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LEGEND:

Reg. = California Code of

Regulations, Title 8, Industrial

Relations effective 2015

LC = Labor Code 2015 Update

In represented cases, the parties reach agreement as to the level of permanent disability described by the medical and medical/legal record. I sented 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. Applicar nay 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 treat ment 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

DISPOSITION OPTIONS

Often termed "full and final" settlement, the Compromise and Release compensates the injured worker for all accrued and future indemnit benefits and includes additional monies for applicant's future medical needs and rights to reopen. The injured worker cannot reopen the case romise and Release in the event of new and further disability. The Employer has no continuing liability to provide medical care. Th interests of Medicare must be considered. Depending on Employee's Medicare status, a Medicare Set Aside may be requested. Several payers have started to waive CMS submission even where the CMS guidelines recommend it. The CMS review process, although recommended, h been understood to be voluntary. 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 Employe

The Open Medical Compromise and Release

his 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.

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 nor 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 ion 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 SJDB 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 (u 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 §4658.7(f), the voucher shall expire 2 years after the date the voucher is fur nished 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. As of 1/1/13, the supplemental job displacement voucher cannot be settled. However, it is still undecided whether this is the case where the settlement leave injury in dispute. See Beltran v. Structural Steel Fabricators, 81 Cal. Comp. Cases 1224 (W.C.A.B. 2016).

The value of supplemental job displacement benefit vouchers is unchanged for dates of injury between 1/1/05 and 12/31/12. However a vouch 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 locumentation to the Employer prior to expiration [LC §4658.5(d)].

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

-\$150 fee to file the lien O/A 1/1/13, recoverable if the lien claimant prevails [LC §4903.05(d)(1)]. Failure to pay the lien filing fee will result in the lien being

-For liens filed O/A 1/1/17 [LC §4903.05(c)] 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 AMF or OME. (3) provided authorized treatment, (4) conducted a diligent search and determined employer does not have an MPN, (5) has documentation that medical trea 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 terpreter 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 prejudic

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. Reg. §§9980-9983 & 9990-9994 Interpreters will have to be certified. Reg. §9795.3

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 Awarr

-If Employer objects to treatment outside of the MPN, and there is a final determination that the Employee is entitled to select treater outside the MPN, then Employee is entitled to continue treatment at the Employer's expense [regardless of the MPN]. mployer required to pay physician from date of initial evaluation if report submitted within 5 days. If report submitted later than 5 days after initial evaluatic

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;

he employer does not pay for services rendered before submission of the report. Labor Code §4603.2(a)(2).

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

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(b)(1)(B)] amended to require request for payment be submitted within 12 months of date of service or date of discharge

patient 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(f)]. 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(b)(1)(A)], 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)(2) 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

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.

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

y 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 8. Provider who disagrees with payment by Employer must request 2nd review to Employer on standardized form within 90 days of service of explanation

view 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.

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

-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(b)(2)]: 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, irrespe

tive of the case-in-chief:[LC §4622(c)]: -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 submis-

sion 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(e)];

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 Reviewe Aggrieved party may file verified appeal from IBR within 20 days of service [LC §4603.6(f)];

alf dispute is amount of payment. Provider may request IRR within 90 days of service of Employer's second review.

n appeal, IBR may only be set aside upon clear and convincing evidence of one or more of the following: [Per LC §4603.6(f)]: 1. AD acting in excess of powers.

3. Determination result of bias.

2. Determination procured by fraud.

4. Determination result of plainly erroneous express or implied finding of fact 5 IRR subject to material conflict of interest

§4622: Payment of Med-Legal Expenses imployer 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 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

nployer must respond to request for 2nd review with a final, written determination of the items in dispute within 14 days of request for 2nd.

