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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2013 WINTER CONVENTION

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I.

INTRODUCTION

The workers' compensation landscape has again changed dramatically. Enacted in August, 2012, Senate Bill 863 essentially took the workers' compensation legal community by surprise. It happened so suddenly that this major piece of legislation was not even on CAAA's radar at the time of their 2012 Summer Convention in late June. During this convention's legislative session, it was clear that there was some resentment with respect to the fact that CAAA had not been included in the negotiations leading up to the introduction of the bill (the exclusion must have been particularly painful when the director of industrial relations, Christine Baker, told the gathering that the negotiations and work leading up to SB 863 "took years"). All of the legislative panelists (Ms. Baker, State Senator Mike Rubio, and Teamsters' representative Rome Aloise) did a remarkable song and dance job in response to the CAAA moderator's repeated question, "Why couldn't we be in the room?" Teamster Aloise told the Convention that other parties to the negotiation wanted to emasculate the system, but that the union "did a good job of holding the line" for employees.

In essence, the implied answer to CAAA's repeated question was, "We didn't mean to cut you guys out, but we did." Ms. Baker half-heartedly rationalized that if they had let CAAA in, then the doctors and who knows who else would have wanted in as well.

In listening to the legislative panel and the commissioners, however, one thing was clear: there seemed to be a consensus that the system was broken; a common theme was that the system was inundated with liens (perhaps as much as 30% of reconsideration petitions involve liens, according to the commissioners), and the commissioners were tired of it.

Perhaps the real answer to CAAA's question could be an unspoken perception that the proliferation of liens and bogus claims had its genesis in the somewhat sizable portion of the applicant's bar (and workers' compensation medical community) who promoted a scorched earth litigation (the skin and contents type claim) and medical treatment (multiple referrals to everyone for everything) type of policy.

Senate Bill 863 makes some very significant changes in the law. Some areas, such as liens, are not as important to the Applicant's Bar, so they received minimal treatment at the

convention (although this paper will give them some more detail). We do know Mr. Ryan Sutherland of our Walnut Creek office did a very nice piece on Senate Bill 863 (The Defense Perspective and Observations on the California Applicants' Attorneys Association October 6, 2012 SB 863 Comprehensive Overview Seminar), which can be found on our firm's website: www.benthalelaw.com. Some of his excellent analysis will be included here.

II.

MEDICAL PROVIDER NETWORKS

There is still a significant number of applicants' attorneys who have deep distrust of medical provider networks, with these attorneys feeling that the MPNs are populated by hand-picked defense doctors who stand ready to wash applicants out. These attorneys have not seen most of the MPN lists which we have seen. Many well known applicants' doctors are on these lists, and the fact that they are on these lists does not seem to have affected the manner in which they render treatment. There seems to be a common perception among the attorneys that MPN doctors are threatened with expulsion by carriers if they do not do the carriers' bidding. This assumes that claims examiners have the luxury of time in which to do this, which they do not.

As will be seen in the section dealing with utilization review, some applicants' attorneys, however, are coming to the view that their clients might actually be much better off in MPNs, as it gives them more medical options.

That being said, it would be helpful for carriers to put together an MPN package which could be used as an exhibit for the purpose of establishing the validity and existence of their MPN, approved by the administrative director. This is because Labor Code § 4616(b)(1) provides that, upon a showing that the MPN has been approved by the administrative director, there is a conclusive presumption that it was validly formed (thus, no more nonsense with the demands from some applicants' attorneys for every scrap of paper which was generated in the MPN formation process). See Clifton v. Sears Holding Corporation, 2012 Cal. Wrk. Comp. PD 1.

Although there was some talk relative to the possibility of attempting to suspend or revoke the approval of MPNs pursuant to Labor Code § 4616(b)(5), the primary focus of attorneys still resistant to MPNs is directed to the concept of medical control.

One method of circumventing the MPN has always been the predesignation by an employee of a treating physician. Labor Code § 4600(d) permits the designation of a personal physician if the employee has healthcare coverage, either through or outside of the employer. The physician must be applicant's regular physician, and must have previously directed

applicant's medical treatment, and retain his records. There was some talk by applicants' attorneys of having their clients pre-designate their primary treating physician in a workers' compensation injury case, so that they could return to that doctor in the event of another injury. Theoretically, this might be possible, if that physician were a covered physician under the employee's healthcare plan.

Where MPNs exist, however, and there is an intent to pull an applicant out of the MPN, the primary struggles are going to be over medical control.

There is still some contention that there must be strict compliance with the MPN notice requirements (employer pre-injury notice, coupled with employer/carrier post-injury notice) in order to force an applicant to treat within the MPN. This relates back to the case of Knight v. United Parcel Service, 71 C.C.C. 1423 (en banc, 2006) which for a long time was said to stand for the proposition that an employer/carrier's failure to provide the required MPN notices was per se a neglect or refusal to provide medical treatment, which justified applicant's self-procuring care outside of the MPN. The en banc WCAB in Valdez stated this was a misreading of the case (this portion of Valdez was not criticized by the Court of Appeals decision, which itself was later vacated by the Supreme's Court's grant of review), and it is noted that Knight simply said that in the context of the provision of medical treatment, failure to provide required notices "may be a neglect or refusal" (the employer notices are referenced in Labor Code § § 3550 and 3551). This is now confirmed by Labor Code 4616.3(b), which provides a failure to provide notice alone does not justify an applicant leaving an MPN (the primary problem to be addressed is the so-called "bust out": applicant is treating with an MPN physician, becomes represented, and immediately self-procures outside of the MPN). The statute (as well as the superseded Valdez en banc decision) actually recognized the reality here, that the legislature favors the use of MPNs and has given carriers some degree of medical control so as to control costs (the policy behind giving employers control of medical treatment, as expressed in Zeeb v. WCAB, 32 C.C.C. 441 (1967)).

Recognizing the importance of the MPN, Labor Code § 5502(b)(1)(B) now extends the expedited hearing process to MPN issues. This section provides that MPN issues must be resolved before other treatment issues are addressed.

