WORKERS' COMPENSATION REFORM:

# Senate Bill 899:
# First Look, First Thoughts

**MICHAEL SULLIVAN & ASSOCIATES**
**6151 W. CENTURY BLVD, SUITE 700**
**LOS ANGELES, CALIFORNIA 90045**
**PH: (310) 337-4480 • FAX: (310) 337-4486**
**E-Mail: mike@mikeslaw.net**

# INTRODUCTION

Well, everybody, it looks like our government is at it again. SB 899 has presented itself as one of the most dramatic workers' compensation reforms in our State's history. We have now radical changes in a spectrum of areas.

This booklet is intended as an initial look at these changes. There are some areas which cannot be well defined, since the statutes make reference to studies that have not yet been promulgated, or need to wait for rules and regulations to clarify how they will work. There are some areas which are simply difficult to understand and which will need judicial scrutiny, or even clean up legislation. Accordingly, this booklet does not attempt to identify every issue or predict every implication of every change. Such an approach would at this point be premature. There are few who doubt that our community will be working this out over many years.

What is presented here is a careful outline of the changes made to the law. Each area is described separately. The statutory changes are clearly laid out. Although we do not editorialize or launch into detailed discussions of possible solutions or implications, we do point out possible trouble or grey areas.

Time is of the essence. SB 899 was passed as emergency legislation and many of its changes have been put into effect right away. Therefore we do not have the luxury of reviewing this Bill at our leisure. Here we do give a clear opinion as to the commencement date of each provision. We also try to explain how claims adjusters should handle the specifics of the more immediate changes.

Finally, a disclaimer. This booklet is a first look only at a very complex and difficult change to and already complex and difficult area of the law. This booklet is written within days of the approval of the reform Bill. Because this is so, it is a virtual certainty that interpretations of this reform will blossom and transform over time, even in the very short term. Therefore, the commentary here should not be utilized as legal advice for any given case or situation without consultation with a licensed attorney.

MICHAEL W. SULLIVAN
MICHAEL SULLIVAN & ASSOCIATES
APRIL 2004

# TABLE OF CONTENTS

# COMMENCEMENT DATES FOR NEW PROVISIONS

SB 899 is an urgency statute. That is, it passed in the legislature with the requisite number of votes to have its provisions take effect without any delay. Included within it is Section 47 of the Act, which says that ". . . any provision of law made by this act shall apply prospectively from the date of enactment of this act regardless of the date of injury, unless otherwise specified . . . "

The same Section specifies that the changes cannot be used to set aside any "order, decision, or award". So if a decision is in place, it seems there is no turning back, regardless of what changes SB 899 presents.

The following is a listing of commencement dates for the various reform areas. The details are reflected in the subsequent text.

**The following provisions of SB 899 take effect without delay; that is, prospective for any date of injury, as of April 19, 2004.**

1. Labor Code section 4062.1 pertains to the unrepresented applicant. Changes in medical legal procedure are implemented prospectively without delay. This means that if the medical-legal procedure has not been initiated prior to April 19, 2004, the new scheme is to be used.

2. Labor Code section 4663 is the new standard for apportionment based upon causation. There is no reason why this should not apply to every date of injury as of April 19, as long as there is no Order or Award issued before that date.

3. Fee Schedule reform pursuant to 4603.2 takes effect right away. The fee schedule in effect at the date of the service applies irrespective of the date of injury.

4. Labor Code section 5402(c) demands the provision of care in delayed cases, until the acceptance or denial. This takes effect for all dates of injury as of April 19, as long as the employer has received the claim.

5. The limitation of temporary disability to 104 weeks in the two year period following commencement of the benefit applies only to dates of injury on or after the date the bill was signed.

6. The treating doctor's presumption is finally repealed in its entirety for all dates of injury.

7. The modified Labor Codes section 3202.5, which affirms the applicant's burden of proof and states that all parties are equal before the law, takes effect without delay.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

8. The specific changes in the requirements for selecting a pre-designated physician under Labor Code section 4600(d) take effect right away.

**The following provisions of SB 899 do not take effect until a later time.**

1. LC section 4062.2, which describes the medical-legal process for cases where the applicant is represented, only applies to those injuries occurring on or after January 1, 2005.

2. LC section 4616 provides for medical control of all dates of injury once a network of treating physicians is established. However this network may not be established until January 1, 2005.

3. Labor Code section 4660 makes radical changes to the concept of permanent disability. However, these changes are deferred pending the Administrative Director's publication of a new schedule.

4. The present form of Labor Code section 5814, which provides for penalties in the event of unreasonably late provision of benefits, becomes inoperative as of June 1, 2004. Therefore if an Award does not issue by that date, the new standard set out by the new section 5814 will rule. The old statute is formally repealed effective January 1, 2005.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 1. Medical-Legal Procedure: A Whole New World

For a long time Labor Code sections 4060, 4061 and 4062 governed the medical-legal process in Workers' Compensation. While those sections as modified remain, medical-legal procedure as we know it has changed radically. To put it succinctly, the dueling QME aspect of the process is now ended. In every case, only AMEs and panel QMEs will be allowed. The Labor Code sections 4061 and 4062 are now eviscerated; they along with section 4060 make reference to a couple of new statutes. These are Labor Code sections 4062.1 and 4062.2, and they will form the heart of the medical legal process.

The process will center around the distinction between represented and unrepresented workers. Labor Code section 4062.1 deals with unrepresented cases, and, put simply, demands the use of a panel physician in every case. Labor Code section 4062.2 deals with represented cases, and basically demands the use of a panel physician where an AME cannot be agreed upon.

### A. Labor Code 4060.

Labor Code section 4060 still applies to denied cases. The original language of this part of the statute remains: "This Section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer." However, where the parties used to select their own QMEs, now only panel QMEs and AMEs are allowed. If a medical evaluation is needed, and the applicant is represented by an attorney, then the procedures set up in Labor Code section 4062.2 are utilized. Those are described below. If the applicant is not represented by an attorney, then the procedures in Labor Code Section 4062.1 are utilized. That is also described in further detail below.

Labor Code section 4060 does demand in an unrepresented case that the defense provide the applicant with notice, either that a comprehensive medical evaluation is needed to determine compensability, or notice that liability is not accepted, and that the employee has a right to a medical evaluation. Also, Section 4060(e) indicates that the applicant is to be notified of his rights to speak to an I&A officer and to have an attorney. Specified language is utilized here. The notice to the applicant is to be accompanied by the form that is prescribed by the Administrative Director for requesting the assignment of a panel doctor.

### B. Labor Code section 4061.

Labor Code sections 4061 and 4062 still deal with accepted claims. They are dramatically scaled back, however, and ultimately make reference to Labor Code section 4062.1 or 4062.2, which, again, are described below. Labor Code section 4061 still deals with situations where temporary disability in an accepted case is coming to an end. It still provides that notices



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

need to be sent to the applicant that permanent disability is not being paid, is being paid in a defined amount, or may be paid.

Labor Code section 4061(c), which applies when the applicant is represented by an attorney, changes dramatically. No longer is an AME to be sought by the parties under this section. Rather medical evaluations are to be obtained only as provided in Labor Code Section 4062.2. Subsection (d) of Labor Code section 4061 applies where an applicant is not represented by an attorney. If the parties do not agree on the permanent disability rating, the form is to be provided to the unrepresented applicant to refer him or her to a panel physician. Either party is allowed to request a panel physician in accordance with Labor Code section 4062.1. The remaining provisions of Labor Code section 4061, describing how a panel physician is to be handled, are left in place.

**C. Labor Code section 4062.**

Labor Code section 4062 still complements its predecessor section, by dealing with situations where either the applicant or the defense objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4061.

