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LEGEND:

Reg. = California Code of Regulations, Title 8, Industrial Relations effective 2015

LC = Labor Code 2015 Update

DISPOSITION OPTIONS

Stipulations with Request for Award
In represented cases, the parties reach agreement as to the level of permanent disability described by the medical and medical/legal record. In unrepresented cases, the parties generally agree to the rating produced by DEU. In both cases, the agreement is formalized within the context of Stipulations. In the overwhelming majority of cases, some provision for future medical care at the expense of the Employer is included. Applicant may Petition to Reopen for New and Further Disability, including T.D., P.D. within five years of date of injury. The Award of future medical treatment is a "lifetime" provision. Stipulations with Request for Award is typically the preferred disposition when the injured worker continues to be employed by defendant. The permanent disability is paid in weekly installments.

Compromise and Release
Often termed "full and final" settlement, the Compromise and Release compensates the injured worker for all accrued and future indemnity benefits and includes additional monies for applicant's future medical needs and rights to reopen. The injured worker cannot reopen the case after Compromise and Release in the event of new and further disability. The Employer has no continuing liability to provide medical care. The interests of Medicare must be considered. Dependent on Employee's Medicare status, a Medicare Set Aside may be requested. The C&R only settles issues within the jurisdiction of the WCAB unless otherwise stated. The proceeds of the Compromise and Release are paid in lump sum. This is the preferred disposition if the Employee is no longer working for the Employer.

The Open Medical Compromise and Release
This agreement compensates the injured worker for all accrued and future TD and PD benefits and like a regular Compromise and Release, the proceeds are paid in lump sum. However, under this agreement, the Employer remains liable for provision of future medical care.

Supplemental Job Displacement Benefit Vouchers
For injuries occurring O/A 1/1/13 an injured Employee shall be entitled to a supplemental job displacement benefit in the form of a non-transferable voucher up to an aggregate of $6000 unless the Employer makes an offer of regular, modified, or alternative work no later than 60 days of the first report received from either the primary Treating Physician, AME or QME finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability [LC §4658.7]. The regular, modified or alternative work offered must last at least 12 months. The $10K shall be offered to the Employee within 20 days after the expiration of the time for making the offer of regular, modified or alternative work. The voucher may be applied to education related retraining and skill enhancements, payment for occupational licensing or professional certification fees, payment for counseling or placement services (up to a combined limit of 10% of the amount of the voucher), computer equipment up to $1000, tools as required by training or educational programs and up to $500 as miscellaneous expense. Pursuant to LC §4658 (d), the voucher shall expire 2 years after the date the voucher is furnished to the Employee or 5 years after the date of injury, whichever is later. The Employee is not entitled to payment or reimbursement of any expenses that have not been incurred and submitted with appropriate documentation to the Employer prior to expiration. The settlement of the supplemental job displacement benefit is not permitted [LC §4658.7].

The value of supplemental job displacement benefit vouchers is unchanged for dates of injury between 1/1/05 and 12/31/12. However a voucher issued O/A 1/1/13 will now expire 2 years after the date the voucher is furnished to the Employee or 5 years after the date of injury, whichever is later. The Employee is not entitled to payment or reimbursement of any expenses that have not been incurred and submitted with appropriate documentation to the Employer prior to expiration [LC §4658.5(d)].

Fraud References
LC §5401.7 requires warning language on Notice of Claim form. Insurance Code §1871, et seq., defines basis for fraud and established penalties. Section 1871.8 permits warning on checks regarding fraudulent receipt of temporary disability. Section 1877, et seq., governs reporting, confidentiality, and immunity from civil liability.

LIENS

Filing
-$150 fee to file the lien O/A 1/1/13, recoverable if the lien claimant prevails [LC §4903.05]. Failure to pay the lien filing fee will result in the lien being invalid and not considered filed;
-For liens filed O/A 1/1/17 [LC §4903.05] amended to require lien claimant to file original bill and declaration under penalty of perjury that dispute is not subject to independent bill review or independent medical review and that lien claimant (1) is the PTP providing care through an MPN, (2) is an AME or QME, (3) provided authorized treatment, (4) conducted a diligent search and determined employer does not have an MPN, (5) has documentation that medical treatment has been neglected or unreasonably refused by employer, (6) can show that expense was incurred for an emergency medical condition or (7) is a certified interpreter rendering services at a medical-legal examination, copy service providing medical-legal services, or has an expense allowed as a lien under rules adopted by the AD. Failure to file a signed declaration results in dismissal of lien by operation of law. Filing a false declaration results in dismissal with prejudice after notice.

