

On August 31, 2012, the California legislature passed SB 863, a comprehensive reform bill designed to address a number of issues in the California workers compensation system that have developed since the last major reform in 2004. One of the major drivers of the reform effort was a recognition that while the 2004 reform was largely successful in correcting a number of defects in the law that were causing significant and uncontrolled increases in costs and indemnity benefits, an unintended side effect of the reform resulted in permanent disability rates that were arguably inadequate to compensate some claimants.

Once the bill was introduced in the legislature, Travelers assumed an active role in the reform effort, primarily through the American Insurance Association. As such, Travelers was able to address some concerns with the early drafts of the proposed legislation and offer suggestions to fix these concerns.

Overall, the reform's purpose is to increase the permanent disability awards while offsetting the increased payments with commensurate decreases in system costs by eliminating waste, unnecessary costs, and inefficiencies. To a large extent, we believe SB 863 has substantially met that goal, but it should be noted that while the PD increases will begin to go into effect soon after the bill is signed, almost every cost reform will require extensive regulatory changes that will take some time and effort to implement, and may acutely tax the limited resources of the Department of Workers' Compensation (DWC).

This paper is intended to discuss the most significant changes to the Act and the work that needs to be done to assure proper implementation of those changes. Overall, we believe the bill will substantially reduce administrative and litigation costs and remain hopeful that the reduction will more than offset the known expected increase in indemnity benefits.

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Major Provisions of SB 863

Indemnity

- Increases permanent disability indemnity payouts phased in over a two-year period, increasing estimated payouts by \$310 million the first year and \$530 million the second year and thereafter, and adjusts the formula for awarding benefits
- Eliminates the “sleep disorder” and “sexual dysfunction” add-ons to permanent disability
- Eliminates most “psychological” add-ons, permitting the add-on to only those cases involving a catastrophic injury or violent workplace incident
- Replaces diminished future earnings capacity (DFEC) with a 1.4 multiplier to the whole person impairment (WPI) in permanent disability determinations
- Creates a Return to Work (RTW) program for those workers whose PD benefits are disproportionately low compared to their earnings loss, to be funded with \$120 million per year from the workers compensation revolving fund (funded through employer assessments), with the Director of the DIR to establish eligibility requirements
- The bill specifically states that it does not overrule *Milpitas (Guzman)*, which held the presumption that while the use of the AMA Guides in rating impairment is presumed to be correct, it may be rebuttable in certain circumstances
- Modifies the Supplemental Job Displacement Benefit (SJDB) rules to establish an earlier trigger date, maximize payout to \$6,000 regardless of level of disability, eliminate “cash-outs,” establish approved schools, limits the benefit to 2 years from the furnishing of the voucher or 5 years from the date of injury, whichever is later, and provides that any injury occurring during retraining shall not constitute a compensable injury
- Prior to award of PD, the employer is not required to advance PD benefits if the employee’s current employment meets certain guidelines
- Eliminates the 15% PD adjustment for returning (“bump down”) or failing to return the injured worker to work (“bump up”)

Analysis/Impact: Currently, some applicant attorneys attempt to artificially increase PD ratings by attacking the presumptions and tables used under the AMA Guides, and using a variety of add-ons to boost the final rating, including additional components such as psychological injury, sleep disorders, and sexual dysfunction. The use of these add-ons proved to be a significant cost driver and increased litigation costs associated with opposing these artificial increases in disability, and their elimination should result in substantial cost savings to defendants. Applicants may still seek to rebut the permanency determination under the AMA Guides by persuading the physician to rely on another section or chapter of the Guides as more accurately reflecting the disability (known as rating by analogy), as allowed under *Guzman*. The law also establishes a return to work program within the Department of Industrial Relations (DIR) that helps supplement PD benefits that are disproportionately low compared to earnings loss. These changes are expected to result in an initial increase in PD benefit payout of \$340 million in 2013, and this figure is