Added here is a provision that issues covered by section 4610 – the utilization review statutes - are not covered by Labor Code section 4062, with one exception: New language here says that if the applicant objects to a decision made pursuant to section 4610, to modify, delay or deny a treatment recommendation, the employee is to notify the employer of the objection in writing within 20 days of receipt of that decision. Time limits as per the original language of the Statute may be extended for good cause or by mutual agreement. However, one is given to wonder as to the implications of the applicant's failure to object in a timely fashion.

No longer does this Statute require that the parties seek an AME. In fact, that entire language is eliminated. The Statute simply makes reference to Labor Code sections 4062.1 and 4062.2 (which does require this discussion), and notes that no other medical evaluation is allowed to be obtained.

The entirety of Labor Code section 4062.01 has been repealed. That provision was part of the 2003 legislation and appears to have been superfluous in regards to Labor Code section 4062.

**D. Procedures under Labor Code section 4062.1.**

This section applies if the applicant is not represented by an attorney. Of special note is the fact that this section does not specify that its procedures are limited to injuries after any specific date of injury. This is in contrast with Labor Code section 4062.2. In its new form, that section describes procedural changes for those injuries which occur on or after January 1, 2005. Since emergency legislation was enacted, it appears that the medical-legal procedure for an



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

applicant who is not represented by an attorney has been changed from April 19, 2004 onwards, for all dates of injury, as long as the medical legal procedures have not yet been initiated.

According to Labor Code section 4062.1, either party can request the medical evaluation, whether the case is accepted or denied. The form prescribed by the Administrative Director that requests a panel of three qualified medical evaluators can be submitted by either side. However, the defense cannot submit the form unless the employee has failed to submit it him or herself within ten days from the defense tendering it to the applicant.

Once the panel of three doctors is submitted, the applicant has the first bite of the apple when it comes to picking the doctor. However, if within ten days the applicant does not select a particular physician, the defense can do it. Thereafter the defense will set the appointment for the applicant as well. Either way, travel expenses must be forwarded.

Interestingly, there is a provision here giving the applicant an "out," when dealing with the independent evaluator. The evaluator has to give the applicant a chance to ask questions concerning the evaluation process and the evaluator's background. The applicant is then supposed to submit to the evaluation as requested. However, if the applicant has good cause to terminate the evaluation, the applicant may do so. Good cause is defined as "evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion or sexual preference, or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure." If the applicant declines to proceed with the evaluation, he or she has the right to a new panel of three qualified medical evaluators, and the process presumably starts all over again. This presents a bit of a conundrum, as one can imagine an applicant refusing over and over again to participate in these medical-legal evaluations. If the Appeals Board later determines that the applicant did not have the good cause necessary, the cost of the evaluation is deducted from the award.

Once a panel physician has been obtained, no further medical evaluation will be allowed to go forward, even if the applicant gets an attorney later on in the case. That is a change from the law enacted in 2003.

**E. Labor Code section 4062.2.**

The former section 4062.2 is repealed in its entirety. That specified how the parties were to handle providing information to doctors in the case. The new section lays out the rules for proceeding in every case where the applicant is represented by an attorney.

First, a written request to obtain an agreed medical evaluator is to be made. That written request is to name at least one proposed physician. Ten to 20 days are allowed for agreement to be reached. If this fails, either party can request the assignment of a three-member panel of qualified medical evaluators. The party submitting the request designates the specialty of the medical evaluator. However, they are supposed to provide information, including the specialty



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

of the medical evaluator requested by the other party and the specialty of the treating physician. Copies are to be served on the other party.

Within ten days of the assignment of the panel, the parties are supposed to confer and see if they can agree on one of the names to be an agreed medical evaluator. If they cannot agree by the tenth day, each party is supposed to strike one name from the panel. Naturally, the question arises as to who has to make the first decision to strike a name. In any case, the third and remaining doctor will be the sole medical evaluator for the case. It is provided that if one party fails to exercise their right to strike a name within three working days of gaining the right to do so, the other party can select the QME on their own. Hopefully, regulations will clear this up.

As with unrepresented employees, a represented applicant is to be responsible for setting up the appointment. However, if the applicant fails to do so within ten days after the selection of the panel physician, the defense is to make the arrangements.

**C. Labor Code section 4062.3: Communication with Qualified Medical Evaluators.**

This new section specifies how information is to be provided to any qualified medical evaluator. It is substantially the same as the former section 4062.2. Ex parte communication with a panel doctor or AME is prohibited, and essentially the same rules for communicating with these sorts of doctors applies.

Upon completing the evaluation, the medical evaluator will summarize the medical findings in a form prescribed by the Administrative Director. This is then to be served on the parties, and is to contain an answer to all contested medical issues. If after the medical evaluation is prepared either party objects to any new medical issue, they are to return to the original evaluator to the extent possible.

Under Labor Code section 4062.5, if a QME selected from a panel fails to complete an evaluation within the time frames of Labor Code section 139.2 (generally one month) a new evaluation can be obtained upon the request of either party.



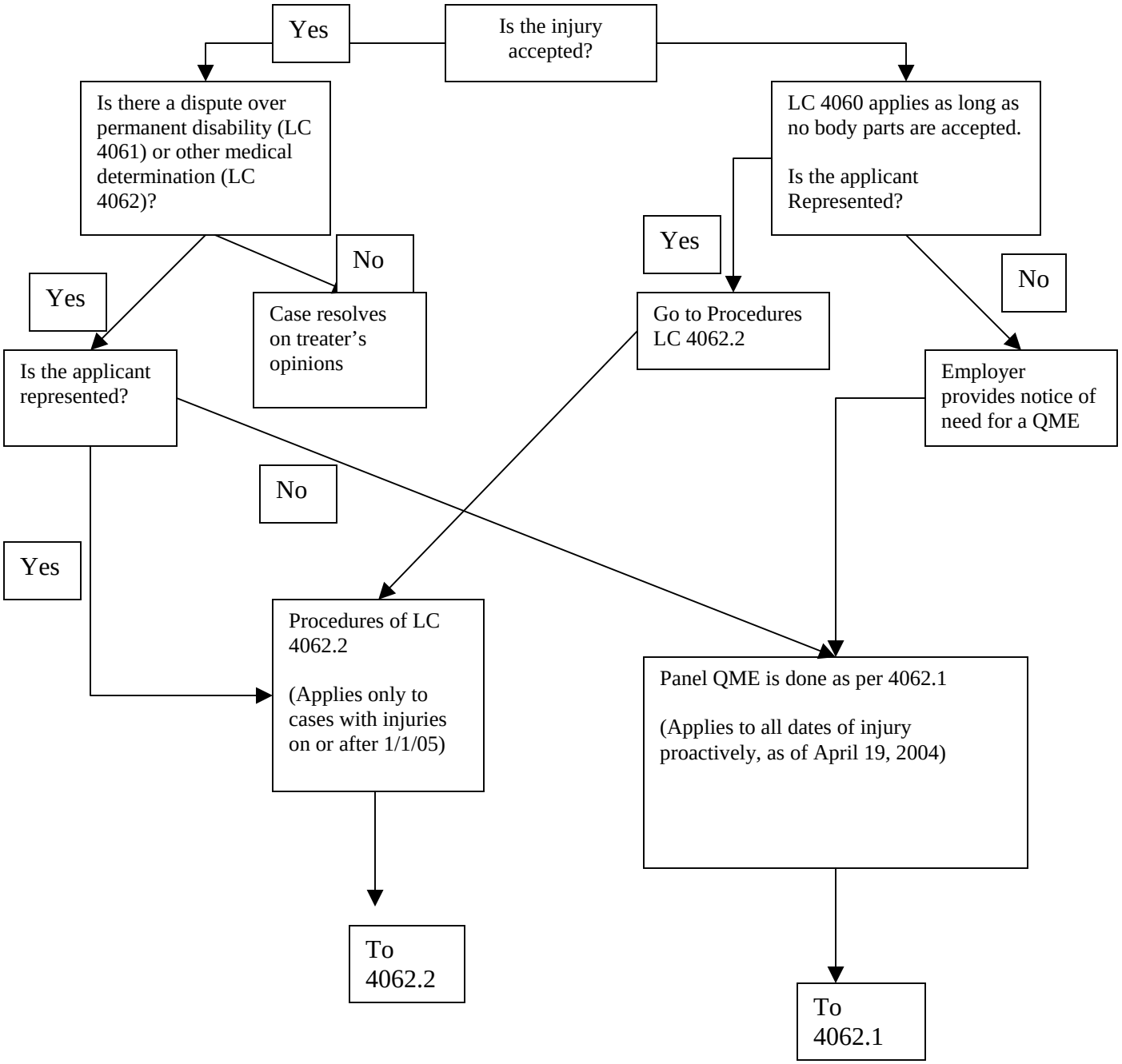
**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