Fee Schedule
-Fees are determined by the Official Medical Fee Schedule as defined in Reg. 9791.1.
Re: Copy Services – AA has to make a request for records from defendant prior to utilizing a copy service.
Interpreters will have to be certified.

MPN
-Liens for unauthorized treatment are not allowed; Liens for treatment outside of a **valid** MPN are not payable and reports cannot be a **sole basis** for an Award;
-If Employer objects to treatment outside of the MPN, and there is a final determination that the Employee is entitled to select Treater outside of the MPN, then Employee is entitled to continue treatment at the Employer's expense
-indefinitely [LC §4603.2(a)(2)]. LC §4603.2(a)(2) does limit the indefinite treatment only to "that physician," may not be transferred to another physician. A refusal to provide care must be done cautiously, because Employer may lose medical control forever.

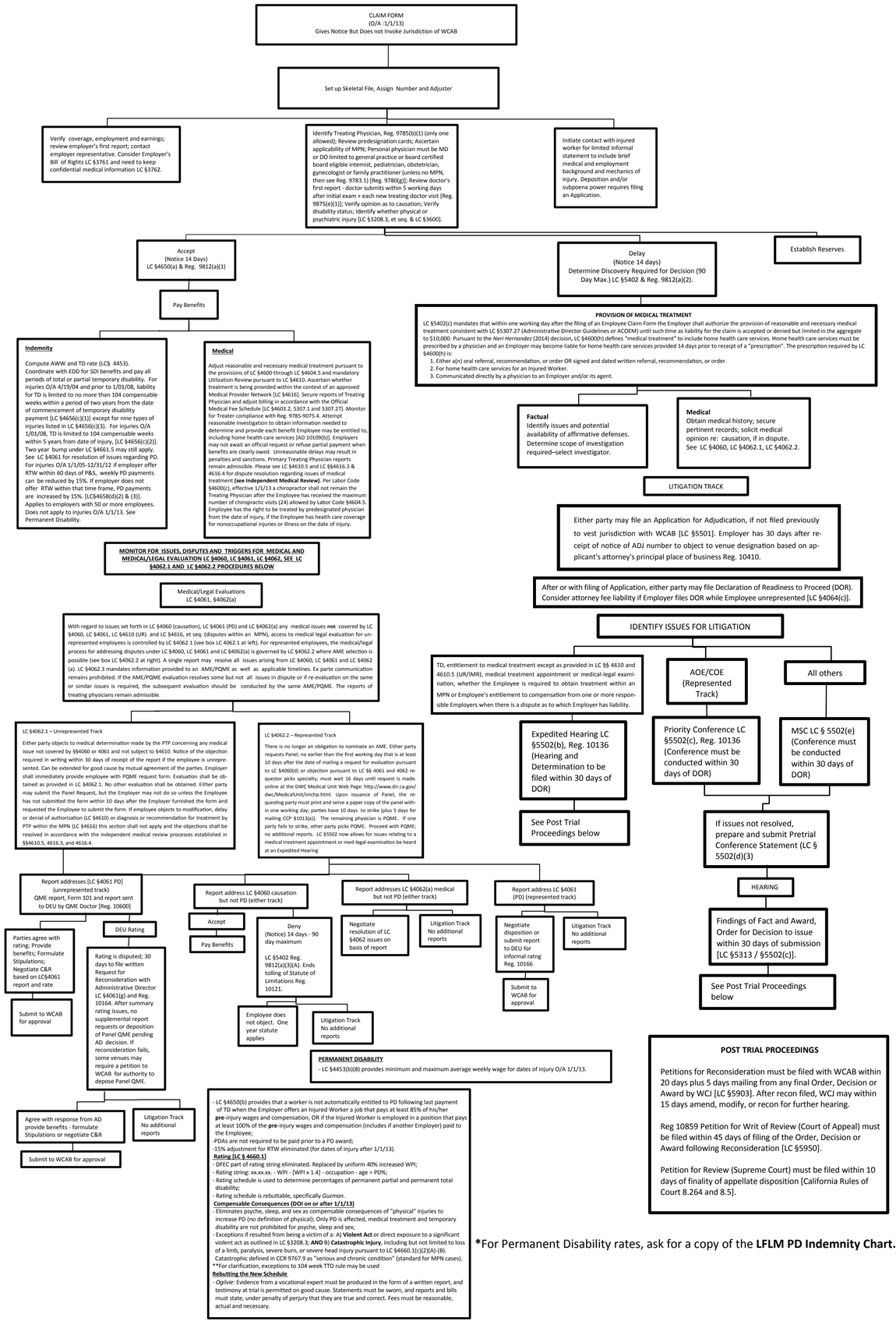
Service of Medical Records
-A non-physician lien claimant may receive medical information **only** with written approval of the Appeals Board [LC §4903.6(d)].

