood, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 213; *Jovel v. Sisters of the Holy Names dba Ramona Convent Secondary School*, 2014 Cal. Wrk. Comp. P.D. LEXIS 616.

<sup>98</sup> *Smith v. Cal West Seeds*, 2014 Cal. Wrk. Comp. P.D. LEXIS 509.

<sup>99</sup> *Weilmann v. United Temporary Service*, 2014 Cal. Wrk. Comp. P.D. LEXIS 163.

<sup>100</sup> See *Andronico v. La Rocca Seafood, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 213; *Mercado v. Park West Enterprises, Inc., dba Co-West Commodities*, 2014 Cal. Wrk. Comp. P.D. LEXIS 532.

<sup>101</sup> *Newton v. Jack-In-The-Box*, 2014 Cal. Wrk. Comp. P.D. LEXIS 356; *Newton v. Jack-In-The-Box*, 2014 Cal. Wrk. Comp. P.D. LEXIS 413.

<sup>102</sup> *Otten v. Cardinal Newman High School*, 2014 Cal. Wrk. Comp. P.D. LEXIS 358. See also *Martin v. City of Richmond*, 2014 Cal. Wrk. Comp. P.D. LEXIS 464.

<sup>103</sup> *Smith v. Plant Construction*, 2014 Cal. Wrk. Comp. P.D. LEXIS 391.

<sup>104</sup> *Garcia-Picen v. Tight Quarters, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 262.

<sup>105</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 566 (appeals board *en banc*).

<sup>106</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298 (appeals board *en banc*).

2. Legal issues regarding the timeliness of a UR decision must be resolved by the appeals board, not IMR.
3. All other disputes regarding a UR decision must be resolved by IMR.
4. If a UR decision is untimely, the determination of medical necessity may be made by the appeals board based on substantial medical evidence consistent with LC 4604.5.

First, the appeals board explained that CCR 10451.2(c)(1)(C), which states that a non-IMR dispute includes whether UR was “procedurally deficient” is inconsistent with its decision, and pending the rule’s amendment, it should not be applied. The board concluded that CCR 10451.2(c)(1)(C) was invalid as contravening the statutes under which they were adopted.<sup>107</sup>

The appeals board then explained that when a UR decision is not timely, there was no dispute for IMR to resolve within the meaning of LC 4610(g)(3)(A)(B). Likewise, it explained that if a treatment request is denied without UR, there is no decision to appeal to IMR. Because IMR determines only the necessity of requested treatment, the appeals board held that it, the board, must resolve legal disputes over UR timeliness.<sup>108</sup>

The board explained, however, that with the exception of timeliness, all defects in the UR process can be remedied when appealed to IMR. It stated, “The legislature made it abundantly clear that medical decisions are to be made by medical professionals. To allow a WCJ to invalidate a UR decision based on any factor other than timeliness and substitute his or her own decision on a treatment request violates the intent of SB 863.” So it held that “where a UR decision is timely, IMR is the sole vehicle for reviewing the UR physician’s expert opinion regarding the medical necessity of proposed treatment, even if the UR process did not fully comply with section 4610’s requirements.”<sup>109</sup>

It explained that a defective UR could be corrected either by exercising an internal UR appeal process, if available, or through IMR, during which both parties may submit records. It added that although failure to comply with the requirements of LC 4610 would not invalidate a UR decision, it could result in administrative penalties and increased compensation under LC 5814.<sup>110</sup>

It also held that without a timely UR decision, the question of medical necessity could be resolved by the appeals board. But, per *Sandhagen*, this does not mean that treatment is automatically awarded. The appeals board explained that when a UR decision is untimely, the injured employee is entitled only to “reasonably required” medical treatment, and it is the employee’s burden to establish his or her entitlement to any particular treatment. The employee must do this by showing that the treatment falls within the presumptively correct MTUS or that this burden has been rebutted by substantial medical evidence consistent with LC 4604.5.<sup>111</sup>

### Analysis of Dubon

Under the *Dubon II* decision, the appeals board retains jurisdiction to decide treatment disputes when the utilization review is untimely, or when no utilization review is performed. It does not have authority, however, to decide treatment disputes on the grounds of a material procedural defect in the UR process. Instead, even if a UR decision suffers from a potential procedural defect, the treatment dispute must be resolved pursuant to the IMR process. Employees must cure any defect in the UR decision through IMR, when both parties may submit records.

<sup>107</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298, 1306, fn. 12 (appeals board *en banc*).

<sup>108</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298, 1306-1307 (appeals board *en banc*).

<sup>109</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298, 1309, 1311 (appeals board *en banc*).

<sup>110</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298, 1310-1311 (appeals board *en banc*).

<sup>111</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298, 1312 (appeals board *en banc*).



The *Dubon II* decision is a partial victory for employers. Employees largely favor adjudicating treatment disputes before the appeals board instead of pursuing them through IMR. It is believed that the board is more favorable to injured workers than IMR. This appears to be true. Although there are no precise numbers on an employee's chances of prevailing at the appeals board for a treatment dispute, the DWC reported that more than 85 percent of IMR determinations uphold UR findings that the treatment request is not medically necessary.<sup>112</sup> So there is no question that requiring treatment disputes to be decided by IMR, rather than the appeals board, favors employers.

Furthermore, even if an employer does not timely perform UR, the employee is not automatically entitled to treatment. Instead, per *Sandhagen*, the employee must demonstrate that the requested treatment is medically reasonable and necessary by showing that it is consistent with the MTUS, or rebutting the presumption with substantial medical evidence consistent with LC 4604.5.

An appellate court has yet to offer a binding opinion on the issue. The 4th District Court of Appeal denied the applicant's petition for writ of review in *Dubon* as moot.<sup>113</sup> The Supreme Court also denied further review of the decision. In one case, the 4th District Court of Appeal found the appeals board's interpretation of the statutes in *Dubon II* to be correct, but did not issue a formal, published opinion.<sup>114</sup>

Currently, *Dubon II* is binding on appeals board panels and WCJs (CCR 10341). With its new decision, the board significantly has curtailed its authority to decide medical treatment disputes. If the appeals board finds that a defendant's UR determination was timely, it will not have jurisdiction to decide the treatment dispute.<sup>115</sup> Accordingly, the failure to sign a UR decision was not a basis for invalidating the decision under *Dubon II*.<sup>116</sup> Likewise, the appeals board does not have jurisdiction just because a UR physician fails to review or list medical records,<sup>117</sup> or because the UR physician failed to review an AME report.<sup>118</sup> The appeals board may return a case to the trial level to conduct proceedings on whether UR was conducted timely if the record is not fully developed on the issue.<sup>119</sup>

## Time Limits for Utilization Review

The time limits for conducting utilization review are discussed earlier. In *Dubon II*, the appeals board held that it had authority to decide a treatment dispute if a UR determination was untimely. Shortly after *Dubon II*, the board issued a significant panel decision, *Bodam v. San Bernardino/Department of Social Services*,<sup>120</sup> explaining what was required before a UR determination could be considered timely. It held:

1. A defendant is obligated to comply with all time requirements in conducting UR, including the time frames for communicating the UR decision.
2. A UR decision that is timely made but is not timely communicated is untimely.
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 on substantial evidence.

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<sup>112</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 3.

<sup>113</sup> *Dubon v. WCAB* (2015) 80 CCC 192 (writ denied).

<sup>114</sup> *Graham v. WCAB* (2015) 80 CCC 461 (writ denied).

<sup>115</sup> See *Filippini v. WCAB* (2015) 80 CCC 377 (writ denied); *McFarland v. WCAB* (2015) 80 CCC 1088 (writ denied) (dissenting Commissioner Sweeney would have allowed applicant to rebut MTUS, arguing that rebuttal should be conducted in legal form, not via IMR); *Briggs v. WCAB* (2015) 80 CCC 454 (writ denied); *Vargas v. Seligman Western Enterprises, Ltd.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 664.

<sup>116</sup> See *Reyes v. Target, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 582; *Desmarais v. California Highway Patrol*, 2014 Cal. Wrk. Comp. P.D. LEXIS 709.

<sup>117</sup> See *Carrico v. Law Offices of Stephen Belgum*, 2014 Cal. Wrk. Comp. P.D. LEXIS 589; *Monreal v. LabCorp*, 2014 Cal. Wrk. Comp. P.D. LEXIS 620; *Smith v. Scholle Packaging*, 2015 Cal. Wrk. Comp. P.D. LEXIS 616.

<sup>118</sup> *Reis v. Silvas Oil Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 605.

<sup>119</sup> See *Avila v. Payless Cashways*, 2015 Cal. Wrk. Comp. P.D. LEXIS 176.

<sup>120</sup> (2014) 79 CCC 1519 (significant panel decision).

In that case, a doctor faxed a request for authorization Oct. 28, 2013, to perform a three-level fusion at L3-S1. The defendant sent the request to UR that day, and the UR physician made a decision Oct. 31, 2013, to deny the treatment on the grounds that the surgery was not medically supported. It was not until Nov. 5, 2013, that the defendant mailed written denial letters to the applicant, the requesting physician and the applicant's attorney. The appeals board concluded that the UR determination was untimely and therefore invalid.<sup>121</sup>

It explained that although the UR decision was timely made three days after receipt of the RFA form, the UR decision was not timely communicated. It explained, "A UR decision that is not timely communicated is of no use and defeats the legislative intent of a UR 'process that balances the interests of speed and accuracy, emphasizing the quick resolution of treatment requests ...'" It explained that under LC 4610(g)(3)(A) and CCR 9792.9.1(e)(3), a decision to modify, delay or deny must be communicated to the requesting physician within 24 hours of the decision initially by telephone, facsimile or electronic mail. For prospective review, the communication must be followed by written communication within two business days.<sup>122</sup>

The appeals board found no evidence that the defendant or its UR provider phoned, faxed or emailed the UR denial to the requesting physician within 24 hours after the UR decision Oct. 31, 2013. It also found that the written notice was not sent to the requesting physician, the applicant and the applicant's attorney within two business days after the UR decision was made. The appeals board concluded that the defendant's UR decision was untimely, and that it had the authority to determine the issue of medical necessity. Because neither party presented substantial evidence that would allow a properly supported decision concerning the proposed surgery, the matter was remanded to further develop the record.<sup>123</sup>

So, under *Bodam*, for a prospective review, three time limits must be met:

1. The UR determination must be made no later than five working days from receipt of an RFA form, but UR may request additional appropriate information within that period and make a decision within 14 calendar days.
2. The decision must be communicated to the requesting physician by telephone, fax or email within 24 hours of being made.
3. The initial communication must be followed by written communication within two business days. The written decision must be provided to the requesting physician, the injured worker and the injured worker's attorney, if any.

The time limits for communicating a UR decision start running from the date the decision is actually made, even if it is made in a shorter time frame than permitted by LC 4610(g)(1).<sup>124</sup> Although the best practice is to include a proof of service of the UR decision, a proof of service is not the exclusive means for proving that a utilization review document has been timely served.<sup>125</sup>

### Application of Time Limits

The appeals board has found that any defect in timely making or timely communicating a UR determination will render a UR decision untimely. A UR decision will be found to be untimely if it was not communicated to the requesting physician within 24 hours of the decision.<sup>126</sup> In one case, although the appeals board explained that a defendant was not required to show that the UR determination was communicated directly

<sup>121</sup> *Bodam v. San Bernardino/Department of Social Services* (2014) 79 CCC 1519 (significant panel decision).

<sup>122</sup> *Bodam v. San Bernardino/Department of Social Services* (2014) 79 CCC 1519, 1522-1523 (significant panel decision).

<sup>123</sup> *Bodam v. San Bernardino/Department of Social Services* (2014) 79 CCC 1519, 1523-1524 (significant panel decision). See also *Rivera v. Valley Radiology*, 2014 Cal. Wrk. Comp. P.D. LEXIS 583 (UR decision untimely when no evidence showed it was communicated initially by telephone, fax or email before written notice was served).

<sup>124</sup> *Mulford v. City of Los Angeles*, 2016 Cal. Wrk. Comp. P.D. LEXIS 296.

<sup>125</sup> *Tablas v. Regents of the University of California*, 2016 Cal. Wrk. Comp. P.D. LEXIS 359.

<sup>126</sup> See *Boone v. Dreyer's Grand Ice Cream*, 2014 Cal. Wrk. Comp. P.D. LEXIS 641; *Tinsley v. Vertis Communications*, 2015 Cal. Wrk. Comp. P.D. LEXIS 575; *Gutierrez v. Biggie Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 591.

to the requesting physician, it found that the defendant did not prove the determination was timely communicated.<sup>127</sup>

In order to be considered timely, the UR determination must address the treatment requested.<sup>128</sup>

The appeals board also determined that a UR decision was untimely when it was completed within the time limits for a regular review, but the treating physician requested an expedited review and the defendant did not meet the 72-hour time frame.<sup>129</sup>

The appeals board has held that a UR decision was untimely when it was not served on the requesting physician, the applicant and the applicant's attorney as required by CCR 9792.9.1(e)(3) and CCR 9792.9.1(e)(5).<sup>130</sup> It held that a UR decision was untimely when it was mailed to incorrect, nonexistent addresses for the applicant's attorney, not to his address of record.<sup>131</sup> Similarly, the board held that a UR decision was untimely when it was served on the applicant's former attorney but not the current attorney, despite the defendant receiving a substitution of attorney notification two years earlier.<sup>132</sup> The appeals board also held that a UR decision was untimely when it was not timely communicated to the applicant and his attorney, even though the applicant's claim settled by stipulated award more than 20 years earlier.<sup>133</sup>

The appeals board held that a defendant did not prove its UR decision was timely communicated when it presented evidence that it left a phone message with the requesting physician on the date of the UR decision but also indicated that peer-to-peer contact was unsuccessful. The appeals board concluded that without specifying the nature or content of the phone message, the defendant had not shown that the messages it left gave notice to the requesting physician that his treatment requests were denied.<sup>134</sup>

In one case, the appeals board held that a UR decision was untimely when a defendant communicated a UR decision to the treating physician by fax within 24 hours of the decision, but it was not communicated in writing a second time. The board explained that LC 4610(g)(3)(A) created a two-step process for timely communication of a UR determination and that both steps must be satisfied in order to comply with the statute. It concluded that a UR decision must be (1) communicated by "telephone or facsimile" to the requesting physician within 24 hours of the decision; and (2) communicated to the physician and employee "in writing" within 24 hours for concurrent review or within two business days for concurrent review. It also held that CCR 9792.9.1(e)(3), which suggests that only a communication by telephone to the requesting physician must be followed by written notice to the requesting physician, was invalid to the extent that it was inconsistent with LC 4610(g)(3)(A).<sup>135</sup>

The appeals board also held that a UR decision was untimely when it issued six working days after receipt of the request for authorization. The defendant argued that the five-day rule did not apply because there was a request for additional information, and the time was extended to 14 days. It referenced the UR determination, which noted that the reviewing physician had attempted a peer-to-peer call on the fifth day

<sup>127</sup> *Gutierrez v. Bigge Crane & Rigging Co.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 383. See also *Van Buren v. Primitive Logic, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 619; *Gloria v. City of Glendale*, 2016 Cal. Wrk. Comp. P.D. LEXIS 91.

<sup>128</sup> See *Arroyo v. Inland Concrete Enterprises, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 10 (UR addressed whether scooter was medically necessary, not whether applicant's existing scooter should be repaired or replaced).

<sup>129</sup> *Rodriguez v. Air Eagle, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 3.

<sup>130</sup> See *Allen v. Providence Holy Cross Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 635; *Taylor v. Blue Go Transit Management*, 2015 Cal. Wrk. Comp. P.D. LEXIS 732; *Vazquez v. Epic Fire Protection*, 2016 Cal. Wrk. Comp. P.D. LEXIS 195.

<sup>131</sup> *Zwicky v. NH Research, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 33. See also *McBurney v. All That Glitters*, 2015 Cal. Wrk. Comp. P.D. LEXIS 637.

<sup>132</sup> *Thompson v. County of Los Angeles*, 2016 Cal. Wrk. Comp. P.D. LEXIS 107.

<sup>133</sup> *Vigil v. Milan's Smoked Meats*, 2014 Cal. Wrk. Comp. P.D. LEXIS 665.

<sup>134</sup> *Shanley v. Henry Mayo Newhall Memorial Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 660. See also *DeRosa v. Office Solutions*, 2015 Cal. Wrk. Comp. P.D. LEXIS 14; *Tolliver v. County of Fresno*, 2015 Cal. Wrk. Comp. P.D. LEXIS 645; *Buhtz v. Selective Employees*, 2015 Cal. Wrk. Comp. P.D. LEXIS 655; *San Francisco 49ers v. WCAB (Visger)* (2016) 81 CCC 295 (writ denied); *Coyle v. Dane Coyle Custom Homes, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 522.

<sup>135</sup> *Dallas v. Pan Pacific Petroleum*, 2016 Cal. Wrk. Comp. P.D. LEXIS 116.

after receipt. But on review of the document, the appeals board found no evidence that the reviewer who called in fact was requesting additional information. It added that although this conclusion might be inferred, the defendant had the burden to establish that the utilization review determination was timely. Because the defendant did not establish that the call was a request for additional information, the UR determination was untimely. Moreover, because the UR determination was untimely and because the defendant failed to authorize the requested treatment once the UR determination was challenged by the applicant, the board found that the medical treatment was unreasonably delayed, and awarded LC 5814 penalties and related attorneys' fees.<sup>136</sup>

In contrast, in one case, a defendant received the RFA form May 11, 2015. The defendant's UR denial was issued May 19, 2015, six working days after receipt of the RFA form. The appeals board noted that the reviewer documented that additional information was required and attempted peer-to-peer review by leaving two messages with the treating physician May 18, 2015. The appeals board found that the reviewer's request for additional information was made within the five-working day timeline in LC 4610(g)(1), and triggered the alternative 14-day timeline. It noted that the reviewer spoke with the treating physician's nurse May 19, 2015, obtained the additional information requested and told the nurse that his recommendation was to deny the request. Because the UR determination was orally communicated by telephone May 19, 2015, and written confirmation was issued the next day, the appeals board concluded that the UR determination was timely and that the applicant's remedy was to appeal the determination through IMR.<sup>137</sup>

In another case, the appeals board held that it lacked jurisdiction to decide whether the applicant required home assistance for cooking, cleaning, self-grooming and transportation when the defendant's UR denial was timely. The applicant's attorney wrote to the defense counsel Sept. 11, 2015, and attached a PR-2 report from the primary treating physician requesting the services. On Sept. 17, 2015, UR denied the requested treatment. The UR decision recited that the UR physician left messages with the requesting physician Sept. 16, 2015, and Sept. 17, 2015. Then, a second UR decision was issued Oct. 2, 2015, explaining that on Sept. 17, 2015, the requesting physician was informed that the requested treatment was deemed to be not medically necessary. The appeals board rejected the WCJ's determination that the Sept. 17, 2015, determination was incomplete because it did not recite the fact that the UR physician spoke to the requesting physician by telephone. The board found that there was no requirement that the UR denial recite the contents of the telephone conference between the reviewer and treating physician. Because the UR decision was timely made and served, the board concluded that the correctness of the determination may be resolved only through IMR.<sup>138</sup>

Also, the appeals board rescinded a WCJ's decision that a defendant's UR determination was untimely because, in violation of CCR 10608 and CCR 10615, the defendant failed to serve the applicant and her attorney with medical records. The board explained that nothing in LC 4610 requires service of medical records considered in connection with a UR as an element of timely completion of UR, and that the statute refers only to service of the UR decision, not service of the medical reports considered in connection with that review. It added that the obligation to serve medical reports in CCR 10608 and CCR 10615 applies generally to all medical reports, and not specifically to medical reports considered in connection with a UR. The appeals board concluded that a defendant's failure to service medical reports was a violation of the administrative rules, but that violation does not render a UR untimely and invalid. The appeals board added that the untimely service of medical reports supported the WCJ order allowing costs and fees per LC 5813, but did not support a penalty under LC 5814 or attorneys' fees and costs under LC 5814.5 because

<sup>136</sup> *Hunter v. Estes Express Lines*, 2015 Cal. Wrk. Comp. P.D. LEXIS 42.

<sup>137</sup> *Smith v. Scholle Packaging*, 2015 Cal. Wrk. Comp. P.D. LEXIS 616.

<sup>138</sup> *Bissett-Garcia v. Peace and Joy Center*, 2016 Cal. Wrk. Comp. P.D. LEXIS 174; *Bissett-Garcia v. Peace and Joy Center*, 2016 Cal. Wrk. Comp. P.D. LEXIS 282.

compensation and medical treatment were not unreasonably delayed.<sup>139</sup> For further discussion on the service of medical reports, see [“Sullivan on Comp” Section 14.7 Service of Medical Reports.](#)

## Burden of Proof Following Untimely Utilization Review

An employer is not automatically liable for medical treatment if it fails to timely perform UR. The applicant retains the burden of proof on the issue. In *Sandhagen*, the California Supreme Court stated, “[N]otwithstanding whatever an employer does (or does not do), an injured employee must still prove that the sought treatment is medically reasonable and necessary. That means demonstrating that the treatment request is consistent with the uniform guidelines (section 4600(b)) or, alternatively, rebutting the application of the guidelines with a preponderance of scientific medical evidence (section 4604.5).”<sup>140</sup>

Relying on *Sandhagen*, the appeals board stated in *Dubon II*, “[W]here a defendant’s UR decision is untimely, the injured employee is nevertheless entitled only to ‘reasonably required’ medical treatment ... and it is the employee’s burden to establish his or her entitlement to any particular treatment ..., including showing either that the treatment falls within the presumptively correct MTUS or that this presumption has been rebutted.” The appeals board added that “to carry this burden, the employee must present substantial medical evidence.”<sup>141</sup> Furthermore, CCR 10451.2(c)(1)(C) states that even if an applicant prevails in an assertion that UR was not timely undertaken, “the employee or provider still has the burden of showing entitlement to the recommended treatment.”

So even if UR is not undertaken or was untimely, the injured employee still must demonstrate that the treatment is reasonably required and either that the treatment falls within the presumptively correct medical treatment utilization schedule, or that this presumption has been rebutted by a preponderance of scientific medical evidence. The employee must show that requested treatment was reasonable and necessary at the time it was requested.<sup>142</sup>

Since *Dubon*, the appeals board has been inconsistent regarding the standard of proof necessary to establish entitlement to medical treatments. Some cases have awarded treatment requested by physicians when the requests were supported by the MTUS or other scientific medical guidelines.<sup>143</sup> But many cases have awarded medical treatment following an untimely utilization review when the appeals board found the

<sup>139</sup> *Keller v. Northern California Medical Associates*, 2015 Cal. Wrk. Comp. P.D. LEXIS 594. See also *Sauceda v. CSUF Association, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 538.

<sup>140</sup> *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, 990. This appears to be true despite some precedent that arguably stands in contrast. In *Cervantes v. El Aguila Food Products, Inc.* (2009) 74 CCC 1336 (appeals board *en banc*), the appeals board *en banc* concluded that the UR deadlines are mandatory, and if an employer fails to complete UR in a timely manner, it must authorize the recommended treatment. This opinion was followed by the Court of Appeal in *Elliott v. WCAB* (2010) 75 CCC 81. Note, however, that this conclusion was drawn in the context of the former spinal surgery dispute process. That process was removed from the workers’ compensation system effective Jan. 1, 2013, so these cases might no longer be relevant to the inquiry. At most, it would seem that the conclusion of these cases on the point should be limited to former spinal surgery cases. Moreover, although *Cervantes* and *Elliott* were issued after *Sandhagen*, neither addressed the language in *Sandhagen*. *Cervantes* recognized that in *Sierra Pacific Industries v. WCAB (Chatham)* (2006) 71 CCC 714, the Court of Appeal stated: “The effect of bypassing the new utilization review process was that the [UR report] was not admissible, but there was no effect on the ability of [the defendant] to challenge the reasonableness of the medical treatment.” The appeals board rejected this statement as dicta, and inconsistent with the decision in *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981 and *J.C. Penney Co. v. WCAB (Edwards)* (2009) 74 CCC 826.

<sup>141</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298, 1312 (appeals board *en banc*). See also *Chairez v. Cherokee Bindery*, 2012 Cal. Wrk. Comp. P.D. LEXIS 506; *Flores v. Harbor Rail Transport*, 2013 Cal. Wrk. Comp. P.D. LEXIS 14; *Sanchez v. Los Angeles Unified School District*, 2013 Cal. Wrk. Comp. P.D. LEXIS 396; *Ruvalcaba v. California Community News*, 2014 Cal. Wrk. Comp. P.D. LEXIS 136; *Salguero v. Charles Gemeiner Cabinets*, 2013 Cal. Wrk. Comp. P.D. LEXIS 450; *Castrillo v. Catholic Health Care West dba Marian Medical Center*, 2012 Cal. Wrk. Comp. P.D. LEXIS 454. Note that many cases have awarded treatment based on a showing of “substantial evidence” without discussing the standard in *Sandhagen*. See *Becerra v. Jack’s Bindery, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 451; *Corona v. Los Aptos Christian Fellowship Childcare*, 2012 Cal. Wrk. Comp. P.D. LEXIS 459; *De Los Rios v. Western Surplus*, 2012 Cal. Wrk. Comp. P.D. LEXIS 462; *Musetti v. Golden Gate Disposal & Recycling dba Recology*, 2013 Cal. Wrk. Comp. P.D. LEXIS 220.

<sup>142</sup> *Herring v. Paradise Valley Hospital*, 2015 Cal. Wrk. Comp. P.D. LEXIS 526.

<sup>143</sup> See *Korn v. Entertainment Partners*, 2014 Cal. Wrk. Comp. P.D. LEXIS 501; *Cabral v. Hal Hays Construction, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 519; *Allen v. Providence Holy Cross Hospital*, 2014 Cal. Wrk. Comp. P.D. LEXIS 635; *Vigil v. Milan’s Smoked Meats*, 2014 Cal. Wrk. Comp. P.D. LEXIS 665; *McBurney v. All That Glitters*, 2015 Cal. Wrk. Comp. P.D. LEXIS 637; *Coyle v. Dane Coyle Custom Homes, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 522; *Gutierrez v. Biggie Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 591.

requests to be supported by substantial medical evidence, even though not supported by any objective treatment guidelines.<sup>144</sup>

For example, the appeals board awarded an applicant continued treatment for a psychiatric injury at Casa Colina Transitional Living Center after it found a UR determination untimely because the defendant did not show it was communicated to the requesting physician within 24 hours as required by LC 4610(g)(3)(A). The applicant attempted to commit suicide and was treated at Casa Colina. The treating physician requested continuing treatment at the facility, and a QME recommended someone who was not a family member care for the applicant. The appeals board found the opinions of the QME and treating physician to be substantial medical evidence that the applicant's continuing treatment at Casa Colina was reasonable.<sup>145</sup> The appeals board did not comment on whether the treatment was supported by the MTUS or other medical guidelines.

In one case, the appeals board awarded the applicant right shoulder surgery when it found that the treating physician's recommendation for surgery was consistent with the MTUS. Although the physician did not specifically cite the MTUS to support the request, the board adopted the WCJ's decision, which reviewed the MTUS and found that it supported the treatment. The majority believed that a requesting physician need not cite the MTUS in order to comply with LC 4604.5. The concurring opinion agreed that the applicant was in need of the surgery but did not agree that a requesting physician need not cite the MTUS in order to comply with LC 4604.5.<sup>146</sup> For further discussion of the requesting physician's duty to document the need for treatment, see ["Sullivan on Comp" Section 7.31 Utilization Review — Medical Treatment Utilization Schedule](#).

Nevertheless, some cases have denied treatment requests if the applicant did not establish that the requested treatment was consistent with the MTUS or other scientific medical evidence. For example, the appeals board concluded that an applicant was not entitled to low-back surgery requested by her treating physician when the physician failed to justify his recommendation by reference to the MTUS. There also was no evidence that the physician addressed the issue of reasonableness and necessity by reference to the other elements of the hierarchy for evidence-based standards and medical opinion under LC 4610.5(c)(2), that is, peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service, nationally recognized professional standards, expert opinion, generally accepted standards of medical practice and treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.<sup>147</sup>

In another case, the appeals board rescinded an order awarding transportation services to and from school for an applicant's children when the applicant did not present substantial evidence to support that the services were medically necessary under LC 4610.5(c)(2). The applicant was unable to drive due to difficulties with his vision as a result of an industrial injury. The treating physician issued an RFA form requesting authorization for transportation to pick up his children from school. Because the defendant did not send this request to UR, the appeals board found that, per *Dubon II*, it had jurisdiction to determine the issue of medical necessity of request for transportation. It also explained, however, that the applicant was required to show that the transportation for his children was reasonably necessary to cure or relieve from the effects of the injury, and that the treatment was consistent with ACOEM guidelines or the MTUS. The

<sup>144</sup> See *Inman v. Lowe's Home Centers*, 2014 Cal. Wrk. Comp. P.D. LEXIS 653; *Boone v. Dreyer's Grand Ice Cream*, 2014 Cal. Wrk. Comp. P.D. LEXIS 641; *Dolan v. The Gap, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 645; *Zwicky v. NH Research, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 33; *Rodriguez v. Air Eagle, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 3; *Carnes v. Auto Zone, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 94; *Rodriguez v. Statek Corp.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 402; *Herring v. Paradise Valley Hospital*, 2015 Cal. Wrk. Comp. P.D. LEXIS 526; *Belling v. United Parcel Service, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 738; *Milton v. County of Tulare*, 2016 Cal. Wrk. Comp. P.D. LEXIS 484.

<sup>145</sup> *Tinsley v. Vertis Communications*, 2015 Cal. Wrk. Comp. P.D. LEXIS 575. See also *Baisch v. Video Only, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 280; *Milton v. County of Tulare*, 2016 Cal. Wrk. Comp. P.D. LEXIS 484; *Rivas v. North American Trailer*, 2016 Cal. Wrk. Comp. P.D. LEXIS 572.

<sup>146</sup> *Sandoval v. San Diego Unified School District*, 2016 Cal. Wrk. Comp. P.D. LEXIS 58.

<sup>147</sup> *Thompson v. County of Los Angeles*, 2016 Cal. Wrk. Comp. P.D. LEXIS 107. See also *Tubbs v. Fresno Chaffee Zoo*, 2015 Cal. Wrk. Comp. P.D. LEXIS 237; *Pollack v. National Auto Sports Association*, 2016 Cal. Wrk. Comp. P.D. LEXIS 103.

applicant could not meet his burden of proof because there was no discussion in the reports of the requesting physician that the services were medically reasonable and necessary to cure or relieve the applicant from the effects of his injury. The appeals board remanded for further development on the record.<sup>148</sup>

Similarly, the appeals board rescinded a WCJ's decision finding that the applicant was entitled to medical treatment in the form of a back defender system to help take weight off his duty belt because the treating physician's opinion requesting the system was not supported by substantial evidence. The board had jurisdiction to decide the treatment dispute because the defendant did not perform UR asserting that the request was a uniform modification and not a medical treatment request. But the board found that a dispute over whether a proposed medical treatment is reasonably required must be determined by evidence-based standards and medical opinion, and that the treating physician did not refer to any applicable standards under LC 4610.5(c)(2) to support his opinion that the back defender system was reasonable and necessary. It concluded that the doctor's medical opinion was not substantial evidence and remanded for development of the record on the reasonableness and necessity of the back defender system.<sup>149</sup>

## **WAIVER OF UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW BY STIPULATION**

Prior to SB 899 and the use of utilization review to decide treatment disputes, medical treatment disputes were resolved by the medical-legal process. In that environment, it was common for parties to stipulate that treatment disputes would be resolved by a particular physician, such as the treating physician or the AME. This was especially common when the parties settled a claim by way of stipulations with request for award. Such settlements generally resolve indemnity benefits but allow an applicant to continue receiving medical treatment (see [“Sullivan on Comp” Section 14.72 Resolution by Stipulations with Request for Award](#)). As discussed in [“Sullivan on Comp” Section 16.21 Evidence at Trial — Effect of Stipulation](#), stipulations generally are binding on the parties and may be set aside only on a showing of good cause.

But what effect do these prior stipulations have on the parties' use of the utilization review and independent medical review processes to resolve treatment disputes? Can the parties bypass both processes and allow an AME or treating doctor to resolve a treatment dispute if there was such a stipulation? Must they? The answer seems to be that parties may agree to another method of resolving disputes over medical care, and thus waive the UR/IMR process, but that such stipulations will be narrowly circumscribed by the court.

In one case, the appeals board concluded that a stipulation would not nullify the employer's right to send a request for treatment to UR, but that a dispute over the result of the UR must be referred to the AME. In that case, the parties entered into stipulations with request for award July 20, 2004, agreeing that all future disputes regarding future medical care would be referred to the AME. Ten years later, the parties proceeded to an expedited hearing on the issue of whether the changes to the Labor Code creating the IMR process or the parties' stipulations controlled the resolution of medical treatment disputes. The WCJ concluded that the stipulations meant that the UR process was not applicable, and that subsequent statutory changes did not nullify the parties' contractual waiver. The appeals board disagreed in part.<sup>150</sup>

The appeals board concurred with the WCJ that the parties contractually may waive their right to pursue the statutory review processes in favor of submitting disputes over medical treatment to a specified AME. But the board also found that in order to implement the parties' stipulation to have medical treatment disputes referred to the AME, there must be a dispute between the parties over a specific treatment request. It believed that for a dispute to exist, there must first be a UR denial, otherwise there would be no dispute

<sup>148</sup> *Villareal v. Fresh Start Bakeries*, 2014 Cal. Wrk. Comp. P.D. LEXIS 632.

<sup>149</sup> *Hill v. California Highway Patrol*, 2016 Cal. Wrk. Comp. P.D. LEXIS 231. See also *Buhtz v. Selective Employees*, 2015 Cal. Wrk. Comp. P.D. LEXIS 655; *Sanchez v. Dunlap Manufacturing Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 407.

<sup>150</sup> *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342.

to refer to the AME. So there was no waiver of UR in that situation. The appeals board, however, believed that the IMR process for reviewing a UR denial of medical treatment may be waived by the parties' stipulation in favor of submitting their disputes to the AME. The board concluded that the recent statutory change to IMR as the method to review medical treatment disputes did not supersede the parties' stipulation. It added that if the AME was not available to act in that capacity, the parties' stipulation would not apply.<sup>151</sup>

In another case, the parties stipulated that the defendant would authorize all transportation to and from medical appointments, and that any dispute would be resolved by a hearing on the issue. The treating physician later reported that the applicant needed transportation to medical appointments, physical therapy, pharmacy trips, errands and grocery markets because she suffered from syncope. This request was denied by UR and later IMR.<sup>152</sup> The appeals board held that because of the stipulation, the defendant must continue to authorize transportation to and from medical appointments, and that such requests were not subject to UR/IMR. It believed, however, that the additional transportation requested was subject to UR/IMR. So the scope of the waiver was narrowly circumscribed to the specific stipulation.<sup>153</sup>

In one case, however, the appeals board held that the parties' prior agreement to use an AME for a one-level spinal fusion surgery did not mean that the parties were required to use the AME to determine the medical necessity of a two-level surgery. The single-level surgery initially requested was authorized, but the two-level surgery was denied by utilization review. The board found the parties' agreement to rely on an AME to resolve medical treatment issues could not be used to avoid application of the statutory requirement in LC 4062(b) that mandates the resolution of medical treatment disputes through the UR/IMR process provided in LC 4610 and LC 4610.5. It believed the provisions implemented by SB 863 apply to all pending cases.<sup>154</sup>

## INDEPENDENT MEDICAL REVIEW — WHEN TO USE

Independent medical review (IMR) is the appeals process used by applicants when utilization review rejects a proposed course of medical care. It is an administrative function in which the administrative director contracts with an outside organization of physicians. If UR denies, delays or modifies a proposed course of care, the applicant may request that these independent physicians review the matter. This, then, is the applicant's appeal from UR, and the resulting decision normally is final.

The independent medical review procedures are established in LC 4610.5 and LC 4610.6, as well as CCR 9792.10.2 - CCR 9792.10.9. They establish that independent medical review "is limited to an examination of the medical necessity of the disputed medical treatment" (LC 4610.6(a)). "Disputed medical treatment" means "medical treatment that has been modified, delayed or denied by a utilization review decision" (LC 4610.5(c)(1)). "Medical necessity" means "medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury" based on specified medical standards (LC 4610.5(c)(2)). So it is the issue of whether medical care is reasonable, and no other, that is the proper subject of independent medical review.

If there are threshold issues, the use of IMR to resolve medical care disputes may be delayed. As discussed in the forthcoming section, just like utilization review, independent medical review normally is deferred if, at the time of a utilization review decision, the employer is disputing liability for the treatment for any reason besides medical necessity (LC 4610.5(k)), and the employee is not required to request an independent

<sup>151</sup> *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342.

<sup>152</sup> *Flores de Lopez v. Facey Medical Foundation*, 2016 Cal. Wrk. Comp. P.D. LEXIS 423.

<sup>153</sup> It also was found in this case that the IMR reviewer incorrectly denied authorization. The reviewer mistakenly had concluded that the only relevant ODG guidelines were the knee guidelines because the applicant's inability to drive was caused by syncope and dizziness. The matter was remanded for the WCJ to address the applicant's appeal of the IMR determination. *Flores de Lopez v. Facey Medical Foundation*, 2016 Cal. Wrk. Comp. P.D. LEXIS 423.

<sup>154</sup> *Garcia v. American Tire Distributors*, 2016 Cal. Wrk. Comp. P.D. LEXIS 527.



medical review until the dispute of liability has been resolved (LC 4610.5(h)(2)). An employer voluntarily may allow a case to proceed to independent medical review, even though it has disputed liability on grounds other than medical necessity. But even in that situation, the employer is not required to implement the decision until the other issue is resolved (LC 4610.6(j)).

Also of note, independent medical review does not resolve issues regarding the value of medical services performed. Such disputes must be resolved pursuant to a separate procedure ending with an independent bill review as discussed in Chapter VII: Independent Bill Review.

### **Exclusive Remedy to Challenge Utilization Review Decision**

In order to ensure that independent medical review is the only procedure that may be employed to challenge a utilization review decision modifying, delaying or denying a request for treatment, SB 863 amended several Labor Code provisions.

Previously, LC 4604 stated that “[C]ontroversies between employer and employee arising under this chapter [which includes disputes over medical treatment] shall be determined by the appeals board, upon the request of either party.” So the board was given exclusive jurisdiction to resolve all medical treatment disputes. Now, LC 4604 states that “Controversies between employer and employee arising under this chapter shall be determined by the appeals board, *except as otherwise provided by Section 4610.5*” (emphasis added). Again, LC 4610.5 establishes the procedures for requesting an independent medical review.

LC 4610(g)(3)(A) states that disputes must be “resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062,” and similar language is found in LC 4610(g)(3)(B). LC 4610.5 establishes that independent medical review is the exclusive option for an employee who wishes to dispute a utilization review decision.

LC 4610.5(d) states, “If a utilization review decision denies, modifies, or delays a treatment recommendation, the employee may request an independent medical review as provided by this section.” LC 4610.5(e) adds, “A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section.” Similar language is contained in CCR 9792.10.1(a). So the employee “may” request independent medical review to challenge a UR decision, or the employee may accept the decision. If the employee elects to challenge the decision, however, it may be reviewed or challenged only by independent medical review.

### **Issues Not Subject to Independent Medical Review**

Because independent medical review applies only to disputes over the necessity of medical treatment if an employer has conducted a timely and otherwise procedurally proper utilization review, CCR 10451.2 establishes a list of disputes that the appeals board deems to be non-IMR disputes. Per CCR 10451.2(c)(1), non-IMR disputes include, but are not limited to:

- A. any threshold issue that would defeat a medical treatment claim (injury, injury to the body part for which treatment is disputed, employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction, etc.);
- B. a dispute over a UR determination if the employee’s date of injury is before Jan. 1, 2013, and the decision is communicated to the requesting physician before July 1, 2013;

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- C. a dispute over whether UR was timely undertaken or was otherwise procedurally deficient; if the employee prevails in this assertion, however, the employee or provider still has the burden of showing entitlement to the recommended treatment;<sup>155</sup>
- D. an assertion by the medical treatment provider that the employer has waived objection to the amount of the bill because the employer allegedly breached a duty prescribed by LC 4603.2 or LC 4603.3, or by the related administrative regulations;
- E. an assertion by the employer that the medical treatment provider has waived any claim to further payment because the provider allegedly breached a duty prescribed by LC 4603.2 or the related administrative regulations;
- F. a dispute over whether the employee was entitled to select a treating physician not within the employer's medical provider network (MPN);
- G. an assertion by the employer that an interpreter who rendered services at a medical treatment appointment did not meet the criteria established by LC 4600(f) and (g) and LC 5811(b)(2) and the administrative regulations, as applicable; and
- H. an assertion by the employer that an interpreter was not reasonably required at a medical treatment appointment because the employee proficiently speaks and understands the English language.

If a dispute is not subject to IMR, the appeals board has jurisdiction. If a non-IMR dispute is between an employee and an employer, the procedures for claims for ordinary benefits must be followed, including the procedures for an expedited hearing, if applicable. In contrast, if the dispute is between a medical treatment provider and a defendant, the procedures applicable to lien claims must be followed, including the filing of a claim under LC 4903(b) and the payment of a lien filing fee or lien activation fee, if applicable (CCR 10451.2(c)(2)).

If a non-IMR is resolved in favor of the employee or the medical treatment provider, any applicable IMR procedures established by the Labor Code and the administrative regulations must be followed, except that any appeal of an IMR determination must comply with CCR 10957.1 (CCR 10451.2(c)(2)). But if the appeals board determines that a UR was untimely undertaken, then it retains jurisdiction to decide whether the treatment is reasonable and necessary.<sup>156</sup>

### INDEPENDENT MEDICAL REVIEW — FORM, TIME LIMITS, SUBMISSION AND FEES

Following receipt of a utilization review decision delaying, denying or modifying a request for medical treatment, the injured employee, or in limited circumstances, the medical provider itself, may request an independent medical review to determine the medical necessity of the requested treatment. The request must be on a specific form and within certain time limits. The request for independent medical review may be made on a regular or expedited basis, depending on whether there is an imminent and serious threat to the employee's health. There are fees for the independent medical review process, which are to be paid by the employer. The fees are not collected until the process is completed.

Assistance in completing an application for an independent medical review is available on the DIR website at [www.dir.ca.gov/dwc/imr.htm](http://www.dir.ca.gov/dwc/imr.htm).

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<sup>155</sup> Note that in *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298 (appeals board *en banc*), the appeals board concluded that CCR 10451.2(c)(1)(C) is invalid to the extent it states that a non-IMR dispute includes whether UR was "procedurally deficient."

<sup>156</sup> *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298 (appeals board *en banc*).

## Form of Request

LC 4610.5(f) describes an employer's notification duties regarding the independent medical review process. As part of its notification to the employee regarding an initial utilization review decision that denies, modifies or delays a treatment recommendation, the employer must provide a form not to exceed two pages, prescribed by the administrative director, and an addressed envelope, which the employee returns to the director to initiate IMR. Except for the employee's signature, the form must be completed by the claims administrator (CCR 9792.9.1(e)(5)(G)).

The employer must include on the form any information required by the administrative director to facilitate completion of the independent medical review. The form must include:

1. notice that the UR decision is final unless the employee requests independent medical review;
2. a statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee has consulted on the matter, to be signed by the employee;
3. notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding:
  - A. the treating physician's recommendation indicating that the disputed treatment is medically necessary for the employee's condition;
  - B. medical information or justification that a disputed urgent or emergency treatment was medically necessary for the employee's condition;
  - C. reasonable information supporting the employee's position that the disputed treatment is or was medically necessary for his or her condition, including all information provided to him or her by the employer or the treating physician still in his or her possession concerning the employer's or physician's decision regarding the disputed medical treatment, as well as any additional material the employee believes is relevant.

The appropriate form is the application for independent medical review, form DWC IMR, established in CCR 9792.10.2. It's available at the DWC website: [www.dir.ca.gov/dwc/forms.html](http://www.dir.ca.gov/dwc/forms.html). This form must be used to request an IMR (CCR 9792.10.1(b)(1)).

## Time Limits for Request

Per LC 4610.5(h)(1), the employee must submit the request for independent medical review no later than:

1. 10 days after service of the utilization review decision to the employee for formulary disputes;  
or<sup>157</sup>
2. 30 days after service of the utilization review decision to the employee for all other medical treatment disputes.

Per CCR 9792.10.1(b)(1), the request must be filed by mail, facsimile or electronic submission within 30 days of service of the written utilization review determination. Along with the IMR form, the employee must submit a copy of the written decision delaying, denying or modifying the request for authorization. Also at the time of filing, the employee must provide the employer with a copy of the signed IMR form, without a copy of the decision delaying, denying or modifying the request for authorization.

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<sup>157</sup> This limit was enacted in 2016 as part of SB 1160. It applies to any dispute on or after Jan. 1, 2018, over medication prescribed per the formulary adopted pursuant to LC 5307.27.

The appeals board has held that pursuant to LC 4610.5(h)(1) and CCR 9792.10.1(b)(1), an IMR application must be received by the administrative director within 30 days of service of the written utilization review determination, and not merely mailed within that time period. The UR determination in this case was served Dec. 24, 2013, and the applicant mailed the IMR application Jan. 23, 2014, but it was not received by the administrative director until Jan. 29, 2014. The appeals board first noted that the mailbox rule, which extends the time to act for five calendar days for service by mail to an address in California (see [“Sullivan on Comp” Section 15.15 Service of Documents](#)), applies to IMR applications. But because the IMR application was not received by the administrative director within 35 days of service of the UR determination, the applicant’s application for IMR was untimely.<sup>158</sup>

If the case is denied, or the body part in question is contested, the 30-day rule does not apply — it is held in abeyance pending resolution of the denial. Per LC 4610.5(h)(2), if, at the time of a UR decision, the employer is disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for IMR is extended 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved (CCR 9792.10.1(c)(1)). This grants indefinite extensions when there is a dispute over injury or body parts.

The time limits also are extended if the employer fails to provide the required notices. LC 4610.5(h)(3) states that if the employer fails to comply with its notification requirements, the time for the employee to submit a request for independent medical review is tolled until the employer does so. CCR 9792.10.1(c)(2) also explains that, at the time of notification of the utilization review decision, if a defendant provides a written UR determination that does not contain the elements required by the regulations, the time limitations for the employee to submit an application for IMR do not run until the defendant does so. As with many service requirements in workers’ compensation, failure to notice or a defective notice results in estoppel.

The statute does not specify what happens if an employee does not timely request an independent medical review. Presumably, a UR decision stands and is effective for 12 months, per LC 4610(g)(6), unless there is a documented change in the employee’s medical condition or another physician requests the treatment.

### Electronic Submission

LC 4610.5(h)(1) provides that a request for independent medical review may be made electronically under rules adopted by the administrative director. The DWC now allows attorneys representing injured workers to submit IMR applications and medical records online with the MOVEit file transfer system.<sup>159</sup> The DWC believes that online submissions will improve the efficiency and predictability of the IMR process and will allow attorneys to know with certainty that their applications have been received.

Whether an applicant attorney chooses to submit a request for IMR via MOVEit or otherwise, it is very important to:

1. include a copy of the complete UR determination with the IMR application form;
2. sign the IMR application form before submitting a request for IMR;
3. send the signed IMR application and the UR determination within 30 days of receiving the UR determination to the address on the form; and
4. serve all parties.

Further information on using MOVEit may be obtained by contacting [IMRHelp@maximus.com](mailto:IMRHelp@maximus.com).

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<sup>158</sup> *Avila v. University of California Irvine Medical Center*, 2015 Cal. Wrk. Comp. P.D. LEXIS 292.

<sup>159</sup> See [www.dir.ca.gov/DIRNews/2016/2016-23.pdf](http://www.dir.ca.gov/DIRNews/2016/2016-23.pdf).

### Submission by Eligible Party

CCR 9792.10.1(b)(2)(A) defines the persons who may file a request for IMR. A request may be filed by the employee, or if represented, by the employee's attorney. If the employee's attorney files the request for IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation. The employee's attorney may sign the request for IMR on the applicant's behalf.<sup>160</sup>

LC 4610.5(j) allows the employee to designate a parent, guardian, conservator, relative or "other designee" as an agent to act on his or her behalf. The statute does not limit this right only to unrepresented employees. An applicant with an attorney obviously has an agent who will be responsible for filing the request. In any event, it is clear that LC 4610.5(j) is designed to help an inarticulate *pro per* applicant. So CCR 9792.10.1(b)(2)(A)(i) restricts this right to an "unrepresented employee."

The statute and regulation provides that this designation must come after the utilization review decision, as both specify that a designation before the decision will not be valid. Perhaps this provision is meant to ensure that family members or others do not insert themselves into the applicant's case except for this limited purpose.

### Submission by Medical Provider

LC 4610.5(j) and CCR 9792.10.1(b)(2)(A)(ii) permit the requesting physician to join with or otherwise assist the employee in seeking an independent medical review. Normally, a requesting physician may not seek an independent medical review on his or her own. But LC 4610.5(h)(4) allows certain medical providers to submit requests for independent medical review. It states, "A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf."

This statute recognizes that in some situations, a medical provider might be required to provide emergency treatment to an injured employee. So the provider needn't rely solely on the injured patient to protect its claim for payment. It may request an independent medical review on its own initiative.

A request submitted by a medical provider per LC 4610.5(h)(4) must be submitted within the same time limitations applicable to an employee. Such requests also may be made only within 30 days after service of utilization review rejection (CCR 9792.10.1(b)(2)(B)).

Note, other medical providers also may submit requests for payment of medical services after performing them, and the employer must submit such requests for retrospective review in order to dispute whether the services were medically necessary. Although the requesting physician may join with or otherwise assist the employee in seeking an independent medical review, it is not clear if nonemergency medical providers may request an IMR on their own behalf. Only providers of emergency medical services specifically are given this right.

One can imagine that after an employee has received the medical treatment, he or she would not be motivated to request IMR for it. So in order to protect their claims to payment for services rendered, it's possible that nonemergency medical providers may request a retrospective IMR, but this will need to be clarified.

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<sup>160</sup> *Horick v. John T. Malloy, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 633.

### Request for Expedited Review

A request for independent medical review may be made on an expedited basis. If it is, unless the initial UR decision was made on an expedited basis, form DWC IMR must include a written certification from the employee's treating physician indicating that the employee faces an imminent and serious threat to his or her health (CCR 9792.10.1(b)(3)). Such a threat includes, but is not limited to, the potential loss of life, limb or other major bodily function, or when the normal time frame for the decision-making process would be detrimental to the employee's life or health or could jeopardize his or her permanent ability to regain maximum function (CCR 9792.6.1(j)).

### Costs for Independent Medical Review

LC 4610.6(l) requires the costs for administration of the independent medical review process to be borne by employers through a fee system established by the administrative director. After considering relevant information on program costs, the administrative director must establish a reasonable, per-case reimbursement schedule to pay the costs of IMRO services and the cost of administering the review system.

Fees for the IMR process are defined in CCR 9792.10.8. Fees differ depending on the type of review performed, as well as the number and credentials of the reviewers involved. Fees also vary depending on when the request is made.

### Fees for 2013

For regular review, the fee for issuing a determination is:

1. \$560 for a medical reviewer who holds an M.D. or D.O. degree;
2. \$760 for two medical reviewers who hold M.D. or D.O. degrees;
3. \$495 for a medical reviewer who holds a degree other than an M.D. or D.O.; and
4. \$655 for two medical reviewers who hold degrees other than an M.D. or D.O.

For expedited review, the fee for issuing a determination is:

1. \$685 for a medical reviewer who holds an M.D. or D.O. degree;
2. \$850 for two medical reviewers who hold M.D. or D.O. degrees;
3. \$595 for a medical reviewer who holds a degree other than an M.D. or D.O.; and
4. \$760 for two medical reviewers who hold degrees other than an M.D. or D.O.

LC 4610.5(g) and CCR 9792.10.6(a) allow the IMR process to be terminated at any time on the employer's written authorization of the disputed medical treatment. For withdrawn reviews, the fee is \$215 if the review is terminated by the independent review organization before the receipt of the documentation and information by a medical reviewer. If the review is terminated by the independent review organization during or after the review by a medical reviewer, the cost will be the same as if a determination had been issued.

### Fees for 2014

Per CCR 9792.10.8(a)(2), for regular review, the fee for issuing a determination is:

1. \$550 for a medical reviewer who holds an M.D. or D.O. degree;
2. \$740 for two medical reviewers who hold M.D. or D.O. degrees;
3. \$475 for a medical reviewer who holds a degree other than an M.D. or D.O.; and

4. \$635 for two medical reviewers who hold degrees other than an M.D. or D.O.

For expedited review, the fee for issuing a determination is:

1. \$645 for a medical reviewer who holds an M.D. or D.O. degree;
2. \$830 for two medical reviewers who hold M.D. or D.O. degrees;
3. \$575 for a medical reviewer who holds a degree other than an M.D. or D.O.; and
4. \$740 for two medical reviewers who hold degrees other than an M.D. or D.O.

For withdrawn reviews, the fee is \$215 if the review is terminated by the independent review organization before receipt of the documentation and information. If the review of an application is terminated by the independent review organization after receipt of the documentation and information by a medical reviewer, the cost will be the same as if a determination had been issued.

Note, however, that the DIR issued a Newsline May 19, 2014, noting that the fees for IMR applications submitted on or after April 1, 2014 would be:<sup>161</sup>

1. \$420 for a standard IMR involving nonpharmacy claims;
2. \$515 for an expedited IMR involving nonpharmacy claims; and
3. \$390 for a standard IMR involving pharmacy-only claims.

Furthermore, effective April 1, 2014, the fee for a withdrawn review is \$160 if the case is not forwarded to a medical professional, and \$420 after a case is forwarded to a medical professional.

## **Fees for 2015**

On Feb. 24, 2015, the DIR issued a Newsline that fees for IMR applications submitted on or after Jan. 1, 2015, would be subject to this fee schedule:<sup>162</sup>

1. \$390 for a standard IMR involving nonpharmacy claims;
2. \$345 for a standard IMR involving pharmacy-only claims;
3. \$515 for an expedited IMR involving nonpharmacy-only claims; and
4. \$123 for an IMR terminated or dismissed before being forwarded to a medical professional reviewer.

## **Payment of Fees**

The IMRO will bill each claims administrator for payment of every review that was completed or terminated before completion. The invoices must identify each IMR, the fees assessed for each review and the aggregate total fee owed by the claims administrator (CCR 9792.10.8(b)).

Total fees owed by the claims administrator for the previous calendar month must be paid to the IMRO within 30 days of the billing. If they are not paid within 10 days after the due date, the claims administrator must pay, in addition to the amount due, a penalty equal to 10 percent, plus interest at the legal rate (CCR 9792.10.8(c)).

The fees paid by claims administrators are nonrefundable and not subject to discount or rebate. Questions or disputes over the total fees and additional payments owed by the claims administrator, late payments

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<sup>161</sup> See <http://www.dir.ca.gov/DIRNews/2014/2014-47.pdf>.

<sup>162</sup> See <http://www.dir.ca.gov/DIRNews/2015/2015-16.pdf>.

and untimely determinations must be submitted to the administrative director for informal resolution. Requests to resolve a dispute must be accompanied by a written statement citing the amount in dispute and the nature of it (CCR 9792.10.8(d)).

### **INDEPENDENT MEDICAL REVIEW — PROCESS**

If a timely request for independent medical review is completed, the administrative director must review the request to determine if it is eligible for review. If it is, it must be forwarded to an independent medical review organization (IMRO), which must assign a reviewer. The employer must and the employee may provide information to the reviewer. Also, the reviewer may request additional records from the parties. Nevertheless, the reviewer must rely on certain standards in determining whether the requested treatment is medically necessary, and must issue a decision within certain time periods.

#### **Initial Review of Application**

The first step in the independent medical review process is to submit the request to the administrative director, who will act as a gatekeeper to the organization(s) performing the review. LC 4610.5(k) requires the administrative director to review requests expeditiously and notify the employee and the employer in writing if the request for IMR has been approved. If it is not approved, the reasons for rejection must be given.

This is because independent medical review resolves disputes regarding medical necessity. LC 4610.5(k) states that “unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.” This is repeated in CCR 9792.10.3(d).

As discussed earlier, if the employer also is disputing liability for the treatment for any reason besides medical necessity, the time to submit a request for IMR is extended 30 days after service of a notice to the employee showing that the threshold issue is resolved. So if there is such a dispute, a request for independent medical review must be deferred unless the employer “agrees that the case is eligible for independent medical review.” The phrase “unless the employer agrees that the case is eligible for independent medical review” seems to mean that if the employer agrees, the IMR may proceed despite the threshold issue. If the employer does not agree, the process is deferred pending resolution of the threshold issue.

#### **Factors in Determining Eligibility**

CCR 9792.10.3 defines the administrative director’s obligations following receipt of an application for independent medical review. Per CCR 9792.10.3(a), in determining whether an application is eligible for review, the administrative director must consider:

1. the timeliness and completeness of the application;
2. any previous application or request for IMR of the disputed medical treatment;
3. any assertion, other than medical necessity, by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body;
4. any assertion, other than medical necessity, by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician;
5. the employee’s date of injury; and



6. the failure of the requesting physician to respond to a request for information reasonably necessary to make the utilization review determination, for additional required examinations or tests or for a specialized consultation.

### **Request for Additional Information**

The administrative director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The director must advise the claims administrator, the employee, the employee's attorney, if any, and the requesting physician, as appropriate, by the most efficient means available (CCR 9792.10.3(b)).

The parties must respond to any reasonable request within five business days following receipt of the request. Following receipt of all information necessary to make a determination, the administrative director must either immediately inform the parties in writing that a disputed medical treatment is not eligible for IMR and the reasons why, or assign the request (CCR 9792.10.3(c)).

### **Appeal of Eligibility Determination**

CCR 9792.10.3(e) states, "The parties may appeal an eligibility determination by the Administrative Director that a disputed medical treatment is *not* eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board" (emphasis added). The appeals process is discussed below. There is no corresponding provision or language allowing a determination that the disputed medical treatment is eligible for an IMR to be appealed.

Per CCR 9792.10.3(f), the administrative director retains the right to determine the eligibility of a request for independent medical review until an appeal of the final IMR determination about the medical necessity of the disputed treatment has been filed with the appeals board, or the time to file such appeal has expired.

### **Assignment and Notification**

Per CCR 9792.10.4(b), within one business day following receipt of the administrative director's finding that the disputed medical treatment is eligible for IMR, the IMRO given responsibility for conducting the review must notify the parties in writing that the dispute has been assigned to it. Specifically, the IMRO must notify the employer, the employee, the employee's attorney, if any, and the requesting physician. The notification must include:

1. the name and address of the IMRO;
2. identification of the disputed medical treatment, including the date of the request for authorization (if available), the name of the requesting physician and the date of the claims administrator's UR decision;
3. the date the application for independent medical review — form DWC IMR — was received by the IMRO;
4. whether the IMR will be conducted on a regular or expedited basis.
5. for regular review, a statement that within 15 calendar days of the notification date, if it was provided by mail, or within 12 calendar days of the notification date, if it was provided electronically, the IMRO must receive the documents indicated in CCR 9792.10.5 (For the notification provided to the claims administrator, the statement must provide that, per LC 4610.5(i), in addition to any other fines, penalties and other remedies available to the administrative director, failure to comply with CCR 9792.10.5 could result in the assessment of administrative penalties of as much as \$5,000.);

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6. for expedited review, a statement that within 24 hours of receipt of the notification, the IMRO must receive the documents indicated in CCR 9792.10.5 (For the notification provided to the claims administrator, the statement must provide that, per LC 4610.5(i), in addition to any other fines, penalties and other remedies available to the administrative director, failure to comply with CCR 9792.10.5 could result in the assessment of administrative penalties of as much as \$5,000.).

A review conducted on a regular basis will be converted into an expedited review if, after receipt of the application, the IMRO receives from the employee's treating physician a written certification with supporting documentation that the employee faces an imminent and serious threat to his or her health as described in CCR 9792.6.1(j). The IMRO immediately must notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review (CCR 9792.10.4(c)).

### **Consolidation of Application**

The IMRO responsible for conducting the independent medical review may consolidate two or more applications for IMR by a single employee for resolution in a single determination. But it may do so only if the applications involve the same requesting physician and the same date of injury (CCR 9792.10.4(a)).

### **Time Limit for Employer to Provide Records**

Separate rules for employers and employees govern how information is to be provided to an independent medical reviewer. The statute and regulations impose on employers an affirmative obligation to serve documents. There are strict rules regarding when the documents must be provided, as well as what documents must be provided. Employees, in contrast, are under no obligation to provide the IMR with records, but there are liberal rules regarding what they may provide if they choose to do so.

For a regular review, LC 4610.5(l) requires the employer to electronically provide all necessary information and documents to the IMRO "within 10 days of notice of the assignment..." But for an expedited review, LC 4610.5(n) requires the information and documents to be delivered within 24 hours of approval of the request for review.

CCR 9792.10.5(a) requires the IMRO to receive from the employer all required documents within 15 days following the mailing of the notification from the IMRO that the disputed treatment has been assigned for an IMR, and within 12 days if the notification was sent electronically. So the mailbox rule applies (see ["Sullivan on Comp" Section 15.15 Service of Documents](#)) for notifications sent by mail, and gives employers two extra days for electronic notifications.

For expedited review, CCR 9792.10.5(a) requires the IMRO to receive the documents within 24 hours following receipt of the notification, rather than approval of the request for review. This, of course, recognizes that employers will not always receive notification of the assignment immediately.

Whether for regular or expedited review, employers do not have much time to provide documents. And, as discussed below, employers may be penalized for failing to timely provide all information required. So as a matter of practice, employers might want to consider preparing all documents that might be needed to respond to an IMR before even receiving the notification.

### **Records That Must Be Provided by Employer**

Per LC 4610.5(l), within the time periods outlined above, the employer must provide the IMRO with:

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1. a copy of all of the employee's medical records in the employer's possession or under the control of the employer relevant to:
  - A. the employee's current medical condition;
  - B. the medical treatment being provided by the employer; and
  - C. the disputed medical treatment requested by the employee;
2. a copy of all information provided to the employee by the employer concerning employer and provider decisions about the disputed treatment;
3. a copy of any materials the employee or the employee's provider submitted to the employer in support of his or her request for the disputed treatment; and
4. a copy of any other relevant documents or information used by the employer or its UR organization in making its treatment decision, and any statements by the employer or its UR organization explaining the reasons for the decision to deny, modify or delay the recommended treatment on the basis of medical necessity. The employer must provide these documents concurrently to the employee and the requesting physician; those previously provided to the employee or physician need not be provided again if a list of them is provided.

CCR 9792.10.5(a) requires the employer to provide many of the same documents, and perhaps clarifies some that must be sent. It requires the employer to provide:

1. a copy of all reports of the employee's physician relevant to the employee's current medical condition produced within six months before the date of the request for authorization, including those specifically identified in the request for authorization or in the UR determination (If the requesting physician has treated the employee for less than six months, the employer must provide a copy of all reports relevant to the employee's current medical condition produced within the six-month period by any prior treating physician or referring physician.);
2. a copy of the written application for IMR, form DWC IMR, that was included with the written determination and notified the employee that the disputed medical treatment was denied, delayed or modified (Neither the written determination nor the application's instructions should be included.);
3. other than the written determination, a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment;
4. a copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment;
5. a copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny, modify or delay the recommended treatment on the basis of medical necessity; and
6. the claims administrator's response to any additional issues raised in the employee's application for IMR.

So although LC 4610.5(l) requires the employer to send "all" documents relevant to the employee's current medical condition, the medical treatment being provided by the employer and the disputed medical treatment requested by the employee, CCR 9792.10.5(a) requires a copy of all reports of the employee's treating physician relevant to the employee's current medical condition produced only within six months before the date of the request for authorization.

Neither the statute nor regulation requires an employer to provide the independent medical review organization with all of its medical records; it is required to provide only those relevant to the current condition, the treatment provided and the disputed treatment requested. So it may be unnecessary for an

employer to send psychiatric medical records for a treatment request for an orthopedic injury. It may be unnecessary to send old records describing the applicant's earlier medical condition, particularly if it is more than a year before the request. The statute leaves it up to the employer to determine what records are relevant. So the parties might disagree about what is relevant, but as discussed below, the employee has a right to send any records he or she believes to be relevant.

### **Service of Documents on Employees and Requesting Physicians**

LC 4610.5(o) requires the employer to issue a notification promptly to the employee after submitting all of the required materials. The notice must list the documents submitted and include copies of materials not previously provided to the employee. CCR 9792.10.5(a)(2) also requires the employer concurrently to forward to the employee or the employee's representative a notification listing all the documents submitted to the IMRO. It also requires the employer to provide with the notification a copy of all documents that were not previously provided to the employee or employee's representative. But the employer must exclude mental health records that were withheld from the employee pursuant to Health and Safety Code 123115(b). It provides that a report should not be given to an employee if an evaluator in a psyche claim determines that there is a substantial risk of significant adverse or detrimental medical consequences to the employee from seeing or receiving a copy of part or all of an evaluation report (see ["Sullivan on Comp" Section 14.47 Service of Comprehensive Medical-Legal Reports](#)).

### **Newly Developed or Discovered Records**

Per LC 4610.5(m) and CCR 9792.10.5(a)(3), any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the IMRO must be forwarded to it immediately. This means within one business day (CCR 9792.6.1(m)). The employer also must provide a copy of such records to the employee, or the employee's representative or treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records must be maintained per state and federal laws.

### **Provision of Records by Employees**

Per LC 4610.5(f)(3), the employee also has the right to provide the IMRO with information, either directly or through a physician. Per CCR 9792.10.5(b)(1), the time periods for the employee to do so are the same as for the employer — 15 days from the mailing of the notification for regular review, 12 days for electronic notification and 24 hours for expedited review. The records may be provided by the employee or the employee's attorney, if represented.

CCR 9792.10.5(b)(1) allows an employee to provide to the IMRO:

1. the treating physician's recommendation that the disputed medical treatment is necessary for the employee's medical condition;
2. medical information or justification that a disputed urgent care or emergency treatment was necessary for the employee's medical condition;
3. reasonable information supporting the employee's position that the disputed treatment is or was necessary for the employee's medical condition, including all information provided to him or her by the employer or by the treating physician, still in his or her possession, concerning the employer's or the physician's decision regarding the disputed treatment, as well as any additional material the employee believes is relevant.

This is extremely broad language allowing, it seems, for almost anything aside from direct oral communication with the reviewer. It allows the employee to provide “medical information or justification,” “reasonable information supporting the employee’s position” and “any additional material that the employee believes is relevant.” It is hard to imagine what may not be included here.

If the employee, or his or her attorney, supplies documents to the IMRO, they also must be forwarded to the employer, except that documents previously provided need not be provided again if a list of them is served (CCR 9792.10.5(b)(2)). After the submission of documents to the IMRO, any newly developed or discovered relevant medical records in the possession of the employee, the employee’s representative or the employee’s attorney “shall” be forwarded immediately to the IMRO. If the employee does send them to the IMRO, he or she must provide a copy concurrently to the employer, unless the offer of medical records is declined or otherwise prohibited by law (CCR 9792.10.5(b)(3)). So the provision of newly developed or discovered relevant medical records is mandatory. But it appears that there are no penalties for an employee’s failure to send such records.

### **Provision of Records by Requesting Physicians**

LC 4610.5(j) allows the requesting physician to join with or otherwise assist the employee in seeking independent medical review. In fact, the requesting physician may advocate on the employee’s behalf. A requesting physician may submit documents on the employee’s behalf and may respond to any inquiry by the IMRO (CCR 9792.10.1(b)(2)(A)(ii)). Accordingly, the requesting physician has the same liberal right as the employee to provide documents.

### **Requests for Additional Information**

Per CCR 9792.10.5(c), at any time following the submission of documents, the IMRO may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. In routine cases, additional information requested must be sent by the party to whom the request was made within five business days after the request is received, or, in expedited cases, one calendar day after the request is received. The copy of the documents must be forwarded to all other parties.

### **Employer’s Failure to Submit Documentation**

If an employer fails to timely submit records to the IMRO, the medical reviewer may issue a determination as to whether the medical treatment is reasonably necessary based on both a summary of the medical records listed in the utilization review determination, and documents submitted by the employee or the requesting physician. No IMR determination, however, may be based solely on information provided by the UR determination (CCR 9792.10.6(b)(2)). An employer that fails to timely submit the required documentation would be subject to administrative penalties.

### **Selection of Reviewer(s) and Review of Documents**

LC 4610.6 and CCR 9792.10.6 describe how an independent medical review organization is required to act on receipt of a case. Per LC 4610.6(a), the organization must conduct a review “limited to an examination of the medical necessity of the disputed medical treatment.” When treatment is partially approved by UR, the IMRO may review only the portion of the treatment that was denied; it may not review the treatment that was authorized.<sup>163</sup>

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<sup>163</sup> See *Hall v. Larry’s Building Material*, 2015 Cal. Wrk. Comp. P.D. LEXIS 631.