# MED-LEGAL PROCEDURE UNDER SB 899

| |
|---|
| No |

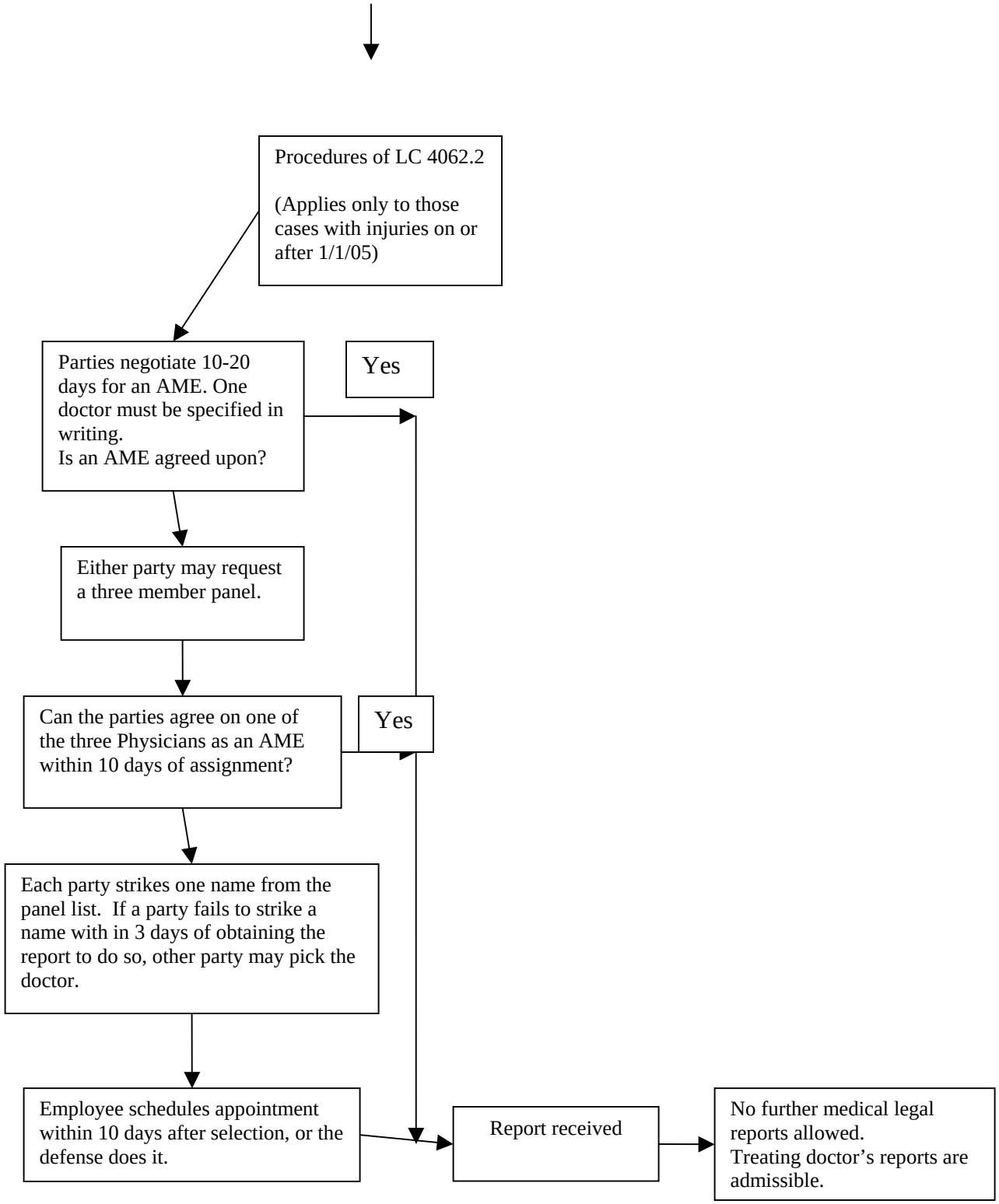


**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**



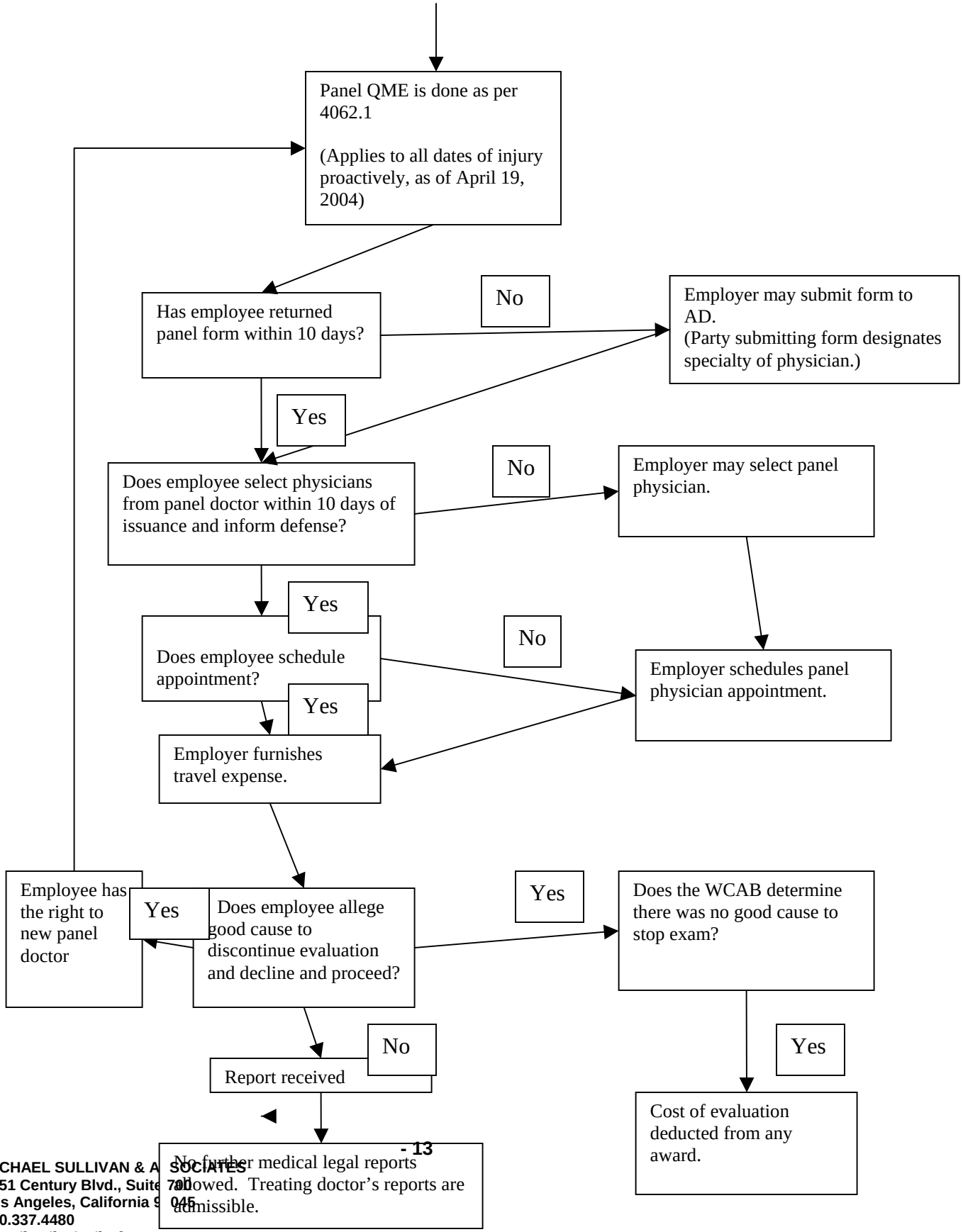



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**






**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**






**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 2. Reform of the Legal Standard

Labor Code section 3202 has long been a major weapon for applicants and their attorneys. It mandates that the workers compensation laws "shall be liberally construed by the courts with the purpose of extending their benefits . . ."

That statute remains in place. However Labor Code section 3202.5 is changed. This used to confirm that section 3202 did not relieve the applicant and lien claimants from meeting their burdens of proof. section 3202.5 now states that "All parties and lien claimants shall meet the evidentiary burden of proof on the issues by a preponderance of the evidence in order that all parties are considered equal before the law."

This is not a change in the standard for interpreting legal questions. It is a reaffirmation that all parties have a burden of proof to meet and all are equal.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 3. Treating Doctor's Presumption Finally Eliminated

Over the last few sessions, the Legislature has tried to scale back and limit the treating doctor's presumption. Now it is finally eliminated, even in cases of a pre-designated physician. Simply stated, Labor Code section 4062.9 is repealed. This has the effect of eliminating the presumption altogether.

Thus, it appears that as of April 19, 2004, if you have not got an award from the judge based on a presumption, you never will.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 4. Limitation of Temporary Disability

In one of the most dramatic parts of this new legislation, the Legislature has decreed that temporary disability may not last for more than two years, following any particular date of injury.

Labor Code section 4656, which had previously provided that temporary disability could not extend for more than 240 weeks within a five year period, has been modified. This statute applies only to those dates of injury which occur on or after April 19, 2004. Labor Code section 4656(c) states specifically that temporary disability for those dates of injury "Shall not extend for more than 104 compensable weeks within a period of two years from the date of this commencement of disability payment."

This does seem to have a serious effect on Labor Code section 4661.5, which had codified a longstanding legal principle: that payment of temporary disability made more than two years from the date of the injury were to be paid at the rate in effect at the time of the payment. This principle will have no force for those cases with a date of injury occurring on or after April 19, 2004. This is especially important in light of the benefit increases enacted in recent years.

Exceptions are made. Any employee who suffers from specified types of conditions has up to 240 aggregate weeks within a period of five years from the date of injury, as per the original law. These conditions are:

A. Acute and Chronic Hepatitis B

B. Acute and Chronic Hepatitis C

C. Amputations

D. Severe Burns

E. Human Immunodeficiency Virus (HIV)

F. High Velocity Eye Injuries

G. Chemical Burns to the Eyes

H. Pulmonary Fibrosis

I. Chronic Lung Disease



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 5. Regulation of Insurance Rates

As is well known, the Democratic Party attempted vigorously to negotiate for regulated insurance rates as part of any overall workers' compensation reform. This battle continues to wage. It was not part of AB 899.

The bill does, however, throw a bone to the Democratic Party on this point. Labor Code section 138.65 is added. This directs the Administrative Director to contract with a qualified organization to study the effects of the 2003 and 2004 Legislative reforms on workers' compensation. This is to identify and quantify the savings generated by the two reforms. Further, the study is to review workers' compensation insurance rates to see how much of the savings actually got passed to the employers from the insurance carriers. Employers bear some of the cost for this. They are to bear up to one million dollars of the cost of the study.