Statute of Limitations
-Liens for services before 7/1/13 have to be filed **within 3 years** from the date of service;
-Liens for services after 7/1/13 have to be filed **within 18 months** from the date of service [LC §4903.5].

Conflict of Interest
-No interested party may have a financial interest in another entity making a referral to it [LC §139.32]. Provision included that attorney violation could result in State Bar action.

INDEPENDENT BILL REVIEW
-Independent Bill Review (IBR) applies to any medical service bill with DOS O/A 1/1/13 and where the fee is determined by an established fee schedule;
-For liens filed O/A 1/1/17 [LC §4603.2] amended to require request for payment be submitted within 12 months of date of service or date of discharge for inpatient facility services, AD to establish rules/exceptions. Payment is barred unless timely submitted.
-IBR process will take medical billing disputes out of the jurisdiction of the WCAB [LC §4603.2]. Lien claimant is entitled to 2 bill reviews by the Employer before proceeding to IBR [LC §4603.2(e)(1)];
-Effective 1/1/13 for **ALL** dates of service after 1/1/13;
-Provider must attach a copy of all reports showing the services performed [LC §4603.2], including itemization of home health care services provided;
-Payment must be made **within 45 calendar days** WITH an explanation of review pursuant to LC §4603.2(b)(1)(C) for each, separate, medical service.
-Pursuant to LC §4603.3(a), explanation of review **must** include:
1. Statement of the items billed and the amounts requested by the Provider to be paid.
2. Amount paid.
3. Basis for any adjustment, change, or denial of the item or procedure billed.
4. Additional information required to make a decision for an incomplete itemization.
5. Reason for the denial of payment if it's not a fee dispute.
6. Information on whom to contact on behalf of Employer if a dispute arises over the payment of the billing (must inform Provider of the time limit to raise any objection to payment or dispute [LC §4603.6].
7. Second review is pre-requisite to IBR.
8. Employer is not required to address or object to duplicate submission of medical services for which an EOR was previously provided.
9. Provider who disagrees with payment by Employer must request 2nd review to Employer **on standardized form within 90 days** of service of explanation of review or order of appeals board [LC §4622(b)(1)].
-Pursuant to LC §4622(b)(1)(A)-(E), request for 2nd review must include:
1. The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.
2. The party or parties requesting the service.
3. Any item and amount in dispute.
4. The additional payment requested with reasons.
5. Any additional information requested in the original explanation of review and any other information provided in support of the additional payment requested.
-If dispute is amount of payment, Provider may request IBR **within 30 days** of service of Employer's **second** review;
-If dispute is over issues other than the amount of the charges: A) **Provider does NOT** object to a denial by Employer in this situation **within 90 days** from service of the EOR that objected to all or part of bill, then neither the Employer nor the Employee are liable for the amount that was denied [LC §4622(a)(1)]; B) **Provider does object**, then DOR must be filed **within 60 days** of service of the objection because Legislature does not want these disputes awaiting resolution, irrespective of the case-in-chief;
-Failure by Provider to request IBR within 30 days results in bill being satisfied, neither Employer nor Provider liable for further payment. Time limit for submission of IBR may be tolled until threshold issue is resolved (i.e. Employer contesting liability);
-Request for IBR must be **on standardized form** prescribed by AD, must include several documents and must be served on Employer;
-Must include: Copies of the original billing itemization; Any supporting documents that were furnished with the original billing; Explanation of review; Request for 2nd review together with any supporting documentation submitted with it; Final explanation of the 2nd review.
-Fee is required when Provider seeking IBR;
-LC §4603.6(d) - AD to assign IBR **within 30 days** of request and final determination to be made within 60 days of receipt of AD assignment;
-LC §4603.6(c) - If IBR finds for Provider, Employer must reimburse Provider for fee **in addition to** amount owed on underlying bill;
-Determination of IBR deemed to be determination of AD, and is final and binding;
-IB Reviewer not afforded same confidentiality as Independent Medical Reviewer;
-Aggrieved party may file verified appeal from IBR **within 20 days** of service [LC §4603.6(f)];
-On appeal, IBR may only be set aside upon clear and convincing evidence of one or more of the following:
1. AD acting in excess of powers.
2. Determination procured by fraud.
3. Determination result of bias.
4. Determination result of plainly erroneous express or implied finding of fact.
5. IBR subject to material conflict of interest.