The approach applicants' attorneys are encouraging with respect to such hearings is litigation with respect to the issue of control, rather than with respect to whether or not there was substantial compliance with notice regarding the requirement of treating within the proper MPN. Primarily, this will relate to a claim by applicants that they are being denied care within the MPN, an argument which, if proven, would result in a forfeiture of employer control over medical care and justification for the employee to treat outside of the MPN (see Zeeb, supra.; Voss v. WCAB, 39 C.C.C. 56 (1974)).

In connection with the denied case, this issue should not arise (at least not until there is some concession, either by agreement or award, that the injury is compensable). Applicants' attorneys are seeing their primary opportunity for defeating an MPN requirement in connection with cases involving denied body parts. Some go so far as to claim that treatment must be authorized with respect to all claimed body parts on the claim form (one panelist asserting that when he lists "orthopedic, internal, and psyche", the MPN doctor has an obligation to treat all of this), and then if a physician fails to treat any of the claimed conditions, that is a denial of care.

There is actually some language in the MPN statutes which implies some support for this (which will be explored in the next section).

If the court determines that the applicant was obligated to treat within the employer's MPN, then defendant has no liability for self-procured treatment outside the MPN, nor does it have any liability for consequential consequence injuries related to that treatment. Labor Code § 4603.2(a)(3).

Applicants' attorneys take the position that, however, if the employee wins on the MPN issue, then he may permanently remove himself from the MPN. (In other words, the defendant cannot transfer the employee back.) That is based upon an interpretation of Labor Code § 4603.2(a)(2), providing that, if the employee prevails, he may select a free choice physician with whom he is entitled to treat "notwithstanding § 4616.2". Labor Code § 4616.2 relates to the requirement that the employer prepare and file a written continuity of care policy, and is the statutory basis for the employer's ability to transfer an injured employee's care from a "terminated" provider (a medical provider no longer within the MPN) to an MPN physician. On

its face, the statute appears to apply to circumstances where a primary treating physician is an MPN provider, but then is dropped from the network (i.e., "terminated").

The issue relates to the interplay between Labor Code § 4616.2, and Regulations 9767.9 (transfer of ongoing care into the MPN) and 9767.10 (relating to the continuity of care policy). The argument from CAAA's standpoint is that both of these Regulations are implementations of the statutory directive set forth in Labor Code § 4616.2 and, if this is a valid argument, then the judicial finding pursuant to Labor Code § 4603.2(a)(2) in favor of the employee does enable the employee to permanently escape from the MPN (at least through the duration of his case).

The defense argument is that the continuity of care policy relates only to a "terminated" provider, i.e., a medical provider who is formerly within the MPN. Quite frankly, that would make the § 4603.2(a)(2) language "not withstanding § 4616.2" somewhat meaningless, since applicant's free choice physician is not going to be an MPN member. The other argument, of course, is that a Regulation has to find its authority within an underlying statute, and the subject matter of Regulation 9767.9 certainly appears to be similar to the subject matter of Labor Code § 4616.2.

There will be litigation.

III.

MEDICAL TREATMENT AND UTILIZATION REVIEW

A. In General. There is still an awful lot of whining about utilization review (hand in hand with the whining about MPNs). To hear some tell it, utilization review is some sort of carrier conspiracy to foster a "culture" of denial of care. It is not.

The California legislature has mandated (Labor Code § 4610(b)) that every employer shall establish a utilization review process, and there is a $50,000.00 administrative penalty if the carrier fails to do so. Regulation 9792.12(a)(1). That does not sound like a carrier conspiracy.

The most significant effect of Senate Bill 863 as to utilization review relates to its attempt to remove utilization review from the adjudicatory process by way of a so-called streamlined independent medical review (IMR). To get to IMR, however, it is first required that there be a a valid utilization review and, despite the apparent legislative policy favoring the making of medical treatment decisions through utilization review, this is an area where fairly strict compliance with the timeline and notices is still required.

Thus, applicants' attorneys will be looking for procedural defects in the utilization process so as to be able to adjudicate treatment decisions which they think are beneficial to their case. In Becerra v. Jack's Bindery, 2012 Cal. Wrk. Comp. PD LEXIS 451, a Board panel held that an expedited hearing was a proper remedy for two utilization reviews which were defective in different ways. Compliance with Labor Code § 4062 was not required by the applicant in connection with the first treatment recommendation since it was not submitted to Utilization Review on a timely basis (strict compliance with the time requirements is required per SCIF v. WCAB (Sandhagen), 73 C.C.C. 981 (2008)). Although the second treatment recommendation was timely submitted to Utilization Review, the decision was not timely and/or appropriately communicated to the treating doctor (within 24 hours by facsimile or telephone to the treating physician, with the telephone decision being confirmed in writing within 24 hours for concurrent review, and two days of the decision for prospective review). See, for example, Regulation 9792.9(c)(3) and (4)). It is noted that a decertification decision needs to include a number of items (there are multiple regulations enacted regarding this, depending upon the date on which

the utilization review was conducted, and the date of injury, with an example of the information and documents to be included with the decision set forth in Regulation 9792.9(k), relating to utilization review decisions issued prior to July 1, 2013, for injuries occurring prior to January 1, 2013.)

It would appear, however, that even if utilization review requirements are not met, so as to justify the employee requesting an expedited hearing, it is still the employee's burden to prove that the treatment request is supported by substantial medical evidence. Corona v. Los Aptos Christian Fellowship Childcare, 2012 Cal. Wrk. Comp. PD LEXIS 459 (2012).

