Overview of Senate Bill 863

Changes in Permanent Disability Benefits

Both the minimum and maximum weekly benefit amounts have been increased, with the increases being phased in over a two year period. At the end of those two years, the maximum weekly permanent disability rate will rise to $290.

How permanent disability ratings are calculated has also been changed. The current rating formula includes a modifier of between 1.1 and 1.4, depending on the body part that is injured. The modifier is intended to take into account the injured workers' diminished future earning capacity, if any, as a result of his or her injury. For injuries that occur on or after Jan. 1, 2013, the rating formula will no longer include the "future earning capacity modifier." Instead, all injuries will be adjusted by a factor of 1.4.

Under the current rating system, there are also modifiers based on the injured worker's age at the time of the injury, and his or her occupation. Those modifiers will continue to be used, and the Administrative Director of the Division of Workers' Compensation has been authorized to develop a new schedule of occupational modifiers, to allow for more accurate consideration of today's wide range of occupations.

Currently, Labor Code Section 4662 describes circumstances in which injured workers may receive a permanent disability award of 100%. That section has not been changed by SB 863.

Add-ons for permanent disability due to sleep disorders or sexual dysfunction resulting from physical injuries, which are now permitted, will no longer be available. Additionally, permanent disability add-ons for psychiatric injuries resulting from physical injuries are limited to "catastrophic" injuries and cases in which the injured worker was either the victim of a violent crime, or witnessed a violent crime.

"Pure" psychiatric claims which do not arise as a result of physical injuries are not affected by this change. Injured workers can still receive treatment for sleep problems, sexual dysfunction and/or psych consequences of their injuries, even if permanent disability is no longer available for them.

Changes to Supplemental Job Displacement

Under the current system, injured workers may be offered supplemental job displacement vouchers that can be used to pay for job retraining. The voucher amount is a sliding scale ranging from $4,000 to $10,000. The amount is based upon the injured worker's permanent disability rating, and it is not required to be offered until the permanent disability rating has been finally determined, either by way of an award by the Workers' Compensation Appeals Board (WCAB), or by a settlement agreement between the injured worker and his or her employer.

As a result of SB 863, the voucher amount will be fixed at $6,000 for all qualifying injured workers, and it is to be offered when the injured worker reaches permanent and stationary status and the treating doctor reports on work abilities and limitations resulting from the injury.

Creation of "Return to Work Fund"

SB 863 also establishes a $120 million per year "Return-to-Work Fund," to be established and administered by the DIR. Payments from the fund will be available to injured workers whose permanent disability ratings are disproportionately low in comparison to their wage loss. Eligibility for the benefits and the specifics of how the fund will be administered will be based on research to be performed by the DIR in consultation with the Commission on Health, Safety and Workers' Compensation (CHSWC).

Injured workers will be able to appeal decisions regarding Return to Work Fund eligibility or the amount to be paid out will be to the trial-level WCAB.

Introduction of Independent Medical Review

Another significant change is in how medical treatment disputes will be resolved. As of Jan. 1, 2013 for injuries occurring on or after that date, and as of July 1, 2013 for all dates of injury, Independent Medical Review (IMR) will be used to decide disputes regarding medical treatment in workers' compensation cases.

Under the current system, it typically takes nine to 12 months to resolve a dispute over the treatment needed for an injury. The process requires: (1) negotiating over selection of an agreed medical evaluator, (2) obtaining a panel, or list, of state-certified medical evaluators if agreement cannot be reached, (3) negotiating over the selection of the state-certified medical evaluator, (4) making an appointment, (5) awaiting the examination, (6) awaiting the evaluator's report, and then if the parties still disagree, (7) awaiting a hearing with a workers' compensation judge and (8) awaiting the judge's decision on the recommended treatment. In many cases, the treating physician may also rebut or request clarification from the medical evaluator, and the medical evaluator may be required to follow up with supplemental reports or answer questions in a deposition.

SB 863 replaces those eight steps with an IMR process similar to group health that takes approximately 40 (or fewer) days to arrive at a determination so that the appropriate treatment can be obtained.

IMR can only be requested by an injured worker following a denial, modification, or delay of a treatment request through the utilization review (UR) process. Employers and insurance carriers cannot request review of treatment authorizations.

An injured worker can be assisted by an attorney or by his or her treating physician in the IMR process.