On assignment of the disputed medical treatment for an IMR, the IMRO must designate a medical reviewer (CCR 9792.10.6(b)). Per LC 139.5(c)(2), the IMRO is required to select reviewers who do not have a conflict of interest with the parties or the physician involved in the medical dispute. The IMRO, on written approval by the administrative director, may engage more than one medical reviewer to reach a determination regarding the medical necessity of a disputed treatment if it is found that the employee's condition and the disputed treatment are sufficiently complex such that a single reviewer could not reasonably address all disputed issues (CCR 9792.10.6(c)).

The selected reviewer or reviewers must examine all pertinent medical records of the employee, all of the provider reports and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any party, a copy of the request and the response must be provided to all of them (LC 4610.6(b)).

### Standards for Review

Following review of records, the reviewer(s) must determine whether the disputed health-care service is necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in LC 4610.5(c) (CCR 9792.10.6(b)(1)). That statute allows the independent medical reviewer to rely on the following, except that reliance on a lower ranked standard is allowed only if every higher ranked standard is inapplicable to the employee's medical condition:<sup>164</sup>

1. the guidelines adopted by the administrative director per LC 5307.27;
2. peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
3. nationally recognized professional standards;
4. expert opinion;
5. generally accepted standards of medical practice;
6. treatments likely to provide a benefit to a patient for conditions for which other treatments are not clinically effective.

So the independent medical reviewer normally is required to rely on the MTUS adopted by the administrative director, and may rely on outside sources only if it is inapplicable to the applicant's medical condition.

### Time Limits for Review

LC 4610.6(d) requires the IMRO to complete its review within these time periods following receipt of the request for review and supporting documentation:

1. five working days for disputes over medication prescribed pursuant to the drug formulary under LC 4610.5(h);
2. 30 days for all other medical treatment disputes, unless there is documentation of an imminent and serious threat to the health of the employee.

LC 5307.27 requires the administrative director to establish a drug formulary on or before July 1, 2017, as part of the medical treatment utilization schedule for medications prescribed in the workers' compensation system. Effective, Jan. 1, 2018, disputes over medication prescribed pursuant to the drug formulary will be subject to UR (LC 4610.5(a)(3)). An IMR determination for a dispute over medication so prescribed must be

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<sup>164</sup> Note that the standards provided here are the same as those used by the appeals board before the advent of IMR. As discussed in ["Sullivan on Comp" Section 7.31 Utilization Review — Medical Treatment Utilization Schedule](#), if the MTUS does not address the proposed treatment, a list of standards to be used is provided, and it's the same list given to IMR reviewers. This does away with any potential disparity between the legal and IMR standard.

made within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director (LC 4610.6(d)(1)(A)).

If two or more requests for independent medical review are consolidated, the 30-day period begins on receipt of the last filed application for independent medical review that was consolidated for determination and the supporting documentation and information for that application (CCR 9792.10.6(g)(1)(A)). If an internal utilization review appeal modifies a UR determination for which an application for independent medical review previously was filed, the 30-day period begins on receipt of the application for IMR requesting review of the modified treatment, and the supporting documentation and information for that application (CCR 9792.10.6(g)(1)(B)).

The time period for review under LC 4610.6(d) does not begin until receipt of the supporting documentation. So the time allowed from the date a regular IMR request is received is 45 days, because 15 days are allowed for submission and receipt of supporting documentation.<sup>165</sup>

### **Imminent and Serious Threat to Employee's Health**

If the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee exists, per LC 4610.6(d) the determination must be expedited and rendered within three days of receipt of the information. CCR 9792.10.6(g)(2) requires an expedited review within three days of receipt of form DWC IMR and supporting documentation only if the disputed medical treatment has not been provided. It seems that if there was an imminent and serious threat to the employee's health, and an expedited review originally was requested, but the treatment was provided before the review could be completed, the normal time limit for review would apply.

### **Extensions of Time**

The administrative director may extend the deadlines for regular and expedited reviews for as long as three days in extraordinary circumstances or for good cause (LC 4610.6(d)). The terms "extraordinary circumstances" and "good cause" are not defined. But any extension of time must be approved by the administrative director (CCR 9792.10.6(g)(3)).

### **Consequences for Untimely IMR**

LC 4610.6(d) provides that the IMRO "shall complete its review ... within 30 days of receipt of the request for review and supporting documentation." But what happens if the IMR is not timely completed? Neither the statutes nor the regulations specify any consequences for an untimely review. The Courts of Appeal, however, have thus far determined that a late IMR does not confer jurisdiction on the WCAB.

In *Stevens v. WCAB*,<sup>166</sup> the 1st District Court of Appeal held that the IMR process does not violate due process simply because there is no meaningful enforcement procedures of the statutory time limits for IMR decisions. In that case, the IMR determination took more than seven months. The court stated, "We are unconvinced that the lack of a mechanism to enforce time limits renders the IMR process unconstitutional. In the absence of a penalty, consequence, or contrary intent, a time limit is typically considered to be directory, and its violation does not require the invalidation of the action to which the time limit applies."<sup>167</sup> The court did not

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<sup>165</sup> *Arredondo v. WCAB* (2015) 80 CCC 1050 (writ denied); *Saunders v. Loma Linda University Medical Group*, 2015 Cal. Wrk. Comp. P.D. LEXIS 311.

<sup>166</sup> (2015) 80 CCC 1262.

<sup>167</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1282-1283.

decide whether a writ of mandate may have been available to enforce the time limit because the applicant did not attempt to seek one.<sup>168</sup>

Despite *Stevens*, the commissioners were split on the issue. Some panels held that under *Stevens*, the time periods within which to complete IMR defined in LC 4610.6(d) are directory, not mandatory, and that an untimely IMR decision is not invalid and doesn't give the appeals board authority to decide the treatment dispute.<sup>169</sup> Other panels, however, believed that the statements in *Stevens* regarding untimely IMR decisions were merely dicta, and not controlling on the issue. They believed the IMR time frames established by LC 4610.6(d) are mandatory, and if an IMR determination does not issue within required time periods, the medical treatment dispute may be heard and decided by the appeals board.<sup>170</sup>

Because of the conflicting decisions on the issue, the 2nd District Court of Appeal decided to hear the issue in *SCIF v. WCAB (Margaris)*.<sup>171</sup> The court held that the 30-day time limit in LC 4610.6(d) is directory and that an untimely IMR determination is valid and binding on the parties as the final determination of the administrative director. It explained that time limits applicable to government action are deemed to be directory unless the Legislature clearly expresses a contrary intent. It found neither LC 4610.5, which relates to the initiation of IMR, nor LC 4610.6, which relates to execution of IMR, provides any consequences or penalty in the event the IMR organization fails to issue an IMR determination within the 30-day period. It explained the exclusive means to challenge an IMR determination is by appeal on expressly limited grounds, and the untimeliness of an IMR determination is not one of the statutory grounds for appeal.<sup>172</sup>

The court also concluded that the purpose of IMR was to remove authority to make decisions about medical necessity of proposed treatment for injured workers from the appeals board and place it in the hands of independent, unbiased medical professionals. It found the appeals board's conclusion that an untimely IMR determination terminates the IMR process and vests jurisdiction within the board to determine medical necessity was wholly inconsistent with this goal. It noted that under LC 4610.5(d), an employer's timely utilization review decision to deny, modify or delay medical treatment "may be reviewed or appealed only by independent medical review," and that under LC 4610.6(i), even if an appeal from an IMR determination is successful, the case does not go to the appeals board for review, but results in a second IMR. It also added that the Legislature's intent, as outlined in LC 4610.6(i) that "[i]n no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization," would be defeated if LC 4610.6(d) was given mandatory effect. It further found that allowing the board to decide treatment disputes for an untimely IMR would perpetuate the time-consuming litigation process the Legislature set out to eliminate.<sup>173</sup>

The court explained that when an administrative body is required to act within a specified time and fails to do so, a writ of mandate probably will compel the body to act. So it held that to the extent the director fails to render an IMR determination within the time frame provided by LC 4610.6(d), a writ of mandamus under CCP 1085, in appropriate circumstances, probably will compel the director to issue an IMR determination.<sup>174</sup>

<sup>168</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1283.

<sup>169</sup> See *Arredondo v. WCAB*, (2015) 80 CCC 1050 (writ denied); *Baker v. Sierra Pacific Fleet Services*, 2015 Cal. Wrk. Comp. P.D. LEXIS 651; *Cohen v. Golden State Overnight*, 2015 Cal. Wrk. Comp. P.D. LEXIS 658; *Guerrero v. McKesson Corp.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 661; *Fimbres v. Dave Williams Plumbing and Electrical*, 2015 Cal. Wrk. Comp. P.D. LEXIS 709; *Lee v. Quality Timber Falling*, 2015 Cal. Wrk. Comp. P.D. LEXIS 717; *Rivas v. Trimac Equipment Leasing*, 2016 Cal. Wrk. Comp. P.D. LEXIS 25; *Diaz v. Lavi Industries*, 2016 Cal. Wrk. Comp. P.D. LEXIS 37; *Blackmon v. ABZ Auto Wreckage*, 2016 Cal. Wrk. Comp. P.D. LEXIS 113; *Hill v. Tuttle Interior Systems*, 2016 Cal. Wrk. Comp. P.D. LEXIS 125; *Walker v. County of Los Angeles-Sheriff's Department*, 2016 Cal. Wrk. Comp. P.D. LEXIS 170; *Correa v. Andiamo, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 256; *Vega v. Maxim Healthcare*, 2016 Cal. Wrk. Comp. P.D. LEXIS 308.

<sup>170</sup> See *Saunders v. Loma Linda University Medical Group*, 2015 Cal. Wrk. Comp. P.D. LEXIS 311; *McFarland v. The Permanente Medical Group*, 2015 Cal. Wrk. Comp. P.D. LEXIS 718; *Gomez v. David Reich Construction, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 261; *Navroth II v. Mervyn's Stores*, 2016 Cal. Wrk. Comp. P.D. LEXIS 297.

<sup>171</sup> (2016) 81 CCC 561.

<sup>172</sup> *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561, 571-573.

<sup>173</sup> *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561, 573-575.

<sup>174</sup> *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561, 577-578.



Note that the 3rd District Court of Appeal also has decided to hear the issues of whether the time periods in LC 4610.6(d) are mandatory, and whether the appeals board may determine a medical treatment dispute if an IMR determination is not timely issued.<sup>175</sup> But it is unlikely that the 3rd District Court of Appeal will depart from the decisions of the 1st and 2nd districts. Unless a contrary appellate level decision issues, the holding of the Court of Appeal in *Margaris* is determinative and the board is bound to follow it.<sup>176</sup>

## Determination

Per LC 4610.6(d), the determination must use “layperson’s terms to the maximum extent practicable.” LC 4610.6(e) requires the determination to state whether the disputed medical treatment is medically necessary and cite the relevant documents to support its decision. CCR 9792.10.6(d) requires the determination to include the employee’s medical condition, a list of documents received, a statement of the disputed medical treatment, references to the specific medical and scientific evidence utilized and the clinical reasons regarding medical necessity. CCR 9792.21.1(b)(3) also requires the IMR determination to include a citation to the guideline or study containing the recommendation guiding the reasonableness and necessity of the requested treatment.

LC 4610.6(f) and CCR 9792.10.6(e) also require the IMRO to provide the administrative director, the defendant, the employee, the employee’s attorney and the employer’s provider with a final determination regarding the medical necessity of the disputed treatment. With that determination, the IMRO must provide a description of the qualifications of each medical reviewer or reviewers. Their names, however, are to be kept confidential.<sup>177</sup>

If more than one professional reviewed the case, the IMRO must provide each reviewer’s determination. The recommendation of the majority will prevail. If the medical reviewers are split evenly on whether the treatment should be provided, the decision will favor providing it (LC 4610.6(e) and CCR 9792.10.6(e)(2)).

## Termination of Process

LC 4610.5(g) and CCR 9792.10.6(a) allow the IMR process to be terminated at any time on notice by the defendant to the IMRO that the disputed medical treatment has been authorized.

## Change of Administrator

LC 4610.5(p) provides that if there is a change in the claims administrator responsible for the claim, the administrator who issued the UR decision in dispute must notify the IMR organization. The notice must be given within five working days of the change in administrator taking effect.

## INDEPENDENT MEDICAL REVIEW — APPEAL AND IMPLEMENTATION OF DETERMINATIONS

A determination issued by the independent medical review organization is deemed to be a determination of the administrative director, and is binding on all the parties (LC 4610.6(g) and CCR 9792.10.6(h)). If the requested treatment is deemed medically necessary, the employer has a limited time to implement the decision. On receiving a determination, the parties have a limited time to appeal the decision. Failure to do so could result in severe penalties.

<sup>175</sup> See *Hallmark Marketing Corp. v. WCAB (Southard)*, case number C079912 and *Baker v. WCAB*, case number C080895.

<sup>176</sup> See *Tyni v. WCAB* (2016) 81 CCC 1050 (writ denied); *Jacobs v. Parsec, Inc./Budco*, 2016 Cal. Wrk. Comp. P.D. LEXIS 352; *Miranda v. California Department of Corrections*, 2016 Cal. Wrk. Comp. P.D. LEXIS 355; *Luhmann v. Torrance Unified School District*, 2016 Cal. Wrk. Comp. P.D. LEXIS 373; *Cronin v. WCAB* (2016) 81 CCC 928 (writ denied); *De Leon v. Safeway, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 481.

<sup>177</sup> In *Stevens v. WCAB* (2015) 80 CCC 1262, the Court of Appeal noted in footnote 18 that the confidentiality of the physician reviewer’s identity did not render the IMR provision unconstitutional.

## Implementation of Determination

LC 4610.6(j) and CCR 9792.10.7 provide that if a disputed health-care service is deemed medically necessary, the employer must implement the decision promptly, unless an appeal is filed, or the employer has disputed liability for any reason besides medical necessity (such as the claim itself being denied).<sup>178</sup>

In the case of reimbursement for services already rendered, the employer must reimburse the provider or employee, whichever applies, within 20 days after the receipt of the final determination, subject to resolution of any remaining issue of the amount of payment, per LC 4603.2 - LC 4603.6 (LC 4610.6(j) and CCR 9792.10.7(a)(1)). Those sections relate to payment of medical expenses (LC 4603.2), notification regarding payment, adjustment or denial of medical services (LC 4603.3), submission and payment of electronic claims for medical payment (LC 4603.4) and independent bill review (LC 4603.6). The IMR process resolves only issues of medical necessity; it does not resolve issues regarding the value of medical services. As discussed in the sections commencing with [“Sullivan on Comp” Section 7.66 Payment of Medical Expenses – Overview](#), there are separate procedures, including an independent bill review process, if the parties dispute the amount of the bill. So after receiving an IMR determination, employers still may dispute the cost.

In the case of services not yet rendered, the employer must authorize them within five working days of receipt of the written determination from the IMRO, or sooner if appropriate for the nature of the employee’s medical condition. The employer also is required to inform the employee and provider of the authorization (LC 4610.6(j) and CCR 9792.10.7(a)(2)). Presumably in cases involving expedited review, the treatment should be authorized as soon as possible. If, at the time of receiving the final determination, the defendant is disputing liability for the medical treatment on grounds other than medical necessity, the implementation of the final determination will be deferred until the liability dispute is resolved (CCR 9792.10.7(a)(3)).

In one case, the appeals board held that an IMR determination that all of the disputed medical services were necessary and appropriate was enforceable, even though a subsequent IMR determination upheld a denial of the same services. The defendant argued that the subsequent IMR determination voided the original IMR determination and that the WCJ was without jurisdiction to enforce the original determination. The appeals board, however, found that the fact that the IMR process denied a subsequently requested course of treatment did not vitiate the course of treatment previously approved by the IMR process.<sup>179</sup>

## Appeal of Determination

The parties may appeal the determination only by filing a verified petition with the appeals board (LC 4610.6(h); CCR 9792.10.7(c)). CCR 10957.1 establishes the rules for appealing an IMR determination. It provides that an aggrieved party may file a petition appealing the administrative director’s IMR determination, including a decision regarding medical necessity and a decision that a dispute is not subject to independent medical review (CCR 10957.1(b)). Any party wishing to appeal an IMR determination must pay careful attention to the requirements of LC 4610.6(h) and CCR 10957.1, as well as the requirements for petitions generally as established in CCR 10450 (see “Sullivan on Comp” Section 15.7 Petitions and Answers).<sup>180</sup>

## Time Limit for Appeal

LC 4610.6(h) provides that an IMR determination may be appealed “within 30 days of the date of the mailing of the determination to the aggrieved employee or the aggrieved employer.” CCR 10957.1(c) similarly

<sup>178</sup> See *Cerruti v. City of Hayward*, 2014 Cal. Wrk. Comp. P.D. LEXIS 520.

<sup>179</sup> *Vo v. Zonare Medical Systems, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 734.

<sup>180</sup> See *Sayed v. Giorgio Armani*, 2014 Cal. Wrk. Comp. P.D. LEXIS 543. Although this case relates specifically to appeals from IBR determinations, the principles announced in that case are relevant to appeals from IMR determinations.

requires the petition to be filed “no later than 30 days after service by mail of the IMR determination.” An untimely petition may be summarily dismissed.

In *Matute v. Los Angeles Unified School District*,<sup>181</sup> the appeals board issued an *en banc* holding that the 30-day period to file a timely appeal from an IMR determination under LC 4610.6(h) is extended by five days per LC 5316 and CCP 1013(a). The board explained that the term “mailing” in LC 4610.6(h) is equivalent to and means “service by mail.” It explained that under LC 5316, any notice, order or decision may be served in the manner provided in Chapter 5, Title 14 of Part 2 of the Code of Civil Procedure, which includes CCP 1013(a), unless otherwise directed by the appeals board. Because CCP 1013(a) extends any right or duty to act by five calendar days by service by mail to an address within California, the appeals board concluded that the 30-day period to file an appeal in response to an IMR determination is extended by five calendar days.<sup>182</sup> For further discussion on the “mailbox rule,” see [“Sullivan on Comp” Section 15.15 Service of Documents](#).

## Grounds for Appeal

Per LC 4610.6(h)), the determination of the administrative director is presumed to be correct and may be set aside only on proof by clear and convincing evidence that:

1. The administrative director acted without or in excess of the administrative director’s powers.
2. The determination was procured by fraud.
3. The independent medical reviewer was subject to a material conflict of interest that is in violation of LC 139.5.
4. The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability. And/or
5. The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review per LC 4610.5 and not a matter subject to expert opinion.

The independent medical reviewer’s decision is intended to be the last word on the medical treatment dispute. The parties may appeal the decision only on limited grounds that are difficult to prove, particularly given that the parties are not entitled to know the identity of the physicians who performed the review. But parties have the opportunity to obtain significant other information bearing on conflicts of interest, including information about the IMR organization’s method of selecting expert reviewers and matching them to specific cases, system of identifying and recruiting expert reviewers and method of ensuring compliance with the statutory conflict-of-interest requirements (LC 139.5(d)(2)(F)(G)(H), (e)).<sup>183</sup> For further discussion on the IMR organization’s duty to avoid any conflict of interest, see [“Sullivan on Comp” Section 7.38 Independent Medical Review — Requirements of Review Organization](#).

## Legal Standard for Appeal

A party challenging the decision must establish one of the grounds for setting it aside by clear and convincing evidence, rather than the usual preponderance of the evidence standard required in all other workers’ compensation issues. This makes it very difficult to challenge an IMR determination. If an applicant cannot prove one or more of five grounds for appeal listed by the Legislature in LC 4610.6(h) by clear and convincing evidence, the appeals board has no jurisdiction to overturn the decision.<sup>184</sup>

<sup>181</sup> (2015) 80 CCC 1036 (appeals board *en banc*).

<sup>182</sup> *Matute v. Los Angeles Unified School District* (2015) 80 CCC 1036 (appeals board *en banc*).

<sup>183</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1281, fn. 18.

<sup>184</sup> See *Willis v. State of California Department of Parks and Recreation*, 2014 Cal. Wrk. Comp. P.D. LEXIS 210; *Gordon v. Frito-Lay, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 649; *Sabelberg v. Department of Corrections Medical Facility*, 2015 Cal. Wrk. Comp. P.D. LEXIS 234; *Medina v. Second Nature*, 2016 Cal. Wrk. Comp. P.D. LEXIS 269.

In *Stevens v. WCAB*,<sup>185</sup> the Court of Appeal held that the board is empowered to review an IMR decision to consider whether care was denied without authority because the care is authorized under the MTUS. The court noted the board's authority to deem whether an IMR determination was adopted without authority or based on a plainly erroneous fact (that is, not a matter of expert opinion) is considerable. The authority allows the board to review both legal and factual questions. The board stated, "If, for example, an IMR determination were to deny certain medical treatment because the treatment was not suitable for a person weighing less than 140 pounds, but the information submitted for review showed the applicant weighed 180 pounds, the Board could set aside the determination as based on a plainly erroneous fact. Similarly, the denial of a particular treatment request on the basis that the treatment is not permitted by the MTUS would be reviewable on the ground that the treatment actually is permitted by the MTUS. An IMR determination denying treatment on this basis would have been adopted without authority and would thus be reviewable."<sup>186</sup>

In *Stevens*, an IMR denied a physician's request for medications and a home health aide eight hours a day, five days a week. The appeals board denied the appeal concluding that it does not matter whether the reasons given for the IMR determination support the determination unless the appealing party proves one or more of the five grounds listed in LC 4610.6(h). The Court of Appeal disagreed.<sup>187</sup> It noted that the guidelines recommend home health aides for patients who are "homebound, on a part-time or 'intermittent' basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning and laundry, and personal care given by home health aides such as bathing, dressing and using the bathroom when this is the only care needed."<sup>188</sup>

The court found the appeals board erred when it ruled it was powerless to review the IMR determination and categorically denied the applicant the services of a home health aide, even though it concluded that the applicant's condition required care other than homemaker's services. It explained that reviewing and interpreting the MTUS would resolve the question of whether home health services are authorized if bathing, dressing and using the bathroom are the only care needed. It added that if the board were to conclude that the IMR determination incorrectly affirmed the denial of these services by wrongly interpreting the MTUS, and it were to find there are no other reasons supporting the denial, it would have the power to conclude that the determination was adopted without authority.<sup>189</sup> The case was remanded for the appeals board to consider whether the request for a home health aide was denied without authority.

## Appeal — Applied Cases

Since *Stevens*, the appeals board upheld a WCJ's decision granting an applicant's appeal of an IMR determination upholding a defendant's UR denial of certain prescription medications on the ground that the IMR applied an incorrect treatment guideline. The IMR denied the medications by referencing the chronic pain medical treatment guidelines, but board found that the postsurgical treatment guidelines under CCR 9792.24.3 applied because the applicant had a spinal fusion within the postsurgical treatment period. The board explained that it has authority to grant an IMR appeal and set aside an IMR determination that relies on an incorrect treatment guideline. It stated that such an error can be described both as an action in excess of the administrative director's powers under LC 4610.6(h)(1), and as a mistake of fact as a matter of ordinary knowledge and not a matter that is subject to expert opinion under LC 4610.6(h)(5).<sup>190</sup>

<sup>185</sup> (2015) 80 CCC 1262.

<sup>186</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1282.

<sup>187</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1269.

<sup>188</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1268.

<sup>189</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1282.

<sup>190</sup> *Nickerson v. Pot Belly Deli*, 2016 Cal. Wrk. Comp. P.D. LEXIS 329. See also *Correa v. Andiamo, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 392.

Similarly, the appeals board reversed an IMR determination that Duragesic patches used by a 100 percent disabled employee were not medically necessary and appropriate when it found that the IMR reviewer applied the wrong part of the chronic pain medical treatment guidelines. It found that in light of the applicant's significant level of permanent disability, the applicable MTUS guideline was the one that provided for continued use of opioids "[i]f the patient has improved functioning and pain," and not the guideline that applied "[i]f the patient has returned to work." The board concluded that the IMR determination was the result of a plainly erroneous finding of fact that is not a matter subject to expert opinion under LC 4610.6(h)(5), and ordered a new IMR pursuant to LC 4610.6(i).<sup>191</sup>

Also in one case, the treating physician reported that an applicant needed transportation to medical appointments, physical therapy, pharmacy trips, errands and grocery markets. Because the requesting physician reported that the applicant's inability to drive was caused by syncope and dizziness, the board found that the IMR reviewer incorrectly denied authorization, mistakenly concluding that the only relevant ODG guidelines were the knee guidelines.<sup>192</sup>

Cases prior to *Stevens* also highlight circumstances under which the appeals board will determine that an IMR decision has been successfully appealed. In one case, an applicant successfully demonstrated that an IMR determination was invalid when the treating physician requested authorization for "left dorsal medial branch block injections," but the IMR determination referenced the MTUS guidelines for "facet injection of cortisone and lidocaine." Because the request for authorization was plainly different from the facet injections evaluated by the IMR review, the appeals board concluded that the IMR determination was an erroneous finding of fact as a matter of ordinary knowledge and not a matter subject to expert opinion per LC 4610.6(h)(5). The IMR determination was set aside and reversed, and the dispute was remanded to the administrative director for submission to a different independent review organization or different reviewer as provided in LC 4610.6(i).<sup>193</sup>

Similarly, the appeals board set aside an IMR determination when it addressed the wrong medical treatment being requested. The treating physician requested authorization for an assessment of the applicant's need for assistive devices in the bathroom, a new lift and possibly a new vehicle. This was timely denied by UR, and an IMR was requested. The IMR reviewer did not address the need for the requested assistive devices, but offered an opinion on whether homemaker services (such as shopping, cleaning, laundry and personal care) and durable medical equipment were necessary for the injured worker. Because the IMR reviewer did not review the medical necessity of the requested assistive devices, the appeals board found an erroneous finding of fact as a matter of ordinary knowledge. The matter was returned to allow an IMR reviewer to address the correct medical treatment being requested.<sup>194</sup>

In one case, the appeals board overturned an IMR determination denying Duragesic patches when the reviewer incorrectly found that nothing indicated that the medication was improving the applicant's pain or function, and that there was no documentation concerning side effects and potential aberrant use of the medication. The appeals board found that the applicant's former treating physician specifically documented his improved function and reduced pain by using Duragesic patches, and further reported that his office employed random urine toxicology screens to monitor narcotics use, avoid diversion and to identify substance abuse. The appeals board concluded that the IMR findings were mistakes of fact as a matter of ordinary knowledge and remanded for review by a different IMR reviewer.<sup>195</sup>

<sup>191</sup> *McAtee v. Briggs & Pearson Construction*, 2016 Cal. Wrk. Comp. P.D. LEXIS 375. See also *Zamudio v. Matos Dairy, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 473.

<sup>192</sup> *Flores de Lopez v. Facey Medical Foundation*, 2016 Cal. Wrk. Comp. P.D. LEXIS 423.

<sup>193</sup> *Hayworth v. KCI Holdings USA, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 234.

<sup>194</sup> *Takafua v. FP International*, 2015 Cal. Wrk. Comp. P.D. LEXIS 86.

<sup>195</sup> *McAtee v. Briggs & Pearson Construction*, 2015 Cal. Wrk. Comp. P.D. LEXIS 475.

Likewise, the appeals board held that an IMR determination incorrectly denied authorization for Synvisc knee injections based on the mistaken conclusion that there was no documentation that the applicant was suffering from osteoarthritis in her knees and that she had not responded to conservative treatment. The board found that the records established that the applicant was diagnosed with arthritis in the knees and that her condition had not responded to conservative therapies other than earlier Synvisc injections. It found that denying authorization based on a finding of no documentation when the documentation was in the possession of the IMR reviewer was plainly erroneous or implied finding of fact as a matter of ordinary knowledge and not a matter that was subject to expert opinion. It also found that denying authorization was without or in excess of the administrative director's powers. It added that the Official Disability Guidelines (ODG) allow for such injections for people who suffer from osteoarthritis in their knees. The board ordered a new IMR and that as part of it, the ODG should be applied based on the documentation in the record.<sup>196</sup>

In another case, the appeals board granted a defendant's appeal of an IMR determination that stated that the requested right knee cartilage transplant surgery was "medically necessary and appropriate," but plainly was contradicted by the IMR rationale stating that the request was "not medically necessary." The appeals board found that in light of that patent discrepancy, it was apparent that either the IMR determination approving the surgery or the IMR rationale stating that the surgery was not medically necessary was in error, and that it did not require an expert to observe it. It added that the IMR statute does not authorize the administrative director arbitrarily to approve surgeries that are not medically supported, nor arbitrarily deny surgeries that are medically supported, and that to do either would be "in excess of the administrative director's powers" as described in LC 4610.6(h)(1). The case was remanded for review by a different IMR reviewer, per LC 4610.6(i).<sup>197</sup>

Also, in one case, the appeals board held that a defendant's failure to provide relevant medical records to the IMR organization constitutes grounds for appeal of the IMR determination under LC 4610.6(g)(h). The applicant asserted that both the UR and IMR physicians failed to review the reports of the AMEs who recommended the proposed treatment. The appeals board explained that LC 4610.5(l) placed a mandatory obligation on the employer to forward all relevant medical records to the IMR, and that no statutory or regulatory obligation was placed on applicants to submit medical records to the IMR. It concluded that by failing to provide the IMR reviewer with all material and relevant medical records, the determination of the IMR organization was an act without or in excess of its powers. The matter was returned for a new IMR application.<sup>198</sup>

In contrast, the appeals board majority reversed a WCJ when she decided that IMR determinations were not substantial evidence because they did not specifically identify the date and author of each report reviewed as part of the IMR process. The majority found nothing in the IMR statutes requiring an IMR determination to state the author and specific date of each report reviewed, and that CCR 9792.10.6(d) requires only a list of the documents reviewed. It found that the IMR determinations listed the documents reviewed by name of provider and by the range of the provider's dates of service, and that this was sufficient. The majority further explained by deciding that the IMR determinations were not substantial evidence because they did not provide sufficient information as to what was reviewed, the WCJ was not making a determination that there was a plainly erroneous finding of fact in the IMR determination per LC 4610(h), but that such a determination was expressly prohibited by LC 4610.6(i). It provides that in no event shall a WCJ make a determination of medical necessity contrary to the determination of the IMRO. Accordingly, the majority concluded that the applicant did not establish grounds for her IMR appeal under LC 4610.6(h), and that the

<sup>196</sup> *Gonzalez-Ornelas v. County of Riverside*, 2016 Cal. Wrk. Comp. P.D. LEXIS 151.

<sup>197</sup> *Stone v. AchieveKids*, 2014 Cal. Wrk. Comp. P.D. LEXIS 663.

<sup>198</sup> *Garibay-Jimenez v. Santa Barbara Medical Foundation Clinic*, 2015 Cal. Wrk. Comp. P.D. LEXIS 130.

IMR determinations were final and binding that the requested medical treatments were not medically necessary.<sup>199</sup>

In one case, the appeals board upheld an IMR decision denying spinal surgery, stating that “the question of whether the IMR reviewer properly applied the MTUS guidelines and/or the ACOEM guidelines is not a matter of ordinary knowledge but rather requires expert medical opinion.” The board did not believe the applicant met his burden of establishing one of the grounds for appeal by clear and convincing evidence.<sup>200</sup>

## Form of Appeal

The appeal must be in the form of a petition identified as a petition appealing administrative director’s independent medical review determination (CCR 10957.1(d)). Per CCR 10957.1(e), the caption of the petition must include the:

1. injured employee’s first and last names;
2. name(s) of the defendant(s) involved in the IMR dispute;
3. case number assigned by the administrative director to the IMR determination; and
4. adjudication case number, if any, assigned by the appeals board to any related application for adjudication of claim(s) previously filed.

The petition must include a copy of the IMR determination and proof of service to that determination (CCR 10957.1(f)). In addition, per CCR 10957.1(g), the petition must:

1. be limited to raising one or more of the five grounds specified in LC 4610.6(h);
2. establish specifically and in full detail the factual and/or legal grounds on which the petitioner considers the IMR determination to be unjust or unlawful, and every issue to be considered by the appeals board (The petitioner will be deemed to have waived all objections, irregularities and illegalities concerning the IMR determination other than those established in the petition.);
3. comply with the requirements of CCR 10842(a) and (c), CCR 10846 and CCR 10852. It also must comply with the provisions of CCR 10845, including but not limited to the 25-page restriction. For further discussion of these requirements, see [“Sullivan on Comp” Section 16.62 Petition for Reconsideration — Form and Content](#).

Failure to comply with the provisions of this subdivision will constitute valid ground for summarily dismissing or denying the petition.<sup>201</sup>

## Verification

LC 4610.6(h) provides that the IMR determination may be “reviewed only by a *verified* appeal” (emphasis added). CCR 10450(e) requires all petitions to be “verified under penalty of perjury in the manner required for verified pleadings in courts of record.” For further discussion on the requirements of a verification, see [“Sullivan on Comp” Section 16.62 Petition for Reconsideration — Form and Content](#). In *Torres v. Contra Costa Schools Insurance Group*,<sup>202</sup> the appeals board issued a significant panel decision holding that while lack of verification does not automatically require dismissal of an unverified petition, an appeal may be

<sup>199</sup> *Hacker v. County of San Bernardino-Public Health Department*, 2015 Cal. Wrk. Comp. P.D. LEXIS 415. The dissent found no basis for removal because the defendant would incur no significant prejudice or irreparable harm if new IMRs were conducted as ordered by the WCJ.

<sup>200</sup> *Torres v. Contra Costa Schools Insurance Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 574.

<sup>201</sup> See *Sanchez v. Forever 21, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 606; *Morales v. County of San Bernardino*, 2014 Cal. Wrk. Comp. P.D. LEXIS 656.

<sup>202</sup> (2014) 79 CCC 1181 (significant panel decision).

dismissed for lack of verification if the appealing party does not cure the defect within a reasonable time after receiving notice of it.

In that case, the defendant raised the lack of verification of the IMR appeal at an expedited hearing, which the applicant did not cure. The appeals board explained that the verification requirement in LC 4610.6(h) was relatively new, and that there was a strong public policy favoring the disposition of cases on their merits. The applicant was given 20 days to file an appropriate verification, and instructed that if he did not do so, his IMR appeal could be dismissed for lack of verification.<sup>203</sup>

### Filing and Service of Petition

The party must file its petition at the district office having venue, rather than with the commissioners of the appeals board.<sup>204</sup> In addition, a copy of it must be served on all interested parties. Specifically, it must be served on: (1) the adverse party(ies) or provider(s) or, if represented, the(ir) attorney or nonattorney representatives; (2) the injured employee or, if represented, the employee's attorney; and (3) the DWC, Independent Medical Review Unit (IMR Unit) (CCR 10957.1(h)).

### Action on Filing Petition

On receiving notice of the petition, the IMR Unit may download the record of the independent medical review organization into EAMS, in whole or in part. The appeals board in its discretion, may: (1) admit all or any part of the downloaded IMR record into evidence; and/or (2) permit the parties to offer in evidence documents that are duplicates of those in the downloaded IMR record (CCR 10957.1(i)).

The petition will not be placed on calendar unless a declaration of readiness (DOR) is filed. The DOR may be filed concurrently with the petition or filed subsequently. Any DOR must be served concurrently on the adverse party(ies) or provider(s) and on the IMR Unit (CCR 10957(j)(1)). Notwithstanding the DOR, a petition to appeal an IMR determination will be deferred if, at the time of the determination, the defendant also is disputing liability for the treatment for any reason besides medical necessity (CCR 10957.1(j)(2)).

The petition will be adjudicated by a WCJ at the trial level utilizing the same procedures applicable to claims for ordinary benefits, including but not limited to the setting of a mandatory settlement conference unless an expedited hearing is being conducted in accordance with LC 5502(b). The IMR determination, however, will be presumed correct and may be set aside only on proof by clear and convincing evidence of one or more of the LC 4610.6(h) statutory grounds for appeal (CCR 10957.1(k)).

Any party aggrieved by a final decision, order or award of the WCJ may file a petition for reconsideration within the same time and in the same manner specified for petitions for reconsideration. Also, the WCJ must prepare a report on the petition for reconsideration in accordance with CCR 10860, unless the WCJ rescinds the decision, order or award in accordance with CCR 10859 (CCR 10957.1(l)). In one case, however, the appeals board held that a WCJ's finding that IMR determinations were not based on substantial evidence, and ordering new IMRs as provided in LC 4610.6(i) was a nonfinal order subject to a petition for removal.<sup>205</sup>

So petitions appealing an IMR decision should be pursued first at the local level. A party may file a petition for reconsideration and/or removal only following a decision from a WCJ. The appeals board will dismiss as premature any petition filed directly from an IMR decision.<sup>206</sup>

<sup>203</sup> *Torres v. Contra Costa Schools Insurance Group* (2014) 79 CCC 1181 (significant panel decision).

<sup>204</sup> See *Sayed v. Giorgio Armani*, 2014 Cal. Wrk. Comp. P.D. LEXIS 543.

<sup>205</sup> *Hacker v. County of San Bernardino-Public Health Department*, 2015 Cal. Wrk. Comp. P.D. LEXIS 415.

<sup>206</sup> See *Sanchez v. Forever 21, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 606; *Sayed v. Giorgio Armani*, 2014 Cal. Wrk. Comp. P.D. LEXIS 543; *Morales v. County of San Bernardino*, 2014 Cal. Wrk. Comp. P.D. LEXIS 656.



## Actions on Decision by Appeals Board

If the IMR determination is reversed by the WCJ or the appeals board, the dispute must be remanded to the administrative director to submit the dispute to independent medical review by a different review organization (or a different reviewer within the original medical review organization if a different review organization is not available). But in no event will the board make a determination of ultimate fact contrary to the determination of the independent medical review organization (LC 4610.6(i)).<sup>207</sup> And an applicant may not compel disclosure of the IMR physician's identity, even if he or she successfully appealed the first IMR.<sup>208</sup>

A decision from the appeals board can still be challenged by filing a petition for writ of review in the Court of Appeal. Appellate courts also are explicitly precluded from making a determination of medical necessity contrary to the determination of the IMR.<sup>209</sup>

## Constitutionality

Because of the due process concerns in allowing an administrative decision to be the last word over the medical treatment dispute, the Legislature added LC 4610.6(n). It states, "If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby." LC 4610.6(n) was added to address any constitutional challenges to the independent medical review process, particularly the appeals process.

Nevertheless, in *Stevens v. WCAB*,<sup>210</sup> the 1st District Court of Appeal held that the IMR process is constitutional under the state Constitution because the Legislature has plenary power over the workers' compensation system under Article XIV, section 4 of the state Constitution. The court explained that an aggrieved worker who contests a board decision affirming a medical necessity determination may challenge the decision, as he or she could before, by seeking a writ of review from the Court of Appeal. It also found that the IMR process furthers, rather than conflicts with, the constitutional mandate that the workers' compensation system provide "substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character."<sup>211</sup>

*Stevens* also rejected a federal due process challenge. The court found California's scheme for evaluating workers' treatment requests fundamentally fair and affords workers sufficient opportunities to present evidence and be heard. It was not convinced that the IMR process violates due process because the physician reviewer is anonymous and not subject to cross-examination. The court explained that the reviewers are not workers' adversaries; they are statutorily authorized decision makers. It found injured workers requesting treatment under the workers' compensation system are given detailed explanations of the reasons for a denial or modification of their request, and they are given multiple opportunities to submit evidence and challenge those decisions. The court found IMR determinations are subject to meaningful review, even though the board is unable to change medical-necessity determinations.<sup>212</sup>

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<sup>207</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1277; *SCIF v. WCAB (Margaris)* (2016) 81 CCC 561, 575.

<sup>208</sup> *Zuniga v. Interactive Trucking, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 514.

<sup>209</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1273.

<sup>210</sup> (2015) 80 CCC 1262

<sup>211</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1274-1276.

<sup>212</sup> *Stevens v. WCAB* (2015) 80 CCC 1262, 1278-1282.

### **Determination Not Conclusive Evidence of Unreasonable Delay**

LC 4610.1 was amended, but it still establishes that an employee is not entitled to an increase in compensation under LC 5814 for unreasonable delay in the provision of medical treatment for the time necessary to complete the UR process. It is amended to state, “A determination by the appeals board or a final determination of the administrative director pursuant to independent medical review that medical treatment is appropriate shall not be conclusive evidence that medical treatment was unreasonably delayed or denied for the purposes of penalties pursuant to Section 5814.”

So the fact that the independent medical reviewer determines that a requested treatment is reasonable and necessary does not render the employer automatically liable for LC 5814 penalties. The employee still must prove that the treatment was unreasonably delayed or refused. If the employer relies on a timely completed utilization review decision to deny medical treatment, it is likely that it would have genuine doubt, which is all that’s required to defeat a claim of LC 5814 penalties. (For a full discussion of this see [“Sullivan on Comp” Section 13.23 Unreasonable Delay – Failure to Pay Medical Treatment Benefits.](#))

### **Publication of Determination**

LC 4610.6(m) allows the administrative director to publish the results of IMR determinations after removing individually identifiable information. This authority is clarified in CCR 9792.10.9, which requires the removal of individually identifiable information as defined LC 138.7, including, but not limited to, the employee, all medical providers, the claims administrator, any of the claims administrator’s employees or contractors or any utilization review organization. Copies of published determinations may be viewed at [http://www.dir.ca.gov/dwc/IMR/IMR\\_Decisions.asp](http://www.dir.ca.gov/dwc/IMR/IMR_Decisions.asp).

## **INVESTIGATION PROCEDURES**

LC 4610(i) gives authority to the administrative director to impose penalties against an employer who has failed to meet the time limits or any other requirements for utilization review. In addition, LC 4610.5(i) specifically prohibits an employer from engaging in conduct that delays the independent review process. It also establishes penalties that may be imposed on an employer that delays or violates the provisions of LC 4610.5. The administrative director’s investigation procedures and the penalties are established in CCR 9792.11 - CCR 9792.15. The various penalties are described in CCR 9792.12. They are severe.

An employer may be penalized for failing to comply with any of the UR requirements in LC 4610, any of the IMR requirements in LC 4610.5 and any of the relevant regulations. The proceedings for such penalties are subject to appropriate notices, and the affected employer or insurer is given an opportunity for a hearing. Penalties are to be deposited in the Workers’ Compensation Administration Revolving Fund.

The administrative director’s investigation procedures for violation of the utilization review process by any employer, insurer or other entity are established in CCR 9792.11. This authority includes, but is not limited to, review of the practices, files, documents and other records, whether electronic or paper, of the claims administrator and any other person responsible for UR processes for an employer. The administrative director, or his or her designee, may conduct a UR investigation that may include, but is not limited to, audit of files and other records (CCR 9792.11(a)(b)).

### **Routine Investigations**

The administrative director may conduct an investigation at any location where the utilization review process occurs. A UR organization is subject to a routine investigation at least once every five years (CCR 9792.11(c)(1)(A)). CCR 9792.11(a) defines a UR organization as a “person or entity with which the employer,

or an insurer, or third party administrator, contracts to fulfill part or all of the employer's utilization review responsibilities." A routine investigation of a claims administrator will be conducted at least once every five years concurrent with the audit review done per LC 129 and LC 129.5 as discussed in ["Sullivan on Comp" Section 3.54 Claims Practices – State Audits](#).

The investigation must include a review of a random sample of requests for authorization received during the three most recent full calendar months preceding the date of the issuance of the notice of UR investigation. Also, the investigation may include a review of any credible complaints received by the administrative director since the previous investigation. If there has not been a previous investigation, a review of any credible complaints received by the administrative director since the effective date of CCR 9792.11 - CCR 9792.15 may be included (CCR 9792.11(c)).

## Target Investigations

The administrative director may conduct target investigations of both utilization review organizations and claims administrators. A return target investigation is performed within 18 months of a previous investigation if the performance rating was less than 85 percent. A special target investigation may be conducted at any time based on credible information indicating the existence of a violation of the utilization review statutes. The return and special target investigations may include several areas of inquiry.<sup>213</sup> If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the administrative director since the effective date of CCR 9792.11 - CCR 9792.15 (CCR 9792.11(c)).

The number of requests for authorization randomly selected for investigation will be based on the number of requests for authorizations received by the defendant (CCR 9792.11(d)). On initiating a special target investigation, the administrative director must provide to the claims administrator or the utilization review organization a written description of the factual information or a copy of the complaint that triggered the investigation, unless it is determined that providing the information would make the investigation less useful. On receipt, the claims administrator or UR organization has 10 business days to respond in writing. After reviewing this response, the administrative director either will close the investigation without the assessment of administrative penalties or investigate further to determine whether a violation exists and whether to impose penalty assessments (CCR 9792.11(q)).

Complaints concerning UR procedures may be submitted with any supporting documentation to the DWC using the sample complaint form posted on the division's website at: <http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf>. Complaints may be mailed to DWC Medical Unit-UR, P.O. Box 71010, Oakland, CA 94612, attention: UR Complaints, or emailed to [DWCManagedCare@dir.ca.gov](mailto:DWCManagedCare@dir.ca.gov). The complaints will be reviewed and investigated, if necessary, to determine if they are credible and indicate the possibility of a violation of the utilization review statutes (CCR 9792.11(e)).

Unless the administrative director determines that advance notice will render a special or return target investigation less useful, the claims administrator or UR organization must be notified (CCR 9792.11(j)). The notice requires the investigation subject to provide complete information.<sup>214</sup>

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<sup>213</sup> They are:

- a review of the requests for authorization previously investigated that contained violations;
- a review of the file or files pertaining to the complaint or possible violation;
- a random sample of requests for authorization received by the UR organization during the three most recent full calendar months preceding the date of the issuance of the notice of UR investigation;
- a sample of a specific type of request for authorization; and
- any credible complaints received by the administrative director since any prior investigation.

<sup>214</sup> Specifically, this includes:

## Provision of Documents

The UR organization or claims administrator must provide the requested information within 14 calendar days of receipt of the notice of investigation. Based on that information, the administrative director will provide the claims administrator or UR organization with a notice of investigation commencement, which will include a list of randomly selected requests for authorization from a three-month calendar period designated by the administrative director and complaint files (if applicable) for investigation (CCR 9792.11(k)).

Within 14 calendar days of receipt of the notice of investigation commencement, a UR organization must deliver to the administrative director a true and complete copy of all records, whether electronic or paper, for each request for authorization. Copies of the records must be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held attesting that all of them are true, correct and complete copies of the originals. After reviewing the records, the administrative director will determine if an on-site investigation is required. If so, 14 calendar days' notice shall be provided to the UR organization (CCR 9792.11(l)).

For claims administrators, the notice of investigation commencement must be provided at least 14 calendar days before the on-site investigation. On the first day of the investigation, the claims administrator must produce the true, correct and complete copies, whether electronic or paper, whether located on-site or off-site, of each request for authorization identified by the administrative director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which they are held attesting that all of them are true, correct and complete copies of the originals (CCR 9792.11(m)).

If the administrative director determines that additional records or files are needed for review during the course of an on-site investigation, the claims administrator or UR organization must produce them within one working day if the records are located at the site of investigation, and within five working days if they are located elsewhere. Any such request may include records or files pertaining to any complaint alleging violations of LC 4610 or CCR 9792.6 - CCR 9792.12. The administrative director or his or her designee may extend the time for production of the requested records for good cause (CCR 9792.11(n)).

If the administrative director requests materials pertaining to the employer's UR process that are created or held outside of California, the claims administrator or utilization review organization either must deliver all such requested files and other records to an address in California specified by the administrative director, or reimburse the director for the expenses of each investigator who travels outside of California to review

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- a description of the system used to identify each request for authorization (if applicable) (To the extent the system identifies any of the following information in an electronic format, the claims administrator or UR organization must provide in an electronic format a list of every request for authorization received at the investigation site during a three-month calendar period specified by the administrative director, or his or her designee, and the following: a) an identifying number for each request for authorization if one has not been assigned; b) the name of the injured worker; c) the claim number used by the claims adjuster; d) the initial date of receipt of the request for authorization; e) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal); f) the disposition (approve, deny, delay, modify, withdrawal); and g) if applicable, the type of person who withdrew the request (physician, claims adjuster, injured employee or his or her attorney or other person). If the claims administrator or UR organization is not able to provide the list in an electronic format, it must be provided in a form such that the listed requests for authorization are sorted by type of UR, type of disposition and date of receipt of the initial request.);
  - a description of all media used to transmit, share, record or store information received and transmitted in reference to each request, whether printed copy, electronic, fax, diskette, computer drive or other media;
  - a legend of all numbers, letters and other symbols used to identify the disposition (for example, approve, deny, modify, delay or withdraw), type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal) and other abbreviations used to document individual requests for authorization and a data dictionary for all data elements provided; and
  - a description of the methods by which the medical director for UR ensures that the process by which requests for authorization are reviewed and approved, modified, delayed or denied and in compliance with LC 4610 and CCR 9792.6 - CCR 9792.10.1.

Also, this information may be requested by the administrative director or his or her designee, as applicable to the type of entity investigated: 1) whether UR services are provided externally; 2) the name(s) of the utilization review organization(s); 3) the name and address of the employer; and 4) the name and address of the insurer (CCR 9792.11(j)(5)).

them, including the per diem expenses, travel expenses and compensated overtime of the investigators (CCR 9792.11(s)).

Utilization review organizations must maintain files and other records, whether electronic or paper, that pertain to the UR process for at least three years following either the most recent UR decision for each injured employee, or the date on which any appeal from the assessment of penalties for violations of LC 4610 or CCR 9792.6 - CCR 9792.12 is final, whichever is later. Claims administrators must retain their files as noted in CCR 10102. That regulation requires claims administrators to keep files until the latest of these dates: (1) five years after the injury; (2) one year from the date compensation was last provided; (3) when all compensation due or that may be due has been paid; or (4) the findings by the audit unit have become final (CCR 9792.11(r)).

### **Date Documents Were Received**

If the deadline in CCR 9792.9.1(c) to perform any act related to the UR process falls on a weekend or holiday, for the purposes of assessing penalties, the act may be performed on the next normal business day. This rule, however, does not apply in cases of concurrent or expedited review. Furthermore, the timelines in CCR 9792.9.1(c) may be extended only as provided under CCR 9792.9.1(f) (CCR 9792.11(o)).

If the claims administrator or the utilization review does not record the date a document is received, generally it will be deemed received by using the method defined in section CCR 9792.9.1(a)(2). When the request for authorization is made by mail through the U.S. postal service and no proof of service by mail exists, the mailbox rule applies. Also, when the request for authorization is made by express mail, overnight mail or courier without proof of service, it will be deemed received by the defendant on the date specified in any written confirmation of delivery (CCR 9792.11(p)).

### **Post-Investigation Reporting**

Following the investigation, a preliminary investigation report will be provided to the claims administrator or utilization review organization. It will consist of the preliminary notice of UR penalty assessments, the performance rating and may include one or more requests for additional documentation or compliance. Also, a conference to discuss the preliminary investigation report will be scheduled, if necessary, within 21 calendar days from the issuance of the preliminary findings. Following the conference, the administrative director will issue an order to show cause regarding the assessment of administrative penalty and the final investigation report. The claims administrator or UR organization may stipulate to the allegations and final report described in the order (CCR 9792.11(t)(u)).

If no answer has been filed within 45 calendar days of the service of the order to show cause, or within 15 calendar days after all appeals have become final, the claims administrator or UR organization must provide a notice including a copy of the final investigation report, the measures implemented to address such conditions and the website address for the division where the performance rating and summary of violations is posted. If a hearing was conducted under CCR 9792.15, the notice must include the final determination in lieu of the final investigation report (CCR 9792.11(v)).

For UR organizations, the notice must be served on any employer or third-party claims administrator that contracted with the organization and whose utilization review process was assessed with a penalty pursuant to CCR 9792.12, and any insurer whose UR process was assessed with a penalty. For claims administrators, the notice must be served on any self-insured employer and any insurer whose UR process was assessed with a penalty pursuant to CCR 9792.12. The notice will be served by certified mail and documentation of

compliance must be served on the administrative director within 30 calendar days from the date the notice was served (CCR 9792.11(v)).

### ADMINISTRATIVE PENALTIES

The penalties for failure to comply with the utilization review requirements of LC 4610, the IMR requirements of LC 4610.5 and LC 4610.6 and the relevant regulations are established in CCR 9792.12.

#### Mandatory Utilization Review Penalties

CCR 9792.12(a) describes mandatory utilization review penalties and provides that notwithstanding LC 129.5(c)(1)(2)(3), the penalties are:

1. failure to establish an LC 4610 UR plan: \$50,000;
2. failure to include all of the requirements of CCR 9792.7(a) in the UR plan: \$5,000;
3. failure to file the UR plan or a letter in lieu of a UR plan with the administrative director as required by CCR 9792.7(c): \$10,000;
4. failure to file a modified UR plan with the administrative director within 30 calendar days after the claims administrator makes a material modification to the plan as required by CCR 9792.7(c): \$5,000;
5. failure to employ or designate a physician as a medical director (per CCR 9792.6(m)) of the UR process, as required by CCR 9792.7(b): \$50,000;
6. issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product if the requested treatment, procedure or service is not within the reviewer's scope of practice (per the reviewer's licensing board): \$25,000;
7. failure to comply with the requirement that only a licensed physician may modify, delay or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in LC 4604.5(c): \$25,000;
8. failure of a nonphysician reviewer (person other than a reviewer, expert reviewer or medical director as defined in CCR 9792.6) who approves an amended request without documenting it as provided under CCR 9792.7(b)(3) when a physician voluntarily has withdrawn a request in order to submit an amended request: \$1,000;
9. failure to communicate the decision in response to a request for an expedited review in timely fashion, as defined by CCR 9792.6(h), in a timely fashion as required by CCR 9792.9 and CCR 9792.9.1: \$15,000;
10. failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the MTUS per LC 5307.27: \$5,000;
11. failure to discuss or document attempts to discuss reasonable options for a care plan with the requesting physician as required by LC 4610(g)(3)(B) before denying authorization of or discontinuing medical care, in the case of concurrent review: \$10,000;
12. failure to respond to a complete form DWC RFA or other request for authorization accepted by the claims administrator under CCR 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, in the case of a nonexpedited concurrent review: \$2,000;
13. failure to respond to a complete form DWC RFA or other request for authorization accepted by the claims administrator under CCR 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, in the case of a nonexpedited prospective review: \$1,000;
14. failure to respond to a complete form DWC RFA or other request for authorization accepted by the claims administrator under CCR 9792.9.1(c)(2) submitted by the injured employee's requesting treating physician, in the case of a retrospective review: \$500;

15. failure to disclose or otherwise make available, if requested, the UR criteria or guidelines to the public, as required by LC 4610(f)(5) and CCR 9792.7(d): \$100;
16. failure to timely serve the administrative director with documentation of compliance per CCR 9792.11(v)(5): \$500; and
17. failure to timely comply with any requirement listed in the final report if no timely answer was filed or any compliance requirement listed in the determination and order after all appeals have become final: \$500.

### **Additional Utilization Review Penalties**

CCR 9792.12(b) describes additional penalties that may be imposed. After conducting a routine or return target investigation, the administrative director, or his or her designee, must calculate the investigation subject's performance rating based on its review of the randomly selected requests. The rating also may be calculated after conducting a special target investigation. The performance rating will be calculated as:

1. The factor for failure to make and/or provide a timely response to a request for authorization is determined by dividing the number of randomly selected such requests by the total number of randomly selected requests.
2. The factor for notice(s) with faulty content is determined by dividing the number of requests involving such notice(s) by the total number of randomly selected requests.
3. The factor for failure to issue notice(s) to all appropriate parties is determined by the number of requests involving the failure to issue such notice(s) by the total number of randomly selected requests.
4. The investigation subject's investigation performance rating will be determined by adding the factors calculated per Nos. 1 - 3 above, dividing the total by three, subtracting from one and multiplying by 100.
5. If the investigation subject's performance rating meets or exceeds 85 percent, the administrative director, or his or her designee will not assess penalties for the violations listed in Nos. 1 - 3. If the performance rating is less than 85 percent, the violations will be assessed as below.

Per CCR 9792.12(b)(4), the penalty is \$100 for each instance of:

1. failure to notify all parties immediately in the manner described in CCR 9792.9(h)(2) and CCR 9792.1(f)(2) of the basis for extending the decision date for a request for medical treatment;
2. failure to document efforts to obtain information from the requesting party before issuing a denial of a request for authorization on the basis of lack of reasonable and necessary information;
3. failure to make a decision to approve, modify or deny the request for authorization within five working days of receipt of a complete form DWC RFA or other request for authorization accepted by the claims administrator under CCR 9792.9.1(c)(2), or receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by CCR 9792.9(h)(3), CCR 9792.9.1(f)(3) and CCR 9792.9.1(f)(4);
4. failure to make and communicate a retrospective decision to approve, modify or deny the request within 30 working days of receipt of a complete form DWC RFA or other request for authorization accepted by the claims administrator under CCR 9792.9.1(c)(2), or receipt of the request information, as required by CCR 9792.9(h)(4), CCR 9792.9.1(f)(5) and CCR 9792.9.1(f)(6);
5. failure to include in the written decision that modifies, delays or denies authorization all of the items required by CCR 9792.9(k)(l) and CCR 9792.9.1(e); and
6. failure to disclose or otherwise to make available, if requested, the UR criteria or guidelines to the injured employee, as required by LC 4610(f)(5) and CCR 9792.8(a)(3).

## 6. UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

Per CCR 9792.12(b)(5), the penalty is \$50 for each instance of:

1. failure by a nonphysician or physician reviewer to timely notify the requesting physician, as required by CCR 9792.9(c)(2) or CCR 9792.9.1(f)(2), that additional information is needed in order to make a decision in compliance with the time limits defined in CCR 9792.9(c) or CCR 9792.9.1(c);
2. failure to communicate the decision to approve to the requesting physician in the case of prospective or concurrent review by phone or fax within 24 hours of the decision, as required by LC 4610(g)(3)(A) and in accordance with CCR 9792.9(c)(3) and CCR 9792.9.1(d)(2);
3. failure to send a written notice of the decision to modify, delay or deny to the requesting party, and to the injured employee and to his or her attorney if any, within 24 hours of making the decision for concurrent review, or within two business days for prospective review, as required by LC 4610(g)(3)(A) and CCR 9792.9(c)(4) or CCR 9792.9.1(e)(3);
4. failure to send written notice of the decision in the case of retrospective review as required by CCR 9792.9(d) or CCR 9792.9.1(d)(3) and CCR 9792.9.1(e)(4) within 30 days of receipt of the medical information that was reasonably necessary to make the determination;
5. failure to document that one of these events occurred before the claims administrator provided written notice for delay under LC 4610(g)(5): the claims administrator had not received all of the information reasonably necessary and requested; the employer or claims administrator had requested a consultation by an expert reviewer; or the physician reviewer had requested an additional examination or test be performed; and
6. failure to explain in writing the reason for delay as required by CCR 9792.9(h)(2) or CCR 9792.9.1(f)(2) when the decision to delay was made under one of the circumstances listed in section CCR 9792.9(h)(1) or CCR 9792.9.1(f)(1).

Per CCR 9792.12(b)(2)(A)(B), the penalties under CCR 9792.12(b)(4)(5) will be waived if the investigation subject's performance rating meets or exceeds 85 percent, or if, following a routine investigation, the claims administrator or UR organization agrees in writing to:

1. deliver to the administrative director within 30 calendar days of the date of the agreement or the number of days otherwise specified, written evidence, tendered with a declaration made under penalty of perjury, that explains or demonstrates how the violation has been addressed in compliance with the applicable statute or regulations and the terms of abatement specified by the administrative director; *and*
2. grant the administrative director entry, on request and within the time limit specified in the agreement, to the site where the violation was found for a return target investigation to verify compliance with the abatement measures reported in CCR 9792.12(b)(1)(A) above and agree to a review of randomly selected requests for authorization; *and*
3. reinstatement of the penalty amount previously waived for each such instance if the violation has not been addressed within the time period specified by the administrative director, or his or her designee, or if such abatement measures are not consistent with abatement terms specified by the administrative director.

The penalty amounts specified for violations CCR 9792.12(a)(b) above may be reduced, in the discretion of the administrative director, after consideration of the factors enumerated in CCR 9792.13. This is discussed below. Failure to abate a violation found under CCR 9792.12(b)(4)(5), in the time period or in a manner specified by the administrative director, will result in the assessment of the full original penalty proposed by the administrative director for that violation (CCR 9792.12(b)(2)(C), CCR 9792.12(e)).



Per CCR 9792.12(b)(3), if the administrative director conducts a return target investigation after the initial violation becomes final, and the subject fails to meet the performance standard of 85 percent, the penalty is calculated as below and in no event will that amount be waived.

1. The penalty for each violation is multiplied by two for a second investigation, but will not exceed \$100,000.
2. The penalty for each violation is multiplied by five for a third investigation, but will not exceed \$200,000.
3. The penalty for each violation is multiplied by 10 for a fourth investigation, but will not exceed \$400,000.

After the time to file an answer to the order to show cause regarding assessment of administrative penalties has elapsed and no answer has been filed, or after all appeals have become final, the administrative director will post on the DWC website the performance rating and summary of violations for each UR investigation (CCR 9792.12(b)(6)).

### **Independent Medical Review Penalties**

CCR 9792.12(c) establishes the independent medical review administrative penalties. It provides that notwithstanding LC 129.5(c)(1)(2)(3), the penalties for failure to comply with the independent medical review process are:

1. failure to provide an application for independent medical review, form DWC IMR, with a written decision modifying, delaying or denying a treatment authorization under CCR 9792.9(l) or CCR 9792.9.1: \$2,000;
2. failure to complete all applicable fields on the application for independent medical review, form DWC IMR, that is provided with a written decision modifying, delaying or denying a treatment authorization under CCR 9792.9(l) or CCR 9792.9.1:
  - A. \$500 for failure to provide the employee's name, address, phone number and date of injury;
  - B. \$500 for failure to provide the requesting physician's name, address, specialty and phone number;
  - C. \$500 for failure to provide the claims administrator name, adjuster/contact name, address and phone number;
  - D. \$500 for failure to complete any field under the section heading "Disputed Medical Treatment;"
  - E. \$100 for failure to provide any field not identified above;
3. failure to include in a written decision modifying, delaying or denying a treatment authorization under CCR 9792.9(l) or CCR 9792.9.1 a clear statement advising the injured employee that any dispute shall be resolved in accordance with the IMR provisions of LC 4610.5 and LC 4610.6, and that an objection to the UR decision must be communicated by the injured worker, the injured worker's representative or the injured workers' attorney on the application for independent medical review, form DWC IMR, within 30 calendar days of receipt of the decision: \$1,000;
4. failure to include in a written decision modifying, delaying or denying a treatment authorization under CCR 9792.9(l) or CCR 9792.9.1 a statement detailing the claims administrator's internal UR appeals process for the requesting physician, if any, and a statement that the internal appeals process is voluntary and neither triggers nor bars use of the dispute resolution procedures of LC 4610.5 and LC 4610.6, but may be pursued on an optional basis: \$1,000;

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5. failure to timely provide information requested by the administrative director under CCR 9792.10.3(b): \$500.00 for each day the response is untimely under CCR 9792.10.3(c), to a maximum of \$5,000;
6. failure to timely provide all information required by CCR 9792.10.5(a)(c): \$500 for each day the response is untimely to a maximum of \$5,000;
7. failure to timely authorize services found to be medically necessary by the IMRO in the final determination within either five business days of receipt of the determination, or sooner if appropriate for the employee's medical condition, or five business days from the date the determination is final, if an appeal of the determination has been filed under LC 4610.6(h): \$1000 for each day to a maximum of \$5,000;
8. failure to reimburse for services rendered that have been found to be medically necessary by the IMRO in the final determination within 20 days after its receipt, or within 20 days from the date the determination is final if an appeal is filed under LC 4610.6(h), subject to resolution of any remaining issue of the amount of payment per LC 4603.2 - LC 4603.6: \$500 for each day to a maximum of \$5,000; and
9. failure to timely pay an invoice from the IMRO under CCR 9792.10.8(c): \$250.

### Penalty Adjustment Factors

The penalty amounts specified for the violations above may be reduced, in the discretion of the administrative director, after consideration of the factors in CCR 9792.13 (CCR 9792.12(e)), which allows the administrative director to mitigate a penalty amount after considering:

1. the medical consequences or gravity of the violation(s);
2. the good faith of the claims administrator or UR organization (Mitigation for good faith will be determined based on documentation of attempts to comply with the Labor Code and regulations and will result in a reduction of 20 percent for each applicable penalty.);
3. the history of previous penalties;
4. the frequency of violations found during the investigation that prompts a penalty; and
5. in the event an objection or appeal is filed per CCR 9792.15, whether the claims administrator or UR organization abated the alleged violation within the time period specified by the administrative director or his or her designee.

Penalties may be mitigated outside the guidelines above in extraordinary circumstances, when strict application of the mitigation guidelines clearly would be inequitable.

The administrative director may assess both an administrative penalty under LC 4610 *and* a civil penalty under LC 129.5(e) based on the same violation(s) (CCR 9792.12(d)). The administrative director, however, may not collect payment for an administrative penalty under LC 4610 from both the utilization review organization and the claims administrator for an assessment based on the same violation(s).

If an injured worker's or a requesting provider's refusal to cooperate in the UR process has prevented the claims administrator or UR organization from determining whether there is a legal obligation to perform an act, the administrative director may forgo a penalty assessment for any related act or omission. The claims administrator or utilization review organization, however, has the burden of proof in establishing both the refusal to cooperate and that such refusal prevented compliance with the relevant applicable statute or regulation.

## **Liability for Penalty Assessments**

Liability for penalty assessments is established in CCR 9792.14. If more than one claims administrator or utilization review organization has been responsible for a claim file, UR file or other file under investigation, penalties may be assessed against each such entity for the violation(s) that occurred during the time each had responsibility for the file or for the UR process.

The claims administrator or UR organization is liable for all penalty assessments made against it, except if the subject of the investigation is acting as an agent — in that case, the agent and the principal are jointly and severally liable for all penalty assessments resulting from a given investigation. An agent and its principal may determine how to allocate the administrative penalty liability between them. But liability may not be allocated for civil penalties assessed per LC 129.5(e) for violations under LC 4610 or CCR 9792.6 - CCR 9792.10.

Successor liability may be imposed on a claims administrator or utilization review organization that has merged with, consolidated or otherwise continued the business of a corporation, other business entity or other person cited by the administrative director for violations of LC 4610 or CCR 9792.6 - CCR 9792.12. The surviving entity or person responsible for administering the UR process for an employer will assume and be liable for all the liabilities, obligations and penalties of the previous corporation or business entity. Successor liability will be imposed if there has been a substantial continuity of business operations and/or the new business uses the same or substantially the same work force.

## **ORDER TO SHOW CAUSE, NOTICE OF HEARING, DETERMINATION AND ORDER AND REVIEW PROCEDURE**

The process for imposing and appealing administrative penalties under LC 4610(i), LC 4610.5(i) and LC 4610.6(k) is established in CCR 9792.15. When the administrative director determines that an employer, insurer or other entity has failed to comply with the utilization review requirements of LC 4610 or its regulations, the director is required to issue an order to show cause regarding assessment of administrative penalty. The order must be in writing and must include:

1. notice that an administrative penalty may be assessed;
2. for administrative penalties under LC 4610(i), the final investigation report, which must include the notice of UR penalty assessment and the performance rating, and may include one or more requests for documentation or compliance;
3. for administrative penalties assessed under LC 4610.5(i) and LC 4610.6(k), the basis for the penalty assessment, including a statement of the alleged violations and the amount of each proposed penalty; and
4. a description of the methods for paying or appealing the penalty assessment.

The order must be served personally or by registered or certified mail.

Within 30 calendar days after the date of service of the order to show cause, the claims administrator or UR organization may pay the assessed administrative penalties or file an answer as a respondent with the administrative director. The answer may:

1. admit or deny in whole or in part any of the allegations in the order to show cause;
2. contest the amount of any or all proposed administrative penalties;
3. contest the existence of any or all of the violations;
4. establish any affirmative and other defenses; and
5. establish the legal and factual bases for each defense.

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A respondent must address any allegation and pay the proposed penalty stated in the order to show cause that it fails to contest within 30 calendar days after the date of service of the order. Failure to timely file an answer constitutes a waiver of its right to an evidentiary hearing. Any defenses not established in the answer to the order to show cause will be deemed waived. If the answer is not filed within 10 days of the date for filing the answer, the respondent may file a written request for leave to file an answer. The respondent also may file a written request for leave to assert additional defenses, which the administrative director may grant on a showing of good cause.

The answer must be in writing and signed by, or on behalf of, the claims administrator or utilization review organization and must include the respondent's mailing address. The answer needn't be verified or follow any particular form. The respondent must file the original and serve one copy of the answer on the administrative director, and concurrently serve one copy on the investigating unit of the DWC (designated by the administrative director). The original and all copies of any filings required by this section must have a proof of service attached.