The Commission is to assess the effect of the reform savings on replenishing surpluses for workers' compensation coverage, and review the overall effects of the reform. The Commission is to review the adequacy and accuracy of the pure premium rate as recommended by the Workers' Compensation Insurance Bureau and adopted by the Insurance Commissioner.

Insurers have to cooperate by providing relevant information. The Administrative Director is then to submit the report to the governor. A progress report is to issue on January 1, 2005, and again on July 1, 2005. A final study is to be given to the governor on or before January 1, 2006. Thereafter, the governor and Insurance Commissioner are to review the results and make some recommendations as to the appropriateness of regulating insurance rates. If it is concluded that the savings have not been passed on to the employers, the governor and insurance Commissioner are allowed to submit proposals to the Legislature. Frankly, this does not seem like a law with much teeth to it. The Governor and Insurance Commissioner presumably can submit proposals any time they wish. For good measure, the bill indicates that “In no event shall the proposals unfairly penalize insurers that have properly reflected the 2003 and 2004 reforms in their rates, or can verify that they have not received any cost savings as a result of the reforms.”



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 6. Labor Code section 5814 Revisited

Labor Code section 5814 has long been the subject of controversy due to its sometimes dramatic consequences. As is well known, Labor Code section 5814 provides for a 10% penalty where payment due for benefits is unreasonably late. In such an event, a penalty is assessed against not only the amount that is paid late, but also the entire species of benefit to which the applicant is entitled throughout the life of the claim. On the larger claims, this has made for what some view as an unfair windfall to the applicant.

In order to rectify this perceived abuse, the Legislature has made Labor Code section 5814 inoperative as of June 1, 2004, and repealed it, as of January 1, 2005.

A new Labor Code section 5814 is added. It indicates that "When compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused shall be increased up to 25%, or up to $10,000, whichever is less." This obviously is a substantial reduction in what would otherwise be owed, despite the higher percentage rate.

In a curious sentence following this language, the Legislature provides that the Appeals Board "shall use its discretion to accomplish a fair balance and substantial justice between the parties." It is unclear to what extent this sentence modifies its predecessor. It is unclear whether this is meant to allow the judge to exceed the limits given here, or to provide penalties of a lesser amount.

The Legislature provides that if the defense discovers prior to an employee claiming a penalty an unreasonable payment, within 90 days of the date of that discovery, it may self-impose a ten percent penalty. This is in lieu of the 25% penalty that would be due on the payment unreasonably delayed or refused. This self-assessment must be made before the applicant makes a claim for a penalty, and must be made within ninety days of the discovery of the "potential violation".

Note that Labor Code section 4650(d) has not been repealed. That section provides that when an indemnity benefit is paid late, it is to be increased by ten percent, regardless of whether the delay was unreasonable. Failure to comply with this requirement can result in a separate penalty under section 5814, old or new.

However, a new Labor Code section 5814(d) does allow that any payment under section 4650(d) reduces the liability under section 5814(a). Presumably then, if a $400 indemnity payment is paid late, $100 would be owed in penalty. A self-imposed penalty under section 4650 would also be owed in the amount of $40. However, this would reduce the original 5814 penalty to only $60. One is given to wonder whether, if the error was discovered within ninety days and before a penalty demand, that ten percent payment under 4650 would also count as the



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

payment under 5814(b), and eliminate the $60 balance as well. This may be unlikely since section 5814(d) makes reference only to section 5814(a).