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anticipated to double in 2014. However, while the impact of eliminating diminished future earning capacity pursuant to the *Ogilvie* decision is reportedly expected to save \$210 million per year, it is possible that applicants will pursue increases by using the decision in *Guzman*, which was not abrogated by the reform. These increases may also encourage more workers to pursue claims and seek permanency benefits, which may result in higher overall payments. An example of how the reforms might affect a Stock Clerk at 21 years and 60 years old, with 10% and 40% whole person impairments (WPI) is shown below:

| 21 yr-old | | | | | | | | |
|-----------|----------|-------------|-------------|----------|-------------|--------------|-------------|--------------|
| WPI | Final PD | Current | | Final PD | 2013 | | 2014 | |
| | | Min | Max | | Min | Max | Min | Max |
| 10% | 12% | \$4,972.50 | \$8,797.50 | 12% | \$6,120.00 | \$8,797.50 | \$6,120.00 | \$11,092.50 |
| 40% | 47% | \$32,500.00 | \$57,500.00 | 52% | \$45,960.00 | \$66,067.50 | \$45,960.00 | \$83,302.50 |
| 60 yr-old | | | | | | | | |
| 10% | 19% | \$9,165.00 | \$16,215.00 | 20% | \$12,080.00 | \$17,365.00 | \$12,080.00 | \$21,895.00 |
| 40% | 62% | \$47,742.50 | \$84,467.50 | 67% | \$65,160.00 | \$109,957.50 | \$65,160.00 | \$118,102.50 |

QME/AME Process

- Chiropractors must now qualify as a Qualified Medical Evaluator (QME) through the same standard process as other doctors, eliminating a simpler post-graduate specialty program as an option for qualification
- Eliminates abuses caused by “professional” QME doctors by limiting the number of office locations a QME may file with the DWC to 10
- Gives preference in assigning QME panel where employee is not represented
- Extends time limits for DWC to assign QME panel from 15 to 20 days from receipt of request
- Restricts employee’s QME selection when the DWC fails to timely assign the QME panel to one within a “reasonable geographic area”
- Parties can use an AME at any time, but need not offer an AME prior to requesting a QME
- Bars use of AME or QME for purposes of addressing medical treatment disputes in favor of independent medical reviews (IMR)
- Timeframes to submit QME request form to DWC cannot be earlier than 1st working day that is at least 10 days from the date of mailing of either a request for a QME under 4060, or an objection under 4061 or 4062
- The employee may not “unreasonably refuse to participate” in the QME evaluation

Analysis/Impact: Extending the time for the assignment of a QME panel may provide enough additional time for the DWC to act, but terms such as “reasonable geographic area” and “unreasonably refuse to participate” will need to be further defined in order to determine their impact. While most of these are

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relatively minor changes, the IMR process is believed to have the most significant impact upon the QME process. This change should remove the vast majority of cases from the QME process, which tended to result in extensive litigation and added costs, and often without significantly affecting quality medical care. No specific savings are attributable to these changes to the QME process, but the substitution of the IMR process is expected to result in some savings, as detailed below.

Independent Medical Review Process

- Establishes an Independent Medical Review (IMR) system for resolving medical treatment issues, reducing the scope of evaluations that QMEs perform
- Establishes a hierarchy of standards of review similar to those used in the health insurance context
- The WCAB will no longer have authority to adjudicate medical treatment disputes that are directed to the IMR process, reducing litigation cost
- The employee will be able to provide new information to the IMR that was not considered by Utilization Review (UR), provided the employee first provides the information to the employer, allowing the employer an opportunity to reconsider the UR decision in light of the new information
- The IMR process is binding on all parties and may be appealed only on a very limited basis
- A court reviewing an appeal from the IMR process may decide the issues only on the limited appeal basis; matters overturned on appeal are sent back to the IMR for additional proceedings
- Employers may be penalized for failing to advise employees of the right to the IMR process, or otherwise fail to implement an IMR decision favorable to the employee
- A reversal of a UR decision by IMR cannot be the basis of an “unreasonable delay” to penalize an insurer for unreasonably denying treatment
- Employers shall fund the IMR process, based upon a fee system to be established by the AD, which may vary dependent on the medical condition under review and other factors
- IMR process implementation is staggered: beginning January 1, 2013, it will apply to UR decisions for injuries occurring on or after that date, but beginning July 1, 2013 it applies to all UR decisions communicated to the requesting physician after that date, irrespective of the date of injury