Within 60 calendar days of the issuance of the order to show cause regarding assessment of administrative penalty, the administrative director is required to issue a notice of the date, time and place of a hearing. That date must be at least 90 calendar days from the date of service of the notice. The notice also must be served personally or by registered or certified mail. Continuances will not be allowed without a showing of good cause.

The administrative director may file or permit the filing of an amended complaint or supplemental order to show cause any time before the hearing. All parties must be notified. If the amended complaint or supplemental order to show cause presents new charges, the administrative director must afford the respondent a reasonable opportunity to prepare its defense, and the respondent is entitled to file an amended answer.

At his or her discretion, the administrative director may proceed with an informal pre-hearing conference with the respondent in an effort to resolve the contested matters. If any of the violations or proposed penalties in the order to show cause, the amended order or the supplemental order remain contested, they will proceed to an evidentiary hearing.

When the order to show cause has been contested, the administrative director may designate a hearing officer to preside over the hearing. The authority of the administrative director or the designated hearing officer includes, but is not limited to: conducting a pre-hearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere in the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas *duces tecum* for the production of documents and material at the hearing; presiding at the hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing pre-hearing orders; and preparing a recommended determination and opinion based on the hearing.

The administrative director or the designated hearing officer must set the time and place for any pre-hearing conference on the contested matters in the order to show cause, and must give 60 calendar days written notice to all parties. The pre-hearing conference may address:

1. exploration of settlement possibilities;
2. preparation of stipulations;
3. clarification of issues;
4. rulings on the identity of witnesses and limitation of their number;
5. objections to proffers of evidence;

6. order of presentation of evidence and cross-examination;
7. rulings regarding issuance of subpoenas and protective orders;
8. schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing; and/or
9. any other matters as shall promote the orderly and prompt conduct of the hearing.

The administrative director or the designated hearing officer must issue a pre-hearing order incorporating the matters determined at the pre-hearing conference. The administrative director or the designated hearing officer also may direct one or more of the parties to prepare the pre-hearing order.

No fewer than 30 calendar days before the date of the evidentiary hearing, the respondent must file and serve the original and one copy of a written statement with the administrative director or the designated hearing officer specifying the legal and factual bases for its answer and each defense. The respondent must list all witnesses it intends to call to testify at the hearing, and append copies of all documents and other evidence it intends to introduce into evidence at the hearing. A copy of the written statement and its attachments concurrently will be served on the investigating unit of the DWC. If the written statement and supporting evidence are not timely filed and served, the administrative director or the designated hearing officer will dismiss the answer and issue a written determination based on the evidence provided by the investigating unit of the DWC. Within 10 calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence that may be granted on a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than 10 calendar days before the date of the hearing.

At the evidentiary hearing, oral testimony will be taken only on oath or affirmation. Each party will have the right to:

1. call and examine witnesses;
2. introduce exhibits;
3. cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination;
4. impeach any witness regardless of which party first called him or her to testify; and
5. rebut the evidence.

The investigating unit of the DWC will present evidence first, unless there is a contrary order by the administrative director or the designated hearing officer.

Generally, the hearing needn't be conducted according to the technical rules relating to evidence and witnesses. Any relevant evidence will be admitted if it is the sort on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of common law or statutory rule that might make the admission of the evidence improper over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining other evidence. But if there is a timely objection to such evidence, it will not be sufficient in itself to support a finding unless it would be admissible over an objection in civil actions. An objection is timely if made before submission of the case to the administrative director or to the designated hearing officer.

The written affidavit or declaration of any witness may be offered and received into evidence provided that:

1. The witness was listed in the written statement.
2. The statement is made by affidavit or by declaration under penalty of perjury.

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3. Copies of the statement have been delivered to all opposing parties at least 20 days before the hearing. And
4. No opposing party, within 10 days before the hearing, has delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing.

The administrative director or the designated hearing officer must disregard any portion of the statement received pursuant to the 10-day regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible. On timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness must ensure he or she appears at the scheduled hearing, at which point the proffered declaration or affidavit from that witness will not be admitted. If the administrative director or the designated hearing officer determines that good cause exists to prevent the witness from appearing at the hearing, the declaration may be introduced in evidence, but it will be given only the same effect as other hearsay evidence.

The administrative director or the designated hearing officer must issue a written determination and order assessing penalty within 60 days of the date the case was submitted for decision. The administrative director must provide a statement of the basis for the determination and each penalty assessed, and the determination must be served on all parties. This requirement, however, is directory and not jurisdictional.

The administrative director has 60 calendar days to adopt or modify the determination and order assessing penalty. If he or she modifies the recommended determination and order of the designated hearing officer, the director must include a statement of the basis for the determination and order assessing penalty signed and served by him or her. If the director does not act within 60 calendar days, the recommendation will become the determination and order on the 61st calendar day.

The determination and order assessing penalty must be served by the administrative director on all parties personally or by registered or certified mail. It will become final on the day it is served, unless the aggrieved party files a timely petition appealing the determination. All findings and assessments in the determination and order not contested in the petition will become final as though no petition were filed. At any time before the date it becomes final, the administrative director or designated hearing officer may correct the determination and order assessing penalty for clerical, mathematical or procedural error(s).

Penalties assessed in a determination and order assessing penalty must be paid within 30 calendar days of the date it became final. A timely filed petition appealing the determination of the administrative director will toll the period for paying the penalty assessed for the item appealed. All appeals from any part or the entire determination and order will be made in the form of a petition appealing the determination of the administrative director, in conformance with the requirements of Chapter 7, Part 4 of Division 4 of the Labor Code. Any such petition will be filed at the appeals board in San Francisco (and not with any district office of the WCAB), in the same manner specified for petitions for reconsideration.

### **PENALTIES UNDER LC 5814**

Penalties due the applicant, rather than the Audit Unit, are described in depth in Chapter 13. But note that the applicant might be entitled to increased benefits if treatment is unreasonably delayed.

LC 4610.1 is careful to state that penalties do not apply when there is a delay because a request for medical care is being put through the utilization review process. Also, just because the WCJ ultimately determines that the treatment in question was warranted does not automatically mean that there was an unreasonable delay. The applicant may overcome the UR findings by rebuttal evidence and ultimately get the treatment

that was denied. As long as the defense has a good-faith legal and medical basis for denial, usually the delay is not unreasonable, and no penalty applies.

But this is not *carte blanche*. LC 4610.1 does not preclude an employee from entitlement to an increase in compensation under LC 5814 if the UR process itself is unreasonably delayed by the defense. An example might be when the request is denied because the defense said it needed further testing to determine if the care was needed, when there was no basis for this assertion. Also, penalties may apply if the UR decision was not based on substantial evidence, meaning that the defendant could not have genuine doubt as to its liability from a medical or legal standpoint.<sup>215</sup> For further discussion of penalties that may be imposed for unreasonable delays in providing medical treatment, see [“Sullivan on Comp” Section 13.23 Unreasonable Delay — Failure to Pay Medical Treatment Benefits](#).

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<sup>215</sup> See *County of Riverside v. WCAB (Salem)* (2014) 79 CCC 946 (writ denied).

## 7. INDEPENDENT BILL REVIEW

Once medical necessity of a disputed service is established, what is it worth? The reasonable amount for medical services is a frequent point of contention in workers' compensation. Despite the Official Medical Fee Schedule (OMFS) that establishes reasonable maximum fees for medical services, defendants and medical providers routinely argue over what is reasonable, and particularly how the schedule applies to a particular case. Some such disputes center on whether the services are coded properly. Other disputes revolve around the appropriate value for a given service. Formerly, if the disputes could not be resolved, defendants and lien claimants were forced to try the issue before a WCJ, who often was ill-equipped to adjudicate it.

Effective Jan. 1, 2013, SB 863 established an independent bill review (IBR) process. Under this process, expert bill reviewers, and not WCJs, make determinations if the dispute is about the monetary value of a medical bill. The process is intended to relieve substantial congestion at the appeals board and speed up dispute resolution. It's also intended to ensure that decisions are made by billing experts, as opposed to judges, who have no special training regarding billing codes and procedures.

In establishing the process, the Legislature stated in Section 1, paragraph (h) of SB 863, "Existing law does not provide for medical billing and payment experts to resolve billing disputes, and billing issues are frequently submitted to workers' compensation judges without the benefit of independent and unbiased findings on these issues." The Legislature added, "Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system."

The IBR process gives authority in disputes over medical billing issues to independently contracted expert bill reviewers. Their decisions are to be the last word on the amount paid for medical services. The IBR process was adopted to provide a quick, efficient way to resolve billing disputes over medical billing and eliminate litigation at the appeals board.

Administrative regulations have been adopted to establish the independent review process. Emergency regulations became effective Jan. 1, 2013, and final regulations became effective Feb. 12, 2014. These regulations are established in CCR 9792.5.7 - CCR 9792.5.15 and outline how the process is to be conducted.

IBR has not been a frequent source of litigation since its adoption. While the total volume of IBRs has increased each year, it remains relatively low in comparison to independent medical review.<sup>1</sup> In 2015, IMR reviewed 165,525 cases, with 282,737 individual treatment requests, while IBR reviewed only 2,732 cases.<sup>2</sup>

<sup>1</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 20.

<sup>2</sup> Department of Industrial Relations, SB 863: Assessment of Workers' Compensation Reports (July 2016), at pps. 13-15.



IBR overturned the decision of the claims administrator in 75 percent of the cases that proceeded to a final decision in 2015, and upheld 25 percent of the cases.<sup>3</sup>

## **AMENDMENTS TO PROCEDURES AND TIME LIMITS FOR PAYING MEDICAL TREATMENT BILLS**

Before a dispute is referred to the independent bill review process, a medical provider must ensure that its bill is properly documented. There are time limits for an employer to dispute the bill and issue an explanation with review. A medical provider who disagrees with the amount paid by the employer must request a second review by the employer before it may request an independent bill review.

LC 4603.2 establishes the procedures and time limits for payment of medical treatment charges. The section was amended by SB 863 and subsections were added to ensure that medical billing disputes are resolved through the independent bill review process. Changes also were made to the rules regarding documents that must be submitted as a condition of entitlement to payment, and time limits for payment of medical treatment services.

### **Documents That Must Be Submitted with Request for Payment**

Effective Jan. 1, 2013, per LC 4603.2(b)(1), “Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received.”

So providers must attach:

1. a request for payment with an itemization of services provided and the charge for each;
2. a copy of all reports showing the services performed;
3. the prescription or referral from the primary treating physician if the services were performed by someone other than the primary treating physician; and
4. any evidence of authorization for the services that might have been received.

These are the prerequisites to an employer’s liability under LC 4603.2(b)(2) for “payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer.” The liability commences when the documents are received.<sup>4</sup> An employer cannot determine its liability for medical expenses without a medical report — it’s required to make an intelligent review of the reasonableness of the charges on a billing statement.

Even if a prescription for the services were made by a secondary treater, a prescription or referral by a primary treating physician is still required under LC 4603.2(b)(1).<sup>5</sup>

Per LC 4603.2(b)(1), “Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for

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<sup>3</sup> Department of Industrial Relations, SB 863: Assessment of Workers’ Compensation Reports (July 2016), at p. 16.

<sup>4</sup> See *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 CCC 1588, 1592-95 (appeals board *en banc*). See *Lopez v. Superba, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 642.

<sup>5</sup> *Neri Hernandez v. Geneva Staffing, Inc. dba Workforce Outsourcing, Inc.* (2014) 79 CCC 682, 696 (appeals board *en banc*).

payment with providers for services provided pursuant to Section 4600.” So a defendant and provider may establish, by written agreement, different requirements for a request for payment.

### **Exception for Pharmacy Services**

Effective Aug. 19, 2013, a request for payment of pharmacy services need not comply with the requirements above. Instead, per LC 4603.2(b)(1)(C), “a copy of the prescription shall not be required with a request for payment for pharmacy services unless the provider of services has entered into a written agreement ... that requires a copy of a prescription for a pharmacy service.” So a bill for pharmacy services need not attach the prescription from the treating physician, unless there is a written agreement requiring it to do so.

But LC 4603.2(b)(1)(D) provides that there is nothing “preclud[ing] an employer, insurer, pharmacy benefits manager, or third-party claims administrator from requesting a copy of the prescription during a review of any records of prescription drugs that were dispensed by a pharmacy.” So the statute allows the defendant to request a copy of the prescription, but does not require submission of a prescription as a prerequisite to payment of a bill.

### **Form of Bills for Submission**

As of Oct. 15, 2011, all paper bills for medical treatment must be submitted on billing forms defined in the California Division of Workers’ Compensation Medical Billing and Payment Guide (CCR 9792.5.2(a)). All medical bills are to conform to the provisions of the guide, including coding, billing standards, time frames and other rules (CCR 9792.5.2(b)). Likewise, as of Oct. 15, 2011, claims administrators are to conform to the payment, communication, penalty and other provisions of the guide, except those relating to electronic medical bills that did not become effective until Oct. 18, 2012 (CCR 9792.5.3(a)). A copy of the guide may be obtained from: <https://www.dir.ca.gov/dwc/EBilling/StandardizedPaperBilling-Oct2015/MBPGClean.pdf>.

Per LC 4603.4(a)(2), the administrative director was required to adopt rules and regulations for employers to accept electronic claims for payment of medical services. The regulations relating to the payment of electronic bills became effective Oct. 18, 2012 (CCR 9792.5.3(a)). As of Oct. 18, 2012, all bills for medical treatment may be submitted electronically to a claims administrator for payment (CCR 9792.5.2(c)). Also, after that date, claims administrators were required to conform to the payment, communication, penalty and other provisions contained in the California Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide (CCR 9792.5.3(b)). A copy of this guide is available at: <https://www.dir.ca.gov/dwc/EBilling/MBPElectronicCompanionGuide.pdf>.

Both guides may be obtained by writing to: Division of Workers’ Compensation, Attn: Medical Billing and Payment Guide or Medical Billing and Payment Companion Guide, P.O. Box 71010, Oakland, CA 94612. Information regarding electronic billing is available at the DWC website at <https://www.dir.ca.gov/dwc/EBilling/EBilling.html>.

### **Time Limit to Submit Bills**

Pursuant to LC 4603.2(b)(1)(B), effective for services provided on or after Jan. 1, 2017, the request for payment with an itemization of services provided and the charge for each must be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services.

This requirement was enacted by SB 1175 in response to concerns over fraudulent or unnecessarily belligerent billing activity by some medical providers. In some cases, the bills were submitted more than a

year after the services were provided. This resulted in the underlying documentation being destroyed or made it difficult for the employer to find, which potentially led to the possibility of a medical provider being paid twice for providing the same service. SB 1175 also was enacted in response to concerns that processing old medical bills could create frictional costs for payors, limiting resources to injured workers and lawful medical providers.

LC 4603.2(b)(1)(B) requires the administrative director to adopt rules to implement the 12-month limitation period. The rules must define circumstances that constitute good cause for an exception to the 12-month period, including addressing the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. Otherwise, a request for payment not submitted within the 12-month period is barred.

Note that the 12-month period to submit a bill is different from the statute of limitations for filing a lien under LC 4903.5. For services on or after July 1, 2013, a lien must be filed no more than 18 months after the date they were provided (see Chapter IX: Lien Reform). Filing a lien invokes the jurisdiction of the appeals board to determine whether the services provided are payable. Under LC 4603.2(b)(1)(B), the provider first must timely submit a bill to the employer. Then the provider should file a lien if it disputes the amount paid. Unless an exception applies, if the provider has not submitted a bill within the 12-month period, the appeals board could not award payment on the bill even if a lien was timely filed.

## Time Limits for Payment

Before Jan. 1, 2013, former LC 4603.2 gave employers and insurers 45 *working* days to make payment. As a result of SB 863, however, the employer must submit payment with an explanation of review (EOR) within 45 *calendar* days after receipt of a bill itemizing the medical services provided and any required reports and written authorization for services that may have been received by the physician unless the itemization is contested, denied or considered incomplete (LC 4603.2(b)(2)).<sup>6</sup> This is true for all requests related to medical care; for example, an employer's liability for medical transportation is subject to the 45-day period.<sup>7</sup> If an applicant has paid for treatment, the payments should be made to the applicant.<sup>8</sup>

If the employer is a government entity, it has 60 days to make payment (LC 4603.2(b)(3)). The employer must issue an explanation of review with the payment.<sup>9</sup>

A properly itemized electronic billing must be paid within 15 working days of receipt (LC 4603.4(d)). The Legislature has determined that these are reasonable time periods within which to process a bill for medical treatment.<sup>10</sup> Per LC 5307.1, the employer must make payment within these limits at the reasonable maximum amounts in the Official Medical Fee Schedule in effect on the date of service. The OMFS is discussed further in [“Sullivan on Comp” Section 7.79 Official Medical Fee Schedule](#). LC 4603.2 does not require an employer to pay for medical treatment services in advance.<sup>11</sup>

## Time Limits for Objection to Payment

If the itemized bill or part of it is contested, denied or considered incomplete, the physician must be notified in the explanation of review within 30 days after receipt of a paper itemization by the employer. An objection

<sup>6</sup> CCR 9792.5(b) still allows for payment within 45 working days. But CCR 9792.5 was amended last in 2011; it hasn't been updated to reflect the new statute. So, to the extent that CCR 9792.5(b) conflicts with the statute, it is invalid and should not be relied on.

<sup>7</sup> *Avalon Bay Foods v. WCAB (Moore)* (1998) 63 CCC 902, 913; *County of Stanislaus/Department of Education v. WCAB (Chamberlain)* (1999) 65 CCC 67 (writ denied). See also *County of San Luis Obispo v. WCAB (Barnes)* (2001) 66 CCC 1261 (court held that quarterly penalty payments agreed to by defendant and applicant were subject to time limits of LC 4603.2).

<sup>8</sup> See *All Tune & Lube v. WCAB (Derbogossian)* (2006) 71 CCC 795 (writ denied).

<sup>9</sup> California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2.2, p. 9.

<sup>10</sup> *Avalon Bay Foods v. WCAB (Moore)* (1998) 63 CCC 902, 913.

<sup>11</sup> See *Murphy v. WCAB* (2015) 80 CCC 1093 (writ denied).

to a paper itemization will be deemed timely if sent by first class mail and postmarked on or before the 30th day after receipt, or if personally delivered or sent by fax on or before the 30th day.<sup>12</sup> If an electronic bill is received, the objection must issue within 15 working days of electronic receipt (LC 4603.4(d)).

The employer must pay any uncontested amount within the appropriate period. So, if a portion of the nonelectronic bill is uncontested, it must be paid within 45 days, or within 60 days of if the employer is a governmental entity.<sup>13</sup> The uncontested amount of an electronic bill must be paid within 15 working days (LC 4603.4(d)).

## Explanation of Review

LC 4603.2(b)(2) requires an employer to issue an explanation of review with each payment and/or if the itemization or part of it is contested, denied or considered incomplete. LC 4603.3 specifies the contents of the explanation. LC 4603.3(a) requires that on payment, adjustment or denial of a complete or incomplete itemization of medical services, an employer must provide an EOR in the manner prescribed by the administrative director that includes:

1. a statement of the items or procedures billed and the amounts requested by the provider;
2. the amount paid;
3. the basis for any adjustment, change or denial of the item or procedure billed;
4. the additional information required to make a decision for an incomplete itemization;
5. the reason for the denial of payment if it's not a fee dispute; and
6. information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing.

The explanation of review must inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill per LC 4603.6.

So to comply with the requirements of the statute, employers must establish proper forms for their explanations of review. Additional instructions for this document are given in the California Division of Workers' Compensation Medical Billing and Payment Guide.

LC 4603.3(b) allows the administrative director to adopt regulations requiring the use of electronic explanations of review. The California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2 allows for both paper and electronic explanations.<sup>14</sup> Electronic explanations of review must comply with the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide. If an entity submits bills electronically it must be able to receive an electronic response from the claims administrator.<sup>15</sup>

## Consequences for Failure to Issue Explanation of Review

The appeals board has explained that the independent bill review process requires the employer to provide an explanation of review when paying less than the amount requested by the provider. It held that the IBR process does not apply to disputes in which an employer failed to provide an explanation of review. It also

<sup>12</sup> California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2.2, p. 9.

<sup>13</sup> California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2.2, p. 9.

<sup>14</sup> California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2.2, p. 57.

<sup>15</sup> California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.2, p. 3.

held that if the employer fails to provide a required explanation of review, the provider is not required to file a request for IBR, and the appeals board will have jurisdiction over the dispute.<sup>16</sup>

The appeals board's opinion regarding its jurisdiction over a billing dispute for an employer's failure to issue an explanation of review mirrors its jurisdiction over medical treatment disputes when an employer fails to timely perform utilization review. This issue is further discussed in Chapter VI: Utilization Review and Independent Medical Review.

## Duplicate Submission of Billing

SB 863 added LC 4603.2(b)(4) to address how employers are required to deal with duplicate submissions. It states, "Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical provider and shall not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission."

So if an employer has issued an EOR for why the medical provider was not paid or paid only in part, the employer is not required to take additional action for a subsequent submission of the same bill. As discussed below, if the medical provider does not timely respond to an explanation of review, it will lose any right to further payment. LC 4603.2(b)(4) explains that this right is not preserved by a duplicate submission.

Still, the claims adjuster must not be capricious. LC 4603.2(b)(4) applies only to duplicate submissions and not to any other penalties or interest that might apply to the original submission. So every bill received should be inspected to see if there is something new.

## Failure to Object to Medical Expenses — Penalty

What happens if an objection does not timely issue? Per LC 4603.2(b)(2), any properly documented list of services provided and not paid within 45 days at the rates then in effect under LC 5307.1 will be increased by 15 percent and accrue interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer:

1. pays the provider at the rates in effect within the 45-day period; and
2. in the explanation of review, advises the physician, or another provider of the items being contested, the reasons for contesting them and the remedies available to the physician or the other provider if he or she disagrees.<sup>17</sup>

So if an employer does not timely pay or object to a properly documented itemization, it is liable for a 15 percent penalty as well as interest from the date of receipt of the itemization. But, penalties under LC 4063.2 are triggered only if the bill is properly documented.<sup>18</sup>

The penalty described in LC 4603.2 gives medical providers their sole remedy for delayed payment of medical treatment expenses.<sup>19</sup> That is, medical providers lack standing to assert additional penalties under LC 5814,<sup>20</sup> although this does not affect an employer's liability to an employee under LC 5814. See ["Sullivan](#)

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<sup>16</sup> *Holder v. Christian dba Adventure Limousine*, 2016 Cal. Wrk. Comp. P.D. LEXIS 232.

<sup>17</sup> Per LC 4603.2(b)(2)(B), when the bill dispute involves services provided by a hospital, outpatient surgery center or independent diagnostic facility, notice that the request has been made for an audit of the itemization is sufficient.

<sup>18</sup> *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 CCC 1588. See *Martinez v. Sifling Brothers*, 2016 Cal. Wrk. Comp. P.D. LEXIS 461.

<sup>19</sup> *Charles J. Vacanti, M.D., Inc. v. SCIF* (2001) 65 CCC 1402.

<sup>20</sup> *Sycamore Pharmacy, Inc. v. WCAB (Reynoso)* (1997) 62 CCC 1322 (writ denied).

[on Comp” Section 13.3 Penalties for Untimely Payment of Medical Bills](#) for a detailed discussion of penalties under LC 4603.2(b)(2).

Any electronically submitted bill determined to be complete and not paid or objected to within 15 working days will be subject to audit penalties per CCR 10111.2(b). In addition, any electronically submitted complete bill not paid within 45 days of receipt, or within 60 days if the employer is a governmental entity, will be increased by 15 percent and carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the provider is notified within 30 days of receipt that the bill is contested, denied or considered incomplete.<sup>21</sup> The penalties and interest are self-executing and apply the portion of the bill that is neither timely paid nor objected to.<sup>22</sup>

Per CCP 685.010(a), the current rate of interest for nonpublic entities is “10 percent per annum on the principle amount of a money judgment remaining unsatisfied,” while the interest rate for public entities is 7 percent.<sup>23</sup>

### **Failure to Object to Medical Expenses — Mandatory Payment?**

And so we see that a penalty applies. The next question is whether a failure to timely object to a properly documented itemization automatically renders an employer liable for payment of the services.

Previously, in *Kunz v. Patterson Floor Coverings, Inc.*,<sup>24</sup> the appeals board held *en banc* that a defendant’s failure to object specifically to a lien on the basis of reasonable medical necessity (or any other basis) does not result in a waiver of that objection under LC 4603.2.<sup>25</sup> It explained that LC 4603.2 required the defendant to advise the provider of the items being contested and reasons for contesting them. But the board also found that nothing in LC 4603.2 stated or implied that the consequence of a failure to make any particular specific objection is that the defendant is thereafter precluded from raising that objection, or that the lien claimant is relieved of any portion of its obligation to prove by a preponderance of the evidence all of the elements necessary to establish its lien.<sup>26</sup> The appeals board also explained that the only consequences of a defendant’s failure to timely state any given specific objection under LC 4603.2 are: (1) the defendant may be liable for a 10 percent (now 15 percent) penalty and/or interest on the unpaid balance of the lien allowed by the appeals board, accrued from when the defendant received the bill, and (2) the defendant may become liable for an LC 5814 penalty to the applicant if the defendant’s failure to object and pay is unreasonable.<sup>27</sup>

Since *Kunz*, however, the Legislature has amended the procedures for payment of a medical provider’s bill and established the IBR process. Effective Oct. 23, 2013, CCR 10451.2 was adopted specifically to deal with medical treatment disputes. CCR 10451.2(c)(1)(D) provides that “an assertion by the medical treatment provider that the defendant has waived any objection to the amount of the bill because the defendant allegedly breached a duty prescribed by Labor Code sections 4603.2 or 4603.3 or by the related Rules of the Administrative Director” is not subject to independent medical review or independent bill review, but remains within the jurisdiction of the appeals board. The board explained that this regulation was adopted

<sup>21</sup> California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2.2, p. 13.

<sup>22</sup> California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2.2, pps. 10 and 13.

<sup>23</sup> GC 970.1(c); *California Federal Savings and Loan Association v. City of Los Angeles* (1995) 11 Cal. 4th 342; *Ayala v. County of Los Angeles/King Drew Medical Center*, 2014 Cal. Wrk. Comp. P.D. LEXIS 45.

<sup>24</sup> (2002) 67 CCC 1588 (appeals board *en banc*).

<sup>25</sup> *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 CCC 1588, 1592 (appeals board *en banc*). See also *Nguyen v. Network Appliance, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 176. In cases that preceded *Kunz*, failure to issue the objection did result in the defense losing the ability to defend against the lien. See *City of Los Angeles v. WCAB (Teitelbaum, Barnes)* (1998) 63 CCC 1415 (writ denied). See also *K-Mart Corp. v. WCAB (Segovia)* (1999) 64 CCC 798 (writ denied); *Bloch Medical Clinic v. WCAB (Rodriguez)* (1997) 62 CCC 589 (Court of Appeal opinion unpublished in official reports).

<sup>26</sup> *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 CCC 1588, 1592 (appeals board *en banc*).

<sup>27</sup> *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 CCC 1588, 1592-1593 (appeals board *en banc*). In one panel decision, the appeals board upheld a decision that a defendant’s failure to object to a lien claimant’s treatment bills prevented it from claiming restitution for payments above the Official Medical Fee Schedule. *Iosty v. PetSmart, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 418.

because “the law establishes that where a party has a duty to take a particular action to preserve a claim or defense, it must timely undertake that action and cannot bypass it; otherwise, the party waives that claim or defense.”<sup>28</sup>

The Court of Appeal also has stated that “under the new system, an employer’s failure to respond to a provider’s bill as required under the statute would mean that the employer would have to pay for the services at the ‘rates then in effect under Section 5307.1 ... and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to date of receipt of the itemization.’”<sup>29</sup> So the court indicates that an employer’s failure to timely object to a properly documented itemization renders it liable for payment of the services, at least at the rate in effect under LC 5307.1, which relates to the Official Medical Fee Schedule. This comment, however, was made in a case in which that issue was not addressed specifically (this is called “dicta”), so the opinion might need to be clarified further

## **SECOND REVIEW AS A PREREQUISITE TO INDEPENDENT BILL REVIEW**

LC 4603.2(e) establishes the second review procedure a medical provider must follow before initiating the independent bill review process. The regulation related to second review is CCR 9792.5.5. Failure to follow the procedure will prevent a medical provider from recovering any additional payments.

### **Applicability of Second Review**

Per CCR 9792.5.5, “If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services or goods rendered on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.” CCR 9792.5.7 also provides that independent bill review may be requested for medical treatment rendered or medical-legal expenses incurred on or after Jan. 1, 2013. The regulations do not specify whether those procedures may be used for services before Jan. 1, 2013. The clear implication, though, is that billings for services done before 2013 are not subject to second review.

### **Time Limits to Request Second Review**

Per LC 4603.2(e)(1), a provider who disagrees with the amount paid by the employer must request that the employer reconsider its findings. The request must be made within “90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review.” This is clarified in CCR 9792.5.5, which states that the second review must issue within 90 days of:

1. the date of service of the explanation of review in conjunction with the payment, adjustment or denial of the initially submitted bill, if a proof of service accompanies the explanation of review;
  - A. The date of receipt of the EOR by the provider is deemed the date of service if a proof of service does not accompany the explanation of review and the claims administrator has documentation of receipt.
  - B. If the EOR is sent by mail and lacks a proof of service or documentation of receipt, the date of service is deemed to be five calendar days after the date of the U.S. postmark on the envelope in which the explanation of review was mailed.
2. the date of service of an order of the appeals board resolving any threshold issue that would preclude a provider’s right to receive compensation for the submitted bill.

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<sup>28</sup> WCAB’s Final Statement of Reasons for the Rule of Practice and Procedure, p. 14. The document may be obtained at: [http://www.dir.ca.gov/WCAB/WCABRulesofPracticeProcedure2013/WCABRulesofPracticeProcedure2013\\_Sup\\_SOR.pdf](http://www.dir.ca.gov/WCAB/WCABRulesofPracticeProcedure2013/WCABRulesofPracticeProcedure2013_Sup_SOR.pdf).

<sup>29</sup> *CIGA v. WCAB* (2014) 79 CCC 1481.



## Form of Request for Second Review

LC 4603.2(e)(1) requires that the request for a second review be submitted to the employer on a form prescribed by the administrative director. CCR 9792.5.5(c) establishes different forms for the request for second review, depending on the type of bill submitted. A request for second review must follow these procedures:

1. For nonelectronic medical treatment bills, the second review request must be made on either:
  - A. the initially reviewed bill submitted on a CMS 1500 or UB04 (The second review bill must be marked using the National Uniform Billing Committee (NUBC) Condition Code Qualifier “BG” followed by NUBC Condition Code “W3” in the field designated for that information to indicate a request for second review. For the ADA Dental Claim Form 2006, or ADA Dental Claim Form (2012), the words “Request for Second Review” must be marked in Field 1. For the NCPDP WC/PC claim form, the words “Request for Second Review” may be written on the form.); or
  - B. the request for second bill review form DWC SBR-1 (This form is established in CCR 9792.5.6, and is available at the DIR website at: <http://www.dir.ca.gov/dwc/forms.html>. Form SBR-2 must be the first page of the request for second review submitted by the provider.).
2. For electronic medical treatment bills for professional, institutional or dental services, the request must be submitted on the correct electronic standard format, using the NUBC Condition Code Qualifier “BG” followed by NUBC Condition Code “W3” as specified in the Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide.
3. For an electronic pharmacy bill that used either the NCPDP Telecommunications D.0 or the NCPDP Batch Standard Implementation Guide 1.2, the method for identifying a request for second review may be addressed in the trading partner agreement, or the second review may be requested on form DWC SBR-1.
4. For medical-legal bills, the second review must be requested on the request for second bill review form DWC SBR-1.

Per LC 4603.2(e)(1) and CCR 9792.5.5(d), the request for second review must include:

1. the original dates of service and the same itemized services rendered as the original bill (no new dates of service or additional billing codes may be included);
2. the date of the explanation of review and its claim number or other identifying number;
3. the item and amount in dispute;
4. the additional payment requested and reason for it; and
5. the additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

## Failure to Request Second Review

LC 4603.2(e)(2) states, “If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.” This is repeated in CCR 9792.5.5(e). So for the bill to be lost, there must be no dispute except the amount owed.

This does not cover cases in which there are issues other than the reasonableness of billing. If there is a threshold issue, the obligation to request second review is deferred until that issue is resolved at the appeals board. Threshold issues include denial of injury, a contested body part or alleged improper treatment



outside a proper MPN. The statute requires a request for second review to be made within 90 days of an appeals board order resolving a threshold issue, and it may be that failure to do so will bar further recovery. But this is not stated explicitly in LC 4603.2(e)(2) or the regulations.

### **Employer's Response to Request for Second Review**

If a provider submits a request for second bill review that does not comply with the requirements outlined above, the employer may respond. Any such response, however, is not subject to the requirements of CCR 9792.5.5(g)(h)) (CCR 9792.5.5(f)).

Per LC 4603.2(e)(3) and CCR 9792.5.5(g), within 14 days of receipt of a request for second review that complies with the requirements of CCR 9792.5.5(d), the employer must respond with a final written determination on each of the items or amounts in dispute by issuing an explanation of review. The determination must contain all of the information required in an EOR under LC 4603.3, including an explanation of the time limit to raise any further objection regarding the amount paid for the services and how to obtain an independent bill review. The 14-day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the employer.

Based on the results of the second review, payment of any balance no longer in dispute, or payment of any additional amount determined to be payable, must be made within 21 days of receipt of the request for second review. The 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator (CCR 9792.5.5(h)).

Per LC 4603.2(e)(4) and CCR 9792.5.5(i), if the medical provider still contests the amount paid after receipt of the second review, the provider must request an independent bill review under LC 4603.6. Failure to timely do so generally results in the inability to pursue the bill any further.

The statute is silent on the consequence to the employer if this response to second review is not made or is made late. CCR 10451.1(f)(1)(A)(ii) provides that a defendant will have waived all objections to a medical-legal provider's billing, other than compliance with LC 4620 and LC 4621, if it fails to serve a final written determination following a timely and proper request for second review. But there is no comparable language for a defendant who fails to timely respond to a request for second review of a medical treatment bill.

### **INDEPENDENT BILL REVIEW — SCOPE OF APPLICATION**

Before SB 863, some appeals board panel cases allowed WCJs to appoint an independent bill reviewer to resolve billing disputes.<sup>30</sup> Now, per LC 4603.2(e)(4), independent bill review is the statutory process that must be employed if a medical provider contests the amount paid after receipt of a second review. Regulations regarding the independent bill review process also are established in CCR 9792.5.7 - CCR 9792.5.15.

Independent bill review, however, may not be used to resolve every medical billing dispute. Per LC 4603.6, independent bill review may be requested if “the only dispute is the amount of payment.” If there is a threshold issue, such as denial of injury or a contested body part, a provider has 90 days from service of an appeals board order resolving that issue in the provider's favor to request second review. CCR 9792.5.7(b) states that “issues of contested liability ... shall be resolved before seeking independent bill review.”

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<sup>30</sup> See *Gross v. State of California*, 2012 Cal. Wrk. Comp. P.D. LEXIS 287; *Garay v. Barrett Business Services, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 342; *Lopez v. Superba, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 642. Also, the parties may agree on a bill reviewer. If so, the report of an agreed bill reviewer is entitled to great weight. *Alvarez v. BAH California*, 2015 Cal. Wrk. Comp. P.D. LEXIS 457.

The regulations further limit the scope of independent bill review. It may be employed to resolve disputes about services performed only on or after Jan. 1, 2013, and the regulations generally limit each independent bill review to one date of service and under one billing code. IBR may not resolve the applicability of a contract for reimbursement rates under LC 5307.11, or services not covered by the Official Medical Fee Schedule or a contract.

### Issues Not Subject to Independent Bill Review

Because independent bill review applies only to disputes related to the amount payable to a medical treatment provider under an official fee schedule, CCR 10451.2 lists disputes that the appeals board deems not subject to IBR. Per CCR 10451.2(c)(1), non-IBR disputes include, but are not limited to:

- A. any threshold issue that would entirely defeat a medical treatment claim (for example, injury, injury to the body part for which treatment is disputed, employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction);
- B. a dispute over a UR determination if the employee's date of injury is before Jan. 1, 2013, and the decision is communicated to the requesting physician before July 1, 2013;
- C. a dispute over whether UR was undertaken in timely fashion or was otherwise procedurally deficient;<sup>31</sup> but if the employee prevails in this assertion, the employee or provider still has the burden of showing entitlement to the recommended treatment;
- D. an assertion by the medical treatment provider that the employer has waived any objection to the amount of the bill because it allegedly breached a duty prescribed by LC 4603.2, LC 4603.3 or the related administrative regulations;
- E. an assertion by the employer that the medical treatment provider has waived any claim to further payment because the provider allegedly breached a duty prescribed by LC 4603.2 or the related administrative regulations;
- F. a dispute over whether the employee was entitled to select a treating physician not within the employer's MPN;
- G. an assertion by the employer that an interpreter who rendered services at a medical treatment appointment did not meet the criteria established by LC 4600(f) and (g), LC 5811(b)(2) and the administrative regulations, as applicable; and
- H. an assertion by the employer that an interpreter was not reasonably required at a medical treatment appointment because the employee proficiently speaks and understands the English language.

If a dispute is not subject to IBR, the appeals board has jurisdiction. If a non-IBR dispute is between an employee and an employer, the procedures for claims for ordinary benefits must be followed, including those for an expedited hearing, if applicable. If the dispute is between a medical treatment provider and a defendant, the procedures applicable to lien claims must be followed, including the filing of a lien claim under LC 4903(b) and the payment of a lien filing fee or lien activation fee, if applicable (CCR 10451.2(c)(2)).

If a non-IBR dispute is resolved in favor of the employee or the medical treatment provider, any applicable IBR procedures established by the Labor Code and the administrative regulations must be followed, except that any appeal of an IBR determination must comply with CCR 10957 (CCR 10451.2(c)(2)). The appeals board may order development of the record by IBR to determine the reasonable value of services.<sup>32</sup>

<sup>31</sup> In *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298 (appeals board *en banc*), the appeals board held that CCR 10451.2(c)(1)(C) is invalid to the extent it states that a non-IMR dispute includes whether UR was "procedurally deficient."

<sup>32</sup> *Yanez v. Specter Off-Road, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 86.

### **Limitation to Services on or After Jan. 1, 2013**

CCR 9792.5.4, which contains definitions relative to the second review and independent bill review states, “This section is applicable to medical treatment, services and goods rendered under Labor Code section 4600, or medical-legal expenses incurred under Labor Code section 4620, on or after January 1, 2013.” In addition, CCR 9792.5.7 states, “If the provider further contests the amount of payment made by the claims administrator on a bill for medical treatment services rendered on or after January 1, 2013, submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses incurred on or after January 1, 2013, submitted pursuant to Labor Code section 4622, following the second review conducted under section 9792.5.5, the provider shall request an independent bill review.”

Likewise, the Court of Appeal has held that the IBR process applies to disputes arising on or after the effective date of SB 863, and not to disputes that were pending at the time the legislation went into effect. It explained that the Legislature required conditions precedent to the availability of the IBR process (an objection and explanation of review, a request for second review and final written determination), and did not provide for an expedited or alternative process for disputed bills that were pending at the time SB 863 was enacted.<sup>33</sup> So, independent bill review is available only for services performed on or after Jan. 1, 2013.

### **Scope of Single Independent Bill Review**

A bill for medical services might be long or short. There might be one or many line items with different codes that are the subject of disagreement. There might be separate medical bills for one case from the same or different providers. Where does the administrative director draw the line on how much reviewing is done in one independent bill review?

Per CCR 9792.5.7(a)(1), independent bill review resolves only:

1. a bill for medical treatment services or goods over which there’s a dispute about the amount of payment for services or goods billed by a single provider involving one injured employee, one claims administrator and either one date of service and one billing code or one hospital stay, under the applicable fee schedule or, if applicable, under a contract for reimbursement rates under LC 5307.11 covering one range of effective dates;
2. a bill for medical-legal expenses over which there’s a dispute about the amount of payment for services billed by a single provider involving one injured employee, one claims administrator and one comprehensive, follow-up or supplemental medical-legal evaluation report as defined in CCR 9794.

The language of CCR 9792.5.7(a) would seem to limit independent bill review to one coded line per bill, per case. That would be limiting indeed! The regulations, however, describe exceptions to these rules under CCR 9792.5.12. A provider may request combining two or more requests, with a maximum of 20, for independent bill review for the purpose of rendering a single determination for more than one dispute (CCR 9792.5.12(a)).

In this way, presumably, the provider will save money on fees for IBR. When a request for IBR is made, a fee must be paid. So parties will want to avoid multiple requests and multiple fees.

Note that the regulation does not clarify whether multiple fees are to be paid if combining is requested, or whether there is the possibility of a refund of one or more fees if they are paid up front and combining follows. There might be situations in which multiple bills are sent to the administrative director in one request for IBR, along with a request that they be combined. In that case there would be one fee. But with

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<sup>33</sup> *CIGA v. WCAB* (2014) 79 CCC 1481.

the reality of continuing medical care one can envision situations in which one request for IBR asks for combining with past or future requests. CCR 9792.5.7(d)(1)(A) says that “payment of the required fee of \$335.00 shall be made at the time the request is submitted.” Perhaps if the request to combine multiple requests for IBR is granted, there could be a refund — but there is no explicit provision for that in the regulation.

Under what circumstances may combining requests for IBR happen? CCR 9792.5.12(c) provides that two or more requests, with a maximum of 20, for independent bill review by a single provider may be consolidated if the administrative director or the independent bill review organization (IBRO) determines that the requests involve common issues of law and fact or the delivery of similar or related services. “Common issues of law and fact” means the denial or reduction of the amount of payment in each request was made for similar reasons and arose from a similar fact pattern material to the reason for the denial or reduction. “Delivery of similar or related services” means like or coordinated medical treatment services or items provided to one or more injured employees (CCR 9792.5.12(b)(2)).

More specifically, CCR 9792.5.12(c)(1)(2) directs that requests may be combined if there is just one date of service, or if there are multiple dates of service but the dispute is just about one billing code, as long as the parties are the same. These are confined circumstances and the regulation appears to limit combining requests for IBR to these particular situations.

Requests for independent bill review by a single provider involving multiple dates of medical treatment services may be consolidated and treated as one single independent bill review request if the requests involve one injured employee, one claims administrator and one billing code under an applicable fee schedule or, if applicable, under a contract for reimbursement rates under LC 5307.11, and the total amount in dispute does not exceed \$4,000 (CCR 9792.5.12(c)(1)). So a provider may request consolidation if the same service involving the same billing code was performed over multiple days, as long as the total amount in dispute does not exceed \$4,000. Because the regulations use the term “total amount in dispute,” it might be permissible to submit a bill totaling more than \$4,000 if the employer made some payments to bring the disputed amount below \$4,000.

Requests for independent bill review by a single provider involving multiple billing codes may be consolidated with no limit on the total dollar amount in dispute and treated as one request if it involves one injured employee, one claims administrator and one date of medical treatment service (CCR 9792.5.12(c)(2)). So if an independent bill review is requested for multiple billing codes, it must relate to a single date of service.

After consultation with the administrative director, the IBRO may allow the consolidation of requests for independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Requests to be consolidated must involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service and aggregated amounts in dispute as high as \$4,000 or individual amounts in dispute less than \$50.00 each (CCR 9792.5.12(c)(3)).

If the IBRO determines that a single request does not meet the standards for consolidation, it will notify the provider who then must submit any additional fees necessary to conduct independent bill review.

### **Scope of Review in Cases Involving Contract for Reimbursement**

LC 5307.11 allows a health-care provider and an employer to contract for reimbursement rates different from those in the fee schedule adopted and revised per LC 5307.1. When there is a contract for different

reimbursement rates, the employer or insurer must pay at the agreed rates. This is discussed in depth in section “Sullivan on Comp” 7.79 Official Medical Fee Schedule. Because the independent bill reviewer normally uses the fee schedule to determine value of services, can independent bill review be used when there is a contract for reimbursement under LC 5307.11? The answer is yes.

As outlined above, CCR 9792.5.7(a) generally limits an independent bill review in cases involving a contract for reimbursement to the same conditions as those allowed under the fee schedule; that is, the bill must be from a single provider involving one injured employee, one claims administrator, one date of service and one billing code unless an exception applies. Review under a contract for reimbursement under LC 5307.11, however, must cover “one range of effective dates.” Obviously, that term will have to be defined at law.

CCR 9792.5.7(b), however, provides that any issue regarding the “applicability of a contract for reimbursement rates under Labor Code 5307.11 shall be resolved before seeking independent bill review.” This probably means that parties must agree that a contract for reimbursement applies, or the appeals board must decide that a contract applies before the independent bill review determines the value under the agreement.

### **Scope of Review for Services Not Covered by Fee Schedule or Contract**

Per CCR 9792.5.7(b)(1)(2), issues that are not eligible for independent bill review include:

1. the determination of a reasonable fee for services if that category of services is not covered by a fee schedule adopted by the administrative director or a contract for reimbursement rates under LC 5307.11;
2. the proper selection of an analogous code or formula based on a fee schedule adopted by the administrative director, or, if applicable, a contract for reimbursement rates under LC 5307.11, unless the fee schedule or contract allows for such analogous coding.

These regulations except from IBR cases in which there is no OMFS or contract to apply. As discussed in section “Sullivan on Comp” 7.81 Allowable Charges Under the Official Medical Fee Schedule, there are many instances in which there is no official fee that applies to a particular service. In these instances, other methods of determining the value of services are used, such as Medicare’s payment schedule.

### **INDEPENDENT BILL REVIEW FEES**

LC 4603.6(c) requires the provider to pay a fee to the administrative director when seeking review. The fee is not to be excessive, but only enough to cover the reasonable estimated cost of independent bill review and administration of the review program. The statute allows the administrative director to prescribe different fees depending on the number of items in the bill or other criteria determined by regulations adopted by the director. Such regulations establishing fees have been adopted.

#### **Amount of Fee**

Per CCR 9792.5.7(d), a provider must pay \$335 when a request for independent bill review is submitted, whether by mail or electronically. But effective April 1, 2014, the fee for an IBR was reduced to \$250.<sup>34</sup> Effective Jan. 1, 2015, the fee for an IBR is \$195.<sup>35</sup> If the request is not eligible for an IBR, a portion of the fee will be reimbursed.<sup>36</sup>

<sup>34</sup> See <http://www.dir.ca.gov/DIRNews/2014/2014-47.pdf>.

<sup>35</sup> See <http://www.dir.ca.gov/DIRNews/2015/2015-16.pdf>.

<sup>36</sup> Before April 1, 2014, the fee for a terminated IBR not set for review was \$65. After April 1, 2014, the fee was \$50. Effective Jan. 1, 2015, the fee for an ineligible IBR is \$47.50.

Sometimes a provider will want to consolidate a request for independent bill review with a previous one for a single determination. In that case, it seems a fee still must be sent with the original request, and the administrative director or the independent bill review organization (IBRO) will decide whether the consolidation will be allowed. In addition to including the fee, the provider must specify all of the requests for independent bill review it wants to consolidate, describing how they involve common issues of law and fact or delivery of similar or related services. Once consolidation has been granted, no other disputes may be added to the consolidated disputes (CCR 9792.5.12(d)).

In contrast, the IBRO may disaggregate into separate review requests a single request that does not meet the standards for consolidation. If requests are disaggregated, the same fee will be charged for each additional independent bill review request (CCR 9792.5.12(e)).

If an IBR request must be separated, the IBRO immediately must provide notice in writing to the provider and claims administrator stating the reasons for disaggregation, and must inform the provider of the additional fee or fees required to perform the review (CCR 9792.5.12(e)(1)). The provider must submit any additional fee or fees necessary to conduct independent bill review within 10 days following receipt of the notification. If the provider fails to pay the additional fee or fees, the request will be deemed ineligible (CCR 9792.5.12(e)(2)).

Obviously, disagreements will occur and fights will ensue. But it is clear that delays caused by any fee issue will not extend the time for issuing a determination by the IBRO (CCR 9792.5.12(f)).

### **Reimbursement of Fees**

If additional payment is found owing from the employer to the medical provider, the employer must reimburse the provider for the fee in addition to the amount owed. This deters the employer from disputing the bill. So both parties are invested in the outcome before they start the process.

The fee structure in LC 4603.6(c) is of an “all or nothing” nature. If, for example, a provider seeks an additional payment of \$10,000 through the independent review process, and a finding is issued allowing an additional payment of only 25 cents, the employer is penalized and must reimburse the provider the full cost of the independent review because an additional payment is due the provider. The only way an employer may escape reimbursement for the cost of the independent review is when the provider is entitled to no additional payment.

Employers might find the fee unfair. But remember, the medical provider must front the costs of the independent bill review fee, and would lose the entire fee if the reviewer determines that the appropriate bill was paid. So both employers and medical providers should attempt to determine the reasonable value of services as accurately as possible — or resolve the issues before going forward.

### **TIME LIMITS FOR REQUESTING INDEPENDENT BILL REVIEW**

Generally, IBR must be requested within 30 days of the rejection of a provider’s second review. If there is a threshold issue (such as whether there actually was an injury on the job), there is a delay until it is resolved. Failure to request IBR in a timely manner generally means that the provider has lost the right to pursue its billing dispute further.

## Time Limits from Second Review

Per LC 4603.6(a), “If the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the [employer’s] second review.” So the provider has 30 days from the rejection of its second review request to seek IBR. As noted below, if the request is not made timely the bill is deemed satisfied.

What, exactly, constitutes service of the employer’s second review? Per CCR 9792.5.7(c), the time for independent bill review must be made within 30 calendar days of:

1. the date of service of the final written determination issued by the employer under CCR 9792.5.5(f) (the response to a request for second review), if a proof of service accompanies the final written determination;
2. the date of receipt of the final written determination by the provider, if a proof of service does not accompany the final written determination and the claims administrator has documentation of receipt;
3. the date that is five calendar days after the date of the U.S. postmark stamped on the envelope in which the final written determination was mailed if the final written determination is sent by mail and there is no proof of service or documentation of receipt;
4. the date of resolution in favor of the provider of any issue of contested liability;
5. the date of service of an order of the appeals board resolving in favor of the provider any threshold issue that would have precluded a provider’s right to receive compensation for medical treatment services per LC 4600 or for medical-legal expenses defined in LC 4620.

So CCR 9792.5.7(c) gives the employer the potential to shorten a provider’s time limit by issuing a proof of service with the final written determination. If it is so issued, the provider has 30 days from the date of service to submit a request for independent bill review. If no proof of service is issued, the provider has 30 days from the date it receives the final written determination, or five days from the date of the postmark.

## Delay Due to Threshold Issues

An exception to the 30-day requirement occurs if there is a threshold issue, which puts IBR on hold until it is resolved. LC 4603.6(a) states that “If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622.”

What sort of threshold issues might this mean? “Contested liability” is defined by CCR 9792.5.4(d) as “the existence of a good-faith issue which, if resolved against the injured worker, would defeat the right to any workers’ compensation benefits or the existence of a good-faith issue that would defeat a provider’s right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 4620.” So a list of possible threshold issues might include injury, denied body parts, affirmative defenses to injury or body parts (such as LC 3208.3 for psyche claims), or disputes over entitlement to treat outside a medical provider network. Medical-legal expense threshold issues might include the timeliness of reports or whether the report constitutes evidence that is substantial enough to be used in court.

CCR 9792.5.7(c) also clarifies that if the employer has contested liability for any issue other than the reasonable amount payable for services, the provider must request an independent bill review within 30

days of the date of resolution in favor of the provider of any issue of contested liability, or the date of service of an order of the appeals board resolving any threshold issue in favor of the provider. The regulation does not explain what happens if the employer appeals an order and prevails. It would seem, though, that the time limits run from the date of the order regardless of whether there is an appeal.

### **Consequences of Failure to Timely Request IBR**

LC 4603.6(a) expressly provides that if the only dispute is the amount of payment and the provider fails to request an independent bill review within 30 days, “the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment.” So a failure to request IBR ends the provider’s right to pursue the billing any further.

What about cases in which there is a threshold issue that delays the use of IBR? Suppose the employer has contested liability for an issue other than the reasonable amount payable for services. The threshold issue resolves in favor of the provider. Then the provider is supposed to request an independent bill review within 30 days following an order resolving the threshold issue in favor of him or her. There is no statutory language for these cases that would deem the bill satisfied. Presumably, however, the provider would be barred from requesting an IBR because CCR 9792.5.7(c) mandates that a request *must* be made within 30 days. This is an issue that will have to be decided in the courts.

### **FORM FOR REQUESTING INDEPENDENT BILL REVIEW**

LC 4603.6(b) requires that a request for independent review be made on a form prescribed by the administrative director. Per CCR 9792.5.7(d), a request for independent bill review may be made by:

1. completing and electronically submitting the online request for independent bill review form, which can be accessed at the DWC website at <http://www.dir.ca.gov/dwc/IBR.htm>; or
2. mailing the request for independent bill review form DWC IBR-1. It may be obtained at <http://www.dir.ca.gov/dwc/forms.html>.

The request must be accompanied by the \$335 fee whether submitted electronically or by mail. Per CCR 9792.5.7(d), the request also must include:

1. copies of the original billing itemization;
2. any supporting documents that were furnished with the original billing;
3. if applicable, the relevant contract provisions for reimbursement rates under LC 5307.11;
4. the explanation of review;
5. the request for second review;
6. any supporting documentation submitted with the request for second review; and
7. the final explanation of the second review.

Note that LC 4603.6(b) states in pertinent part, “Only the request form and the proof of payment of the fee... shall be filed with the administrative director. Upon assignment of the independent bill reviewer, the requesting party shall submit the documents listed in this subdivision to the independent bill reviewer within 10 days.” So under the statute, only the request form and the proof of payment of the fee must be filed with the administrative director, and the remainder of the documents must be submitted to the independent bill reviewer after assignment.

But, in an apparent departure from the statute, CCR 9792.5.7(f) requires the provider to include with the request form the documents in question. Regulations that contradict a statute are not valid, but in an excess



of caution, providers would do well to submit all of the required documents with any request for independent bill review.

In addition, the provider must serve a copy of the request and the supporting documents on the claims administrator. Duplicate service is not required; any document that was provided previously to the employer or that originated with the employer need not be served if a written description of it with its date is served (CCR 9792.5.7(f)).

## **INDEPENDENT BILL REVIEW — PROCESS**

If a timely request for independent bill review is completed, the administrative director must determine whether it is eligible for review. If the request is eligible for review, it must be forwarded to an independent bill review organization, which must assign a reviewer. The reviewer may request additional records from the parties, but must rely on specified standards in determining whether the employer owes additional money.

### **Initial Review and Assignment**

Per LC 4603.6(d), on receipt of a request for independent bill review and the required fee, the administrative director or his or her designee must assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the reviewer assigned. There are no secret identities here as there are with independent medical review.

Per CCR 9792.5.9(a), however, before assigning the independent bill reviewer, the administrative director is required to conduct a preliminary review to determine whether the request is eligible for review. In making this determination, the administrative director must consider:

1. the timeliness and completeness of the request;
2. the date the medical treatment services or goods were rendered or the medical-legal expenses incurred;
3. whether the second request for review of the bill under CCR 9792.5.5 was timely made by the provider;
4. whether the second review of the bill under CCR 9792.5.5 was timely completed by the claims administrator;
5. whether, regarding a bill for medical treatment services, the medical treatment was authorized by the claims administrator under LC 4610;
6. if the required fee for the review was paid;
7. any previous or duplicate requests for independent bill review of the bill for medical treatment services or medical-legal expenses;
8. if the dispute between the provider and the claims administrator is ineligible under CCR 9792.5.7(b) or contains any other issue than the amount of payment of the bill.

### **Initial Determination of Eligibility**

If the request appears to be eligible for review, within 15 days of the determination the administrative director must notify the provider and the claims administrator by the most efficient means that request for independent bill review has been submitted for assignment to an IBRO (CCR 9792.5.9(b)). The notification must contain:

1. an independent bill review case or identification number;

2. the date the request for IBR was received;
3. a statement that the claims administrator may dispute both eligibility of the request for IBR and the provider's reasoning for requesting it with supporting documents that must be received within 15 calendar days of the date on the notification if it was provided by mail, or within 12 calendar days of the date on the notification if it was provided electronically.

The third requirement gives the employer a chance to make the case that the request is not eligible for review. If the employer has submitted a statement with supporting documents, or after the time for doing so has expired, the administrative director will conduct a further review in order to make a determination about the request's eligibility for independent bill review (CCR 9792.5.9(d)).

Any document filed with the administrative director must be served concurrently on the provider. But any document that was provided previously to the provider, or originated from the provider, need not be served if a written description of it and its date is served (CCR 9792.5.9(c)).

### **Request Eligible for Review**

If the administrative director determines that the request is eligible for independent bill review, the request will be assigned to an IBRO (CCR 9792.5.9(e)). On assignment, the IBRO must notify the parties in writing that the request has been assigned. The notification must contain:

1. the name and address of the IBRO;
2. an independent bill review case or identification number;
3. identification of the claim and disputed amount of payment made by the claims administrator on a bill for medical treatment services submitted per LC 4603.2 or LC 4603.4, or bill for medical-legal expenses submitted per LC 4622.

After the assignment to the IBRO, it must assign an independent bill reviewer immediately who has no material professional, familial or financial affiliation with any of the individuals, institutions, facilities, services or products as described in LC 139.5(c)(2) to review and resolve the dispute (CCR 9792.5.9(f)). If it is determined that the assigned bill reviewer has a prohibited interest, the IBRO must reassign the matter to a different reviewer (CCR 9792.5.9(g)). On reassignment, the IBRO immediately must notify the administrative director, the provider and claims administrator of the reassignment to a different reviewer (CCR 9792.5.9(h)).

### **Request Ineligible for Review**

If the administrative director finds that the request is ineligible for independent bill review, he or she must issue a written determination so informing the provider and claims administrator and the reasons why. The determination must be issued within 15 days following receipt of the documents or after the time period for submitting them has expired (CCR 9792.5.9(e)).

If the request is deemed ineligible, the provider will be reimbursed \$270 — not the full \$335 (CCR 9792.5.9(e)(1)). The provider or the claims administrator may appeal an eligibility determination by filing a petition with appeals board and serving a copy on all interested parties, including the administrative director. The petition must be filed within 30 days of receipt of the determination (CCR 9792.5.9(e)(2)).

## Review and Request for Additional Records

Under LC 4603.6(e), the independent bill reviewer must review the materials submitted by the parties, make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination. As seen in the previous section, on application for IBR, the provider is obligated to supply just about every conceivable relevant document to the IBRO, so there probably is no need for further documentation in almost all cases.

With that said, it is notable that the defense is not allowed to send any “additional documents” to the IBRO except on request. In fact, except for documents requested by the reviewer under CCR 9792.5.10 or CCR 9792.5.12 (which relates to consolidation), neither the provider nor claims administrator may file any additional documents with the independent bill reviewer (CCR 9792.5.10(c)).

It is clear that the reviewer may decide that it needs more documentation and request it. LC 4603.6(e) states that if necessary, the independent bill reviewer may request additional documents from the medical provider or employer, and clarifies that in these situations the employer has no independent obligation to serve medical reports on the provider unless they are requested by the reviewer.

CCR 9792.5.10(a) contains similar language but requires the independent bill reviewer to contact the claims administrator *and* the provider to request the information. It also requires the request to be *in writing*. So although the independent bill reviewer may request information from either the medical provider or the employer, both must be notified of the request in writing.

If additional documents are requested, LC 4603.6(e) requires the parties to respond within 30 days and provide the other party with copies of any documents submitted. CCR 9792.5.10(b) provides that if information is requested from the claims administrator, the provider or both, the documents must be filed with the independent bill reviewer at the address listed in the correspondence. The documents must be received within 35 days of the request, if made by mail, or 32 days if the request is made electronically. The filing party concurrently must serve the nonfiling party with the documents requested.

## Withdrawal of Independent Bill Review

Per CCR 9792.5.11, following the submission of all required documents, the provider may withdraw a request for independent bill review before a determination is made on the amount of payment owed. The provider concurrently must provide written notice to the claims administrator. If the request is withdrawn subsequent to assignment to an IBRO, the provider will not be reimbursed the fee.

CCR 9792.5.11 provides that if the request is withdrawn before assignment to an IBRO for an independent bill review, the provider will be reimbursed \$270 from the fee provided with the request. But effective April 1, 2014, the fee for an IBR was reduced to \$250.<sup>37</sup> The fee for a terminated IBR is \$50, so \$200 will be reimbursed.

## Independent Bill Review Standards

CCR 9792.5.13 outlines the standards to be used by the independent bill reviewer. If the request for IBR involves the application of the Official Medical Fee Schedule (OMFS) for the payment of medical treatment services or goods as defined in LC 4600, the reviewer must apply the provisions of CCR 9789.10 to CCR 9789.111, which relate to the OMFS, to determine the additional amounts, if any, to be paid to the provider (CCR 9792.5.13(a)).

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<sup>37</sup> See <http://www.dir.ca.gov/DIRNews/2014/2014-47.pdf>.

If the request involves the application of a contract for reimbursement rates under LC 5307.11 for the payment of medical treatment services, the reviewer must apply the contract to determine the additional amounts, if any, to be paid to the provider (CCR 9792.5.13(b)). CCR 9792.5.13(b) requires a request for independent bill review to include the relevant contract provisions for reimbursement rates under LC 5307.11, if applicable. For a discussion of contracts under LC 5307.11, see [“Sullivan on Comp” Section 7.79 Official Medical Fee Schedule](#) in the subsection Contract for Reimbursement Rates Outside Fee Schedule.

If the request involves the application of the medical-legal fee schedule for services defined in LC 4620, the independent bill reviewer must apply the provisions of CCR 9793 - CCR 9795 and CCR 9795.1 - CCR 9795.4 to determine the additional amounts, if any, to be paid to the provider (CCR 9792.5.13(c)). For a discussion of the schedule, see [“Sullivan on Comp” Section 14.66 Medical-Legal Fee Schedule](#). Note that CCR 9795.1 - CCR 9795.4 relate to fees for interpreters. Those regulations are discussed in [“Sullivan on Comp” Section 15.111 Interpreters](#).

The independent bill reviewer must apply the provisions of the OMFS and, if applicable, the contract for reimbursement rates under LC 5307.11 as if the bill is being reviewed for the first time. The reviewer also must apply, as necessary, all billing, payment and coding rules (CCR 9792.5.13(d)).

## **INDEPENDENT BILL REVIEW — DETERMINATION AND APPEAL**

LC 4603.6(e) requires the independent bill reviewer to make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination within 60 days of receipt of the administrative director’s assignment. CCR 9792.5.14 adds that the written determination must be in “plain language” if any additional amount of money is owed to the provider. The determination also must state the reasons for it, and the information received and relied on by the independent bill reviewer in rendering the determination (CCR 9792.5.14(a)).

If the independent bill reviewer finds an additional amount is owed, the determination must order the claims administrator to reimburse the provider the amount of the filing fee in addition to the money owed. (CCR 9792.5.14(b)). The reviewer’s written determination must be sent to the administrative director and to both the medical provider and the employer (CCR 9792.5.14(c)).

### **Implementation of Determination**

Unless appealed, per LC 4603.6(h) and CCR 9792.5.15(a), on receiving a determination that money must be paid to the medical provider, the employer must pay per the requirements in LC 4603.2 and LC 4603.4. These sections require payments to be made within 45 days for normal requests for payment, and 15 working days for electronic receipt of an itemized billing. Per LC 4622(a), the employer must make payment for medical-legal charges within 20 days of service of the determination.

The statute presumes that it is possible for an employer only to underpay a medical bill; it provides no remedy if the independent bill reviewer determines that the employer overpaid. Because there is no statutory authority for reimbursement of the employer, the medical provider may not be required to pay the employer back for any over payments, at least as a result of the IBR process.

### **Appeal of Determination**

Per LC 4603.6(f) and CCR 9792.5.14(d), the determination of the independent bill reviewer is deemed a determination and order of the administrative director. The determination is final and binding on all parties unless an aggrieved party files with the appeals board a verified appeal from the medical bill review

determination. Per CCR 10957, an aggrieved party may appeal a decision regarding the amount payable to the provider, if any, and a decision that a dispute is not subject to independent bill review.

The appeal must be filed with the appeals board within 20 days of the service of the determination (LC 4603.6(f)). An untimely petition may be summarily dismissed (CCR 10957(b)).

## Grounds for Appeal

Per LC 4603.6(f), the independent bill review determination is presumed to be correct and may be set aside only on clear and convincing evidence of one or more of these grounds for appeal:

1. The administrative director acted without or in excess of his or her powers.
2. The determination of the administrative director was procured by fraud.
3. The independent bill reviewer was subject to a material conflict of interest in violation of LC 139.5.
4. The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability.
5. The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake is a matter of ordinary knowledge based on the information submitted for review and not a matter subject to expert opinion.

The independent bill review process is designed to be the last word on the reasonable amount for medical services. So the grounds for appeal are limited. That the decision may be set aside only on a showing of clear and convincing evidence is a higher standard than the usual preponderance of the evidence standard required in all other workers' compensation issues.

## Form of Appeal

The appeal must be in the form of a petition identified as a petition appealing the administrative director's independent bill review determination (CCR 10957(c)). Per CCR 10957(d), the caption of the petition must include the:

1. injured employee's first and last names;
2. name(s) of the defendant(s) in the IBR dispute;
3. case number assigned by the administrative director to the IBR determination; and
4. adjudication case number, if any, assigned by the appeals board to any related application for adjudication of claim(s) previously filed.

The petition must include a copy of the IBR determination and proof of service to it (CCR 10957(e)). In addition, per CCR 10957(f), the petition must:

1. be limited to raising one or more of the five grounds specified in LC 4603.6(f);
2. establish specifically and in full detail the factual and/or legal grounds on which the petitioner considers the IBR determination to be unjust or unlawful, and every issue to be considered by the appeals board (The petitioner will be deemed to have waived all objections, irregularities and illegalities concerning the IBR determination other than those established in the petition.);
3. comply with the requirements of CCR 10842(a) and (c), CCR 10846 and CCR 10852. Also, it must comply with the provisions of CCR 10845, including but not limited to the 25-page restriction. For further discussion of these requirements, see ["Sullivan on Comp" Section 16.62 Petition for Reconsideration — Form and Content.](#)

Any failure to comply with the provisions of this subdivision will constitute valid ground for summarily dismissing or denying the petition. For example, the appeals board dismissed a lien claimant's petition when it did not first file an appeal of the disputed IBR determination as required by LC 4603.6(f), and filed only a petition for reconsideration.<sup>38</sup>

In addition, it has been held that, in general, the requirements for petitions before the appeals board are all to be met. These requirements are established in CCR 10450 and explained in [“Sullivan on Comp” Section 15.7 Petitions and Answers](#). In one case, it was explained that any party wishing to appeal an IBR determination must pay careful attention to the requirements of LC 4603.6 and CCR 10957, as well as the requirements for petitions under CCR 10450 regarding verification and service. After ensuring that its petition meets all requirements, the party must file it at the district office having venue. If no WCAB adjudication case number exists, the party also must file an application for adjudication of claim.<sup>39</sup>

### Service of Petition

In addition to filing the petition with the appeals board, a copy must be served on all interested parties. Specifically, it must be served on: (1) the adverse party(ies) or provider(s) or, if represented, their attorneys or nonattorney representatives; (2) the injured employee or, if represented, the employee's attorney; and (3) the DWC Independent Bill Review Unit (IBR Unit) (CCR 10957(g)).

### Action on Filing Petition

On receiving notice of the petition, the IBR Unit may download the record of the independent bill review organization into EAMS, in whole or in part. The appeals board in its discretion, may: (1) admit all or any part of the downloaded IBR record into evidence; and/or (2) permit the parties to offer in evidence documents that are duplicates of those in the downloaded IBR record (CCR 10957(h)).

The petition will not be placed on calendar unless a declaration of readiness (DOR) is filed.<sup>40</sup> The DOR may be filed concurrently with the petition or filed subsequently. Any DOR must be served concurrently on the adverse party(ies) or provider(s), and on the IBR Unit (CCR 10957(h)).

The petition will be adjudicated by a WCJ at the trial level following the same procedures applicable to claims for ordinary benefits, including but not limited to setting a mandatory settlement conference. The IBR determination will be presumed correct and may be set aside only on proof by clear and convincing evidence of one or more of the LC 4603.6(f) statutory grounds for appeal (CCR 10957(j)).

Any party aggrieved by a final decision, order or award of the WCJ may file a petition for reconsideration within the same time and in the same manner specified for petitions for reconsideration. Also, the WCJ must prepare a report on the petition for reconsideration in accordance with CCR 10860, unless the WCJ rescinds the decision, order or award in accordance with CCR 10859 (CCR 10957(k)).