Gives Notice But Does not Invoke Jurisdiction of WCAB Set up Skeletal File, Assign Number and Adjuster dentify Treating Physician, Reg. 9785(b)(1) (only one allowed); Revie erify coverage, employment and earnings itiate contact with injured eview employer's first report; contact edesignation cards; Ascertain applicability of MPN; Personal physivorker for limited informal tian must be MD or DO limited to general practice or board certified nployer representative. Consider Employe atement to include brief med Bill of Rights LC §3761 and need to keep pard eligible internist, pediatrician, obstetrician, gynecologist or cal and employment backgroun nfidential medical information LC §3762 mily practitioner (unless no MPN, then see Reg. 9783.1) [Reg. 9780 and mechanics of injury. Depos e)]; Review doctor's first report - doctor submits within 5 working day ion and/or subpoena power after initial exam + each new treating doctor visit [Reg. 9785(e)(1)]; uires filing an Application Verify opinion as to causation; Verify disability status; Identify wheth physical or psychiatric injury [LC §3208.3, et seq. & LC §3600]. C §4650(a) & Reg. 9812(a)(1 (90 Day Max.*) LC §5402 & Reg. 9812(a)(2) See LC §§3212 & 3212.2. C §5402(c) mandates that within one working day after the filing of an Employee Claim Form the Employer shall authorize the provision of reasonable and necessary medical tre istent with LC §5307.27 (Administrative Director Guidelines or ACOEM) until such time as liability for the claim is accepted or denied but limited in the aggregate to \$10,000 rsuant to the Neri Hernandez (2014) decision, LC §4600(h) defines "medical treatment" to include home health care services. Home health care services must be prescribed by a ysician and an Employer may become liable for home health care services provided 14 days prior to receipt of a "prescription". The prescription required by LC §4600(h) is: 1. Either a(n) oral referral, recommendation, or order OR signed and dated written referral, recommendation, or or pute AWW and TD rate (LC§ 4453). Coordinate wit 2. For home health care services for an Injured Worker. ons of LC §4600 through LC §4604.5 and mandatory Utilizatio DD for SDI benefits and pay all periods of total or partia 3. Communicated directly by a physician to an Employer and/or its agent uant to LC §4610. Ascertain whether treatment is being provided wi nporary disability. For injuries O/A 4/19/04 and prior context of an approved Medical Provider Network [LC §4616]. Secure 01/08, liability for TD is limited to no more than 104 mpensable weeks within a period of two years from t pliance with Reg. 9785-9785.5. Attempt reasonable investigation to te of commencement of temporary disability paymer C §4656(c)(1)] except for nine types of injuries listed y be entitled to, including home health care services [Regs.10109(b)]. Obtain medical history; secure perti dentify issues and potential availabi ers may not await an official request or refuse partial payment w \$4656(c)(3). For injuries O/A 1/01/08, TD is limited to ent records; solicit medical opinion 4 compensable weeks within 5 years from date of ity of affirmative defenses. Determine nctions. Primary Treating Physician reports remain admissible. Please se §4610.5 and LC §§4616.3 & 4616.4 for dispute resolution regarding issu jury, [LC §4656(c)(2)]. Two year bump under LC §4661.5 e: causation, if in dispute. See LC cope of investigation required-sele ay still apply. See LC §4061 for resolution of issues §4060. LC §4062.1. LC §4062.2. nedical treatment (see Independent Medical Review). Labor Code §461 nvestigator. garding PD. For injuries O/A 1/1/05-12/31/12 if emplo ated effective 1/1/18 to require that the AD adopt regulations to prooffer RTW within 60 days of P&S, weekly PD paym in be reduced by 15%. If employer does not offer RTW LITIGATION TRACK ithin that time frame, PD payments are increased by d the maximum number of chiropractic visits (24) allowed by Labo 5%, [LC§4658(d)(2) & (3)], Applies to employers with ! de §4604.5. Employee has the right to be treated by predesignated more employees. Does not apply to injuries O/A ician from the date of injury, if the Employee has health care coverage tional injuries or illness on the date of inju 1/13. See Permanent Disability. ther party may file an Application for Adjudication, if not filed previously to vest urisdiction with WCAB [LC §5501]. Employer has 30 days after receipt of notice of ADJ umber to object to venue designation based on applicant's attorney's principal place of business Reg. 10488. Venue may also be changed for good cause under LC §5501.6 NITOR FOR ISSUES, DISPUTES AND TRIGGERS FOR MEDICAL AND MEDICAL/LEGAL EVALUATI LC §4060, LC §4061, LC §4062, SEE LC §4062.1 AND LC §4062.2 PROCEDURES BELOW After or with filing of Application, either party may file Declaration of Readiness to Proceed (DOR) nsider attorney fee liability if Employer files DOR while Employee unrepresented [LC §4064(c **IDENTIFY ISSUES FOR LITIGATION** egard to issues set forth in LC §4060 (causation), LC §4061 (PD) and LC §4062(a) any medical issues not covered by LC §4060 4061, LC §4610 (UR) and LC §4616, et seq. (disputes within an MPN), access to medical legal evaluation for unre ntrolled by LC §4062.1 (see box LC 4062.1 at left). For represented employees, the medical/legal process for addressing dispu nder LC §4060, LC §4061 and LC §4062(a) is governed by LC §4062,2 where AME selection is possible (see box LC §4062,2 at right), a esolve all issues arising from LC §4060, LC §4061 and LC §4062 (a). LC §4062.3 mandates in entitlement to medical treatment except as provided in LC §§ 4610 and AME/PQME