Analysis/Impact: The IMR process should serve to eliminate much of the delays and costs involved in litigating medical disputes. Many questions remain, including the establishment of qualifications, the criteria to be used in evaluating these disputes, whether evidence-based medicine will be accurately applied, and so forth. Further, the California Applicant Attorneys Association is questioning whether the process meets minimum due process requirements as set forth in the *Sandhagen* decision, and this aspect of the reform may therefore be challenged in court. The increased documentation demands associated with the IMR process is also likely to generate some administrative costs.

Independent Bill Review Process

- Creates a comprehensive Independent Bill Review (IBR) process that removes WCAB jurisdiction over medical bill disputes if the only dispute is the amount of the payment
- AD shall contract with independent, qualified organizations to implement the IBR and IMR processes, but allows AD to initially use the Department of Health's contracts with IMRs and IBRs until credentialing and contracts with the Division are in place
- Establishes process and time frames for application, notice of service, documentation required, as well as appeals procedures
- Requires providers to include all reports for services performed with any request for payment
- Claims administrator need not address duplicate billings where a previous EOR was submitted
- Shortens timeframes from 45 working days to 45 calendar days (a 28% reduction in time) to issue payment
- The IBR process is expected to eliminate the filing of thousands of liens, by providing an Independent Bill Review process that is similar in scope to the IMR process

Analysis/Impact: Billing disputes constitute one of the more common reasons for filing a lien. The Commission on Health and Safety and Workers' Compensation (CHSWC) conducted a study last year that revealed one out of three medical liens involved billing disputes. Understanding the various codes, modifiers, and their applications have given rise to a whole cottage industry and a complexity that leaves most judges ordering the parties "out in the hall" to resolve their differences. Consequently, settlements of billing disputes – even for similar services – vary widely. The independent bill review will remove the resolution of billing disputes from judges unfamiliar with the billing process and pricing methodologies, and place the responsibility with bill review experts. This is anticipated to bring uniformity into the system and ultimately reduce the frequency of disputes. IBR determinations will have a presumption of correctness and can only be set aside for certain limited reasons. Reversed determinations will be reassigned to a different reviewer, removing jurisdiction of the Appeals Board. Providers, as with treatment disputes, may not file liens for billing disputes.

Liens

- Firms time limits in which liens may be filed – three years from date of service for services performed prior to July 1, 2013, and within 18 months for dates of service thereafter
- \$150 filing fee to file a lien on or after January 1, 2013 (recoverable if the lien claimant prevails)
- \$100 "activation fee" for "legacy liens" that were filed before January 1, 2013 (recoverable if the lien claimant prevails)
- Activation fees must be paid no later than January 1, 2014, otherwise, are dismissed as an operation of law

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- Health care service plans, group disability insurers and self-insured employee welfare benefit plans are exempted from the filing and activation fee requirements
- Liens not correctly filed are null and invalid, and incorrect filing does not prevent (toll) limitations from running
- Lienholder must make a clear demand for payment at least 30 days prior to filing a lien
- Prohibits “bundling” of liens of two or more providers of goods or services
- In the event the employer is contesting the underlying claim, liens are “stayed” pending resolution of underlying compensability issues
- Prohibits the filing of liens against an award if the lien is subject to the IMR or IBR process