§4622: Payment of Med-Legal Expenses
Employer required to pay for med-legal expenses **within 60 days**; if Employer wishes to contest reasonableness of fees, must issue EOR within that time [LC §4603.3];
Employer to issue payment **within 20 days** of an order directing payment by the appeals board or the AD;
If Provider disagrees with first bill review/reduction and if a 2nd review is desired it must be requested **within 90 days of service or order**, or lien/bill is waived. Request must be submitted **on standardized form**;
Employer must respond to **request** for 2nd review with a final, written determination of the items in dispute **within 14 days** of request for 2nd.



*For Permanent Disability rates, ask for a copy of the **LFLM PD Indemnity Chart.**

ISSUES, DISPUTES AND TRIGGERS FOR MEDICAL AND MEDICAL/LEGAL EVALUATIONS
Labor Code Sections controlling as to procurement and admissibility of medical and medical/legal evaluations of injuries on or after 1/1/05.

LC §4060 (Causation)
This section applies to disputes over the compensability of any injury. This section shall not apply where injury to any part or parts of the body is accepted as compensable. Access to LC §4060 is by notice either that the Employer requests a comprehensive medical evaluation to determine compensability or that the Employer has not accepted liability, and the Employee requests a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained pursuant to the procedure set forth in LC §4062.1 (unrepresented) or LC §4062.2 (represented). If liability is not rejected within 90 days of filing of the claim form, injury shall be rebuttably presumed compensable [LC §5402]. See Mendoza v. Huntington Hospital 75 CCC 634 (Writ Denied by Supreme Court) holding Reg. 30(d)(3) invalid and that a defendant can obtain a Panel QME opinion after denial of the claim.

LC §4061 (Permanent Disability)
LC §4061 applies to disputes regarding nature and extent of permanent disability. Together with the last payment of TD, the Employer must issue a benefits notice regarding PD (none due, amount of PD due or deferral of PD pursuant to LC §4650(b)(2) and whether there is a need for continuing medical care. Either party may request a comprehensive medical evaluation to determine permanent disability.

LC §4062(a) (P&S Status/R TW/Medical Issues Not Subject to UR/IMR)
LC §4062(a) encompasses any medical issue not covered by LC §4060 and LC §4061 or subject to LC §4610 (Utilization Review) and LC §4610.5 (Independent Medical Review). Issues include industrial liability for medical treatment, in limited cases, P&S status and return to work. Access to medical/legal evaluation is triggered by objection to the medical determination of the Treating Physician (see LC §4062.1 and LC §4062.2 below). The objecting party shall notify the other party in writing within 20 days of the receipt of the medical report if the injured worker is represented by an attorney and within 30 days of receipt of the report if the Employee is unrepresented. A comprehensive medical evaluation is obtained pursuant to LC §4062.1 (unrepresented) or LC §4062.2 (represented) below.