Assuming, however, that a utilization review is going to be appropriately completed, then there are two tracks, as follows:

B. Non-MPN Utilization Review Followed By IMR. When referencing utilization review, most of us think of the process established by Labor Code § 4610. As will be seen, however, this process does not apply to situations where the employee disputes recommendations (or lack thereof) of a treating physician within an MPN. The process commences with a request for authorization. Up to this time, the technically formal way of doing this was by way of a primary treating physician report as defined in Regulation 9792.6(o), but that is going to change. Although it is unclear what the final regulations are going to look like, the emergency regulations (amendments to Regulation 9785(g) and 9792.6.1(t)) provide that treatment authorization requests will now be submitted on a specific form, entitled "Request for Authorization of Medical Treatment," DWC form RFA. The request procedure is no longer limited to the primary treating physician, as the form may be submitted by "a treating physician", (old Regulation 9792.6(o) remains in effect until July 1, 2013, for injuries occurring prior to January 1, 2013). The new RFA form is specific with respect to what type of treatment is requested, and why (something a lot of PR-2 forms have been lacking; we think doctors are going to have to make an attempt to make these forms legible, since they are a key part of the IMR process).

If the medical treatment is certified and authorized, then that is the end of the process. However, if there is a modification, delay, or denial of requested treatment, then, within the timeframes established by statute and regulation, the carrier shall provide to the physician and

applicant (or representative) the decision (Regulation 9792.9.1(e)(5). Included in the decision is the date on which the RFA was received, the date on which the decision was made, a description of the specific course of treatment for which authorization was requested, a list of all medical records reviewed (we think this also includes the notes/recommendation of the consultant nurse), a description of the treatment approved, an explanation of the reasons for the decertification, and a fully completed (with the exception of signature) application for Independent Medical Review, DWC form IMR-1, together with advice relating to the IMR procedure. The employee has 30 days in which to appeal the utilization review decision (Labor Code § 4610.5(h). IMR is deferred if there is a dispute with respect to any issue other than medical necessity, such as parts of the body; and actually, utilization review is not even required under these circumstances per Labor Code 4610(g)(7).) There are multiple requirements on the carrier with respect to timeframes, documents to be provided to the independent review organization (Labor Code § 4610.5(l)), and delays by the carrier toll the employee's time requirements, as well as subjecting the carrier to administrative penalties.

Labor Code § 4610.6 establishes the procedure for the Independent Medical Review process, setting forth time limits, providing that the determination of the independent medical reviewer is deemed to be the determination of the Administrative Director and providing for very limited review by the WCAB (the merits of the medical necessity decision are immune from attack as it is pretty much conclusively presumed correct. Labor Code § 4610.6(h)). It may be somewhat difficult to establish the actual grounds for appeal (conflict of interest, bias, fraud) since the identity of the actual utilization reviewer is to remain anonymous (the statute does not actually reference a specific individual, but speaks in terms of the IMR being performed by "the independent medical review organization").

There is no provision for evaluation of the employee by the independent medical review organization and final utilization review decisions are deemed to be in effect for a year (Labor Code § 4610(g)(6)).

Significantly, medical-legal evaluators selected under the medical-legal statutory system (Labor Code § 4060 et. seq.) are precluded from rendering opinions with respect to medical treatment issues (except with respect to issues of future medical treatment). There was some question raised with respect to whether this preclusion actually relates to Panel Qualified

Medical Examiners, since Labor Code § 4062.2 specifically precludes the comments only by Agreed Medical Examiners (subdivision (f)). However, we do think the preclusion applies to Panel Qualified Medical Examiners by virtue the general enabling statute: Labor Code § 4062(b) provides that utilization review objections pursuant to Labor Code § 4610 are to be resolved only in accordance with the independent medical review process.

C. MPN-IMR. If an applicant is treating within an MPN, the procedures relating to utilization review where an applicant objects to a treating doctor's opinions are actually substantially different. The general enabling statute here is Labor Code § 4062(c), and actually may broaden the decision making process to include a parts of the body dispute. For example, in connection with non-MPN medical treatment, Labor Code § 4062(b) references a utilization review decision made in connection with a modification, delay, or denial of a request for authorization of medical treatment. On the other hand, Labor Code § 4062(c) references an employee's objection to a "diagnosis or recommendation for medical treatment". The big issue here relates to the "diagnosis". It may not be as onerous to defendants as applicants' attorneys may think, since these review provisions (Labor Code § 4062(b) and (c)) are objections/appeal provisions which are available only to the applicant. The character of independent medical review (once it gets to that stage), is probably necessarily limited to the medical necessity of medical treatment; we do not think the program is really designed to confirm actual diagnosis and/or causation (but as will be seen below, the statute may be susceptiable to such an interpretation).

In any event, the MPN review process, as it relates to an applicant's objection to a medical decision made by his treating physician in the MPN begins with applicant's resort to the second and third opinion process (note that the applicant is not objecting here to a utilization review decision, but to a decision made by his own treating physician). The second and third opinion process is described in Labor Code § 4616.3(c), and if the employee remains dissatisfied, then the employee is to follow the procedure set forth in Labor Code § 4616.4(b) through (h), with Labor Code § 4616.4(i) providing that an applicant is entitled to drop out of the MPN if the independent medical reviewer disagrees with the MPN physicians regarding treatment (including a diagnostic service,a lthough there is no reference here to a "diagnosis.")

There is no right of appeal set forth in the statute at all with respect to this type of independent medical review.

Significantly, where an MPN is involved, medical-legal evaluators are permitted to comment with respect to the reasonableness and necessity of medical treatment (Labor Code § 4062.2(f) only extends its preclusion to the independent medical review process established under Labor Code § 4610.5). It is also noted that the independent medical reviewer in an MPN dispute is capable of conducting a physical examination of the applicant if the employee requests (Labor Code § 4616(e)). To a certain extent, this difference may enable the utilization reviewer to render opinions with respect to diagnosis and causation, and it is noted that Regulation 9767.7(g) requires the carrier to permit recommended treatment within the MPN.

We are certain there is going to be litigation with respect to whether, in connection with this MPN independent medical review, the employer actually has an appeal right in connection with an adverse determination with respect to a part of the body.

D. Fees. These have not yet been finalized, but it appears that the carrier is going to be paying fees in the area of $400.00 to $600.00 for each independent medical review conducted.

