

SB 899
SUMMARY AND ANALYSIS

By: Mark E. Gearheart
May 2004

Introduction:

On April 16, 2004, the Legislature passed SB 899. On April 19, 2004, the Governor signed the bill into law. SB 899 is a radical bill that fundamentally alters the workers' compensation system in California, shifting the balance of power to insurance companies and depriving injured workers of many benefits and protections. The following is a preliminary analysis. We have only had the bill to study for a short time, and of course there are not yet any court decisions interpreting its meaning. The reader is cautioned to carefully review the statutory language for him or herself and come to their own conclusions.

User Funding:

Section

Discussion

62.5 Workers' Compensation Administration Revolving Fund is created. This is essentially user funding. The bill prohibits borrowing it for purposes other than administration of the workers' compensation program. The fund consists of surcharges on workers' compensation insurance policies.

Section 62.5 involves funding for the Uninsured Employers' Benefits Trust Fund (formerly the UEF) and the Subsequent Injuries Benefit Trust Fund (formerly the SIF).

Rate Study:

Section

Discussion

138.65 This section requires a study of the effects of the 2003 and 2004 legislation and its effect on insurance rates and premiums. The study is to identify and quantify the savings generated by reforms. Review the extent to which savings were reflected in insurance rates and examine the insurance marketplace and competition. It requests carriers submit certain information. The study is to be paid for by the insurance industry

(with a limitation on their costs at \$1,000,000).

QME Appointment/Qualifications:

<u>Section</u>	<u>Discussion</u>
139.2	Provides the Administrative Director shall appoint QMEs to two year terms and sets forth the requirements to qualify as a QME.
139.2(h)	<p>Provides that when requested by the employer or employee under Section 4062.1, the Medical Director shall appoint a panel of QMEs within 5 working days of the receipt of the request. If no panel is assigned within 15 working days, the employee has the right to go any QME of his or her choice.</p> <p>The Medical Director shall select evaluators who are specialists of the type requested by the employee.</p>
139.2(i)	Sets forth the requirements to qualify as a QME and provides that the Medical Director shall review reports randomly, and any report alleged by a party to be inaccurate or incomplete and shall adopt various regulations.
139.2(j)	<p>Generally requires reports to be issued within 30 days of the examination. If one of the QMEs on a panel is not available within time frames to be determined in subsequent regulations, then one may request another QME be added to the panel.</p> <p>The Administrative Director may issue regulations regarding reporting standards and discipline for AMEs and QMEs.</p>

Return to Work Program:

<u>Section</u>	<u>Discussion</u>
139.48	The Administrative Director shall establish a return to work program. Provided that funds are available, the Administrative Director shall reimburse eligible employers a maximum of \$1,250 to help return temporarily disabled workers to employment and \$2,500 to help return permanently disabled workers to employment. This may be for various types of modifications of the workplace,

equipment, devices, furniture, tools or other necessary costs.

139.48(e) The above provision applies to employers with less than 50 workers.

139.48(i) The return to work program sunsets January 1, 2009.

Vocational Rehabilitation:

Section

Discussion

139.5 The old Section 139.5 providing vocational rehabilitation services with a cap of \$16,000 is reenacted, however, benefits are limited only to injuries occurring before January 1, 2004. Futhermore, this section sunsets January 1, 2009.

"Private Attorney General", Doesn't Apply to Workers' Comp.:

Section

Discussion

2699(a) Notwithstanding any other provision of law, any provision of this code that provides a civil penalty to be assessed and collected by the Labor and Workforce Development Agency or its departments or boards for a violation of this code may alternatively be recovered through a civil action brought by an aggrieved employee. However, the "penalty" is minuscule: \$100 per employee for a first offense and \$200 per employee for a second offense.

2699(f) However, any employee who prevails under the above section may recover attorney fees and costs.

The above section is not intended to alter or otherwise effect the exclusive remedy provided by the workers' compensation law, and the section does not apply to the recovery of administrative and civil penalties in connection with the workers' compensation law as contained in Division 1, commencing with Section 50 and Division 4, commencing with Section 3200 including, but not limited to, Sections 129.5 and 132(a).