LC §4610 (Utilization Review)
For concurrent or prospective requests for authorization, UR has five working days to modify, deny or delay treatment recommendations and request reasonable, appropriate information required to reach a decision. If additional information is timely requested, UR has up to 14 days from the date of the treatment request to modify, deny or delay treatment. For retrospective review, the determination must be communicated to the injured worker or his/her attorney within 30 days from the receipt of information reasonably necessary to make the determination. If the UR Determination certifies the recommended treatment, the treatment must be authorized. If the UR Determination denies or modifies the treatment recommendation, the injured worker's remedy is dispute resolution through the Independent Medical Review Process (see below). The Administrative Director has discretion to assess administrative penalties if UR is untimely.

LC §4610.5 (UR/Independent Medical Review)
For dates of injury O/A 1/1/13 issues subject to Utilization Review under LC §4610 shall be resolved pursuant to LC §4610.5 if requested medical treatment recommendations are modified, delayed or denied. [LC §4062(b)]. This section will apply to all UR disputes on Communicated to requesting physician O/A 7/1/13 regardless of DOI. UR is not required where liability is disputed or Employer disputes body part for which treatment is sought [LC §4610(g)(7)]. In the event of Utilization Review denial or modification, independent medical review is the injured worker's remedy for medical necessity disputes. A UR decision is invalid and not subject to IMR only where it is untimely. Under Dubon II, WCAB has power to determine non-medical disputes over timeliness of UR [LC §4610.5]. An unchallenged UR determination to modify, delay or deny stays in effect for 12 months from the date of the decision. No further action is required to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by change in facts material to the basis of the UR decision. There is no process for an Employer to dispute a UR determination. The Employee may submit a request for IMR no later than 30 days after the service of the UR decision. Along with the notice of UR determination the Employer shall provide the Employee with a one-page form indicating the Employee's rights and obligations prescribed by the AD and an addressed envelope to return to the AD or the AD's designee to initiate an independent medical review (IMR). If the Employer fails to provide the required notice the 30 day time period to request IMR is extended until the notice is provided. The Employee can provide medical documentation or other information concerning the Employer's or the physician's decision regarding the disputed medical treatment and any additional material that the Employee believes is relevant.

The IMR process may be terminated at any time upon the Employer's written authorization of the disputed treatment. An Employee may designate a parent, guardian, conservator, relative or other designee of the Employee to act on his or her behalf but not before the UR decision issues.

Within 10 days of the assignment of the IMR by the AD the Employer shall provide all of the Employee's medical records relevant to the current medical condition, current treatment being provided, disputed medical treatment requested by the Employee, all information provided to the Employee concerning Employer and provider decisions regarding the disputed treatment, any materials the Employer or Employee's provider submitted to the Employer in support of the request for disputed treatment, and any other relevant documents or information used by the Employer or its UR organization and any statements by the Employer or its UR organization explaining the reasons for the decision to deny, modify or delay the recommended treatment. The Employee is to receive a copy of the documents provided to the independent medical reviewer. IMR determination to be made in "lay" terms within 30 days. Thereafter the Employee has 30 days to file an appeal with the WCAB. Independent medical reviewers are confidential. The determination is deemed a determination of the AD and binding on all parties. The determination shall be presumed correct and shall be set aside only upon proof of clear and convincing evidence that the AD acted without or in excess of the AD's powers, the determination was procured by fraud, conflict of interest, bias or plainly erroneous mistake of fact that is a matter of ordinary knowledge or information. If reversed by the WCAB the matter is remanded to the AD for IMR by a different reviewer. Where the determination of the AD is upheld the Employer must implement the treatment unless liability is disputed for any reason other than medical necessity.