E. Other Medical Treatment Issues. The good news is that after a chiropractor has exhausted the statutory maximums on treatment set forth in Labor Code § 4604.5(c), the chiropractor can no longer act as a primary treating physician (Labor Code § 4600(c)). One has to wonder, however, why it is that chiropractors are still permitted to be Qualified Medical Examiners.

IV.

LIMITATIONS ON COMPENSABLE CONSEQUENCES

In connection with injuries occurring after January 1, 2013, Labor Code § 4660.1(c) contains important limitations, providing that "there shall be no increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, arising out of a compensable physical injury", except that an increased rating for psychiatric injury is permitted if the consequential psychiatric injury results from being a victim of a violent act, exposure to a significant violent act, or catastrophic injury "including, but not limited to, loss of a limb, paralysis, severe burn, or severe head injury."

It is as important to understand what this does not mean as much as what it does. First, the only benefit which seems to be affected by this section is permanent disability.

Direct psychiatric injuries (the so-called harassment cases) or injury to organs (i.e., direct urologic injuries) are not affected by this limitation. Furthermore, Labor Code § 4660.1(c) specifically permits an employee to obtain medical treatment with respect to sleep or sexual dysfunction, or consequential psychiatric disorders, if that is needed (very similar to Braewood Convalescent Hospital v. WCAB, 34 Cal. 3d 159 (1983), which found that there was industrial responsibility for treating a non-industrial condition in order to effectively treat the admitted industrial condition).

Thus, the question is whether this statute will really be effective in curtailing the liens we have been seeing from the various sleep, sex, and psychiatric consultants to which applicants' free choice physicians routinely refer.

There are also going to be substantial issues with respect to how a physical injury is defined, as well as what constitutes a violent act or catastrophic injury.

With respect to the physical injury, we suspect that the key may be in the mechanism of injury itself. Most of us view physical injuries as being in the nature of orthopedic injuries, but we do not think that is necessarily true. Furthermore, a physical injury (for example, a direct injury to an applicant's genitals which results in a lack of sexual function) might have to be actually measured by one of the disabilities referenced in the section relating to that body part so, in that respect, the impairment would not actually be an "add on" (another example would be

the psychiatric trauma which results from a robbery, although that is probably covered by one of the exceptions).

We think a violent act is relatively easy to understand. It is certainly much narrower than the "sudden and extraordinary employment condition" described in Labor Code § 3208.3(d), although that term is certainly broad enough to encompass a violent act or exposure to a significant violent act (these terms are actually used in Labor Code § 3208.3(d)(2), which lowers the threshold for establishing psychiatric injury in cases involving such acts).

All of the relatively few cases in workers' compensation examining these terms appear to involve what is essentially criminal activity by third persons: Woodland Joint USD v. WCAB, 65 C.C.C. 131 (writ denied, 1999), (principal observes student hit by a drunk driver in the parking lot); Hampton v. WCAB, 63 C.C.C. 1195 (writ denied, 1998) (practical jokes are not necessarily violent); Crandler v. The Customer Company, 2007 Cal. Wrk. Comp. PD LEXIS 47 (2007) (robbery); Abushi v. Burger King, Panel decision, Case No. SFO 492440, (2007) (robbery). Black's Law Dictionary defines violent as relating to or characterized by strong physical force, or resulting from extreme or intense force.

We actually think CAAA came up with a pretty good working definition of a violent act: something which is done or performed by a person intentionally, which occurs suddenly and unexpectedly, involves a considerable amount of physical force, and causes injury.

Considerably more difficult is the definition of catastrophic injury. We think the CAAA panelists are correct in their assertion that outcome is the key here, rather than the cause (in other words, apportionment does not play a role in determining whether or not an injury is "catastrophic"). The term "catastrophic injury" is actually used in a number of other statutes (Government Code Section 19991.13; Education Code Sections 44043.5 and 87045), although the context may be a bit different. The common theme, however, appears to involve a financial component. Villarreal v. Village of Schaumburg, 759 N.E. 2d 76 (2001): catastrophic injury refers to an injury that is financially ruinous. The examples contained in section 4660.1(a) (which are not exclusive) would also seem to suggest injury which involves significant impairment or disability.

CAAA panelists attempt to analogize the referenced injuries to impairment ratings (loss of a leg results in a 28% to 40% whole person impairment, depending upon where the amputation is; serious burns can rate at 20% WPI), for the purpose of attempting to show that a catastrophic injury may exist with a relatively low rating. Perhaps that is true in some cases (i.e., amputations), but we think one reason these examples may have been listed was to ensure that they would be included within exceptions despite the AMA Guides somewhat low WPIs with respect to them.

The bottom line is that catastrophic injury is going to be difficult to define, and is probably going to have to be decided on a case by case basis.

What applicants' attorneys are interested in doing, however, is attempting to categorize the precluded impairments (sex, sleep, and psyche) as something different under the Guides (urological injury, neurological injury, dementia), and obtaining an increased rating by this method. However, these "analogies" relate to physical or organic conditions, and we believe that the terms of the statute would preclude resort to an analogy for physical impairment.

The other argument relates to a situation where the actual physical injury results in no impairment, but there is a claimed psychiatric, sex, or sleep component. We do not believe this works either, since if the rating for the physical injury is "zero", reference to a psychiatric, sleep, or sexual dysfunction impairment which is said to be a compensable consequence of the physical injury, results in an "increase" of that impairment rating.

V.

RE-CHARACTERIZATION OF IMPAIRMENT BARRED BY LABOR CODE SECTION 4660.1(C)

For injuries occurring after January 1, 2013, Labor Code section 4660.1(c) states that "there shall be no increase in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, arising out of a compensable injury."

Obviously, Applicant Attorneys believe that this will result in deflated impairment ratings. As such, they are already working on strategies to recapture this potential loss. A recurring theme throughout the conference was that physicians may simply re-characterize an injury in order to find a permissible basis for impairment with the focus being on finding impairment under Internal or Neurology specialties, instead of psych, sleep or sexual dysfunction.

