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SB 863: The New California Workers Compensation Reform

There is a saying that has been loosely attributed to Otto von Bismarck, i.e. laws are like sausages: "It is better not to see them being made" (which is probably insulting to the sausage making process). The point of this saying, regardless of who came up with it, is that while the legislative process can be messy, lengthy and involve many different parties and their opinions the result should be a well-written law that benefits society. SB 863 certainly took a long time to come to fruition and is certainly lengthy; California residents, including the insurance industry, can only hope that the result is beneficial. The question is for whom? To the injured worker, the employer, the insurance company or the attorney? It is unlikely that it will be beneficial for all parties concerned, but perhaps that is too pessimistic.

Now, before getting into the specifics of this new law, I need to tell you that I have spent the past several weeks reading this law (I wish I had had a nice bottle of Zinfandel to go with) as well as countless articles, opinion letters, blogs and whatnot. Most of the articles provide a very short analysis and do not go into very many details. So, here's my warning before you read further: This is a serious article and I have no more humor left in me after going through all of this. You may discover the same after slogging your way through this. You can also stop reading if I have totally discouraged you and attend our webinar on this topic scheduled for February 13th. With that, here goes…

SB 863 was signed into law by Governor Brown on September 18, 2012 to take effect January 1, 2013 after months of negotiations among representatives of labor unions and several large self-insured employers to create significant reform desperately needed in the California Workers' Compensation system. This is the first workers' compensation regulatory reform in California since the passage of SB 899 in 2004

At the core of this new law are two specific goals:

1. Increase permanent disability benefits
2. Cost containment for medical treatment, benefits and administration of workers compensation claims

Because the costs of the foregoing have been significantly increasing, employees and employers alike agreed that in order for benefits to be increased costs would have to be decreased and the process involved with the workers compensation system must be streamlined.. In the past two years, the costs of workers' compensation insurance have risen from $14.8 billion to $19

billion with a projected 12.6% increase above that in the coming months, prior this reform being enacted.

Oversight and implementation of the revisions will be handled by the California Department of Industrial Relations and the Division of Worker's Compensation

Some of the changes that this law requires are fairly straightforward and involve specific dollar amounts for benefits as well as calculations for disability ratings. Some of the other changes are not as black-and-white so we will discuss the intent along with the specifics in those areas.

Permanent Disability

Minimum and maximum weekly benefit amounts will be phased in over the next two years. At the end of that time, the maximum benefit will be $290 / week.

The permanent disability rating calculations have also been changed. Prior to January 1, 2013, the rating formula used modifiers that range between 1.1 and 1.4 depending on the injury. The modifier is used to take into account the injured workers diminished future earning capacity as a result of the injury. The rating formula will no longer include the future earning capacity modifier. All injuries that occur on or after January 1, 2013 will be adjusted by a factor of 1.4. The rating system also uses the injured workers age and occupation as modifiers. Those modifiers will continue to be used.

Injuries that took place prior to January 1, 2013 will continue to be calculated at the same modifier that was initially used.

Section 4662 of the Labor Code provides specific circumstances under which the injury is soon to be total disability: (1) loss of both eyes or site (2) loss of both hands or use (3) effective total paralysis (4) brain injury resulting in incurable mental incapacity or insanity. All other cases are decided in accordance with the facts of the injury. This section of the Labor Code has not been changed.

Previously, permanent disability awards were available due to sleep disorders or sexual dysfunction resulting from physical injuries. These circumstances will no longer qualify for permanent disability awards. Psychiatric injuries resulting from physical injuries will no longer qualify for permanent disability unless the injured worker with either the victim of a violent crime or witnessed a violent crime.

Psychiatric claims involving treatment for sleep problems, sexual dysfunction and or psychological consequences of their injuries will still be compensable under the new law.

The combination of the increase in benefits and the methods used to calculate permanent disability ratings results in approximately $850 million in additional benefits for permanently disabled workers.

Job Displacement Vouchers

An injured worker has been eligible to receive the middle job displacement voucher that could be used to pay for job retraining. The amount of this voucher was based upon the permanent disability rating and was on a sliding scale that ranged between $4,000 and $ 10,000. In order to be eligible for this retraining voucher the permanent disability rating had to be fully determined either by a ruling by the Workers' Compensation Appeals Board or by a settlement agreement between the injured worker and the employer.

The voucher amount is now fixed at $6,000 when the injured worker reaches permanent and stationary status and the treating physician reports on the injured workers abilities and limitations resulting from the injury.

Return To Work Fund

The Department Of Industrial Relations is responsible for establishing and administering a $120 mil per year Return To Work Fund. The reason that this new fund is being established is to take care of the worker when their disability is disproportionately low compared to their earnings. The new Labor Code Section 139.48 says:

139.48. There shall be in the department a return-to-work program administered by the director, funded by one hundred twenty million dollars ($120,000,000) annually derived from non-General Funds of the Workers' Compensation Administration Revolving Fund, Eligibility for payments and the amount of payments shall be determined by regulations adopted by the director, based on findings from studies conducted by the director in consultation with the Commission on Health and Safety and Workers' Compensation. Determinations of the director shall be subject to review at the trial level of the appeals board upon the same grounds as prescribed for petitions for reconsideration.

The term director in this law refers to the director of the DIR. Where will the money come from? It will be 100% funded by surcharges on the Workers' Compensation policies purchased by California employers. The payment of benefits will not be paid by the insurance companies, but will be determined and administered by the DIR. Any appeal from a determination of benefit will be made to the Workers' Compensation Appeals Board. A number of attorneys have opined that since the law specifically allows review at trial level, that it is implied their fees will be paid from the fund. There are no current regulations that expressly provide for those

payments. The regulations to comply with this requirement have not yet been written, or at least published.