The Legislature has provided some protection for the defense on issues of penalty in regards to resolution of cases. The new Labor Code section 5814(c) indicates that it is conclusively presumed that any claims for penalties have been resolved, whether a Petition for the penalty has been filed or not, when the Court approves a Compromise and Release, a stipulated award, or issues a Finding and Award, unless a claim for penalty is expressly excluded in the Order or Award. Furthermore, it is conclusively presumed that any issue or claim for penalty has been resolved when the case is submitted for determination at a regular trial hearing, if the penalty issue has not been specifically raised in the pre-trial statement.

There is further protection available as well. The new Labor Code section 5814(e) indicates that "No unreasonable delay in the provision of medical treatment shall be found when the treatment has been authorized by the employer in a timely manner, and the only dispute concerns payment of a billing submitted by a physician or medical provider." This is a real change, as previously parties were able to request penalties based on an unreasonable refusal to pay a lien.

Finally, it is specified that nothing in this new Statute shall be construed to create a civil cause of action. In a final act of protection for the defense, the new Labor Code section 5814(g) indicates that "Notwithstanding any other provision of the law, no action may be brought to recover penalties that may be awarded under this section more than two years from the date the payment of compensation was due." This is a new statute of limitations for penalty issues.

The new section becomes operative on June 1, 2004. Furthermore, it is specifically indicated that this penalty reform applies to all injuries without regard to when they occurred. Therefore, it appears that if a party is not able to get a judicial award regarding a penalty before June 1, this reform will eliminate pursuit of the claim under the original statute.

Probably to address concerns regarding insurers or self-insured's taking advantage of this situation to deliberately delay payments, Labor Code section 5814.6 is enacted, and provides for a $400,000 punishment for any such organization that "knowingly violates section 5814 with a frequency that indicates a general business practice." Any assessment will be deposited in the Return-To-Work fund. This reform also becomes operative on June 1, 2004. In order to protect against employees trying to institute civil actions as a result of this section, Labor Code section 2699 of the Labor Code is amended. This section provides that employees can pursue civil penalties through a civil action on behalf of that person or other current or former employees where that civil penalty could otherwise be assessed and collected by the Labor and Workforce Development Agency or any of its Departments, Divisions, Commissions, Boards, etc. The new Subsection (k) of this Labor Code Section specifies that Labor Code section 2699 does not apply to the recovery of administrative and civil penalties in connection with the workers compensation law.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 7. Immediate Medical Care

Section 5402 of the Labor Code is well known by all parties in the system. That section does provide that a claim must be accepted or denied in ninety days.

This section has been amended to indicate that an employer must, during the delay period preceding denial, provide medical treatment to the applicant. Specifically, the new Labor Code section 5402(c) specifies that within one working day after the employee files a claim form, the employer must authorize the provision of all treatment consistent with the utilization guidelines. This treatment is to continue until the date that liability for the claim is accepted or rejected. It is not too hard to see some issues arising from this rule, such as the consequences of the employer failing to offer such treatment, or the employer's duty to provide allegedly unnecessary care. It appears that under the current law the employer does maintain medical control for at least the first thirty days.

There is a $10,000 limit on the expense of this medical treatment up until the time of denial or acceptance of the claim. Furthermore, it is specified in Labor Code section 5402(d) that this treatment provided does not give rise to a presumption of liability.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 8. Medical Treatment Redefined

There are many changes made in Labor Code section 4600, which is of course the foundational Code for the provision of medical care.

### A. Definition of Medical Treatment.

Labor Code section 4600 has provided a relatively broad definition of medical treatment, which has set the tone for workers' compensation treatment for decades. Specifically, treatment is mandated "that is reasonably required to cure or relieve the injured worker from the effects of his or her injury." Subsection (a) of Labor Code Section 4600 specifies that this treatment must be provided in a "reasonable" fashion. The formerly used word was "seasonable."

Added is Labor Code section 4600(b). It provides that notwithstanding any other provision of the law, medical treatment that is reasonably required to cure or relieve the injured worker means treatment that is based upon the Utilization Guidelines as adopted by the Administrative Director, or prior to the Administrative Director's action, per the terms set out in ACOEM. This is a definition of reasonable care that is a radical departure from the previous understandings of the same in the system. Furthermore, it is a "clean-up" measure, which strengthens the Utilization Guidelines that were originally enacted in the 2003 legislation.

### B. Establishment of the Network.

Labor Code section 4600(c) is also radically altered to help with the establishment of a treatment network as described later herein. This section had provided that after 30 days from the date of injury, the applicant could chose his or her own physician at a facility of his or her own choice within a reasonable geographic area. This is now limited to those circumstances where an employer network is not otherwise created.

### C. Pre-designation of Physicians.

Section 4600(c) had also laid out a provision wherein the applicant could pre-designate a physician with the employer prior to the injury, and provided that the applicant could chose to be treated by that pre-designated physician regardless of employer control rules. This has been eliminated.

There is still a provision in Labor Code section 4600(d) which allows for treatment by a pre-designated physician. Such a scenario is allowed when the applicant has notified the employer in writing prior to the date of injury that the applicant has a personal physician, and one of the two following conditions exist: First, the employer provides a non-occupational group health coverage in the health care service plan, or second, the employer provides non-occupational health coverage in a group health plan or group health insurance policy. Thus, to



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

put it very simply, and employer has to have non-industrial health insurance for the applicant to be allowed to pre-designate and use a personal physician. Furthermore, there are limits on what can constitute a personal physician. The personal physician has to meet all of the following conditions:

1. The physician must be the applicant's regular "physician and surgeon", and must be licensed. One wonders if the legislature really intended for this requirement that the doctor be a surgeon.

2. The physician has to be the applicant's primary care physician. This means that he or she has previously directed the medical treatment of the applicant and retains the applicant's medical records, including his or her medical history.

3. The physician agrees to be pre-designated. This could create a significant procedural barrier. The timing of this agreement is not specified.

Subsection (d)(5) indicates that no more than seven percent (7%) of all employees who are covered under the paragraph are allowed to pre-designate physicians at any given time. Obviously all this is in place at least in part to ensure that there is no illusory pre-designation of a physician in order to circumvent the purposes of employer's establishment of a physician network and resulting control of medical care.

The Legislature is careful to avoid any disputes over medical treatment that will involve qualified medical evaluations and Court intervention. Labor Code section 4600(d)(3) specifies that if the employer does have non-occupational health care, those provisions of health care law which put into place a system for resolution of medical disputes are dispositive of any such disputes.

The rules regarding pre-designation are given a sunset provision. That is, unless they are re-ratified by the Legislature and passed by April 30, 2007, they will no longer exist.

**D. Demand for Prior Authorization.**

Labor Code Section 4600(d)(5) indicates that the insured may require prior authorization of any non-emergency treatment or diagnostic service, and may conduct a necessary utilization review pursuant to Section 4610.

This has a huge potential. The defense may under the language here decide to demand pre-authorization for all non-emergency care and diagnostics. A failure to obtain such pre-authorization could be a basis for avoiding liability. The defense should make sure that the requirement of pre-authorization is clear if this tact is taken.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 9. Fee Schedule Reform

Labor Code section 4603.2 is amended. Subsection (b) formerly provided that the defense had to make payment for medical treatment within 45 days after receipt of each separate billing. Language has been added here to indicate that such payment is to be made "at the reasonable maximum amount in the official medical fee schedule, pursuant to Section 5307.1 in effect on the date of service." This mandates payment according to fee schedule without qualification. It also "cleans up" the 2003 reform bill language, which did not specify what dates of injury or dates of service would apply for implementation of new fee schedule rules.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 10. Permanent Disability Redefined

A number of changes have been made to the concept of permanent disability.

