CAAA Bulletin

SB863 Practice Tips

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#01 SB 863 Practice Tip: Implementing SB 863 Changes ***Date: December 10, 2012***

Governor Brown signed SB863 on September 18, 2012. The last major revision to workers compensation law, SB899 in April 2004, took effect immediately as an urgency measure. In contrast, SB 863 was adopted on a non-urgency basis, so this legislation will take effect on 1/1/13. Although SB 863 takes effect 1/1/13, some of its provisions will not become operative until a later date.

The first section of this Practice Tip briefly outlines the operative dates for the various provisions in SB 863. But simply listing the operative dates is the easy part; more difficult is to figure out how the changes affect your clients and your practice. To help answer that question, the second section of this Tip outlines some initial thoughts from CAAA's SB 863 Committee. Of course, because regulations to implement many of the amendments in SB 863 have yet to be finalized, this list is only preliminary.

Look for additional Practice Tips over the next few months as new and amended regulations are adopted. In addition, CAAA's upcoming January 2013 Convention will focus on updating you further on many of these changes.

Operative Dates of SB 863's Provisions

A non-urgency bill enacted in the second year of the two-year Legislative session goes into effect on January 1 following a 90-day period from the date of enactment. In this case, 90 days from the date of enactment will be 12/17/12, so SB 863 takes effect the next January 1, or 1/1/13.

The operative date of most changes in SB 863 is governed by Section 84 of the bill, which states:

> "*This act shall apply to all pending matters, regardless of date of injury, unless otherwise specified in this act, but shall not be a basis to rescind, alter, amend, or reopen any final award of workers' compensation benefits.*" [emphasis added]

Thus, most of the provisions of SB 863 are applicable as of 1/1/13 to every issue that is not final in every case regardless of the date of injury. The exceptions – sections with "otherwise specified" application dates – fall into two general categories: benefit changes that apply only to injuries occurring on and after 1/1/13, and other changes that become operative sometime after 1/1/13.

Most benefit changes are applicable as of 1/1/13 for injuries occurring on and after 1/1/13:

- Minimum and maximum permanent partial disability weekly benefit amounts are increased. [§4453 (b)(8)] In addition, the maximum weekly benefit amount is increased again for injuries occurring on and after January 1, 2014. [§4453(b)(9)]
- The FEC factors in the PDRS are eliminated, replaced by a standard 1.4 modifier that is applied to all WPI ratings. [§4660.1(b)]
- The "bump-up / bump down" is eliminated. [§4658 (e)]
- Sleep dysfunction and sexual dysfunction arising out of a compensable physical injury cannot increase the impairment rating, but medical treatment must still be provided for these conditions. [§4660.1(c)(1)]
- Psychiatric disorders arising out of compensable physical injuries cannot increase the impairment rating unless the disorder is a result of a violent act, direct exposure to a significant violent act, or a catastrophic injury, but medical treatment must still be provided for such a disorder. [§4660.1(c)(1)&(2)]
- A new and revised Supplemental Job Displacement Voucher is adopted. [§4658.7]
- Burial expenses are increased to $10,000. [§4701(a)(3)]

In addition, there are a number of other amendments that become applicable after 1/1/13:

- A new Permanent Disability Rating Schedule applicable to injuries on and after 1/1/13 will be adopted but no effective date is specified. Until the new schedule is adopted, permanent disabilities for injuries occurring on and after 1/1/13 are to be rated using the age and occupation modifiers from the 2005 PDRS along with the 1.4 standard modifier. [§4660.1(d)]
- Independent Medical Review (IMR) is applicable on 1/1/13 but initially only for new cases with dates of injury on and after 1/1/13. IMR becomes mandatory for all cases, without regard to date of injury, where the UR decision is communicated to the requesting physician on or after 7/1/13. [§4610.5(a)(1)&(2)]
- A lien "activation fee" of $100 must be paid before any lien conference after 1/1/13 or the lien will be dismissed with prejudice, and in all cases the activation fee must be paid before 1/1/14 or the lien will be dismissed by operation of law. [§4903.06(a)(4)&(5)]
- A fee schedule for home health care services must be adopted by 7/1/13. [§5307.8]
- A fee schedule for copy and related services must be adopted by 12/31/13. [§5307.9]
- A physician fee schedule based on the resource-based relative value scale must be adopted with a four year transition starting in January 2014. [§5307.1(a)(2)]
- Commencing 1/1/14 there are new requirements for MPNs, including a requirement that all physicians in an MPN must have a written acknowledgment that they agree to be an MPN provider, a mandate that an internet listing of physicians be posted and updated quarterly, and a requirement that all MPNs must have medical access assistants. [§4616(a)(3),(4), & (5)]
- MPN certification by the AD is valid for a term of four years, and as of 1/1/14 existing MPNs are deemed approved for a period of four years from the most recent application or modification approval date.