as well as applicable timelines. Ex parte communication remains prohibited. If the AME/PQME evaluation resolves 4610.5 (UR/IMR), medical treatment appointment or medical-legal exam AOE/COE it not all issues in dispute or if re-evaluation on the same or similar issues is required, the subs tion, whether the Employee is required to obtain treatment within an MPN d by the same AME/PQME. The reports of treating physicians remain admissible epresented Track r Employee's entitlement to compensation from one or more responsible oyers when there is a dispute as to which Employer has liability. riority Conference §4062.2 - Represented Track Expedited Hearing LC C §5502(c), Reg. 10785 §5502(b), Reg. 10782 Conference must be cone not covered by §§4060 or 4061 and not subject to §4610. Notice of the objection ests Panel; no earlier than the first working day that is at leas ired in writing within 30 days of receipt of the report if the employee is unrepr days after the date of mailing a request for evaluation purs Hearing and Determiducted within 30 days of 1060(d) or objection pursuant to LC §§ 4061 and 4062 requ . Can be extended for good cause by mutual agreement of the parties. Employer shal nation to be filed within nediately provide employee with PQME request form. Evaluation shall be obtained a ks specialty; must wait 16 days until request is made, online at t 30 days of DOR) nel Request, but the Employer may not do so unless the Employee has not submitted dicalUnit/imchp.html. Upon issuance of Panel, the requesting form within 10 days after the Employer furnished the form and requested the Em y must print and serve a paper copy of the panel within o to submit the form. If employee objects to modification, delay or denial of authoriz rking day; parties have 10 days to strike (plus 5 days for mailin on (LC §4610) or diagnosis or recommendation for treatment by PTP within the MPN (Lt 1616) this section shall not apply and the objections shall be resolved in accordance wit P §1013(a)). The remaining physician is POME. If one party fails fissues not resolved, prepare ike, other party picks PQME. Proceed with PQME; no additio pendent medical review processes established in §§4610.5, 4616.3, and 4616.4. ports. LC §5502(b) now allows for issues relating to a medical Proceedings below and submit Pretrial Conference Statement (LC § 5502(d)(3) Report addresses [LC §4061 PD] HEARING QME report, Form 101 and report sen but not PD (either track) to DEU by QME Doctor [Reg. 10600] indings of Fact and Award, Order for Decision to issue Parties agree with ithin 30 days of submissio ort to DEU fo ormal ratng R [LC §5313 / §5502(c)]. its; Formulate Stipu C §5402 Reg. ing is disputed; 30 day ions; Negotiate C&R ed on LC§4061 olling of Statute of port and rate istrative Director See Post Trial Proceedings below §4061(g) and Reg. 10164 ubmit to WCAE ssues, no supplementa ort requests or depo on of Panel QME pendir AD decision. If reconsider POST TRIAL PROCEEDINGS ion fails, some venues PERMANENT DISABILITY quire a petition to WCA Petitions for Reconsideration must be filed with WCAB within 20 um and maximum average weekly wage for dates of injury O/A 1/1/13. or authority to depose days plus 5 days mailing from any final Order, Decision or Award nel QME. by WCJ [LC §5903]. After recon filed, WCJ may within 15 days amend, modify, or recon for further hearing. C §4650(b)(2) provides that a worker is not automatically entitled to PD following last payment of en the Employer offers an Injured Worker a job that pays at least 85% of his/her pre-injury wages a Reg. 10832 Petition for Writ of Review (Court of Appeal) must be ppensation. OR if the Injured Worker is employed in a position that pays at least 100% of the prewages and compensation (includes if another Employer) paid to the Employee filed within 45 days of filing of the Order, Decision or Award fol-Stipulations or negotiate C&R PDAs are not required to be paid prior to a PD award; lowing Reconsideration [LC §5950]. Post Trial Proceedings: Five-1.5% adjustment for RTW eliminated (for dates of injury after 1/1/13). day mailing rule does not apply to Petitions for Writ of Review. See Rating [LC § 4660.1] Submit to WCAB for approva DFEC part of rating string eliminated. Replaced by uniform 40% increased WPI: Camper v. Workers' Comp. Appeals Bd., 3 cal. 4th 679 (Cal. 1992). Rating string: xx.xx.xx. - WPI - [WPI x 1.4] - occupation - age = PD%; Petition for Review (Supreme Court) must be filed within 10 days Rating schedule is used to determine percentages of permanent partial and permanent total disabil Rating schedule is rebuttable, specifically Guzz of finality of appellate disposition [California Rules of Court 8.264 Compensable Consequences (DOI on or after 1/1/13) ates psyche, sleep, and sex as compensable consequences of "physical" injuries to increase PD and 8.5]. (no definition of physical): Only PD is affected, medical treatment and temporary disability are not rohibited for psyche, sleep and sex; Exceptions if resulted from being a victim of a: A) Violent Act or direct exposure to a significant viole act as outlined in LC §3208.3(b)(2); AND B) Catastrophic Injury, including but not limited to loss of a mb, paralysis, severe burn, or severe head injury pursuant to LC §4660.1(c)(2)(A)-(B). Catastrophic defined in CCR 9767.9(e)(2) as "serious and chronic condition" (standard for MPN cases). *For clarification, exceptions to 104 week TTD rule may be used *For Permanent Disability rates, ask for a copy of the **LFLM PD Indemnity Chart.** Rebutting the New Schedule **LFLM has developed a flow chart specifically covering the Covid 19 rules. Ask for a copy