### A. Continuity of Payments.

Labor Code section 4650(b) had provided that if injury caused permanent disability, the first payment was to be made within fourteen days after the last payment of temporary disability indemnity. It was provided that where the standard of permanent disability could not be determined at the date of the last payment of temporary disability, the employer nevertheless should commence the timely payment required of permanent disability.

New language has been added here to reinforce the requirement of continuous payments without a break. It is indicated that "When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of section 4656, and regardless of whether the extent of permanent disability can be determined at that date, the employer nevertheless shall commence the timely payment required . . ." Payment is still to be made based upon a reasonable estimate of the amount due at the end of the period for the payment of temporary disability, regardless of whether the permanent disability can be precisely defined.

### B. Permanent Disability Redefined.

According to Labor Code section 4600(a), permanent disability is determined based upon the nature of the physical injury or disfigurement, the occupation of the injured employee, his or her age at the time of the injury, and the employee's diminished ability to compete in an open labor market.

This has been changed. No longer is permanent disability based upon an assessment of the applicant's loss of ability to compete in an open labor market. The new standard for permanent disability is what the applicant's lost future earning capacity is as a result of the injury.

Furthermore, the "nature of the physical injury or disfigurement" is now to incorporate descriptions and measurements of physical impairments and corresponding percentages of impairments that has already been published in the American Medical Association's (AMA) Guide to the Evaluation of Permanent Impairment, Fifth Edition.

Under the new Labor Code section 4660(b)(2), the Administrative Director is now charged with producing a new schedule for rating permanent disabilities. This schedule is to produce a measure of the applicant's diminished future earning capacity by producing a numeric formula based upon empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees. In



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

making this numeric formula, the Administrative Director is to use the Evaluation of California's Permanent Disability Rating Schedule Interim Report. This was published in 2003 by the Rand Institute, and at this writing the final needed numbers are coming. Unfortunately, we will have to wait to really understand the impact this will have on permanent disability in our system until this information is out and the new schedule is published.

It appears that the target date for this is January 1, 2005. By that date the Administrative Director is to adopt regulations to implement the changes made here. Labor Code section 4660(d) states that the new schedule shall apply only prospectively for those dates of injury occurring on or after the publication of the new schedule. It also makes provisions for cases with dates of injury before the publication. Interpretation of these provisions shall await the formation and issuance of the schedule, as well as the rules promulgated.

The Administrative Director is to review and amend this schedule at least once every five years. The schedule "shall promote consistency, uniformity and objectivity."

**C. Increase in Permanent Disability for Serious Injuries.**

Labor Code section 4658 lays out the number of weeks of permanent disability which are to be paid depending on the percentage of permanent disability. New subsection (d)(1) sets forward a new standard here. This Labor Code applies to injuries on or after the effective date of the revised permanent disability schedule described herein under Labor Code section 4660. There is other language here regarding the implementation of this increase, but a firm understanding will await the new schedule's publication.

For those injuries which result in permanent disability of 70 to 99.75% (life pension cases), the number of weeks for which permanent disability is paid is raised to sixteen. This is a dramatic increase from prior allowances.

**D. Permanent Disability Benefits Modified for Return To Work.**

Labor Code section 4658(d)(2) specifies that the applicant may receive an increase in some permanent disability if he or she is not put back to work by the original employer. Subsection (d)(3) also decreases permanent disability if the applicant is put back to work. This concept does not apply to those employers with less than fifty employees.

If within sixty days of permanent and stationary status the employer does not offer the applicant regular, modified or alternative work under certain conditions, one of which is a 12-month duration for this work, the applicant is entitled to a 15% increase in the payments of permanent disability. Note that this is not a 15% increase to permanent disability in general. Rather, it is a 15% add-on to each check sent to the applicant for permanent disability following the close of the 60-day period.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

On the other hand, if within the same 60 days the employer does offer the applicant regular, modified or alternative work that would last the 12-month period, each permanent disability payment made after the date of the offer is decreased by 15%. If the applicant is terminated by the employer before the end of the permanent disability payout, the payments are again increased by 15%. If the applicant voluntarily terminates employment, he or she does not get the increase.

This structure is curious, especially in light of the provisions in the 2003 legislation respecting modified or alternative work in the "voucher" system. Those provisions had provided for an offer to be made to the applicant at the end of temporary disability payment—not the permanent and stationary status as specified in these statutes—and seem to coincide somewhat. This is made even more interesting by the new Labor Code Section 4658.1. This defines regular work, modified work and alternative work, and lays out the conditions under which these terms may be properly utilized for purposes of employing an increase or decrease in permanent disability as noted herein.

Regular work means "the employee's usual occupation or the position in which the employee was engaged at the time of injury, and that offers wages and compensation equivalent to those paid to the employee at the time of the injury and located within a reasonable commuting distance of the employee's residence at the time of injury." Modified or Alternative work offered must be within reasonable commuting distance as well, and must be within 85% of the original wage. Modified work is essentially a return to the original position, with accommodations made so that the employee can continue to perform the functions of the job. He or she must be able to perform the functions of the alternative job too.

Further guidance is given by section 4658.1, subsections (d), (e) and (f). Subsection (d) specifies that increasing working hours does not count for purposes of specifying comparative wages. Subsection (e) specifies that when determining the actual wages and compensation, the minimums and maximums for purposes of permanent disability are not considered. Subsection (f) indicates that the reasonable distance of the employee's residence may be waived by the employee, that any objection is deemed waived if the employee accepts the work and does not object to the location within 20 days of being informed of the right to object; and finally, if the offered work is at the same location and the same shift as the employment at the time of injury, it is conclusively deemed to be a non-issue.

The Administrative Director is directed to create rules and regulations for implementation of this scheme. This will likely clarify a lot of the issues here.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 11. Apportionment

Traditionally, apportionment of permanent disability was only allowed within specific parameters. These parameters were judged by some to be rather strict. Certainly an attempt at a finding of apportionment would meet with specific challenges. In addition, the maxim that apportionment applies to disability, and not to causation, was a long-standing principle of workers' compensation law. All this has been radically changed.

There were three Labor Code sections which defined apportionment. Labor Code section 4750 provided for apportionment to disability which existed at the time of the industrial injury that was the result of a prior injury that the applicant had suffered. Labor Code section 4750.5 provided for apportionment to a subsequent incident of injury which created a definable disability. Labor Code section 4663, arguably the most difficult of the three, provided that apportionment could result from a non-industrial progressive disease. All of this has been completely repealed.

It has been replaced by a new Labor Code section 4663, which makes the astounding revision in subsection (a) that "Apportionment of permanent disability should be based on causation."

This section goes on to state that any physician preparing a report has to specifically address the issue of the causation of permanent disability. That is necessary for any physician's report to be considered complete. The physician is to identify "what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment, and what approximate percentage of the permanent disability was caused by other factors, both before and subsequent to the industrial injury, including prior industrial injuries." Newly enacted Labor Code section 4664 states that "The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment."

If a physician is unable to make an apportionment determination, he or she is to state specific reasons why he or she could not do it. The physician is then to consult with other physicians or refer the employee to another physician "from whom the employee is authorized to seek treatment or evaluation," in order to make his final determination.

Under Labor Code section 4663, an applicant is mandated where requested to disclose all previous permanent disabilities and physical limitations. This seems to result in a new rule for discovery in workers compensation, and there appears to be no reason why the defense would not routinely make this demand.

Labor Code section 4664(b) takes this to the next step and closes a classic "apportionment loophole." This "loophole" applied to situations where a Findings and Award or



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

Stipulation was made regarding permanent disability in the past, but which was subject to the applicant's argument that he or she had recovered from that permanent disability, and thus apportionment should not apply. This argument often worked in litigation up until this point.

