CALIFORNIA SENATE BILL 863

INTRODUCTION

California SB 863 will change many aspects of the workers' compensation system. This brief outline serves as a summary of some of the major changes which is meant to provide assistance with comprehending the changes in store for us. A majority of the new laws will take effect on January 1, 2013.

PERMANENT DISABILITY CHANGES

The statutory changes will increase rates for PD for injuries occurring on or after 1/1/13 (LC 4453(d)(8)) with additional increases for injuries occurring on or after 1/1/14 (LC 4453(d)(9). Under both statutes, $240 is the minimum earnings rate for calculating PD. The minimum weekly PD rate will be $160 (2/3 of $240).

There are also changes to the maximum earnings rates for calculating PD benefits. With dates of injury occurring on or after 1/1/13, the maximum PD rate is $345 for injuries with PD between 1% and 55%, $405 per week for injuries with PD between 55% and 69% and $435 per week for injuries with PD between 70% and 99%. The resulting weekly PD rates correspond to $230, $270 and $290.

With injuries occurring on or after 1/1/14, the maximum earnings rate is $435 no matter the PD %. Therefore, if a worker's earnings are sufficient, the worker will be entitled to a weekly PD rate of $290.

LC 4650(b)(2) now provides that workers are not automatically entitled to PD benefits after the last payment of TTD. In cases where the employer makes an offer for a position that pays at least 85% of wages and compensation or the worker is working when the payment would be owed and is making what he/she made at the time of the injury, PD is not owed until an Award is issued. In such a situation, permanent disability advances will not be required. As a practical matter, this provision may facilitate settlement of cases as there will not be a PD advance to deduct from a settlement.

LC 4658 will no longer contain a section requiring the 15% PD increase or decrease depending on whether an employer offers work to an injured worker. This section applies to injuries on or after 1/1/13; therefore, the 15% adjustments will still apply to injuries occurring between 1/1/05 and 1/1/13.

NEW PD SCHEDULE

SB 863 charges the Administrative Director with creating a new PD schedule. LC 4660 has been amended only to apply to injuries occurring on or before 1/1/13.

SB 863 does away with the various Future Earnings Capacity (FEC) modifiers. It has replaced the modifiers with a standard multiplier of 1.4 or 40%, which is the highest modifier of the previous ranges. The practical effect of this is that it will increase PD for many injuries.

LC 4660.1 has been added and as with the 2005 rating schedule, the *AMA Guides to the Evaluation of Permanent Impairment, Fifth* Edition are to be used for rating purposes. Until the Administrative Director adopts the new schedule, we will continue to use the 2005 Schedule, but without the FEC modifiers. We will use the standard 1.4

multiplier. The PD schedule is still rebuttable in accordance with the *Almaraz* and *Guzman* decisions.

LC 4660.1 also provides that the new PD schedule will apply in cases of both permanent partial disability and permanent total disability. However, LC section 4662 pertaining to permanent total disability is still applicable.

SB 863 added LC 5703(j), which provides that evidence from a vocational expert must be produced in the form of a written report. Furthermore, direct examination testimony from a vocational witness is not to be received at trial except upon a showing of good cause. A party may request a continuance for rebuttal testimony if a report was not served sufficiently in advance of the close of discovery to permit rebuttal.

Pursuant to LC 4660.1(c)(1), SB 863 has eliminated PD add-ons for sleep dysfunction, sexual dysfunction and psychiatric disorders that arise out of a compensable physical injury. However, the employer is still responsible for treatment for these conditions that are a consequence of an industrial injury.

There is an exception, of course, under LC 4660.1(c)(2)(A) and (B) providing that there may be an increased impairment rating for a compensable psychiatric disorder if the psychiatric injury resulted from (A) being a victim of a violent act or direct exposure to a significant violent act within the meaning of LC 3208.3, or (B) if the psychiatric injury is the result of a "catastrophic" injury such as a loss of limb, paralysis, severe burn, or severe head injury.

RETURN-TO-WORK PROGRAM

SB 863 added LC 139.48, which provides for the creation of a return-to-work program. This program is to be created by the Administrative Director and is to be funded by employers. The particulars have yet to be set forth, but the purpose of the statute is for making supplemental payments to workers whose permanent disability benefits are proportionately low in comparison to their earnings loss.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS (VOUCHERS)

For injuries occurring from 1/1/04 through 1/1/13, LC 4658.5(d) does not identify a time limit for vouchers issued before 1/1/13. However, LC 4658.5(d) now provides a time limit for using a voucher for injuries occurring on or after 1/1/13. A worker must use the voucher within 2 years after the voucher is furnished or 5 years after the date of injury, whichever is later.

SB 863 added LC 4658.7 to the Labor Code and this applies to all injuries occurring on or after 1/1/13. This statute provides for a voucher to a worker with PD unless the employer makes an offer or regular, modified or alternate work lasting at least 12 months. (see LC 4658.1). Rather than having to make the offer within 30 days of stopping TTD payments, LC 4658.7 permits the employer to make the offer within 60 days of receiving a report determining that all conditions have become permanent and stationary and that the worker has PD. The medical report establishing these conditions must be from a primary treating physician, AME or QME.

An employer is not liable for injuries incurred while using voucher.

Per LC 4658.7(d), the voucher is redeemable for up to $6,000. LC 4658.7(e) outlines the allowable use of the voucher.

Settlement or commutation of supplemental job displacement benefits is not permitted per LC 4658.7(g).