Practical Considerations Regarding These Changes

The question many members are asking is this: With most of SB 863's amendments becoming operative on 1/1/13, what does that mean for my clients and my practice? Of course, the list of impacts will grow over time as both the regulator and the reviewing courts interpret the new statutory language. Consequently, only initial observations can be offered now; nevertheless, below are some points you may want to consider:

- Vocational experts

Section 5703(j) provides that direct examination of a vocational witness is not to be received at trial except upon a showing of good cause. Vocational written reports are to be admitted if they are otherwise admissible. Note that the vocational expert must state in the body of the report that the contents of the report are true and correct to the best knowledge of the expert, *etc*. This means that if you already have a report, you may need your expert to prepare an amended report that includes the required elements. Of course, the report still has to be admissible, which means you still need to show that the expert is qualified, *etc*.

For cases that you have set for trial or that you are proceeding to litigate after 1/1/13, this means all of your vocational evidence should come in written format, except in cases where you can get a judge to allow direct testimony. If you have cases that are post-MSC or set for trial and you intend to have a vocational expert testify, you should consider one or more of the following:

(1) communicate with defense counsel and the judge and figure out how you are going to handle it.
(2) obtain a written report, and request that the MSC Exhibit list be amended to include a written report.
(3) try to agree with the defendant on a deposition(s) of the expert(s) in lieu of live testimony, but if you plan to have the expert testify, you should document in writing your efforts to resolve the issue with the defense counsel in order to demonstrate good cause (*e.g.*, defense refuses to discuss payment for the report; defense counsel refuses to waive cross examination of expert, etc.).
(4) petition the WCAB for admission of the report in lieu of testimony.
(5) defer action until you are certain that the case is going to trial, although you still must be prepared to make the necessary arguments at trial.

In addition, since live testimony is no longer allowed without a determination of good cause by the judge, you should make certain that your expert addresses in his or her written report any defects in defense expert report.

For cases that have not yet gone to an MSC, you need to have your vocational evidence (written report complying with all technical requirements) ready to go and served on defendants before the MSC. Discovery closes at the MSC, absent a showing of good cause. [§5502(e)(3)]

- Home Health Care

Section 4600(h) states that health care services are provided only if prescribed by a physician and that the employer is not liable for services provided more than 14 days before the employer's receipt of the prescription. Forthcoming regulations should provide guidance on the format of the required prescription but in the meantime consider advising your clients about this new requirement and encourage them to get a script from their physician. Some members suggest creating a form to send to the physician – or have it personally delivered by your client – that specifically details and

prescribes a level of home health care following surgery, or on-going care needs. You should keep in mind that any non-physician recommendation for home health care services should be reviewed by a physician and that a prescription for the necessary services should be obtained from the physician. The physician should also state when the use of an outside non physician expert is required.

You should note that §4600(h) does not specify a different effective date, so this provision takes effect 1/1/13 and applies to all dates of injury. Consequently, regarding home health care services on existing cases, you may want to attempt to resolve any and all such issues prior to 1/1/13. Alternatively, you can look in the medical records for discharge instructions which can include instructions for release to supervised care.

Finally, you should be aware that as of 1/1/13 both new and existing cases will be affected by amendments to §4603.2. Those amendments require that any billing for home health care services must include an itemization of services provided and the charge for each service, a copy of reports showing the services provided, the prescription, and any evidence of authorization.

- Utilization Review

SB 863 significantly changed the consequence of failing to both timely and properly object to an adverse utilization review decision. Utilization review decisions to modify, delay or deny a treatment recommendation remain in effect for 12 months, unless a further recommendation is supported by a documented change in facts material to the determination. [§4610(g)(6)] You need to make certain you follow the appropriate timeline and procedure for objecting to a UR determination because they differ depending upon whether you use a QME or IMR to resolve the dispute.

Another change is that the employer may defer utilization review while the employer is disputing liability for the injury or treatment of the condition for which the treatment is recommended. Draft regulations posted on the Forum by the DWC require the claims administrator to send written notice to the employee, the requesting physician, and the employee's attorney if utilization review is deferred pursuant to this provision. [§4610(g)(7)]

- Independent Medical Review (IMR)

As noted, for cases with dates of injury on or after 1/1/13, in order to object to a UR denial you need to request IMR within 30 days after service of the UR decision. This must be accomplished by submitting a one-page form that is now being created by the AD.