However, this new subsection indicates that a prior award of permanent disability is conclusively presumed to be just that - permanent disability, and apportionment automatically applies. To use a traditional example, a back injury that results in 40% disability would be reduced by 20% if there were a prior injury which resulted in a prior Award of 20%. Given the changes in this reform legislation in the way permanent disability is to be valued, understanding how to apportion a prior Award will be difficult once the new schedule issues. The two (or more) assessments of permanent disability will have been made under different standards.

Labor Code section 4664(c) chimes in along these lines and states that applicants may not accumulate, over one lifetime, permanent disability awards on the same body part and exceed 100%. An exception applies if the applicant's injury or illness is conclusively presumed to be total in character, pursuant to section 4662. Specific regions of the body are listed in Labor Code section 4664(c), even beyond those of the statute it references, including: a) Hearing; b) Vision; c) Mental and behavioral disorders; d) The spine; e) The upper extremities, including the shoulders; f) The lower extremities, including the hip joints; g) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs a to f inclusive. This obviously is every part of the body, and it is wondered why the Legislature bothered to list them specifically.

Subsection (c)(2) states that "Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100%."

It appears that this emergency legislation applies for all dates of injury as of Monday, April 19, 2004, as long as such application is prospective; that is, it does not follow an Award or Order.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 12. Employer Controlled Medical Treatment

Employer control of medical treatment was one of the most hotly contested and most dramatic changes of this reform legislation. To put it simply, as of January 1, 2005, if the defense has a network of physicians in place, it retains complete medical control throughout the lifetime of any claim for injury on any date.

As noted herein, Labor Code section 4600 commences the discussion of an employer network. Labor Code section 4600 used to provide for the applicant's ability to select a physician of his or her own choice at a facility of his or her own choice, 30 days after the date the injury was reported. This is now conditioned on the factor of whether the "employer or the employer's insurer" has established a medical provider network as provided for in Labor Code section 4616. Where such a network is established, the choice is limited to those physicians that exist inside the network.

It appears, then, that the defense industry has some work to do before the end of the year.

### A. Establishment of a Medical Network.

Labor Code section 4616 indicates that on or after January 1, 2005, a medical provider network may be set up by an "insurer or employer." There is a considerable amount of speculation at this writing regarding the constitution of such networks. Will the industrial networks be reinvented? Will existing HCOs or PPOs be utilized? Naturally this means a big shift away from many doctors who have set up their businesses based on the concept of treating applicants. Naturally those who represent applicants are especially concerned regarding the orientation of network physicians.

However, the legislature has provided quite a bit of guidance on the establishment and makeup of these networks. Not only must any proposed network be approved by the Administrative Director, but there are specific conditions that must be met. On or before November 1, 2004, the Administrative Director is to adopt regulations interpreting the process of establishing a network. Hopefully, this will provide more specificity to these requirements.

Here are the factors involved as presented by the statutes.

1. The network is to include "physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of non-occupational injuries. The goal shall be at least 25% of physicians primarily engaged in the treatment of non-occupational injuries." The Administrative Director is to encourage the integration of occupational and non-occupational providers in the process of creation of these networks. This seems like fairly loose language.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

2. It is important that the network be able to provide whatever treatment is necessary. Labor Code section 4616(a) indicates that the number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. There is also to be an adequate number and types of physicians "to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and the geographic area where the employees are employed."

3. Section 4616(a)(2) indicates that medical treatment for injuries is to be readily available for reasonable times to all employees. The Administrative Director in approving any medical network and is to consider the availability and accessibility of treatment. Rural areas are specified, and, even more specifically, those in which health care facilities are located at least 30 miles apart.

4. In order to establish a network, the employer or insurer is to submit a plan to the Administrative Director for approval. The Administrative Director is to approve it if he or she determines that the plan meets the requirements of the section. If he or she does not act on the plan within sixty days of its submission, it is deemed approved.

5. 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.

6. On the other hand, physician compensation may not be structured in order to achieve the goal of reducing, delaying or denying medical treatment or restricting access to medical treatment.

7. Treatment is to be provided only in accordance with medical utilization guidelines.

8. Only licensed physicians and those competent to evaluate the specific clinical issues involved in the treatment services are allowed to practice.

9. Labor Code section 4616.1 talks about the use of "economic profiling." This is the process of evaluating a particular physician or provider medical group or individual practice association, based on whole or in part on the economic cost of utilization and services associated with the medical care provided. If such profiling is utilized, the Administrative Director must be provided with a copy of the filing, and it must be available for public view as well.

10. Health care organizations and health care service plans, and even a group disability insurance policies under some conditions are deemed approved provided certain conditions are met as determined by the Administrative Director. This may allow them to circumvent the approval process to some extent. The specifics of this are outlined by Labor Code Section 4616.7.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

**B. Continuity of Care**

The establishment of a treating network will enable the employer or insurer to control medical care for all dates of injury, whether before or after the establishment of the network. Therefore following the timely establishment of such a network, those injuries in the process of treatment will be transferred to within the network. Special provisions have been made for continuity of care that is in process from pre-existing claims by Labor Code section 4616.2.

When a network plan is approved by the Administrative Director, the written Continuity of Care policy is to be filed and considered. The insurer or employer is to provide all employees entering the workers' compensation system notice of its written Continuity of Care policy and information regarding the process for an employee to request a review under the policy. Upon request, the defense has to provide a written policy to the public.

This statute makes reference to a terminated relationship with a prior medical care provider. Under certain circumstances, that prior provider is allowed to continue treatment. If the applicant is receiving care from that provider at the time of the implementation of the employer network, he or she will be allowed to continue treatment for some period of time under the following conditions:

1. He or she has an "acute condition". This is defined as a medical condition that involves a sudden onset of symptoms due to an illness or injury "or other medical problem that requires prompt medical attention and that has a limited duration." This is obviously an extremely broad definition. It can mean a lot of things. However, it just as obviously contemplates a short-term condition. The Statute concludes that "completion of treatment shall be provided for the duration of the acute condition."

2. A serious chronic condition will merit continual care of the original treating physician as well. This is defined as "a medical condition due to a disease, illness or other medical problem or mental disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration." Once again, this is an extremely broad definition. Completion of treatment under this standard is not to exceed 12 months from the commencement of the employer network.

This statute says that completion of treatment is to be provided for a period of time necessary to complete a course of treatment, and to arrange for a safe transfer to another provider. Consultation is to take place between the insurer or employer and the injured employee and the former treating physician, and is to be consistent with good professional practice. All these general terms do not really give us much. The bottom line is that care is to continue unbroken to the extent possible, and not a year is to go by before transfer is complete.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

3. A terminal illness. Completion of the treatment is to be provided throughout the illness until the point of death. Terminal illness is defined as an "incurable or irreversible condition that has a high probability of causing death within one year or less."

4. Performance of a surgery or other procedure that is authorized by insurer or employer. This surgery is to occur within 180 days of the establishment of the network.

Conditions of continuing medical care are also laid out. The defense can require the former treater to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. This of course assumes a specific contract. If the former provider does not agree, the care does not have to continue. That seems problematic if an injured worker is caught in the middle.

The defense can agree to provide continuity of care beyond these requirements. It is not obligated to continue treatment with a provider whose contract has been terminated or not reviewed for reasons relating to medical disciplinary cause or reason. Rates and methods of payment are to be continued as per the original contract, or as what would be applicable in a similar geographic area.

**C. Treatment and Dispute Resolution.**

Labor Code section 4616.3 provides that when first notified, the employer is to arrange an initial medical evaluation and begin treatment. The employee is to be notified of his or her choice to choose a physician within the provider network.

If an applicant disputes either the diagnosis or the treatment prescribed by the treating physician, he or she may seek an opinion with another physician within the same network. A third opinion may also be sought.