MEDICAL PROVIDER NETWORK

SB 863 has made changes to the MPN framework; however, a worker may still predesignate a personal physician in writing before an injury and treat outside of an MPN. LC 4616(a)(3) provides that a treating physician will be included in the MPN if the physician provides a written acknowledgement that the physician elects to be a member of the network. This should help eliminate situations where an injured worker seeks treatment with a physician who refuses to see the worker and contends he/she has no information about inclusion in an MPN.

SB 863 also deals with situations when an injured worker may treat outside an MPN. LC 4616.3(b) provides for the notice requirements of an MPN. Importantly, the statute provides that there must be a "denial of medical care" to permit an injured worker to treat outside of the MPN. LC 4616.3(b) provides that failure to simply post the notice pursuant to LC 3550 "shall not be a basis for the employee to treat outside the network unless it is shown that the failure to provide notice resulted in a denial of medical care."

Another important change is contained in LC 4603.2(a)(2). Per this statute, if there is a dispute regarding whether an employee improperly sought treatment outside of an MPN, and the WCAB determines the worker was entitled to treat outside the MPN, the worker may continue to treat with "that" physician. This should eliminate requests to transfer care from one physician to another outside of the MPN. However, if the employee continues to treat with "that physician," the employer may not require the worker to transfer care back into an MPN.

TREATMENT LIMITS/CHIROPRACTIC TREATMENT

LC 4604.5 was amended and provides a limit of no more than 24 chiropractic, 24 occupational therapy and 24 physical therapy visits per each industrial injury occurring on or after 1/1/04. An employer may authorize more than 24 visits; however, doing so is not a waiver of the treatment limits. Therefore, an employer should not have to worry that authorizing a few visits over 24 will open the door for unlimited treatment.

SB 863 amended LC 4600(c). This statute provides that chiropractors may serve as a primary treating physician; however, after the maximum number of chiropractic visits (24), a chiropractor is not to serve as the treating physician.

INDEPENDENT MEDICAL REVIEW (IMR)

SB 863 amends the handling of medical treatment disputes. These disputes will no longer be subject the AME and QME process or LC 4061 and LC 4062. The new process applies to all injuries occurring on or after 1/1/13 and it also applies to all utilization review decisions communicated to the requesting physician after 7/1/13.

LC 139.5 was added to the Labor Code and provides that the Administrative Director is to contract with one or more independent medical review organizations and one or more

independent bill review organizations to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4.

Pursuant to LC 4604, medical treatment disputes will be controlled by the IMR process. Following an IMR, an aggrieved party may not seek review by the WCAB. LC 4610.5 provides that utilization review decisions are only to be reviewed or appealed by IMR. A worker must submit a request for IMR no later than 30 days after service of a utilization review decision.

LC 4610(h) provides that IMR determinations may be appealed with a verified appeal from the medical review determination of the administrative director, filed with the appeals board within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one of several limited circumstances outlined in the statute.

QME PROCESS

With unrepresented employees, LC 139.2(h) has been amended to reflect that if a 3 member panel has not been assigned within 20 working days, the employee may select a QME to perform an evaluation. The prior rule allowed the employer to select a QME if the panel was not assigned within 15 working days.

For represented employees, LC 4062.2 no longer requires the proposal of an AME before seeking assignment of a panel QME. There are also changes to the process of striking names from the panel. Per LC 4062.2(c), parties no longer have to attempt to agree upon one member of the panel. Parties may strike one name from the panel within 10 days of assignment of the panel by the administrative director. Also, if a party does not timely strike a name from the panel, the other party may designate any remaining physician as the QME. An employee is not to unreasonably refuse to participate in the evaluation pursuant to LC 4062.2(d).

INTERPRETERS

SB 863 provides that the Administrative Director is to adopt a fee schedule that applies to interpreters. Per LC 4600(g), interpreters who attend medical appointments are to be paid pursuant to this fee schedule. This statute provides that interpreters may be present during medical evaluations if the employee cannot effectively communicate with the physician. Interpreters at medical-legal evaluations, depositions and WCAB hearings will be subject to the fee schedule.

LIEN CLAIMANTS

SB 863 has many changes pertaining to lien claimants and lien filing.

For all liens filed after 1/1/13, there is a $150 filing fee. LC 4903.05(c). For liens filed before 1/1/13, there will be a $100 activation fee per LC 4903.06. If the activation fee is not filed on or before 1/1/14, the lien will be dismissed by operation of law pursuant to LC 4903.06(a)(5).

Per LC 4903.5, liens are not to be filed after three years from the date the services were provided, nor more than 18 months after the date the services were provided, if the services were provided on or after 7/1/13. For services provided on or after 7/1/13, the statute of limitations for filing a lien is 18 months, which is much shorter than the current filing limit.

Pursuant to LC 4903.6, liens are not to be filed with the WCAB until 60 days have passed from either claim acceptance or denial or expiration of the time for investigating liability of a claim in accordance with LC 5402(b), which is 90 days after receiving notice or knowledge of an injury.

Per LC 4903.6, lien claimants must provide notice to the WCAB within 5 days when they obtain representation or change their representative.

LC 4903.8 limits the ability to assign liens. Only if the original lien claimant is no longer doing business in the capacity it held when the expenses were incurred, may payment be made to an assignee. Also, lien assignments must be filed with the WCAB.

DEATH BENEFITS

Pursuant to LC 4701, reasonable expenses for an employee's burial have been increased to $10,000 for injuries occurring on or after 1/1/13.