So petitions appealing an IBR to the appeals board come first, a trial is conducted and a decision issues; only later may a petition for reconsideration be filed by an aggrieved party. Accordingly, in one case, the appeals board dismissed as premature a defendant's petition for reconsideration filed directly following an independent bill review determination.<sup>41</sup>

<sup>38</sup> *Carrasco v. City of Los Angeles*, 2016 Cal. Wrk. Comp. P.D. LEXIS 225.

<sup>39</sup> *Sayed v. Giorgio Armani*, 2014 Cal. Wrk. Comp. P.D. LEXIS 543.

<sup>40</sup> *Sayed v. Giorgio Armani*, 2014 Cal. Wrk. Comp. P.D. LEXIS 543.

<sup>41</sup> *Sayed v. Giorgio Armani*, 2014 Cal. Wrk. Comp. P.D. LEXIS 543.

## **Actions on Decision by Appeals Board**

If the IBR determination is reversed by the appeals board, per LC 4603.6(g) and CCR 9792.5.15(c), the dispute must be remanded to the administrative director to submit the dispute to independent bill review by a different review organization or a different reviewer within the original review organization if a different organization is not available. In no event, however, will the appeals board or any higher court make a determination of ultimate fact contrary to the determination of the bill review organization.

If a final decision of the appeals board results in the defendant being liable for any payment to the provider, the amount for which the defendant is liable must be paid to the provider “forthwith.” The regulation does not specify a period of time for payment, but requires payment to be made immediately. If the defendant fails to pay forthwith, the provider is not required to file a lien claim and may file a petition to enforce under CCR 10451.4 (CCR 10957(m)).

## **PETITION TO ENFORCE INDEPENDENT BILL REVIEW DETERMINATION**

CCR 10451.4 allows a provider to file a petition to enforce a decision in its favor by an independent bill reviewer. The petition must be identified as a petition to enforce IBR determination (CCR 10451.4(c)). It may be filed to enforce the IBR determination and/or recover an IBR fee under LC 4603.6 if, per CCR 10451.4(a):

1. The administrative director has issued an IBR determination and order requiring payment and either:
  - A. a petition appealing this determination and order is not filed with the appeals board; or
  - B. the appeals board has issued a final order affirming this determination and order. And
2. The defendant has not paid the full amount allowed, including any penalties and interest payable under LC 4622(a) and/or any IBR fee reimbursement payable under LC 4603.6(c) within 20 days of finality of the determination and order, as extended by CCR 10507 and CCR 10508 (see [“Sullivan on Comp” Section 15.15 Service of Documents](#)).

If these conditions are met, the medical treatment or medical-legal provider is not required to file an LC 4903(b) lien or a claim of costs lien and is not required to pay a lien filing or activation fee (CCR 10451.4(b)).

The petition must attach a copy of the administrative director’s IBR determination and order requiring payment. If an appeal was filed, a copy of the appeals board’s final order affirming the determination and order must be attached (CCR 10451.4(d)). If the petition is filed by a person or entity who is not a party or lien claimant of record, the petition must be accompanied by a notice of representation, even if the petitioner is self-represented (CCR 10451.4(e)).

The petition may include a request for penalties and interest in accordance with LC 4603.2(b) and/or LC 4622(a). LC 4603.2(b) applies to medical treatment and allows a penalty of 15 percent and interest to accrue at the same rate as judgments in civil actions, retroactive to the date of receipt of the itemization (see [“Sullivan on Comp” Section 13.3 Penalties for Untimely Payment of Medical Bills](#)). LC 4622(a) applies to medical-legal expenses and allows a penalty of 10 percent plus interest at the rate of 7 percent per annum, retroactive to the date the employer received the bill and the report (see [“Sullivan on Comp” Section 14.65 Payment of or Objection to Medical-Legal Expenses](#)). For purposes of penalties and interest, a final decision of the appeals board that affirms a determination of the administrative director requiring payment will be deemed an “award” (CCR 10451.4(f)).

Within 15 days of filing the petition, the appeals board must issue a notice of intention to grant or deny it, in whole or in part. The notice must give the petitioner and any adverse party no fewer than 15 calendar days to file written objection showing good cause to the contrary. If no timely written objection is filed, or if the written objection on its face fails to show good cause, the appeals board, in its discretion, may issue an order regarding the petition to enforce, consistent with the notice of intention, or set the matter for hearing (CCR 10451.4(g)).



## 8. FEE SCHEDULE CHANGES

Generally, most services in workers' compensation are subject to a fee schedule. This is because the Legislature recognized that market pricing does not work well in workers' compensation. The injured workers receiving the services do not pay for the services; employers or insurers do. There is no market pressure for injured workers to say no to overpriced, and perhaps unnecessary, services.

The existing law established an Official Medical Fee Schedule (OMFS) in LC 5307.1. But with the growth of workers' compensation claims, the services that came with it and the expansive definitions by the courts of what constitute "medical treatment," the fee schedule did not cover all potential services available to injured workers. Furthermore, employers argued that some allowances by the fee schedule were overly generous.

With SB 863, the Legislature sought to update the fee schedule for physician services, ambulatory surgical center fees and implantable surgical hardware. It also required the administrative director to establish new fee schedules for interpreter services, vocational experts, home health-care services and copy services.

The administrative director was slow to respond to the requirements of SB 863. Although the regulations have been adopted for ambulatory surgical center fees, physician services, implantable surgical hardware and copy services, as of this writing, the other fee schedules have not been created. So the savings from the fee schedule changes made by SB 863 have not been fully realized.

### FEE SCHEDULE FOR PHYSICIAN SERVICES

Prior to SB 863, LC 5307.1 required that all fees in the adopted schedule must be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems — except for physician services. This was a big hole. So LC 5307.1 was amended to require the administrative director to adopt a fee schedule for both physician and nonphysician services.<sup>1</sup>

The term "physician" is defined under LC 3209.3 to include physicians and surgeons holding an MD or DO degree, psychologists, acupuncturists, optometrists, dentists, podiatrists and chiropractors (see ["Sullivan on Comp" Section 7.12 Treatment by Authorized Physician](#)). Nonphysician services include, but are not limited to, physician assistant, nurse practitioner and physical therapist services. In order for physician and nonphysician services to be paid, the employer's liability for medical treatment, including issues of reasonableness, necessity, frequency and duration, must be determined in accordance with LC 4600.

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<sup>1</sup> Former LC 5307.1(f) permitted the administrative director to adopt a fee schedule for physician services.

In adopting the fee schedule, the administrative director was provided these instructions:

1. The fee schedule must be updated annually to reflect changes to the procedure codes, relative weights and the adjustment factor.<sup>2</sup> Per LC 5307.1(g)(3)(D), the “relative value scale adjustment factor” means “the annual factor applied by the federal Centers for Medicare and Medicaid Services to the Medicare conversion factor to make changes in relative value units for the physician fee schedule budget neutral.”
2. The maximum reasonable fees paid must not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services as it appeared on July 1, 2012, before application of the adjustment factor.
3. Any service provided to injured workers that is not covered under Medicare shall be included in its rate of payment established by the administrative director.
4. There is a four-year transition between the estimated aggregate maximum allowable under the OMFS for physician services before Jan. 1, 2014, and the relative value scale at 120 percent of the Medicare conversion factors.
5. The fee schedule must include payment ground rules that differ from those of Medicare, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery.

Consistent with these rules, the administrative director adopted an Official Medical Fee Schedule for Physician and Non-Physician (Physician Fee Schedule). The Physician Fee Schedule is established in CCR 9789.12.1 - CCR 9789.19. It is based on the “resource-based relative value scale.”

The Physician Fee Schedule applies to goods and services rendered on or after Jan. 1, 2014. Services rendered before that date must be determined in accordance with the fee schedule in effect at the time the service was rendered. Also, the Physician Fee Schedule does not apply to services covered by a contract under LC 5307.11 (CCR 9789.12.1(a)).

The maximum fees for services of a physician or nonphysician practitioner are governed by the Physician Fee Schedule, regardless of specialty, for services performed within the scope of his or her practice or license, except that: (1) evaluation and management codes are to be used only by physicians as defined by LC 3209.3, as well as physician assistants and nurse practitioners who are acting within the scope of their practice and are under the direction of a supervising physician; and (2) osteopathic manipulation codes are to be used only by a doctor of osteopathy and medical doctors (CCR 9789.12.1(b)).

Physicians and nonphysician practitioners must use other applicable parts of the OMFS to determine maximum fees for goods or services not covered by the Physician Fee Schedule. These include pharmaceuticals, pathology and clinical laboratory, durable medical equipment, prosthetics, orthotics or supplies, except: (1) when such goods or services are bundled into the Physician Fee Schedule payment; and/or (2) as otherwise specified in the Physician Fee Schedule (CCR 9789.12.1(c)).

The Physician Fee Schedule establishes separate formulas to calculate reasonable maximum fees for services depending on whether they were performed at a facility or nonfacility site (CCR 9789.12.2). It includes instructions to bill an unlisted procedure code (CCR 9789.12.4), consultations services (CCR 9789.12.12), supplies (CCR 9789.13.1) and physician-administered drugs, biologicals, vaccines or blood products (CCR 9789.13.2). It establishes the reports that are or are not separately reimbursable (CCR 9789.13.13). It establishes rules regarding when a nonphysician practitioner’s services are incidental to a physician’s service (CCR 9789.15.2). It also establishes rules for payment of anesthetist services (CCR 9789.15.3), physical

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<sup>2</sup> Per LC 5307.1(g)(1)(A)(iii), the annual adjustment factor for physician services must be based on the product of one plus the percentage change in the Medicare Economic Index and any relative value scale adjustment factor.

medicine/chiropractic/acupuncture multiple procedure payment reduction (CCR 9789.15.4), ophthalmology multiple procedure reduction (CCR 9789.15.5) and multiple procedure payment reduction on diagnostic cardiovascular procedures (CCR 9789.15.6).

The Physician Fee Schedule establishes rules regarding billing for global surgeries (CCR 9789.16.1, CCR 9789.16.2, CCR 9789.16.3), multiple surgeries (CCR 9789.16.5) and bilateral surgeries (CCR 9789.16.6). It establishes rules of payment for multiple surgeons on a procedure (CCR 9789.16.7) and surgical assistants (CCR 9789.16.8). It also establishes rules for radiology procedures (CCR 9789.17.1 and CCR 9789.17.2) and anesthesia services (CCR 9789.18.1 - CCR 9789.18.12).

## **FEES FOR AMBULATORY SURGICAL CENTERS**

Previously, LC 5307.1(c) decreed that the maximum fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, were not to exceed 120 percent of the fees paid by Medicare for services that required comparable resources. The maximum fees for services in a hospital outpatient department were not changed by SB 863. But the maximum fees for services in an ambulatory surgical center were reduced. Now, those fees must not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

The changes were made to reflect the lower costs of performing ambulatory surgery in a freestanding surgical center. Ambulatory surgical centers can perform procedures more efficiently because they have lower infrastructure costs and concentrate on a narrower range of procedures than hospitals.

Regulations regarding the fees for services performed in an ambulatory surgical center are established in CCR 9789.30 - CCR 9789.39. The regulations were amended effective Sept. 1, 2014, so that fee allowances paid under the pre-2014 OMFS can transition to the new Resource-Based Relative Value Scale (RBRVS) physician fee schedule.

The WCIRB reports that after the implementation of SB 863, the average reimbursement to ambulatory surgical center was reduced by 21 percent. It found no significant shift from ambulatory surgical centers to outpatient hospital facilities occurred. It also found that the relative cost per outpatient hospital episode compared to the average ambulatory surgical center cost has increased significantly, and so outpatient hospitals represent a larger share of the total paid amounts after Jan. 1, 2013.<sup>3</sup>

## **FEES FOR IMPLANTABLE MEDICAL DEVICES**

In 2003, the Legislature enacted former LC 5318, which required separate reimbursement for implantable hardware for specific spinal surgery DRGs (diagnostic-related group) based on the provider's documented paid cost plus 10 percent.<sup>4</sup> Although LC 5318 was operative only until the administrative director adopted a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries, this payment methodology was adopted in former CCR 9789.22(f).

So duplicate reimbursement for spinal implants was available in California workers' compensation, even though Medicare does not support an additional surgical hardware pass-through payment for back

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<sup>3</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 14.

<sup>4</sup> Former LC 5318 stated, "Implantable medical devices, hardware and instrumentation for Diagnostic Related Groups (DRGs) 004, 496, 497, 498, 519 and 520 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10 percent of the provider's documented paid cost, not to exceed a maximum of two hundred fifty dollars (\$250), plus any sales tax and shipping and handling charges actually paid."

surgeries.<sup>5</sup> Because Medicare's reimbursement accounts for the implantable hardware, the 120 percent reimbursement along with the added payment for implantable hardware created a potential incentive to perform spinal surgeries with high-cost surgical instrumentation.<sup>6</sup> The California Workers' Compensation Institute estimated that in 2010, the duplicate payment for spinal instrumentation added approximately \$20,137 to each surgical procedure.<sup>7</sup>

So effective Jan. 1, 2013, SB 863 repealed LC 5318. It added LC 5307.1(m), which required the administrative director, on or before July 1, 2013, to adopt a regulation specifying an additional reimbursement for Medicare Severity Diagnostic Related Groups (MS-DRGs) 028, 029, 030, 453, 454, 455 and 456 to ensure that the aggregate reimbursement is sufficient to cover costs, including the implantable medical device, hardware and instrumentation. So although certain spinal procedures were entitled to an additional reimbursement, the added reimbursement was specified, rather than based on the provider's documented paid cost. This creates a disincentive to use the most expensive hardware for the surgery. Moreover, the statute specified that the regulation must be repealed as of Jan. 1, 2014, unless extended by the administrative director.

The administrative director adopted new regulations. Per CCR 9789.22(g)(2), for discharges occurring on or after Jan. 1, 2013, but before Jan. 1, 2014, an additional \$9,140 was allowed for spinal devices used during complex spinal surgery MS-DRGs 453, 454 and 455, and an additional allowance of \$3,170 was made for spinal devices used during complex spinal surgery MS-DRG 456. Also, there was an allowance of \$670 for spinal devices used during complex spinal surgery MS-DRGs 028, 029 and 030. But CCR 9789.22(g)(3) directs that for discharges occurring on or after Jan. 1, 2014, complex spinal surgery DRGs shall not receive additional or separate reimbursement for spinal devices, unless the administrative director extends CCR 9789.22(g)(2).

The WCIRB reports that as a result of SB 863, the average cost of these procedures was reduced by 28 percent, or \$26,000 per episode. It also reports that utilization of these types of procedures has decreased by more than 40 percent.<sup>8</sup>

The appeals board also has responded negatively to known fraud regarding spinal surgery implants. In one case, in light of the admitted fraudulent activities of Michael Drobot, owner of Pacific Hospital of Long Beach, the appeals board disallowed a lien for surgical hardware when it was invoiced after surgery, and there was no evidence that it actually was used during the procedure. Furthermore, because the lien did not originate from the hospital, the appeals board determined that there could be no liability under CCR 9789.22(d).<sup>9</sup> For further discussion on the Legislature's efforts to limit fraudulent activity, see Chapter XIV: Anti-Fraud Efforts.

## FEE SCHEDULE FOR COPY SERVICES

Costs for the photocopying of medical records may be included as a medical-legal expense. But costs for the photocopying of medical records also may be considered litigation costs (see [“Sullivan on Comp” Section 15.110 Litigation Costs](#)). Previously, there was no fee schedule for such services, and it was up to copy enterprises to prove the reasonable value of their services.<sup>10</sup>

<sup>5</sup> Swedlow, Alex and Ireland, John, "Preliminary Estimate of California Workers' Compensation-System Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries," California Workers' Compensation Institute, June 2012, p. 2.

<sup>6</sup> Swedlow, Alex and Ireland, John, "Preliminary Estimate of California Workers' Compensation-System Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries," California Workers' Compensation Institute, June 2012, p. 5.

<sup>7</sup> Swedlow, Alex and Ireland, John, "Preliminary Estimate of California Workers' Compensation-System Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries," California Workers' Compensation Institute, June 2012, p. 5.

<sup>8</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 13.

<sup>9</sup> *Olivas v. North American Plywood Corp.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 270.

<sup>10</sup> See *Vela v. Service Master CBM* (2008) GOL 0099195 (panel decision); *Sweet v. Santa Maria Joint UHSD* (2007) GOL 0098326 (panel decision); *Reale v. Casa Dorinda* (2008) GOL 0097704 (panel decision); *Taylor v. WCAB* (1998) 63 CCC 350 (writ denied); *Jarostchuk v. San Francisco 49ers*, 2014 Cal. Wrk. Comp. P.D. LEXIS 152.

SB 863 added LC 5307.9 requiring the administrative director to establish a schedule of maximum allowable fees for copy and related services. Regulations establishing the fee schedule were adopted in CCR 9980 et seq, and became effective July 1, 2015.

Under CCR 9980(b), “copy and related services” are defined as “all services and expenses that are related to the retrieval and copying of documents that are responsive to a duly issued subpoena or authorization to release documents for a workers’ compensation claim.” Per LC 5307.9, the fee schedule applies to all copy and related services regardless of whether the costs are claimed under the authority of LC 4600 (medical treatment), LC 4620 (medical-legal) or LC 5811 (costs). The statute, however, allows the employer and the copy service provider to contract for costs outside the fee schedule (CCR 9982(a)).

## **Bills for Copy Services**

LC 5307.9 demands a fee schedule that requires “specificity in billing.” Accordingly, per CCR 9981, bills for copy services provided on or after the effective date of the copy service fee schedule, regardless of the date of injury, must comply with certain requirements.

Bills for copy services must include: the services provided; the provider tax identification number and professional photocopier registration number; county of registration; date of billing; case information including employee name; claim number; case number (if applicable); source information including type of records; date of service; description of services; and the number of pages produced (CCR 9981(b)).

According to the regulations: “Bills for records may include billing codes. WC 020 is for Flat Fee of \$180, WC 021 is for Cancelled Service of \$75, WC 022 is for Certificate of No Record of \$75, WC 023 is for Per Page Fee of .10 per page, WC 024 is for records from the Employment Development Department (EDD) of \$20, WC 025 is for records from the Workers’ Compensation Insurance Rating Bureau of \$30, WC 026 is for an Additional Electronic Set of \$5, WC 027 is for an Additional Electronic Set of \$30, WC 028 is for Duplication of X-Ray or scan of \$10.26, WC 029 is for CD of X-rays and scans of \$3,” (CCR 9981(b)(1)). These codes correspond with the allowable charges for copy services as discussed below.

Each bill for services must include a statement that there was no violation of LC 139.32 with respect to the services described (see [“Sullivan on Comp” Section 3.68 Illegal Referrals](#)) (CCR 9981(b)(2)).

## **Allowable Services**

In creating the fee schedule, LC 5307.9 provides that it “shall not allow for payment for services provided within 30 days of a request by an injured worker or his or her authorized representative to an employer, claims administrator, or workers’ compensation insurer for copies of records in the employer’s, claims administrator’s, or workers’ compensation insurer’s possession that are relevant to the employee’s claim.” That is, the defendant is not liable for the services if the records are in its possession, and it is not given 30 days to produce them. The statute recognizes that duplicate records are not payable because it would not be fair for defendants to have to pay for duplicate records requested by both defendants and injured workers.

CCR 9982(b), however, provides that if the defendant fails to serve records in its possession requested by an injured worker or his or her representative within the 30-day time frame or fails to serve a copy of any subsequently received medical report or medical-legal report within the time frames defined in CCR 10608, the copy service fee schedule applies to obtaining those records. CCR 9982(c) also states that if the claims

administrator fails to provide written notice per LC 4055.2<sup>11</sup> to the injured worker of records sought by subpoena, the fee schedule applies to obtaining them.

According to CCR 9982(d), there will be no payment for copy and related services that are:

1. provided within 30 days of a written request by an injured worker or his or her authorized representative to a defendant for copies of records in the defendant's possession that are relevant to the employee's claim; or
2. provided by any person or entity that is not a registered professional photocopier.

CCR 9982(e) also states that a defendant is not liable for payment of:

1. records previously obtained by subpoena or authorization by the same party and served from the same source, unless the subpoena or authorization is accompanied by a declaration from the party requesting the records defining good cause to seek duplicate records;<sup>12</sup>
2. summaries, tabulations or for indexing of documents; or
3. subpoenaed records obtainable from the Workers' Compensation Insurance Rating Bureau (WCIRB), and the Employment Development Department (EDD) that can be obtained without a subpoena at lower cost.

Records from the WCIRB and the EDD were excluded from payment because it was believed that copies of such records were not needed often and could be obtained at less cost than through a copy service. These entities also objected to being needlessly inundated with requests for records from copy services. So, as outlined below, fees for copies from these entities are much lower.

### **Fees for Copy and Related Services**

CCR 9983 establishes the reasonable maximum fees, not including sales tax, payable for copy and related services. They are:

1. a flat fee of \$180 for a set of records of as many as 500 pages from a single custodian of records, which includes, but is not limited to, mileage, postage, pick up and delivery, phone calls, repeat visits to the record source and records locators, page numbering, witness fees for delivery of records, check fees, fees for release of information services, service of the subpoena, shipping and handling and subpoena preparation;
2. \$75 in the event of cancellation after a subpoena or request for records by authorization has been issued but before records are produced;
3. \$75 for a certificate of no records;
4. \$20 for records obtained from the EDD; and
5. \$30 for records obtained from the WCIRB.

In addition to the flat fee, these separate fees apply:

1. 10 cents per page for copies in excess of 500 pages;
2. \$5 for each additional set of records in electronic form ordered within 30 days of the subpoena, or \$30 if ordered after 30 days and the copy is retained by the registered photocopier (If the injured worker requests an additional set of records in electronic form ordered within 30 days of the

<sup>11</sup> LC 4055.2 states, "Any party who subpoenas records in any proceeding under this division shall concurrent with service of the subpoena upon the person who has possession of the records, send a copy of the subpoena to all parties of record in the proceedings."

<sup>12</sup> Good cause includes new counsel seeking duplicate records for review, and loss or destruction of records due to natural disaster.

subpoena, the claims administrator is liable for one additional set in electronic form for no more than \$5 if ordered within 30 days and for no more than \$30 if ordered after 30 days and the copy is retained by the registered photocopier. All other additional sets of records are payable by the party ordering the additional set.); and

3. \$10.26 per sheet of X-rays and scans, and \$3 per CD of X-rays and scans.

Per CCR 9983(e), release of information services of witness costs for the retrieval and return of physical records held off-site by a third party are included in the flat fee. It further provides that disputes over production of records may be resolved by filing a petition with the appeals board or by filing a petition with the Superior Court, per LC 132. As discussed in [“Sullivan on Comp” Section 14.10 Subpoena and Subpoena Duces Tecum](#), LC 132 allows a Superior Court to issue an order compelling witnesses to attend and testify or produce the papers before the appeals board, although as a practical matter, that court almost never becomes involved in these disputes. Release of information services of witness costs for retrieval and return of physical records held off-site by a third party are governed by Evidence Code 1563.

## **Fees Charged by DWC**

Fees charged by the DWC are not part of the copy service fee schedule. CCR 9990 establishes the fees that will be charged by the DWC for copies of records or documents. The charges apply to any records or documents, in whatever form, produced by the DWC. Fees charged and collected by the DWC are:

1. For copies of papers, records or documents, not certified or otherwise authenticated, \$1 for the first copy and 20 cents for each additional copy of the same page, except to the injured worker to whom the fee will be 10 cents per page. State sales tax and postage will be added to this fee.
2. For certification of copies of official records or documents and orders of evidence taken or proceedings conducted, \$10 for each certification.
3. For paper transcripts of any proceeding of record, \$100 for 33 pages or fewer. For transcripts longer than 33 pages, \$3 is charged for each additional page, and \$1.50 per page for each page of additional copies of the transcript. The fees must be paid before the transcripts are released. Sales tax and postage will be added to this fee. Transcripts delivered on a medium other than paper are charged at the same rate for paper transcripts, with an additional fee to cover the cost of the medium and any copies of it.
4. For inspection of a case file not stored in the place where the inspection is requested, \$10 plus postage or other delivery costs, except when requested by an injured employee or his or her attorney or his or her representative of record.
5. For electronic records maintained by the division:
  - Listing of WCAB new case filings is \$85 per complete download for WCAB new case opening records transmitted to the requester by direct electronic download. Paper copies of these records provided in addition to the electronic data will be subject to a separate charge of 10 cents per page, plus postage.
  - Electronic response to an electronic inquiry concerning a case’s status, a lien’s status or other case-specific information available in electronic form, through EDEX, 20 cents per transaction.
  - The DWC will provide electronic copies of WCAB new case opening records or EDEX access only pursuant to a written agreement with the administrative director.
  - Copies of existing electronic records, other than those enumerated above, that constitute disclosable public records, will be provided as required by law for the DWC’s actual costs of retrieving and transmitting the data, including staff research, downloading redaction and transfer to storage media time, programming and processing time, storage media, postage or shipping costs and sales tax. All staff research, downloading redaction and

transfer, programming and processing time required to create new data sorts of existing electronically maintained records will be charged at the DWC's standard rate of \$85 per hour, billed in 15-minute increments.

Per CCR 9991, fees must be paid either in cash or by check or money order made payable to the Division of Workers' Compensation, except as otherwise provided in the establishment of payment accounts.

## FEE SCHEDULE FOR HOME HEALTH CARE

LC 4600(h) provides that home health-care services are subject to LC 5307.1 or LC 5307.8. The former pertains to the Official Medical Fee Schedule (OMFS) and the latter is a statute as of 2013 requiring the administrative director to adopt a schedule for payment of home health services not covered by the OMFS. The home health-care services schedule (which was supposed to have been adopted on or before July 1, 2013, but wasn't), must define the maximum hours and fees for that care.

The schedule must be based on the regulations adopted "pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code." Nevertheless, in *Neri Hernandez*,<sup>13</sup> the appeals board concluded that neither the provisions of Welfare and Institutions Code 12300 et seq nor the IHSS regulations govern home health-care services under LC 4600(h).<sup>14</sup>

Generally, whether treatment is medically necessary must be determined by the utilization review process, and the Medical Treatment Utilization Schedule (MTUS) is presumptively correct on issues regarding the reasonableness and necessity of medical treatment (see ["Sullivan on Comp" Section 7.31 Utilization Review — Medical Treatment Utilization Schedule](#)). The chronic pain medical treatment guidelines, which have been incorporated into the MTUS, clarify that home health care is recommended only for patients who are homebound, and only on a part-time or "intermittent" basis. The guidelines limit services to no more than 35 hours per week, and do not include homemaker services such as shopping, cleaning and laundry.<sup>15</sup> It remains to be seen whether these limits will be included in the home health-care services fee schedule.

The DWC contracted with the RAND Corp. to provide a study and recommendations for a home health care fee schedule.<sup>16</sup> It has also posted draft regulations on the DWC rule-making page. In July 2016, the Department of Industrial Relations indicated that the home health care and interpreter fee schedules should be completed by the end of 2016.<sup>17</sup> This timeline, however, was not met.

Because a fee schedule has not been adopted, an injured worker continues to bear the burden to demonstrate, based on substantial evidence, a reasonable hourly rate for the type of services provided and the number of reasonably required hours. Home health care is further discussed in ["Sullivan on Comp" Section 7.4 Home Health Care and the Official Medical Fee Schedule](#) is discussed further in ["Sullivan on Comp" Section 7.79 Official Medical Fee Schedule](#).

## FEE SCHEDULE FOR INTERPRETERS

SB 863 changed several provisions requiring interpreters to be paid pursuant to the fee schedule adopted by the administrative director. Currently, a limited fee schedule in CCR 9795.3(b) sets the amount for an appeals

<sup>13</sup> (2014) 79 CCC 682, 694 (appeals board *en banc*).

<sup>14</sup> Welfare and Institutions Code 12303.4 generally limits services to 195 hours per month, but allows for 283 hours per month if someone requires in-home supportive care for at least 20 hours for bowel and bladder care, dressing, oral hygiene, grooming, food preparation, moving out of bed, bathing or ambulation.

<sup>15</sup> For a copy of the chronic pain medical treatment guidelines, see

[http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS\\_Regulations/MTUS\\_ChronicPainMedicalTreatmentGuidelines.pdf](http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_ChronicPainMedicalTreatmentGuidelines.pdf).

<sup>16</sup> The study is available at: <https://www.dir.ca.gov/dwc/Reports/HomeHealthCareCAIW.pdf>.

<sup>17</sup> Department of Industrial Relations, SB 863: Assessment of Workers' Compensation Reports (July 2016), at p. 24.



board hearing, arbitration or deposition at the greater of a half or full day at the Superior Court rate or market rate. For all other events, the fee is \$11.25 per quarter hour with a two-hour minimum, or market rate, if it's greater. This is discussed in [“Sullivan on Comp” Section 15.111 Interpreters](#).

DWC is working on a new fee schedule for interpreters. It believes that 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.<sup>18</sup> In April 2015, the DWC posted draft regulations for the interpreter fee schedule to its online forum. It expected the interpreter fee schedule to be completed in 2016, but missed this goal. It seems that the fee schedule will be established soon.

## **FEE SCHEDULE FOR VOCATIONAL EXPERTS**

Although nonmedical vocational expert witness fees are reimbursable, for a long time there was no standard on how much these experts should be paid. So as part of SB 863, the Legislature added LC 5307.7 to the statutes. It directs the administrative director to adopt, after public hearings, a fee schedule to establish reasonable fees for services provided by vocational experts, including, but not limited to, vocational evaluations and expert testimony. But a vocational expert may not be paid, and the appeals board must not allow, fees in excess of those that are reasonable, actual and necessary, or that are not consistent with the fee schedule.<sup>19</sup>

The schedule was to be adopted on or before Jan. 1, 2013, but it wasn't. It's unclear what progress has made on the vocational expert fee schedule. Draft regulations have still not been posted. So it does not appear to be forthcoming soon.

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<sup>18</sup> Department of Industrial Relations, SB 863: Assessment of Workers' Compensation Reports (July 2016), at p. 28.

<sup>19</sup> LC 5307.7 originally was added in 2011 by AB 1168 requiring a fee schedule to establish “reasonable hourly fees.” It was amended in 2012 by SB 863 to require a fee schedule based on “reasonable fees.”

## 9. LIEN REFORM

SB 863 made sweeping changes to the lien system. When SB 863 was enacted, the lien system was out of control. There was no effective statute of limitations because case law had developed tolling rules that resulted in most billing matters remaining alive indefinitely. Employers expressed concerns that providers were filing liens for months of treatment when they had no idea that treatment was even being provided. In addition, the process of litigating liens at the WCAB level resulted in a backlog of hundreds of thousands of liens, many of which involved long-closed cases.

The problems with liens weren't related only to treatment of which the employer had late notice. It was common for third parties to purchase old receivables from providers who billed at high rates, but were paid according to established fee schedules. The third parties would file liens in an effort to leverage settlements. And it was common for providers themselves to file liens after being paid, seeking additional money through settlements.

So numerous changes were made by SB 863 to deal with the perceived problem of liens within the workers' compensation system. The statute of limitations for filing liens was strengthened. A \$150 lien filing fee and a \$100 lien activation fee were adopted to create a disincentive to filing frivolous liens. SB 863 required any payment of a lien to be made only to the person who was entitled to payment for the expenses at the time they were incurred, and not to an assignee, except as specified. It required that certain documentation relating to a lien filing include certain declarations made under penalty of perjury. SB 863 enacted penalties for lien claimants who fail to comply with these new provisions. It also precludes reimbursement for services if certain providers either knew or in the exercise of reasonable diligence should have known that the condition being treated was caused by the employee's employment subject to certain exceptions.

Emergency regulations for the lien filing and lien activation fees were adopted effective Jan. 1, 2013, the date the fees went into effect. The final regulations became effective Dec. 16, 2013. The appeals board also amended its own procedures to deal with the lien regulations.

After the effective date of SB 863, litigation regarding the lien filing and lien activation fees came fast and furious. Multiple decisions from the appeals board were issued explaining how and when the fees should be paid, as well as the consequences for failing to do so. Providers challenged the constitutionality of the lien filing and lien activation fees, but both have been upheld by the courts.

The WCIRB initially estimated that SB 863's lien-related changes would result in a 1.8 percent reduction in medical costs and a 7.8 percent reduction in loss adjustment expense, resulting in a 2.5 percent reduction in

total costs.<sup>1</sup> In 2013 and 2014, the number of liens filed decreased by approximately 60 percent when compared to pre-reform levels. In 2015 and 2016, however, the number of lien filings increased significantly. It was believed that the low lien filings in 2013 and 2014 may have been the result of a temporary transition period. Nevertheless, the WCIRB believes its prospective estimates related to the savings from SB 863's lien provisions are generally consistent with the emerging results.<sup>2</sup>

## STATUTE OF LIMITATIONS

The statute of limitations for filing a lien under LC 4903.5 has been amended. The statute of limitations applies to a lien claim for expenses under LC 4903(b), which relates to claims for medical treatment and medical-legal expenses. LC 4903.5 does not impose a time limit for any other type of lien. The statute of limitation for liens is discussed in [“Sullivan on Comp” Section 6.51 Statute of Limitations for Filing Lien](#).

LC 4903.5 currently states, “A lien claim for expenses as provided in subdivision (b) of Section 4903 shall not be filed after three years from the date the services were provided, nor more than 18 months after the date the services were provided, if the services were provided on or after July 1, 2013.”<sup>3</sup>

So the time limits are different depending on when the services were provided. Under the amended LC 4903.5(a), a lien for medical services before July 1, 2013, must be filed within three years from the date the services were provided.<sup>4</sup> If the services were provided on or after July 1, 2013, a lien must be filed no more than 18 months after the date they were provided. A lien is deemed filed on the date it is received by the appeals board; proof of service and/or receipt of the document by the opposing party is not proof of filing.<sup>5</sup>

If a lien is not timely filed, an employer would not be liable for any of the medical services provided. Furthermore, the injured worker is not liable for any underlying obligation if a lien claim has not been filed and served within the allowable period (LC 4903.5(c)). A lien claimant also can be sanctioned per LC 5813 for proceeding to trial when its lien was clearly barred by the statute of limitation per LC 4903.5(a).<sup>6</sup>

## Retroactive Application of Statute of Limitations

The appeals board has held that the amendments to LC 4903.5(a) apply retroactively to all liens not yet filed.<sup>7</sup> For example, in one case, the board consolidated the cases of a lien claimant who provided surgical hardware to various employees in 2009 or 2010, but did not file its liens until early 2014. Many of the services would have been timely under the former statute, which allowed liens to be filed five years from the date the services were provided. But the appeals board held that the liens were barred under the amended LC 4903.5(a) because they were not filed within three years of the dates of services.<sup>8</sup>

The appeals board explained that under the uncodified section 84 of SB 863, the act applied to all pending matters, regardless of date of injury, unless otherwise specified. Because nothing in LC 4903.5 expressly specified that it did not apply to all pending matters, it did apply to all pending cases regardless of the date

<sup>1</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at p. 12.

<sup>2</sup> WCIRB, Senate Bill No. 863 WCIRB Cost Monitoring Report - 2016 Retrospective Evaluation (Nov. 17, 2016), at pps. 12-13.

<sup>3</sup> Former LC 4903.5 provided that a lien shall not be filed from the latest of: (1) six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings or order, including an order approving a compromise and release, or award, on the merits of the claim; (2) five years from the date of the injury for which the services were provided; or (3) one year from the date the services were provided.

<sup>4</sup> *Archibald, Galicia v. Access Mediquip*, 2014 Cal. Wrk. Comp. P.D. LEXIS 587.

<sup>5</sup> *Perez v. Uniserve Facilities Services Corp.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 101.

<sup>6</sup> See *Cruz v. The Regent Beverly Wilshire*, 2015 Cal. Wrk. Comp. P.D. LEXIS 554.

<sup>7</sup> See *Medina v. Robinsons May*, 2012 Cal. Wrk. Comp. P.D. LEXIS 89; *Ravizza v. Albertson's*, 2010 Cal. Wrk. Comp. P.D. LEXIS 254; *Villatoro v. Kern Labor Contracting*, 2012 Cal. Wrk. Comp. P.D. LEXIS 321.

<sup>8</sup> *Archibald, Galicia v. Access Mediquip*, 2014 Cal. Wrk. Comp. P.D. LEXIS 587.

of the employee's injury or the date the medical treatment services were provided, except for cases that were "final" subject only to the WCAB's continuing jurisdiction under LC 5803 and LC 5804.<sup>9</sup>

The appeals board further explained that SB 863 was enacted Sept. 19, 2012, and was not urgency legislation. So the lien claimant had from Sept. 19, 2012, until Jan. 1, 2013 — the effective date to perfect any liens that would have been timely under former LC 4903.5. The board found that the lien claimant sat on its right to timely file its liens under former LC 4903.5(a) and to bring those lien claims to a vested final judgment. So its rights to timely pursue its liens remained inchoate and subject to the risk that the Legislature subsequently would modify the right.<sup>10</sup>

The amendments to LC 4903.5(a), however, do not apply retroactively to liens filed prior to the effective date. For example, the appeals board rescinded a WCJ's decision that a lien filed May 25, 2012, for services rendered between July 2, 2007, and Aug. 27, 2007, was untimely. It explained that the amendments to LC 4903.5 became effective Jan. 1, 2013, and there was no expressed intent by the Legislature that liens already timely filed pursuant to the prior statutes of limitations were subject to the new limitations period. The matter was returned to the WCJ to determine whether the lien was timely filed pursuant to the limitations period in effect at that time.<sup>11</sup>

### **Date Services Were Provided**

For services on or after July 1, 2013, per LC 4903.5, a lien must be filed no more than 18 months after "the date the services were provided." Does the time limit apply to each date of service? That is, if a lien is filed, are the services performed more than 18 months before the filing barred by LC 4903.5? Or is a lien timely filed as to all dates of service if it was filed within 18 months from the last date of service?

Generally, the appeals board holds that liens may be filed within 18 months after the last date on which services were provided. In one case, the board explained that the alternative interpretation would create a separate statute of limitations for each date of treatment rather than for the entire lien. It added that requiring lien claimants to file a lien for each date of treatment rather than simply filing a lien at the conclusion of treatment would flood defendants and the WCAB with multiple extraneous liens.<sup>12</sup>

In another case, the appeals board held that a lien claim was timely when it was filed within 18 months after the last date on which services were provided. The last date of treatment was Aug. 1, 2013, and the appeals board found that 18 months afterward was Feb. 1, 2015. But the board found the lien filed Feb. 2, 2015 was timely because Feb. 1, 2015 was a Sunday. It explained that when the last day for the performance of an act falls on a holiday (which includes Sundays), the time period for acting extended to include the next day that is not a holiday.<sup>13</sup>

Note, however, that if services started before July 1, 2013, but were provided continuously until after that, the entire lien is subject to the 18-month filing deadline. In one case, a lien claimant provided services from June 19, 2013, through Oct. 28, 2013, but did not file its lien until Sept. 24, 2015. It asserted that because its services began before July 1, 2013, the statutory deadline to file the lien was three years from the dates of services, not 18 months. The appeals board explained that the last date the services were provided was the measuring tool. It believed that applying the 18-month limitations period was reasonable because the amendments to LC 4903.5(a) became effective Jan. 1, 2013, and the lien claimant had a reasonable time within

<sup>9</sup> *Archibald, Galicia v. Access Mediquip*, 2014 Cal. Wrk. Comp. P.D. LEXIS 587.

<sup>10</sup> *Archibald, Galicia v. Access Mediquip*, 2014 Cal. Wrk. Comp. P.D. LEXIS 587.

<sup>11</sup> *De La Luz Garcia v. Morton Manufacturing*, 2016 Cal. Wrk. Comp. P.D. LEXIS 480.

<sup>12</sup> *Kindelberger v. City of Los Angeles*, 2013 Cal. Wrk. Comp. P.D. LEXIS 209. See also *Allgreen Landscape v. WCAB (Mota)* (2012) 77 CCC 541, 542 (writ denied). Contra *Medina v. Robinsons May*, 2012 Cal. Wrk. Comp. P.D. LEXIS 89; *Guerrero v. Easy Staffing*, 2016 Cal. Wrk. Comp. P.D. LEXIS 123.

<sup>13</sup> *Liu v. Adventurer Hotel*, 2016 Cal. Wrk. Comp. P.D. LEXIS 326.

which to timely file its claim. Because the lien claim was filed nearly two years after the last date services were provided, the claim was barred by LC 4903.5(a).<sup>14</sup>

### Exception to Limitations Period for Certain Providers

Notwithstanding these limits, certain medical providers may file a lien within 12 months after the entity knew or in the exercise of reasonable diligence should have known that an industrial injury was being claimed. Even in these cases, though, the lien may not be filed more than five years from the date the services were provided. These providers are:

1. a health-care service plan licensed per Health and Safety Code 1349;
2. a group disability insurer under a policy issued in California per IC 10270.5;
3. a self-insured employee welfare benefit plan as defined by IC 10121 issued in California;
4. a Taft-Hartley health and welfare fund;
5. a publicly funded program providing medical benefits on a nonindustrial basis.

Also, LC 4903.5 does not apply to civil actions brought under the Cartwright Act, the Unfair Practices Act or the federal Racketeering Influenced and Corrupt Organization Act (LC 4903.5(d)).

### Elimination of Zombie Liens

In many cases, an employer will issue partial payment on a medical provider's bill. Such payments commonly are made pursuant to the Official Medical Fee Schedule (OMFS). So the employer is aware that its payments are short of those billed by the medical provider. Problems arise, however, when the medical provider initially writes off the difference without protest, then, years later, seeks payment for the difference of the balance. These were called "zombie liens" by some practitioners because they were dead and buried only to come back to life.<sup>15</sup>

In the past, the appeals board struggled with whether these zombie liens were viable. Some cases concluded the liens were viable by interpreting former LC 4904(a)<sup>16</sup> and LC 4903.1(b)<sup>17</sup> as creating a loophole in the statute of limitations under LC 4903.5.<sup>18</sup> The cases held that the partial payments created a lien because the defendants had written notice of facts sufficient to constitute a lien, and that the statute of limitations in LC 4903.5 was tolled when the defendants failed to serve the lien claimants with the settlement documents.<sup>19</sup> Other cases, however, concluded that LC 4904(a) did not create an automatic notice of lien every time a defendant paid less than the amount billed, and that defendants were under no obligation to serve settlements on such claimants.<sup>20</sup>

<sup>14</sup> *Miranda v. El Super Market*, 2016 Cal. Wrk. Comp. P.D. LEXIS 434. See also *Escamilla v. Pelican Products, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 451; *Flick v. A and M Engineering*, 2016 Cal. Wrk. Comp. P.D. LEXIS 453; *Ruiz v. Best American Hospitality, Inc., dba Church's Chicken*, 2016 Cal. Wrk. Comp. P.D. LEXIS 465; *Tri-County Medical Group, Inc. v. WCAB (Paz)*, 2017 Cal. Wrk. Comp. LEXIS 1 (writ denied).

<sup>15</sup> WCAB's Final Statement of Reasons for CCR 10770, p. 4. A copy of this document may be found at [http://www.dir.ca.gov/wcab/WCABProposedRegulations/WCAB\\_July2011/FinalStatementofReasons.pdf](http://www.dir.ca.gov/wcab/WCABProposedRegulations/WCAB_July2011/FinalStatementofReasons.pdf). As that document notes, for a general discussion of zombie liens see the Jan. 5, 2011 Liens Report of The California Commission on Health and Safety and Workers' Compensation, pps. 32-33 ([http://www.dir.ca.gov/chswc/reports/2011/chswc\\_lienreport.pdf](http://www.dir.ca.gov/chswc/reports/2011/chswc_lienreport.pdf)).

<sup>16</sup> Before Jan. 1, 2013, LC 4904(a) stated in pertinent part, "If notice is given in writing to the insurer, or to the employer if uninsured, setting forth the nature and extent of any claim that is allowable as a lien, the claim is a lien against any amount thereafter payable as compensation, subject to the determination of the amount and approval of the lien by the appeals board."

<sup>17</sup> Before Jan. 1, 2013, LC 4903.1(b) stated in pertinent part, "When a compromise of claim or an award is submitted to the appeals board ... the parties shall file ... any liens served on the parties."

<sup>18</sup> WCAB's Final Statement of Reasons for CCR 10770, p. 4.

<sup>19</sup> See *Tran v. Viet Nguyen Trucking Co.*, 2007 Cal. Wrk. Comp. P.D. LEXIS 42; *Campos v. St. Johns Regional Medical Center*, 2011 Cal. Wrk. Comp. P.D. LEXIS 416; *Reynoso v. Welcome Home*, 2011 Cal. Wrk. Comp. P.D. LEXIS 554; *Marriott International v. WCAB (Torres)* (2013) 78 CCC 240 (writ denied); *Serrano v. Wild Things*, 2016 Cal. Wrk. Comp. P.D. LEXIS 332; *Aucar v. American Copak Corp.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 413.

<sup>20</sup> See *Welch v. East Ventura Medical Group*, 2012 Cal. Wrk. Comp. P.D. LEXIS 108; *Cisneros v. Grimmway Enterprises*, 2011 Cal. Wrk. Comp. P.D. LEXIS 107; *Fields v. Raymond Interior Systems*, 2011 Cal. Wrk. Comp. P.D. LEXIS 530; *Segura v. Technicolor*, 2010 Cal. Wrk. Comp. P.D. LEXIS 448; *Ravizza v. Albertson's*, 2010 Cal. Wrk. Comp. P.D. LEXIS 254; *Villatoro v. Kern Labor Contracting*, 2012 Cal. Wrk. Comp. P.D.

Effective 2013, as part of SB 863, the Legislature amended LC 4904(a) and LC 4903.1(b) to compromise the viability of zombie liens. LC 4904(a) was amended to clarify that only notice of any claim that is allowable as a lien in favor of the EDD is a lien against compensation.<sup>21</sup> LC 4904(f) added that the amendment in LC 4904(a) was “declaratory of existing law.”

And the language of former LC 4903.1(b) requiring parties to file any liens served on them at the time a C&R is submitted was eliminated altogether. Per CCR 10886, a settlement needs to be served on a lien claimant only when a lien claim is on file with the appeals board.<sup>22</sup> Instead, under SB 863, on receipt of a partial payment, LC 4603.2(e) requires medical providers to request a second review followed by an independent bill review (see Chapter VII: Independent Bill Review). So lien claimants may not rely on partial payments or failure to serve a C&R to relieve them of a failure to timely file a lien.

Since SB 863, the appeals board held in one case that a lien filed Sept. 11, 2012, for services performed June 30, 2003, was barred by the statute of limitations under former LC 4903.5(a), because the lien was filed more than six months after a stipulated award Jan. 10, 2011. The appeals board rejected the lien claimant’s argument that receipt of the billing constituted constructive knowledge of the lien under LC 4904(a), finding that the amendments to LC 4904(a) made crystal clear that the concept of constructive filing applies only to liens that attach against compensation such as those of the EDD. Furthermore, the appeals board found that because the lien claimant was not a claimant of record when the award was approved Jan. 10, 2011, the defendant did not breach a duty under CCR 10866 in its failure to serve the lien claimant with the settlement documents and award. So failure to serve the award did not toll the time limit to file a lien under LC 4903.5(a).<sup>23</sup>

The appeals board also has taken steps to address the problem of zombie liens. It amended CCR 10770 and subdivision (c)(9)<sup>24</sup> was adopted to interpret LC 4904(a) to mean that if a lien claim (or notice of any claim that would be allowable as a lien) is served on a defendant, it does not constitute the filing of a lien with the appeals board. Furthermore, CCR 10770(c)(10) provides that if a lien has been served on a party, the party has no obligation to file that lien with the appeals board. These provisions were adopted to give greater force to the statute of limitations provisions of LC 4903.5. They were intended to create more certainty and predictability in workers’ compensation claims management and, ultimately, cause lien claimants to act promptly when there is a legitimate lien dispute. So, in cases of partial payment, a lien claimant may not resurrect a zombie lien and avoid application of LC 4903.5 by relying on the provisions of LC 4904(a) and LC 4903(1)(b).

Note that the provisions of CCR 10770(c)(9) and CCR 10770(c)(10) do not apply to all lien claims. They do not apply to any notice of claim or lien claim of: (1) the Employment Development Department; (2) the California Victims of Crime Program; (3) any lien claimant listed as being excepted under CCR 10205.10(c)(5)(A)-(C);<sup>25</sup> (4) any governmental entity pursuing a lien claim for child support or spousal support; and the Uninsured Employers Benefits Trust Fund (CCR 10770(l)).

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LEXIS 321; *Reznicek v. The Kroger Co. dba Ralph’s Grocery Store*, 2012 Cal. Wrk. Comp. P.D. LEXIS 432; *Hoffman v. All State Insurance*, 2013 Cal. Wrk. Comp. P.D. LEXIS 53.

<sup>21</sup> In some cases, the WCAB had determined that LC 4904(a) does not apply only to EDD liens. See, e.g., *Hingtgen v. County of San Bernardino*, 2011 Cal. Wrk. Comp. P.D. LEXIS 536; *Zepeda v. Fremarc Designs*, 2008 Cal. Wrk. Comp. P.D. LEXIS 446; *County of San Bernardino v. WCAB (Hansen)* (2013) 78 CCC 232 (writ denied).

<sup>22</sup> *Gutierrez v. Marriott International (LAX)*, 2014 Cal. Wrk. Comp. P.D. LEXIS 19.

<sup>23</sup> *Gutierrez v. Marriott International (LAX)*, 2014 Cal. Wrk. Comp. P.D. LEXIS 19.

<sup>24</sup> CCR 10770(c)(9) states, “The service of a lien claim on a defendant, or the service of notice of any claim that would be allowable as a lien, shall not constitute the filing of a lien claim with the Workers’ Compensation Appeals Board within the meaning of its rules of practice and procedure or within the meaning of Labor Code section 4903.1 et seq., including but not limited to section 4903.5.”

<sup>25</sup> These are: (A) a lien claimant asserting a living expense lien under LC 4903(c); (B) a lien claimant asserting a burial expense lien under LC 4903(d); and (C) a nongovernmental lien claimant asserting a spousal or child support expenses lien under LC 4903(e).

## Application of Statute of Limitations Following Award

LC 4903.5 establishes clear time limits for filing a lien for medical services. In one case, however, the appeals board held that LC 4903.5 does not apply if a provisional award of medical care previously was issued. In that case, the applicant's claim was settled by way of stipulated award in 1995 allowing provision for future medical care. In 2008, the applicant was provided with air ambulance services, and the defendant claimed it paid pursuant to the Official Medical Fee Schedule. But in 2012, a lien in the amount of \$9,723.58 was filed for such services. The appeals board upheld a determination that the lien was not barred by the statute of limitations pursuant to LC 4903.5.

It explained that because of the provisional award of medical treatment issued in 1995, the defendant was under obligation to provide medical treatment under LC 4600. It also explained that in the same way it has continuing jurisdiction to enforce an award beyond LC 5804's five-year limitations, it also has continuing jurisdiction to enforce an award beyond the applicable statute of limitation in LC 4903.5. It regarded the award of medical care not as a new order, but as an interpretation of the existing provisional award. So because the medical service was provided after issuance of a provisional award of future medical treatment, the service was subject to the award, and the appeals board had continuing jurisdiction to enforce it.<sup>26</sup>

This area probably will see more development as employers certainly will take exception to this reasoning.

## Waiver of Statute of Limitations

Because the statute of limitations is an affirmative defense, an employer may waive it under LC 4903.5 by not timely raising the issue.<sup>27</sup> Furthermore, an employer may be estopped from raising LC 4903.5 as a defense when its conduct or representations induce the claimant to refrain from filing the lien until after the statute of limitations has run.<sup>28</sup>

## Time Limits to File a Lien

SB 863 also added LC 4903.6, which places restrictions on filing liens with the appeals board. It provides that, except as necessary to avoid violating the statute of limitations under LC 4903.5, the lien is not to be filed with the appeals board unless two conditions are met:<sup>29</sup>

1. Sixty days have elapsed after the date of acceptance or rejection of liability for the claim, or expiration of the time for investigation of liability per LC 5402(b), whichever date is earlier.
2. Either:
  - A. The time allowed for payment of medical treatment bills per LC 4603.2 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined per LC 4603.6, and, if authorization for the medical treatment has been disputed per LC 4610, the necessity of the medical treatment has been determined per LC 4610.5 and LC 4610.6. Or
  - B. The time allowed for payment of medical-legal expenses per LC 4622 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined per LC 4603.6.

<sup>26</sup> *Mires v. Shasta County Sheriff's Department*, 2014 Cal. Wrk. Comp. P.D. LEXIS 598.

<sup>27</sup> *Federal Express v. WCAB (Rozek)* (2004) 69 CCC 393 (writ denied).

<sup>28</sup> *Dicalite Minerals Corp. v. WCAB (Karr)* (2008) 73 CCC 686 (writ denied).

<sup>29</sup> Former LC 4903.6 provided that a lien could not be filed until the expiration of: (1) 60 days after the date of acceptance or rejection of liability for the claim, or expiration of the time provided for investigation of liability per LC 5402(b), whichever date is earlier; or (2) expiration of the time provided for payment of medical treatment bills per LC 4603.2; or expiration of the time provided for payment of medical-legal expenses per LC 4622.

So a lien may not be filed or served until 60 days after the claim has been accepted or denied, or 60 days after the 90-day investigation period (see [“Sullivan on Comp” Section 5.16 Presumption of Injury — 90-Day Rule](#)), whichever is earlier. Nor may a lien be filed and served until after the 45-day period defined in LC 4603.2 (see [“Sullivan on Comp” Section 7.67 Submission of Bills and Employer’s Response](#)) or the 60-day period for payment defined in LC 4622 has expired (see [“Sullivan on Comp” Section 14.65 Payment of or Objection to Medical-Legal Expenses](#)).

If the employer disputes the amount of the bill, the lien may not be filed until after the independent bill review process established in LC 4603.6 has been completed and it has been determined that the fee is reasonable (see Chapter VII: Independent Bill Review). Also, if the employer disputes authorization in its entirety, the lien may not be filed until after the independent medical review process established in LC 4610.5 and LC 4610.6 has been completed and it has been determined that the treatment was medically necessary (see Chapter VI: Utilization Review and Independent Medical Review).

The prohibitions of LC 4309.6 do not apply to lien claims, applications for adjudication or declarations of readiness to proceed filed by or on behalf of the employee, or to the filings by or on behalf of the employer (LC 4903.6(e)).

## LIEN FILING FEE

As a result of SB 863, LC 4903.05(d) added a filing fee for liens filed on or after Jan. 1, 2013. The fee was added to address the lien crisis in the workers’ compensation system, and the growing backlog of liens. It was intended as a disincentive to file frivolous liens.<sup>30</sup>

The fee does not apply to all liens — only to liens under LC 4903(b) or for claims of costs. Regulations regarding the lien filing fee are established in CCR 10207.

## Liens and Costs Subject to Filing Fee

The filing fee under LC 4903.05(d) applies to “expenses under subdivision (b) of Section 4903 or for claims of costs.” LC 4903(b) covers reasonable treatment expenses under LC 4600, and medical-legal expenses under LC 4620. The regulations define a “Section 4903(b) lien” as “a lien claim filed in accordance with Labor Code section 4903(b) for medical treatment expenses incurred by or on behalf of the injured employee, as provided by Article 2 (commencing with Labor Code section 4600)” (CCR 10205(hh); CCR 10301(ii)). It includes, but is not limited to:

1. expenses for interpreter services;
2. copying and related services; and
3. transportation services incurred in connection with medical treatment.

A “Section 4903(b) lien” does not include any amount payable directly to the injured employee (CCR 10205(hh); CCR 10301(ii)).

A “cost” is “any claim for reimbursement of expense or payment of service that is not allowable as a lien against compensation under Labor Code section 4903” (CCR 10205(h); CCR 10301(h)). Costs include, but are not limited to:

1. expenses and fees under LC 5710;

<sup>30</sup> *Angelotti Chiropractic, Inc. v. Baker* (2015) 80 CCC 672, 676; *Chorn v. WCAB*, 2016 Cal. App. LEXIS 232.



2. costs under LC 5811, other than interpreter services rendered during a medical treatment appointment;
3. any amount payable as a medical-legal expense under LC 4620 et seq; and
4. any amount payable under LC 4600 that would not be subject to a lien against the employee's compensation, including but not limited to any amount payable directly to the injured employee for reasonable transportation, meal and lodging expenses and for temporary disability indemnity for each day of lost wages.

### **Liens and Costs Not Subject to Filing Fee**

Per LC 4903.05(d)(7), certain providers explicitly are excluded from payment of the filing fee (CCR 10207(c)). They are:

1. a health-care service plan licensed per Health and Safety Code 1349;
2. a group disability insurer under a policy issued in California per IC 10270.5;
3. a self-insured employee welfare benefit plan issued in California as defined by IC 10121;
4. a Taft-Hartley health and welfare fund; and
5. a publicly funded program providing medical benefits on a nonindustrial basis.

Because their liens are not for medical costs per LC 4903(b), claimants for these liens, per CCR 10207(c)(2), are not required to pay the initial lien filing fee:

1. reasonable attorneys' fees per LC 4903(a);
2. living expense liens per LC 4903(c);
3. burial expense liens per LC 4903(d);
4. spousal and child support liens per LC 4903(e);
5. EDD liens per LC 4903(f)(g)(h);
6. victims-of-crime liens per LC 4903(i);
7. a defendant filing a DOR on a lien claim;
8. claims not being made as a lien; and
9. lien in companion cases. If one or more liens or one or more costs filed as a lien is filed in more than one case involving the same injured worker and same service or services by the same lien claimant, only one filing fee must be paid.

If the lien claimant asserts it is exempt from payment of the filing fee because it is not filing an LC 4903(b) or claim of costs lien, or because it is an entity specified in LC 4903.05(d)(7), it must so indicate in the designated field of the lien form (CCR 10770(c)(6)).

As discussed above, deposition attorneys' fees under LC 5710 are classified as a claim of cost subject to a filing fee, while reasonable attorneys' fees per LC 4903(a) are not. Attorneys' fees under LC 5710 are paid to an applicant's attorney based on the time related to the applicant's deposition; liens under LC 4903(a) are payable as a percentage of the applicant's recovery. This difference might explain why the two types of attorneys' fees are treated differently for the purposes of the filing fee.

### **Payment of Filing Fee**

Unless exempt, a lien claimant must pay a \$150 filing fee to the DWC before or at the filing of a LC 4903(b) lien. LC 4903.05(d)(1) requires the fee to be collected through an electronic payment system that accepts major credit cards and other forms of electronic payment selected by the administrative director. The director is authorized to contract with a service provider for the processing of electronic payments, but a processing

fee must be absorbed by the division and must not be added to the fee charged to the lien claimant. The fees must be deposited into the Workers' Compensation Administration Revolving Fund.

Per CCR 10207(d)(1), the filing fee will be collected and made electronically consistent with these procedures:

1. E-Forms filers must pay the initial lien filing fee per the EAMS E-Form Filing Reference Guide.<sup>31</sup>
2. JET Filers must pay the initial lien filing fee per the EAMS JET File Business Rules and Technical Specifications, Version 4.0.<sup>32</sup>

When a lien claimant files liens or claims of costs filed as a lien in more than one case at the same time, the filing fee or fees may be paid in a single transaction following the instructions in the EAMS E-Form Filing Reference Guide or the EAMS JET File Business Rules and Technical Specifications, Version 4.0 (CCR 10207(j)). For further discussion of electronic filing, see [“Sullivan on Comp” Section 15.17 Electronic Adjudication Management System \(EAMS\)](#).

If required to pay the filing fee, the lien claimant must file a confirmation of payment with a DOR for a lien conference (CCR 10207(h)). If the LC 4903(b) lien filing fee has been previously paid, the lien claimant must submit written documentation of confirmation of payment when filing the DOR for a lien conference (CCR 10207(d)). If a lien claimant claims that a filing fee is not required or that a lien filed under LC 4903(b) is exempt from the filing fee, it must indicate that status on the lien form (CCR 10207(f)).

If no application exists for the employee at the time of the initial LC 4903(b) lien filing, the claimant must file any necessary application(s) and duty to investigate verification per CCR 10770.5. The lien claimant may file the initial lien claim or claim of cost with the filing fee or confirmation of payment after receiving a notice of application assigning a case number (CCR 10207(g)).

When the attorney for the employee or dependent or any assignee of the lien claimant files the initial lien for medical costs, that filing will be deemed to have been made by an agent for the medical provider. In that situation, payment of the filing fee will be required of the filing party as if the lien had been filed directly by the lien claimant (CCR 10207(n)). Of course, a medical provider need not pay the lien filing fee until it files a lien.<sup>33</sup>

## No Merger of Liens

LC 4903.05(d)(3) requires that claims of two or more providers may not be merged into a single lien. Each provider is required to file a separate lien and pay separate filing fees. An individual provider, however, may claim more than one type of lien on a single lien form by checking the “Other Lien(s)” box and by specifying the nature and statutory basis for each lien where indicated (CCR 10770(b)(3)).

## Consequences of Failing to Pay Filing Fee

Unless exempt, no LC 4903(b) lien or claim of costs filed as a lien will be accepted for filing on or after Jan. 1, 2013, unless accompanied by full payment for the filing fee. Until receipt of proper payment or confirmation of payment, the lien will not be deemed to have been received or filed for any purpose (CCR 10207(m)).

<sup>31</sup> Instructions for payment are available at <http://www.dir.ca.gov/dwc/Liens/Paying%20the%20lien%20fee%20using%20E-form.pdf>.

<sup>32</sup> Instructions are available at [http://www.dir.ca.gov/dwc/eams/JetFiling/BusinessRulesAndJET\\_File\\_Technical\\_Specifications.pdf](http://www.dir.ca.gov/dwc/eams/JetFiling/BusinessRulesAndJET_File_Technical_Specifications.pdf).

<sup>33</sup> See *Godoy v. Destination Shuttle Services*, 2014 Cal. Wrk. Comp. P.D. LEXIS 428.

An LC 4903(b) lien or claim of costs filed as a lien that does not comply with the filing fee requirements will be invalid, even if lodged with the appeals board. It will not operate to preserve or toll any time limit for filing of the lien (LC 4903.05(d)(2); CCR 10207(k)). It will be deemed dismissed by operation of law (CCR 10770(c)(6)). The appeals board has held that liens may be dismissed for failure to pay the filing fee only if a lien has been filed with the board.<sup>34</sup>

There seems to be no reason, within the time limits of the statute of limitations, why a lien dismissed for failure to pay the filing fee may not be refiled. In one case, the appeals board held that a lien that was filed without a filing fee was invalid and should be dismissed by operation of law. But the board added that because the case involved a filing fee, rather than an activation fee, the lien claimant could refile its lien as long as it did so within three years from the date services were provided and contemporaneously paid the required lien filing fee.<sup>35</sup> Nevertheless, the appeals board may consider sanctions under LC 5813 for failing to pay the lien filing fee.<sup>36</sup>

CCR 10770.1(c)(3)(B), however, states, “... if the lien claimant filed a declaration of readiness its lien shall be dismissed with prejudice.” So if a lien claimant who files a DOR fails to pay the lien filing fee, the lien must be dismissed with prejudice; the lien may not be refiled.

## LIEN ACTIVATION FEE

The lien activation fee also was added as part of SB 863 to combat an acute lien crisis in the workers’ compensation system. In an effort to clear an enormous and rapidly growing backlog of liens, SB 863 imposed a \$100 “activation fee” on liens filed prior to Jan. 1, 2013. Like the lien filing fee, the purpose of the activation fee was to provide a disincentive to file frivolous liens.<sup>37</sup>

Regulations regarding the lien activation fee are established in CCR 10208. No lien claimant that is required to pay an activation fee is allowed to file a declaration of readiness or participate in any lien conference, including obtaining an order allowing its lien in whole or in part, without submitting written proof or prior payment, or without electronic proof of prior payment that is available to the judge and the parties at the conference (CCR 10208(a)).

As discussed below, the constitutionality of the lien activation fee was challenged, and from Nov. 19, 2013, to Nov. 8, 2015, was not collected by the administrative director. As of Dec. 31, 2015, activation fees no longer are accepted.

## Liens and Costs Subject to Activation Fee

The activation fee applied to medical treatment liens under LC 4903(b) and liens for costs. Generally, the same entities and persons who are not required to pay the lien filing fee were exempt from paying the activation fee (LC 4903.06; CCR 10208(a)).<sup>38</sup>

In addition, a lien claimant might be excused from paying the lien activation fee if it provides proof of having paid a filing fee as required by former LC 4903.05 (LC 4903.06(a); CCR 10208(a)(2)(I)). LC 4903.05 existed briefly from 2003 legislation and required the filing of a payment fee of \$100 for a lien for medical costs or

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<sup>34</sup> *Cox v. Wellpoint, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 98.

<sup>35</sup> *Aguilar v. Sawers*, 2013 Cal. Wrk. Comp. P.D. LEXIS 235. See also *Hopkins v. TJ Maxx*, 2013 Cal. Wrk. Comp. P.D. LEXIS 376; *Yaguas v. Inland Landscape Maintenance, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 524.

<sup>36</sup> See *Hopkins v. TJ Maxx*, 2013 Cal. Wrk. Comp. P.D. LEXIS 376.

<sup>37</sup> *Angelotti Chiropractic, Inc. v. Baker* (2015) 80 CCC 672, 676.

<sup>38</sup> See *Hinks v. Pavlo, Weinberg & Associates*, 2013 Cal. Wrk. Comp. P.D. LEXIS 258 (CCR 10208 requires payment of only one lien activation fee when there are companion cases); *Medrano v. La Curacao*, 2013 Cal. Wrk. Comp. P.D. LEXIS 268 (no fee required when paid in companion case).

medical legal expenses under former LC 4903(b). The claimant must provide proof of having paid a filing fee as required by former LC 4903.05.

### Payment of Activation Fee

By statute, lien claimants were required to pay the activation fee before Jan. 1, 2014 (LC 4903.06(a)(1)). But because the administrative director did not collect it for almost two years, the courts allowed the activation fee to be paid before Jan. 1, 2016. The lien activation fee was collected by the administrative director electronically.<sup>39</sup> All fees were deposited in the Workers' Compensation Administration Revolving Fund and applied for the purposes of that fund (CCR 10208(b)).

The activation fee was collected in the same manner as the filing fee for liens filed on or after Jan. 1, 2013. If the activation fee previously was paid, the lien claimant must submit confirmation of payment with the DOR for a lien conference (LC 4903.06(a)(2); CCR 10208(c)). All lien claimants who were required to pay an activation fee and who did not file the DOR and remain a lien claimant of record at the time of a lien conference or consolidated lien conference must submit confirmation of payment of the lien activation fee at the lien conference (LC 4903.06(a)(4); CCR 10208(d)).

In a significant panel decision, *Mendez v. Le Chef Bakery*,<sup>40</sup> the appeals board held that under the statute, if a lien claimant is subject to a lien activation fee, LC 4903.06 contemplates that it must be paid by the earliest of:

1. the date the lien claimant files the DOR, if it is filed on or after Jan. 1, 2013;
2. before the scheduled starting time of the lien conference, if the lien conference occurs on or after Jan. 1, 2013, whether or not the lien claimant filed the DOR; or
3. Jan. 1, 2014.

The appeals board held that a lien claimant is not required to pay a lien activation fee prior to a 2013 lien trial if: (1) the declaration of readiness is filed before Jan. 1, 2013; (2) the lien conference takes place before Jan. 1, 2013; and (3) the lien trial takes place in 2013, without any intervening 2013 lien conference. But if a lien subject to the lien activation fee is not resolved or withdrawn by Jan. 1, 2014, the lien activation fee must be paid by that date, or the lien will be dismissed by operation of law.<sup>41</sup>

### Consequences of Failing to Pay Activation Fee

Per LC 4903.06(a)(4), if a lien claimant appears at a lien conference and the activation fee has not been paid or no proof of payment is made, the lien "shall" be dismissed with prejudice. In an *en banc* decision, *Figueroa v. B.C. Doering Co.*,<sup>42</sup> the appeals board held that:

1. The lien activation fee must be paid before the commencement of a lien conference, which is the time the conference is scheduled to begin, not the time the case actually is called.
2. If the lien claimant fails to pay the lien activation fee before the commencement of a lien conference and/or fails to provide proof of payment at the conference, its lien must be dismissed with prejudice.

<sup>39</sup> In *Ramos v. Hibachi Sushi & Grill*, 2013 Cal. Wrk. Comp. P.D. LEXIS 278, the WCAB found payment by check permissible.

<sup>40</sup> (2013) 78 CCC 454 (significant panel decision).

<sup>41</sup> *Mendez v. Le Chef Bakery*, (2013) 78 CCC 454 (significant panel decision). In *Matusevic v. Channel Technologies*, 2013 Cal. Wrk. Comp. P.D. LEXIS 167, the appeals board did not dismiss liens per LC 4903.06 because the WCJ converted a lien trial to a lien conference on the hearing date.

