



California Workers' Compensation Institute

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SB 899 (Poochigian) Summary

Section 1, amending LC §62.5 – WC Administration Revolving Fund

- Reinstates 100% user funding for administration of the workers' comp program except for the Self-Ins. Program and the Return-To Work Program.
- Clarifies that employer's payments to the Workers' Compensation Administration Revolving Fund are paid through a surcharge and not an assessment.
- Funds to be expended by the DIR upon appropriation by the Legislature.

Section 1.5, adding LC §138.65 – Study of the Impact of the 2003 and 2004 Reforms

- Administrative Director to consult with the Insurance Commissioner
- Administrative Director to contract with "a qualified organization" to study the impact of the 2003 and 2004 reforms.
- Study to include: savings generated from reforms, rates, surpluses, worker compensation marketplace, as well as adequacy/accuracy of pure premium rate.
- Insurers to pay up to \$1 million for the study.

Section 2, amending LC §139.2 QME Appointment and Regulation

- Minor changes to reflect changes in other sections.
- Requires QME procedures for evaluation of PD with AMA Guidelines.
- Requires QME procedures for determination of disputed medical issues to be consistent with the ACOEM or AD Utilization Schedule, when adopted.

Section 3, amending LC §139.48, Return-to-Work Program

- Revises the 3-element AB 749 created program to reimburse employers only for workplace modifications with the same dollar limits.
- Funding from new 5814.6 pattern and practice penalties and transfers from the WC Administration Revolving Fund. (Note: Conflict with Labor Code § 62.5)
- Makes the state, local government and joint powers ineligible for the reimbursement program.
- Eligible employers are those with fewer than 50 full time employees on the date of injury.
- Eligible employees are those with a date of injury on/after 7/1/2004
- Sunsets 1/1/09.

**Section 4, repealing & adding LC §139.5, Supplemental Job Displacement Benefit/
Vocational Rehabilitation**

- Clean-up from AB 227
- The original 139.5 language is reinstated for Pre- 2004 injured workers.
- This language will sunset 1/1/2009
- Note: The Supplemental Job Displacement Benefit for 1/1/2004 and ongoing injuries is unchanged as the deleted language in 139.5 is also found in 4658.5.

Section 5.5, amending L C. §2699, Private Attorneys General Act

- Strengthens exclusive remedy by exempting both Division 1 and Division 4 of the Labor Code from the 2003 act.

Sections 6, 7 and 8, amending LC §§3201.5, 3201.7 and 3201.9, Carve-outs

- Parties to collective bargaining agreement may negotiate all aspects of delivery of group health and disability compensation if the employees are eligible for employer provided group health and non-occupational disability benefits.

Section 9, amending LC §3202.5, Equal Treatment of all Parties

- Requires all parties and lien claimants to meet the same evidentiary burden of proof on all issues by a preponderance of evidence.
- All parties to be considered equal before the law.
- Note: This does not repeal or affect the Liberal Construction Doctrine in L.C. §3202.

Section 10, amending LC §3207, Defining “Compensation”

- Clean-Up from SB 228
- Deletes vocational rehabilitation from definition.

Section 11, amending LC §3823 Fraud

- Clean-up from AB228
- Provides immunity from civil liability to insurers, self-insured employers, TPAs and others who comply with a 2003 mandate to report suspected medical provider and billing fraud.

Section 12, amending LC §4060: Compensability issues

- Represented injured workers to use LC §4062.2 process. (For dates of injury on/after 1/1/2005)
- Unrepresented injured workers to use LC §4062.1 process. Notice to employee is required. (No specific date is specified so the effective date of the new legislation, 4/19/04, applies.)
- Only admissible reports are from treaters and evaluations obtained as above.

Section 13, amending LC §4061: PD issues

- Represented injured workers to use LC §4062.2 process. (For dates of injury on/after 1/1/2005)
- Unrepresented injured workers to use LC §4062.1 process. (No specific date is specified so the effective date of the new legislation, 4/19/04, applies.) Form to employee is required but either party may request evaluation.
- Only admissible reports are from treaters and evaluations obtained as above.

Section 14, amending LC §4062: Medical issues

- States that this is not the correct process for initial UR disputes.
- Time frames for objection are unchanged
- Employee may object to a UR decision within 20 days
- Represented injured workers to use LC §4062.2 process. (For dates of injury on/after 1/1/2005)
- Unrepresented injured workers to use LC §4062.1 process. (No specific date is specified so the effective date of the new legislation, 4/19/04, applies.)
- Only admissible reports are from treaters and evaluations obtained as above.
- Note: Second Spinal Surgery Opinion is unchanged.