Dr. Lisa Wolf opined that while psych impairment would be disallowed per Labor Code section 4660.1(c), some of the applicant's symptoms may cross over into other specialties which could be used to increase impairment ratings. For example, stress can be considered a psychiatric injury. Stress can also lead to ailments such as hypertension. Thus, an internist can be consulted to diagnose the hypertension and provide an internal impairment rating, which would encompass the underlying stress complaints.

Another theory is that Sleep could be recharacterized as a neurological injury. Specifically, under the AMA guides Neurology chapter, a physician may provide a neurological rating using the table for loss of consciousness, memory loss, clinical dementia, memory loss, etc; in other words, focusing on the effects of sleep loss, rather than the sleep loss itself. If the complaint is obstructive sleep apnea, this could be addressed by an internist as it can potentially increase the risk of hypertension, stroke, blood clots, weight gain, and diabetes. Again, the focus was on the effect, rather than on the cause. Presumably, a defendant may simply be able to show that loss of sleep is the underlying cause, and thus, the impairment should be barred per LC 4660.1(c).

Dr. Fred Kuyt, a urologist, discussed the interplay between sexual dysfunction and a corticospinal tract injury. The corticospinal tract conducts impulses from the brain to the spinal cord. Sexual dysfunction could be caused by an injury to the tract. If the injury is characterized as a corticospinal tract injury, then a neurologist would be consulted and impairment rated under the neurology chapter of the AMA guides. Essentially, the physician would focus on the underlying cause of injury, rather than the effect, in order to avoid the implications of Labor Code 4660.1(c).

Another example of looking at the underlying cause occurs in cases of hip injuries. According to Dr. Kuyt, a pelvic fracture can cause sexual dysfunction. Clearly, the impairment of the hip is allowable, but the additional impairment for sexual function is not. It seems that a physician may simply use Almarez/Guzman to recover any loss of impairment under LC 4660.1(c).

Finally, this idea of re-characterizing an injury to increase impairment was discussed in the realm of Pain add-ons. Under the AMA guides, pain is limited to 3% WPI. However, a panel discussion on the effects of pain on the brain theorized that there could potentially be a separate neurological injury to the brain. This is based on the idea that pain is perceived by the brain. As impairment ratings for neurology can exceed 3%, it may be in the best interest for the applicant's attorney to pursue injuries such as chronic pain syndrome or fibromyalgia. The physician then would likely attempt to rate the neurological impairment using Activities of Daily Living or Almarez/Guzman.

Overall, most of these discussions were just theories at this point. Whether Applicant Attorneys or physicians actually try to push these ideas remains to be seen. We might see an increase in referrals to internists and neurologists to make up for the psych impairment loss.

VI.

REBUTTING THE PERMANENT DISABILITY SCHEDULE

In enacting Senate Bill 863, the legislature found that the current workers' compensation system had become overly litigious, time consuming, procedurally burdensome, and unpredictable (Section (b)), but that while the system needed fixing, "it is not the intent of the legislature to overrule the holding in Milpitas Unified School District v. WCAB (Guzman), 187 Cal. App. 4th 808 (2010)". On the other hand, we note the other very significant decision (Ogilvie) was not mentioned, so we can probably assume that the legislature had a different intention with respect to that. (During the commissioner's report, Commissioner Moresi essentially pronounced Ogilvie dead; he softened that a bit having been reminded that the commissioners had not yet been called upon to rule on the issue). However, since Ogilvie was a case which specifically related to a rebuttal of the future earning capacity component of the permanent disability schedule, last rites are probably in order, since Senate Bill 863 has eliminated this component from the rating schedule. (See Labor Code § 4660.1(a).) Future earning capacity is retained as an element of the permanent disability schedule with respect to pre-January 1, 2013 injuries (Labor Code § 4660(a), so Ogilvie may see some continued use in connection with those injuries.

Obviously, with Ogilvie out, there is an issue with respect to the role of vocational evaluators in connection with post-January 1, 2013 injuries. It is thought that Lebouf still has life, but the role at this point in time may, therefore, be limited to total disability-type cases (whereas Ogilvie permitted rebuttals where there was less than total disability).

Many of the cases which we are seeing on review (while not being terribly precedential) are suggesting that vocational experts are receiving close scrutiny. Thus, in Mrozek-Payne v. SCIF, 40 C.W.C.R. 218 (2012), and Rodrigues v. WCAB, 77 C.C.C. 669 (2012), it was held that where the vocational expert did not do an individualized workup of the applicant, but instead relied upon general pronouncements regarding a psychiatric impairment (Mrozek), or did not take into consideration non-industrial, limiting factors (Rodrigues), the opinions of the vocational expert did not constitute substantial evidence. We do note Giroux Glass v. WCAB,

77 C.C.C. 730 (2012), which stands for the proposition that if an applicant's expert renders an opinion which is supported by substantial evidence, a decision will be based upon it if the defendant does not produce a competent rebuttal.

Dahl v. Contracost County, 40 C.W.C.R. 117 involved an Ogilvie analysis, and it was held that the percentage loss of earning capacity determined in such a case actually becomes the disability rating, in place of a disability rating which would be established by application of the permanent disability rating schedule.

It is noted that the vocational expert ambush conducted by some applicants' attorneys (designating a vocational expert to testify at the time of the MSC) is at an end. Vocational experts are now expected to submit their opinions by report (Labor Code § 5502(j)).

In connection with the Guzman type rebuttal, Olguin v. WCAB, 77 C.C.C. 585 (2012), again warns that attempted rebuttals which appear to be referencing factors of disability utilized under the old 1997 schedule are not going to be permitted (in this case, the doctor actually attempted an analogy by applying a percentage loss of ability with respect to the effected body part to the total loss of function with respect to that body part, an approach the Board felt was rooted in activity preclusions arising out of the 1997 schedule). However, in Fresno Unified School District v. WCAB, 77 C.C.C. 566, even where the AMA Guides provided that two types of impairments should not be combined (in this case, loss of motion and grip loss), the Board upheld the finding of the evaluating doctor who explained his reasoning that one impairment was not affecting the other, and that either impairment alone would not accurately assess the applicant's impairment.