timony at trial is permitted on good cause. Statements must be sworn, and reports and bills mus

tate, under penalty of perjury that they are true and correct. Fees must be reasonable, actual and

SSUES, DISPUTES AND TRIGGERS FOR MEDICAL AND MEDICAL/LEGAL EVALUATIONS

abor Code Sections controlling as to procurement and admissibility of medical and medical/legal evaluations of injuries on or after 1/1/05.

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 bo s accepted as compensable. Access to LC §4060 is by notice either that the Employer requests a comprehensive medical evaluation to dete nine compensability or that the Employer has not accepted liability, and the Employee requests a comprehensive medical evaluation to etermine compensability. The evaluation shall be obtained pursuant to the procedure set forth in LC §4062.1 (unrepresented) or LC §4062. represented). If liability is not rejected within 90 days of filing of the claim form, injury shall be rebuttably presumed compensable [LC §5402 ee Mendoza v. Huntington Hospital 75 CCC 634 (Writ Denied by Supreme Court) holding Reg. 30(d)(3) invalid and that a defendant can obta

LC §4061 applies to disputes regarding nature and extent of permanent disability. Together with the last payment of TD, the Employer mu ssue 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 nee 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 Independent Medical Review). Issues include industrial liability for medical treatment, in limited cases, P&S status and return to work. Acces to medical/legal evaluation is triggered by objection to the medical determination of the Treating Physician (see LC §4062.1 and LC §4062. 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 epresented by an attorney and within 30 days of receipt of the report if the Employee is unrepresented. A comprehensive medical evaluati s 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 request reasonable, appropriate information required to reach a decision. If additional information is timely requested, UR has up to 14 day from the date of the treatment request to modify, deny or delay treatment. For retrospective review, the determination must be commi cated to the injured worker or his/her attorney within 30 days from the receipt of information reasonably necessary to make the determ ion. If the UR Determination certifies the recommended treatment, the treatment must be authorized. If the UR Determination denies nodifies the treatment recommendation, the injured worker's remedy is dispute resolution through the Independent Medical Review Proce: see below). The Administrative Director has discretion to assess administrative penalties if UR is untimely.