Analysis/Impact: The constant influx of liens continues to be one of the most troublesome areas in the workers’ compensation system. Overall, the changes affecting liens is believed to provide a clear process for addressing liens, reduce notice requirements on defendants, eliminate the filing of frivolous liens, eliminate multiple filings for a single lien, and reduce assignee fraud and illegitimate/untimely liens. The process also establishes a useful statute of limitations, deters the filing of *de minimis* liens, and provides that liens can be dismissed as a matter of law. The bill also lengthens the statute of limitations for certain health care service plans, self-insured employee welfare plans, and publicly funded plans providing medical benefits on a non-industrial basis, and also eliminates the filing and activation fees for such plans. The imposition of a filing fee remains somewhat controversial. Prior iterations of the law and DWC regulations required a lien filing fee, but that fee was abandoned when the DWC found it was spending more to administer the fee than it was actually collecting in fees. The DWC has announced that this “should no longer be an issue.” According to the WCIRB’s preliminary analysis, the virtual elimination of the current litigation process should result in a \$450 million annual savings to the industry in loss and loss adjustment expenses. More recent analyses have reduced the expected impact to \$350 million annually. We expect it will also be advantageous for legitimate lien holders to embrace and use this process.

Fee Schedule

- Fee schedule applies to vocational expert compensation
- Adopts fee schedule for ambulatory surgical centers
- Provides that decreases in Medi-Cal fee schedule for prescriptions shall not be included in the official medical fee schedule
- Permits AD to develop home health care services fee schedule
- No payment for home services that were already being provided by another person prior to the injury
- Limits re-opening of cases where home services were allegedly provided but were not authorized or ordered by a physician before the services were rendered

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- AD to create a fee schedule for copying services, along with rules governing same
- Eliminates “double payment” for implantable surgical hardware, but allows the AD may establish a regulation to allow additional reimbursement for implantable surgical hardware where the basic hospital fee schedule does not adequately cover the cost of the hardware
- Requires DIR to conduct a study to determine the feasibility of establishing a facility fee for services performed in ambulatory surgical centers
- Medical fee schedule tied to Medicare’s resource base relative value system (RBRVS)

Analysis/Impact: The use of a fee schedule is always a welcome alternative to the inconsistent results caused by its absence. The use of a fee schedule for ambulatory surgical centers is expected to result in a one third reduction in facility fee payments, generating a savings of approximately \$110 million.

Medical Provider Networks (MPN)

- Eliminates the requirement that 25% of the MPN consist of non-occupational medicine specialists
- Holds that the employer’s failure to provide the required MPN notices or post the notice required by section 3550, does not constitute a basis to allow the employee to treat outside of the network, unless the failure to provide notice resulted in a denial of care
- The MPN must obtain a “written acknowledgement” that the physician agrees to be in the MPN, unless the physician is part of a group that elects to be part of the network
- The AD may approve the MPN entities directly, eliminating the requirement of a separate approval for each employer
- Approval of the MPN by the AD is valid for 4 years, and is a conclusive presumption that the MPN is valid, subject to proof of a specific failure as to a specific injured worker
- Networks must begin posting their physician membership on a public website by 1/1/14
- MPNs must continually review for quality of care, performance of personnel, utilization of services and facilities, and costs, and failure to meet the requirements may result in suspension, revocation, or denial of the plan, as well as administrative penalties
- Periodic audits of the MPN by the AD are required
- MPNs must employ a “medical access assistant” in the United States to aid injured workers in obtaining appointments and/or referrals within the MPN
- Discretionary audits of the MPN by the AD are permitted
- Strengthens the requirements to treat within the MPN by limiting exceptions, while providing an expedited process to resolve disputes as to whether treatment within the MPN is required
- Physicians who know or should know the treatment is for an occupational injury must notify the employer, within 5 days, of treatment outside the MPN; failure to provide notice relieves the employer of payment obligations

Analysis/Impact: Travelers uses its own MPN in California, providing injured workers with a broad selection of qualified treating doctors in every specialty, and we applaud the legislature’s commitment to

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strengthening the MPN process. The use of a medical access assistant (MAA) is expected to add significant administrative costs to the process, since the MAA must be available 7am to 8pm Monday through Saturday. The ability to enforce network participation despite a failure to serve a particular notice should result in significant savings. Although there is limited data to support a hard estimate of projected savings, the WCIRB estimates that strengthening the MPN is expected to result in \$120 million in annual savings to the industry, while other analyses believe it may have a negligible impact on overall savings.