VII.

THE MEDICAL-LEGAL PROCESS

The basic medical-legal process as set forth in Labor Code § 4060, et. seq. is essentially similar, with one substantial change. Utilization review issues based upon decisions pursuant to Labor Code § 4610 to modify, delay, or deny medical treatment are now specifically exempted from the normal medical-legal process. Labor Code §§ 4061 (introductory paragraph); 4062(b), as noted in the previous sections, provides that utilization review undertaken pursuant to Labor Code § 4610 is now exclusively reviewed through an independent medical review process.

Although objections with respect to specified issues covered by Labor Code §§ 4061 and 4062 still must be made, there is no longer a requirement that the parties must attempt to agree upon an Agreed Medical Examiner (Labor Code § 4060 does not require an objection, only a notice by the employer to the effect that a comprehensive medical-legal evaluation is being requested, or that liability is contested, and the employee has the right to request one). The basic procedure for requesting a panel is set forth in Labor Code § 4062.2. Quite frankly, it is unclear why three separate statutes (Labor Code §§ 4060, 4061, and 4062) are necessary to get to this point, but that is the way it is. Labor Code § 4062.2 now reflects the reality of current practice, by allowing the parties to agree upon an Agreed Medical Examiner at any time, except as to Labor Code § 4610.5 utilization review issues, and there is no longer any requirement that the parties attempt to agree upon one of the Panel QMEs before making a strike.

While Labor Code § 4605 still permits applicants to provide, at their own expense, consulting or attending physicians, a report prepared by such a physician cannot be the sole basis of an award of compensation, although Qualified Medical Evaluators and authorized treating physicians are required to address issues raised in the consulting or attending reports. Interestingly, Labor Code § 4061(i) provides no issue relating to permanent disability may be the subject of a Declaration of Readiness to Proceed unless there has first been a medical evaluation by a treating physician and by either an AME or Panel QME, so it would appear that applicants are not going to proceed to trial based upon the reporting of a free choice treater alone.

Labor Code § 4066, relating to the payment of attorney fees by the employer if the opinions of an AME are challenged by the employer at trial has been repealed, and Labor Code § 4064 has been amended to provide that, in the case of an unrepresented applicant, the employer is liable for attorneys' fees only upon the filing of a Declaration of Readiness to Proceed (thus, the employer is not liable for attorneys' fees when an Application is filed for the purpose of engaging in discovery).

The spinal surgery exception set forth in Labor Code § 4062 has now been repealed, and spinal surgeries are now treated like any other form of medical treatment. Labor Code § 5502(b) also adds medical-legal disputes as an additional subject for expedited hearings.

Relative to the myriad of regulations relating to the preparation and service of Panel QME reports (and the gamesmanship this can cause), we note Flores v. United Domestic Workers of America, 40 C.W.C.R. 219 (2012), where a Panel Qualified Medical Examiner failed to serve his report within 30 days of the evaluation as required by Regulation 38(a), and defendant objected, but did nothing else. The report was served, and the Board held, essentially, that defendant had waived the objection, as it had not perfected the objection by requesting a replacement Panel pursuant to Regulation 31.5 prior to the service of the PQME report. This, of course, appears to be an appropriate result (CAAA describes the case as standing for the proposition that a party is not entitled to a "Mulligan").

VIII.

LIENS

As noted, even though there have been substantial changes to lien procedures, this subject was not extensively covered during the convention (most applicants' attorneys tend to forget about the liens once the case is settled). However, from a defense standpoint, liens are a major problem, a concern which was shared by the Director of Industrial Relations, Christine Baker, during the legislative panel, and the participating workers' compensation commissioners during the commissioner's report. Even some of the applicants' panelists gave some lip service to the nature of the problem by observing that the days of hand-picked doctors with the primary view being getting the best disability results are probably over (although this remains to be seen).

The panelists' primary attention was with respect to the case of Torres v. AJC Sandblasting, 77 C.C.C. 1113 (en banc, 2012), which upheld the sanctioning of a lien claimant for attempting to proceed to trial with nothing more than a billing. The lien claimant placed its reliance on two old cases, Kaiser Foundation Hospitals v. WCAB (Kiefer), 39 C.C.C. 857 (1974) and Garcia v. I.A.C., 18 C.C.C. 290 (1953), which essentially stood for the proposition that, since it was difficult for lien claimants to prove up the elements of a workers' compensation case once an applicant was out of the picture, the only thing the lien claimant really had to do was show that the case-in-chief had been compromised and released, and that it had provided medical services which were related to the industrial injury. The court noted that those days were long gone, at least since the adoption of Labor Code § 3202.5 in 1993, providing that a lien claimant was required to meet its evidentiary burden of proof. Since the lien claimant in this case utterly failed to do this, it wasted the court's time, and sanctions were appropriate.

The panelists felt that this case has application beyond liens, and we think there is something to this. We think the rationale of this case may be appropriately applied to any attempt to proceed to trial, either with respect to liens, or with respect to the case-in-chief, where a party really has no evidence to present in support of its position. Quite frankly, we would be surprised if the rationale for imposing sanctions was ever applied to an applicant who insisted

upon a trial relating to the substantive merits of the case. Labor Code § 3202 still gives an applicant favored status, and it is no secret (except to some of the more rabid applicants' attorneys) that the playing field is dramatically slanted in applicants' favor (as one attorney once remarked at a convention several years ago: "I have a tremendous advantage; I represent applicants."). We could, however, see this rationale being applied against a defendant, possibly in a situation where a defendant was contesting an issue in the face of overwhelming medical evidence and/or other evidence in opposition to the defendant's position.

Senate Bill 863 does make an attempt to deal with the problem of liens. The statute of limitations, with respect to liens, has been tightened up by Labor Code § 4903.5, shortening the period for filing a lien to three years from the date of service with respect to services provided prior to January 1, 2013, and the 18 months after date of service for services provided after that date. If a healthcare provider was providing services on a non-industrial basis, it has 12 months from the date of knowledge that an industrial injury was involved in which to file its lien.