<sup>42</sup> (2013) 78 CCC 439 (appeals board *en banc*). The appeals board earlier had issued a significant panel decision, *Figueroa v. B.C. Doering Co.* (2013) 78 CCC 336 (significant panel decision), reflecting the same holding. But it granted reconsideration and issued an *en banc* decision to ensure uniform application of the law concerning payment of the lien activation fee and the consequences for failure to do so.

3. Breach of the defendant's duty to serve required documents or to engage in settlement negotiations does not excuse a lien claimant's obligation to pay the lien activation fee.
4. Notice of intention is not required before 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.

Furthermore, CCR 10770.1(c)(3)(A) states, "If the proof of prior timely payment of the activation fee is not submitted, the lien claim shall be dismissed with prejudice. This provision shall apply even if, but for the lien conference, the activation fee would not have been due until December 31, 2013." It adds, "A lien claimant shall not avoid dismissal by attempting to pay the fee at or after the hearing." "Prior timely payment" means "any payment of the activation fee (1) prior to the filing of a declaration of readiness for a lien claimant filing a declaration of readiness, or (2) prior to an appearance at a lien conference by a lien claimant that did not file the declaration of readiness" (CCR 10208(a)).

Lien claimants must pay the lien activation fee before a lien conference or their liens will be dismissed with prejudice. The dismissal is mandatory, not discretionary.<sup>43</sup> If a WCJ does not dismiss a lien at the lien conference, he or she has jurisdiction to do so later.<sup>44</sup> If two separate liens are filed covering separate services, two activation fees must be paid.<sup>45</sup>

The defendant's actions or inaction will not be considered until the fee has been paid, and will not excuse nonpayment. For example, the appeals board dismissed a lien pursuant to LC 4903.06 for failure to pay the lien activation fee, even though it was asserted that the defendant had not served closing documents or medical records on the lien claimant.<sup>46</sup> Likewise, a defendant's failure to negotiate a lien is no excuse from paying the lien activation fee.<sup>47</sup> Failure to calendar the lien conference properly is not good cause to excuse failure to appear at a properly noticed hearing or failure to pay the activation fee.<sup>48</sup> Also, paying the fee in the wrong case was not a basis for avoiding dismissal.<sup>49</sup>

In one case, a lien conference was scheduled for Jan. 2, 2013. The lien activation fee was not paid by then, so the WCJ dismissed the lien. The claimant paid the fee six days later, and sought reconsideration. The appeals board denied it, finding that under LC 4903.06(a)(4), the WCAB was required to dismiss the lien with prejudice.<sup>50</sup>

In another case, a lien conference was scheduled for 8:30 a.m. Jan. 10, 2013, but the lien claimants paid their activation fees between 10:56 a.m. and 11:06 a.m. that day. The appeals board explained that in order to have been "prior timely payments," the payments should have been made before 8:30 a.m. So it concluded that the liens were properly dismissed.<sup>51</sup> The board has dismissed other liens when the claimants paid the fees during, not "prior to," the lien conference.<sup>52</sup> An order of dismissal is not defective if the appeals board

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<sup>43</sup> See *Lopez v. Stoneledge Furniture, LLC*, 2013 Cal. Wrk. Comp. P.D. LEXIS 123; *Rodriguez v. Auto Auction Center*, 2013 Cal. Wrk. Comp. P.D. LEXIS 124; *Villanueva v. Tech Data Product Management Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 135; *Figueroa v. Baja Fresh Baja Best, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 147; *Mena v. Priority Building Services*, 2013 Cal. Wrk. Comp. P.D. LEXIS 169; *Elliott v. National Housing Ministries*, 2013 Cal. Wrk. Comp. P.D. LEXIS 362; *Rizo v. Joel Fischer Construction, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 392.

<sup>44</sup> *Jimenez v. Crowther Prentiss*, 2013 Cal. Wrk. Comp. P.D. LEXIS 378; *Pena v. Frito Lay*, 2013 Cal. Wrk. Comp. P.D. LEXIS 508.

<sup>45</sup> *Inniss v. Culver City Unified School District*, 2013 Cal. Wrk. Comp. P.D. LEXIS 260.

<sup>46</sup> *Henriquez v. Vallarta Food Enterprises, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 150.

<sup>47</sup> *Jacinto v. Excel Direct*, 2013 Cal. Wrk. Comp. P.D. LEXIS 261.

<sup>48</sup> *Guzman v. Sique Corp.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 205.

<sup>49</sup> *Rivas v. Koos Manufacturing*, 2013 Cal. Wrk. Comp. P.D. LEXIS 578. Compare *Garcia v. Sundance Spas/Jacuzzi Brands, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 546.

<sup>50</sup> *Innovative Orthopedic Solutions v. WCAB (Meyer)* (2013) 78 CCC 795 (writ denied).

<sup>51</sup> *Soto v. Marathon Industries, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 81.

<sup>52</sup> See *Perez v. Bloomington High School*, 2013 Cal. Wrk. Comp. P.D. LEXIS 176; *Ponce v. L.W. Reinhold Plastics Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 178; *Ramirez v. The Kroeger Co./Ralphs*, 2013 Cal. Wrk. Comp. P.D. LEXIS 179; *Langston v. Custom Building Projects, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 161; *Larios v. Staffmark Inc. West*, 2013 Cal. Wrk. Comp. P.D. LEXIS 162; *Cervantes v. Minnig Plastering*, 2013 Cal. Wrk. Comp. P.D. LEXIS 248.

delegates service of it to the defendant because it is not subject to CCR 10500(b), which applies to final orders after submission.<sup>53</sup>

There's a duty to pay the activation fee regardless of the case history. So if there was a lien conference before Jan. 1, 2013, that has no effect on the obligation to pay after that date. In one case, a lien conference was scheduled for Sept. 5, 2012, but was rescheduled to Jan. 9, 2013, because the WCJ was out of the office on the original date. The lien claimant failed to pay the lien activation fee at the rescheduled conference. The appeals board affirmed an order dismissing the lien and held that although new legislation was not in effect at time of the originally scheduled conference, the provisions took effect Jan. 1, 2013, so they applied to the rescheduled conference.<sup>54</sup>

Moreover, in one case the appeals board dismissed a lien when the claimant failed to pay the activation fee at a status conference that served as a lien conference. That case-in-chief was settled and a lien conference was scheduled for July 25, 2012. The lien claimant failed to appear for the lien conference. The WCJ issued a notice of intent to dismiss the lien, and later an order dismissing it. When the lien claimant filed a petition for reconsideration, the WCJ rescinded the order and set the matter for a status conference Jan. 14, 2013. The lien claimant failed to appear again and the WCJ issued another order dismissing the lien for failure to appear. The appeals board held that this was improper because before issuing the dismissal, the WCJ was required to issue a notice of intent for failure to appear. It added, however, that no notice of intent was required if a lien claimant failed to pay the lien activation fee before the commencement of a lien conference. The appeals board treated the status conference as the equivalent of a lien conference and issued an order dismissing the lien with prejudice for failure to pay the lien activation fee per LC 4903.06.<sup>55</sup>

### Cases Excusing Nonpayment of Activation Fee

Despite the strict time limits for payment of the lien activation fee, there were several instances in which the appeals board refused to dismiss liens despite a failure to pay the fee. If a lien claimant didn't file a lien, a WCJ could not dismiss a lien for failure to pay the activation fee based on a belief that the claimant should have filed a lien.<sup>56</sup>

If a lien claimant, or its attorney of record, did not receive timely notice of the lien conference, an order dismissing the lien for failure to pay the activation fee at the lien conference could be invalid.<sup>57</sup> In one case, the appeals board declined to dismiss a lien when a defective notice was issued, without a prior lien conference, regarding the type of conference being held. That case-in-chief settled by way of compromise and release, but the DWC issued a notice of a mandatory settlement conference. The defendant served notice of a lien conference, but no proof of service was attached to it. When the lien claimant did not appear for the conference, the WCJ dismissed the lien with prejudice. The appeals board granted reconsideration. It explained that the notice of hearing issued by the DWC clearly referenced an MSC, not a lien conference, and that the lien claimant should not be prejudiced due to the service of an erroneous official notice. It added that because the defendant's notice did not contain a proof of service on the lien claimant, the record was ambiguous as to whether the claimant received it. So the board concluded that the lien claimant should not be precluded from proceeding on its lien.<sup>58</sup> In one case, the appeals board excused a lien claimant's

<sup>53</sup> *Garate v. Leading Edge Aviation Services*, 2013 Cal. Wrk. Comp. P.D. LEXIS 203; *Utvitch v. Brotman Medical Center*, 2013 Cal. Wrk. Comp. P.D. LEXIS 232; *Venegas v. American Honda Motor Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 233; *Flores v. Silk*, 2013 Cal. Wrk. Comp. P.D. LEXIS 421. But see *Jusufbegovic v. Fiesta Ford Lincoln Mercury*, 2013 Cal. Wrk. Comp. P.D. LEXIS 381 (although order dismissing a lien is a final order that should have been served by the WCAB, service by defendant did not void the order).

<sup>54</sup> *Hamilton v. Med Shores Home Care*, 2013 Cal. Wrk. Comp. P.D. LEXIS 107. See also *Kovalenko v. PESP dba Action Production*, 2013 Cal. Wrk. Comp. P.D. LEXIS 210.

<sup>55</sup> *Alexandrescu v. Walmart Stores*, 2013 Cal. Wrk. Comp. P.D. LEXIS 137. See also *Anderson v. Eco Building Systems*, 2013 Cal. Wrk. Comp. P.D. LEXIS 237.

<sup>56</sup> *Nava v. Owens Corning*, 2014 Cal. Wrk. Comp. P.D. LEXIS 74.

<sup>57</sup> See *Flamenco v. Keiro Nursing Home*, 2013 Cal. Wrk. Comp. P.D. LEXIS 303; *Agustin v. Deardorff Jackson Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 337; *Cervantes v. Total Resources International, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 478.

<sup>58</sup> *Morales v. R&D Farms, LLC*, 2013 Cal. Wrk. Comp. P.D. LEXIS 113.

appearance when, due to being very ill and forced to retire, he failed to file a notice of change of address.<sup>59</sup> Note, however, that a bare allegation of nonreceipt of the notice of hearing may be insufficient to avoid dismissal of a lien.<sup>60</sup>

The appeals board rescinded an order dismissing a lien for failure to timely pay the lien activation fee when the lien claimant submitted evidence — a computer screen printout — that it attempted to pay the fee a day before the lien conference but couldn't because EAMS was not functioning properly. The appeals board explained that the burden of the system's inadequacies should not fall on a party, particularly because of the novelty of the process for paying the lien activation fee. It further advised, however, that a more heightened showing would be necessary in the future and that a lien claimant will be required to make a showing of diligence, including proof of multiple attempts to pay the lien activation and will be required to raise the issue of any EAMS failure at the lien conference.<sup>61</sup> If a lien claimant has problems paying the activation using EAMS, some evidence of them must be presented at or before the time of the lien conference to show good cause not to dismiss.<sup>62</sup>

In one case, an applicant filed two workers' compensation claims, one for a specific injury and one for a CT injury, which were settled by way of C&R, and the lien claimant filed liens in both cases. But only the lien in the specific injury reflected that the lien claimant was represented by a hearing representative. Subsequently, a different lien claimant filed a DOR requesting a lien conference for only the CT injury. Because the hearing representative did not give its notice of representation in that case, it was not sent notice of the hearing. Because the lien claimant did not appear and did not pay the lien activation fee, the WCJ dismissed the lien claimant's lien, but did so for both cases. The appeals board granted reconsideration and instructed the WCJ to issue an order dismissing the lien only in relation to the claim for the CT injury. It found that the order of dismissal in the specific injury was improper because there was never a properly noticed lien conference in that case. It concluded that the lien claimant could continue to assert its lien in the specific claim, subject to all appropriate defenses.<sup>63</sup>

In one case, the appeals board rescinded a WCJ's order dismissing a lien for failure to submit proof of payment of the lien activation fee when the lien claimant filed two identical original liens in the same case, and timely paid the lien activation fee for one of the original liens. The appeals board found that the lien claimant had timely paid the activation fee, and that two fees were not required. The lien claimant, however, was admonished for filing two identical original liens, and for failing to demonstrate it paid the lien activation fee at the lien conference. The appeals board warned that continued actions of this nature could warrant imposition of sanctions under LC 5813.<sup>64</sup>

Furthermore, in another case, the appeals board held that lien claimants were not required to appear or pay the activation fee at an inappropriately scheduled lien conference. In that case, a lien claimant filed a DOR for a lien conference, along with a verification under CCR 10770.6 declaring that the underlying case had been resolved. But the case had not been resolved, so the defendants filed an objection. Three nonexempt liens were on file at the time of the hearing, but no representatives appeared and no activation fees were paid. The WCJ issued a notice of intention to impose sanctions against the lien claimant that filed the DOR, but declined to dismiss the liens of the nonappearing lien claimants. The appeals board explained that because the lien claimants had not yet achieved "party" status when the DOR was filed (see ["Sullivan on Comp" Section 15.30 Lien Conference](#)), the action of one lien claimant could not confer "party" status on

<sup>59</sup> *Moe v. Ralphs Grocery Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 387.

<sup>60</sup> See *Camacho v. Nick's Doors, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 297; *Garcia v. Jose Martinez Enterprises*, 2013 Cal. Wrk. Comp. P.D. LEXIS 422.

<sup>61</sup> *Ramos v. KDK Investment, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 227. See also *Arizmendi v. Spires Restaurant*, 2016 Cal. Wrk. Comp. P.D. LEXIS 412.

<sup>62</sup> *Hernandez v. Ceramic Tile Art, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 309.

<sup>63</sup> *Arballo v. Nature's Best*, 2013 Cal. Wrk. Comp. P.D. LEXIS 238.

<sup>64</sup> *Ovando v. 99 Cent Only Store*, 2013 Cal. Wrk. Comp. P.D. LEXIS 275.

the other lien claimants. So the lien claimants were not required to comply with the activation fee or appear at the inappropriately scheduled lien conference.<sup>65</sup>

Note that in a similar case, the opposite result was reached. In that case, a lien claimant also filed a DOR for a lien conference before the underlying case was resolved. A lien conference was scheduled, and many lien claimants appeared. But one lien claimant did not appear or pay the activation fee, and its lien was dismissed. The lien claimant filed a petition for reconsideration admitting that it had notice of the lien conference, but asserting that it was improper for the lien to be scheduled, so the lien claimant assumed that the lien conference would be taken off calendar. The appeals board adopted a WCJ's decision that even though the lien conference was set inappropriately, the lien should be dismissed for failure to pay the lien activation fee. The appeals board found the lien claimant's assumption that it did not have to appear and did not have to pay the activation fee showed a complete disregard for the authority of appeals board.<sup>66</sup>

### Activation Fee Versus Petition for Costs

Following the enactment of SB 863, many service providers attempted to avoid payment of the lien activation fee by withdrawing their liens and filing petitions for costs instead. They asserted that such petitions were not subject to the lien activation fee under LC 4903.06. In *Martinez v. Terrazas*,<sup>67</sup> the appeals board issued an *en banc* decision putting an end to this practice.

In that case, a copy service filed a lien for copying and related services in 2011. Before Jan. 1, 2013, the copy service filed a DOR, but after that date, in an attempt to avoid the lien activation fee under LC 4903.06, it withdrew its lien and filed a petition for costs under LC 5811. The WCJ denied the petition for costs on the grounds that the copy service could not "abrogate" its obligation to pay the lien activation fee, and the appeals board agreed. The board first held that a claim for medical-legal expenses may not be filed as a petition for costs under LC 5811 (see ["Sullivan on Comp" Section 15.110 Litigation Costs](#)).

In light of the uncertainty over the new law, however, the appeals board was loath to penalize lien claimants who had tried this approach. It held that medical-legal lien claimants who withdrew their liens and filed petitions for costs prior to the decision still may pursue recovery through the lien process if they comply with the lien activation fee requirements of LC 4903.06 and if their liens otherwise have not been dismissed.<sup>68</sup>

The appeals board found that LC 4903.06 mandates that a lien claimant who filed a medical-legal expense or claim of cost lien before Jan. 1, 2013, must pay a lien activation fee by the earliest statutorily required time; otherwise, its lien must be dismissed. The appeals board explained that "when it adopted lien filing and activation fees, the Legislature's purposes were to overhaul a 'lien system (that) is out of control,' to diminish the burden on the workers' compensation system of 'hundreds of thousands of backlogged liens,' and to curtail 'lien abuse.'" It added, "These legislative purposes would be frustrated if individuals and entities who would otherwise have to pay lien filing and activation fees could avoid them by the simple stratagem of filing a petition for costs." So the board concluded, "A lien claimant cannot circumvent the statutory scheme established by the Legislature, including the requirement to pay a lien activation fee, by withdrawing its lien and refile it as a petition for costs."<sup>69</sup>

The appeals board added that its decision would apply only to any lien withdrawals and/or petitions for costs filed after the issuance date of the decision. In that case, the appeals board reinstated the copy service

<sup>65</sup> *Marshall v. Santa Maria Joint Union High School District*, 2013 Cal. Wrk. Comp. P.D. LEXIS 247.

<sup>66</sup> *Garibay v. Federated Logistics, dba Macy's*, 2013 Cal. Wrk. Comp. P.D. LEXIS 255.

<sup>67</sup> (2013) 78 CCC 444 (appeals board *en banc*). The Court of Appeal denied review at *New Age Imaging, Inc. v. WCAB (Martinez)* (2013) 78 CCC 1006 (writ denied).

<sup>68</sup> *Martinez v. Terrazas* (2013) 78 CCC 444 (appeals board *en banc*).

<sup>69</sup> *Martinez v. Terrazas* (2013) 78 CCC 444 (appeals board *en banc*).



provider's lien claim because none of the triggering events under LC 4903.06 for payment of the lien activation fee had occurred.<sup>70</sup> But if a lien claimant has not paid an activation fee with a DOR before a lien conference, or before Jan. 1, 2014, the lien must be dismissed.<sup>71</sup>

## CONSTITUTIONAL CHALLENGES

Following the enactment of SB 863, lien claimants challenged the constitutionality of both the lien filing fee and the lien activation fee. But all constitutional challenges to the changes enacted by SB 863 have been rejected.

The constitutionality of the lien activation fee was challenged in the matter of *Angelotti Chiropractic, Inc. v. Baker*. The plaintiff lien claimants sued various state officials and agencies, asserting that the lien activation fee violated the taking, due process and equal protection clauses of the U.S. Constitution. The plaintiffs also filed a motion for a preliminary injunction. Initially, on Nov. 12, 2013, the U.S. District Court for the Central District of California dismissed the lien claimants' takings and due process clause claims, but denied a motion to dismiss on the equal protection claim. That court believed there were serious questions going to the merits of the equal protection claim and issued an order for a preliminary injunction restraining the Department of Industrial Relations from enforcing the lien activation fee against any lien claimant.<sup>72</sup> Accordingly, on Nov. 19, 2013, the DWC stopped collecting lien activation fees in compliance with the ruling.<sup>73</sup>

On June 29, 2015, the 9th U.S. Circuit Court of Appeals affirmed the District Court's dismissal of the plaintiffs' claims under the takings and due process clauses. It reversed, however, the District Court's denial of the motion to dismiss the equal protection claim, and vacated the preliminary injunction.<sup>74</sup> The 9th Circuit concluded that the takings claim was properly dismissed because the economic impact of SB 863 and its interference with the plaintiffs' expectations were not sufficiently severe to constitute a taking. It also concluded that the retroactivity of the lien activation fee did not violate the due process clause because it was justified by the rational legislative purpose of clearing the lien backlog.<sup>75</sup>

With regard to the equal protection claim, the 9th Circuit found that the California Legislature's decision to impose the activation fee on some lien claimants, while exempting others, was rationally related to the goal of clearing the backlog because the Legislature reasonably concluded that the nonexempt entities are primarily responsible for the backlog. It found that the plaintiffs' did not meet their burden to negate every conceivable basis that might have supported the distinction between exempt and nonexempt entities. The 9th Circuit concluded that the District Court abused its discretion in finding that a serious question exists as to the merits of the plaintiffs' equal protection claim. So the 9th Circuit reversed the District Court's denial of the defendant's motion to dismiss the equal protection claim and also vacated the preliminary injunction.<sup>76</sup>

As a result, on Nov. 2, 2015, the U.S. District Court issued an order vacating the preliminary injunction and giving the DWC until Nov. 9, 2015, to re-establish the payment systems that were in place prior to the entry

<sup>70</sup> See *Oceguera v. Rich Products Corp.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 222; *Chavez v. Simmons Manufacturing Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 300.

<sup>71</sup> See *Lizama v. LA Specialty Produce*, 2013 Cal. Wrk. Comp. P.D. LEXIS 163; *Ramirez v. Dynamic Plumbing Services*, 2013 Cal. Wrk. Comp. P.D. LEXIS 331; *Tenorio v. Deutsch Industrial*, 2013 Cal. Wrk. Comp. P.D. LEXIS 454.

<sup>72</sup> *Angelotti Chiropractic, Inc. v. Baker* (2013) 78 CCC 1218.

<sup>73</sup> See DWC Newsline No. 80-13 (Nov. 15, 2013) at [http://www.dir.ca.gov/dwc/dwc\\_newslines/2013/Newsline\\_80-13.pdf](http://www.dir.ca.gov/dwc/dwc_newslines/2013/Newsline_80-13.pdf). Following the District Court's decision, the appeals board rescinded orders dismissing liens in which timely petitions for reconsideration were filed. See e.g., *Castro v. Distinctive Industries*, 2013 Cal. Wrk. Comp. P.D. LEXIS 597; *Salmeron v. City of Los Angeles*, 2013 Cal. Wrk. Comp. P.D. LEXIS 625; *Santino v. Strategic Alliance Staffing Services*, 2013 Cal. Wrk. Comp. P.D. LEXIS 626. But the appeals board also held that if a lien claimant did not timely file a petition for reconsideration from a prior order dismissing a lien, it has no jurisdiction to act. See e.g., *Ramirez v. Medway Plastic*, 2013 Cal. Wrk. Comp. P.D. LEXIS 620; *Castaneda v. Valley Todeco*, 2014 Cal. Wrk. Comp. P.D. LEXIS 258; *Sattler v. Star HR*, 2014 Cal. Wrk. Comp. P.D. LEXIS 273.

<sup>74</sup> *Angelotti Chiropractic, Inc. v. Baker* (2015) 80 CCC 672.

<sup>75</sup> *Angelotti Chiropractic, Inc. v. Baker* (2015) 80 CCC 672, 681-682.

<sup>76</sup> *Angelotti Chiropractic, Inc. v. Baker* (2015) 80 CCC 672, 682-685.

of the preliminary injunction. The order provided that any lien pursuant to LC 4903(b) or cost filed as a lien filed before Jan. 1, 2013, could pay the lien activation fee from Nov. 9, 2015, to Dec. 31, 2015. The order also specified that any lien pursuant to LC 4903(b) or cost filed as a lien filed before Jan. 1, 2013, for which a lien activation fee was not paid on or before Dec. 31, 2015, would be dismissed by operation of law, per LC 4903.06(a)(5).<sup>77</sup> The 2nd District Court of Appeal later denied a petition for writ of mandate filed by lien claimants who were seeking a stay or injunctive relief against the DWC from enforcing LC 4903.06.<sup>78</sup>

Since then, the appeals board has allowed lien claimants to prove they paid the lien activation fee before dismissing their liens.<sup>79</sup> It also allowed lien claimants to pay the activation fee at any time during the period from Nov. 9, 2015, to Dec. 31, 2015.<sup>80</sup> Also, in one case in which it was impossible for a lien claimant to pay the lien activation fee because the case was being reviewed on reconsideration, the appeals board refused to dismiss the lien, but instead instructed the administrative director to contact the lien claimant to arrange payment.<sup>81</sup>

The constitutionality of the lien filing fee was challenged in *Chorn v. WCAB*.<sup>82</sup> The Court of Appeal rejected a medical provider's argument that the lien filing fee per LC 4903.05 deprived lien claimants of due process, equal protection and the right to petition for redress of grievances. It explained that LC 4903.05 was enacted to provide a disincentive to file frivolous liens and that it was not the courts' role to second-guess the wisdom of the Legislature. It added that the filing fee was enacted to combat lien abuse and improve the functioning of an out-of-control lien system. The court determined that the filing fee did not impermissibly preclude lien claimants from participating at the WCAB. Liens are not the only means by which medical providers may receive payment because medical providers may settle their bills outside of the legal system. The court believed that the compromise effected by LC 4903.05 — lien claimants must pay to file their liens but may recoup their filing fees if they ultimately prevail — sufficiently protects the due process right of lien claimants while serving the legitimate goal of deterring frivolous filings.<sup>83</sup>

## PROOF OF PAYMENT OF LIEN FILING FEE AND ACTIVATION FEE

LC 4903.06(a)(4) requires lien claimants to “submit proof of payment of the activation fee at the lien conference.” There is a rebuttable presumption that a lien claimant is required to pay a lien filing or lien activation fee at a lien conference (CCR 10770.1(c)(1)).

If a lien claimant asserts that it is an entity listed in LC 4903.05(d)(7) or LC 4903.06(b),<sup>84</sup> it must be prepared to file proof or submit a stipulation to that effect at the lien conference, and it may be requested by the WCJ. The judge, however, may take judicial notice formally or informally that the lien claimant is such an entity. This may include, but is not limited to, taking judicial notice of prior decisions of the appeals board and taking judicial notice based on the “common knowledge” or the “not reasonably subject to dispute” provisions of Evidence Code 452(g)(h) (see [“Sullivan on Comp” Section 16.2 Trial — Evidence Admitted](#)) (CCR 10770.1(c)(1)(A)).

<sup>77</sup> *Angelotti Chiropractic, Inc. v. Baker* (2015) 80 CCC 1323. See *Alday v. Leynes*, 2016 Cal. Wrk. Comp. P.D. LEXIS 9. See also *Green v. Westech International Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 754 (appeals board held that lien claimant was not required to pay lien activation fee prior to lien trial when lien conference occurred prior to Nov. 9, 2015, and only lien trial occurs afterward. Lien activation fee was to be paid as of Dec. 31, 2015).

<sup>78</sup> *California Lien Professionals Association, Inc. v. California Department of Industrial Relations* (2016) 81 CCC 395 (writ denied).

<sup>79</sup> See *Abril v. Bardon Enterprises*, 2016 Cal. Wrk. Comp. P.D. LEXIS 172.

<sup>80</sup> See *Alberdin v. SCIF*, 2016 Cal. Wrk. Comp. P.D. LEXIS 516; *Duran v. Donut Inn*, 2016 Cal. Wrk. Comp. P.D. LEXIS 483.

<sup>81</sup> *Shaya v. Fontana Unified School District*, 2016 Cal. Wrk. Comp. P.D. LEXIS 303.

<sup>82</sup> (2016) 81 CCC 332.

<sup>83</sup> *Chorn v. WCAB* (2016) 81 CCC 332.

<sup>84</sup> They are: a health-care service plan licensed per Health and Safety Code 1349; a group disability insurer under a policy issued in California per IC 10270.5; a self-insured employee welfare benefit plan issued in California as defined by IC 10121; a Taft-Hartley health and welfare fund; and a publicly funded program providing medical benefits on a nonindustrial basis.

If a lien claimant asserts under LC 4903.06(a) that it has paid a filing fee as required by former LC 4903.05, it must submit written proof of such payment at the lien conference (CCR 10770.1(c)(1)(B)).

Otherwise, in order to meet its burden of demonstrating prior timely payment, the lien claimant must present proof of prior timely payment in the form provided by the administrative rules or by a printout from the Public Information Search Tool of EAMS. An offer of proof or a stipulation that payment was made will not be adequate (CCR 10770.1(c)(1)(B)). If a lien filing fee is involved, the lien claimant must present proof that the fee was paid contemporaneously with filing the lien. If a lien activation fee was involved, the claimant must present proof that the fee was paid before the scheduled starting time of the lien conference cited in the notice of hearing, unless the lien claimant filed the DOR, on which the proof must establish that the activation fee was paid contemporaneously with the filing of the document (CCR 10770.1(c)(2)).

If a lien claimant fails to appear at a lien conference and fails submit proof that the fee has been paid, its lien may be dismissed.<sup>85</sup> If a lien claimant fails to submit proper written proof of prior timely payment, the appeals board may elect to conduct a search within EAMS to confirm it. But the board is not obligated to do so, and a failure to conduct such a search will not be a proper basis for a petition for reconsideration, removal or disqualification.<sup>86</sup>

## REIMBURSEMENT OF LIEN FILING FEE AND ACTIVATION FEE

LC 4903.07 describes the limited situations in which lien claimants may be reimbursed by the defendant for filing or activation fees. Reimbursement, along with interest at the rate allowed for civil judgments, occurs only if all of these conditions are satisfied:

1. The lien claimant made written demand for settlement of the lien for a clearly stated sum inclusive of all claims of debt, interest, penalty or other claims potentially recoverable on the lien not fewer than 30 days before filing the lien for which the filing fee was paid or filing the DOR for which the lien activation fee was paid.
2. The defendant failed to accept the settlement demand in writing within 20 days of receiving it, or within any additional time granted by the demand.
3. A final award is made in favor of the lien claimant of a specified sum equal to or greater than the amount of the settlement demand after submission of the lien dispute to the appeals board or an arbitrator. The amount of the interest and filing or lien activation fee will not be considered in determining whether the award is equal to or greater than the demand.

So in order to be reimbursed for lien filing or activation fees, the lien claimant must proceed to trial and receive an award that was equal to or greater than the amount demanded. This is rare in a high-volume litigation environment, so once the fee is paid it must be considered lost by the claimant. Realistically, the only way that the lien claimant will recover it is from the defendant.

LC 4903.07(b) specifically provides that nothing precludes an order or award of reimbursement of a filing or activation fee per the express terms of an agreed disposition of a lien dispute. The appeals board may not award reimbursement of the fee on its own unless the conditions of LC 4903.07 are satisfied. But the parties may agree to reimburse the lien claimant's fee as part of a settlement. So in the (admittedly rare) case in which a reasonable demand was made and not addressed, lien claimants and defendants will be involved in the proverbial game of chicken. They may have a number for settlement, but will reimbursement of the fee be added to it or not?

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<sup>85</sup> See *Sikes v. AAA Quality Services*, 2013 Cal. Wrk. Comp. P.D. LEXIS 516.

<sup>86</sup> See *Zambrano v. La Pinata Mexican Restaurant*, 2013 Cal. Wrk. Comp. P.D. LEXIS 191 (WCAB reviewed the information in the EAMS public records database and confirmed that the lien claimant paid the activation fee before the lien conference).

## REFUND OF LIEN FILING AND ACTIVATION FEES

CCR 10208.1 establishes when the DWC, rather than the employer, must refund money to a lien claimant for filing and activation fees. CCR 10208.1(a) explains that those fees automatically will be refunded when any of these occurs:

1. A lien filing or activation fee is paid properly but the lien or lien activation was not processed due to a system error. In this case, the fee must be resubmitted in order for it to be processed. But the fee will be deemed to be paid as of the date it was first properly paid.
2. A lien activation fee is paid and it is confirmed by the fee payment system that it was paid previously for the same lien, or the lien is not available for activation.
3. An improper amount is paid for a lien filing fee or activation fee. In this case, the filing or activation fee must be repaid in the proper amount in order for the lien filing or lien activation to be effective. The lien filing or activation date will be deemed to be the date the filing or activation fee is properly paid.
4. A lien filing fee is properly paid, but due to a procedural defect in the filing of the lien, it is not effective and the filer was not able to refile and cure the defect with 15 days, per CCR 10222(a). The lien filing date will be deemed to be the date the lien is properly filed.

Per CCR 10208.1(b), if a refund is not issued within 10 days under Nos. 1 - 3, or within 25 days for No. 4, the lien claimant must complete a lien filing fee refund request. That form is available at: <http://www.dir.ca.gov/dwc/Liens/LienFeeRefundREQPayer.pdf>. It must be submitted no later than 30 days from the date of payment of the contested fee. Any required documentary proof must be filed with the request, or if specified by the DWC, as a supplement to the request.

Even if a refund is requested, it will be issued only on a showing of good cause. This includes, but is not limited to:

1. A fee was paid for a lien for which no filing or activation fee is required per LC 4903.05 or LC 4903.06.<sup>87</sup>
2. An activation fee erroneously was paid for a lien other than the lien for which payment was intended and the lien for which the fee was paid erroneously was filed by a lien claimant other than the one that paid the contested fee.
3. An activation fee erroneously was paid for a lien other than the one for which payment was intended and the lien for which the fee was paid erroneously was filed by the same lien claimant that paid the contested fee. In this case, a refund will be provided only if all of these apply:
  - A. The lien claimant did not file a DOR and was not a lien claimant of record at any lien conference with respect to the erroneously paid lien from Jan. 1, 2013, up to the date of the filing of the request.
  - B. The erroneously paid lien is not set for a lien conference on any date up to 30 days following the filing of the request. And
  - C. Proof of payment for the correct lien is provided with the request for refund.
4. An activation fee is paid that was paid previously for the same lien but the duplicate payment is not confirmed by the fee payment system and no refund was issued in accordance with No. 2 above. Proof of the previous payment must be provided with the request.

<sup>87</sup> Per LC 4903.05(d)(6) and CCR 10207(l), if a lien is filed for goods and services that are not the proper subject of a lien, and the lien is dismissed, the filing fee will not be reimbursed. This regulation allows for a refund if a lien is proper, but the lien filing or lien activation fee was not required.

Based on a finding of good cause in accordance with these rules, a WCJ or the appeals board has determined that the lien claimant is entitled to a refund of the fee. A final order from a judge or the board authorizing the refund must be provided with the request for refund.

## FILING REQUIREMENTS

LC 4903.05 was added as part of SB 863. It describes the filing requirements for a lien, which were contained in former LC 4903.1(c). The appeals board amended CCR 10770 effective Oct. 23, 2013. CCR 10770 establishes the rules for filing and service of liens. Liens submitted in violation of these rules will not be deemed filed for any purpose, will not be acknowledged or returned and may be destroyed without notice (CCR 10770(b)(1); CCR 10770(c)(8)).

### Format of Lien Claims

Per LC 4903.05(a), every lien claimant must file its lien with the appeals board in writing on a form approved by the appeals board. Section LC 4903(b) *requires* liens and liens for claims of cost to be filed electronically, although other lien claims *may* be so filed. Under CCR 10770(b)(1), any electronically submitted lien claim will be deemed filed only if it utilizes an e-form approved by the appeals board and it is submitted in accordance with the requirements of:

1. the electronic filing or JET-filing procedures established by the administrative director under CCR 10205.11 and CCR 10206 et seq; or
2. any other administrative procedures or standards for electronic filing established by statute, regulation, *en banc* decision of the appeals board, published appellate opinion or policy of the administrative director applying to documents to be filed with the appeals board.

All other lien claims must be filed using an optical character recognition (OCR) lien form approved by the appeals board (CCR 10408). The appropriate document is form DWC/WCAB 6, notice and request for allowance of lien. It is available at the DWC website at <http://www.dir.ca.gov/dwc/forms.html>.

Lien claimants, who are allowed to submit paper copies, generally must complete the form using a computer or typewriter. These claimants, however, are exempt from this requirement:

1. claimants asserting a living expenses lien under LC 4903(c);
2. claimants asserting a burial expenses lien under LC 4903(d); and
3. nongovernmental claimants asserting spousal or child support expenses under LC 4903(e).

They may file a lien claim utilizing an approved OCR form or complete a non-OCR paper lien hand-printed in black ink (CCR 10770(b)(2)).

For all liens, whether or not filed electronically, only original (that is, initial or opening) lien claims will be accepted for filing. No amended liens should be filed, except in accordance with CCR 10393(g) or CCR 10393(h), which pertain to filing exhibits at conferences and trials. Any amended lien may be destroyed without notice (CCR 10770(c)(2)).

### Attachments to Lien

Per LC 4903.05(a), every lien filed with the appeals board must be accompanied by a full statement or itemized voucher supporting the lien, justifying the right to reimbursement and proving service on the injured worker or, if deceased, on the worker's dependents, the employer, the insurer and the respective attorneys or other

agents of record. For liens filed on or after Jan. 1, 2017, the lien also must be accompanied by an original bill in addition to either the full statement or itemized voucher supporting the lien. Medical records are to be filed only if they are relevant to the issues being raised by the lien.

CCR 10770(c)(3) requires supporting documents to be filed at the MSC in accordance with CCR 10393(g) or trial in accordance with CCR 10393(h), unless otherwise ordered by the appeals board. The regulation provides that if an original lien claim is filed with supporting documentation, the lien claim will be filed, but not the supporting documentation, which may be destroyed without notice.

Per CCR 10770(c)(4), these documents must be filed concurrently with each lien claim:

1. a proof of service;
2. the verification under penalty of perjury required by CCR 10770.5 (see below);
3. a true and correct copy of any assignment of the lien, if required by LC 4903.8(a)(b);
4. the declaration under penalty of perjury required by LC 4903.8(d) (see below); and
5. any other declaration or form required by law to be filed concurrently with a lien claim.

Unless the lien claimant concurrently is filing an initial (case-opening) application in accordance with CCR 10770.5, a lien claim must bear the adjudication case number(s) previously assigned by the appeals board for the injury or injuries (CCR 10770(c)(5)).

The form also requests the injured worker's Social Security number. The inclusion of this information is voluntary, not mandatory. Failure to provide a Social Security number will have no adverse consequences. But lien claimants are encouraged to include it to facilitate the processing and filing of the lien claim. Social Security numbers are used solely for identification and verification purposes in order to administer the workers' compensation system. A Social Security number will not be disclosed, made available or otherwise used for purposes other than those specified, except with the consent of the applicant or as permitted or required by statute, regulation or judicial order (CCR 10770(j)).

As discussed below, additional declarations must be attached to the lien under LC 4903.05(c) and LC 4903.8(d).

### **Lien for Treatment on or After July 1, 2013**

For medical treatment provided on or after July 1, 2013, an LC 4903(b) lien must not be filed if the only remaining dispute(s) must be resolved by the independent medical review procedures established by LC 4610.5 and LC 4610.6 (see Chapter VI: Utilization Review and Independent Medical Review), the MPN independent medical review process pursuant to LC 4616.3 and LC 4616.4 (see [“Sullivan on Comp” Section 7.55 Medical Provider Network — Dispute Resolution](#)) and/or by the independent bill review procedures established by LC 4603.2 et seq (see Chapter VII: Independent Bill Review). Nevertheless, a medical treatment lien claimant may file a claim if there are other outstanding disputes, including but not limited to injury, employment, jurisdiction or the statute of limitations (CCR 10770(c)(7)).

### **Service of Lien on Party Does Not Qualify as Filing of Lien with Appeals Board**

A document is deemed filed when it is lodged with the appeals board. This is different from serving a document on a party. The service of a lien claim on a defendant, or the service of notice of any claim that would be allowable as a lien, will not constitute the filing of a lien claim with the appeals board (CCR 10770(c)(9)). Also, if a lien has been served on a party, that party has no obligation to file the lien with the appeals board (CCR 10770(c)(10)).

## SERVICE OF LIENS

CCR 10770 limits the documents to be filed with the appeals board, but the service requirements of a lien are different. Lien claimants are required to serve all original liens, amended liens and all related documents, including supporting documents, on the parties.

### Parties Who Must Be Served

CCR 10770(d)(1) provides that the lien and supporting documents must be served on:

- A. the injured worker (or, if deceased, the dependent or dependents of the worker), unless:
  - i. The worker or dependent is represented by an attorney or other agent of record, in which event service may be made solely on the attorney or agent of record. Or
  - ii. The underlying case of the worker or dependent(s) has been resolved. The underlying case will be deemed to have been resolved if:
    - I. In a stipulated findings and award or in a compromise and release agreement, a defendant has agreed to hold the worker or dependent(s) harmless from the specific lien claim being filed and has agreed to pay, adjust or litigate that lien.
    - II. A defendant had written notice of the lien claim before the lien was filed and, in a stipulated findings and award or in a compromise and release agreement, that defendant has agreed to pay, adjust or litigate all liens.
    - III. The application for adjudication filed by the worker or the dependent(s) has been dismissed, and the lien claimant is filing or has filed a new application. Or
    - IV. The worker or the dependent(s) choose(s) not to proceed with the case.
- B. any employer(s) or insurance carrier(s) that are parties to the case, and, if represented, the attorney(s) or other agent(s) of record.

Failure to serve an employer with a lien claim and relevant medical reports may invalidate an award favoring the lien claimant.<sup>88</sup>

### Documents That Must Be Served

A lien claimant is required to attach several documents with its lien. The claimant must serve any document that must be filed with the appeals board (CCR 10770(d)(1)). In addition, per LC 4903.05, a lien must be accompanied by “a full statement or itemized voucher supporting the lien and justifying the right of reimbursement and proof of service upon the injured worker or, if deceased, upon the worker’s dependents, the employer, the insurer, and the respective attorneys or other agents of record.” CCR 10770(d)(2) defines what must be included in a “full statement or itemized voucher” supporting a lien claim:

- A. any amount(s) previously paid by any source for each itemized service;
- B. a statement that clearly and specifically establishes the basis for the claim for additional payment;
- C. proof of ownership of the debt if the lien claimant is not the original service provider or is not an entity described in LC 4903.05(d)(7) or LC 4903.06(b); and
- D. a declaration under penalty of perjury under the laws of the state of California that all of the foregoing information provided is true and correct.

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<sup>88</sup> See *Katzin v. WCAB (Guerra)* (1992) 57 CCC 230.

This requirement applies to all liens, including those filed before the effective date of the regulation — May 21, 2012. So in one case, the appeals board affirmed a WCJ's decision to dismiss a lien when the judge ordered the claimant, per CCR 10770, to produce evidence that it owned the lien and the claimant failed to do so.<sup>89</sup>

Per CCR 10770(e), a lien claimant must provide the name, mailing address and telephone number of a person with authority to resolve the lien claim on behalf of the claimant.

## AMENDMENT OF LIEN

After a lien has been filed, a lien claimant must serve any amendments to the lien, together with a full statement or itemized voucher supporting the amendment. When filing an amended lien, the lien claimant must indicate in the box on the lien form that it is an “amended” lien (CCR 10770(d)(3)). An amended lien, per CCR 10770(f), includes one that:

1. is for or includes additional services or charges for the same injured employee for the same date or dates of injury;
2. reflects a change in the amount of the lien based on payments made by the defendant;
3. has been corrected for a clerical or mathematical error.

A subsequent lien claim that adds an additional adjudication case number or numbers is an “amended” lien claim with respect to the adjudication case number(s) originally listed.

## NOTIFICATIONS FOLLOWING FILING OF LIEN

After a lien has been filed, the appeals board must either serve or, under CCR 10500(a) and CCR 10544, cause to be served notice on all lien claimants of each hearing scheduled, whether or not the hearing directly involves that lien claimant's lien claim (CCR 10770(i)).

The lien claimant also has notification requirements if its lien is resolved or withdrawn. A lien is considered “resolved” if there is payment in accordance with an order or an informal agreement has been made and payment received (CCR 10770(g)).

Within five business days after a lien has been resolved or withdrawn, the lien claimant must provide written notification to: (1) the appeals board; (2) the party defendant(s), or, if represented, the attorney(s); and (3) the worker or dependent(s) or, if represented, the attorney(s) for them, except that no notification is required if the underlying case has been resolved. If the notification of lien resolution or withdrawal is being filed by a lien claimant's attorney or nonattorney representative, a copy also must be served on the lien claimant. If the notification is being filed by a lien claimant who is represented, a copy also must be served on the attorney or nonattorney representative. In either case, the written notification must include a request to end the participation of both the lien claimant and its representative in EAMS (CCR 10770(g)).

If a lien claimant notifies the appeals board in writing that its lien has been resolved or withdrawn, the lien claim will be deemed dismissed with prejudice by operation of law. Then the claimant will be excused from appearing at any noticed hearing (CCR 10770(h)). A lien claimant cannot be sanctioned for failing to appear at a hearing if it timely notifies the appeals board in writing that its lien has been resolved or withdrawn.<sup>90</sup> If a lien claimant files a DOR and fails to give the appeals board the requisite notice, it may be sanctioned per LC 5813.<sup>91</sup>

<sup>89</sup> *Pappas v. TNT Grading, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 120. See also *Injury Treatment Clinics/Terry Hunt D.C. v. WCAB (Rodriguez)* (1995) 60 CCC 502 (writ denied); *Beverly Hills Multispecialty Medical Group v. WCAB (Wesley)* (2006) 71 CCC 804 (writ denied).

<sup>90</sup> *Arias v. Superbra, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 549.

<sup>91</sup> See *Palacios v. Paragon Building Products*, 2013 Cal. Wrk. Comp. P.D. LEXIS 276.



Note that in one case, a lien claimant attempted to withdraw its lien after it was paid in excess of the amount determined to be reasonable by an independent bill reviewer. The defendant sought reimbursement for the overpaid amounts, but the lien claimant asserted that the appeals board did not have jurisdiction because the lien was withdrawn. Without deciding the issue, the appeals board noted that the defendant was entitled to be heard on its claim for reimbursement. The board explained that it was empowered to join necessary parties, per LC 5307.5(b) and CCR 10380, and stated that the lien claimant may be required to appear and participate in future proceedings.<sup>92</sup>

## **SANCTIONS FOR FAILURE TO COMPLY WITH FILING AND SERVICE REQUIREMENTS**

Any violation of CCR 10770 may give rise to sanctions under LC 5813. CCR 10770(k) states, “Any violation of the provisions of this section may give rise to monetary sanctions, attorney’s fees, and costs under Labor Code section 5813 and Rule 10561.” See [“Sullivan on Comp” Section 13.4 Sanctions Under LC 5813](#) for further discussion of these provisions.

Note, however, that specified provisions of CCR 10770 do not apply to liens or claims of: (1) the EDD; (2) the California Victims of Crime Program; (3) any lien claimant listed as being excepted under CCR 10205.10(c)(5)(A)-(C); (4) any governmental entity pursuing a lien claim for child support or spousal support; and (5) the Uninsured Employers Benefits Trust Fund. Specifically, these lien claimants are not subject to subdivisions (c)(4)(D) (declaration under penalty of perjury required by LC 4903.8(d)); (c)(8) (lien claims submitted in violation with filing requirements); (c)(9) (service on defendant is not service on the appeals board); and (d)(2) (full statement or itemized voucher).

## **DECLARATIONS UNDER PENALTY OF PERJURY**

A medical lien claimant must file certain declarations with its liens under penalty of perjury. Under LC 4903.05(c), for liens filed on or after Jan. 1, 2017, any lien claim under LC 4903(b) that is subject to a filing fee must be accompanied by a declaration stating, under penalty of perjury, that the dispute is not subject to an independent bill review or independent medical review under LC 4603.6 and LC 4610.5, respectively. A lien claimant must declare that it satisfies one of these:

1. The provider is the employee’s treating physician providing care through a medical provider network.
2. The provider is an agreed medical evaluator or qualified medical evaluator.
3. The provider provided treatment authorized by the employer or claims administrator under LC 4610.
4. The provider made a diligent search and determined that the employer does not have a medical provider network in place.
5. The provider has documentation that medical treatment has been neglected or unreasonably refused to the employee as provided by LC 4600.
6. The provider can show the expense was incurred for an emergency medical condition, as defined by Health and Safety Code Section 1317.1(b).
7. The provider is a certified interpreter rendering services during a medical-legal examination, a copy service providing medical-legal services or has incurred an expense allowed as a lien under rules adopted by the administrative director.

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<sup>92</sup> *Arias v. Superbra, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 549.

All other lien claimants under LC 4903(b) have until July 1, 2017 to file such a declaration for any lien filed before Jan. 1, 2017. The failure to file a signed declaration will result in the dismissal of the lien with prejudice by operation of law. Filing of a false declaration will be grounds for dismissal with prejudice after notice.

Per LC 4903.8(d), for liens filed before Jan. 1, 2013, a lien claimant must file one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring:

1. The services or products described in the bill for services or products were provided to the injured employee. And
2. The billing statement attached to the lien accurately describes the services or products provided to the injured employee.

The declaration must be filed at the earliest of the filing of a DOR, a lien hearing or Jan. 1, 2014. Per LC 4903.8(e), a lien for medical expenses submitted for filing on or after Jan. 1, 2013, that does not comply with its requirements will be deemed invalid, whether or not accepted for filing by the appeals board. Such a filing will not operate to preserve or extend any time limit for filing of the lien. The requirement for a declaration applies without regulatory action, but the appeals board and the administrative director have discretion to formulate regulations and forms for implementation of LC 4903.8.

Although the statute is silent as to whether a lien without a declaration filed before Jan. 1, 2013 is invalid, the appeals board has held that such liens may be dismissed for failure to provide proof of compliance with LC 4903.8(d). The board explained that pre-2013 liens are subject to certain mandatory filing and timing requirements, and that the LC 4903.8(d) declarations must have been filed by the earliest of Jan. 1, 2014, the filing of a DOR or a lien hearing. Because the lien claimant failed to prove that the required LC 4903.8(d) declaration was timely filed, or prove that the required supporting materials in support of its lien were filed, the appeals board found that the lien claimant failed to meet its prima-facie burden to recover on its lien.<sup>93</sup> Sanctions may be awarded for failure to attach the declaration under LC 4903.8(d).<sup>94</sup>

In another case, however, the appeals board held that liens filed prior to Jan. 1, 2013 were not invalid for failing to comply with the requirements of LC 4903.8(d). Those lien claimants had filed their declarations after the WCJ issued a notice of intention to dismiss their liens for failure to comply with LC 4903.8(d). The appeals board explained that there was no substantial prejudice to the defendant in allowing lien claimants to prosecute their liens, because they eventually filed the declarations as required by LC 4903.8(d). The board was convinced that the claimants had shown good cause to have their liens heard on the merits.<sup>95</sup>

## VERIFICATION OF MEDICAL LIEN

CCR 10770.5 was adopted in response to LC 4903.6. CCR 10770.5(a) provides that any LC 4903(b) lien, a lien for medical-legal costs and any application related to such lien must attach to the claim a verification under a penalty of perjury specifying in detail the facts establishing that:

1. Sixty days have elapsed since the date of acceptance or rejection of liability for the claim, or the time provided for the investigation of liability per LC 5402(b) has elapsed, whichever is earlier.
2. And either:
  - A. The time provided for payment of medical treatment bills per LC 4603.2 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined by IBR per LC 4603.6, and, if authorization for the medical treatment has been disputed

<sup>93</sup> *Mendoza v. Oak Grove, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 393.

<sup>94</sup> See *Hopkins v. TJ Maxx*, 2013 Cal. Wrk. Comp. P.D. LEXIS 376.

<sup>95</sup> *Gallegos v. Barrett Business Services*, 2015 Cal. Wrk. Comp. P.D. LEXIS 686.

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per LC 4610, the medical necessity of the medical treatment has been determined by IMR per LC 4610.5 and LC 4610.6. Or

- B. The time provided for payment of medical-legal expenses per LC 4622 has expired and, if the employer objected to the amount of the bill, the reasonable fee has been determined by IBR per LC 4603.6

The verification under penalty of perjury also must declare that the lien is not being filed solely because of a dispute subject to the IMR and/or the IBR process (CCR 10770.5(b)).

If an application for adjudication also is being filed, per CCR 10770.5(c) the verification under penalty of perjury must:

1. state in detail the facts establishing that the venue in the district office being designated is proper per LC 5501.5(a)(1) or LC 5501.5(a)(2); and
2. state in detail the facts establishing that the filing lien claimant has made a diligent search and has determined that no adjudication case number exists for the same injured worker and same date of injury at any district office. A diligent search must include contacting the injured worker, contacting the employer or carrier or inquiring at the district office with appropriate venue per LC 5501.5(a)(1) or LC 5501.5(a)(2).

Finally, CCR 10770.5(d) establishes a format for the verification under penalty of perjury. It is:

“I declare under penalty of perjury under the laws of the State of California:

(1) that the time periods set forth in Rule 10770.5(a) have elapsed;

(2) that the section 4903(b) lien, the lien for medical-legal costs, or the application is not be filed solely because of a dispute subject to the independent medical review and/or independent bill review process; and

(3) that, if an application for adjudication is being filed, that venue is proper as set forth in Rule 10770.5(b) and that I have made a diligent search and have determined that no adjudication case number exists for the same injured worker and the same date of injury. In determining that no adjudication case number exists for the same injured worker and the same date of injury, I have made a diligent search consisting of the following efforts (specify):

.....

.....

.....

s/s .....on .....

A failure to attach the verification or an incorrect verification may result in sanctions.”

## NO RECOVERY FOR NONAUTHORIZED TREATMENT OF KNOWN INDUSTRIAL CONDITION

LC 4903.1 allows a lien for benefits paid or services provided by a health-care provider; a health-care service plan; a group disability policy; or a self-insured employer welfare plan. Former LC 4903.1(b) was eliminated, and a new subsection (b) was added.

LC 4903.1(b) does not allow payment or reimbursement if, at the time the expense was incurred, the provider either knew or in the exercise of reasonable diligence should have known<sup>96</sup> that the condition being treated was caused by the employee's employment. LC 4903.1(b) precludes recovery whether payable by the employer or payable as a lien against the employee's recovery. Furthermore, it provides that the employee will have no liability for the expense.

LC 4903.1(b), however, defines several exceptions to this general rule. It says that a medical provider may recover if it knew or should have known that the employee's condition was industrial because:

1. The expense was authorized by the employer.
2. The expense was incurred for services furnished while the employer failed or refused to furnish treatment as required by LC 5402(c) (regarding provision of treatment at the beginning of the claim for as much as \$10,000).
3. The expense necessarily was incurred for an emergency medical condition.

The term "emergency medical condition" is defined by Health and Safety Code 1317.1(b). It states that an "emergency medical condition" manifests by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any body organ or part.

Before enactment of this provision, these kinds of liens usually were defended only by the statute of limitations. That is, large health-care organizations would become aware after the fact (even if they should have known) that the treatment provided was compensable under workers' compensation, and would file a lien. Sometimes this lien was filed right away, and sometimes very late in the game. They would proceed to recover on the theory that LC 4600 allowed for all reasonable care. This language places an additional barrier to such liens. Regardless of how much time has passed, the conditions established here must be met. This serves the dual function of having the nonindustrial providers take greater responsibility for screening industrial cases ahead of time, and enforcing respect for the rules concerning medical control.

## NOTIFICATION OF REPRESENTATION

Effective Jan. 1, 2013, LC 4903.6(b) requires all lien claimants under LC 4903 to notify the employer, the employee, their respective representative, if any, and the appeals board within five days of obtaining, changing or discharging representation by an attorney or nonattorney representative. The notification must include the legal name, address and telephone number of the attorney or nonattorney representative.

This requirement places notification requirements on lien claimants. Often, lien claimants do not appear at lien conferences. They hire a lien collection service to represent them at appeals board hearings, and it is not uncommon for a defendant not to know with whom it would be dealing until arriving at the appeals board.

<sup>96</sup> The "knew or in the exercise of reasonable diligence should have known" standard certainly will be tested in the courts. There is no precedent for what constitutes knowledge by physicians or medical groups. There are two places in the law where a court might seek guidance — the applicant's required knowledge of cumulative trauma injury under LC 5412 (see ["Sullivan on Comp" Section 5.5 Cumulative Injury](#)), and an employer's knowledge of industrial injury (see ["Sullivan on Comp" Section 5.16 Presumption of Injury — 90-Day Rule](#)).

Now, just like regular parties, lien claimants must notify the parties and the appeals board if they have obtained attorney or nonattorney representation. CCR 10774.5 was adopted to give force to LC 4903.6(b). It requires a lien claimant to file a notice of representation when it first obtains an attorney or nonattorney representative.

### **Notification of Representation Requirements**

Per CCR 10774.5(a), the notice must be provided to: (1) the appeals board; (2) the injured employee and dependents of a deceased employee *or*, if represented, to the attorney or representative of the employee or dependents; and (3) each defendant *and* each defendant's attorney or representative, if any. The notice must be accompanied by a proof of service and made under penalty of perjury.

CCR 10774.5(b) requires the notice to:

1. caption the case title (that is, include the name of the injured employee and the name of the defendant or primary defendant(s)) and the adjudication case number(s) to which the notice relates;
2. include the full legal name, mailing address and telephone number of the lien claimant; and
3. include the full legal name, mailing address and telephone number of the initial or new attorney or nonattorney representative or, if a lien claimant becomes self-represented, the name of the former attorney or nonattorney representative.

The notice must be verified by a declaration under penalty of perjury stating: "I declare under penalty of perjury that the statements and information contained in this notice are true and correct" (CCR 10774.5(d)).

The notice must be filed and served within five working days of when: (1) a self-represented lien claimant obtains an attorney or a nonattorney representative; (2) a represented lien claimant changes to a new attorney or nonattorney representative; or (3) a represented lien claimant becomes self-represented (CCR 10774.5(c)).

### **Requirements for Nonattorney Representatives**

Per CCR 10774.5(e), if a lien claimant obtains an attorney or changes attorney representation, the claimant's notice requirements, as discussed above, may be satisfied by a notice of representation or change of representation filed and served by the attorney. If the lien claimant is represented by a nonattorney representative, however, additional requirements apply.

If a self-represented lien claimant obtains a nonattorney representative, a notice of representation must be filed. Also, if a represented lien claimant changes to a new representative, a notice of change of representation must be filed (CCR 10774.5(e)(1)).

If a lien claimant becomes represented or changes representation fewer than five working days before a scheduled hearing or if, for any reason, a copy of the notice of representation or change of representation does not appear in the appeals board's record by the time of hearing, a copy of the fully executed notice must be lodged with the WCJ presiding over the hearing. Also, it must be served personally and concurrently on each party or lien claimant appearing at the hearing (CCR 10774.5(e)(2)).<sup>97</sup> This rule was adopted to help ensure that when a new nonattorney representative unexpectedly appears, the WCJ and the other parties and lien claimants will know that the representative has the authority to appear, negotiate and settle.

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<sup>97</sup> See *Tsao v. Fletcher Jones Motor Cars*, 2016 Cal. Wrk. Comp. P.D. LEXIS 307.

The notice is required even if the initial or new representative has signed or is signing a pleading on behalf of the lien claimant (CCR 10774.5(e)(3)). Both the claimant and the new representative must sign and date the notice before the relationship becomes effective.<sup>98</sup> If the lien claimant or the representative is a partnership, corporation or other organization, the notice may be signed by a corporate officer, partner or fiduciary under a statement certifying that the person signing has the authority to do so (CCR 10774.5(e)(4)).

An entity may be designated to represent a lien claimant's interests at hearings, and different individuals from the entity may appear as the lien claimant's representative.<sup>99</sup> The appeals board has held that CCR 10774.5 does not require the person signing to identify his or her relationship to the lien claimants. It explained that the purpose of that regulation is to ensure that lien claimants endorse and identify who will represent the lien interests in the matter. It found no restriction on the representatives contracting out hearing appearances.<sup>100</sup>

A notice must not be filed for the sole purpose of allowing a third-party agent, such as a copy service, to sign and issue a subpoena or subpoena *duces tecum* under LC 130, LC5710 or CCR 10530 et seq (CCR 10774.5(e)(6)). This rule was adopted because the appeals board believed that the responsibility for signing and issuing subpoenas should not be delegated to a third-party agent; that responsibility should be assumed by an attorney or nonattorney representative who is employed or intended to be employed on a continuing or extended basis.

Also, per CCR 10774.5(e)(7) and verified under penalty of perjury, the notice must contain:

- A. a declaration executed by both the lien claimant and by the representative assuming representation stating: "I declare that the named initial or new representative has consented to represent the interests of the named lien claimant and that the named lien claimant has consented to this representation.";
- B. a declaration executed by both the lien claimant and by the representative assuming representation stating, as appropriate, either:
  - i. "This representation began on \_\_\_\_\_, \_\_, 20\_\_\_\_. I am not aware of any other attorney or non-attorney who was previously representing the lien claimant."; or
  - ii. "This representation began on: \_\_\_\_\_, \_\_, 20\_\_\_\_. I am aware that \_\_\_\_\_ [specify person or entity] was previously representing the lien claimant. This Notice of Change of Representation supersedes a previous Notice of Representation dated \_\_\_\_\_, 20\_\_\_\_. I hereby certify that I have notified the previous attorney or non-attorney representative in writing of the change of representation."; and
- C. a declaration executed by the representative stating: "By signing below, I affirm that I am not disqualified from appearing under Labor Code section 4907, WCAB Rule 10779 (Cal. Code 51 Regs., tit. 8, Section 10779) or by any other Rule, order, or decision of the Workers' Compensation Appeals Board, the State Bar of California, or court."

## Termination of Representation

If a lien claimant's representation by an attorney or nonattorney representative terminates for any reason (including the advocate's discharge or death, or the suspension or removal of his or her right to appear), and the lien claimant does not concurrently execute a notice of change of representation, the lien claimant will

<sup>98</sup> *Jimenez v. Steel Tech Industrial Corp.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 429.

<sup>99</sup> *Flores (Balentin Lopez) v. Action Tile & Coping*, 2015 Cal. Wrk. Comp. P.D. LEXIS 490.

<sup>100</sup> *Lopez v. Sheraton Park Hotel*, 2015 Cal. Wrk. Comp. P.D. LEXIS 326. See also *Perez v. Agriculture Installations, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 330.

be deemed self-represented. The claimant must file and serve a notice of nonrepresentation to comply with CCR 10774.5(a)-(d), as discussed above (CCR 10774.5(f)).

## Consequences of Failure to File Notice of Representation

Per CCR 10774.5(e)(5), if no fully executed notice of representation or change of representation has been filed at or before the time of any hearing, the lien claimant will be deemed not to be represented even if someone who purportedly has assumed representation appears. Also, “if the lien claimant does not otherwise appear at the hearing, it will be subject to all of the consequences of a failure to appear.”

In one case, the appeals board explained that compliance with LC 4903.6(b) is necessary to assure that an agent is authorized in writing to provide representation and to assure that the board and the parties are fully apprised of the fact. The appeals board affirmed a WCJ’s decision that without a representation letter pursuant to LC 4903.6(b), a lien representative’s actions have no legal effect.

In that case, a hearing representative appeared at a lien conference on behalf of the two lien claimants and issued an objection to the notice of intention to dismiss their liens for failure to appear. A letter of representation, however, was not filed. So the appeals board considered the lien claimants to be unrepresented and determined that they did not appear at the lien conference and did not object to the notice of intent. The board also warned that the hearing representative’s failure to provide necessary documentation before appearing at the lien conference, before filing two petitions for reconsideration and before filing two requests to dismiss the petitions for reconsideration, was unexplained and might support the issuance of sanctions. So the liens were dismissed per CCR 10562 (see [“Sullivan on Comp” Section 15.50 Requirement to Appear at Hearings](#)), and the matter was returned to trial level to address the issue of sanctions per LC 5813 (see [“Sullivan on Comp” Section 13.4 Sanctions Under LC 5813](#)).<sup>101</sup>

In another case, a hearing representative was physically present at a lien trial on behalf of three lien claimants, but there were no notices on file at the time of the hearing in compliance with CCR 10774.5. The WCJ issued a 10-day notice of intent to dismiss under CCR 10562. No lien claimant named in the notice of intent to dismiss objected to it, nor did the purported lien representative(s). The appeals board noted that under CCR 10774.5(e)(5), failure to comply with the requirements of that regulation was a basis for finding that the lien claimants had not appeared at the hearing. It further noted that it was a waste of the board’s resources to respond to the petition for reconsideration when the lien claimants (and/or their purported representative(s)) had ample opportunity to object to the notice of intent when it issued and chose to do nothing until after the WCJ issued the order dismissing the lien claims. So the appeals board also imposed a sanction of \$300 against each lien claimant and each lien representative individually for filing a petition that was frivolous within the meaning of LC 5813 and indisputably without merit within the meaning of CCR 10561(b).<sup>102</sup>

Also in one case, a hearing representative appeared at a lien conference and a notice of representation was filed. But, the notice was not signed by both the lien claimant and the representative. The WCAB noted that CCR 10774.5(e)(4) required the lien claimant and the representative to sign and date the notice of representation before the relationship became effective. Because no fully executed notice of representation was filed, the lien claimant was subject to all of the consequences of a failure to appear. The WCAB also noted that the lien was assigned after Jan. 1, 2013, but a copy of the assignment as required by LC 4903.8 had been filed. So the lien claim was dismissed.<sup>103</sup>

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<sup>101</sup> *Ochoa v. Checkmate Staffing*, 2014 Cal. Wrk. Comp. P.D. LEXIS 269. See also *Garcia v. Healthcare Services Group, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 426.

<sup>102</sup> *Martinez v. Mainstay Business Solutions*, 2014 Cal. Wrk. Comp. P.D. LEXIS 355.

<sup>103</sup> *Jimenez v. Steel Tech Industrial Corp.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 429.

In one case, however, the appeals board rescinded a WCJ's order finding that there was no valid appearance by lien claimants at trial when a contract hearing representative for the representative of record appeared and presented notice that he was appointed to represent the lien claimants, even though the notices did not comply with LC 4903.6(b) and CCR 10774.5. The lien claimants were represented by Landmark Medical Management (Landmark), but Israel Figueroa presented notice that the lien claimants appointed him and/or F&A Lien Services to appear and negotiate for Landmark on behalf of the lien claimant.<sup>104</sup>

The board noted that the notices did not state that the lien claimants were changing representation, and that Landmark continued to be the lien claimant's representative. It explained that there was a distinction between entities identified by lien claimants as their representatives, and agents who represent the lien claimants at a hearing. It stated that this was similar to attorney representation for parties as different attorneys may appear on behalf of the party, but as long as the representing law firm is the same, there is no requirement that a substitution of attorneys be filed. Because notices of representation were properly signed and verified per CCR 10774.5(e)(4), there was no basis for finding that the lien claimants did not appear at the hearing.<sup>105</sup>

Also, in one case, a hearing representative appeared at the board stating that he appeared on behalf of a lien claimant. When the representative did not submit an adequate notice of representation per CCR 10774.5, the WCJ issued a notice of intention to dismiss the lien for failure to appear. The notice was served personally on the hearing representative. Later, the lien claimant objected, claiming that there was no proper service. The appeals board agreed that because the hearing representative was a stranger to the case, personal service on the representative did not constitute service to the lien claimant. The board noted that a lien claim could not be dismissed or reduced unless the lien claimant was given notice and opportunity to be heard, and so the WCJ's order of dismissal was rescinded.<sup>106</sup>

### Defective Notice of Representation

CCR 10774.5 contains multiple requirements for a notice of representation filed by an attorney or nonattorney representative for a lien claimant. Failure to comply with all of the requirements will not automatically result in rejection of the notice. Whether the notice is rejected largely depends on the extent of its deficiencies.

In one case, the appeals board did not sanction a lien claimant when it filed a notice of change of representation that did not technically comply with all of the requirements of CCR 10774.5. The deficiencies were not deemed sufficiently egregious to warrant the imposition of sanctions. The lien claimant and its representative were instructed to review CCR 10774.5 and were warned that failure to comply with the requirements in the future could result in sanctions.<sup>107</sup>

In contrast, the appeals board dismissed a lien claimant's lien for failure to appear at a lien conference due to an insufficient notice of representation per CCR 10774.5. The board found that the notice did not conform to the requirements of CCR 10774.5 because: (1) it was neither filed nor served; (2) it failed to include the full legal name, mailing address and telephone number of the lien claimant, or the full legal name, mailing address and telephone number of the nonattorney representative; (3) the signatures of the lien claimant and the representative were not dated; (4) there was no statement certifying that the lien claimant or representative had authority to sign on behalf of the lien claimant and representative, respectively; (5) CCR 10774.5 requires both the lien claimant and the representative to execute declarations regarding consent to representation and the consent declaration in the notice was vague as to who was making the declaration;

<sup>104</sup> *Gonzalez v. R. Moody Construction, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 289.

<sup>105</sup> *Gonzalez v. R. Moody Construction, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 289.

<sup>106</sup> *Cux v. The Cheesecake Factory*, 2015 Cal. Wrk. Comp. P.D. LEXIS 343.

<sup>107</sup> *Arredondo v. Corporate Image*, 2016 Cal. Wrk. Comp. P.D. LEXIS 173.



and (6) the notice failed to include a sufficient declaration regarding the dates of representation, or a certification regarding any change in representation.<sup>108</sup>

## RESTRICTIONS ON ENTITLEMENT TO MEDICAL INFORMATION

LC 4903.6(d) was added to restrict the disclosure of medical information to some lien claimants. LC 4903.6(d) states, “With the exception of a lien for services provided by a physician ..., a lien claimant shall not be entitled to any medical information ... without prior written approval of the appeals board.” That is, nonphysician lien claimants are restricted from receiving any medical information without prior written approval of the appeals board. Most liens are for medical treatment or for medical-legal services, and are filed by lien claimant physicians; as such, most are not subject to this restriction. But for nonphysicians, the restrictions are serious, and specified procedures must be followed before the information may be disclosed.