COMMENT: This latter provision which was added (subsection k specifically saying that this does not apply to workers'

compensation issues) seems to limit the usefulness of this provision to the workers' compensation practice. If it applied to workers' compensation, it would mean that applicant's attorneys who prevailed would be entitled to fees for enforcing their client's rights under the workers' compensation law. Unfortunately, the amendments make clear that this is not intended to the effect of this section.

Alternative Dispute Resolution:

<u>Section</u>	<u>Discussion</u>
3201.5	This section sets forth the provisions regarding Alternative Dispute Resolution where such agreements have been negotiated between a union and an employer.
3201.5 (b) (1)	Alternative Dispute Resolution agreements may not diminish the injured workers' rights to temporary disability, permanent disability, medical treatment or vocational rehabilitation.
3201.7	This section sets forth the requirements of Labor Management Agreements.
3201.7 (b) (1)	This section provides that Labor Management Agreements may not deny the employee right to representation by counsel at all stages of the Alternative Dispute Resolution process.

Burden of Proof:

<u>Section</u>	<u>Discussion</u>
3202.5	The old Section 3202.5 is repealed. It is reenacted to require all parties and lien claimants to meet their burden of proof on all issues by a preponderance of the evidence. COMMENT: This section is essentially the same as it was before except they added a phrase: "In order that all parties are considered equal before the law". Perhaps this means that defendants were

not really required to prove apportionment by a preponderance of the evidence before? Interestingly, Section 3202 is left undisturbed which means that liberal construction of Division 4 and 5 with the purpose of extending their benefits for the protection of persons injured in the course of their employment survived.

Fraud:

Section

Discussion

3823(c) Requires the adoption of protocols concerning medical billing and provider fraud. Subsection (c) specifically provides immunity for those who report alleged workers' compensation fraud in good faith.

Medical-Legal Procedures:

Section

Discussion

4060 This section applies to disputes over compensability. It does not apply where injury to any part of the body is accepted. This section continues to provide the treating physician reports are admissible. However, subsection (c) requires that if a medical evaluation is necessary to determine compensability and the applicant is represented by an attorney, the procedures set forth in Section 4062.2 applies to all cases (Section 4062.2 is discussed below).

4060(d) Unrepresented applicants involved in disputes over compensability are subject to the procedure contained in Section 4062.1 (discussed below).

4061 This section provides that with the last payment of temporary disability, the employer must notify the employee either that there is no permanent disability, that there is permanent disability and what the amount is, or that permanent disability cannot yet be determined and what further information or steps need to be taken to determine that.

4061(c) If the parties cannot agree on the permanent disability rating, and the insured worker is

represented by counsel, the parties shall follow Section 4062.2 regarding medical-legal evaluations.

4061(d) Unrepresented injured workers are under the procedures contained in Section 4062.1 (see below).

4061(h) If a comprehensive medical evaluation by a treater, QME or AME resolves any issues so as to require the payment of compensation, the employer shall promptly commence payment or WCAB proceedings.

4061(i) No issue regarding permanent disability may be subject to a Declaration of Readiness to Proceed unless there has been a comprehensive medical evaluation by the treater, a QME, or an AME. Only the reports of the treating physician, or reports obtained pursuant to Section 4062.1 or 4062.2 are admissible.

4062 If either party objects to the opinions of the treater regarding medical issues not covered by Sections 4060 or 4061, and not subject to Section 4610 (Utilization Review), the objecting party must notify the opposing party in writing within 20 days if applicant is represented or within 30 days if applicant is not represented.

4062 If applicant is represented by an attorney, the procedures set forth in Section 4062.2 applies. If applicant is unrepresented, the procedures set forth in Section 4062.1 applies. No other medical evaluations shall be obtained.

4062(b) The employer has 10 days to object to the treating doctor's opinion regarding spinal surgery. If applicant is represented, the parties have 10 days after the objection to agree on an AME. If applicant is unrepresented or if the parties cannot agree on an AME for a represented employee after 10 days, the matter is referred to the Administrative Director who will assign an orthopedic or neurosurgeon.

The spinal surgery second opinion report is to be served on the parties within 45 days of receipt of the treating physician's report.