LC §4616 (Medical Provider Network/Independent Medical Review)
On or After 1/1/05, this section allows Employers and insurers to establish Medical Provider Networks (MPN) for provision of medical treatment to injured Employees. Employees who pre-designate a Treating Physician may be treated outside of the MPN if the Employee has health care coverage for non-occupational injuries on DOI, the doctor is the Employee's regular physician who retains the Employee's medical records and has directed treatment, and agrees to be pre-designated [LC §4600(d)]. Failure to provide this notice or post notice as required by LC §3550 shall not be a basis for treatment outside of the MPN unless it is shown that the failure to provide notice resulted in denial of medical care, [LC §4616.3(b)]. Treatment shall be provided in accordance with AD's guidelines [LC §5307.27]. Upon filing of the claim, the Employer shall arrange an initial medical evaluation within the MPN [LC 4616.3(a)]. The Employer shall notify the Employee of the MPN and the Employee's right to change Treating Physicians within the network after the initial visit [LC §4616.3(b)]. If the Employee disputes the diagnosis or treatment prescribed, the Employee may seek the opinion of another physician within the MPN [LC §4616.3(c)]. If the Employee disputes the diagnosis or treatment of the second physician, the Employee may seek a third opinion within the MPN [LC §4616.3(c)]. If the diagnosis or treatment remains disputed after the third opinion, the Employee may request independent medical review (IMR) [LC §4616.4(b)]. The request for IMR is triggered by the Employee's filing a one page form with the AD entitled "Independent Medical Review Application" [LC §4616.4(c), Reg. 9768.1]. The AD shall assign the independent medical reviewer. The Employer shall provide the independent medical reviewer with all medical records and other pertinent information [LC §4616.4(d)]. The Employee at his/her discretion may be examined by the Independent Medical Reviewer. The Independent Medical Reviewer shall report to the Administrative Director within 30 days. The AD shall adopt the determination of the Independent Medical Reviewer and issue a written decision [LC 4616.4(h)]. If the IMR determines that the disputed treatment or diagnostics is consistent with the AD's guidelines or ACOEM, the Employee may seek the treatment either within or outside the MPN [LC 4616.4(i)]. No additional examinations shall be ordered by the WCAB and no other reports shall be admissible to resolve any controversy [LC §4616.6] LC §4616, et seq., does not reference an Employer's right to object, only that of the Employee.
at an Expedited Hearing.

Apportionment
LC §4663 mandates that for a physician's report to be considered complete on the issue of permanent disability, it must include apportionment determination by finding 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 [LC §4663]. Note that LC §4663(e) precludes percentage apportionment to causation in cases involving presumed injuries to safety officers [LC §§3212 - 3213.2]. LC §4664 (b) mandates that if the Applicant has received a prior Award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at a time of any subsequent industrial injury. This largely eliminates the reduction of apportionment from a prior award by the Employee's claim of medical rehabilitation between injuries. LC §4664(c) acknowledges that the accumulation of all permanent disability Awards issued with respect to any one region of the body shall not exceed 100% over the course of the Employee's lifetime unless the most recent injury or illness is conclusively presumed to be total in character pursuant to LC §4662.

Penalties
Sanctions: LC §5813, Reg. 10561 provided up to $2,500 for tactics which are frivolous or solely intended to cause unnecessary delay for all Applications filed O/A 1/1/94.

Penalties: LC §4650(d) provides for a 10% self imposed penalty on any late payment of temporary or permanent disability.

LC §5814(a) imposes a penalty of up to 25% or up to $10,000, whichever is less, of the value of any payment of compensation unreasonably delayed or refused. Compensation as defined by LC §3207 includes every benefit or payment conferred by Division 4 including TD, PD, vocational rehabilitation, death benefits and medical treatment. If medical treatment has been timely authorized, and the only dispute concerns payment of a medical bill, the provisions of LC §5814(a) are not applicable though the Employer may be subject to a 15% increase as to the late medical bill pursuant to LC §4603.2 [§5814(e)]. The payment of any penalty pursuant to LC §5814(a) shall be reduced by any amount paid under LC §4650(d) for the same untimely disability payment [LC § 5814(d)].

LC §5814(b) penalties refer to those raised or pled by the Employer. If an Employer first identifies a potential LC §5814 violation, LC §5814(b) allows the employer, within 90 days of date of discovery, to pay a self-imposed penalty in the amount of 10% of the payment delayed in lieu of (up to) 25% penalty in subdivision (b), along with amount of payment delayed. This 10% self-imposed penalty in LC §5814(b) is not reduced by LC §4650(d) penalties and is in addition to LC §4650(d) penalties if the payment delayed is an indemnity benefit.

Upon the approval of a Compromise and Release, Findings and Award, or Stipulations and Orders by the Appeals Board, it shall be conclusively presumed that any accrued penalty has been resolved, unless the claim for penalty is expressly excluded under terms of the Order or Award [LC §5814(c)]. No penalty can be claimed more than two years after the delayed compensation due [LC §5814(g)].