In order to ensure compliance with LC 4903.6(d), the appeals board amended CCR 10608. That regulation establishes two sets of rules for service of medical reports, medical-legal reports and other medical information. One set applies to “parties” and “physician lien claimants,” and the other set of provisions applies to “non-physician lien claimants.”

### Party and Physician Lien Claimant Defined

A party and a physician lien claimant may be served with medical reports and medical information without restriction. For the purposes of serving medical information, a “party” means an injured employee, the dependent of a deceased injured employee, a party defendant or the attorney or nonattorney defendant of any of these parties (CCR 10608(a)(4)).

In order to be a “physician lien claimant,” the lien claimant must be a “physician” under LC 3209.3, an entity described in LC 4903.05(d)(7) and LC 4903.06(b), or the attorney or nonattorney representative for either. But an attorney or nonattorney representative does not include any person or entity to whom a physician lien claimant’s lien has been assigned, either as an assignment of all right, title and interest in the accounts receivable or as an assignment for collection (CCR 10608(a)(5)). A “non-physician lien claimant” is defined as a lien claimant not defined as a physician by LC 3209.3, and that is not an entity described in LC 4903.05(d)(7) and LC 4903.06(b) (CCR 10608(a)(3)).<sup>109</sup> The appeals board has held that the EDD is not a nonphysician lien claimant in the traditional sense and should be served with medical reports.<sup>110</sup>

Per LC 3209.3, the term “physician” is defined as “physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law” (see [“Sullivan on Comp” Section 7.12 Treatment by Authorized Physician](#)). LC 4903.05(d)(7) and LC 4903.06(b) cover:

1. a health-care service plan licensed per Health and Safety Code 1349;
2. a group disability insurer under a policy issued in California per IC 10270.5;
3. a self-insured employee welfare benefit plan issued in California as defined by IC 10121;
4. a Taft-Hartley health and welfare fund; and
5. a publicly funded program providing medical benefits on a nonindustrial basis.

<sup>108</sup> *Lopez v. The Edward Thomas Cos.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 357.

<sup>109</sup> Before the adoption of the regulations, in *Allen v. Universal Bank*, 2013 Cal. Wrk. Comp. P.D. LEXIS 406 and *Kayl v. The Vitamin Store*, 2013 Cal. Wrk. Comp. P.D. LEXIS 464, the appeals board held that LC 4903.6(d) applied to health plans.

<sup>110</sup> *Calderon v. The Lazy Dog Cafe*, 2016 Cal. Wrk. Comp. P.D. LEXIS 34.

## Medical Information Defined

LC 4903.6(d) prevents nonphysician lien claimants from receiving medical information. The term “medical information” is defined in Civil Code 56.05(j) as “any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical history, mental or physical condition, or treatment.”<sup>111</sup>

CCR 10608(a)(2) provides that medical information includes, but is not limited to:

1. medical reports;
2. medical-legal reports;
3. deposition transcripts (including but not limited to depositions of physicians) containing references to medical reports, medical-legal reports, medical treatment, medical diagnoses or other medical opinions;
4. medical chart notes; and
5. diagnostic imaging as defined CCR 10603(a)(2).

So the statutes and regulations cover practically all medical information about an injured worker, in whatever form it takes. Several sections in “Sullivan on Comp” Chapter 14: Discovery and Settlement discuss privacy, but Civil Code 56 is discussed in particular in [“Sullivan on Comp” Section 14.16 Privacy – General Privacy Law, Health Insurance Portability and Accountability Act and Confidentiality of Medical Information Act.](#)

## Service of Medical Information on Parties and Physician Lien Claimants

CCR 10608(b) establishes the rules for service of medical reports and medical-legal reports on a party or physician lien claimant. It requires such reports to be served after several events. The rule does not require that the physician lien claimant become a party before being entitled to service of medical report and medical-legal reports.<sup>112</sup>

After the filing of an application or other case-opening document, a party or lien claimant must serve copies of medical reports in its possession or under its control on the requesting party or physician lien claimant within 10 calendar days of the request if the reports previously have not been served. The party or lien claimant must serve a copy of any subsequently received medical reports or medical-legal reports on a party or physician lien claimant within 10 calendar days of receipt (CCR 10608(b)(1)).

When filing a declaration of readiness to proceed (DOR), including a DOR to expedited hearing, the filing party concurrently must serve copies of all medical reports and medical-legal reports relating to the claim that previously have not been served and that are in the possession or under control of the filing party. The reports must be served on: (1) all other parties, whether or not they have requested service, and (2) all physician lien claimants that have requested service. The filing party also must serve a copy of any subsequently received medical reports relating to the claim on all other parties and each physician lien claimant within 10 calendar days of receipt (CCR 10608(b)(2)).

Within 10 calendar days after service of any DOR, all other parties and lien claimants are required to serve copies of all medical reports and medical-legal reports relating to the claim that are in their possession or under their control, and have not been served, on: (1) all other parties, whether or not they have requested

<sup>111</sup> LC 4903.6(d) refers to Civil Code 56.05(g), but Civil Code 56.05 was amended effective Jan. 1, 2014, and the subdivisions were renumbered.

<sup>112</sup> *Kane v. Raleys*, 2015 Cal. Wrk. Comp. P.D. LEXIS 284.

service, and (2) all physician lien claimants that have requested service. The other parties and lien claimants also must serve a copy of any subsequently received medical reports relating to the claim on a party or physician lien claimant within 10 calendar days of receipt (CCR 10608(b)(3)).

If, any time after the periods defined above, a physician lien claimant initiates a request for service of medical reports and medical-legal reports, the parties and other lien claimants must serve the claimant within 10 calendar days of the request. Any subsequent reports also must be served within 10 calendar days of receipt (CCR 10608(b)(4)).

Finally, all medical reports or medical-legal reports relating to the claim that previously have not been served must be served on all other parties and physician lien claimants on the filing of a compromise and release or stipulations with request for award, unless the rights and/or liabilities of those parties or physician lien claimants previously were resolved fully (CCR 10608(b)(5)).

## Medical Records That Must Be Served

CCR 10608(b) requires service of “all medical reports and medical-legal reports relating to the claim.” That requires service of all medical reports in a party’s possession, not just those on which the party intends to rely.<sup>113</sup> This requirement is broad and includes many documents a practitioner may not consider to be a medical report.

In an *en banc* decision, the appeals board said, “[A]ny written communication from a physician which in any way refers to the case in which he or she has been asked to report should be filed and served pursuant to the Board rules.”<sup>114</sup> In that case, the appeals board held that a medical report must be served even though it was undated and unsigned because the lack of a signature goes to the admissibility rather than to the duty to file and serve.<sup>115</sup>

The duty to serve applies to a short report, even reports consisting of just two sentences.<sup>116</sup> A party may not return a report to a physician simply because it disagrees with its contents; it must serve the report on the other parties.<sup>117</sup> Furthermore, an attorney may not delay serving medical reports just because the reports refer to surveillance evidence.<sup>118</sup>

There is case law holding that an employer is not required to file and serve medical reports pertaining to a prior industrial injury.<sup>119</sup> CCR 10616, however, requires an employer to serve any written communication from a physician containing any information listed in CCR 10606 that is contained in any record maintained by the employer. CCR 10606 effectively covers everything related to an employee’s medical condition.<sup>120</sup> So CCR 10616 appears to require the employer to serve relevant medical records pertaining to a prior injury.

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<sup>113</sup> *Ramirez v. Giant Dollar*, 2010 Cal. Wrk. Comp. P.D. LEXIS 313.

<sup>114</sup> *Payne v. Mattel, Inc.* (1980) 45 CCC 745 (appeal board *en banc*).

<sup>115</sup> *Payne v. Mattel, Inc.* (1980) 45 CCC 745, 752 (appeals board *en banc*).

<sup>116</sup> *In re Alleged Contempt of Martin M. Berman* (1976) 41 CCC 754 (appeals board *en banc*).

<sup>117</sup> *In the Matters of Proceedings for the Discipline or Removal of Ernest Kessler* (1974) 39 CCC 336 (appeals board *en banc*); *In re Alleged Contempt of Transport Indemnity Co. and M. J. Harvey* (1974) 39 CCC 411 (appeals board *en banc*); *In re Alleged Contempt of SCIF* (1979) 44 CCC 335 (appeals board *en banc*).

<sup>118</sup> *In re Alleged Contempt of American Motorists Insurance Co. and Harold L. Schmidt* (1976) 41 CCC 95 (appeals board *en banc*).

<sup>119</sup> See *Du Bray v. WCAB* (1987) 52 CCC 120 (writ denied).

<sup>120</sup> CCR 10606 provides that a report should include, if applicable: (1) the date of the examination; (2) the history of the injury; (3) the patient’s complaints; (4) a listing of all information received in preparation of the report or relied on for the formulation of the physician’s opinion; (5) the patient’s medical history, including injuries and conditions and their effects, if any; (6) findings on examination; (7) a diagnosis; (8) opinion as to the nature, extent and duration of disability and work limitations, if any; (9) cause of the disability; (10) treatment indicated, including past, continuing and future medical care; (11) opinion as to whether permanent disability has resulted from the injury and whether it is stationary, and if stationary, a description of the disability with a complete evaluation; (12) apportionment of disability, if any; (13) a determination of the percent of the total causation resulting from actual events of employment, if the injury is alleged to be a psychiatric injury; (14) the reasons for the opinion; and (15) the signature of the physician. Cases before the enactment of CCR 10616 requiring the service of dispensary records include *In re Alleged Contempt of Martin J. Wall, Esq.* (1981) 46 CCC 14 and *Keeney v. WCAB* (1981) 46 CCC 39 (writ denied).

Nevertheless, if an employer offers its employees medical care under an Employee Assistance Program (EAP), CCR 10616 provides that records from the EAP are not required to be filed or served unless it is so ordered by the appeals board. This regulation is a two-way street: CCR 10616 does not “require nor prohibit” the filing and service of EAP reports. Presumably, EAP medical reports may support or rebut a party’s interests so, their introduction into evidence may be allowed depending on the circumstances of the case.<sup>121</sup>

### Service Under Appeals Board’s Continuing Jurisdiction

CCR 10615 provides that during the continuing jurisdiction of the appeals board, the parties have a continuing duty to serve on each other any physicians’ reports received. So, following an award, the parties have a duty to serve medical reports as long as the appeals board has continuing jurisdiction under LC 5410 and LC 5803.<sup>122</sup> The purpose of these regulations is to require full disclosure of medical evidence before, during and following litigation.<sup>123</sup>

### Service of Medical Information on Nonphysician Lien Claimants

CCR 10608(c) regulates the service of medical reports, medical-legal reports and medical information on nonphysician lien claimants. If such information is requested by a nonphysician lien claimant, a party or a lien claimant must not serve the information on that claimant unless ordered to do so by the appeals board (CCR 10608(c)(1)).

A nonphysician lien claimant is not permitted to subpoena any medical information, and any subpoena will be deemed quashed in its entirety by operation of law (CCR 10608(c)(2)). Furthermore, a nonphysician lien claimant is not permitted to obtain any medical information using a waiver, release or other authorization signed by the employee. Any such waiver, release or other authorization is invalid by operation of law (CCR 10608(c)(3)).

In order to obtain medical information, a nonphysician lien claimant must petition the appeals board for an order directing service of medical information (CCR 10608(c)(4)).<sup>124</sup> The petition must be identified as a petition by a nonphysician lien claimant for medical information (CCR 10608(c)(7)). For each document sought, or a portion of it, the petition, per CCR 10608(c)(5), must specify:

1. the name of the issuing physician, medical organization (for example, a group medical practice or hospital), or other entity and the date of the document containing medical information, if known, or if not known, sufficient information that the party or lien claimant from whom it is sought reasonably may be expected to identify it; and
2. the specific reason(s) why the nonphysician lien claimant believes that the document containing medical information, or a portion of it, is or is reasonably likely to be relevant to its burden of proof on its lien claim or its petition for costs.

The petition concurrently must be served on the applicant and the defendant or, if represented, the attorney or nonattorney of record. If the medical information is alleged to be in the possession or control of a nonparty

<sup>121</sup> See *Pomona College v. WCAB (Robusto)* (2009) 74 CCC 1284 (writ denied); *Ellis v. WCAB* (1996) 61 CCC 502 (writ denied).

<sup>122</sup> Former CCR 10608 required that a party had a duty to serve copies of all medical reports “until a final decision, order or award in the proceedings,” and that following an award, reports were to be served “upon written request.” So, in an unpublished opinion, the Court of Appeal held that the employer had no duty to provide an applicant’s attorney with copies of post-award medical reports and that failure to serve such reports did not estop the employer from asserting the statute of limitations. *Berchtold v. WCAB* (1992) 57 CCC 535 (Court of Appeal opinion unpublished in official reports).

<sup>123</sup> *Payne v. Mattel, Inc.* (1980) 45 CCC 745, 752 (appeals board *en banc*).

<sup>124</sup> Before the amendments to CCR 10608, in *Valiente v. Custom Furniture and Cabinets Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 288, the appeals board explained that in order to obtain an order pursuant to LC 4903.6(d), a nonphysician lien claimant must file a petition specifying the medical information to be provided.

or another lien claimant, a copy of the petition must be served concurrently on that nonparty or lien claimant or, if represented, its attorney or nonattorney of record (CCR 10608(c)(6)).

The appeals board is given discretion to take whatever action on the petition it deems appropriate. It may choose to deny the petition if it is inadequate on its face; issue a notice of intention to order that the nonphysician lien claimant is entitled to service of all, some or none of the medical information sought; or set the petition for a hearing, either without or after issuing a notice of intention. Whatever it decides to do, the appeals board must serve or cause to be served each notice of hearing or notice of intention pertaining to the petition (CCR 10608(c)(8)(A)).

If the appeals board issues a notice of intention or sets a hearing, it may order that the party or lien claimant send the medical information to the personal and confidential attention of the assigned WCJ, in a sealed envelope lodged by mail or personal service only, for in camera review. Medical information received in this manner will not be deemed filed or admitted in evidence and does not become part of the record (CCR 10608(c)(8)(B)).

If a notice of intention is issued, it must occur within 15 business days after the filing of the petition, and must give the petitioner and any adverse party 10 days to file a written response (CCR 10608(c)(8)(C)). If a hearing is set after the issuance of a notice of intention, the date must be within 45 days after the lapse of the period for the timely filing of a response (CCR 10608(c)(8)(D)).

If a notice of intention is not issued and the nonphysician lien claimant is a “party” per CCR 10301(dd)(4)-(6),<sup>125</sup> a hearing must not be set unless a declaration of readiness is filed. If the nonphysician lien claimant is not yet a “party” and is therefore precluded from filing a DOR by CCR 10414,<sup>126</sup> the hearing date must be within 60 days after the petition was filed (CCR 10608(c)(8)(D)).

The appeals board must serve any order disposing of the petition on the petitioner and each party. Designated service must not be used for such service. If the appeals board orders that the nonphysician lien claimant is entitled to service of medical information, it also may order portions of the medical information to be redacted before it is served on the nonphysician lien claimant (CCR 10608(c)(8)(E)).

## No Service Required If No Dispute Over Liability

Generally, the appeals board will allow a nonphysician lien claimant to receive medical records if there is a dispute over whether an applicant’s injury arose out of and in the course of employment.<sup>127</sup> As discussed in [“Sullivan on Comp” Section 15.94 Liens — Procedure and Payment](#), when a lien claimant, rather than the employee, is litigating the issue of entitlement to payment on its lien, the claimant must establish all of the necessary elements of its lien by a preponderance of the evidence, including the threshold issue of industrial injury. Without medical evidence, a nonphysician lien claimant would not be able to meet its burden of proof.

But in one case, the appeals board denied a union trust fund’s request for medical reports when the defendant notified the board that it disputed the cost of services provided and not liability of the services. The appeals board concluded that the trust fund did not require additional medical records because the only

<sup>125</sup> Per CCR 10301(dd), “Party” means: (1) a person claiming to be an injured employee or the dependent of a deceased employee; (2) a defendant; (3) an appellant from an independent medical review or independent bill review decision or an injured employee or provider seeking to enforce such a decision; (4) a medical-legal provider involved in a medical-legal dispute not subject to independent bill review; (5) an interpreter filing a petition for costs in accordance with section 10451.3; or (6) a lien claimant where either (A) the underlying case of the injured employee or the dependent(s) of an injured a deceased employee has been resolved or (B) the injured employee or the dependent(s) of a deceased employee choose(s) not to proceed with his, her, or their case.”

<sup>126</sup> CCR 10250 was renumbered CCR 10414 effective Jan. 1, 2015.

<sup>127</sup> See *Carranza v. Saticoy Lemon Association*, 2015 Cal. Wrk. Comp. P.D. LEXIS 548; *Soto v. State of California, Department of Correction (Avenal State Prison)*, 2015 Cal. Wrk. Comp. P.D. LEXIS 617.

outstanding issue was the amount of reimbursement, and none of the medical-legal reports had any bearing on that.<sup>128</sup> Disputes regarding the amount of payment for medical services is covered in the sections commencing with [“Sullivan on Comp” Section 7.66 Payment of Medical Expenses — Overview](#).

## RESTRICTIONS ON ASSIGNMENT OF LIEN

SB 863 added LC 4903.8, which severely limits assignment of liens. LC 4903.8(a) provides that any order or award for payment of a lien filed pursuant to LC 4903(b) must be made only to the person who was entitled to it for the expenses at the time they were incurred, and not to an assignee. Payment may be made to the assignee only if the original lien claimant 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. So if the original lien claimant is still in business, payment must be made to that party. For liens filed on or after Jan. 1, 2017, the assignment of a lien in violation of this rule is invalid by operation of law.

In 2014, AB 2732 amended LC 4903.8 to clarify that this restriction does not apply to an assignment that was completed prior to Jan. 1, 2013, or that was required by a contract that became enforceable and irrevocable prior to Jan. 1, 2013. This change was made declaratory of existing law.<sup>129</sup>

Per LC 4903.8(f), these provisions took effect without regulatory action. Lien claimants challenged the constitutionality of LC 4903.8, but this challenge was rejected.<sup>130</sup>

## Filing of Assignment

Assignments must be filed with the appeals board. Per LC 4903.8(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 must be filed and served. If a lien is filed on or after Jan. 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment must be served when the lien is filed. If a lien is filed on or after Jan. 1, 2013, and the assignment occurs after it's filed, the copy of the assignment must be served within 20 days of the date of the assignment. If a lien is filed before Jan. 1, 2013, the copy of the assignment must be served by Jan. 1, 2014, or with the filing of a DOR or at the time of a lien hearing, whichever is earlier.

Per LC 4903.8(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 this is found by the appeals board, it may issue appropriate sanctions, including costs and attorneys' fees, against the assignor, assignee and their respective attorneys. Obviously, this provision is made in response to perceived abuse in the area.

<sup>128</sup> *Wood v. Vons Safeway Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 85.

<sup>129</sup> See *Padilla v. Archdiocese of Los Angeles*, 2015 Cal. Wrk. Comp. P.D. LEXIS 142; *Duenas v. Wal-Mart Associates Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 183; *Flores v. Morse, Geisler, Callister & Karlin, LLP*, 2015 Cal. Wrk. Comp. P.D. LEXIS 188; *Sapo v. Snooky's*, 2015 Cal. Wrk. Comp. P.D. LEXIS 203; *Monkiewicz v. RM Store Fixtures*, 2016 Cal. Wrk. Comp. P.D. LEXIS 186; *Gituku v. Alta Home Care*, 2016 Cal. Wrk. Comp. P.D. LEXIS 395. The appeals board previously held that LC 4903.8 applies retroactively to liens filed before its enactment. *Barrientos v. Alamo Motor Lodge*, 2013 Cal. Wrk. Comp. P.D. LEXIS 245.

<sup>130</sup> *Chorn v. WCAB* (2016) 81 CCC 332, 347-348.

## What Constitutes Assignment?

Lien claimants have the burden of proving a valid assignment, and may be ordered to produce contracts showing whether there is a valid assignment.<sup>131</sup> If a defendant asserts that a lien was improperly assigned, the issue should be raised for trial so that the lien claimant can produce proper documentation.<sup>132</sup>

LC 4903.8 does not define what constitutes an assignment for the purposes of that section. In *CIGA v. WCAB (Jenkins)*,<sup>133</sup> the Court of Appeal explained that an assignment is a commonly used method of transferring a cause of action; an assignment means to transfer title or ownership of property. It stated, “In determining whether an assignment has been made, ‘the intention of the parties as manifested in the instrument is controlling.’” The court added, “It is the substance and not the form of a transaction which determines whether an assignment was intended. ... If from the entire transaction and the conduct of the parties it clearly appears that the intent of the parties was to pass title to the [property], then an assignment will be held to have taken place.”<sup>134</sup> In that case, the court determined that there was no evidence presented that it was the intent of the medical providers to pass legal title to a collection service, or that the collection service proceeded as if it had such title. Furthermore, the evidence showed that any money owed to the medical providers would be paid by check directly to them using their tax identification numbers, and not to the collection service. So the court found that there was no assignment. For further discussion of this case, see [“Sullivan on Comp” Section 3.47 California Insurance Guarantee Association — Coverage Limitations](#).

In one case, the appeals board explained that in order to have a valid assignment, there must be a transfer of title to a then-existing interest. In that case, the assignment documents were executed before any receivables were generated. The appeals board noted that the purported assignments may not be valid at law because an existing interest was not transferred and the record provides no equitable reason to enforce an attempted assignment of future receivables to claimants. The matter was remanded for the parties to present evidence concerning the claimants’ status as valid assignees under LC 4903.8 and the validity of the underlying lien claims.<sup>135</sup>

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<sup>131</sup> See *Arreola v. American Western Door & Trim*, 2016 Cal. Wrk. Comp. P.D. LEXIS 254; *Trujillo v. County of Riverside*, 2016 Cal. Wrk. Comp. P.D. LEXIS 333; *Ortiz v. JH Design Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 379.

<sup>132</sup> *Arredondo v. Corporate Image*, 2016 Cal. Wrk. Comp. P.D. LEXIS 173.

<sup>133</sup> (2012) 77 CCC 143.

<sup>134</sup> *CIGA v. WCAB (Jenkins)* (2012) 77 CCC 143.

<sup>135</sup> *Rojas v. Tri-State Staffing*, 2015 Cal. Wrk. Comp. P.D. LEXIS 446.

## 10. MEDICAL-LEGAL PROCESS

SB 863 made several changes to the medical-legal process, which, of course, is how medical evidence is obtained to resolve disputed issues. (This subject is discussed fully in several sections of “Sullivan on Comp” Chapter 14: Discovery and Settlement.) The bill changed the qualification requirements of QMEs, and particularly those for chiropractors. It limited the number of locations from which a QME could conduct evaluations. It limited the scope of medical-legal evaluations, denying QMEs and AMEs the ability to decide disputed medical treatment issues. SB 863 streamlined the process for obtaining an AME or QME in an effort to minimize unnecessary delays and friction. It also established distinct provisions governing communications with AMEs and QMEs.

SB 863 made no substantive changes to the medical-legal process; it addressed mostly procedural issues. Regulations were adopted effective Sept. 16, 2013. Additional regulations were adopted effective Sept. 1, 2015 to require electronic submission of panel requests in represented cases and to the process for challenging the specialty of panel.

Also, on Jan. 23, 2017, the appeals board issued an *en banc* in *Maxham v. California Department of Corrections and Rehabilitation*,<sup>1</sup> explaining when advocacy letters will constitute “information” or “communication” for the purposes of LC 4062.3. Because *Maxham* was decided so recently, further legal development will be required.

### CHANGES TO QUALIFICATION REQUIREMENTS

Existing law establishes certain requirements relating to QMEs who evaluate medical-legal issues (see [“Sullivan on Comp” Section 14.57 Appointment and Reappointment of Qualified Medical Evaluators](#)). SB 863 modifies the requirements for chiropractors to become QMEs, and limits the number of locations from which QMEs may conduct evaluations.

#### Chiropractor QME Qualifications

SB 863 altered the requirements for chiropractors to become QMEs by amending LC 139.2(b)(4). Previously, a chiropractor could become a QME by either:

1. completing a chiropractic postgraduate specialty program including a minimum of 300 hours taught by a school or college recognized by the administrative director, the Board of Chiropractic Examiners and the Council on Chiropractic Education; or

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<sup>1</sup> (2017) ADJ3540065 (appeals board *en banc*).



2. being certified in California workers' compensation evaluation by a provider recognized by the administrative director.

Now, only the second pathway to becoming a QME exists for chiropractors. That is, a chiropractor may become a QME only by being certified by a provider recognized by the administrative director.

### **Limitation on Number of Offices**

LC 139.2(h)(3)(B) directs that an evaluator must not conduct qualified medical evaluations at more than 10 locations. This is a requirement of SB 863, effective Jan. 1, 2013. Previously, there was no statutory limit to the number of offices from which a QME could practice.

In addition to the usual QME fees, a physician must pay \$100 per year for each additional office location. Each office listed with the medical director must be located within California, be identified by a street address and suite or room number, if applicable, and must contain the usual and customary equipment for the type of evaluation appropriate for the QME's specialty or scope of practice. The physician may have as many as 10 additional offices, the limit established in LC 139.2(h)(3) (CCR 26(a)).

An office location must be maintained by a QME at least 180 days from the date the Medical Unit lists it as available to perform comprehensive medical-legal evaluations, except on a showing of good cause to the medical director (CCR 26(b)). The term "good cause" includes, but is not limited to:

1. natural disasters or other community catastrophes that interrupt the operation of the evaluator's business;
2. the expiration of a written lease agreement of no fewer than 12 months' duration; or
3. the sale of the real property of the location, which the QME vacates.

All changes of office location or requests to change office locations, except in the case of natural disaster or community catastrophes, must be communicated to the medical unit at least 30 days in advance (CCR 26(c)).

### **LIMITATION ON SCOPE OF MEDICAL-LEGAL EXAMINATIONS**

As discussed in Chapter VI: Utilization Review and Independent Medical Review, SB 863 created a new independent medical review process to resolve disputes regarding medical treatment. Now, if an injured worker challenges a utilization review decision to deny or modify requests for treatment, he or she must request an independent medical review to determine whether the requested medical treatment is reasonable and necessary. The independent medical review process was intended to be the only option for resolving disputes regarding requests for medical treatment. Accordingly, various provisions of the Labor Code relating to the medical-legal process were amended.

LC 4061 was amended and an introduction was added stating, "This section shall not apply to the employee's dispute of a utilization review decision under Section 4610, nor to the employee's dispute of the medical provider network treating physician's diagnosis or treatment recommendations under Sections 4616.3 and 4616.4." So LC 4061, which deals with situations in which temporary disability in an accepted case is coming to an end, may not be used to resolve medical treatment disputes that should be resolved via utilization review under LC 4610. Such disputes must be resolved by the new independent medical review process. Also, LC 4061 may not be used to resolve disputes over an MPN doctor's diagnosis and treatment recommendations. Those should be resolved by the little-used process for a second and third opinion, or ultimately an IMR under LC 4616.3 and LC 4616.4.

Also, changes to LC 4061(b) and LC 4061(c) now state that objections “to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for *future* medical care” must be resolved pursuant to LC 4062.2 and LC 4062.1, respectively (emphasis added). “Future medical care” is defined as medical treatment that is reasonably required to cure and relieve an injured worker of the effects of the industrial injury after the worker has reached maximum medical improvement or permanent and stationary status, including a description of the type of medical treatment that might be necessary in the future (CCR 1(t)). Previously, LC 4061(b) and LC 4061(c) directed that the medical-legal procedures of LC 4062.2 and LC 4062.1 would be utilized for disputes regarding “the need for *continuing* medical care” (emphasis added). Again, these changes reflect that continuing medical care issues must be resolved by independent medical review.

LC 4062, which covers any medical issues not covered by LC 4060 or LC 4061, also was amended. Former LC 4062(b), which related to the second opinion spinal surgery process, has been eliminated. LC 4062(b) now states, “If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5.” LC 4062(c) states, “If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the employer’s medical provider network established pursuant to Section 4616, the objection shall be resolved only in accordance with the independent medical review process established in Sections 4616.3 and 4616.4.” Spinal surgery issues, like all other medical treatment issues, must be decided by UR and IMR.

LC 4062.2 was amended so that the parties may agree to an AME, “except as to issues to the independent medical review process established pursuant to Section 4610.5.” Also, LC 4064(a) was amended and a sentence added stating, “Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms, except medical treatment recommendations, which are subject to utilization review as provided by Section 4610, and objections to utilization review determinations, which are subject to independent medical review as provided by Section 4610.5.”

In response to these legislative changes, CCR 35.5(g)(2) was adopted stating, “For any evaluation performed on or after July 1, 2013, and regardless of the date of injury, an Agreed Medical Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue, but shall provide an opinion about whether the injured worker will need future medical care to cure or relieve the effects of an industrial injury.”

Together, these changes were made so that independent medical review is the sole process for resolving disputes regarding ongoing or continuing medical treatment issues. Under the statutes, treatment issues may not be referred to or decided by panel QMEs or AMEs. Such doctors still are required to address issues such as causation, temporary disability, permanent disability, apportionment and future medical care. But the reasonableness and necessity of all medical treatment is the exclusive domain of the independent medical review process.

But in *Dubon v. World Restoration, Inc.*,<sup>2</sup> the appeals board held *en banc* that if a UR is found to be untimely, the issue of medical necessity is not subject to independent medical review but is to be determined by the board based on substantial medical evidence consistent with LC 4604.5, with the employee having the burden of proving the treatment is reasonably required. So if a UR determination is untimely, the appeals board still may rely on an AME or QME’s opinion on the treatment issue.

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<sup>2</sup> 2014 Cal. Wrk. Comp. LEXIS 131 (appeals board *en banc*).

## CHANGES TO MEDICAL-LEGAL PROCESS IN CASES INVOLVING UNREPRESENTED EMPLOYEES

Generally, LC 4062.1 establishes the procedure for requesting a panel QME in cases involving unrepresented employees. Although it was not modified by SB 863, several other sections were amended. An administrative change was made in LC 139.2(h)(1) requiring the medical director to give preference in assigning panels to cases in which the employee is not represented. This acknowledges the strict time limits imposed on the administrative director for assigning panel QMEs in unrepresented cases. Other changes also were enacted.

### QME Panel Request

When an employee is not represented by an attorney, and either the employee or the employer requests a QME panel pursuant to LC 4062.1, the request must be submitted on form QME 105 (request for QME panel under Labor Code Section 4062.1 — unrepresented). The employer must provide to the employee that form along with the attachment (how to request a qualified medical evaluator if you do not have an attorney) by means of personal delivery or by first-class or certified mailing (CCR 30(a)). A copy of the form and the attachment can be obtained from the DWC website at: <http://www.dir.ca.gov/dwc/forms.html>.

The party requesting a QME panel must attach a written objection indicating the identity of the primary treating physician, the date of the physician's report that is subject to the objection and a description of the medical determination that requires a comprehensive medical-legal report. Or, the requesting party must attach a request for an examination to determine compensability under LC 4060. The requesting party also must designate a specialty for the QME panel requested (CCR 30(a)(1)(2)).

If the request form is incomplete, or improperly completed, so that a QME panel selection cannot properly be made, it will be returned to the requesting party with an explanation of why the QME panel selection could not be made. The medical director also may delay issuing a QME panel until receiving additional, reasonable information requested from one or both parties that is necessary to resolve the panel request. Reasonable information includes, but is not limited to, whether a QME panel previously issued to the injured worker was used (CCR 30(c)). If the medical director asks a party for such additional information, the periods for selecting an evaluator from a QME panel and for scheduling an appointment will be tolled and will remain tolled until the date the medical director issues either a new QME panel or a decision on the panel request (CCR 30(h)).

If the request form is submitted and the employee no longer resides in California, the geographic area of the QME panel selection within the state will be determined by agreement between the parties. If the parties cannot agree, the geographic area will be determined for an unrepresented employee by his or her former residence within the state. If the employee never resided in the state, the location will be determined by where the employee worked for the employer (CCR 30(e)).

If the unrepresented employee has sustained injury to multiple body parts, it might be necessary to request QME panels in different specialties. This means the parties must confer with an I&A officer, explain the need for an additional evaluator in another specialty and reach an agreement in the presence of and with the assistance of the officer on the specialty requested for the additional panel. The procedure for obtaining panel QMEs in more than one specialty is discussed in ["Sullivan on Comp" Section 14.52 Subsequent Evaluations and Additional Qualified Medical Evaluator Panels in Different Specialties](#).

### Time for Assignment of a Panel QME

LC 139.2(h)(1) still requires the medical director to assign a three-member panel of QMEs in unrepresented cases within five working days of a request. It was amended, however, to provide that if a panel is not assigned within 20 working days, the employee has a right to choose a QME to perform the evaluation. Previously, the employee had a right to choose a QME if the assignment was not made within 15 working days. So now the medical director has an extra week to assign a panel.

### Free Choice of QME Limited to Reasonable Geographic Area

LC 139.2(h)(1) also was amended to limit the employee's choice of QMEs if the medical director does not timely assign a QME panel. Previously, if a QME panel was not timely assigned, the employee had the unrestricted right to be evaluated by "any qualified medical evaluator of his or her choice." So an unrepresented worker who lived in San Francisco, theoretically, could request an evaluation with a panel QME in San Diego, and per LC 4062.1(c), an employer would be required to furnish payment of the estimated travel expenses.

LC 139.2(h)(1) now provides that if the medical director does not timely issue a QME panel, the employee has the right to obtain a QME of his or her choice "within a reasonable geographic area." What constitutes a "reasonable geographic area" is not defined in the statute. The term is explained in CCR 9780(h)<sup>3</sup> based on consideration of several factors, rather than any specific mileage limits. As discussed in ["Sullivan on Comp" Section 7.50 Medical Control If There Is No Established Network](#), the courts have been fairly liberal in determining whether a physician is within a "reasonable geographic area," at least for the purposes of medical treatment. It is not clear whether the same standards will apply for medical-legal examinations, as they are different from medical treatment. There has been no case law on this issue since SB 863 became effective.

### REQUEST FOR FACTUAL CORRECTION FOR UNREPRESENTED EMPLOYEE

LC 4061(d) was amended, and former subsection (d) was moved to subsection (e). LC 4061(d)(1) now states, "Within 30 days of receipt of a report from a qualified medical evaluator who has evaluated an unrepresented employee, the unrepresented employee or the employer may each request one supplemental report seeking correction of factual errors in the report." The right to request a supplemental report under LC 4061(d) is defined further in CCR 37.

### Correction of Factual Errors Defined

LC 4061(d)(1) specifies that the supplemental report is limited to "seeking correction of factual errors in the report." CCR 1(cc) says a "[r]equest for factual correction" means a request by an unrepresented injured worker or claims administrator, or their representative, to a panel QME to change a statement or assertion of fact contained in a comprehensive medical-legal evaluation that is capable of verification from written records submitted a panel QME ... So it seems that a request under LC 4061(d)(1) may not be used to address errors in reasoning or situations in which the physician simply fails to address an issue. As discussed below, however, the QME must address whether the factual corrections change his or her opinion on the case.

<sup>3</sup> (CCR 9780(h) states, "Reasonable geographic area" within the context of Labor Code section 4600 shall be determined by giving consideration to: (1) The employee's place of residence, place of employment and place where the injury occurred; and (2) The availability of physicians in the fields of practice, and facilities offering treatment reasonably required to cure or relieve the employee from the effects of the injury; (3) The employee's medical history; (4) The employee's primary language."

## **Time Limits and Forms for Corrections**

Either the unrepresented employee or the employer may request the factual correction of a comprehensive medical-legal report within 30 days of the receipt of a QME report that is required to be filed with the DEU pursuant to LC 4061(e) (CCR 37(a)). The request must be made on form QME 37, and must be served on the QME, the party who did not file the request and the DEU office where the report was served (CCR 37(b)(f)). If the request is served by the employer, it must inform the employee of the availability of information and assistance officers to help him or her in responding to the request (LC 4061(d)(1)).

The injured worker is given five days after service of the request to respond. If the worker prepares a response, it must be served on the QME and the employer (CCR 37(b)). There is no provision allowing an employer to respond to an employee's request for a factual correction.

A party is not permitted to file any documents with the QME other than the form indicating the facts that should be corrected. And the QME is not allowed to review any documents not previously filed (CCR 37(e)).

## **Response to Request for Factual Correction**

If the request for factual correction is filed by the injured worker, the QME has 10 days after its service to review the corrections requested and determine if they are necessary to ensure the accuracy of the comprehensive medical-legal report. If the request is filed by the employer or by both parties, the time to review it is extended to 15 days after its service (CCR 37(c)).

Within these time limits, the QME must file a supplemental report indicating whether the factual correction of the comprehensive medical-legal report is necessary to ensure its accuracy. If factual corrections are necessary, the QME must report whether they change his or her opinion. The report must be filed at the DEU office where the original comprehensive medical-legal report was filed (CCR 37(d)).

## **Other Supplemental Reports**

The provisions of LC 4061(d)(1) and CCR 37 pertain only to supplemental reports seeking correction of factual errors in the medical-legal report. The provisions do not preclude other types of supplemental reports. CCR 36(e), however, provides that a party wishing to request a supplemental report based on the party's objection to or need for clarification of the evaluator's discussion on permanent impairment, permanent disability or apportionment may not do so until after the DEU has issued an initial summary rating, or unless the evaluator is otherwise directed to issue a supplemental report by the DEU, the administrative director or the WCJ. A party wishing to obtain a supplemental report to clarify permanent disability or apportionment may do so only by sending a detailed request within the time limits of CCR 10160(f) directly to the DEU office where the report was served by the evaluator, and not to the evaluator, and only after the initial summary rating has been issued.

CCR 38(i) states, "Except as provided in Section 37 with respect to a request for factual correction, the time frame for supplemental reports shall be no more than sixty (60) days from the date of a written or electronically transmitted request to the physician by a party. ... The request for a supplemental report, except for requests for factual correction, shall be accompanied by any new medical records that were unavailable to the evaluator at the time of the original evaluation and which were properly served on the opposing party as required by Labor Code section 4062.3." So although no other documents may be sent with a request for factual correction, new medical records may be sent to the QME for supplemental reports on other issues.

## CHANGES TO MEDICAL-LEGAL PROCESS IN CASES INVOLVING REPRESENTED EMPLOYEES

LC 4062.2 establishes the procedure for requesting a panel QME in cases involving represented employees. It was amended to streamline the procedure. Regulations were also adopted effective Oct. 1, 2015, providing that in represented cases, requests for an initial QME panel for all cases with a date of injury on or after Jan. 1, 2005 must be submitted electronically via the DWC website.

### Requests for Panel QME

SB 863 eliminated the requirement that the parties must propose an AME before requesting a panel QME. LC 4062.2(b) states, “No earlier than the first working day that is at least 10 days after the date of mailing of a request for a medical evaluation pursuant to Section 4060 or the first working day that is at least 10 days after the date of mailing of an objection pursuant to Sections 4061 or 4062, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation.”

So, under LC 4061 and LC 4062, to begin the QME process the parties must object to a treating physician’s recommendation. For an evaluation under LC 4060, which relates to cases in which there are disputes over the compensability of an injury (that is, when a case is denied), a party must request a medical evaluation per LC 4060. LC 4062.2(b) provides that a QME panel may be requested “the first working day that is at least 10 days after the date of mailing of a request” under LC 4060 or objection per LC 4061 and LC 4062.

In *Messele v. Pitco Foods, Inc.*,<sup>4</sup> the appeals board held *en banc* that CCR 10507 applied to requests for QME panels under the former medical-legal statutes. CCR 10507 establishes what commonly is called the “mailbox rule” and extends five calendar days if the physical address of the party being served with the first written proposal is within California (see [“Sullivan on Comp” Section 15.15 Service of Documents](#)).<sup>5</sup>

Since *Messele*, the time limits for requesting a panel QME have been modified by SB 863. When *Messele* was decided, the time limits for requesting a panel QME were based on the period of time for reaching an agreement on an AME. Under the current statutes, however, the parties are not required to reach an agreement on an AME before requesting a QME panel. Instead, LC 4062.2(b) allows a party to request a QME panel “at least 10 days after the date of mailing of a request” under LC 4060 or objection per LC 4061 and LC 4062.

In one case, the appeals board held that the mailbox rule still applies to QME panel requests, but that *Messele* was not applicable to LC 4062.2 in its current version. The board concluded LC 4062.2 now allows a request for a QME panel to be made on the 10th day after a written objection (or, on the 15th day, if the request is mailed).<sup>6</sup>

### Request for Medical Evaluation Pursuant to LC 4060

LC 4062.2(b) requires a party to wait at least 10 days after the date of mailing “a request for a medical evaluation pursuant to Section 4060” before requesting a QME panel. Following the adoption of SB 863, however, there was confusion as to what qualified as such a request. Generally, a party issued a letter in advance notifying the opposing party that a panel QME under LC 4060 will be requested. On June 11, 2013,

<sup>4</sup> (2011) 76 CCC 956 (appeals board *en banc*). See also *Perez v. Accord Lodging North America/Motel 6*, 2011 Cal. Wrk. Comp. P.D. LEXIS 135; *Smith v. Pacific Autism Center For Education*, 2011 Cal. Wrk. Comp. P.D. LEXIS 506.

<sup>5</sup> In *Messele v. Pitco Foods, Inc.* (2011) 76 CCC 1187 (appeals board *en banc*) (*Messele II*) and *Messele v. Pitco Foods, Inc.* (2011) 76 CCC 1318 (appeals board *en banc*) (*Messele III*), the appeals board amended the decision to apply only prospectively.

<sup>6</sup> *Murray v. County of Monterey*, 2015 Cal. Wrk. Comp. P.D. LEXIS 304. See also *Adams v. Merced City School District*, 2015 Cal. Wrk. Comp. P.D. LEXIS 649.

the DWC issued a Newsline stating that for disputes over compensability under LC 4060, a QME panel request must include a written objection identifying that a compensability examination is required.<sup>7</sup>

But in *Bahena v. Charles Virzi Construction*,<sup>8</sup> the appeals board allowed an applicant not to issue an objection before requesting the panel. Rather, the request was found to be proper when the applicant simply waited until 10 days after the defense denied the case. The board explained that the prevailing view among workers' compensation practitioners was that LC 4062.2 required a party seeking a QME panel under LC 4060 first to send a letter to the other party and wait 10 days before requesting a panel. It added, however, that SB 863 was intended to streamline the AME/QME process to eliminate unnecessary delays and friction in the system. It believed that the changes enacted by SB 863 to the process of obtaining a comprehensive medical evaluation for represented employees in denied injury cases were intended to bring that process more in line with the procedures for unrepresented employees. The appeals board added that once a denial letter is issued, if a medical evaluation is required to determine compensability, no purpose is served by holding up that process until one party sends a letter to the other to initiate it.<sup>9</sup>

It also explained that eliminating the requirement that a party requesting a QME panel propose an AME first while retaining the requirement that a letter be sent and an additional 10-day waiting period must pass before a panel can be requested does nothing to streamline the current process and eliminate unnecessary delays. So the appeals board concluded that the applicant's panel request, which was made more than 10 days after the denial letter was sent, satisfied the requirements of the statutory framework for obtaining a QME panel.<sup>10</sup>

Subsequently, the appeals board allowed an applicant to request a QME panel by submitting the defendant's delay letter with his request. The board analogized the situation to *Bahena*, and explained that although the matter involved a delay letter rather than a denial letter, the purposes for allowing a compensability examination in accordance with LC 4060 were the same, especially in light of the language in the defendant's delay letter that an LC 4060 evaluation would be needed to complete the investigation. The board believed that making one party wait to request a QME panel would do nothing to streamline the AME/QME process.<sup>11</sup>

## Request for Panel

Effective Oct. 1, 2015, in represented cases, requests for an initial QME panel for all cases with a date of injury on or after Jan. 1, 2005 must be submitted electronically via the DWC website at [http://www.dir.ca.gov/dwc/MedicalUnit/QME\\_page.html](http://www.dir.ca.gov/dwc/MedicalUnit/QME_page.html). The Medical Unit will not accept or process panel requests on the panel QME request form (form 106) postmarked after Sept. 3, 2015. It will accept requests on form 106 in cases with dates of injury prior to Jan. 1, 2005 only if the represented parties agree to obtain a panel QME pursuant to the process under LC 4062.2 (CCR 30(b)).

Per CCR 30(b)(1)(A), a party requesting a QME panel online must identify the:

1. date of injury;
2. claim number;
3. requesting party;
4. reason QME panel is being requested;
5. dispute type (that is, LC 4060, LC 4061 or LC 4062);

<sup>7</sup> [http://www.dir.ca.gov/dwc/dwc\\_newsline/2013/Newsline\\_37-13.pdf](http://www.dir.ca.gov/dwc/dwc_newsline/2013/Newsline_37-13.pdf).

<sup>8</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 638.

<sup>9</sup> *Bahena v. Charles Virzi Construction*, 2014 Cal. Wrk. Comp. P.D. LEXIS 638.

<sup>10</sup> *Bahena v. Charles Virzi Construction*, 2014 Cal. Wrk. Comp. P.D. LEXIS 638. See also *Lopez v. California Pizza Kitchen*, 2016 Cal. Wrk. Comp. P.D. LEXIS 399.

<sup>11</sup> *Montoya v. Burger Buddies, LLC dba Carl's Jr. Restaurant*, 2016 Cal. Wrk. Comp. P.D. LEXIS 242.

6. name of primary treating physician;
7. date of report being objected to;
8. date of objection communication;
9. specialty of treating physician;<sup>12</sup>
10. QME specialty requested; and
11. opposing party's QME specialty preferred (if known).

The request also must provide information regarding the applicant, the applicant's attorney, the employer, the claims administrator and the defense attorney. Per CCR 30(b)(1)(B), the requesting party must upload either:

1. a written request for an examination to determine compensability for disputes covered by LC 4060; or
2. a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical determination that requires a comprehensive medical-legal report to resolve, for disputes covered by LC 4061 and LC 4062.

Following the online submission, the requesting party must print and serve a paper copy of the online request, the panel list and a copy of any submitted supporting documentation on the opposing party with proof of service within one working day after generating the QME panel list (CCR 30(b)(1)(C)). Failure to serve the required documents, or at least establish proof of service, may allow the appeals board to invalidate the panel.<sup>13</sup> The board, however, may ignore failure to comply with the specific requirements of the regulation if the other party was not prejudiced by the failure.<sup>14</sup>

Requests may be made 24 hours a day, seven days a week. For the purposes of determining the timeliness of a request under LC 4062.2, requests made on Saturday, Sunday or a holiday will be deemed to have been made at 8 a.m. on the next business day. Requests made Monday through Friday after 5 p.m. and before 12 a.m. are deemed to have been made at 8 a.m. on the next business day, and requests made between 12 a.m. and 8 a.m. will be deemed to have been made at 8 a.m. on the same business day (CCR 30(b)(2)).

After submission of the request online, the QME panel will be generated automatically. After issuance of a panel, any subsequent request on the same claim, whether made on the same day or not, will be considered a duplicate request. If there are technical difficulties such that the QME panel cannot be generated online, the requesting party may contact the Medical Unit, and must reference the error code or message (CCR 30(b)(3)).

## Revocation of Panel

After the issuance of a panel, if the medical director determines that: it was issued by mistake; there is a misrepresentation of fact in the forms or document filed in support of the request, or; the parties have agreed to resolve their dispute using an AME or by other agreement, the panel may be revoked. Notice of the revocation must be sent to parties listed on the panel request (CCR 30(c)).

<sup>12</sup> See *Mariscal v. St. Francis Assisted Care, Inc.* 2015 Cal. Wrk. Comp. P.D. LEXIS 22 (invalidating a panel requested by a defendant when it did not list the specialty of the PTP).

<sup>13</sup> See *Pizano v. Azusa Unified School District*, 2016 Cal. Wrk. Comp. P.D. LEXIS 439.

<sup>14</sup> *Aguilar v. Healthcare Services Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 515.



## QUALIFIED MEDICAL EVALUATOR PANEL DISPUTES

Under LC 4062.2, either party may request the assignment of a panel of QMEs after a request under LC 4060 or an objection under LC 4061 or LC 4062. Per CCR 30.5, the medical director generally will opt for the type of specialist indicated in the request form in the panel selection process. Sometimes the designating party might select a specialist type that suits its purposes in litigation. For example, an applicant attorney may designate a pain management specialist, a neurologist, rheumatologist or a chiropractor, believing that such doctors will issue more favorable reports for the injured worker, even though an orthopedic surgeon is selected as the primary treating physician. The employer may dispute the selection, believing that an orthopedic surgeon should evaluate the applicant. How should these disputes be resolved? The Legislature empowers the Department of Industrial Relations to establish regulations regarding the panel selection process,<sup>15</sup> and CCR 31.1 establishes the procedures when there are QME panel selection disputes.<sup>16</sup>

### Disputes Over Panel Validity

Per CCR 31.1(a), the appeals board must resolve “[d]isputes regarding the validity of panel requests.” So if the issue is whether the QME panel was requested validly, it must be resolved by the appeals board. Issues of validity may involve whether the panel was selected prematurely, or whether an appropriate objection per LC 4061 or LC 4062 was made before a panel was requested.

### Disputes Over Panel Specialty

CCR 31.1(b) states, “Disputes regarding the appropriateness of the specialty designated shall be resolved pursuant to [CCR 31.5(a)(10)].” In accordance with that regulation, a new panel may issue if “The Medical Director, upon written request, ... determines after a review of all appropriate records that the specialty chosen by the party holding the legal right to designate a specialty is medically or otherwise inappropriate for the disputed medical issue(s).” So if there is a dispute regarding the specialty of the QME panel, it must be addressed first by the medical director. There is no specific time frame for objecting to the panel specialty assigned.<sup>17</sup> But a party should object within a reasonable time.

To dispute the specialty of the assigned party, CCR 31.5(a)(10) requires the opposing party to file a copy of the doctor’s first report of occupational injury or illness (DLSR form 5021) and the most recent copy of the primary treating physician’s progress report (DWC form PR-2) or a narrative report in lieu of the PR-2. It also seemingly allows the opposing party to submit “all appropriate records.” Following receipt of these documents, the medical director must determine whether the chosen specialty is medically inappropriate for the applicant’s injury. If necessary, CCR 31.5(a)(10) allows the medical director to request additional information or records.

The party aggrieved by the medical director’s decision regarding the specialty of the QME panel may appeal the decision to a WCJ (CCR 31.1(b)). Also, if the medical director is unable to issue a QME panel in a represented case within 30 days of receiving a request, either party may seek an order from a WCJ that a

<sup>15</sup> *Aguirre v. Marley*, 2016 Cal. Wrk. Comp. P.D. LEXIS 277.

<sup>16</sup> CCR 31.1 was amended effective Sept. 1, 2015. It was altered significantly because with the implementation of online requests, parties will be unable to make simultaneous requests, so the former subdivisions are now inapplicable. For cases discussing the law as it applied prior to that date, see *Gomez v. Janco Industries, Inc.*, 2011 Cal. Wrk. Comp. P.D. LEXIS 161; *Acosta v. Trinity Nursing Home Management*, 2014 Cal. Wrk. Comp. P.D. LEXIS 481; *Chanchavac v. LB Industries, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 555; *Garcia v. Alameda Unified School District*, 2014 Cal. Wrk. Comp. P.D. LEXIS 347; *De La Cruz v. Evergreen Aviation*, 2014 Cal. Wrk. Comp. P.D. LEXIS 590; *Lagunas v. Mi Pueblo*, 2014 Cal. Wrk. Comp. P.D. LEXIS 655; *Alderete v. Adventist Medical Center*, 2014 Cal. Wrk. Comp. P.D. LEXIS 702; *Linscott v. All Tech Machine Engineering, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 719; *Rivera v. Jaco Environmental, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 58; *Chavez v. Miracle Farms, d/b/a Golden Valley Farms*, 2015 Cal. Wrk. Comp. P.D. LEXIS 276; *Melendez v. B&D Upholstery*, 2015 Cal. Wrk. Comp. P.D. LEXIS 303; *Natividad v. Sherbourne Properties, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 305; *Gonzalez v. CK Enterprises*, 2015 Cal. Wrk. Comp. P.D. LEXIS 382; *Garcia v. Jack in the Box*, 2015 Cal. Wrk. Comp. P.D. LEXIS 413; *Gonzalez v. Rancho Harvest*, 2015 Cal. Wrk. Comp. P.D. LEXIS 558; *Nieto v. Avitus, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 96.

<sup>17</sup> See *Aguilar v. Healthcare Services Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 515.

QME panel be issued. Any such order must specify the specialty of the QME panel or the party designated to select the panel (CCR 31.1(c)). A party aggrieved by the WCJ's decision on the specialty of the QME has the right to file a petition for removal if it wishes to appeal the decision further.

The appeals board has held that this procedure must be followed before a WCJ may decide a dispute over the panel specialty. In that case, a defendant requested a QME panel in orthopedic surgery and an applicant simultaneously requested a QME panel in physical medicine and rehabilitation. Panels in both specialties were issued because each party requested a panel for a different date of injury. Instead of submitting the dispute to the medical director, as required by CCR 31.1(b), the defendant filed a DOR and requested an MSC. The board found that although a trial would result in a more expeditious determination of the dispute than if it was first submitted to the medical director, the applicable rules do not permit the parties to bypass the requirement that QME specialty disputes “shall be resolved” by the medical director. The board concluded that the WCJ acted in excess of his authority by submitting the dispute for decision and issuing a determination without first directing the parties to submit the dispute to the medical director, and remanded the case for the parties to submit their dispute over the appropriate QME panel specialty to the medical director.<sup>18</sup>

### Applied Cases

The appeals board has been inconsistent in its handling of QME panel specialty disputes. In one case, the board upheld a WCJ's decision that an orthopedic panel QME was appropriate, even though the applicant's treating physician was a chiropractor. The applicant alleged injury to his hip and because medical reports indicated he was a surgical candidate, the appeals board believed that an evaluation with an orthopedic surgeon was in his best interest.<sup>19</sup>

In another case, however, the applicant requested a chiropractic QME panel, but the defendant objected and requested a replacement panel in orthopedics. A doctor from the Medical Unit reviewed the defendant's request and determined, based on the available evidence, that an orthopedic QME would be in the applicant's “best interest.” The appeals board, however, held that CCR 31.5(a)(10) does not provide for the selection of a replacement panel based on a determination of what is in the injured worker's best interest, but instead requires a determination that the original panel is “medically or otherwise inappropriate for the disputed medical issue(s).” Because that Medical Unit did not decide the treatment dispute under this standard, the appeals board affirmed an order directing the parties to use the chiropractic QME panel. The board added that if additional specialties were needed in the future, the panel QME could identify that need and a request for another QME panel could be made.<sup>20</sup>

In one case, the appeals board held that an applicant was entitled to a chiropractic QME panel, despite the fact that the PTP was in family practice, when the defendant failed to timely object to the chiropractic panel in the manner provided by CCR 31.1. The board explained that the chiropractic panel was validly requested 10 days after a denial letter was sent by the defendant. It found no requirement that a QME panel issue in the same medical specialty as that of the primary treating physician. It then explained that as the first party to file a QME panel request, the applicant was the “party holding the legal right to designate a specialty” under CCR 31.5(a)(10).<sup>21</sup>

<sup>18</sup> *Portner v. Costco*, 2016 Cal. Wrk. Comp. P.D. LEXIS 499.

<sup>19</sup> *Papageorge v. YMCA of San Francisco*, 2015 Cal. Wrk. Comp. P.D. LEXIS 398. See also *Adams v. Merced City School District*, 2015 Cal. Wrk. Comp. P.D. LEXIS 649; *Garcia v. Simon*, 2016 Cal. Wrk. Comp. P.D. LEXIS 323.

<sup>20</sup> *Harding v. ABM Industries*, 2015 Cal. Wrk. Comp. P.D. LEXIS 434. See also *Montoya v. Burger Buddies, LLC dba Carl's Jr. Restaurant*, 2016 Cal. Wrk. Comp. P.D. LEXIS 242; *German v. E&J Gallo Winery*, 2016 Cal. Wrk. Comp. P.D. LEXIS 347.

<sup>21</sup> *Lopez v. California Pizza Kitchen*, 2016 Cal. Wrk. Comp. P.D. LEXIS 399.

It stated that if the defendant believed the applicant's designation of a chiropractic medical specialty for the QME panel was "medically or otherwise inappropriate for the disputed medical issue(s)," it had an obligation to state as much in a written objection to the medical director asking for a review of the panel assignment. Instead, defendant simply voiced an objection to the selection in a letter sent to the applicant's counsel. The board found that by not raising an objection in the manner prescribed by the rules within a reasonable time following assignment of the QME panel, the defendant invited error and waived any objection to the chiropractic panel.<sup>22</sup>

Of course, in some cases an injured worker may require evaluations with several different specialists. This can happen if the worker has an injury to different body parts. For example, the worker may need treatment for an orthopedic and a psychiatric injury. In such cases, panel QMEs in different specialties may be obtained. The procedure for obtaining panel QMEs in more than one specialty is discussed in ["Sullivan on Comp" Section 14.52 Subsequent Evaluations and Additional Qualified Medical Evaluator Panels in Different Specialties.](#)

## STRIKING PROCESS

LC 4062.2(c) describes the process by which the parties are to strike doctors and ultimately select a QME from the panel issued by the Medical Unit. It provides, "Within 10 days of assignment of the panel by the administrative director, each party may strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within 10 days of assignment of the panel by the administrative director, the other party may select any physician who remains on the panel to serve as the medical evaluator."<sup>23</sup>

On its face, this is not a very complicated process, but issues do arise. Usually they present when a party does something incorrectly.

## Timing of Strike

The statute specifies that each party may strike a physician "[w]ithin 10 days of assignment of the panel by the administrative director." CCR 30(b)(1)(C) states, "Within 10 (ten) days of service of the panel, each party may strike one name from the panel." As discussed above, effective Oct. 1, 2015, QME panels in represented cases must be requested online. So the date the requesting party serves the panel triggers the time limits for striking.

In *Razo v. Las Posas Country Club*,<sup>24</sup> the appeals board held that pursuant to the discussion of CCP 1013 in *Messele*, LC 4062.2(c) allows a party 10 days from the service of a QME panel, plus five days for U.S. mail, to strike a name from the QME panel.<sup>25</sup> This has been upheld in several cases.<sup>26</sup> So the mailbox rule and CCR

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<sup>22</sup> *Lopez v. California Pizza Kitchen*, 2016 Cal. Wrk. Comp. P.D. LEXIS 399.

<sup>23</sup> This time limit for striking a doctor from a panel was effective Jan. 1, 2013. Former LC 4062.2(c) stated, "Within 10 days of assignment of the panel by the administrative director, the parties shall confer and attempt to agree upon an agreed medical evaluator selected from the panel. If the parties have not agreed on a medical evaluator from the panel by the 10th day after assignment of the panel, each party may then strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within three working days of gaining the right to do so, the other party may select any physician who remains on the panel to serve as the medical evaluator." For issues related to this time limit, see *Alvarado v. WCAB* (2007) 72 CCC 1142 (writ denied); *Punzalan v. Albertsons*, 2009 Cal. Wrk. Comp. P.D. LEXIS 546; *Haile v. Fair Oaks Estates*, 2010 Cal. Wrk. Comp. P.D. LEXIS 585; *Navarro-Perez v. The Cheesecake Factory Bakery*, 2012 Cal. Wrk. Comp. P.D. LEXIS 482; *Adir International, LLC, dba LA Curacao v. WCAB (Guillen)* (2012) 77 CCC 1124 (writ denied); *Lucero v. City of Fresno*, 2012 Cal. Wrk. Comp. P.D. LEXIS 584.

<sup>24</sup> 2014 Cal. Wrk. Comp. P.D. LEXIS 12.

<sup>25</sup> Before SB 863, the board held that the time period for striking a doctor runs from the date of assignment of the three-member panel, not from service of the panel. *Alvarado v. WCAB* (2007) 72 CCC 1142 (writ denied). *Razo* found that *Alvarado* was distinguishable because it involved former LC 4062.2, but also explicitly disagreed with the decision.

<sup>26</sup> See *Dack v. Cemex*, 2012 Cal. Wrk. Comp. P.D. LEXIS 565; *Sanchez v. McDonalds/MJD'S, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 388; *Maya v. Wente Vineyards*, 2015 Cal. Wrk. Comp. P.D. LEXIS 600; *Rodriguez v. Manuel Villa Enterprise*, 2015 Cal. Wrk. Comp. P.D. LEXIS 641; *Salazar v. Motel 6*, 2015 Cal. Wrk. Comp. P.D. LEXIS 642.

10507 apply to the striking process, and allow an additional five days to strike a physician for service of the panel to an address in California (see [“Sullivan on Comp” Section 15.15 Service of Documents](#)).

As discussed above, QME panels are assigned electronically. The appeals board has not specifically addressed whether the mailbox rule applies to electronically assigned panels.<sup>27</sup> But there is no reason to believe it would not apply if the opposing party served the QME panel by regular mail.

Per CCR 30(g), the time period for striking a physician under LC 4062.2(c) will be tolled whenever the medical director asks a party for additional information needed to resolve the panel request. The time period will remain tolled until the date the director issues either a new QME panel or a decision on the panel request.

### **Manner of Striking Physician**

LC 4062.2(c) states, “The administrative director may prescribe the form, the manner, or both, by which the parties shall conduct the selection process.” The statute itself does not specify the manner in which a name must be struck. In one panel decision, the appeals board recognized that the most logical practice is to serve the opposing counsel with written notification that a panel member has been struck. Nevertheless, the appeals board determined that a letter to the Medical Unit objecting to a doctor on the panel was an effective strike.<sup>28</sup>

Usually, a party will strike the name by sending a letter clearly identifying the name struck; a copy of the panel letter with the name crossed out may be attached. A party may wait until the last day to serve this if it feels its opponent may otherwise be alerted also to strike timely. Often, the letter will be sent by fax and mail. If sent by mail only, the party should take care to ensure a proper postmark.

### **Striking Same Physician**

Because the parties are provided with the same 10-day window to strike a name, and because neither party is motivated to provide the other with notice except at the last possible minute, it is entirely possible that the letters may pass in the mail. It can and does happen that the parties both strike the same doctor.

LC 4062.2 does not address what happens in this case. The statute assumes that each party will strike a different physician. Under the former statute, at least one local judge allowed the applicant to select from the two remaining doctors when both parties struck the same physician, citing the principle of liberal construction.<sup>29</sup> Perhaps a better outcome, absent agreement on a physician, is a new panel. This is a remedy that probably would be pursued by an aggrieved party.

### **Selection of Agreed Panel QME**

Prior to Jan. 1, 2013, former LC 4062.2(c) required the parties to “confer and attempt to agree upon an agreed medical evaluator selected from the panel,” before exercising the right to strike. If the parties agreed on a physician, the doctor was called an “agreed panel QME.”

<sup>27</sup> See *Salazar v. Motel 6*, 2015 Cal. Wrk. Comp. P.D. LEXIS 642.

<sup>28</sup> *Gaines v. City of Fresno*, 2008 Cal. Wrk. Comp. P.D. LEXIS 826. Note, however, that in *Schneider v. County of San Bernardino*, 2012 Cal. Wrk. Comp. P.D. LEXIS 388, the appeals board concluded that an “objection” to a doctor from a panel did not qualify as a strike. The applicant’s attorney struck a panel three days after assignment and attempted to schedule an evaluation with a panel QME 10 days after assignment. The appeals board did not address any of the applicant’s shortcomings. But it found that the defendant’s “objection” was not proper even though it was “within three working days of gaining the right” to strike. It was noted that the defendant did not restate his objection until almost 18 months later, after two DORs were filed, and after there were two attempts to depose the QME. So the appeals board’s decision may have been based on the doctrine of waiver.

<sup>29</sup> *Lloyd v. Public Storage & PSSC, Inc.* (2009) ADJ427611 (LAO 0888062), ADJ1914800 (LAO 0888063).

Although LC 4062.2(c) no longer requires to parties to attempt to agree on a physician from a panel before exercising the right to strike, there is nothing in the statute preventing the parties from doing so. In fact, CCR 1(c) defines an “agreed panel QME” as a QME that the employer and represented employee “agree upon and select from a QME panel list issued by the Medical Director without using the striking process.” If an agreed panel QME is selected, he or she is entitled to be paid at the same rate as an AME under CCR 9795 (see [“Sullivan on Comp” Section 14.66 Medical-Legal Fee Schedule](#)).

## NO UNREASONABLE REFUSAL TO PARTICIPATE

SB 863 amended LC 4062.2(d) to state, “The employee shall not unreasonably refuse to participate in the evaluation.” The statute does not define what it means to “unreasonably refuse to participate.” This probably will need to be decided by the appeals board on a case-by-case basis.

The statute also does not specify any consequences for an employee who unreasonably refuses to participate in a QME examination. But LC 4053 and LC 4054, which provide for suspension and barring of proceedings for a refusal to submit to medical examination, were unchanged and probably will apply (see [“Sullivan on Comp” Section 14.67 Compelling Attendance at Medical Examinations](#)). Likewise, sanctions pursuant to LC 5813 are available (see [“Sullivan on Comp” Section 13.4 Sanctions Under LC 5813](#)).

For example, in one case, the parties selected a panel QME, but the applicant refused to attend the initial evaluation due to a conflict concerning medical records to be provided to the doctor. The defendant told the applicant’s attorney that he could send the records over the applicant’s objection, and filed a petition to compel attendance at the panel QME’s evaluation. The matter proceeded to a hearing, and the applicant’s attorney agreed to attend the QME examination, which was memorialized in the minutes of hearing. But the next day, the applicant’s attorney canceled the examination because the defendant neglected to pay round-trip mileage. The required payment would have been \$6.81. The applicant’s attorney also prepared a letter stating, “I do not like Panel QMEs. If you want to use that route, God Bless you. It is going to be an impossible route because I know what I have to do.” The defendant later obtained an order for the applicant to appear, cooperate and submit to a medical evaluation with the panel QME. The applicant appeared at the evaluation with a tape recorder, and canceled the appointment when the panel QME refused to proceed if she recorded it. Later, the panel QME agreed to permit a court reporter to be present, and another examination was scheduled, but the applicant’s attorney instructed his client not to attend.

The WCJ found that the applicant had a right to tape record the QME evaluation, and ordered the parties to obtain a new panel QME or AME. But the appeals board rescinded the decision. It found that the cases cited by the applicant’s attorney supporting the right to tape record a QME evaluation were not relevant to the procedures under SB 899 (see [“Sullivan on Comp” Section 14.44 Evaluation Requirements and Rights](#)). The board cited LC 4062.2(d) that “the employee shall not unreasonably refuse to participate in the evaluation” and stated that it would not condone the applicant’s efforts to obstruct the panel QME’s evaluation. The appeals board ordered the applicant to attend the next scheduled evaluation in the presence of a court reporter, and that if she refused to submit to the examination, or in any way obstructed it, her right to maintain proceedings would be suspended per LC 4053, and would be barred per LC 4054 if she continued to do so. The appeals board also ordered the WCJ to consider the defendant’s request for imposition of sanctions per LC 5813, finding that the defendant was entitled to payment of its costs expended in litigating the applicant’s unreasonable refusal to submit to the QME process, including the costs of any missed appointments.<sup>30</sup>

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<sup>30</sup> *Bernal v. Rincon Taurino Restaurant, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 246.

## AGREEMENTS TO PROCEED TO AGREED MEDICAL EXAMINER

Former LC 4062.2 required the parties to negotiate for an agreed medical evaluator before requesting a panel QME. This is not required under the current statute. But the parties still may employ AMEs to resolve disputed issues in represented cases. An AME is a physician selected by agreement between the claims administrator (or if none, the employer), and a represented employee to resolve disputed medical issues referred by the parties in a workers' compensation proceeding (CCR 1(e)).

An AME may be employed under LC 4062.2 only if the applicant is represented, but there is no requirement that the defendant be represented.<sup>31</sup> It is clear that a QME panel may be revoked when the parties agree to an AME (CCR 30(c)(2)). Because the parties may agree to use an AME "at any time," the statute seemingly allows the parties to use one even after a panel QME has evaluated the applicant.

### AME Agreements

An AME must be selected by agreement of the parties. Nothing requires that an agreement may be formed only by written consent, but as discussed in ["Sullivan on Comp" Section 16.21 Evidence at Trial — Effect of Stipulation](#), the appeals board has been reluctant to enforce oral agreements. So AME agreements should be documented in writing.