There is a right to appeal an IMR determination, to the trial level WCAB, on the basis of fraud, conflict of interest, or mistake of fact. The reviewer's underlying medical decision-making, however, cannot be overturned by a judge. The remedy, if an appeal is granted, is referral to a different reviewer for another review.

IMR will not be available in cases in which there is a dispute over anything other than the medical necessity of a particular treatment requested by the injured worker's physician (such as cases where the injury itself is in dispute).

Improving Medical provider Networks

Medical Provider Networks (MPNs) have been criticized for including doctors who are no longer practicing, do not accept workers' compensation patients, or are otherwise unavailable to injured workers. Injured workers have also expressed frustration at not being able to obtain care in specialty areas, and doctors not being available within reasonable time frames.

SB 863 addresses these issues in several ways. First, the current requirement that 25% of doctors within an MPN practice in areas other than occupational medicine has been removed. Also, doctors are required to affirmatively confirm their participation in a network.

Networks will also be required to provide medical access assistants who will be available to injured workers to assist them in locating appropriate doctors within the network.

SB 863 also provides for better monitoring of MPNs by the DWC through continuous and random reviews, and authority to impose penalties less severe than revocation to address access problems.

Additionally, disputes about whether or not an injured worker is subject to an MPN will now have to be resolved as soon as they arise, rather than being held over to the end of a claim. Treatment obtained from a non-network provider, without either authorization from the employer or insurance carrier or a workers' compensation judge's order permitting outside of network treatment, will not have to be paid for by the employer or carrier. If unauthorized treatment is unsuccessful, and results in a worsening of the injured worker's condition, or a need for additional treatment, the employer/carrier will have no obligation to pay for that, either.

Similarly, reports issued by unauthorized non-network providers cannot be the sole basis for an award of compensation by a workers' compensation judge. Those reports must be reviewed and commented on by the authorized network treater and any qualified medical evaluator (QME) or agreed medical evaluator (AME).

Introduction of Independent Bill Review

SB 863 creates an In Independent Bill Review (IBR) process to resolve disputes regarding the amount to be paid to doctors.

IBR will not apply to disputes about treatment authorization (those will go through IMR), cases where the injury itself is in dispute, or where there is a dispute about whether or not the provider is authorized to treat the injured worker.

There are also new requirements regarding how billing is to be submitted, and how employers or carriers communicate their payment decisions to providers.

Changes Regarding Liens

There are also changes regarding liens filed against an injured workers' claim, for medical treatment and other services provided in connection with the claim, but not paid for by the employer or insurance carrier.

A filing fee of $150 will now be required for all liens filed after Jan. 1, 2013, and a $100 activation fee will be required for liens filed before then, but activated for a conference or trial after Jan. 1, 2013.

There are also provisions for dismissal of liens by operation of law after Jan. 1, 2014 if no filing or activation fee has been filed, as well as an 18-month statute of limitations for filing liens for services rendered after July 1, 2013 and a 3-year statute of limitations for services provided before then.

Assignments of lien claims are also now strictly limited, and are allowed only where the assignor has gone out of business.

New Fee Schedules

SB 863 requires the creation of fee schedules for copy services, home health care, vocational expert fees and interpreters. The DWC will also be able to administer interpreter certification exams and post lists of certified interpreters on its web site.

The Official Medical Fee Schedule (OMFS), which governs fees paid to medical providers, will also be updated, to incorporate Medicare's Resource-Based Relative Value Scale.

Changes for Qualified and Agreed Medical Evaluators

There is a new limit of ten office locations for QMEs.

In cases in which the injured worker is represented by an attorney, there is no longer a requirement that the parties try to reach an agreement on an AME before seeking a QME panel. Additionally, in cases in which the injured worker is represented, the parties may agree to use an AME.

Changes for Self-Insured Employers

Private self-insured employers are required to pay deposits to help ensure that their workers' compensation liabilities will be covered. SB 863 changes the method of calculating the deposit amount, basing it now on an annual actuarial report to be issued by Dec. 31 of every year.

The bill also precludes "professional employer organizations," temporary agencies, and employee leasing organizations from being self-insured, as well as prohibiting an employer who has been illegally uninsured from becoming self-insured unless the employer receives approval from the Self-Insurers' Security Fund.

Self-insured public entities' annual reporting requirements have been strengthened, and the CHSWC is now required to perform a study of the self-insured public entity program and make preliminary recommendations to improve the program by Oct. 1, 2013.