Section 15, repealing LC §4062.01: Objections to Medical Determinations**Section 16, adding LC §4062.1: Unrepresented worker QME procedures**

- Either party may request a Medical-Legal evaluation pursuant to L. C §§ 4060, 4061, or 4062-employer can not submit form unless the employee has not done so within 10 days of receipt of the form.
- Party submitting the form chooses the specialty.
- Within 10 days of receiving the 3 QME panel the employee is to select QME, schedule appointment, and inform employer.
- If employee doesn't inform employer of selection within 10 days, then employer may select the physician.
- If employee notifies employer of selection within 10 days but has not made the appointment, employer makes the appointment, notifies the employee and provides employee with travel expenses.
- If unrepresented employee has an evaluation under this section and later becomes represented, they are not entitled to another evaluation.

Section 17 and 18, repealing and adding LC §4062.2: Represented worker AME/QME procedures

- Effective for Dates Of Injury on/after 1/1/2005
- Either party may request a Medical-Legal evaluation pursuant to L. C §§ 4060, 4061, or 4062
- Either party may initiate process by sending the name of at least 1 physician to act as an AME.

- If no agreement within 10 days (or up to 20 days if agreed) either party may request a 3 QME panel.
 - Party submitting the request states their preferred specialty, opposing party's preference, if known, and specialty of the treater. Serve copy on other party.
 - Within 10 days of panel assignment, parties to agree on one QME. If not, each party may strike one name.
- Employee to set appointment but if not done within 10 days, employer sets, notifies employee and provides travel expenses.
- If represented employee has an evaluation under this section and later becomes unrepresented, they are not entitled to another evaluation.

Section 21, adding LC §4062.8, Educational materials for Treating Physicians

- Restatement from SB 228
- Administrative Director to have developed by 1/1/2004.

Section 22, repealing LC §4062.9 –Repeal of the Presumption of Correctness

- Presumption repealed for all issues and all dates of injury.

Section 23, amending LC §4600, Liability for Medical Treatment

- States that “reasonably necessary to cure or relieve” is defined as those services/goods that are based on utilization schedule adopted by the Administrative Director and the ACOEM guidelines until that adoption.
- 30-day employer medical control remains unless employer or insurer have established a Medical Provider Network.
- Pre-designation is still possible but only for employees whose employers provide non-occupational group health coverage via a HMO, Health Care Plan, HCO, or other entity described in Labor Code § 4600.5.
- Definition of pre-designated physician remains the same but the physician must agree.
- If the non-occupational health coverage is provided through an HMO or Health Care Plan, and the employee pre-designates as provided above, all treatment, access to care, UR and other medical care issues will be governed by laws regulating these plans (the Health and Safety Code)
- If non-occupational health coverage is provided through an HCO, or other entity described in Labor Code § 4600.5, all medical treatment, access to care, UR and other medical care issues will be governed by the Insurance Code.
- Insurer has the right to require pre-authorization of non-emergency treatment and to conduct “reasonably necessary” Utilization Review.
- Statewide limit for pre-designation is 7% of employees.
- Administrative Director to evaluate program and report to Governor and Legislature by 3/1/2006
- Repealed unless reinstated by 4/30/07
- Clarifies that regardless of date of injury, mileage is calculated at current rate.

Section 24, amending LC §4603.2, Reimbursement for Medical Services

- Current law requires insurer to pay uncontested portion of a bill and notify the provider of the reasons for the contested items. This has been amended to require the insurer to pay the maximum allowable fee in effect at the time of service and notify the provider of the reasons for the objection.
- Changes “billing” to “itemization” throughout the section.
- Clarifies that payment for medical services is controlled by the date of service.

Section 25, amending LC §4604.5, Treatment Guidelines Presumption

- Strengthens the presumption accorded to the ACOEM/AD-adopted treatment utilization schedule by adding requirements that the presumption can only be contested by a preponderance of “scientific medical” evidence.
- Clarifies that the presumption is one affecting the burden of proof.
- Clarifies that ACOEM/ utilization schedule adopted by the Administrative Director are presumed correct, regardless of date of injury.
- Adds a limitation of 24 occupational therapy visits during the life of a claim. This is in addition to the allowable 24 chiropractic visits and 24 physical therapy visits.
- SB 228 Clean-Up, Amended section to allow for authorizing more than 24 visits without losing other UR rights.