The employee is supposed to choose the physician with the appropriate specialty or expertise in treating the particular condition. If there is no specialist in the network who can handle the particular problem, a specialist outside the network may be permitted on a case by case basis to the extent necessary to provide reasonable treatment to the applicant.

The next step of review in the event of a dispute over medical treatment is the newly established independent medical reviewers. These must be licensed physicians, but are not necessarily QMEs. The Administrative Director is to contract with individual physicians or an independent medical review organization to perform these reviews. The Administrative Director is responsible to make sure that these doctors are credentialed and privileged and that the reviews provided by the medical professionals are timely, clear and credible. He or she is to be sure that medical professionals who provide a fair and impartial panel are selected, that confidentiality of medical records is respected, and that there is no conflict of interest. All individuals selected must be licensed physicians, and in a particular case, the medical professional is to be



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with the guidelines and protocols in the area of treatment under review. The physicians are also to hold a current certification by a recognized American specialty board. Their license does not have to be in California. Each medical professional is to have no history of disciplinary action or sanctions.

If there is still a dispute over treatment or diagnostic service after the third physician's opinion, the employee can request an independent medical review. The standard to be used is that of the Utilization Schedule. The Administrative Director is to create a one-page form that can be submitted to him or her, called an Independent Medical Review Application. It is to contain a signed release from the applicant, authorizing the release of medical and treatment information.

The applicant can provide any relevant material or documentation with the application. The defendant can provide the reviewer with information "that was considered in relation to the disputed treatment or diagnostic service." This can include:

> "1. A copy of all correspondence from and received by any treating physician who provided a treatment or diagnostic service to the injured employee in connection with the injury.
>
> 2. A complete and legible copy of all medical records and other information used by the physicians in making a decision regarding the disputed treatment or diagnostic service."

The medical reviewer then conducts the examination. He or she is to do a physical examination. He can order any diagnostic tests necessary. He or she is to utilize the Utilization Schedule and make a decision about the proposed diagnostic or treatment. The reviewer issues a report to the Administrative Director within 30 days of examination, unless there is a serious threat to the health of the applicant, when the report is to be expedited and rendered within three days of the examination. A serious threat to the applicant's health is loosely defined as "including but not limited to serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the injured employee." The Administrator can add on up to three days to the three-day period in extraordinary circumstances for good cause.

Whether or not there are special considerations, the Administrative Director upon receipt of the reporting is to "immediately" adopt the determination of the reviewer and issue a written decision to the parties. This does seem like a burden on the office.

If the applicant wins, and the disputed treatment or diagnostic service is awarded, he or she can get it from an outside physician, and the defense is liable for the cost.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

That will be the end of the line for the parties. Labor Code section 4616.6 says that "No additional examination shall be ordered by the Appeals Board, and no other report shall be admissible to resolve any controversy arising out of this article." It would seem that doctor's depositions would be allowed. It would seem also that if the reasonableness of the reviewer's opinion were challenged, a request for expedited hearing could be filed. Nevertheless, this structure remains designed to tightly control any disputes over medical treatment.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

## 13. Clean-Up Legislation

A variety of provisions in this new set of statutes seem to have been put into place at least in part to "clean up" some of the enactments of the 2003 legislation.

### A. Vocational Rehabilitation.

Labor Code section 139.5 had been completely repealed. This had been confusing to some, since the voucher system was not put into place except for injuries on or after January 1, 2004. Accordingly, it was wondered how the Vocational Rehabilitation Bureau was going to continue to exist, and how there would be a legal basis for their decisions for injuries preceding that date.

Accordingly, Labor Code section 139.5 has been re-added to the Labor Code. It has one extra provision; the statute will remain in effect only until January 1, 2009. It will then "sunset" unless the legislature takes further action.

Note that the repeal of section 139.5 in its present form is not a repeal of the voucher system. That system was enacted in 2003 in its entirety in two separate Labor Codes. Labor Code section 4658.5, which independently provides for the existence of the entire voucher system.

### B. Fraud.

Labor Code section 3823 is part of the 2003 legislation. A variety of persons were charged with the duty of reporting fraud when they became aware of the same. This caused a fear of liability, as any "apparent fraudulent claim" had to be reported. We now have Labor Code section 3823(c), which indicates that those persons reporting this apparent fraud are not subject to civil liability, as long as they act in good faith without malice, and reasonably believe that the action taken was warranted by the known facts. This is of only limited comfort.

### C. Utilization Review.

There are a variety of items here which are obviously intended to reinforce and better define utilization review, which was of course a major part of the 2003 legislation. One of these areas, the definition of utilization review as "reasonable" in accordance with Labor Code section 4600, has already been described in the text of this review. We have also seen the requirement that the applicant object if displeased with a decision to delay, refuse or modify a request for medical treatment.

In addition, we have new language added to Labor Code section 4604.5. This refers to the presumption in favor of utilization review guidelines. The question of the strength of that



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

presumption had been raised by some following the 2003 legislation. However, new language is added here that "The presumption created is one affecting the burden of proof." This is no doubt intended to rectify any question in that area. Also, overcoming the presumption requires scientific medical evidence.

This provision takes effect right away as noted herein. Finally, it should be noted that throughout the entirety of this Bill the authors have taken care to reinforce the seriousness of utilization review wherever appropriate.

**D. Collective Bargaining Agreements.**

The 2003 law established a collective bargaining agreement between a private employer or groups of employers engaged in certain industries with their unions to create a dispute resolution process and terms for workers' compensation in general. Labor Code section 3201.5 is now amended to allow the parties to negotiate any aspect of the delivery medical benefits, and the delivery of disability compensation to the employees who are eligible for group health benefits and non-occupational disability benefits. This is a possibly serious opportunity for these sorts of organizations.

**E. Return to Work Fund and Funding.**

This statute restores user funding and allows it to be allocated to the Return to Work program. Employer assessments and as surcharges are to account for the total funding of this program. This is done pursuant to Labor Code section 62.5 and 139.48.

Other changes are made too in accordance with Labor Code section 139.48. It is specifically stated that the entire program is to be implemented only to the extent funds are available. One is given to wonder if the funds will ever be available. Also, the employer will not be able to apply for reimbursement of wages, which was one of the original items intended to attract the dense to the program. Other benefits remain available.

It looks like the legislature may be pinning its hopes on the thirty percent swings available under the new permanent disability rules. Those rules apply to those employers with fifty or more employees. The Return to Work Program is now limited, under this new Bill, to those employers with less than fifty employees.

**F. Limitations on Chiropractic and Physical Therapy Visits.**

The 2003 legislation specified that an employee would be limited to no more that 24 chiropractic and 24 physical therapy visits per industrial injury. This new legislation similarly provides that an employee is entitled to no more that 24 occupational therapy visits per industrial injury. That language does not seem to solve a many of the potential problems with the original statute. This is a modification 4604.5(d).



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**

There is a modification here to Labor Code section 4604.5(f); it is clarified that if the defense authorizes the applicant to get more than 24 visits, there is no waiver of the entire section. That was a concern that has now been "cleaned up".

**G. Safety Program Changes.**

As part of the 2003 legislation, each insurer was required to establish and review an injury prevention program with its insureds. The program was to be reviewed within four months of writing a new policy. This standard has been replaced; the insurer now has to only review the programs of insureds with experience modifiers of 2.0 or greater to determine whether the insured has implemented the program within six months of writing the initial policy. This gives the insurers a little more room to breathe.



**MICHAEL SULLIVAN & ASSOCIATES**
**6151 Century Blvd., Suite 700**
**Los Angeles, California 90045**
**310.337.4480**
**E-Mail: mike@mikeslaw.net**