There have been some questions raised concerning the provision in §4610.5(j) that allows employees to name a designee as an agent to act on their behalf in the IMR process. When SB 863 was being drafted, this provision was borrowed from a similar statutory provision in the group health IMR statutes [see California Health and Safety Code §§ 1368(b)(2) and 1374.30(e)]. It should be understood that in the group health setting the right to appoint a designee is important because some patients (minors, incapacitated) may not have the legal capacity to submit the IMR request, and few if any group health patients have legal representation.

In the workers' compensation setting the situation is significantly different. Accordingly, the draft IMR regulations posted on the DWC Forum recognize that you, as the applicants' attorney, are the employee's legal representative and that you can submit the IMR application form on behalf of your client. Under these draft regulations unrepresented workers are allowed to designate an agent to act

on their behalf. The draft regulations posted on the DWC Forum specify that either the employee, the unrepresented employee's representative / designated agent, or the represented employee's attorney may submit the IMR application form.

The statute also mandates that the one-page IMR application form notify the employee of his or her right to submit to the IMR reviewer any "material that the employee believes is relevant." [§4610.5(f)(3)(C)] The draft IMR regulations provide that the employee, the employee's representative, or the employee's attorney may submit information to the IMR Organization within 15 days of receipt of the notice of assignment of the request. Although you should check the final regulations when adopted (and CAAA will issue additional Practice Tips as new regulations are adopted), it appears that you will need to carefully calendar the relevant dates in the IMR process – 30 days after service of the UR decision to submit the application form, then 15 days after receipt of notice of assignment of the request to submit relevant information to the IMR Organization.

- AME / QME process

Amendments to §4062.2(b) deleted the requirement to seek agreement on an AME. In practice, however, you may want to consider suggesting an AME to the defendant even after 1/1/13. The reason for this is that the language of §4662(b) that references "mailing an objection pursuant to Sections 4061 or 4062" is unclear as to what exactly is required.

Draft regulations posted on the DWC Forum require that the party requesting a panel (in represented cases) must "attach 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 dispute." One possible strategy would be to maintain your current procedure – send a letter proposing an AME and request the panel 15 days later. For example, you might send the following: "Please consider this an objection to the treating physician per statute, Labor Code Sections 4060/4061/4062. I propose the following as an AME:_____. Within 10 days of the first working day after this letter I will request a panel QME if we cannot agree to an AME." You should include a proof of service, and you will have to wait at least 15 days after the date of your letter (10+ 5 for mailing) to file the PQME request.

Note that it is still true that the party submitting the request designates the specialty. For this reason, you should carefully scrutinize defense letters. If the defense sends you a letter objecting under 4061 or 4062, even without naming a proposed AME, that letter may trigger the time limit following which either party can request a QME panel. Make sure that you calendar it so that <u>you</u> make the first timely request and get to designate the specialty. Also remember that the time to strike a QME has been extended to 10 days after the assignment of a panel. [§4062.2(c)]

Another change is the deletion of the spinal surgery second opinion process. This means that for any recommendation for spinal surgery received by the employer after 1/1/13, the treatment request will first go to UR and any dispute will then be resolved by either a QME or through IMR (depending upon the date of injury, see the IMR section above).

You may want to instruct your staff that – until July 2013 – a dispute over a UR denial for a <u>pre-1/1/13</u> injury will be resolved using the AME / QME process, while a <u>post-1/1/13</u> injury will go through IMR. Starting in July every UR dispute will go to IMR.

Finally, the statute now limits a QME to no more than 10 office locations. [§139.2(h)(3)(B)] The draft QME regulations posted on the DWC Forum contain two provisions to enforce this new rule. First, as of January 1, 2013, QMEs must notify the DWC of the 10 or fewer locations where evaluations will be performed. Second, any QME that has not provided that notice to the DWC by January 1, 2013 will be designated as "unavailable" and will not be assigned to panels. Consequently, if these rules are adopted as proposed, panels assigned on and after January 1, 2013 will consist only of QMEs with 10 or fewer locations.

- Medical Provider Networks (MPNs)

Section 5502 was amended to provide for expedited hearings regarding "whether the injured employee is required to obtain treatment within a medical provider network." The legislature intended to require a judicial determination at the outset of a claim to test whether the employer has a legally valid basis to extend medical control beyond the standard 30 days. This amendment takes effect 1/1/13, therefore either the applicant or defendant will be able to file for an expedited hearing on that issue to establish entitlement to medical control. Also note that although the drafting of this section leaves much to be desired in terms of clarity, the statute may prevent any other issue from being heard at an expedited hearing until the medical control dispute is resolved.

If you have a client who is treating with non-MPN physicians (if known), you should also be aware of the changes in §4603.2. Under paragraph (2) of subdivision (a), if there is a final determination that treatment outside the MPN was justified, the employer cannot later claim extended medical control. However, the non-MPN physician must submit a report to the employer within 5 working days of the initial examination, or the employer is not liable for payment for any services provided prior to the date the physician's report is submitted. In addition, under paragraph (3), if it is held that treatment should have been provided in the MPN, the employer is not liable for either the cost of the non-MPN treatment or the "consequences" of that treatment.