For example, the appeals board rescinded a WCJ's finding that a doctor was an AME when there was no evidence that the defendant entered into an agreement to that effect. At deposition, the doctor testified that he was selected by the defendant to undertake a consultation as part of the MPN. But the doctor and the applicant's attorney asserted that he was an AME, and supported the argument with evidence that he was paid at the AME rate. The appeals board noted that the focus was on whether there was an agreement to use an AME. Because there was no evidence that the defendant agreed to that, the board found that the doctor was not an AME.<sup>32</sup>

Note that before 2013, parties were required to propose an AME before being allowed to proceed with a panel QME. Such a proposal in the present environment could result in a binding agreement if accepted, so it's best to avoid it. For example, in one case, an applicant issued a letter objecting to the opinion of a treating physician and offering the name of an AME. The letter stated that if the defendant did not reply within 15 days, the applicant would request a panel QME. The defendant responded by letter and agreed to utilize the AME proposed by the applicant. The applicant then tried to withdraw from the AME, arguing that there was no agreement, but the appeals board disagreed. It explained, "A party cannot make an offer of an AME, to which the opposing party agrees, and then simply withdrawn [*sic*] from it for the sole purpose of initiating the panel process. This would obviate the intent of the section. If such were the case, no party could rely on their counterpart's offer of an AME as a sincere one."<sup>33</sup>

### Canceling an AME Agreement

LC 4062.2(f) states, "A panel shall not be requested pursuant to subdivision (b) on any issue that has been agreed to be submitted to or has been submitted to an agreed medical evaluator unless the agreement has been canceled by mutual written consent." So if the parties have agreed to use an AME, a QME panel will not be assigned unless the agreement has been canceled by mutual written consent. This prevents a party

<sup>31</sup> *Odom v. Century Lighting, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 304.

<sup>32</sup> See *Tenorio v. Coachella Valley Unified School District*, 2016 Cal. Wrk. Comp. P.D. LEXIS 507.

<sup>33</sup> *Castorena v. Mark One Corp.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 643.

from unilaterally canceling an AME agreement after it is made. Per LC 5813, a party may be sanctioned for attempting to cancel an AME agreement.<sup>34</sup>

There might be exceptions when the AME does not do his or her job. For example, although LC 4062.2(f) provides that an AME may be canceled only by mutual written consent, as discussed in [“Sullivan on Comp” Section 14.42 Timeliness Requirements](#), AMEs are subject to time limits for producing their reports. In one case, the appeals board affirmed a decision that LC 4062.2(f) did not preclude an applicant from unilaterally terminating an AME agreement when the doctor failed to timely issue supplemental reports, even though the delay was due to his wife’s illness.<sup>35</sup>

An AME may withdraw from a case.<sup>36</sup> The courts, however, may order an AME to continue participating in a case. For example, an independent medical evaluator attempted to withdraw from a claim, citing harassment by the applicant. The Court of Appeal ordered the doctor to submit to a deposition requested by the defendant on the issue of apportionment.<sup>37</sup>

If the parties mutually decide to withdraw from an agreement to proceed to an AME, the appeals board cannot compel them to proceed with the AME evaluation.<sup>38</sup>

## COMMUNICATIONS WITH QUALIFIED MEDICAL EVALUATORS AND AGREED MEDICAL EXAMINERS

Previously, the rules regarding communications with QMEs and AMEs generally coincided; that is, the rules that applied to QMEs also applied to AMEs. SB 863 established distinct provisions governing the information that may be provided to each, as well as the communications with each. It also defines communications, albeit poorly, that may constitute ex parte communications with AMEs.

### Information to Qualified Medical Evaluators

LC 4062.3(a) describes the “information” that may be provided to a QME. Any party may provide to the QME:

1. records prepared or maintained by the employee’s treating physician or physicians; and/or
2. medical or nonmedical records relevant to determination of the medical issues.<sup>39</sup>

CCR 35 further specifies the information that may be provided to an AME, agreed panel QME or QME. It states that an employer must provide, and an applicant may provide:

1. all records prepared or maintained by the employee’s treating physician or physicians;
2. other medical records, including any previous treatment records or information, that are relevant to the determination of the medical issue(s) in dispute;
3. a letter outlining the medical determination of the primary treating physician or compensability issues the evaluator is requested to address in the evaluation; and

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<sup>34</sup> See *Rasmussen v. J&J Maintenance, Inc.*, 2004 Cal. Wrk. Comp. P.D. LEXIS 92 and *Rasmussen v. J&J Maintenance, Inc.*, 2004 Cal. Wrk. Comp. P.D. LEXIS 91. In one case, the WCAB allowed an applicant to withdraw from an AME agreement when it was made by his former attorney, the applicant was not examined by the AME and the applicant later became unrepresented. *Rahmatian v. WCAB* (2014) 79 CCC 611 (writ denied).

<sup>35</sup> *Mayne v. Intel Corp.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 70.

<sup>36</sup> See *Press v. Los Angeles Unified School District*, 2015 Cal. Wrk. Comp. P.D. LEXIS 725.

<sup>37</sup> *Ogden Entertainment Services v. WCAB (Von Ritzhoff)* (2014) 80 CCC 1, 28.

<sup>38</sup> See *Montebello Unified School District v. WCAB (Gallardo)* (2011) 76 CCC 582 (writ denied).

<sup>39</sup> “Medical information” for the purposes of service of medical reports is defined in CCR 10608(a)(2) as including but not limited to: “(A) medical reports; (B) medical-legal reports; (C) deposition transcripts (including but not limited to depositions of physicians) containing references to medical reports, medical-legal reports, medical treatment, medical diagnoses, or other medical opinions; (D) medical chart notes; and (E) diagnostic imaging as defined in section 10603(a)(2).”

4. nonmedical records, including films and videotapes, that are relevant to the determination of the medical issue.

For injuries occurring before Jan. 1, 2013, if the disputed UR decision is communicated on or before June 30, 2013, an employer must provide, and an applicant may provide:

1. a copy of the treating physician's report recommending the medical treatment with all supporting documents;
2. a copy of the employer's decision to approve, delay, deny or modify the disputed treatment with the documents supporting the decision; and
3. all other relevant communication about the disputed treatment exchanged during the utilization review process.

For injuries occurring on or after Jan. 1, 2013, and utilization review decisions communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury, disputes regarding a treating physician's recommended treatment must be resolved pursuant to the utilization review and independent medical review processes. They are discussed in Chapter VI: Utilization Review and Independent Medical Review.

### **Time Limit for Service of and Objection to Records**

LC 4062.3(b) describes how information is to be provided to the QME. If a party proposes to provide information to a QME, it must be served on the opposing party 20 days before it is provided to the evaluator. CCR 35 further specifies how information is to be provided. Per CCR 35(c), if mental health records are being sent and there is a substantial risk of significant adverse or detrimental consequences to an employee in seeing or receiving a copy of mental health records, they must not be served directly on the injured employee but may be provided to a designated health-care provider.<sup>40</sup> The injured employee must be notified in writing of this option for each such record to be provided to the evaluator (CCR 35(c)).

In both unrepresented and represented cases, the claims administrator — or defense attorney in his or her stead — must attach a log to the front of the records and information being sent to the opposing party. The log must identify each record or other information to be sent to the evaluator and list each item in the order it is attached to or appears on the log. In a represented case, the injured worker's attorney must do the same for any records or other information to be sent to the evaluator directly from the attorney's office, if any (CCR 35(c)). The claims administrator or employer must include a cover letter or other document when providing such information to the employee and must clearly and conspicuously include this language: "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days" (CCR 35(c)).

Copies of all records being sent to the evaluator must be sent to all parties. Per LC 4062.3(b), if the opposing party objects to consideration of nonmedical records within 10 days, the records must not be provided to the evaluator. The nonmedical records must not be sent unless ordered by a WCJ (CCR 35(d)).

Per LC 4062.3(e), all communications with a QME must be in writing and served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator must be in writing and served on the opposing party when sent to the medical evaluator. Although these rules seem straightforward, issues frequently can and do arise regarding how information and communications can be sent to the QME.

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<sup>40</sup> Health and Safety Code 123115(b).



## Information Versus Communication

LC 4062.3 makes a distinction between “information” and “communications.” Although the term “information” encompasses records by the employee’s treating physician(s) and medical and nonmedical records, and the term “communications” contemplates documents prepared directly by the parties to a QME, the line between the two is blurred when “communications” by the parties discuss the medical and nonmedical records sent to the QME, or outline the parties’ arguments and position in the case. These letters, sometimes known as advocacy letters, become a frequent source of contention between the parties.

In *Maxham v. California Department of Corrections and Rehabilitation*,<sup>41</sup> the appeals board *en banc* held:

1. “Information” constitutes (1) records prepared or maintained by the employee’s treating physician or physicians, and/or (2) medical and nonmedical records relevant to determination of medical issues. And
2. A “communication” can constitute “information” if it contains, references or encloses (1) records prepared or maintained by the employee’s treating physician or physicians, and/or (2) medical and nonmedical records relevant to determination of medical issues.

The board held that ordinarily, advocacy letters discussing legal positions or decisions would not constitute “information.”<sup>42</sup> It stated that engaging in legitimate advocacy does not transform correspondence with a medical examiner from “communication” to “information.” It added, however, that correspondence engaging in advocacy or asserting a legal or factual position can cross the line into “information” without explicitly containing, referencing or enclosing it. The board explained that misrepresentation of case law or legal holdings, engaging in sophistry regarding factual or legal issues or misrepresentation of actual “information” in a case are three ways in which a party might attempt to convey purported “information” to a medical examiner to which the opposing party has not agreed. The board also explained that if the correspondence contains, references or encloses information that the parties previously agreed to provide to the evaluator, serving that correspondence on the evaluator without giving the other party an opportunity to object would not violate LC 4062.3.<sup>43</sup>

The board held that the WCJ retains wide discretion in assessing the contents of a parties’ advocacy letters to ensure parties do not serve correspondence that could confuse or misdirect the attention of a medical examiner, even if that communication does not expressly contain, reference or enclose information. It added that if the WCJ determines a party improperly provided information to the medical evaluator, he or she has wide discretion in fashioning an appropriate remedy.<sup>44</sup>

## Service of Information on Opposing Party

LC 4062.3(b) requires a party to serve information on an opposing party 20 days before it is provided to the QME. In *Nehdar v. Washington Mutual*,<sup>45</sup> however, the appeals board explained that it is not enough simply to serve the information on the opposing party; the serving party must state that it intends to send the information to the QME. In that case, the applicant’s attorney drafted a letter serving a nurse’s report stating

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<sup>41</sup> (2017) ADJ3540065 (appeals board *en banc*).

<sup>42</sup> Previously, various panel decisions attempted to delineate between “communication” and “information” and whether engaging in advocacy crossed that line. *Maxham* disagreed with the decisions to the extent they were inconsistent with that decision. See *Ferniza v. Rent A Center, Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 624; *Bing v. Long Beach Unified School District*, 2010 Cal. Wrk. Comp. P.D. LEXIS 461; *Ibarra v. ABM Industries, Inc.*, 2009 Cal. Wrk. Comp. P.D. LEXIS 231; *Medina v. City of Huntington Park*, 2012 Cal. Wrk. Comp. P.D. LEXIS 32; *Aguilar v. Snelling Staffing*, 2012 Cal. Wrk. Comp. P.D. LEXIS 109; *Nehdar v. Washington Mutual*, 2013 Cal. Wrk. Comp. P.D. LEXIS 221; *Antunez v. Seaside Printing Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 292; *Lopez v. C&S Wholesale Groceries*, 2013 Cal. Wrk. Comp. P.D. LEXIS 562; *Hidalgo v. Casa Del Mar*, 2014 Cal. Wrk. Comp. P.D. LEXIS 714; *McFerson v. Gooing*, 2016 Cal. Wrk. Comp. P.D. LEXIS 376; *Castaneda v. Forever 21*, 2016 Cal. Wrk. Comp. P.D. LEXIS 565; *Pecoraro v. PT Gaming, LLC*, 2016 Cal. Wrk. Comp. P.D. LEXIS 620.

<sup>43</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065 (appeals board *en banc*).

<sup>44</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065 (appeals board *en banc*).

<sup>45</sup> 2013 Cal. Wrk. Comp. P.D. LEXIS 221.

that the applicant would require home health care. Three weeks later, the defendant sent a letter objecting to the admissibility of the report, but despite the objection, the applicant's attorney served the report on an AME and a QME. The appeals board found that this was impermissible.

The appeals board first found that the nurse's report was nonmedical information because a nurse is not a medical doctor, and she did not provide any type of treatment. It then found that the applicant's attorney's file and serve letter did not constitute 20 days' advance notice under LC 4062.3 because the letter did not state that he intended to serve the report to the evaluators. So because the defendant did not receive sufficient notice of the applicant's attorney's intention to send the report to the medical evaluators, the defendant could not have been expected to have foreseen the necessity of making a timely objection. The appeals board struck the nurse's report along with those of the AME and QME, and found that new evaluators should be selected for the claim.<sup>46</sup>

### Objections to Nonmedical Evidence

Per LC 4062.3(b), following the receipt of information that a party proposes to send to an evaluator, the opposing party has a right to object to any nonmedical records within 10 days. Nonmedical record is not defined explicitly, but it presumably means information that is not produced by a medical provider. The appeals board has concluded that a vocational expert's report qualifies as nonmedical information.<sup>47</sup>

If the opposing party objects within 10 days to any nonmedical evidence or information proposed to be sent to an evaluator, that material must not be sent unless ordered by a WCJ (CCR 35(d)).<sup>48</sup> Either party may use discovery to establish the accuracy or authenticity of nonmedical records or information prior to the evaluation (CCR 35(f)). The appeals board has jurisdiction to determine disputes arising from objections (CCR 35(k)).

This rule can throw a wrench in the works. If the nonmedical evidence is material to the case, the evaluator clearly needs to see it. But the opposing party can prevent this simply by objecting. Without the evidence, the evaluator may give an opinion that he or she otherwise would not have given. It may well be that the resulting report is not substantial evidence. The party wishing to provide the evidence to the evaluator is then forced to go to the board to get the order.

If the opposing party objects to sending a panel QME nonmedical evidence, it may not be sent unless so ordered by a WCJ. The appeals board then has discretion to decide whether the evidence may be sent. In one case, the board denied an employer the right to send unsworn statements of defense witnesses to a panel QME after the applicant timely objected to service of them. The applicant claimed stress as part of his injury, and the employer moved to send witness statements to the panel QME to complete his report on a "good-faith personnel action issue." The appeals board denied the request, noting it was the WCJ's job to rule on the credibility of the witnesses on the issue of good-faith personnel action, not the doctor's.<sup>49</sup>

In contrast, the appeals board allowed a defendant to send a QME an unredacted police report. It explained that by allowing both parties to supply all available information concerning the incident to the QME, the trier of fact could make a more thorough determination as to the various circumstances surrounding the incident. It added that if the applicant believed that there were any gaps or inaccuracies contained in the police report statements, she could take the depositions of the other witnesses.<sup>50</sup>

<sup>46</sup> *Nehdar v. Washington Mutual*, 2013 Cal. Wrk. Comp. P.D. LEXIS 221.

<sup>47</sup> *Trapero v. WCAB* (2013) 78 CCC 183 (writ denied).

<sup>48</sup> See *Forsythe and Associates v. WCAB (Taylor)* (2004) 69 CCC 396 (writ denied) (panel QME report offered into evidence by defendant was inadmissible because of defendant's failure to serve applicant with *sub rosa* videotape it had taken before providing it to panel QME).

<sup>49</sup> *Stein v. State of California, Department of General Services*, 2010 Cal. Wrk. Comp. P.D. LEXIS 506.

<sup>50</sup> *Jarjour v. County of Los Angeles*, 2016 Cal. Wrk. Comp. P.D. LEXIS 291.

In another case, the appeals board allowed an applicant to send medical study abstracts and citations relevant to the AMA guides to the QME because it believed they related to whether the Combined Values Chart should be applied to the applicant's claim. But the board did not allow the applicant to send various panel decisions because they were not binding precedent, and it believed that providing the decisions could create an inference that those panel decisions were controlling.<sup>51</sup>

Nevertheless, LC 4062.3(b) limits the right of a party to object to *nonmedical records* to be provided to a panel QME. It does not allow a party to object to medical records. So, in one case, the applicant alleged injury to his eyes, gastrointestinal system and psyche. A panel QME in psychology provided a report, and the applicant later selected a panel QME in ophthalmology. The applicant objected to sending the report of the psyche QME to the ophthalmologic panel QME on the grounds that it contained erroneous information. The WCJ upheld the objection on the grounds that the psychologist's report was not relevant to the ophthalmologist's evaluation. The appeals board, however, granted removal. It found that because LC 4062.3(b) limited objection to nonmedical records, there was no statutory provision for objecting to the psychologist's report. The board found that the panel QME in ophthalmology should be provided with the psychologist's report in order to assure that he was informed of the applicant's psychological condition, which was part of his relevant medical history. The appeals board added that the panel QME in ophthalmology was expected to inquire into the applicant's medical history and correct any misinformation.<sup>52</sup>

## Consequences of Not Serving Other Parties

Copies of all records being sent to the evaluator must be sent to all parties. Per CCR 35(g), a failure to do so will constitute ex parte communication by the party transmitting the information to the evaluator. Also, CCR 35(k) provides that if any party communicates with a QME in violation of LC 4062.3, the medical director "shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator." Accordingly, in many cases, the appeals board has held that failure to serve records to all parties 20 days before they are provided to a QME will entitle an opposing party to a replacement panel of QMEs.<sup>53</sup>

For example, the appeals board affirmed a decision that a defendant engaged in an impermissible ex parte communication with a QME when it attached and requested that the QME address a letter by the applicant's counsel alleging that the QME engaged in misconduct during the evaluation. The appeals board found that without allowing the applicant an opportunity to object to the enclosure, the defendant violated the requirements of LC 4062.3(b) and CCR 35(k). It found that sending the applicant's counsel's letter had no legitimate purpose, but rather was sent to create a bias against the applicant. The appeals board concluded that the applicant was entitled to a replacement panel under CCR 35(k).<sup>54</sup>

In one case, the appeals board concluded that LC 4062.3 was violated when documents that were sent to a panel QME were served on one defendant but not another co-defendant. In that case, a defendant and applicant had obtained a panel QME. On July 10, 2010, a co-defendant, Tower Select Insurance Co. (Tower), served the parties with a letter of representation. On July 13, 2010, an appointment was scheduled with the panel QME for Sept. 15, 2010. The medical records and documents were served on the attorney for the defendant and the panel QME but not on Tower, which objected to the panel QME. The WCJ found that the

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<sup>51</sup> *Cervantes v. Quality Farms Labor*, 2016 Cal. Wrk. Comp. P.D. LEXIS 478.

<sup>52</sup> *Banks v. Sacramento Bee/McClatchy Newspapers, Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 272. The case did not address CCR 35(d), which allows a party to object to any nonmedical records or information proposed to be sent to an evaluator.

<sup>53</sup> See *Villalpando v. Cintas Corp., Inc.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 392; *Hess v. Bloomingdale's Inc., Macy's Corporate Services* 2012 Cal. Wrk. Comp. P.D. LEXIS 187; *Roy v. Gallo Sales Co. Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 207; *Matthies v. WCAB* (2013) 78 CCC 718 (writ denied); *Quintero v. Pacific Triple E. Ltd.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 506; *Vaughn v. Central Coast Community Healthcare*, 2016 Cal. Wrk. Comp. P.D. LEXIS 217.

<sup>54</sup> *Garcia v. Sweetwater Union High School District*, 2015 Cal. Wrk. Comp. P.D. LEXIS 750.

failure to serve Tower with the documents/medical records sent to the panel QME constituted a prohibited ex parte communication. So the WCJ ordered a new panel QME. The appeals board denied removal and affirmed the WCJ's decision.<sup>55</sup>

In another case, the appeals board upheld an order striking a supplemental report from an AME when the defendant sent a letter to the AME requesting the report but failed to serve the request on any lien claimants after they became parties. The underlying case was resolved by compromise and release and the defendant forwarded a request for a supplemental report to the AME to address how reasonable the lien claimants' medical treatment was. The lien claimants were not copied with the request. The panel found this to be an improper ex parte communication. It explained that although lien claimants do not have the procedural right to participate in the selection of an AME, when the injured workers have settled their claims, the lien claimants stand in their shoes and can proceed with further proceedings derivative of the injured employee. The lien claimants have the right to participate in further development of the record, including the right to be served with any post-award interrogatories to an AME, especially if it directly affects the liens. So the panel found that when the lien claimants became parties, the defendant should have accorded them the same due process as the applicant, per LC 4062.3(e), which included copying them with the request for a supplemental report. The defendant's failure to do so constituted an improper ex parte communication.<sup>56</sup>

*Maxham*, however, indicated that WCJs have wide discretion to fashion appropriate remedies for improperly providing information to a medical evaluator.<sup>57</sup> In the past, the appeals board has not allowed a replacement QME in all cases. In one case, it concluded that the applicant's advocacy letter to a QME was not ex parte because it was served on the defendant more than 20 days prior to the evaluation. The board found the applicant's failure to serve the letter on defendant's address was due to the defendant's failure to serve a change of address on the applicant's correct serve address. The appeals board added that even if the advocacy letter was an ex parte communication, the defendant waived its right to object to the QME letter by waiting 35 days to make the objection, and by waiting to make the objection after receiving the QME report.<sup>58</sup>

In another case, the appeals board denied removal of an applicant's request for a replacement QME panel even though the defendant simultaneously sent a letter and medical records to the panel QME and the applicant. The board found that this was a technical violation of CCR 35(c) because the information was not sent to the applicant at least 20 days before being sent to the QME. But it found that nothing other than medical records and the letter was sent to the doctor, and there was nothing inappropriate and/or objectionable in the letter. The appeals board then explained that the applicant received the medical report and opinion of the QME before any objection regarding failure to follow the rules. It concluded that allowing a replacement panel after receipt of the report would do nothing other than open the door for doctor shopping.<sup>59</sup>

### Evaluation Within 20-Day Limit

CCR 35(h) contains a special rule to deal with the situation in which an unrepresented employee schedules an appointment with a panel QME within 20 days of receipt of a panel. It provides that the employer or the claims administrator is not required to comply with the 20-day time frame for sending *medical* information.

<sup>55</sup> *Morales v. WCAB* (2011) 76 CCC 841 (writ denied).

<sup>56</sup> *Tinoco v. R A Phillips Industries, Inc.* 2011 Cal. Wrk. Comp. P.D. LEXIS 403.

<sup>57</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065 (appeals board *en banc*).

<sup>58</sup> *Amador v. Ruby's Diner, Inc.* 2015 Cal. Wrk. Comp. P.D. LEXIS 486.

<sup>59</sup> *Martinez v. Golden Valley Health Center*, 2013 Cal. Wrk. Comp. P.D. LEXIS 166. See also *Perry v. City and County of San Francisco, San Francisco Municipal Transport Agency* 2013 Cal. Wrk. Comp. P.D. LEXIS 226 (applicant not entitled to a second QME panel; defendant sent letter and medical records 10 days before they were provided to QME when applicant proceeded with examination after receiving defendant's "information" fewer than 20 days before it was provided to QME and objected after receiving the report); *Antunez v. Seaside Printing Co.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 292 (WCAB struck report obtained without giving the other party time to object but did not dismiss AME entirely).

But the unrepresented employee must be served all nonmedical information at least 20 days before the information is served on the QME so that he or she has an opportunity to object to any nonmedical information. Note that there is no similar provision for cases in which the employee is represented.

## Providing Information to and Communicating with Agreed Medical Examiner

LC 4062.3 establishes different rules for information that may be provided to an AME and communications with an AME. Per LC 4062.3(c), in represented cases in which an AME has been selected for an evaluation, as part of their agreement, the parties must agree on what information is to be provided. Per LC 4062.3(f), communications with an AME must be in writing, and served on the opposing party when sent to the AME. The Labor Code requires the parties' agreement before any information is provided to an AME, but when a party wishes to send a communication to an AME, it is necessary only to serve the opposing party with that communication. Obtaining the opposing party's consent regarding a communication with an AME is not necessary.<sup>60</sup>

Unlike for QMEs, LC 4062.3 contains no rule that initial communications with an AME must be served on the opposing party 20 days in advance of the evaluation — the party simply must ensure that the communication is served concurrently on the opposing party when it is sent to the AME.<sup>61</sup> But CCR 35 still imposes generally the same rules for providing information to AMEs and QMEs.<sup>62</sup> It still requires a party providing medical and nonmedical reports and information to serve the information on the opposing party at least 20 days before the information is provided to the AME.<sup>63</sup>

Moreover, because LC 4062.3(c) requires the parties to agree on the information that must be provided to an AME, there are limits to what a party unilaterally may send to an AME. As discussed above, in *Maxham v. California Department of Corrections and Rehabilitation*,<sup>64</sup> the appeals board held *en banc* if a correspondence contains, references or encloses (1) records prepared or maintained by the employee's treating physician or physicians, or (2) medical and nonmedical records relevant to determination of the medical issue *that the parties previously agreed to provide to the AME*, serving that correspondence on the AME without giving the opposing party an opportunity to object would not violate LC 4062.3(c). The board held that it is only when the correspondence contains, references or encloses "information" that the parties have not agreed to provide to the AME does it violate LC 4062.3(c).<sup>65</sup>

As an example, the board explained that an advocacy letter citing portions of an applicant's deposition testimony would constitute information because it references medical and nonmedical records relevant to determination of the medical issue (i.e., applicant's deposition). If the parties previously agreed that applicant's deposition transcript would be provided to the AME, the board explained that serving the advocacy letter on the AME would not violate LC 4062.3(c) because the parties previously agreed that the "information" at issue would be provided to the AME. The board explained litigants are entitled to reference (1) records prepared or maintained by the employee's treating physician or physicians, and (2) medical and nonmedical records relevant to determination of the medical issue in advocacy letters if the parties have previously agreed to provide that referenced "information" to the AME.<sup>66</sup>

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<sup>60</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065 (appeals board *en banc*).

<sup>61</sup> This difference is due to SB 863, effective Jan. 1, 2013. Former LC 4062.3(e) required communications with an AME or a QME to be served on the opposing party 20 days in advance of the evaluation. The section was amended to create distinct rules for communications with AMEs and QMEs.

<sup>62</sup> CCR 35(c) states, "At least twenty (20) days before the information is to be provided to the evaluator, the party providing such medical and non-medical reports and information shall serve it on the opposing party." Various other provisions of CCR 35 also refer to an "evaluator." CCR 1(r) defines an "evaluator" as any QME, AME, agreed panel QME or panel QME. So CCR 35(c) would impose the 20-day requirement for service of information on AMEs as well as QMEs.

<sup>63</sup> See *Vaughn v. Central Coast Community Healthcare*, 2016 Cal. Wrk. Comp. P.D. LEXIS 217; *Sharp v. Nevada County Sheriff*, 2016 Cal. Wrk. Comp. P.D. LEXIS 302.

<sup>64</sup> (2017) ADJ3540065 (appeals board *en banc*).

<sup>65</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065 (appeals board *en banc*).

<sup>66</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065 (appeals board *en banc*).

As discussed above, *Maxham* gave the WCJ wide discretion in determining whether the contents of an advocacy letter constitutes “information,” as opposed to a communication. It also gave the WCJ wide discretion to fashion remedies for violations of LC 4062.3(c).<sup>67</sup>

### Use of Joint Letters

Often, the parties will issue a joint letter that agrees to the information to be provided to the AME. But in practice, when parties agree on an AME, they rarely agree on a list of what evidence will be provided with the joint letter. It is presumed that the parties have disclosed all evidence to each other and that all of it will be sent. But disagreements arise if one party does not like what a proposed joint letter says or wants to exclude certain evidence.

LC 4062.3 does not describe what will happen if the parties are unable to agree on the information to be provided to an AME. The parties, of course, may bring the matter before the appeals board. Usually, it’s apparent only to the parties shortly before the examination that the issue cannot be worked out. Because it takes time to bring such issues to the attention of the appeals board, the parties generally are unable to have a board resolution before an AME examination. So if at all possible, parties should endeavor to work out an agreement on the information to be provided to an AME without intervention from the appeals board.

### Providing Information at Deposition

As discussed above, LC 4062.3(b) requires a party to serve information on an opposing party 20 days before it is provided to the QME. Furthermore, the parties must agree on what information is to be provided to an AME. The parties may not circumvent these requirements by providing information to AMEs or QMEs at deposition.

For example, in one case, an applicant’s attorney presented a defendant with a vocational evaluation report a few minutes before an AME’s deposition. Then the attorney provided the report to the AME during the deposition, and the AME was asked to “take a look” and “perform a cursory review.” The defendant objected on the record, and filed a petition to strike the AME’s report and deposition. The WCJ found that the applicant’s attorney’s actions were permissible, but the appeals board granted removal. It explained that the vocational report fell within the definition of “information” that is a nonmedical record relevant to the determination of a medical issue, and that the parties were required to agree on what information was to be provided. By springing the report on the defendant when the AME was about to be deposed, the applicant’s attorney denied the defendant the opportunity to determine if this new information was something he would agree to provide to the AME. The defendant also objected to the information during the AME’s deposition, so it was not agreed to and should not have been provided. The board also found that the service of the report at the deposition was not just a “subsequent communication” because it also contained information. The board found the doctor disqualified as the AME and the applicant’s attorney liable for the costs incurred by the defendant, including the costs of the medical evaluation, additional discovery and attorneys’ fees for related discovery.<sup>68</sup>

In another case, the appeals board held that a defendant violated LC 4062.3 and CCR 35 by providing *sub rosa* surveillance video at the deposition of the QME without previously having served the video on the applicant. The board noted that LC 4062.3(b) requires that information sought to be provided to the QME must be served on the opposing party 20 days before the information is provided to the evaluator. It strongly admonished the defendant to avoid the employment of discovery practices that do not comport with the

<sup>67</sup> For cases prior to *Maxham*, see *Torres v. Staffmark, Inc.*, 2008 Cal. Wrk. Comp. P.D. LEXIS 921; *Catlin v. JC Penney, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 616; *Dodley v. Professional Security Consultants*, 2016 Cal. Wrk. Comp. P.D. LEXIS 258; *Gaona v. Capital Builders Hardware*, 2016 Cal. Wrk. Comp. P.D. LEXIS 148.

<sup>68</sup> *Trapero v. WCAB* (2013) 78 CCC 183 (writ denied).

appeals board's policy against unfair surprise. The board ordered the QME's deposition testimony and the previously obtained *sub rosa* video stricken from the record, but allowed the QME reports prepared prior to the date of the deposition to be considered in determining the merits of the applicant's claim of injury. It noted that attorneys' fees pursuant to LC 4062.3(h) were not applicable because the defendant's conduct was not a prohibited communication. But it remanded for the WCJ to determine whether the defendant's conduct was sanctionable under LC 5813 for failing to honor the applicant's counsel's discovery request for copies of all surveillance videos and withholding the videos for the purpose of surprise at the QME deposition.<sup>69</sup>

In one case, the appeals board upheld an order disqualifying an AME because of an ex parte communication with him at deposition. That defendant properly noticed the AME's deposition, but the applicant's attorney did not appear. The appeals board found that merely proceeding with a duly noticed deposition of the AME in the absence of the applicant's attorney did not constitute impermissible ex parte communications. But it found that the defendant engaged in an impermissible ex parte communication when it made comments to the AME on the record that showed the applicant's attorney in a negative light. Such comments called into question the impartiality of the AME. So the AME was disqualified, and the administrative director was ordered to issue a QME panel.<sup>70</sup>

### Medical Documents That May Not Be Forwarded

Notwithstanding the above, per CCR 35(e), certain medical documents must not be provided to either an AME or QME. They are:

1. any medical-legal report that has been rejected by a party as untimely pursuant to LC 4062.5 (This provision and accompanying regulations allow a party to object to an untimely report and seek a new AME or panel physician.);
2. any evaluation or consulting report written by any physician *other* than a treating physician (the primary treating physician or secondary physician), or an evaluator through the medical-legal process in LC 4060 - LC 4062 that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report first was ruled admissible by a WCJ (Examples are exams done under LC 4050 or LC 4064.);<sup>71 72</sup>
3. any medical report, record, other information or thing that has been stricken, or found inadequate or inadmissible by a WCJ, or that otherwise has been deemed inadmissible to the evaluator as a matter of law. A report may be inadequate for various reasons — for example, a report may be wholly insubstantial because it leaves out too many elements or it may violate statutes such as LC 4628 (the anti-ghostwriting statute).

So although medical records that are relevant to the determination of medical issues in dispute may be provided to an AME or a QME, CCR 35(e) excepts the documents listed above: They must not be provided to an AME or a QME. For example, the appeals board refused to allow a defendant to submit to a QME epidemiology report and/or studies provided by a medical expert that was obtained as a work product.<sup>73</sup> If any prohibited documents are sent to an AME or QME, any reports produced may be stricken by the appeals board.<sup>74</sup>

But note that in one case, the appeals board reached a decision seemingly contradictory to the language of CCR 35(e). In that case, the board held that the reports of a treating physician should be provided to an AME

<sup>69</sup> *Wan v. Community Health Network (San Francisco General Hospital)*, 2015 Cal. Wrk. Comp. P.D. LEXIS 243.

<sup>70</sup> *Ford v. County of San Bernardino*, 2012 Cal. Wrk. Comp. P.D. LEXIS 467.

<sup>71</sup> Before the adoption of the new regulations, in a panel decision the appeals board held that medical reports obtained pursuant to an employer's duty to investigate a claim could be sent to a QME. *Lambert v. San Diego Unif. School Dist.* (1998) 26 CWCR 263 (panel decision).

<sup>72</sup> See *Marciano v. Ameriflight, Inc.*, 2013 Cal. Wrk. Comp. P.D. LEXIS 384; *Davis v. City of Modesto*, 2016 Cal. Wrk. Comp. P.D. LEXIS 523.

<sup>73</sup> *Roberts v. City of Los Angeles*, 2016 Cal. Wrk. Comp. P.D. LEXIS 31.

<sup>74</sup> See *Mosby v. Best Buy*, 2011 Cal. Wrk. Comp. P.D. LEXIS 229.

or QME regardless of whether they are admissible unless they contain materially false, inaccurate or inflammatory material.

It explained that under Evidence Code 801(b), an expert witness may consider a matter “whether or not admissible, that is of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates, unless an expert is precluded by law from using such matter as a basis for his opinion,” and there is no applicable prohibition. It also explained that medical-legal evaluators are scientists who are trained to consider all relevant data, and that they are entitled to consider all relevant evidence, even if later found to be inadmissible. It also explained, “Rule 35 is designed to exclude from review all material that the parties fail to agree on so as to prevent false or inflammatory data from reaching the AME. It was not designed to prevent the AME from seeing inadmissible evidence.”<sup>75</sup>

Parties also should consider privacy concerns before sending any and all medical reports to a physician. For example, it may not be appropriate, and may even be a violation of civil rights, to send irrelevant information about psychiatric history to a doctor performing an orthopedic evaluation. Privacy concerns are discussed in various sections earlier in this chapter.

### **Failure to Provide Records**

If the parties fail to provide an AME or a QME any relevant medical records the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health-care provider to obtain such records. If the parties fail to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator is still required to complete and serve the report to comply with the statutory time frames. The evaluator must note in the report that the records were not received within the required period. On request by a party or the appeals board, the evaluator must then complete a supplemental evaluation when the relevant medical records are received. For a supplemental report, the evaluator is not required to conduct an additional physical examination of the employee if the evaluator thinks that a review of the additional records is sufficient (CCR 35(i)).

### **EX PARTE COMMUNICATION PROHIBITED**

LC 4062.3(g) states, “Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited.” A panel QME must also refrain from engaging in ex parte communications with a party (CCR 41(b)). An ex parte communication is a communication between an attorney and the AME or QME when opposing counsel is not present.<sup>76</sup> Ex parte communication can occur by way of letter or by an oral conversation between the evaluator and a party. The appeals board retains jurisdiction in all cases to determine whether ex parte contact in violation of LC 4062.3 has occurred (CCR 35(k)).

<sup>75</sup> *Montebello Unified School District v. WCAB (Gallardo)* (2011) 76 CCC 582 (writ denied).

<sup>76</sup> *Maxham v. California Department of Corrections and Rehabilitation* (2017) ADJ3540065.



## Ex Parte Communications Under Alvarez

In *Alvarez v. WCAB*,<sup>77</sup> the Court of Appeal explained the type of communications that would violate LC 4062.3(g). In that case, a panel QME in a death case determined that a claim was not compensable. His report referred to an “investigative report” to support his conclusion but did not identify the source of information in the report. At the deposition, the QME could not identify the source of information and agreed to review and clarify the records he had received. A day after the deposition, the QME called the defense attorney and stated that the records could not be located and requested another copy. The same day, the defense attorney notified opposing counsel by letter that she received a brief phone call from the QME, who stated that the records could not be found and were presumably shredded by his staff and that the records should be resent to the QME. The applicant’s attorney then filed a petition objecting to the ex parte communication between the QME and the defense attorney, and requested that the QME’s report be stricken and that a new panel QME be selected. At trial, the defense attorney testified that the QME called on her direct line, that the call lasted for less than a minute and that she notified the QME that he should not be calling directly. The defense attorney also testified that the QME only requested medical documents that his office could not find and that there was no discussion of the merits of the case. The appeals board determined that there was no improper ex parte communication, explaining that the ex parte communications related to an administrative matter discussed at deposition, which was not ex parte. The appeals board added that LC 4062.3 is concerned with a party initiating an ex parte communication, which did not occur in the case. The case went to the Court of Appeal.

Initially, the Court of Appeal strictly interpreted the preclusion against ex parte communications. It held that LC 4062.3(f) explicitly precludes *any* ex parte communication between a panel QME and a party. Such a communication allows the aggrieved party to seek a new evaluation from another evaluator.<sup>78</sup> But the court granted a rehearing on the issue. The Court of Appeal again held that LC 4062.3 “expressly prohibits ex parte communications with a panel qualified medical evaluator, with no exception based on the initiator of the communication or for ‘administrative’ matters.”<sup>79</sup> The court explained that the statute does not distinguish between ex parte communications on the basis of whether the communication was initiated by a party or by the medical evaluator, nor does it state that ex parte communications are permissible if the subject matter is administrative or procedural rather than substantive and on the merits. The court added that a violation of an unqualified prohibition on ex parte communications did not require a showing of prejudice, that is, harm to the other party from the communication.<sup>80</sup> Rather, ex parte communication is prohibited as a matter of law.

Nevertheless, the court also recognized that “because a certain degree of informality in workers’ compensation procedures has been recognized, not every conceivable ex parte communication permits a party to obtain a new evaluation from another panel qualified medical evaluator.” The court explained that “an ex parte communication may be so insignificant and inconsequential that any resulting repercussion would be unreasonable” and that it should not “interpret or apply statutory language in a manner that will lead to absurd results.” The court added that comments about the weather or traffic would not invoke the remedy under LC 4062.3.<sup>81</sup>

With regard to the facts of the case, the court did not reach a decision. It noted that the QME’s communication in the case might be so inconsequential that it was not covered by LC 4062.3, or that the communication

<sup>77</sup> *Alvarez v. WCAB (Parades)* (2010) 75 CCC 817 (*Alvarez II*). In *Capital Builder Hardware, Inc. v. WCAB (Goana)* (2016) 81 CCC 1122, the Court of Appeal believed that *Alvarez* erred in issuing a writ of review because the issue of whether there was an ex parte communication was not a final order.

<sup>78</sup> See *Alvarez v. WCAB* (2010) 75 CCC 397.

<sup>79</sup> *Alvarez v. WCAB (Parades)* (2010) 75 CCC 817, 819 (*Alvarez II*).

<sup>80</sup> *Alvarez v. WCAB (Parades)* (2010) 75 CCC 817 (*Alvarez II*). See also *United Parcel Service v. WCAB (Lee)* (1997) 62 CCC 837 (writ denied) (prohibitions against ex parte communications should be strictly enforced without weighing intent and effect of communication).

<sup>81</sup> *Alvarez v. WCAB (Parades)* (2010) 75 CCC 817 (*Alvarez II*).

could suggest that the QME and defense attorney agreed on how to proceed so that LC 4062.3(f) was violated. The court remanded the case for the appeals board to decide based on the principles it announced rather than the “administrative” and “substantial” distinctions made by the appeals board.<sup>82</sup>

Note, however, that since *Alvarez*, LC 4062.3(f) was amended effective Jan. 1, 2013. It states, “Oral or written communications with physician staff or, as applicable, with the agreed medical evaluator, relative to nonsubstantial matters such as the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, do not constitute ex parte communication in violation of this section unless the appeals board has made a specific finding of an impermissible ex parte communication.”

LC 4062.3(f) appears to be an awkward attempt to minimize *Alvarez*. The section specifically applies only to communications with AMEs, and does not specifically apply to communications with QMEs. The appeals board, however, has held that such communications with QMEs are also permissible.<sup>83</sup> Furthermore, LC 4062.3(f) makes a general statement that communications relating to the scheduling of appointments, missed appointments, the furnishing of records and reports and the availability of the report do not constitute ex parte communications, but adds that such statements are permissible “unless the appeals board has made a specific finding of an impermissible ex parte communication.” So, essentially, it says that such communications are not prohibited unless the appeals board says they are prohibited. Accordingly, LC 4062.3(f) doesn’t necessarily protect communications between a party and an AME regarding topics such as scheduling and furnishing of records. The appeals board is left to decide whether the communications are prohibited.

### Insignificant or Inconsequential Communications

Under *Alvarez*, although ex parte communications may not be justified based on the fact that they were initiated by the AME or the QME, or that they related to administrative, rather than substantive matters, not all communications will result in a new evaluator. If the communications were so insignificant or inconsequential as not to be covered by LC 4062.3, there would be no sanctions. Whether a given communication is sufficiently “insignificant and inconsequential” is a legal standard still under development. Several panel decisions have spoken to individual instances, but, again, the law on this point is being constructed.<sup>84</sup>

In one panel decision, the appeals board reversed a WCJ’s decision that a six-second voicemail by a panel QME was an ex parte communication requiring assignment of a replacement QME panel. In that case, following the QME’s evaluation of the applicant, the doctor left a voice message for the claims examiner to return his telephone call, but left no other information. After hearing the message, the claims examiner contacted the defense counsel, who in turn notified the applicant’s attorney. The defendant sent a letter to the QME notifying him that ex parte communications were prohibited. The letter was copied to the applicant’s attorney, who did not take any action until after receiving the QME’s report, which was favorable to the defendant. The panel explained that under the circumstances, the QME’s voicemail was so peripheral

<sup>82</sup> *Alvarez v. WCAB (Parades)* (2010) 75 CCC 817 (*Alvarez II*). Subsequent to the decision, on remand the appeals board in the *Alvarez* case concluded that the communication was not an ex parte greeting or comment about the weather or traffic, but was precisely about the “operative proceedings” of the case. So it held that the communication between the QME and the defense attorney was a prohibited ex parte communication that required a new evaluation. *Parades, Alvarez v. Andromeda Entertainment*, 2010 Cal. Wrk. Comp. P.D. LEXIS 637.

<sup>83</sup> *Ruiz v. Hawksley Masonry, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 113.

<sup>84</sup> In a case before *Alvarez*, the appeals board held that a defendant’s letter to an AME was not an ex parte communication even though it was not served on the applicant when the parties agreed that they could write their own letters to the AME, and that by doing so LC 4062.3(f) was waived. *Pineda v. WCAB* (2005) 70 CCC 1550 (writ denied). Similarly, in another case, an employer engaged in an ex parte communication with an AME by sending a job analysis to the AME without notifying the applicant. The appeals board admitted the AME’s report, noting that the employer’s ex parte communication was not intended to influence the AME. *Carchidi v. WCAB* (1998) 63 CCC 291 (writ denied). These decisions no longer would be valid under *Alvarez* or CCR 35.

to the operative proceedings as to be insignificant. It found that pursuant to *Alvarez*, there was no ex parte communication by the QME.<sup>85</sup>

It may be important if it is a member of the attorney's staff, not the attorney, who communicates with the medical-legal evaluator. In one panel decision, the appeals board held that an attorney's communications with the QME's staff regarding the scheduling of an appointment with the QME did not constitute a prohibited ex parte communication under LC 4062.3(f). The panel explained that by its own terms, LC 4062.3(f) did not include "staff" among the restricted communications.<sup>86</sup>

In another case, the appeals board concluded that a panel QME's reports were admissible even though he served the final version of his reports only on the defendant. The appeals board adopted the WCJ's reasoning that the panel QME's reports should not be stricken because service only on the defendant appeared to be an oversight, and not the type of communication that LC 4062.3(e) and (f) were enacted to protect against. It was noted that the "communications" were medical reports in their final version, not information provided by the defendant to the panel QME to try to influence him before his opinion was issued, and that the defendant served the reports on the applicant shortly after receiving them. The appeals board also concluded that even if the panel QME's service of his report solely on the defendant could be deemed an ex parte communication, it fell within the "insignificant and inconsequential" exception defined in *Alvarez*.<sup>87</sup>

In one case, the appeals board rejected a defendant's argument that a telephone conversation with an AME was not ex parte communication when it was performed as part of a criminal investigation (the employer was a correctional facility), both before and after the applicant was charged with insurance fraud. The defense contended that the call was protected as part of that investigation, and in any case did not have an impact on the case sufficient to warrant striking the AME. The board found no exception to the rules when the communication was done as part of a criminal investigation, and pointed out that the defendant's ex parte communications with the AME were not confidential because they were disclosed to the adjusting agent in the workers' compensation claim. Because the board found that the defendant's ex parte communications were not so insignificant or inconsequential that any resulting repercussions would be unavoidable, it concluded that the defendant violated LC 4062.3.<sup>88</sup>

## Exception to Preclusion Against Ex Parte Communications

LC 4062.3(i) provides an exception to the preclusion against ex parte communications. It allows "oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination."<sup>89</sup> Similar language is contained in CCR 35(k).

So an applicant's communications with an AME or a QME during the course of an examination do not constitute ex parte communications. This makes sense. The physician can hardly perform an effective evaluation without speaking with the applicant. And communications in connection with the examination

<sup>85</sup> *Degen v. Bonita Unified School District*, 2011 Cal. Wrk. Comp. P.D. LEXIS 425. See also *Nelson v. County of Solano*, 2012 Cal. Wrk. Comp. P.D. LEXIS 527 (emails from QME to applicant were insignificant when they simply contained adjuster's phone number and had something to do with "personnel records"; later, the emails were forwarded to the adjuster).

<sup>86</sup> *O'Reilly v. State of California, Department of Corrections*, 2010 Cal. Wrk. Comp. P.D. LEXIS 376. See also *Sanchez v. Pitney Bowes*, 2012 Cal. Wrk. Comp. P.D. LEXIS 385 (communication between applicant's attorney's secretary and panel QME secretary to reschedule tests was permissible); *Cunningham v. County of San Bernardino*, 2011 Cal. Wrk. Comp. P.D. LEXIS 525 (communications with applicant's attorney's office and QME's office to obtain a copy of echocardiogram report, schedule deposition of QME and reschedule QME deposition did not rise to the level of significance or consequence); *Ruiz v. Hawksley Masonry, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 113 (conversation between attorney and QME's staff to schedule evaluation was permissible).

<sup>87</sup> *Lenier v. Brookdale Living Communities*, 2010 Cal. Wrk. Comp. P.D. LEXIS 423. See also *Mojica v. Jo Silveira, dba Silveira & Sons*, 2012 Cal. Wrk. Comp. P.D. LEXIS 145 (mailing a report to only one party by mistake was a communication so inconsequential as to not be covered by LC 4062.3).

<sup>88</sup> *State of California Department of Corrections and Rehabilitation v. WCAB (Loving)* (2016) 81 CCC 822 (writ denied).

<sup>89</sup> Note that LC 4062.3(i) references only subsection (e), which relates only to communications with QMEs, and not (f), which relates to communications with AMEs. But there seems to be no question that the prohibition was intended to apply to both AMEs and QMEs.

are permitted. In one case, the appeals board found that a QME's emails to an unrepresented applicant regarding the employee's disability questionnaire were needed to complete the examination and were not prohibited.<sup>90</sup>

Whether a communication is made by an applicant "in the course of the examination," however, is open to interpretation and various panel decisions have spoken on the issue. None of the cases is binding. So the types of communication that are "in the course of the examination" for the purposes of LC 4062.3(i) will require further legal development.

### Cases Finding Impermissible Communications

In one case, a panel QME had issued three reports. He testified at his deposition that he examined his file in preparation for the deposition and that it contained the three reports and a letter from the applicant written on the date of the last evaluation. The content of the letter made clear that it was written after the applicant had left the evaluation. The letter had not been provided previously to either the defendant's or applicant's counsel. The appeals board ordered the panel QME be stricken. It explained that the communication by an applicant "in the course of the examination" for the purposes of LC 4062.3(h) must have occurred when the applicant was in the doctor's office and have been made during the examination. If the communication by the applicant was not during the examination, the only other exception for a communication by the applicant would be at the request of the doctor in connection with an evaluation. Because the letter was prepared and sent after the examination had concluded, and was not solicited by the panel QME, it was an ex parte communication.<sup>91</sup>

In another case, the appeals board found that an applicant engaged in ex parte communications with a panel QME when she: (1) sent the QME a copy of his own report with 56 separate items of correction or elaboration she provided; (2) telephoned the QME directly to voice her concerns; and (3) sent the QME treatment reports from a marriage and family therapist, and there was no evidence that the applicant copied the defendant with her communications. The appeals board found that all of the communications were initiated by the applicant, and not the panel QME, and all of the communications were substantive and occurred well after the examination.<sup>92</sup>

### Cases Finding Permissible Communications

In contrast, in one case, an applicant was re-evaluated by a panel QME. The applicant provided him with a written statement and photographs he had prepared on the date of the re-evaluation. The applicant testified that he prepared the materials the previous day so that he would remember everything he needed to tell the doctor because his heavy narcotic medication caused memory problems. The appeals board upheld a WCJ's decision that there was no good cause to remove the panel QME.<sup>93</sup>

It explained that the written statement and photographs provided by the injured worker to the panel QME during the re-evaluation fell within LC 4062.3(h). It noted that the fact that the statement was prepared a

<sup>90</sup> *Nelson v. County of Solano*, 2012 Cal. Wrk. Comp. P.D. LEXIS 527.

<sup>91</sup> *Giammona v. Fisher Development*, 2011 Cal. Wrk. Comp. P.D. LEXIS 160. Note that this case was appealed but the Court of Appeal declined to review it. *Fisher Development v. WCAB (Giammona)* (2012) 77 CCC 1171 (writ denied). Previously, the appeals board liberally interpreted the term "in the course of the examination." It held that an applicant who telephoned a QME six weeks after the evaluation seeking psychiatric advice after she was unable to reach her treating psychiatrist and her primary care provider did not engage in an ex parte communication. The applicant had expressed concern about hitting her stepfather, and the QME instructed her to go to an emergency room. The appeals board reasoned that the communication with the QME was close enough in time and subject matter to find that it was within the course of the examination. The appeals board also explained that the employer was not prejudiced by the communication because the QME revealed the communication in her report, and the employer could obtain records from the applicant's hospitalization and cross-examine the QME on the significance of the records and the communications. *Koenig v. AT&T Mobility, Inc.* (2010) 39 CWC 37 [2010 Cal. Wrk. Comp. P.D. LEXIS 295]. This decision, issued prior to *Alvarez*, is likely invalid, as prejudice is not relevant under *Alvarez*.

<sup>92</sup> *Geiger v. Brayton Purcell*, 2013 Cal. Wrk. Comp. P.D. LEXIS 256.

<sup>93</sup> *Bartleson v. Roadway Express*, 2011 Cal. Wrk. Comp. P.D. LEXIS 518.

day in advance did not take it out of the course of the re-examination. It added that the panel QME asked the applicant for the documents. The panel found that the applicant should not be penalized for his preparation in order to provide an accurate and comprehensive history to the physician. The appeals board also noted that the defendant was served with all the materials, but it is not clear from the facts when the materials were served. The appeals board found it relevant that the defendant did not file its petition to remove the panel QME until after receiving his report, and concluded that the defendant waived its rights to object. The appeals board further rejected an argument that the panel QME should be stricken because the applicant's letter and exhibits to the panel QME went out a week before the examination and were sent concurrently to the defendant, rather than being served on the defendant 20 days before the examination, with 10 days to object as required by LC 4062.3(b). It stated that, arguably, LC 4062.3(b) did not apply to re-evaluations. It further found that neither party complied with the requirements of LC 4062.3(b) as both parties concurrently filed and served all materials on opposing counsel, and that the defendant did not raise the issue until long after receiving the panel QME's report.<sup>94</sup>

Similarly, an applicant brought a document with him to his examination with an AME. The document memorialized the applicant's recollection of incidents during his employment. The appeals board again upheld a WCJ's decision that the document was permissible under LC 4062.3(h). The appeals board did not see a difference between an applicant who brought notes regarding what he perceived to be stressful events during his employment to a medical examination, as opposed to an applicant who extemporaneously discussed the alleged stressful events with a doctor. It concluded that the fact that the applicant brought notes with him to the examination did not rise to the level of an ex parte communication.<sup>95</sup>

These cases are problematic for defendants. Although the statements in the cases purportedly were prepared by the applicants themselves, it is not difficult to imagine a scenario in which a statement is prepared with the assistance of the applicant's attorney for the purposes of manipulating an applicant's medical history toward a finding of compensability. Furthermore, in the first case, the appeals board never really justified the admission of the photographs that were provided to the panel QME. LC 4062.3(b) allows a party to object to nonmedical evidence and this seems to be an unwarranted extension of the law.

## Communications with Spouse or Dependent

LC 4062.3(i) also permits an AME or QME to communicate with an employee's dependent in the course of an examination if the employee is deceased. (For a discussion on the medical evidence needed to establish industrial causation of an employee's death, see [“Sullivan on Comp” Section 12.2 Compensability – Employee Death](#)). But may an AME or QME communicate with a spouse or dependent while the employee is still alive?

In one case, the appeals board allowed a panel QME to communicate with an applicant's wife during a psychiatric evaluation. In his report, that QME noted that he spoke with the applicant's wife by telephone and she confirmed that he was depressed and was a different person. The appeals board explained that although the exception in LC 4062.3(i)<sup>96</sup> applies to cases involving a deceased employee, it was applicable by analogy in cases of psychiatric or psychological evaluation. The board added that in such cases, it may be appropriate for the medical evaluator to interview the applicant's spouse to confirm or expand on the narrative the applicant has given. The appeals board then stated that as long as such oral or written communications are disclosed, there would be no reasonable basis to order a replacement panel, and that

<sup>94</sup> *Bartleson v. Roadway Express*, 2011 Cal. Wrk. Comp. P.D. LEXIS 518.

<sup>95</sup> *Mibeck v. County of San Bernardino Sheriff Department*, 2011 Cal. Wrk. Comp. P.D. LEXIS 543. See also *Mason v. Fremont-Rideout Health Group*, 2016 Cal. Wrk. Comp. P.D. LEXIS 268.

<sup>96</sup> The decision refers to LC 4062.3(h), but this was changed to LC 4062.3(i) effective Jan. 1, 2013, by SB 863.

the defendant had the option of deposing the panel QME to determine what effect, if any, the input from the applicant's wife had on the doctor's opinion.<sup>97</sup>

In another case, the appeals board denied a defendant's request for a new QME when a psychiatric QME communicated with an applicant's daughter during the course of the examination. The appeals board found the communications between the daughter and the QME were not ex parte communications because LC 4062.3 and CCR 35(k) contemplate that an ex parte communication may be made only by a party, and the daughter was not a party in the case. The appeals board went on to find that the communications between the daughter and the QME could be regarded as "nonmedical information" provided to the QME, to which the defendant had a right to object. But it added that the defendant was required to file an objection within a reasonable time of acquiring knowledge of the communications. Because the defendant had explicit knowledge of the QME's interview with the daughter two years before it filed its petition to strike, the WCAB found the defendant's objection was not made within a reasonable time.<sup>98</sup>

In one case, the appeals board held that a QME did not engage in an impermissible ex parte communication with an applicant's wife during an evaluation when the applicant could not communicate with the QME due to his severe disability. The applicant suffered a stroke on an industrial basis, leaving him with severe expressive neurocognitive deficits. The appeals board found that because the applicant was unable to talk or otherwise communicate, he would be deprived of a panel QME without the assistance of someone to transmit the required information (history of injury, complaints, medical history) on his behalf. It concluded the assistance the applicant's wife provided was akin to the assistance provided by a language interpreter on behalf of a non-English speaking injured employee during such an evaluation. It believed interpreter services came within the exception defined in LC 4062.3(i), were transmissions of information on the injured employee's behalf and, thus, were communications by the employee. It added that the fact that the wife filed a lien for home health-care services did not preclude the communications because she had not achieved party status as defined by CCR 10301(dd).<sup>99</sup>

In addition, in one case, the appeals board concluded that there was no improper ex parte communication between the applicant or applicant's spouse and the AME when the applicant could not effectively attend any medical evaluation by himself. The applicant fell 20 feet from a roof, landing on his head, neck and shoulders. The applicant's wife transported and accompanied him to his medical appointments, and provided background information and history because of the applicant's failing memory. The appeals board found it necessary for the wife to attend and participate in the evaluation. It also found that the wife did not violate any rules by providing the AME with notes and video on her cellphone. The appeals board found that the wife mentioned the notes and video in passing. But it found that the materials were requested by the AME. So the notes and video were exempted by LC 4062.3(i) as "oral or written communications" that were made "in the course of the examination or made at the request of the evaluator in connection with the examination."<sup>100</sup>

### Evaluation with New Physician for Ex Parte Communications

If a party engages in an ex parte communication with the AME or the QME, the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another panel QME or proceed with the initial evaluation (LC 4062.3(g)).<sup>101</sup> Only the aggrieved party — the party who did not engage in an ex

<sup>97</sup> *Frost v. East Bay Municipal Utility District*, 2012 Cal. Wrk. Comp. P.D. LEXIS 623.

<sup>98</sup> *Torres v. Pacific Coast Products*, 2013 Cal. Wrk. Comp. P.D. LEXIS 287.

<sup>99</sup> *Belling v. United Parcel Service, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 738. Note the case refers to CCR 10301(x), but CCR 10301(dd) is the current regulation. Per CCR 10301(dd), a lien claimant becomes a "party" when the underlying case of the injured employee has been resolved or when the injured employee chooses not to proceed with a case.

<sup>100</sup> *Geiger v. Geiger*, 2015 Cal. Wrk. Comp. P.D. LEXIS 751.

<sup>101</sup> Note that LC 4062.3(g) references only subsection (e), which relates only to communications with QMEs, and not (f), which relates to communications with AMEs. But there seems to be no question that the prohibition was intended to apply to both AMEs and QMEs.

parte communication — has a right to seek a new evaluation.<sup>102</sup> CCR 35(k) similarly provides that if any party communicates with any evaluator in violation of LC 4062.3, the medical director “shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator.” Furthermore, CCR 35(g) defines improperly providing information to an evaluator as an ex parte communication.

Parties naturally have seen this provision as an opportunity to dispose of an undesired evaluator. As discussed above, in many cases, the appeals board has ordered a replacement panel when a party provided information to a QME in violation of the rules. In *Maxham v. California Department of Corrections and Rehabilitation*,<sup>103</sup> however, the appeals board stated that if the WCJ determines a party improperly provided information to the medical evaluator, he or she has wide discretion in fashioning an appropriate remedy. In the past, the board has not allowed a new QME panel for all ex parte communications.

The appeals board has been reluctant to allow this if the first evaluation has gone forward. In a panel decision, the appeals board limited the remedies for an ex parte communication to striking evidence that is produced as a result of the ex parte communication rather than striking all of the evaluator’s reports and depositions. In that case, the AME already had produced four reports and taken part in two depositions. The applicant’s attorney scheduled a third deposition with the AME. The defense counsel was unable to attend because of a scheduling conflict. So the deposition took place without the defendant in attendance. The appeals board found that a party could properly notice a deposition of an AME and that the defense counsel had a responsibility to send another attorney in his place if he had a scheduling conflict. The appeals board also concluded that the deposition did not necessarily constitute an ex parte communication, but that the applicant’s attorney violated LC 4062.3(f) when he engaged in an off-the-record discussion at the deposition. The appeals board excluded the deposition from evidence but did not exclude the AME’s earlier reports or depositions because they were not tainted by the last deposition.<sup>104</sup>

Similarly in one case, an applicant violated the rules by sending an AME documents without notification to the defendant. The appeals board held that it was proper to disqualify the AME and that the defendant was entitled to a new QME panel. But it also concluded that only the report generated as a result of the ex parte communication was inadmissible, and that all of the AME’s prior reports were admissible.<sup>105</sup>

In one case, the appeals board refused to order a replacement QME when an applicant’s attorney sent a communication 19 days before an appointment, rather than 20 days, because it concluded that the remedy for a late-served communication applied only to the initial evaluation, and not a re-evaluation, at least when the panel QME had conducted three examinations. The appeals board found that a communication served a day late should not be the basis for setting discovery back three years.<sup>106</sup>

Similarly, the appeals board held that an applicant was not entitled to a new QME panel even though the defendant violated LC 4062.3(e) by not serving a communication to a QME 20 days before a re-examination, and violated LC 4062.2(b) by not serving the applicant with documents 20 days before sending them to the QME. The appeals board again explained that, per LC 4062.3(g), if there is an improper communication, an aggrieved party may “terminate” or “proceed with the *initial* evaluation” (emphasis added). Because the defendant’s communications involved a re-examination and not an initial examination, the remedy was not a new panel QME. But because the defendant improperly communicated with the QME, it was liable for

<sup>102</sup> See *Berke v. Bloomingdales, Macys Corporate Services*, 2012 Cal. Wrk. Comp. P.D. LEXIS 112; *Hernandez v. Carlucci*, 2013 Cal. Wrk. Comp. P.D. LEXIS 552; *Cantu v. Roman Catholic Bishop of Monterey*, 2014 Cal. Wrk. Comp. P.D. LEXIS 48.

<sup>103</sup> (2017) ADJ3540065 (appeals board *en banc*).

<sup>104</sup> *Young v. Reviewco, Inc.*, 2009 Cal. Wrk. Comp. P.D. LEXIS 558. See also *Vallem v. State of California, CDCR*, 2015 Cal. Wrk. Comp. P.D. LEXIS 407.

<sup>105</sup> *Jackson v. Alia Corp.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 73. See also *Vaughn v. Central Coast Community Healthcare*, 2016 Cal. Wrk. Comp. P.D. LEXIS 217.

<sup>106</sup> *Chand v. Bank of America*, 2012 Cal. Wrk. Comp. P.D. LEXIS 455.

attorneys' fees and costs under LC 4062.3(h). The appeals board also concluded that the applicant did not waive her rights under LC 4062.3 by attending the QME re-examination or by failing to raise the issue of entitlement to fees until after the QME reported.<sup>107</sup>

### Contempt, Costs, Fees and Sanctions

Additional penalties may be imposed against the party that engaged in the prohibited communication. LC 4062.3(h) provides that the party making the prohibited communication is subject to being charged with contempt before the appeals board. The offending party also is liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the medical evaluation, additional discovery costs and attorneys' fees for related discovery.

In one case, the appeals board explained that fees under LC 4062.3(h) are awarded only for time spent related to discovery that was the result of the ex parte communication, not time spent in the normal course of litigation. In that case, a defendant sent inappropriate correspondences to two QMEs resulting in the need for a third QME. The WCJ awarded the applicant's attorney \$23,065 for 72.4 hours incurred as a result of the defendant's violation of LC 4062.3. But the board awarded only \$7,490, based on 21.4 billable hours at \$350 per hour. It explained that the attorney's fees were owed up to the date of the applicant's evaluation with the third QME, and that discovery after the evaluation was done in the regular course of litigating the applicant's claim. It was not caused by, or related to, the ex parte communications. The board added that the attorney was not automatically entitled to all hours claimed in the fee request, but had to prove the hours sought were reasonable and necessary.<sup>108</sup>

So, to justify an award of fees, the WCJ should establish a connection between the amount of the fee and how the services rendered were related to the applicant's discovery efforts from an improper ex parte communication.<sup>109</sup>

There seems to be no reason why LC 5813 would not apply. Sanctions under LC 5813 are discussed further in [“Sullivan on Comp” Section 13.4 Sanctions Under LC 5813](#). Furthermore, the administrative director, at his or her discretion, may suspend or terminate any physician from the QME list without a hearing for engaging in an ex parte contact prohibited by LC 4062.3 (CCR 60(b)(7)).

### PAYMENT OF MEDICAL BENEFITS FOLLOWING RECEIPT OF MEDICAL-LEGAL REPORT

Previously, LC 4063 required an employer to commence payment to the employee if an AME or QME determined that disability was due. SB 863 amended LC 4063 to direct that if the resolution of a formal medical evaluation from an AME or QME selected from a three-member panel requires an employer to provide compensation, the employer must commence the payment *or file a declaration of readiness to proceed*. It also establishes an exception per LC 4650(b), under which PD payments are not required before an award of permanent disability indemnity if the employer has offered the employee a position that pays at least 85 percent of the wages and compensation paid to him or her at the time of injury, or if the employee is working in a position that pays at least 100 percent of the wages and compensation paid to him or her at the time of injury. This is discussed further in Chapter I: Permanent Disability

Also, LC 4063 is not applicable if the defendant has legitimate legal defenses to the payment of compensation, a medical report is not dispositive of compensability, and thus the report does “not require

<sup>107</sup> *Robles v. State of California — Department of Motor Vehicles*, 2014 Cal. Wrk. Comp. P.D. LEXIS 415.

<sup>108</sup> *Ramirez v. Parking Concepts*, 2013 Cal. Wrk. Comp. P.D. LEXIS 511; *Ramirez v. Parking Concepts*, 2014 Cal. Wrk. Comp. P.D. LEXIS 78.

<sup>109</sup> *Aguayo v. American Golf Corp.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 454; *Aguayo v. American Golf Corp.*, 2010 Cal. Wrk. Comp. P.D. LEXIS 521; *Ramirez v. Parking Concepts*, 2012 Cal. Wrk. Comp. P.D. LEXIS 154; *Ramirez v. Parking Concepts*, 2014 Cal. Wrk. Comp. P.D. LEXIS 78.



an employer to provide compensation.” For example, an employer was not liable for benefits despite a QME reporting that a psychiatric injury was compensable when the claim was barred by the post-termination defense per LC 3208.3(e) (see [“Sullivan on Comp” Section 5.32 Psychiatric Injury — Post-Termination Claims](#)).<sup>110</sup>

## REPORTING UNDER LC 4064

LC 4064 was unaltered by the dramatic changes to the workers’ compensation system brought by SB 899. It was amended by SB 863, although much of the language remains intact. LC 4064(a) provides that an employer is liable for legitimate medical-legal expenses under LC 4060, LC 4061 and LC 4062. LC 4064(d) also provides that “no party is prohibited from obtaining any medical evaluation or consultation at the party’s own expense.” So, on its face, LC 4064(d) appears to allow parties to obtain medical evaluations or consultations at their own expense in addition to what is established in LC 4060 et seq. After SB 899 passed, some parties tried to use this section to do just that.

But in a significant panel decision, *Ward v. City of Desert Hot Springs*,<sup>111</sup> the appeals board rejected this idea. It held that for claimed industrial injuries occurring on or after Jan. 1, 2005 in which the employee is represented by an attorney, under LC 4060(c) medical disputes regarding the compensability of the alleged injury must be resolved solely by the procedure provided in LC 4062.2. The board also held that an evaluation regarding the compensability of a claim may not be obtained pursuant to LC 4064(d), and that if one were obtained, it would not be admissible.<sup>112</sup>

The appeals board explained that because LC 4060(c) and LC 4062.2(a) state that medical evaluations “shall be obtained only” by the procedures they specify, it found the Legislature intended that the medical-legal procedure defined in those sections was the exclusive method for obtaining medical-legal evaluations on compensability. The board found that the language of LC 4064(d) could not be harmonized with the current law, and that LC 4060(c) and LC 4062.2, as the most recently enacted or amended statutes, have control over LC 4064(d).<sup>113</sup>

Because LC 4061 and LC 4062 also provide that disputes about medical issues “shall be obtained” by the procedures established in LC 4062.1 and LC 4062.2 in an accepted claim, a party also would not be permitted to obtain a medical report under LC 4064(d) to deal with disputed issues, or, if the party did so, such a report would not be admissible.<sup>114</sup> In addition, effective Jan. 1, 2013, LC 4064(d) was amended to state, “All comprehensive medical evaluations obtained by any party shall be admissible in any proceedings before the appeals board except as provided in Section 4060, 4061, 4062, 4062.1, or 4062.2.”<sup>115</sup>

Accordingly, in *Batten v. WCAB*,<sup>116</sup> the Court of Appeal cited *Ward* and held that a privately retained expert’s opinion obtained per LC 4064(d) is not admissible as evidence before the appeals board. The court explained

<sup>110</sup> *Rich v. California Department of Corrections*, 2016 Cal. Wrk. Comp. P.D. LEXIS 597.

<sup>111</sup> (2006) 71 CCC 1313 (writ denied) (significant panel decision) review denied in *City of Desert Hot Springs v. WCAB (Ward)* (2006) 71 CCC 1900 (writ denied).