After January 1, 2013, there is a $150.00 filing fee for the filing of liens (Labor Code § 4903.05), or a $100.00 activation fee for liens already on file as of this date (Labor Code § 4903.06). Failure to pay these fees will result in a dismissal with prejudice of the lien at the time of a scheduled lien conference, or by operation of law as of January 1, 2014. In order to be entitled to a reimbursement of the filing or activation fee from a defendant, a lien claimant must show that it made a pre-filing demand for payment, and that it was awarded at least as much as its demand by the Board. Labor Code § 4903.07.

Furthermore, a lien claimant can no longer file its lien, and just sit on it for years. Rule 10582.5 provides that a lien claim may be dismissed for lack of prosecution either by petition (initiated in a similar manner as inactive case dismissals under Rule 10582), or on the Workers' Compensation Appeals Board's own motion if the lien claimant fails to file a DOR within 180 days after the lien claimant becomes a party (applicant's case is resolved, and the lien claimant becomes of record), or 180 days after a lien conference or lien trial at which the lien claim was ordered off calendar.

Putting a stop to the practice of non-medical lien claimants (interpreters, transportation companies, probably pharmacies and the like) demanding vast amounts of medical documents in

connection with lien disputes, Labor Code § 4903.6(d) provides that only medical lien claimants are entitled to medical information, without specific Workers' Compensation Appeals Board approval.

There are amendments to the medical payment statutes, which represent an attempt to remove from the Workers' Compensation Appeals Board the many lien claims which are filed for balances which exist after Fee Schedule payments have been made. There is going to be some revamping of the Fee Schedule, based upon amendments to Labor Code § 5307.1 (surgery center fees are going to be reduced somewhat, but unfortunately, it does not appear there is going to be much change with respect to compounded drugs, the astronomical charges for which have essentially been validated by the current Fee Schedule. It would appear that the most effective weapon which can be used in connection with compounded drugs is timely utilization review, since utilization review generally allows these prescriptions under only very limited and restricted circumstances).

The typical bill disputes, however, are going to be handled administratively. New Labor Code § 139.5 gives the Administrator Director the authority to contract with independent bill reviewers for the purpose of establishing the independent bill review system which is set forth in Labor Code § 4606.6. To take advantage of this system, a medical provider must exhaust its administrative remedies (the common complaint of defendants under the present system is that lien claimants do not do this), and Labor Code § 4603.2(e)(1) requires the provider to appeal an adverse audit within 90 days. If this appeal is not done, the audit is final, and the defendant has no further liability (Labor Code § 4603.2(e)(2)).

The statute provides that the dispute resolution system which follows applies only where the dispute relates to the amount of payment. We suspect we are going to see some argument from lien claimants that the statute should not apply to cases where the issue relates to "coding". Lien claimants frequently miscode medical procedures in order to justify higher payments under the Fee Schedule, and reviewers "re-code" so as to properly classify the procedure which was actually performed (and lien claimants claim that this is improper).

In any event, if the appeal does not satisfy the provider, then it may invoke the independent bill review process set forth in Labor Code § 4603.6, and the provider has 30 days

after the second review in which to request an IBR, or the carrier's review is final. There is a filing fee, and the medical provider is responsible to provide the relevant documents to the Administrative Director. Interestingly, Labor Code § 4603.6(e) provides that there is no obligation on the part of the defendant to serve medical reports on a lien claimant unless the independent bill reviewer so orders (thus, no more of the nonsense of a surgical center demanding service of a 10,000 page medical file because it did not like the audit). The decision of the independent reviewer is deemed to be the decision of the administrative director, and is presumed correct, with the same limited rights of appeal as exist with independent medical review in cases of utilization review.

Medical-legal liens, pursuant to Labor Code § 4620, are treated a bit differently. Labor Code § 4622(b) through (c), relates to the challenge of medical-legal objections. A provider is required to request a second review within 90 days of the services of the EOB. If it disagrees with the defendant's assessment with respect to what is reasonable, and if it does not do this, then the employer's decision is final. If a provider is still not satisfied after the second review, then the independent bill review provisions relating to medical treatment billings are utilized.

There is supposed to be new Fee Schedules being adopted with respect to interpreters, copy services, and home healthcare providers, and while there are emergency regulations in effect attempting to implement much of Senate Bill 863, we are not aware of final regulations having yet been adopted with respect to these schedules.

IX.

MISCELLANEOUS

A. Jurisdiction. Professional athlete cases really seem to stretch the rules relating to jurisdiction and the statute of limitations. California seems to bend over backwards to make its workers' compensation system available to professional athletes, even if all of their employment was with out-of-state teams and their contacts with California were limited to the occasional road games against California teams. Matthews v. Nashville, 77 C.C.C. 711 (2012) involved a member of the Tennessee Titans who signed a player contract agreeing that any workers' compensation claim he might have against the team would be adjudicated under Tennessee law. A binding arbitration clause of the collective bargaining agreement was invoked when he attempted to file a California workers' compensation claim and the arbitration award barred him from pursuing his claim in California. In an effort to overturn the arbitration award, the federal court found that the award was valid, and did not violate an explicit, well-defined, and dominant California policy.

The question is whether a contractual provision will preclude a player from litigating his workers' compensation case in California. Up to this time, California has not required much by way of contact for the purposes of exercising jurisdiction, but perhaps the true issue is not really jurisdiction. As a practical matter, what compelling interest could California have in extending California workers' compensation benefits to an applicant who is neither employed in the state (except for occasional visits), or is not even a resident of the state? Perhaps the real issue is "choice of law" (what state has the greatest interest in connection with the claim for benefits). California may have jurisdiction to decide this question, but just because it has the jurisdiction does not mean California law should be applied.