If the spinal surgery second opinion recommendation is that surgery proceed, the

employer shall authorize it. If the second opinion does not recommend surgery, the employer shall file a Declaration of Readiness to Proceed.

4062.1

This section and the following section (4062.2) are the core of the new QME/AME process. For unrepresented injured workers, Section 4062.1 applies. There cannot be an AME. Either party may request a medical evaluation. If the employee does not submit the panel QME papers to the AD within 10 days of receipt, the employer may submit them for the employee. The party submitting the request shall designate the speciality requested.

COMMENT: Many injured workers will not know what to do with the papers and so the employer will submit them and designate the speciality they are requesting. In some geographic areas, this may be a problem because designating the speciality may effect the odds that the pool of doctors available is either conservative or liberal.

4062.1

Within 10 days of the issuance of a panel, the employee shall select a physician and schedule the appointment. If the employee does not inform the employer of the section and appointment within 10 days of the assignment of the panel, the employer may select the QME and schedule the appointment!

COMMENT: Many injured workers will not get their act together and select the QME within the 10 days. At that point, the employer will make the selection. This is a trap for the unrepresented.

If the unrepresented worker later retains counsel, he or she cannot get an additional evaluation.

4062.2

This section applies where the employee is represented by an attorney. If a comprehensive medical evaluation is required to resolve any issue, the parties must follow new Section 4062.2. This section specifically applies to post January 1, 2005 injuries.

COMMENT: The bill repeals the predecessor statute. This leaves us with somewhat

of a void as to what to do in the immediate future with represented cases that need a QME. Presumably, the intent was that they would stay under the old statute as set forth in the 2003 Labor Code?

Under the new Section 4062.2 (applicable to post January 1, 2005 injuries), if either party requests a medical-legal evaluation pursuant to 4060, 4061 or 4062, that party must make a written request naming at least one doctor they would use as an AME. The parties then have 10 days to agree on an AME. This can be extended to 20 days by agreement. If after the time to agree is expired there is no AME agreement, either party may request the assignment of a three member panel. The party submitting the request shall designate the speciality requested and also list the speciality requested by the opposing party if known, and the speciality of the primary treating physician.

COMMENT: Obviously, this is designed to make it more difficult for attorneys to do their jobs. Instead of selecting the best QME for the case, we will be left to go to a panel if there is no AME. Given the anticipated increased demand for AMEs, the few acceptable AMEs will be booked up very far into the future, and the parties will be left with the unenviable choice of waiting a very long time for an AME or rolling the dice with a panel.

4062.2(c) Within 10 days of the assignment of the panel, the parties shall confer and attempt to agree on an AME from the panel. If the parties cannot agree on an AME from the panel within the 10 day period, each party may strike one name. If any party fails to strike a name within 3 working days of gaining the right to do so, the other party may simply select the QME.

COMMENT: This will require close calendar attention by the parties or they will be giving the other party the choice of QME from the panel.

4062.3 This section discusses what may be provided to a panel QME or an AME. With AMEs', the parties must agree on what is to be submitted. There are other requirements set out in the section.

- 4062.3(e) All communications are to be writing and copied to the other side at least 20 days before the evaluation by the panel QME.
- 4062.3(f) Ex parte communications with the AME or QME are forbidden. However, this does not apply to oral communications between the employee (or dependent of a deceased employee) and the QME or AME.
- 4062.3(j) If a new issue arises later, the parties must to the extent possible use the same evaluator.
- 4062.3(k) No disputed medical issue may be subjected to a Declaration of Readiness to Proceed unless first there has been an evaluation by the treater or a QME or an AME.
- 4062.5 If the panel QME does not issue a report in a timely fashion, either party may request a new panel. The Administrative Director is mandated to establish appropriate time guidelines.

Treater Presumption:

<u>Section</u>	<u>Discussion</u>
4062.9	The treater presumption is repealed. (Later in the bill it is made clear that this applies to all cases and all dates of injury.)