Interpreters

- Injured worker must notify the Employer of the need for interpreter services, and the Employer shall pay for such services
- Interpreters for med-legal purposes shall be certified through an interpreter certification program that is established, operated and/or contracted for by the AD
- Interpreters for medical purposes need not be certified, but will be subject to requirements to be established by the AD
- Employers are not required to pay for non-certified or provisionally-certified interpreters used during medical treatment, unless it consents in advance to the selection of the interpreter
- The interpreter certification entity shall have no financial interest in training or employing interpreters
- The AD shall create a fee schedule for interpreters

Analysis/Impact: Travelers welcomes the use of a fee schedule for interpreters, but otherwise believes these provisions will have little immediate impact on costs.

Other Medical Issues

- Employee with health insurance may pre-designate a primary treating physician in the event of a workplace injury (the physician still needs to agree to be so pre-designated)
- Eliminates the “second opinion” requirement for spinal surgery
- Streamlines and provides needed guidelines around the AME and QME process
- Eliminates ACOEM as basis for determining what is reasonable medical treatment
- A self-procured medical report cannot be the sole basis for an award of compensation, but must be corroborated by the QME or authorized treating physician
- Home health care must be prescribed and reasonable
- Employer is not liable for home health care provided more than 14 days prior to employer’s receipt of prescription
- Conflict of interest clauses – to eliminate churning and referrals to another entity in which the referrer has a financial interest or receives/pays compensation, where the employer is paying the charges
- Payment beyond the 24-visit cap for physical medicine treatment does not constitute a blanket waiver of the cap

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- Chiropractor who has reached the 24-visit cap cannot serve as the primary treating physician
- Vocational experts shall testify via written report, and direct examination of a vocational expert shall not be received at trial except for good cause

Analysis/Impact: Elimination of the “second opinion” for spinal surgery is a positive development, as the requirement did not substantially improve medical care and added unnecessary costs and delays. Corroboration of self-procured medical opinions should limit the impact of “doctor shopping” and maintain the integrity of the MPNs, while conflict of interest clauses will help eliminate the use of medical referrals to other owned businesses that churned medical treatment and reaped excessive profits from such referrals. Finally, enforcement of the 24-visit cap will prevent chiropractors from continuing to act as the PTP when they can no longer provide the medical care themselves. The financial impact of these reforms is difficult to ascertain at this time.

Self-Insurance

- PEOs and temporary staffing agencies may no longer be self-insured for workers compensation; those that are currently self-insured must obtain insurance coverage by 1/1/2015
- Public sector self-insurers are required to submit certain data to the Department of Industrial Relations
- Funding for administrative costs incurred by the DIR are to be funded by the Workers’ Compensation Administrative Revolving Fund
- SISF can obtain reimbursement from special employers who obtained employees from the self-insured employer

Analysis/Impact: While PEOs and temporary staffing agencies serve an important business purpose by supplying workers to numerous industries on an as-needed basis, the DWC has apparently recognized the inherent difficulties in ascertaining and tracking the financial health of these employers where payrolls and contractual relationships are fluid. As these employers enter the voluntary insurance market, the DWC should remain vigilant and assist insurers in properly analyzing and pricing for the increased exposures involved in underwriting this business segment. The changes also solve some solvency issues and provide other limitations on obtaining self-insurance status, which should provide some relief to the Self-Insurance Security Fund (SISF) in the wake of the Mainstay litigation. The bill also extends the right of the SISF to obtain reimbursement to “any employer who obtained employees from a self-insured employer.”

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