B. Temporary Disability. The 15% increase/decrease in temporary disability depending upon whether applicant receives an offer of work has been repealed by Senate Bill 863. A significant case on the subject, however, is City of Sebastopol v. WCAB, 77 C.C.C. 783 (2012), wherein it was held that a worker who did not miss a day of work as a result of his injury should not be subject to the 15% decrease in permanent disability, despite a timely offer of work

from his employer pursuant to Labor Code § 4658(b)(3). The court reasoned that the purpose of the statute was to encourage employers to return disabled workers to the labor market, and that there seemed to be no reason to create a return-to-work incentive when the employee had lost no time from work, and was currently working. Thus, it found this section of the statute to be inapplicable. Although the Court noted that it was not addressing the question of whether an employee in a similar circumstance who did not receive a timely notice of work would be entitled to a 15% increase, this same rationale would seem to apply.

Also with respect to temporary disability is Meeks Building Center v. WCAB, 77 C.C.C. 615 (2012), involving an injury of which we will likely see less and less (as it involved a pre-January 1, 2008 injury). Applicant attended a medical evaluation at the request of the defendant, which paid one day of temporary disability. After two years had passed, applicant became temporarily disabled, and the carrier refused to pay claiming that more than two years had passed since the first payment. The court held that the character of the temporary disability payment made in this case did not qualify as a temporary disability payment for the purpose of starting the clock under Labor Code § 4656 (the payment was actually made pursuant to Labor Code § 4600(e)(1)).

C. Nurse Case Managers: There appears to be an inherent mistrust by applicant attorneys in the use of a Nurse Case Manager (NCM) assigned by the insurance carrier. Several panelist encouraged attorneys to utilize a neutral and independent nurse case manager in complex cases.

If a NCM has already been assigned, the applicant's attorney may object and offer a list of proposed Agreed NCM. If they cannot agree, they may simply refer the applicant to their own NCM on the notion that it is considered treatment per Labor Code section 4600. In the alternative, they could file a Declaration of Readiness to proceed citing a treatment dispute.
Either way, this appears to apply to complex cases only, where the applicant's treatment or prescription use needs to be monitored. If the issue is put before the judge, this may simply be a question of reasonable medical necessity.

D. Discovery and Right to Privacy: In Southern California, some applicant attorneys have begun to challenge the most basic discovery devices, such as medical release forms sent

from the adjuster and subpoenas. The basic argument is that the requested information is too broad, and a simple workers' compensation claim does not open the book to the applicant's entire medical history. For example, if the Applicant is claiming a hand only, the applicant attorney's position would be that discovery should be limited to the hand.

In addressing subpoenas, rather than filing a Motion to Quash, the applicant's attorney may file a Regulation section 10281 motion. Essentially, this requests an order to stay the subpoena. The applicant attorney can file this motion and appear before the presiding judge ex parte, to obtain the order. This is much quicker than filing a Motion to Quash along with a Declaration of readiness to Proceed. In reality, this seems like a strategy that the applicant attorney would use in order to try and obtain attorney fees, rather than protect the applicant's privacy. If defendants obtain the records after the order is issued, then arguably, this could be a basis for penalties. The applicant's attorney would request fees for "enforcement of the order."

At this point, this issue may be confined to a couple of attorneys in Marina Del Rey. Additionally, Judge Levy, Marina Del Rey WCAB PJ, may be the only judge entertaining these types of motions. Generally, the court prefers that discovery issues of this sort be handled informally and without the need for WCAB intervention.

E. This is Strictly Academic. Rehabilitation has been dead for years, but the occasional case still pops up, probably the result of some applicant's attorney holding a forgotten about notice in their file, hoping for a big score on a retroactive award. Kroger Company v. WCAB, 77 C.C.C. 945 (2012) involved a defendant who filed a rehabilitation appeal with respect to a large retroactive VRMA award (about eight years), but did not file a Declaration of Readiness to Proceed as was required under Regulation 10955. Holding that the substantive requirement was the filing of the appeal, and that the additional requirement of the Regulation could not obviate defendant's compliance with the substantive requirements of the statute, it was found that the violation of the regulation was nothing more than a curable defect, that defendant's appeal was valid, and that the rehabilitation statute sunsetted on the retroactive award, so that it was a nullity.

XI.

CONCLUSION

The landscape has changed again. This presentation attempts to provide an overview of what the workers' compensation community may be facing, but we do not think anyone can guarantee what the ultimate outcome is going to be. There is likely to be some relief from the onslaught of lien claims which the Board presently faces, if for no other reason than that a substantial number of these disputes relate to the amount of payment. However, to the extent that there is still litigation with respect to the reasonable and necessity of services, those liens are going to remain in the system.

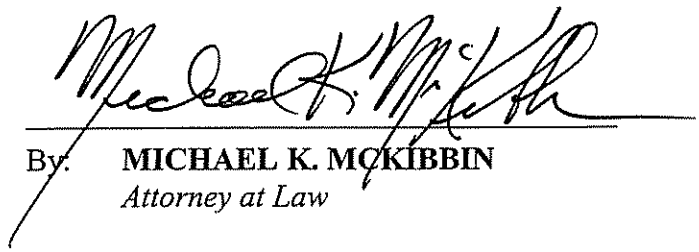
Assuming a carrier can comply with the multiple requirements relating to utilization review, the independent review process may take some pressure off the system. Quite frankly, an efficient use of utilization review may actually make use of the MPN unnecessary. In fact, the MPN statutes contain general language which suggests that the MPN review process (second and third opinions, followed by independent review) may actually supersede a defendant's ability to obtain a medical-legal evaluation on some aspects of causation. Given the character of some of the providers in many of the MPNs, that is not a good thing.

Many of the regulations which we have noted are emergency regulations. They may change in the coming weeks and months. There are new Fee Schedules to be adopted, which we hope will bring some semblance of sanity to some of the astronomical costs which applicants and their vendors have been trying to saddle on carriers. However, the only thing which can be said with certainty is that things are again uncertain, and we are just all going to have to see how it eventually shakes out.

If you have any questions with respect to this presentation, or any interest in seminars or continuing education, please contact us and we will be happy to assist.

Very truly yours,

BENTHALE, MCKIBBIN & MCKNIGHT



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