<sup>112</sup> *Ward v. City of Desert Hot Springs* (2006) 71 CCC 1313 (writ denied) (significant panel decision). See also *Delgadillo v. Construction Forklift Services*, 2011 Cal. Wrk. Comp. P.D. LEXIS 209.

<sup>113</sup> *Ward v. City of Desert Hot Springs* (2006) 71 CCC 1313, 1315-17 (writ denied) (significant panel decision).

<sup>114</sup> See *Gambito v. Farmers Insurance Group* 2008 Cal. Wrk. Comp. P.D. LEXIS 431 (applicant not entitled to medical examination at her own expense when medical report had been obtained under LC 4062.1).

<sup>115</sup> In *Valdez v. WCAB* (2013) 78 CCC 1209, 1212, fn. 2, the California Supreme Court stated, “Currently, none of the statutes referenced in section 4064, subdivision (d) include any specific restriction on the admissibility of medical evaluations.” This language suggests that either party may obtain admissible reports under LC 4064(d). But the Supreme Court did not decide this issue or specifically consider the language of the other statutes. *Valdez* did not reference *Ward v. City of Desert Hot Springs* (2006) 71 CCC 1313 (writ denied) (significant panel decision). So it isn’t clear if the Supreme Court intended to allow parties to bypass the medical-legal process under LC 4060 et seq and to obtain their own medical-legal evaluations under LC 4064(d). In *Mr. Bult’s, Inc. v. WCAB (Montejo)* (2014) 80 CCC 55 (writ denied), the defendant cited *Valdez* to argue that its report under LC 4064(d) should have been admitted. But the WCAB refused to admit the report on the grounds that it lacked evidentiary value because the physician did not evaluate the applicant. It added that even if defendant had the right under LC 4064(d) to obtain a report, it did not automatically have a right to use the report as evidence.

<sup>116</sup> (2015) 80 CCC 1256.

that the procedures established in LC 4062.2 are the exclusive method for obtaining medical evaluations for compensability when an applicant is represented because of the mandatory language used in LC 4060 and LC 4062.2. It noted that under LC 4064(d), “All comprehensive medical evaluations obtained by any party shall be admissible in any proceedings before the appeals board *except as provided* in Section 4060, 4061, 4062, 4062.1, or 4062.2” (emphasis added). It added that although LC 4060, LC 4062, 4062.1 and 4062.2 do not specifically preclude the admission of an independently retained expert, LC 4061(i) does prohibit the admission of privately retained reports, unless they are prepared by a treating physician.<sup>117</sup> It stated that “[h]ad the Legislature intended to permit the admission of additional comprehensive medical reports, obtained at a parties’ own expense for the sole purpose of rebutting the opinion of the qualified medical expert, it would have said so.”<sup>118</sup>

*Batten* then rejected the applicant’s argument that her privately retained reports were admissible per LC 4605. That statute states, “Nothing contained in this chapter shall limit the right of the employee to provide, at his or her own expense, a consulting physician or any attending physicians whom he or she desires.” But the court held that the term “consulting physician” in LC 4605 means “a doctor who is consulted for the purposes of discussing proper medical treatment, not one who is consulted for determining medical-legal issues in rebuttal to a panel QME.” It concluded that neither LC 4605 nor LC 4061(i) permits the admission of a report by an expert who is retained solely for the purposes of rebutting the opinion of the agreed medical expert’s opinion.<sup>119</sup>

But LC 4064 will allow for the admissibility of reporting properly obtained in other, related cases, as such reports are not obtained in violation of the statutory scheme. In one case, the appeals board held that an AME’s report obtained in two cases against one employer could be used in a case against another employer. That applicant claimed two specific injuries against one employer and a cumulative trauma injury against a subsequent employer. An AME was selected for the two specific injuries, but the AME apportioned the applicant’s permanent disability among the three injuries. The second employer argued that the AME’s report was not admissible against it because it did not agree to use the AME in its case. The board disagreed.

It explained that under LC 4064(d), medical-legal evaluations obtained by any party are admissible in any proceedings unless prohibited by LC 4060 et seq. The appeals board explained that the AME’s report was obtained validly under LC 4062.2 and was admissible. It added that if the second employer wished to dispute the AME’s opinion, it was required to request a QME panel under LC 4060 et seq, and not to sit idly by. The appeals board concluded that the AME’s report was admitted properly to support an award against the second employer.<sup>120</sup>

Parties should be careful to raise objections to inadmissible reports at the mandatory settlement conference or at trial. Otherwise, a party may be deemed to have waived any objection to the report.<sup>121</sup> This is discussed further in [“Sullivan on Comp” Section 15.42 Mandatory Settlement Conference — Raising Issues.](#)

<sup>117</sup> LC 4061(i) states in relevant part, “With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations resulting from the injury shall be obtained, except in accordance with Section 4062.1 or 4062.2. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board.”

<sup>118</sup> *Batten v. WCAB* (2015) 80 CCC 1256, 1259-1260.

<sup>119</sup> *Batten v. WCAB* (2015) 80 CCC 1256, 1261. See also *Borunda v. Ruskin Manufacturing*, 2014 Cal. Wrk. Comp. P.D. LEXIS 255; *Silva v. WCAB* (2016) 81 CCC 637 (writ denied).

<sup>120</sup> *Lorenz v. Encino Hospital Medical Center*, 2014 Cal. Wrk. Comp. P.D. LEXIS 410. See also *Cahill Contractors v. WCAB (Hallquist)* (2015) 80 CCC 815 (writ denied); *Cuate v. Metro Pads, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 459; *Hunter v. Entertainment Partners*, 2016 Cal. Wrk. Comp. P.D. LEXIS 233; *CIGA v. WCAB (Claiborne)*, 2016 Cal. Wrk. Comp. LEXIS 127 (writ denied).

<sup>121</sup> See *Guerra v. WCAB* (2016) 81 CCC 324, 327, fn. 3; *County of Riverside v. WCAB (Hedden)* (2012) 77 CCC 995 (writ denied).

## ATTORNEYS' FEES FOR DECLARATIONS OF READINESS TO PROCEED FILED BY EMPLOYERS IN UNREPRESENTED CASES

Per LC 4064(c), subject to LC 4906, if an employer files a declaration of readiness to proceed when the employee is unrepresented, the employer is liable for any reasonable attorney's fee incurred by the employee in connection with the DOR. The employer is required to pay those fees in addition to the compensation recovered by the applicant.<sup>122</sup> This may be so even if the employer ultimately wins the dispute over benefits that motivated filing the DOR,<sup>123</sup> or if the applicant ultimately is awarded zero PD.<sup>124</sup>

Previously, LC 4064(c) provided that when an employee was unrepresented, if an employer filed an application for adjudication, it was liable for all attorneys' fees in connection with the application.<sup>125</sup> These fees were awarded potentially for all of the applicant's attorney's activities in connection with the application, including settlement of the claim.<sup>126</sup> Effective Jan. 1, 2013, LC 4064(c) was amended to supplant "application for adjudication" with "declaration of readiness to proceed."

The amendment does not relieve employers of the risk of attorneys' fees entirely. Rather, it limits them to the events prompted by the employee in connection with the DOR. The statute does not define what fees will be considered to be incurred by the employee in connection with a DOR. It seems, however, that such fees could encompass several conferences or trials.

For example, in one case, an employer filed a DOR requesting an MSC on the issue of the LC 4658(d) reduction (see ["Sullivan on Comp" Section 11.6 Adjustment of Permanent Disability Payments for Offer of Work](#)). The matter proceeded to an MSC, but was taken off calendar so the applicant could seek an attorney. The applicant retained an attorney who filed a DOR on the LC 4658(d) issue, and the matter proceeded to trial. The appeals board concluded that because the case was tried on the issue that the employer initially raised in its DOR, the employer was liable for fees under LC 4064(c) in connection with the trial.<sup>127</sup>

The amendment to LC 4064(c) applies to all cases not filed as of Jan. 1, 2013. So if an employer filed a DOR before Jan. 1, 2013, while an applicant was unrepresented, it may be liable for fees under LC 4064(c), even though such fees were not authorized at the time of filing.<sup>128</sup> If the applicant filed a DOR, the employer would not be liable for fees under LC 4064(c).<sup>129</sup> Also, if an employer filed an application before Jan. 1, 2013 while an applicant was unrepresented, but did not file a DOR, fees would not be warranted.<sup>130</sup>

## ATTORNEYS' FEES FOR APPLICATIONS FILED BY EMPLOYER CONTESTING FINDINGS OF AGREED MEDICAL EXAMINER

Under former LC 4066, if an employer filed an application for adjudication to contest a formal medical evaluation prepared by an agreed medical examiner, the employer was liable for the employee's reasonable

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<sup>122</sup> See *Capistrano Unified School District v. WCAB (Eads)* (1996) 61 CCC 844 (writ denied) (attorney's fees paid under LC 4064 were in addition to award of PD).

<sup>123</sup> See *Lompoc Unified School District v. WCAB (Cortez)* (1998) 64 CCC 105 (writ denied).

<sup>124</sup> See *Luna v. Zenith Insurance Co.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 688.

<sup>125</sup> For cases applying former LC 4064(c), see *Ford v. Lawrence Berkeley Laboratory* (1997) 62 CCC 153 (appeals board *en banc*); *Ford v. WCAB* (1998) 63 CCC 1121 (Court of Appeal opinion unpublished in official reports); *Bray v. Porterville Public Schools* (2000) 28 CWCR 240 (panel decision); *Save Mart v. WCAB (Young)* (2008) 73 CCC 23 (writ denied) (Court of Appeal opinion unpublished in official reports); *Mendieta v. Copenhagen House of Danish*, 2008 Cal. Wrk. Comp. P.D. LEXIS 789; *Corrales v. Voler Team Apparel*, 2012 Cal. Wrk. Comp. P.D. LEXIS 17.

<sup>126</sup> *Bimbo Bakeries USA v. WCAB (Shriver)* (2009) 74 CCC 766 (writ denied).

<sup>127</sup> *Blessing v. City of Sacramento*, 2013 Cal. Wrk. Comp. P.D. LEXIS 593.

<sup>128</sup> See *Sealy, Inc. v. WCAB (Chan)* (2014) 79 CCC 1211 (writ denied); *Garcia v. Los Angeles Unified School District*, 2015 Cal. Wrk. Comp. P.D. LEXIS 39.

<sup>129</sup> *San Francisco State University v. WCAB (Jones)* (2014) 79 CCC 1235 (Court of Appeal opinion unpublished in official reports); *Jones v. San Francisco State University*, 2015 Cal. Wrk. Comp. P.D. LEXIS 74.

<sup>130</sup> See *Solano v. Wal-Mart Associates Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 447.

attorneys' fees regardless of the outcome.<sup>131</sup> Effective Jan. 1, 2013, this section was repealed by SB 863. So employers no longer face the threat of attorneys' fees if they need to file an application to contest an AME's findings before the appeals board.

## EXPEDITED HEARING FOR MEDICAL-LEGAL ISSUES

LC 5502(b) limits the issues that may be heard at an expedited hearing. It was amended by SB 863 so that issues relating to "[a] medical treatment appointment or medical-legal examination" may be heard at an expedited hearing. So if the parties have a dispute regarding whether the medical-legal process was followed properly, or whether an employee may be compelled to attend a medical-legal examination, it may be heard on an expedited basis. Expedited hearings are discussed further in ["Sullivan on Comp" Section 15.32 Expedited Hearing](#).

## LIMITATIONS ON FILING A DECLARATION OF READINESS TO PROCEED

Previously, a DOR could be filed on issues of permanent impairment and limitations if "there has first been a medical evaluation by a treating physician *or* an agreed or qualified medical evaluator." Effective Jan. 1, 2013, per LC 4061(i), "No issue relating to a dispute over the existence or extent of permanent impairment and limitations resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician and by either an agreed or qualified medical evaluator." So under LC 4061(i), a DOR may not be filed for issues relating to permanent disability and limitations from an injury unless the applicant has been evaluated by a treating physician *and* an AME or QME. The idea, it seems, is that if there is no dispute over a treating physician's findings of permanent disability and limitations, there is no dispute for the appeals board to resolve, and the treating physician should be followed.

LC 4061(i) doesn't preclude parties from settling claims based on a treating physician's opinion. AMEs or QMEs are used only if at least one of the parties objects to the treating physician's opinion. Parties still may settle claims based on a treating physician's reporting, and may walk-through any settlement based on a treating physician's report (see ["Sullivan on Comp" Section 15.33 Walk-Throughs](#)). LC 4061(i) precludes the parties only from filing a DOR.

Furthermore, LC 4061(i) precludes the filing of a DOR only over an "issue relating to the existence or extent of permanent impairment and limitations resulting from the injury ...." The parties still may file DORs on issues of injury arising out of and in the course of employment, statutes of limitation, discovery or any other issues not covered by LC 4061(i). Perhaps parties may get around this provision by filing a DOR on another issue, if one can be found.

Note that LC 4062.3(l) also contains a limitation on the filing of DORs. It states, "No disputed medical issue specified in subdivision (a) may be the subject of declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator." LC 4062.3(a) relates to the information that may be provided to QMEs. It allows a DOR to be filed if there has been an evaluation by a treating physician *or* an AME or QME.

## Consequences of Failure to Object

<sup>131</sup> For cases applying former LC 4066, see *Peterson v. State of California, Employment Development Department* (1995) 60 CCC 1206 (appeals board *en banc*); *Peterson v. WCAB* (1996) 61 CCC 1081 (writ denied); *Hagemeister v. WCAB* (1996) 61 CCC 622 (writ denied); *Meler v. WCAB* (1997) 62 CCC 536 (writ denied); *Hoss v. WCAB* (1997) 62 CCC 1164 (writ denied); *Los Angeles Unified School District v. WCAB (Gore)* (2000) 65 CCC 1174 (writ denied); *Rowland Unified School District v. WCAB (Avalos)* (1998) 63 CCC 218 (writ denied); *Smith v. WCAB* (1995) 60 CCC 799 (writ denied); *Salazar v. Sims Metal America*, 2009 Cal. Wrk. Comp. P.D. LEXIS 129; *Cortez v. WCAB* (2011) 76 CCC 561 (writ denied).

The appeals board has been inconsistent on whether a failure to object to a DOR will constitute a waiver of LC 4061(i). In one case, the appeals board upheld a WCJ's order setting a case for trial, even though the parties had not yet obtained a panel QME report as required by LC 4061(i), because the defendant failed to timely object to the DOR as required by CCR 10416. The board found that by failing to object, the defendant waived the requirements of LC 4061(i).<sup>132</sup>

But in other cases, the appeals board has refused to set a case for MSC if a DOR was filed before an AME/QME evaluation.<sup>133</sup> In one case, the appeals board concluded that if multiple body parts are at issue, without an AME or QME for one of them, a WCJ may refuse to set a matter for trial and may order the appointment of a QME panel per CCR 31.7(b)(3).<sup>134</sup> For further discussion on obtaining QMEs in different specialties, see ["Sullivan on Comp" Section 14.52 Subsequent Evaluations and Additional Qualified Medical Evaluator Panels in Different Specialties.](#)

In another case, the appeals board upheld a WCJ's order taking a case off calendar to obtain a QME in orthopedics even though the applicant did not timely object to the defendant's DOR. It explained that the purpose of LC 4061(i) is to ensure that a complete medical record is available to a WCJ before a final determination is made on the issue of permanent disability. The board added that the applicant's failure to object to a DOR and failure to object to a medical determination could not be a basis to override the mandatory requirements of LC 4061(i). The board concluded that the issues of permanent disability and apportionment had to be deferred pending medical-legal reporting from an AME or QME.<sup>135</sup>

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<sup>132</sup> *Orellana v. Pro Wash, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 401.

<sup>133</sup> *Franco v. Clougherty Packing, LLC, dba Farmer John*, 2014 Cal. Wrk. Comp. P.D. LEXIS 194.

<sup>134</sup> *Ventura v. The Cheesecake Factory*, 2014 Cal. Wrk. Comp. P.D. LEXIS 417.

<sup>135</sup> *Villa v. Sierra Pacific Farms, Inc.*, 2016 Cal. Wrk. Comp. P.D. LEXIS 543. See also *Jacquez v. Andres Management, Inc.*, 2014 Cal. Wrk. Comp. P.D. LEXIS 574.

## 11. INTERPRETERS

SB 863 made several changes to the law regarding interpreter services. Both the Government Code and the Labor Code were modified. Rules were enacted regarding the use of interpreters at medical treatment appointments, medical-legal examinations, depositions and appeals board hearings. SB 863 generally requires interpreters to be certified. In addition, the duties of an interpreter have been codified along with a requirement that interpreters are to be paid according to a fee schedule adopted by the administrative director (see Chapter VIII: Fee Schedule Changes).

Regulations regarding the certification of interpreters became effective Aug. 13, 2013. Interpreters are discussed in [“Sullivan on Comp” Section 15.111 Interpreters](#).

### INTERPRETER CERTIFICATION

Pursuant to SB 863, effective Jan. 1, 2013, the administrative director must establish lists of certified interpreters for both workers’ compensation hearings and medical examinations.

GC 11435.30(c) states that the administrative director may establish, or contract with an independent organization to establish, maintain, administer and publish annually an updated list of “certified administrative hearing interpreters” who it has determined meet the requirements for interpreting skills and linguistic abilities “for the purposes of administrative hearings conducted pursuant to proceedings of the Workers’ Compensation Appeals Board.” GC 11435.30(c)(2)(A) requires the administrative director to collect a fee from each interpreter seeking certification.

GC 11435.35(c) also states that the administrative director may establish or contract with an independent organization to establish, maintain, administer and publish annually an updated list of “certified medical examination interpreters” who it has determined meet the requirements for interpreting skills and linguistic abilities “for the purposes of medical examinations conducted pursuant to proceedings of the Workers’ Compensation Appeals Board, and medical examinations conducted pursuant to Division 4 (commencing with Section 3200 of the Labor Code).” GC 11435.35(c)(2)(A) directs the administrative director to collect a fee from each interpreter seeking certification.

LC 5811(b)(2) defines a “qualified interpreter” as a language interpreter who is certified, or deemed certified, pursuant to the provisions of the Government Code (GC 68566), which relates to certified court interpreters.<sup>1</sup> Generally, only interpreters who are certified and included on these lists are to be used in the system.

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<sup>1</sup> GC 68566 states, “A natural person who either (1) holds a valid certificate as a certified court interpreter issued by a certification entity approved by the Judicial Council, or (2) until January 1, 1996, is named and maintained on the list of recommended court interpreters previously

Per LC 5811(c), no later than Jan. 1, 2018 the administrative director must promulgate regulations establishing criteria to verify the identity and credentials of individuals who provide interpreter services in all necessary settings and proceedings within the workers' compensation system. LC 5811(c) was added by SB 1160 in 2016, and was intended to make it easier to verify that interpreters are credentialed.

## **INTERPRETERS FOR MEDICAL TREATMENT APPOINTMENTS OR MEDICAL-LEGAL EXAMINATIONS**

### **Interpreters for Medical Treatment Appointments**

LC 4600 requires the employer to provide medical treatment that is reasonably required to cure or relieve an employee from the effects of his or her injury. As discussed in [“Sullivan on Comp” Section 7.5 Reasonable Expenses Incidental to Treatment](#), in *Guitron v. Santa Fe Extruders*,<sup>2</sup> the appeals board *en banc* held that per the employer's obligation to provide medical treatment to cure or relieve the injured worker, it is required to provide reasonably required interpreter services during medical treatment appointments for an injured worker who is unable to speak, understand or communicate in English. Effective Jan. 1, 2013, this right is codified in LC 4600(g), which states, “If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments.”

### **Interpreters for Medical-Legal Examinations**

LC 4600(f) allows for interpreters at medical-legal examinations at the request of the employer, the administrative director, the appeals board or a WCJ. LC 4620 reinforces this right and states, “If the injured employee cannot effectively communicate with an examining physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during the medical examination.” For further discussion of when interpreters may be allowed as medical-legal costs, see [“Sullivan on Comp” Section 14.64 Defining Medical-Legal Expenses](#).

## **Qualifications for Interpreters for Medical Treatment Appointments or Medical-Legal Examinations**

LC 4600(g) defines a qualified interpreter for the purposes of a medical treatment appointment. It states, “To be a qualified interpreter for purposes of medical treatment appointments, an interpreter ..., shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code, notwithstanding any other effective date established in the regulations.”

LC 4600(g) adds, “An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.” GC 11435.40 covers the most commonly spoken foreign languages.<sup>3</sup>

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established by the State Personnel Board or established by an entity provisionally approved under subdivision (b) of Section 68562, shall be designated a ‘certified court interpreter.’”

<sup>2</sup> (2011) 76 CCC 228 (appeals board *en banc*).

<sup>3</sup> GC 11435.40(a) states, “The Department of Human Resources shall designate the languages for which certification shall be established under Sections 11435.30 and 11435.35. The languages designated shall include, but not be limited to, Spanish, Tagalog, Arabic, Cantonese, Japanese, Korean, Portuguese, and Vietnamese until the Department of Human Resources finds that there is an insufficient need for interpreting assistance in these languages.”



LC 4620(d) deals with medical-legal — not treatment — evaluations. It similarly provides, “An employer shall not be required to pay for the services of an interpreter who is provisionally certified unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language designated pursuant to Section 11435.40 of the Government Code.”

The administrative director has adopted CCR 9795.1.6 defining qualifications for interpreters for medical treatment appointments and medical-legal evaluations. Under that regulation, the interpreter must be either: (1) certified; (2) certified for medical treatment appointments or medical-legal exams; or (3) provisionally certified.

To be “certified,” the interpreter must be listed on the State Personnel Board webpage at <http://jobs.spb.ca.gov/InterpreterListing/> or the California Courts webpage at <http://courts.ca.gov/programs-interpreters.htm>.

To be certified for medical treatment appointments or medical legal exams, the interpreter must:

1. pass the Certification Commission for Healthcare Interpreters (CCHI) exam evidenced by a CCHI certification/credential so indicating, and specifying the language, if indicated;<sup>4</sup> or
2. pass the National Board of Certification for Medical Interpreters (National Board) exams evidenced by a National Board credential so indicating, and specifying the language.<sup>5</sup>

Certified interpreters for the purposes of medical treatment appointments and medical-legal exams are listed in the registry for Certification Commission for Healthcare Interpreters (CCHI) or National Board of Certification for Medical Interpreters (National Board) at these websites: <https://cchi.learningbuilder.com/Account/Login?ReturnUrl=%2f> or <http://www.certifiedmedicalinterpreters.org/registry> (CCR 9795.5(b)). If the interpreter is not listed in the CCHI or National Board directory, the employer may request, and the certified interpreter must provide, proof of certification (CCR 9795.5(c)).

Finally, an interpreter may be certified provisionally for medical treatment appointments or medical legal exams if:

1. The defendant has given prior written consent to the interpreter who provides the service. Or
2. The injured worker requires interpreter services in a language other than Spanish, Tagalog, Arabic, Cantonese, Japanese, Korean, Portuguese or Vietnamese, in which case the physician may use a provisionally certified interpreter if that fact is noted in the record of the medical evaluation.

So the employer does not have to pay for an interpreter who is not certified, unless it consents, or the interpreter is required in a language that is not designated in GC 11435.40.

<sup>4</sup> The certification procedure is described on the CCHI webpage at <http://www.healthcareinterpretercertification.org/>. The CCHI certification/credentials are valid for four years from the date granted or issued. Individuals who are granted a CCHI certification or credential must comply with the CCHI requirements to be recertified within this four-year period to maintain their certification/credential. Questions about an application may be sent by email to [apply@healthcareinterpretercertification.org](mailto:apply@healthcareinterpretercertification.org) or to CCHI, 1725 I Street NW, Suite 300, Washington, D.C., 20006 (866) 969-6656).

<sup>5</sup> The certification procedure is described on the National Board webpage at <http://www.certifiedmedicalinterpreters.org/>. The National Board certification is valid for five years from the date granted or issued. Individuals who are granted a National Board certification must comply with the National Board requirements to be recertified within this five-year period to maintain their certification. Questions about an application may be sent by email to [info@certifiedmedicalinterpreters.org](mailto:info@certifiedmedicalinterpreters.org) or to National Board, P.O. Box 300, Stow, MA 01775 (765) 633-2378).



## INTERPRETERS FOR DEPOSITIONS, HEARINGS OR ARBITRATIONS

### Interpreters for Depositions

LC 5710(b)(5) relates to interpreters at deposition. It states, “If interpretation services are required because the injured employee or any other deponent does not proficiently speak or understand the English language, upon a request from either, the employer shall pay for the services of a language interpreter certified or deemed certified.”

Per GC 68561(h), at a deposition where a judge is not present, a certified or registered interpreter must state all of the following for the record:

1. his or her qualifications, including his or her name and certification or registration number;
2. a statement that the interpreter’s oath was administered to him or her, or that he or she has an oath on file with the court; and
3. a statement that he or she has presented to both parties the interpreter certification, registration badge or other documentation that verifies his or her certification or registration, accompanied by photo identification.

The requirements for certified interpreters are discussed below. For further discussion of depositions under LC 5710, see [“Sullivan on Comp” Section 14.12 Depositions](#).

### Allowable Charges at Deposition

Per LC 5710(b)(5), an interpreter’s fee must be in accordance with the fee schedule adopted by the administrative director. The fee must include any other deposition-related events as permitted by the administrative director. Per CCR 9795.3(a)(4), fees for a deposition include:

1. preparation of the deponent immediately before the deposition;
2. reading of a deposition to a deponent before signing; and
3. reading of previous volumes to a deponent in preparation for continuation of a deposition.

Interpreter fees for depositions should not be denied unless the WCJ provide the interpreter with a rationale for the denial and an opportunity to be heard.<sup>6</sup>

### Interpreters for Hearings, Arbitration or Other Settings

LC 5811(b)(2) recognizes that a qualified interpreter may render services at an appeals board hearing or “settings [in] which the administrative director determines it’s necessary to ascertain the validity or extent of injury to an employee who does not proficiently speak or understand the English language.”

CCR 9795.3 enumerates the settings in which the administrative director has determined that an interpreter might be reasonable and necessary. In addition to the circumstances above, CCR 9795.3(a) allows an interpreter at an appeals board hearing or arbitration, a conference held by an I&A officer to assist in resolving a dispute between an injured employee and a claims administrator or other similar setting determined by the WCAB to be reasonable and necessary to determine the validity and extent of injury to an employee.

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<sup>6</sup> See *Fabian v. Command Guard Services*, 2016 Cal. Wrk. Comp. P.D. LEXIS 553.

Normally, interpreters used between applicants and their attorneys are part of the attorneys' overhead. But in a couple of instances, applicant attorneys have attempted to submit interpreters' bills for reading a proposed compromise and release settlement in the office. Such efforts have met with mixed results.<sup>7</sup>

### **Qualifications for Interpreters for Hearings, Depositions or Arbitrations**

CCR 9795.1.5 establishes the qualifications for an interpreter at a hearing, deposition or arbitration. The interpreter must be either certified or provisionally certified.

An interpreter is certified if he or she is listed on the State Personnel Board webpage at <http://jobs.spb.ca.gov/InterpreterListing/> or the California Courts webpage at <http://courts.ca.gov/programs-interpreters.htm> (CCR 9795.1.5(a)(1)).

An interpreter is certified provisionally when he or she is deemed qualified to perform services when a certified interpreter cannot be present. A provisionally certified interpreter is permitted if there is either an agreement of the parties, or there is a finding by the WCJ conducting a hearing (or by the arbitrator conducting the arbitration) that the interpreter is qualified to interpret. The finding of the WCJ or arbitrator and the basis for the finding must be noted in the record of proceedings (CCR 9795.1.5(a)(2)).

### **Notice of Right to Interpreter**

The notice of hearing, deposition or other setting must explain the party's right to have an interpreter present if the party does not speak or understand English proficiently. If a party is designated to serve a notice, it is that party's responsibility to include a statement of the right to an interpreter (CCR 9795.2).

### **PARTY WITH RIGHT TO SELECT INTERPRETER**

LC 5811(b)(1) states, "It shall be the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter." This language also is reflected in CCR 9795.3(f) and CCR 10564. What does it mean for a party to produce a witness? The appeals board has interpreted this to mean that the party scheduling the discovery event — whether it be a doctor's appointment, deposition or other — gets to choose and schedule the interpreter.

In one panel case, the appeals board upheld a WCJ's decision that when a defendant sets an applicant's deposition, the defendant is the party that has produced the witness and has the right to select the interpreter. It concluded that the person producing the testimony is the person who brings it forward or offers it to notice and view.<sup>8</sup>

That defendant was considered to be the active party, as it caused the deposition to be taken. The appeals board also noted, however, that at trial, the roles are likely to be reversed and applicants frequently may be said to produce their own testimony. The board added that in the workers' compensation field, it was "the universal practice for the party setting a deposition to arrange for both a court reporter and an interpreter where an interpreter was needed, except in rare cases where the deposing attorney was from out of town and asked for help with these assignments as an accommodation." The appeals board also rejected the

<sup>7</sup> *Rosas-Olmeda v. SCIF* (1994) 22 CWR 116 (panel decision) (interpreter's bill was compensable); *Laris-Weinberg and Associates, Inc. v. WCAB (Gonzalez)* (1995) 60 CCC 230 (writ denied) (billing was found to be noncompensable); *Osuna v. Sun View*, 2005 Cal. Wrk. Comp. P.D. LEXIS 21 (interpreter's bill was compensable); *Navarette v. SCIF*, 2010 Cal. Wrk. Comp. P.D. LEXIS 542 (billing to interpret C&R found to be noncompensable).

<sup>8</sup> *Contreras v. Gibson Farms*, 2013 Cal. Wrk. Comp. P.D. LEXIS 462.

applicant's assertion that he should select the interpreter to protect attorney-client privilege, as well as for practical considerations.<sup>9</sup>

Similarly, in another case, the appeals board upheld a WCJ's decision that because the defendant scheduled the applicant's deposition, it had the right to select the interpreter. Because the defendant noticed the applicant's deposition, it was the party "producing the witness" within the meaning of LC 5811(b)(1). The board explained that neither the applicant's concerns over attorney-client privilege nor his potential anxiety over the litigation process were sufficient to strip the defendant of its right to select the interpreter. The applicant raised concerns over the neutrality of the particular interpreter, who had an exclusive fee agreement with the defendant. But the appeals board noted that such agreements expressly were allowed in CC 9797.3(d).<sup>10</sup>

The board also found safeguards in the Labor Code to preserve neutrality. Specifically, as discussed below, LC 5811(b)(2) requires a translator to "accurately and impartially translate oral communications and transliterate written materials, and not to act as an agent or advocate." LC 5811(b)(2) also mandates that all interpreters be qualified by way of certification, or deemed certified, and must not disclose confidential communications. The appeals board observed that there was a long tradition of defendants hiring interpreters for applicants' depositions. It further dismissed the applicant's concerns over the relationship between the defendant and its interpreter, finding there was no relationship between the two, other than the defendant's obligation to pay the interpreter's bill.<sup>11</sup>

## DUTIES OF INTERPRETER

LC 5811(b)(2) describes the duties of an interpreter. It states in pertinent part, "The duty of an interpreter is to accurately and impartially translate oral communications and transliterate written materials, and not to act as an agent or advocate. An interpreter shall not disclose to any person who is not an immediate participant in the communications the content of the conversations or documents that the interpreter has interpreted or transliterated unless the disclosure is compelled by court order. An attempt by any party or attorney to obtain disclosure is a bad faith tactic that is subject to Section 5813." So LC 5811(b)(2) imposes a duty on the interpreter not only to translate the communications accurately, but not to disclose them to nonparticipants in the communication unless ordered to do so.

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<sup>9</sup> *Contreras v. Gibson Farms*, 2013 Cal. Wrk. Comp. P.D. LEXIS 462.

<sup>10</sup> *Solano v. WCAB* (2014) 79 CCC 1092 (writ denied).

<sup>11</sup> *Solano v. WCAB* (2014) 79 CCC 1092 (writ denied).

## 12. BURIAL EXPENSES

SB 863 made only a minor change to a dependent's right to death benefits: It increased the maximum amount available for burial expenses. Per LC 4701(a), the limits are:

1. \$2,000 for injuries before Jan. 1, 1991;<sup>1</sup>
2. \$5,000 for injuries on or after Jan. 1, 1991;
3. \$10,000 for injuries on or after Jan. 1, 2013.

No regulations were needed to implement this change. No controversy has arisen over it, so there has been no case law. See [“Sullivan on Comp” Section 12.17 Burial Expense](#) for a full exposition on this subject.

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<sup>1</sup> For a three-year period, from Jan. 1, 1986, to Jan. 1, 1989, the death benefit for public employees was limited to \$1,500, and to \$2,000 for everyone else.

## 13. REMOVAL OF THE PRIVILEGE TO APPEAR BEFORE THE WCAB

SB 863 amended the appeals board's authority to remove, deny or suspend the privilege of individuals to appear as representatives pursuant to LC 4907. More than 30 years ago, the California Supreme Court held that the appeals board's disciplinary power per LC 4907 could not be applied to attorneys.<sup>1</sup> But, LC 4907 gives the appeals board the authority to remove or suspend nonattorney representatives from practicing in front of it. As explained by the appeals board, "The privilege of a nonattorney to appear was created by the Legislature in sections 5501 and 5700. Having created this privilege, the Legislature also vested the Appeals Board with the power to deny, suspend or revoke it. There is no other tribunal to regulate the conduct of non attorney hearing representatives appearing in WCAB proceedings."<sup>2</sup> SB 863 finally amended the Labor Code so that the appeals board's disciplinary power applies to anyone "except attorneys admitted to practice in the Supreme Court of the state."

### GROUND'S FOR REMOVAL OR SUSPENSION

SB 863 also amended LC 4907 to specify the conditions under which a nonattorney could be suspended. It allows the appeals board to remove or suspend a nonattorney for:

1. a violation of Division 4, Part 3, Chapter 1 of the Labor Code commencing with LC 4900, the rules of the appeals board or the rules of the administrative director; or
2. other good cause, including, but not limited to, failure to pay a final order of sanctions, attorneys' fees or costs issued under LC 5813.

LC 4907(b) also requires that nonattorney representatives be held to the same professional standards of conduct as attorneys. But this is a codification of existing law because the appeals board has held since 1980 that nonattorney representatives must comply with the state Bar rules if they represent a party in workers' compensation proceedings.<sup>3</sup>

### DUE PROCESS BEFORE REMOVAL OR SUSPENSION

LC 4907 provides that the privilege of a nonattorney hearing representative to appear before the appeals board may be removed or suspended "after a hearing." A nonattorney representative is entitled to due process before his or her privilege to appear before the appeals board is suspended or removed. So if the

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<sup>1</sup> *Husted v. WCAB* (1981) 46 CCC 1284.

<sup>2</sup> *In re Daniel Escamilla* (2013) 78 CCC 134, 144 (appeals board *en banc*).

<sup>3</sup> *In re Discipline, Suspension or Removal of the Privilege of Louis Moran to Appear in Proceedings before the Board* (1980) 45 CCC 519, 525 (appeals board *en banc*).

appeals board intends to suspend or remove a hearing representative's privilege to appear, it must give notice of the conduct it believes to be sanctionable, and give the hearing representative an opportunity to show good cause why his or her privilege to appear should not be suspended.<sup>4</sup>

## APPLIED CASES

Generally, a single violation of the appeals board rules or a single failure to pay sanctions, attorneys' fees or costs issued under LC 5813 will not result in a hearing representative's removal or suspension from practicing before the appeals board. Removal or suspension is considered a harsh remedy: LC 4907 has been invoked to remove or suspend only hearing representatives who engaged in egregious conduct or who demonstrated a pattern of misconduct.<sup>5</sup>

For example, the appeals board found good cause to remove a hearing representative from appearing before the board when he fraudulently altered a compromise and release, represented conflicting interests without having obtained the consent of the adverse parties and falsely represented himself to be an attorney. The appeals board explained that these actions are exactly what the public must be protected from, and that the hearing representative's actions could not be attributed to mistake or ignorance. Instead, they reflected an unwillingness to accept certain basic values.<sup>6</sup>

In another case, a hearing representative instructed an applicant not to attend medical evaluations and not to complete her deposition, and disobeyed multiple orders to attend the medical examinations and deposition. The hearing representative then failed to appear for his removal hearing. The appeals board found good cause to remove him from appearing before it and any of its judges.<sup>7</sup>

The appeals board also found good cause to suspend a hearing representative from appearing before the appeals board when he had been sanctioned for misconduct in 11 cases. The appeals board found that he had "repeatedly violated our regulations, misrepresented facts either intentionally or with reckless disregard for the truth, filed frivolous petitions and engaged in other sanctionable conduct in violation of section 5813 and WCAB Rule 10561." It added that the hearing representative had "wasted valuable court time, delayed proceedings, burdened the Appeals Board with frivolous petitions, inconvenienced other parties and exposed his clients to monetary sanctions." The hearing representative was found to have "engag[ed] in a pattern of conduct which evidences no intent to reform." So the board found good cause to suspend the hearing representative from appearing before it for 90 days.<sup>8</sup>

<sup>4</sup> See *In re Daniel Escamilla* (2011) 76 CCC 944 (appeals board *en banc*); *Trinh v. Tzeng Long USA, Inc.* (2015) 80 CCC 1045 (appeals board *en banc*); *In re: Javier Jimenez* (2015) 80 CCC 1460 (appeals board *en banc*).

<sup>5</sup> See *Vasquez v. Marion Residence*, 2013 Cal. Wrk. Comp. P.D. LEXIS 84; *Faulkner v. City of Lompoc*, 2013 Cal. Wrk. Comp. P.D. LEXIS 302.

<sup>6</sup> *In re Discipline, Suspension or Removal of the Privilege of Louis Moran to Appear in Proceedings before the Board* (1980) 45 CCC 519 (appeals board *en banc*).

<sup>7</sup> *Removal of Privilege to Appear before the WCAB of legal representative, Mr. Jacques Melek (Watung)* (2003) 68 CCC 1602 (appeals board *en banc*) (writ denied); *Watung, Melek v. WCAB* (2003) 68 CCC 1757 (writ denied).

<sup>8</sup> *In re Daniel Escamilla* (2013) 78 CCC 134 (appeals board *en banc*); *Escamilla v. WCAB* (2013) 78 CCC 466 (writ denied). The proceeding commenced with a decision Sept. 21, 2011, in which the appeals board issued notice that it would suspend or remove a hearing representative's privilege to appear in any proceedings before it or a WCJ per LC 4907 unless good cause was shown why the privilege should not be suspended or removed. The hearing representative was to be given due process and opportunity to be heard before his privilege was suspended or revoked. *In re Daniel Escamilla* (2011) 76 CCC 944 (appeals board *en banc*). Subsequently, the Court of Appeal denied a petition for writ of review because the appeals board had not ruled on a petition for reconsideration. *Escamilla v. WCAB* (2011) 77 CCC 118 (writ denied). The appeals board then dismissed the hearing representative's petition for reconsideration on the grounds that its prior decision was not a final order, and because the petition for reconsideration was not timely filed. *In re Daniel Escamilla* (2012) 77 CCC 71 (appeals board *en banc*). The Court of Appeal denied review of the decision on the same grounds as *Escamilla v. WCAB* (2012) 77 CCC 603 (writ denied). On Jan. 20, 2012, the appeals board dismissed the hearing representative's petition for change of venue and denied a request for immediate stay of proceedings. The board explained that it initiated the proceedings under LC 4907, and that it has only one location, San Francisco. It added that there was no local office in the proceeding, but that the appeals board had requested a WCJ in the San Francisco district office to serve as the hearing officer. This was a direct delegation from the appeals board for its convenience, not because the San Francisco district office had venue. The board upheld a request to relieve the hearing representative's attorney as counsel of record when he rejected the attorney's advice, which made continuing representation pointless. It added that there was no authority for the WCAB to appoint an attorney to represent him in the proceeding, regardless of indigence. The proceeding was not a criminal or quasi-criminal matter, and obtaining counsel was the hearing representative's choice and responsibility. To afford the hearing representative the "utmost due process," however, the appeals board gave him one final opportunity to retain counsel and directed that a pre-hearing conference be scheduled no fewer than 45 days from service of its present decision. *In re Daniel Escamilla* (2012) 77 CCC 75 (appeals board *en banc*). On April 20, 2012, the WCAB denied the hearing representative's petition for order

In one case, the appeals board gave notice to suspend a hearing representative when he had been sanctioned numerous times for engaging in bad-faith actions or tactics that were frivolous or solely intended to cause unnecessary delay while representing lien claimants. Sanctions had been imposed for knowingly proceeding to trial without necessary evidence, repeatedly presenting meritless arguments, making a false statement of material facts in a petition presented to the appeals board, impugning the integrity of the WCAB and WCJs and other willful failures to comply with statutory and regulatory obligations. The representative also failed to pay several orders for attorneys' fees and costs.<sup>9</sup> The hearing representative was suspended for 180 days when he did not respond to the appeals board's notice.<sup>10</sup>

Furthermore, in one case, a hearing representative was ordered to "cease and desist from using abusive, insulting, insolent, scandalous, and contemptuous language and/or disruptive or inappropriate conduct towards a workers' compensation administrative law judge, his staff, or members of the Workers' Compensation Appeals Board, tending to impede the process of the Workers' Compensation Appeals Board, or embarrass, or impugn the authority, integrity, or dignity of the Workers' Compensation Appeals Board." He was warned that further misconduct at the appeals board or disrespectful language in his pleadings and documents would result in the instigation of proceedings pursuant to LC 4907 to remove his privilege to appear before the appeals board as a nonattorney hearing representative.<sup>11</sup>

In one case, a lien representative was sanctioned for proceeding to a lien trial without evidence adequate to meet its burden of proof. On Aug. 14, 2013, the representative was ordered to pay the defendant's costs and attorneys' fees in the amount of \$2,355, and a separate court sanction of \$1,000. The lien representative failed to pay after multiple attempts for recovery by the defendant and Deputy Commissioner Dietrich, and even after being warned Sept. 5, 2014, that an action to suspend the privilege to appear would be instituted if payment of the court sanction was not received. On Aug. 27, 2015, the appeals board issued notice that the privilege of the lien representative and its hearing representative would be suspended for good cause for 90 days per LC 4907 for willful failure to pay the \$1,000 court sanction, attorneys' fees and costs as ordered Aug. 14, 2013, unless good cause was shown in writing why the suspensions should not be imposed.<sup>12</sup> The lien representative was suspended for 90 days when he did not respond.<sup>13</sup>

## CONSEQUENCES OF REMOVAL OR SUSPENSION

Acting as a hearing representative and appearing before the appeals board and WCJs constitutes the performance of legal services. If a hearing representative's privilege to appear has been suspended or removed, he or she may not perform any legal services. They include, but are not limited to:

1. drafting and/or filing pleadings or other documents;
2. negotiating and settling claims related to workers' compensation proceedings;
3. appearing at depositions;
4. appearing at appeals board hearings; and
5. engaging in discovery or responding to discovery requests.<sup>14</sup>

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requiring the board to produce all case documents relating to sanction proceedings in 11 cases being used against respondent, as well as the objection to the order requiring submission of offer of proof and petition for removal to obtain ruling on the petition to produce and to obtain clarification of specific issues to be determined by board. The WCAB explained that the documents already provided to the hearing representative were the only ones the WCAB intended to submit and that he was free to inspect these files at his convenience during the regular business hours of the various district offices. Also, the hearing representative's objection to provide his witness list and offer of proof was untimely. *In re Daniel Escamilla* (2012) 77 CCC 430 (appeals board *en banc*).

<sup>9</sup> *In re: Javier Jimenez* (2015) 80 CCC 1460 (appeals board *en banc*).

<sup>10</sup> *In re: Javier Jimenez* (2016) 81 CCC 288 (appeals board *en banc*).

<sup>11</sup> *Moore v. County of Los Angeles*, 2013 Cal. Wrk. Comp. P.D. LEXIS 70.

<sup>12</sup> *Trinh v. Tzeng Long USA, Inc.* (2015) 80 CCC 1045 (appeals board *en banc*).

<sup>13</sup> *Trinh v. Tzeng Long USA, Inc.* (2016) 81 CCC 197 (appeals board *en banc*).

<sup>14</sup> *In re Daniel Escamilla* (2013) 78 CCC 134 (appeals board *en banc*); *In re: Javier Jimenez* (2015) 80 CCC 1460 (appeals board *en banc*).

## 14. ANTI-FRAUD EFFORTS

The Labor Code contains several provisions that prohibit referring a person to another entity in exchange for money or something else. LC 3215, LC 3219 and LC 3820(b)(3) generally prohibit anyone from offering or receiving compensation or inducements for referring clients or patients (see [“Sullivan on Comp” Section 3.64 Fraud — In General—](#)). In addition, LC 139.3 specifically prohibits a physician from referring a person for specified medical goods or services, whether for treatment or medical-legal purposes, if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral, except as specified.

Effective Jan. 1, 2013, SB 863 enacted LC 139.32 to “additionally prohibit, except as specified, an interested party, as defined, from referring a person for certain services relating to workers’ compensation provided by another entity, if the interested party has a financial interest in the other entity ...” LC 139.32 is modeled after LC 139.3. But it creates a new crime and new penalties applicable to all interested parties, not just physicians.

Building on the framework of SB 863, in 2016, the Legislature passed both SB 1160 and AB 1244 to further stop fraudulent activity in workers’ compensation. Section 16 of SB 1160 explains, “Despite prior legislative action to reform the lien filing and recovery process within the workers’ compensation system, including Senate Bill 863 in 2012, there continues to be abuse of the lien process within the workers’ compensation system by some providers of medical treatment and other medical-legal services who have engaged in fraud or other criminal conduct within the workers’ compensation system.” The Legislature adds, “Notwithstanding fraudulent and criminal conduct by some providers of medical treatment or other medical-legal services, those providers have continued to file and to collect on liens within the workers’ compensation system while criminal charges alleging fraud within the workers’ compensation system.”

SB 1160 was passed to stay the liens of medical providers on the filing of criminal charges for an offense involving fraud against the workers’ compensation system. AB 1244 was adopted to suspend medical providers convicted of fraud and to create a special lien process for suspended providers.

After those two bills went into effect, the Department of Industrial Relations (DIR) issued a release stating that it stayed more than 200,000 liens worth a combined value of more than \$1 billion associated with 75 medical providers facing criminal fraud charges.<sup>1</sup> The DIR has posted information on its fraud prevention efforts, including information on the indicted medical providers at the following: [http://www.dir.ca.gov/fraud\\_prevention/](http://www.dir.ca.gov/fraud_prevention/).

<sup>1</sup> <http://www.dir.ca.gov/DIRNews/2017/2017-04.pdf>.



## PROHIBITION AGAINST ILLEGAL REFERRALS

### Definitions

SB 863 adopted LC 139.32 to prevent illegal referrals. LC 139.32(a) begins with a definition of terms used throughout the statute. LC 139.32(a)(1) defines a “financial interest in another entity” as:

- A. any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy or other form of direct or indirect payment, whether in money or otherwise, between the interested party and the other entity to which the employee is referred for services; or
- B. an agreement, debt instrument or lease or rental agreement between the interested party and the other entity that provides compensation based on, in whole or in part, the volume or value of the services provided as a result of referrals.

So a “financial interest in another entity” includes almost any situation in which a referring party would benefit financially from the referral.

The term “interested party” is defined broadly in LC 139.32(a)(2) to encompass virtually all of the participants in a workers’ compensation claim. It means:

- A. an injured employee;
- B. the employer of an injured employee, and, if the employer is insured, its insurer;
- C. a claims administrator;<sup>2</sup>
- D. an attorney at law or law firm representing or advising an employee regarding a claim for compensation;
- E. a representative or agent of an interested party, including an employee of an interested party or any individual acting on behalf of an interested party, including the immediate family or employee of the interested party;<sup>3</sup> and
- F. a provider of any medical services or products.

The term “service” also is defined broadly. Per LC 139.32(a)(3), “service” means, but is not limited to:

- A. a determination regarding an employee’s eligibility for compensation, including a determination of a permanent disability rating under LC 4660 and an evaluation of an employee’s future earnings capacity resulting from an occupational injury or illness;
- B. services to review the itemization of medical services denoted on a medical bill submitted under LC 4603.2;
- C. copy and document reproduction services;
- D. interpreter services;
- E. medical services, including the provision of any medical products such as surgical hardware or durable medical equipment;
- F. transportation services;
- G. services in connection with utilization review pursuant to LC 4610.

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<sup>2</sup> This includes, but is not limited to, a self-administered workers’ compensation insurer, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured employer, a third-party claims administrator for an insurer, a self-insured employer, a joint powers authority or a legally uninsured employer or a subsidiary of a claims administrator;

<sup>3</sup> Immediate family includes spouses, children, parents and spouses of children.

So LC 139.32 applies to all of the major participants in any given workers' compensation claim as well as all of the services normally required. The clear intention of LC 139.32 is to preclude any interested party from financially benefiting from a referral.

### **What Is Prohibited?**

The prohibitions of the statute are enumerated in LC 139.32 (b)-(d), but subject to the exceptions in LC 139.32(h)(i). LC 139.32(b) requires all interested parties to disclose any financial interest in an entity providing services. LC 139.32(c) states, "Except as otherwise permitted by law, it is unlawful for an interested party other than a claims administrator or a network service provider to refer a person for services provided by another entity, or to use services provided by another entity, if the other entity will be paid for those services pursuant to Division 4 (commencing with Section 3200) and the interested party has a financial interest in the other entity." It is notable that claims administrators are excepted, although full disclosure is required even for them.

LC 139.32(d)(1) states, "It is unlawful for an interested party to enter into an arrangement or scheme, such as a cross-referral arrangement, that the interested party knows, or should know, has a purpose of ensuring referrals by the interested party to a particular entity that, if the interested party directly made referrals to that other entity, would be in violation of this section." LC 139.32(d)(2) adds, "It is unlawful for an interested party to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement to refer a person for services."

Together, these provisions prohibit an interested party from: (1) referring a person for any paid services if that party has a financial interest in referral; (2) entering an agreement to refer persons to another entity in exchange for return referrals; and (3) receiving any compensation or inducement for a referral.

### **Penalties for Prohibited Referrals**

If services were performed based on a prohibited referral, the service provider is not entitled to payment. LC 139.32(e) prohibits an entity who received a prohibited referral for presenting a claim for payment. LC 139.32(f) says that an insurer or other payor must not knowingly pay a charge or lien for any services resulting from a referral or use of services in violation of LC 139.32.

The statute imposes criminal penalties. Violations, per LC 139.32(g), will result in a misdemeanor. If an interested party is a corporation, any director or officer of it who knowingly concurs in a violation is guilty of a misdemeanor.

LC 139.32(g) also covers possible licensing and disciplinary action. It requires the appropriate licensing authority for any person who violates these rules to review the facts and circumstances of any conviction and take appropriate disciplinary action if the licensee has committed unprofessional conduct. The licensing authority also may act on its own discretion, independent of the initiation or completion of a criminal prosecution.

Furthermore, LC 139.32(g) allows for civil penalties of as much as \$15,000 for each offense. The penalties may be enforced by the insurance commissioner, attorney general or a district attorney.

If the interested party is a claims administrator, violation of LC 139.32 constitutes a general business practice that discharges or administers compensation obligations in a dishonest manner. The claims administrator will be subject to a civil penalty that, per LC 129.5(e), is not to exceed \$100,000. If an interested party is an

attorney, violation of LC 139.32 (b) or (c) will be referred to the Board of Governors of the State Bar of California, which must review the facts and circumstances of any violation and take appropriate disciplinary action if the attorney has committed unprofessional conduct. Note that the statute does not require referral for violations of LC 139.32(d), which relates to cross-referral arrangements and compensation or inducements for referrals.

Also, any determination regarding an employee's eligibility for compensation will be void if that service was provided in violation of LC 139.32. So, even if there is an award in favor of a service provider, it will be void if it is determined that the service was performed as a result of a prohibited referral.

### **Exceptions to Prohibited Referrals**

Despite the broad prohibitions regarding referrals established in LC 139.32, there are exceptions. Per LC 139.32(h), these arrangements between an interested party and another entity do not constitute a "financial interest in another entity":

1. a loan between an interested party and another entity, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured and the loan terms are not affected by either the interested party's referral of any employee or the volume of services provided by the entity that receives the referral;
2. a lease of space or equipment between an interested party and another entity if the lease is written, has commercially reasonable terms, a fixed periodic rent payment, a term of one year or longer and the lease payments are not affected by either the interested party's referral of any person or the volume of services provided by the entity that receives the referral;
3. an interested party's ownership of the corporate investment securities of another entity, including shares, bonds or other debt instruments purchased on terms available to the general public through a licensed securities exchange or NASDAQ.

So if an interested party has a loan, has leased space or equipment or has a corporate investment security from an entity receiving the referral that would be available and allowable to anyone else, and there is no indication these transactions were affected by the referrals, the transactions do not constitute a "financial interest in another entity," and referrals would not be prohibited.

LC 139.32(i) also specifies that the prohibitions do not apply to:

1. services performed by, or determinations of compensation issues made by, employees of an interested party in the course of that employment;
2. a referral for legal services if it is not prohibited by the Rules of Professional Conduct of the state Bar; or
3. a physician's referral that is exempted by LC 139.31 from the prohibitions prescribed by LC 139.3 (see ["Sullivan on Comp" Section 7.77 Medical Expense — Illegal Conduct](#)).

### **STAY OF LIENS FOR CRIMINAL CHARGES**

Effective Jan. 1, 2017, SB 1160 added LC 4615, which provides that any lien filed by or on behalf of a physician or provider of medical treatment services under LC 4600 or medical-legal services under LC 4621, and any accrual of interest related to the lien, automatically will be stayed on 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 will be in effect from the time charges are filed until the disposition of the criminal proceedings. If a medical provider is cleared of all charges, his or her lien will be adjudicated the same as other liens without prejudice.

The administrative director may promulgate rules for the implementation of this rule. LC 4615(b) requires the administrative director promptly to post on the DIR website the names of any physician or provider of medical treatment services whose liens were stayed pursuant to this section. For further discussion on the procedures and restrictions for pursuing liens before the appeals board, see Chapter IX: Lien Reform.

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 it claims, all of those liens will be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding; orders notifying of those dismissals will be entered by workers' compensation judges. If the disposition of the criminal proceeding fails to specify the disposition to be made of lien filings in the workers' compensation system, all liens pending in any workers' compensation case in any district office within the state must be consolidated and adjudicated in a special lien proceeding (LC 139.21(e)).

## SUSPENSION OF MEDICAL PROVIDERS

Effective Jan. 1, 2017, AB 1244 added LC 139.21 to the Labor Code. It requires the administrative director to promptly suspend any physician, practitioner or provider from participating in the workers' compensation system if the individual or entity meets any of these criteria:

- A. The individual has been convicted of any felony or misdemeanor and that crime comes within any of these 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.

The administrative director is required to exercise due diligence to identify physicians, practitioners or providers who have been suspended 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> (LC 139.21(a)(2)).

The administrative director is also required to adopt regulations for suspending a physician, practitioner or provider from participating in the workers' compensation system (LC 139.21(b)(1)). The physician, practitioner or provider must be provided written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice must state that the administrative director is required to suspend the physician, practitioner or provider after 30 days from the date the notice is mailed unless that person requests a hearing. The physician, practitioner or provider may request a hearing within 10 days from the date the notice is sent by the administrative director. Such request will stay the suspension. The hearing must be held within 30 days of the receipt of the request. On completion of the hearing, if the

administrative director finds any of the above criteria apply, he or she must immediately suspend the physician, practitioner or provider (LC 139.21(b)(2)).

The administrative director has power and jurisdiction to do all things necessary or convenient to conduct the hearings. 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, subpoenas 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 manner prescribed for civil actions under CCP 2016.010 et seq (LC 139.21(b)(3)).

The administrative director must promptly notify the appropriate state licensing, certifying or registering authority if a suspension is imposed. The administrative director also must update the DWC's qualified medical evaluator and medical provider network databases, as appropriate (LC 139.21(c)).

If a provider is suspended, the administrative director must give notice to the chief judge of the DWC. The judge must promptly provide written notification of the suspension to district offices and all workers' compensation judges. The chief judge has discretion to determine the appropriate method of notification to all district offices. The administrative director must post notification of the suspension on the DWC's website (LC 139.21(d)).

Under Welfare and Institutions Code 14123, a provider will be suspended from participation in the Medical program for conviction of any felony or misdemeanor involving fraud or abuse of that program. If the provider is suspended, written notice of the suspension must be provided to the administrative director for the purposes of LC 139.21.

## **SPECIAL LIEN PROCEEDING FOR SUSPENDED PROVIDERS**

After notice of suspension, if the suspended provider has liens that were not dismissed in the final disposition in the criminal proceeding, the administrative director must appoint a special lien proceeding attorney. Based on the information that is available, the attorney must identify liens that were not disposed of in the criminal case and the workers' compensation cases in which those liens are pending. The attorney must notify the chief judge of such liens. The judge must identify a district office for a consolidated special lien proceeding to adjudicate the liens, and must appoint a WCJ to preside over that proceeding (LC 139.21(f)).

In those proceedings, the presumption will be that payment on the disputed liens is not due because they arise from, or are connected to, criminal, fraudulent or abusive conduct or activity. A lien claimant will not be entitled to payment unless he or she rebuts that presumption by a preponderance of the evidence (LC 139.21(g)).

The special lien proceedings will be governed by the same laws, regulations and procedures that govern all other matters before the appeals board. The administrative director must promulgate regulations for the implementation of this special lien proceeding (LC 139.21(h)).

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 WCJ has discretion to adjudicate the lien or transfer it back to the district office having venue over the case in which it was filed (LC 139.21(i)).

At any time following suspension, a provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice (LC 139.21(j)). These provisions do not affect, amend, alter or in any way apply to the provisions of LC 139.2 that govern QMEs (see [“Sullivan on Comp” Section 14.57 Appointment and Reappointment of Qualified Medical Evaluators](#)).

## 15. VOCATIONAL EXPERTS

Even before the enactment of SB 863, courts long recognized that vocational experts may present opinions in workers' compensation proceedings.<sup>1</sup> Such evidence is marshaled almost exclusively when a party wishes to try and rebut the schedule (see [“Sullivan on Comp” Section 10.19 Rebutting Schedule Under Ogilvie](#)).

SB 863 added LC 5703(j) explicitly allowing the appeals board to receive into evidence the opinions of vocational experts. But LC 5703(j) also places restrictions on the use of such evidence at trial. CCR 10606.5 was adopted later to expand on the rules for using vocational experts' reports as evidence. Although LC 5703(j) became effective Jan. 1, 2013, it applies to any reports of testimony by vocational experts if no final decision was issued by the effective date.<sup>2</sup> For further discussion on the evidence that may be admitted at trial, see [“Sullivan on Comp” Section 16.2 Trial — Evidence Admitted](#).

SB 863 also added LC 5307.7, which required the administrative director to adopt a fee schedule for services by vocational experts by Jan. 1, 2013. To date, however, this fee schedule has still not been adopted (see Chapter VIII: Fee Schedule Changes).

### VOCATIONAL EXPERT'S EVIDENCE MUST BE IN WRITING

LC 5703(j) states, “If vocational expert evidence is otherwise admissible, the evidence shall be produced in the form of written reports.” CCR 10606.5(a) adds that the appeals board “favors the production of vocational expert evidence in the form of written reports.” So an opinion from a vocational expert must be in the form of a report. Generally, a vocational expert no longer is permitted to testify at trial.

Direct examination of a vocational witness will not be received at trial except on a showing of good cause. The statute does not define what constitutes good cause. But CCR 10606.5(a) specifies, “Good cause shall not be found if the vocational expert witness has not issued a report and the party offering the witness fails to demonstrate that it exercised due diligence in attempting to obtain a report.”<sup>3</sup> In one case, the appeals board held that a defendant failed to exercise good cause when it received a report by the applicant's vocational expert by Sept. 9, 2014, and failed to submit a written report from its own vocational expert by the MSC date Dec. 5, 2014.<sup>4</sup>

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<sup>1</sup> See *LeBoeuf v. WCAB* (1983) 48 CCC 587; *Ogilvie v. WCAB* (2011) 76 CCC 624; *Costa v. Hardy Diagnostic* (2007) 72 CCC 1492, 1499 (appeals board *en banc*).

<sup>2</sup> *Barbosa v. Greenhart Farms*, 2014 Cal. Wrk. Comp. P.D. LEXIS 166.

<sup>3</sup> Before 2013, there was no restriction against vocational experts testifying at trial. See *Grupe Co. v. WCAB (Ridgeway)* (2005) 70 CCC 1232; *Costa v. Hardy Diagnostic* (2007) 72 CCC 1492 (appeals board *en banc*); *Rea, as Acting Director of the DIR v. WCAB (Dias)* (2007) 72 CCC 705 (writ denied); *Richison v. California Wallboard, Inc.*, 2012 Cal. Wrk. Comp. P.D. LEXIS 662; *Smith v. Osmosis Day Spa*, 2013 Cal. Wrk. Comp. P.D. LEXIS 181.

<sup>4</sup> *Engle v. Ace Sierra Tow*, 2015 Cal. Wrk. Comp. P.D. LEXIS 69.

## SERVICE OF VOCATIONAL EXPERT'S REPORT BEFORE CLOSE OF DISCOVERY

Even if a vocational expert's report is obtained, it must be served within a reasonable amount of time prior to a hearing in order to allow the opposing party to act. Both LC 5703(j) and CCR 10606.5(a) provide that continuance may be granted for rebuttal testimony if a report that was not served sufficiently in advance of the close of discovery to permit rebuttal is admitted into evidence. So an opposing party cannot be surprised with a vocational expert's report immediately before or at a mandatory settlement conference. If it happens, the appeals board may grant a continuance to allow the opposing party to obtain his or her own vocational expert, or otherwise rebut the report.<sup>5</sup> (For the general rules about discovery closing at an MSC and continuances, see [“Sullivan on Comp” Section 15.28 Mandatory Settlement Conference](#).)

For example, in one case, the appeals board rescinded an order closing discovery and allowed a defendant to supplement the record with a report from its vocational expert when the applicant served a report from his vocational expert only five days prior to filing a DOR. The board noted that the defendant had no reason initially to obtain a report from a vocational expert because the applicant's own expert reported that there was no diminished future earning capacity consideration in determining his permanent disability. But in a second report served five days prior to the applicant's DOR, his vocational expert found diminished earning capacity. The appeals board concluded that the defendant had not had a reasonable time to obtain a rebuttal report.<sup>6</sup>

In another case, the appeals board allowed a defendant to depose an applicant's vocational expert when the defendant noticed his deposition one month after receiving the vocational expert's report.<sup>7</sup> The appeals board also took the matter off calendar and allowed a defendant's vocational expert to evaluate an applicant when it was undisputed that he failed to cooperate with the defendant's efforts to prepare a rebuttal vocational report prior to the MSC.<sup>8</sup>

Per CCR 10622, a vocational expert's report must not be refused admission into evidence at a hearing solely on the ground of a late filing, if the examination diligently was sought and the report came into possession or control of the party offering it within the preceding seven days. But if a willful suppression of the vocational expert's report is shown, it will be presumed that its findings, conclusions and opinions would be adverse, if produced. For further discussion of CCR 10622, see [“Sullivan on Comp” Section 14.7 Service of Medical Reports](#).

## REQUIREMENTS FOR VOCATIONAL EXPERT'S REPORT

Per LC 5703(j) and CCR 10606.5(b), a vocational expert's written report must meet certain requirements. If they are not met, the reports will be inadmissible.<sup>9</sup>

One, LC 5703(j)(2) requires the expert to state in the body of the report “that the contents of the report are true and correct to the best knowledge of the vocational expert.” The statement must be made under penalty of perjury. CCR 10606.5(b)(1) directs a report to include this statement by the vocational expert who signed it: “I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately

<sup>5</sup> Previously, in *Grupe Co. v. WCAB (Ridgeway)* (2005) 70 CCC 1232, the Court of Appeal allowed a vocational expert to testify at trial event though his opinion was not formed before the MSC.

<sup>6</sup> *Groth v. Coastland, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 467.

<sup>7</sup> *Kenzy v. Penske Truck Leasing*, 2015 Cal. Wrk. Comp. P.D. LEXIS 635. *Contra Rivera v. Good Samaritan Hospital*, 2015 Cal. Wrk. Comp. P.D. LEXIS 611 (panel majority did not allow defendant to obtain vocational expert even though defendant scheduled an evaluation a month after receiving applicant's report).

<sup>8</sup> *Brod v. Lowes Home Improvement*, 2015 Cal. Wrk. Comp. P.D. LEXIS 740.

<sup>9</sup> See *SMT Resource v. WCAB (Crane)* (2013) 78 CCC 999 (writ denied).



describes the information provided to me and, except as noted herein, that I believe it to be true. I further declare under penalty of perjury that there has not been a violation of Labor Code section 139.32.” The declaration must be dated and signed by the vocational expert and must indicate the county where it was signed. Statements concerning any vocational expert’s bill for services are admissible only if they comply with CCR 10606.5(b)(1).

Two, CCR 10606.5(b)(2) requires a report disclosing the qualifications of the vocational expert signing it. This requirement may be satisfied by attaching a curriculum vitae. The appeals board has held that if a vocational expert initially fails to comply with this requirement, he or she should be afforded the opportunity to cure the defect.<sup>10</sup>

Three, CCR 10606.5(b)(3) requires that the body of the report normally must contain a statement, above the declaration and under penalty of perjury, that: “No person, other than the vocational expert signing the report, has participated in the nonclerical preparation of the report, including all of the following: (i) taking a history from the employee; (ii) reviewing and summarizing medical and/or non-medical records; and (iii) composing and drafting the conclusions of the report.”

Four, per CCR 10606.5(b)(4), it is permissible for a person or persons other than the vocational expert signing the report to prepare an initial outline of the employee’s history and/or to excerpt previous medical and nonmedical records. In such cases, the vocational expert signing the report must:

- A. review the excerpts and the entire outline and make additional inquiries and examinations as necessary and appropriate to identify and determine the relevant issues;
- B. include in the statement required by No. 3 that, as applicable, an initial outline of the employee’s history and/or an excerpt of the employee’s previous medical and nonmedical records were prepared by another person or persons, and that the vocational expert signing the report has reviewed any such excerpts and/or outline and has made any additional inquiries and examinations necessary and appropriate to identify and determine the relevant issues; and
- C. disclose the names and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation.

In fact, the CCR 10606.5(b)(5) requires the report to disclose the names and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation in all cases.

## **CONTENTS OF VOCATIONAL EXPERT’S REPORT**

In addition to the requirements, CCR 10606.5(c) also directs, if applicable, that a vocational expert’s reports should include:

1. the date(s) of any evaluation(s), interview(s) and tests;
2. the history of the injury;
3. the employee’s vocational history;
4. the injured employee’s complaints;
5. a listing of all information reviewed in preparation of the report or used in the formulation of the expert’s opinion;
6. the injured employee’s medical history, including injuries and conditions, and effects of them, if any;
7. findings and opinion on evaluation;

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<sup>10</sup> See *Puentes v. First Transit*, 2014 Cal. Wrk. Comp. P.D. LEXIS 536.

8. the reasons for the opinion; and
9. the expert's signature.

Failure to comply with the requirements of CCR 10606.5(c) will not make the report inadmissible. But it must be considered by the appeals board in weighing the evidence (CCR 10606.5(c)). If a report fails to meet these standards, it may not be considered substantial evidence and may not be relied on to support an opinion. For further discussion on the standards for substantial evidence, see ["Sullivan on Comp" Section 16.19 Evidence at Trial — Substantial Medical Evidence](#).

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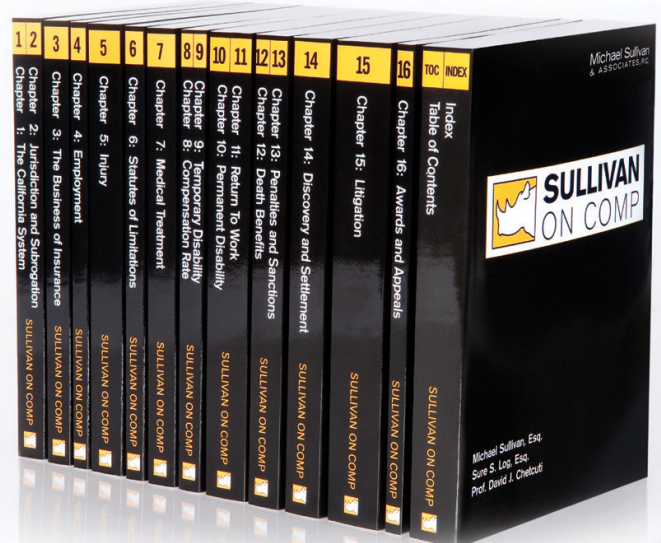
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