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 reque medical treatment recommendations are modified, delayed or denied. [LC §4062(b)]. This section will apply to all UR disputes on Commi cated to requesting physician O/A 7/1/13 regardless of DOI. UR is not required where liability is disputed or Employer disputes body part f which treatment is sought [LC §4610(i)]. In the event of Utilization Review denial or modification, independent medical review (IMR) is the njured worker's remedy for medical necessity disputes. A UR decision is invalid and not subject to IMR only where it is untimely. Under Dubc 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 t same physician for the same treatment unless the further recommendation is supported by change in facts material to the basis of the U decision. There is no process for an Employer to dispute a UR determination. The Employee may submit a request for IMR no later than 3 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 design ee to initiate an 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 egarding 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 m designate a parent, guardian, conservator, relative or other designee of the Employee to act on his or her behalf but not before the UR dec

Vithin 10 days of the assignment of the IMR by the AD the Employer shall provide all of the Employee's medical records relevant to t rrent medical condition, current treatment being provided, disputed medical treatment requested by the Employee, all information provi ed to the Employee concerning Employer and provider decisions regarding the disputed treatment, any materials the Employer or Employe rovider submitted to the Employer in support of the request for disputed treatment, and any other relevant documents or information us by the Employer or its UR organization and any statements by the Employer or its UR organization explaining the reasons for the decision deny, modify or delay the recommended treatment. The Employee is to receive a copy of the documents provided to the independent med cal reviewer. IMR determination to be made in "lay" terms within 30 days. Thereafter the Employee has 30 days to file an appeal with th WCAB. Independent medical reviewers are confidential. The determination is deemed a determination of the AD and binding on all partie The determination shall be presumed correct and shall be set aside only upon proof of clear and convincing evidence that the AD acter without or in excess of the AD's powers, the determination was procured by fraud, conflict of interest, bias or plainly erroneous mistake o 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 differei reviewer. Where the determination of the AD is upheld the Employer must implement the treatment unless liability is disputed for any reasc 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 treations. ment to injured Employees. Employees who pre-designate a Treating Physician may be treated outside of the MPN if the Employee has healt care coverage for non-occupational injuries on DOI, the doctor is the Employee's regular physician who retains the Employee's medica 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 .C §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 me cal care, [LC §4616.3(b)]. Treatment shall be provided in accordance with AD's guidelines [LC §5307.27]. Upon filing of the claim, the Employe shall arrange an initial medical evaluation within the MPN [LC 4616.3(a)]. The Employer shall notify the Employee of the MPN and the Empl ee's right to change Treating Physicians within the network after the initial visit [LC §4616.3(b)]. If the Employee disputes the diagnosis eatment prescribed, the Employee may seek the opinion of another physician within the MPN [LC §4616.3(c)]. If the Employee disputes liagnosis or treatment of the second physician, the Employee may seek a third opinion within the MPN [LC §4616.3(c)]. If the diagnosis eatment remains disputed after the third opinion, the Employee may request independent medical review (IMR) [LC §4616.4(b)]. equest for IMR is triggered by the Employee's filing a one page form with the AD entitled "Independent Medical Review Application" [§4616.4(c), Reg. 9768.9]. The AD shall assign the independent medical reviewer. The Employer shall provide the independent medical revie er with all medical records and other pertinent information [LC §4616.4(d)]. The Employee at his/her discretion may be examined by the ndependent Medical Reviewer. The Independent Medical Reviewer shall report to the Administrative Director within 30 days. The AD sha 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 Expedite

All others

MSC LC § 5502(d)

(Conference must be

conducted within 30

days of DOR)

** For Procedures and timelines for Public Safety claimants, please request a copy of the

LFLM Public Agency Guidebook

C §4663 mandates that for a physician's report to be considered complete on the issue of permanent disability, it must include app nent determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising o of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors bot before and subsequent to the industrial injury, including prior industrial injuries [LC §4663]. Note that LC §4663(e) precludes percentag Applicant has received a prior Award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at 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 wit respect to any one region of the hody shall not exceed 100% over the course of the Employee's lifetime unless the most recent injury or illne conclusively presumed to be total in character pursuant to LC §4662.

Sanctions: LC §5813, Reg. 10421 provided up to \$2,500 for tactics which are frivolous or solely intended to cause unnecessary delay for al Applications filed O/A 1/1/94.

nalties: 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 unre delayed or refused. Compensation as defined by LC 83207 includes every benefit or payment conferred by Division 4 including TD. PD. voc tional rehabilitation, death benefits and medical treatment. If medical treatment has been timely authorized, and the only dispute conc 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 t ate 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 pai under LC §4650(d) for the same untimely disability payment [LC § 5814(d)].

C §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 I 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 reduceby 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 conclusi presumed that any accrued penalty has been resolved, unless the claim for penalty is expressly excluded under terms of the Order or Awarc [LC §5814(c)]. No penalty can be claimed more than two years after the delayed compensation due [LC §5814(g)].

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