Section 27, adding Article 2.3, Chapter 2, Part 2, Division 4, Medical Provider Networks (Section 4616 to 4616.7)

- Employers and insurers may establish or modify provider networks to treat injured workers on or after 1/1/2005.
- The Medical Network provides all medical care for the life of the claim, subject to medical review.
- Networks must include occupational medicine specialists but at least 25% must be physicians who primarily treat non-occupational injuries.
- Network must include an “adequate” number of all types of physicians and allied health professionals
- Must provide timely medical treatment and must be “readily” accessible to employees.
- Network plan must be pre-approved by Administrative Director. Deemed approved 60 days after plan filed, unless approved earlier. HCOs, HMOs, group health insurers, and union health plans (Taft-Hartley) are deemed to have approval if they have a “reasonable” number of occupational physicians.
- All treatment shall be consistent with ACOEM/ utilization schedule adopted by the Administrative Director.
- Administrative Director to consult with the Department of Manage Health Care to devise regulations by 11/1/2004.
- If economic profiling is used, policies and procedures and their impact on UR, peer review, incentive and penalty programs, and provider retention and termination decisions must be filed with the Administrative Director and will be publicly available.

- Requirements for continuity of treatment and employee's right to request continued treatment with a terminated provider are required. Written continuity of care policy and any revisions must be filed with Administrative Director. Written notice of the policy must be provided to employees on request.
- Requires employer to arrange initial medical evaluation. Employee permitted to select a new physician from the network after the first visit.
- If employee disputes diagnosis or treatment, a second and third opinion must be obtained from within the network.
- After third opinion, employee entitled to an independent medical reviewer appointed by the AD. Employee may waive physical exam.
- Independent medical reviewer must use ACOEM Guidelines or AD-adopted utilization schedule in preparing his report. Report must be delivered within 30 day of the physical exam, with certain exceptions. AD must adopt the IMR's opinion and issue a written decision to the parties.
- If IMR believes service is consistent with ACOEM Guidelines or AD-adopted utilization schedule, the employee may receive the service either within or out of network.
- No other examinations shall be ordered by the WCAB and no others shall be admissible.

Section 28, amending LC §4650, Benefit payments

- Clarifies that PD payments must commence within 14 days of the last payment of TD, whether or not the extent of PD can be determined at that time.

Section 29, amending LC §4656, TD Benefit Cap

- For injuries on or after the effective date of the bill (4/19/04), TD benefits are capped at 104 weeks within 2 years of the date of the first payment of TD.
- Exceptions for certain specified injuries (Acute and Chronic Hepatitis B or C, Amputations, Severe Burns, HIV, High velocity eye injuries, Chemical burns to the eyes, Pulmonary Fibrosis, Chronic Lung Disease) are capped at 240 weeks within a 5 year period.

Sections 30 and 31, amending LC §§4658 and 4658.1, Permanent Disability Benefits.

- Applies to injuries on or after the effective date of a revised permanent disability rating schedule (Due 1/1/2005) per (d) (1). (A conflicting provision ((d) (4)) makes the new benefit payments applicable to injuries arising prior to 4/30/04 unless a treater or medical-legal report has already been completed indicating that the employee has a permanent disability, or the employer has already issued a PD notice at the end of TD.)
- Raises number of weeks of PD from 9 to 16 per 1% of disability for workers with disability ratings between 70 and 99.75%, and decreases the number of weeks payable to those with PD from .25% to 15% by 1 week/1% of disability.
- Increases the PD benefit by 15% if within 60 days of the P&S date, the employer fails to offer regular, modified or alternative work, as defined in §4658.1, lasting at least one year. Does not apply to employers with fewer than 50 employees.

- Decreases PD benefit by 15% if, within 60 days of the P&S date, the employer offers suitable regular, modified or alternative work lasting at least one year, whether or not the employee accepts the offer. Restores the 15% reduction if the employee is involuntarily terminated before PD has been paid out. Does not apply to employers with fewer than 50 employees.
- If employee voluntarily quits, the employee is not eligible for 15% increase.
- Provides definitions for regular, modified and alternative work that are slightly different from those found in the vocational rehabilitation section.

Section 32, amending LC §4660, PD Determinations

- Establishes a new method for determining the existence and extent of permanent disability.
- Eliminates consideration of the employee's post-injury ability to compete in the open labor market.
- Schedule to "incorporate" the worker's physical injury or disfigurement by preparing an impairment rating based on the AMA Guides 5th edition "descriptions and measurements" and the corresponding percentages of impairment.
- Age and occupation modifiers will continue to be applied to the rating.
- A formula to produce an estimate of the worker's future loss of earning capacity will be derived. from aggregate data re: average % of long term income loss for each type of injury (RAND Interim Report Dec. 2003 and other empirical data).
- Schedule to be public and prima facie evidence of the percentage of permanent disability attributable to each covered injury.
- Schedule to promote consistency, uniformity and objectivity.
- AD to adopt a new rating schedule by 1/1/05 and amend at least every 5 years.
- Applies to all injuries unless there has been a final treater report or medical-legal report indicating PD or the employer has been required to issue a 4061 notice at the end of TD.