Independent Medical Review

This portion of the new law is designed to create a significant change in resolving medical treatment disputes. As of January 1, 2013 for injuries occurring on or after that date and as of July 1, 2013 for all injury dates, an Independent Medical Review will be used to decide these types of disputes.

Currently it can often take 12 months to resolve a dispute and requires specific steps that must be taken. The process involves (1) negotiating the selection of a medical evaluator (2) obtaining a listing of state-certified medical evaluators (if an agreement is not reached) (3) negotiating over the selection of the state-certified medical evaluator (4) making the appointment (5) examination (6) obtaining the evaluator's report (7) obtaining a hearing date with the judge if there is a disagreement on the evaluation (8) waiting for the judge's decision. In addition, the treating physician can rebut a request clarity from the medical evaluator and the evaluator may be required to submit supplemental reports.

The IMR process that will replace the prior system is similar to the process used by the group health industry and should reduce the time (and concurrent costs) to obtain a determination. It should be noted that an insurance companies cannot request an IMR; only the injured worker may do so following a denial, modification or delay of a treatment request.

The law does proscribe the process for an injured worker to appeal an IMR determination and again, that will go to the trial level of the WCAB. The basis for the appeal is either fraud, conflict of interest or a mistake of fact. The IMR is only available if there is a dispute over the requested medical treatment. It is not available to resolve other types of dispute, such as the injury itself.

Medical Provider Networks

Due to the prevalence of complaints involving MPNs, such as including doctors who do not accept workers compensation patients and the lack of availability of care and specialty areas the bill includes several modifications of the MPN system.

- Removal of the current requirement that 25 percent of doctors within the Network practice in areas other than occupational medicine
- Physicians must affirmatively confirm participation in a network
- Each Network will have to provide medical access assistants who will help the injured worker find an appropriate doctor for treatment

- The Division of Workers' Compensation must perform continuous and random reviews. The DWC has been provided the authority to impose penalties if the Network fails to properly address and correct access problems
- Disputes regarding whether or not an injured worker is subject to utilizing a Network will now be resolved at the time of the dispute, rather than holding resolution over until the end of a claim.
- Treatment from a non-Network provider without authorization from the insurance company or a judge's order will no longer be paid by the insurance company or the employer
- If the injured worker obtains treatment from an unauthorized provider that is either unsuccessful or worsens the injury, those medical costs will not be paid by the insurance company or the employer
- Medical reports submitted by a non-Network provider can no longer be the sole basis for a compensation award. These types of reports must be reviewed by the authorized physician and a qualified or agreed medical evaluator

Independent Bill Review

This is a new process that is being established to resolved medical billing disputes. This portion of the law also contains new requirements for submitting a bill and how insurance companies or employers must communicate their payment decisions to the medical providers.

Liens

This is one of the most significant modifications to the workers' compensation system in California.

A lien is a direct claim against the defendant typically submitted by medical providers or other service providers that the employer was required to provide. The medical provider uses a lien to contest the employer's determination of the amount payable for the medical services. This legal tool is relatively unique to California and has resulted in a significant number of liens to be filed through the court system. In 2010 there were approximately 350,000 liens filed and in 2011 approximately 450,000. The result of this is an expense incurred by insurance companies and employers alike of approximately $200,000,000 a year. Because of the sheer volume of filed liens the courts encouraged settlement of these liens and as a result many unjustifiable claims were paid.

The bill requires that a lien filing contain certain declarations made under penalty of perjury. The filer will also have to pay a filing fee of $150.00. All fees collected will be deposited into the

Workers' Compensation Administration Revolving Fund. There are also provisions for dismissal of liens after January 1, 2014 as well as a statute of limitations (18 months) for filing liens for services rendered after July 1, 2013. Another statute of limitations (3 years) applies for services provided prior to that date.

The bill also requires the employer to pay for interpreter services.

The specific language in the bill relative to the subject of liens is contained in many, many pages of the bill. Undoubtedly the wording and intent will be clarified over the course of the next several years as to the legislative intent and the various loopholes will be found by the courts, whether favorable to the employer, the injured worker or the service provider.

A schedule of maximum service provider fees are to be developed and implemented. The Official Medical Fee Schedule will be updated and will incorporate Medicare's Resource Based Relative Value Scale.

Self-Insured Employers

Required to pay deposits to ensure that their responsibilities to pay losses will be to be issued by December 31st annually.

The bill also precludes Professional Employer Organizations (PEOs), temporary employment agencies and employee leasing organizations from being a self-insured employer. The bill also tightens the restrictions that could allow an illegally uninsured employer from claiming self-insured status. The employer must receive approval from the Self-Insurers' Security Fund.

Self-insured public entities' annual reporting requirements have also been strengthened and a required study of the self-insured public entity programs must be performed by the Commission on Health and Safety and Workers' Compensation and a report completed with preliminary recommendation for improvement of the program by October 1, 2013.

This law has been touted by many different groups as a streamlining, cost-saving reform that will also include significant increase in benefits, particular for those persons deemed permanently disabled. The funding of the increase in benefits is supposed to be funded by the streamlining of the compensation claim process and the other procedures identified above. Well, there is no doubt that the scope of this reform bill will have significant impact on the entire workers' compensation system in California for years to come. One can hope that the employers will actually see cost-savings relief and that those seriously injured workers get the help they deserve. There is also little doubt that the legal jousting will continue.