- Copy services / records subpoena

On or before December 31, 2013, the AD must adopt a fee schedule for copy and related services, and that schedule "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." [§5307.9]

Although this provision may not apply until there is a fee schedule, even before adoption of the fee schedule you may want to consider changing your procedure to make a written demand upon the defendant for whatever records you want and calendar it for 30 days. You might consider amending your opening letter to the employer and carrier, or creating a separate letter, that makes a demand for service of relevant documents consistent with the statute, along with a request for certification or a declaration that all the documents sought are included and a log of those items excluded. For example, a letter might read: "This letter shall be considered a demand within 30 days 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. In addition, production of these records shall be accompanied by a certification or declaration that all records demanded have been produced and a log detailing those items not produced."

If you do not have the records after 30 days (plus 5 days for mailing), then consider issuing a subpoena for them. You should also consider providing to the copy service a copy of your initial letter to the defendant so it can later demonstrate that the requisite time elapsed before a subpoena issued. Remember too that although there is no prohibition to subpoenaing any records you deem relevant to the claim after the time limit for the employer to serve them has expired, the intent of this provision is to reduce unnecessary system costs by eliminating duplicative copies of records at the onset of the claim. Abuse of this provision will inevitably lead to further restrictions on your ability to obtain necessary records in future regulations and/or legislation.

In addition, you and your staff should be aware of the provisions of new §139.32, made specifically applicable to copy services by §139.32(a)(3)(c), that prohibits them and you from offering, delivering, receiving or accepting "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." [§139.32(d)(2)] Violation of this statute is a misdemeanor. [§139.32(g)(1)] Copy services are considering whether and how this language may affect their legitimate advertising and marketing practices. Applicants' attorneys should carefully review this statute and devise guidelines for themselves and their staff, as well.

- Vouchers

For vouchers issued after 1/1/13, regardless of the date of injuries, the voucher must be used within two years after the voucher is furnished to your client or five years after the date of injury, whichever is later. The preliminary draft of regulations implementing the voucher changes did not require that employees be given much information about this deadline, so you may want to develop a notice to those of your clients who receive a voucher after 1/1/13 informing them of this new time limit for using the voucher. All workers who receive a voucher should also be made aware that the employer will not be liable for compensation for any injury that occurs while using the voucher.

- PD advances

A new provision in §4650(a)(2) provides that permanent disability advances are not required if the employer has offered the employee a position that pays at least 85% of pre-injury wages and compensation or if the employee has work that pays at least 100% of pre-injury wages and compensation. Like most provisions in SB 863, this change takes effect on 1/1/13, and it applies to all dates of injury. Consequently, you may want to inform clients who become P&S after 1/1/13 and who return to work that they may not receive PD advances. In addition, there have been suggestions that some employers may stop permanent disability advances on existing cases, so you may also want to have a notice ready to explain to existing clients the reason their PD advances have been stopped. Keep in mind that it is the employer's burden to prove that the employee is earning the requisite wages and compensation.

- Interpreters:

There are several provisions in SB 863 that affect interpreters. Under §4600(g), your client is entitled to a qualified interpreter at all medical appointments. For appropriate cases, you may want to include a demand on the employer for an interpreter to your opening letter. To be qualified to interpret at a medical appointment an interpreter need not be certified but must meet requirements established in rules adopted by the AD. However, if the interpreter is not certified or is provisionally certified by the physician, the employer is not required to pay unless the employer agrees in advance or the employee speaks an atypical language.

Similarly, amendments to §4620 provide that the employer's liability to pay for an interpreter at a medical-legal evaluation is limited to a certified interpreter, unless the employer agrees in advance to the use of a provisionally certified interpreter or the employee speaks an atypical language.

CAAA 2013 Winter Convention

As noted earlier, we will be issuing additional Practice Tips in the coming weeks to keep you informed as to what is happening as SB 863 takes effect and the many planned emergency regulatory changes are adopted. But Practice Tips, by their very nature, can only provide a brief explanation of the changes that are occurring to the workers' compensation system and your practice. For an in-depth analysis of many of the changes in SB 863, plan on attending CAAA's winter convention, January 24 - 27, 2013 in San Diego. The easiest way to register is to go on-line at www.caaa.org. In addition, save the date of March 9, 2013 when we will be putting on a seminar to help your staff understand the changes and intricacies of SB 863.

Note: This practice tip is intended to be advisory only, and does not define or establish any new standard or duty for practitioners.