Sections 33, 34 and 35 repealing and reenacting LC §4663, and adding LC §4664, Apportionment

- Requires apportionment to be based on causation of permanent disability and requires all reports addressing PD to address the apportionment issue, i.e. what portion is directly attributable to the job.
- States that a physician's report is incomplete if it does not address apportionment.
- If the physician is unable to make the determination, requires consult or referral to another physician to make the determination.
- Employee is required to disclose all previous permanent disability and physical impairments, upon request.
- Employer is only liable for the percentage of PD directly caused by the work injury.
- Creates a conclusive presumption that a previous permanent disability exists, if the employee received a prior PD award.
- Allows 100% PD for each of seven listed body regions over the employee's lifetime.

- A single 100% cap applies only to multiple injuries arising from the same industrial accident.
- LC §4750 and 4750.5 re: Limitation of Employer Liability for Combined Injuries are repealed

Sections 36, amending LC §4706.5, Non-Dependent Death Benefits

- In cases of fatality with no spouse, dependents or heirs, requires Claims Administrator to pay to the Department of Industrial Relations , an amount equal to that payable to a spouse with no dependent children.
- Also payable to Department of Industrial Relations is any accrued compensation. These funds go to the General Fund for credit against Subsequent Injury Fund Payments.
- Note: AB 749 requirement to make payment to the estate where there are no dependents remains unchanged.

Section 39, amending LC §4903.05, Lien Claimant Filing Fee

- SB 228 cleanup, Clarifies that the filing fee must be paid whether the lien is filed by a provider or on behalf of the provider.

Section 40, amending LC §5402, Immediate Medical Care

- Requires an employer to authorize medical care within one day of receipt of a claim form and to reimburse for all medical treatment provided in accordance with ACOEM or AD-adopted utilization schedule until the claim is accepted or denied up to maximum of \$10,000.
- Note: 90 day compensability presumption still applies.

Section 41, amending LC §5703, Acceptable Evidence

- WCAB to accept into evidence the ACOEM or AD-adopted utilization schedule.

Section 42 & 43, amending LC §5814, Unreasonable Delay Penalties

- Current law becomes inoperative 6/1/04 and is repealed on 1/1/05.
- New provisions operative 6/1/04.
- New section caps the penalty at the lesser of 25% or \$10,000.
- Penalty is based on the amount of the delayed or refused benefit.
- WCAB to accomplish a fair balance and substantial justice between the parties.
- Permits the employer to avoid 5814 penalty if the employer discovers a potential violation before the employee claims a penalty and, within 90 days of discovery, pays the amount owing plus the 10% self-imposed penalty.
- Conclusively presumes that any accrued penalty claims have been resolved unless a claim for penalty is expressly excluded from a C&R, F&A or Stipulation.
- Conclusive presumption that any accrued penalty claims have been resolved also applies on issues submitted at a regular trial hearing unless a claim for penalty is expressly included.
- Reduces the amount of the 5814 penalty by the amount of any self-imposed 4650 penalty paid.
- Eliminates liability for 5814 penalties for billing disputes as long as medical treatment has been provided timely. Note: Labor Code § 4610.1 exemption to penalty while Utilization Review process is on-going remains unchanged.

- Establishes a 2-year statute of limitations from the date payment of compensation was due.
- Clarifies that no civil cause of action is created by the section.
- Applies to all dates of injury.

Section 44, adding LC §5814.6, Pattern and Practice Penalty

- Effective 6/1/04
- Authorizes the AD to impose a penalty of up to \$400,000 on any employer or insurer who knowingly incurs 5814 penalties with such frequency as to indicate a general business practice.
- Monies collected will fund the Return To Work program.

Section 45, amending LC 6401.7, Injury & Illness Prevention Program (IIPP)

- Limits the scope of the insurer mandate to review employer IIPPs to those employers with experience modifications of 2.0 or higher.
- Provides greater flexibility in assigning personnel to review IIPPs by allowing the use of in-house personnel and personnel who work under the supervision of a Certified Safety Professional, Certified Industrial Hygienist, or California Professional Engineer.

Section 46

Repeal of the presumption of correctness shall not be cause to reopen, rescind, alter, or amend any existing order.

Section 47

Amendment, addition, or repeal of any law herein shall apply prospectively from the date of enactment, regardless of the date of injury unless otherwise specified but shall not be cause to reopen, rescind, alter, or amend any existing order.

Section 48

Provisions are severable.

Section 49

Contains urgency clause-shall go into effect immediately (4-19-04).