Medical Treatment:

<u>Section</u>	<u>Discussion</u>
4600	Section 4600(a) has survived more or less in tact, indicating that the employer shall provide medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury.
4600(b)	However, subsection (b) states that as used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve means treatment that is based upon the guidelines adopted by the Administrative Director pursuant to Section 5307.27 or prior to adoption of those guidelines, the updated ACOEM practice guidelines.
4600(c)	Unless the employer or the employer's insurer has

established a medical provider network as set forth in Section 4616, the injured worker may select a physician of his or her choice for treatment 30 days after the injury is reported.

4600

(d) (1)

Predesignation: This section sets forth the limited conditions under which an employee has a right to be treated by a predesignated physician. The employer must provide non-occupational group health coverage and a health care service plan licensed pursuant to the Health and Safety Code, and the physician selected must be the employee's regular physician and surgeon, and also must be the employee's primary care physician who has previously directed the medical treatment of the employee and retains the employee's records. The physician must agree to be predesignated. Furthermore, subsection (d)(1) (C)(6) states that the maximum percentage of all employees who are covered under this paragraph that may be predesignated at any time in this state is 7%. (The 7% solution? What does this mean?)

Also note that any disputes regarding care by the predesignated doctor are to be adjudicated under the Health and Safety Code or Insurance Code which suggests that HMO type standards would apply. The insurer may require pre-authorization of any non-emergency care and conduct utilization review under Section 4610. (See Section 4600(d)(3)(4)(5).)

4600

(d) (9)

Provides the subdivision sunsets April 30, 2007. Presumably this refers to the predesignation subdivision.(?)

4603.2

Upon selection, the treating physician must notify the employer of his/her name and address and submit a report within 5 working days. Payment is to be made pursuant to the official Medical Fee Schedule within 45 days, bills must be objected to within 30 days.

4603.2

(b) (1)

If the bills are not objected to within 30 days or paid within 45 days, the amount it is delinquent is automatically increased 15%.

If the employer is a government agency, they have 60 days to pay.

4604.5(a) The medical treatment guidelines as adopted (meaning ACOEM now and the AD Guidelines when they are adopted) are presumed correct. They are rebuttable but only by a preponderance of scientific medical evidence.

4604.5(c) Section 4604.5(c) provides that 3 months after the publication date of the updated ACOEM guidelines, they will be presumed correct until such time as the Administrative Director adopts official guidelines. The presumption is rebuttable and is controvertible only by a preponderance of evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury in accordance with Section 4600. The presumption is one effecting the burden of proof.

COMMENT: This section adopts the language to cure and relieve. Was this intentional or inadvertent? Does it mean that if you are going to challenge the guidelines, you have to prove that your treatment will both cure and relieve even though Section 4600 says cure or relieve?

4604.5
(d) (1) This section provides that notwithstanding the medical treatment guidelines, for injuries after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic visits, 24 occupational therapy visits, and 24 physical therapy visits per industrial injury. Subsection (2) provides that an employer may authorize in writing additional physical medicine services if they want.

4604.5(e) For all injuries not covered by the Administrative Director's guidelines (or prior to that by ACOEM guidelines), authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

COMMENT: For some types of injuries, there may not be guidelines. Does that mean they don't get any treatment? How easy is it going to be to get the treating doctors to do reports about what treatment is needed that cite national medical

treatment guidelines that are evidence/scientifically based? This seems like an unreasonably high impediment to a benefit as important as medical treatment. But then, that's the theme underlying all of the rules regarding treatment.

4616 Medical Provider Networks: This section specifically does not apply until January 1, 2005. On or after that date, a carrier or employer may establish a Medical Provider Network to provide medical treatment to injured workers. This section sets forth the requirements including that there must be a diversity of the type of physician and number of physicians, and timely treatment must be available. Specific regulations are left to the Administrative Director.

The plan must be submitted to the Administrative Director for approval. If the AD does not act within 60 days, the plan is deemed approved.

4616(c) Physician compensation may not be structured so as to reduce delay or deny treatment.

4616(e) All treatment provided shall be in accordance with the ACOEM guidelines or, once adopted, the Administrative Director's guidelines.

4616(g) By November 1, 2004, the Administrative Director is to issue regulations implementing the article. Subsequent sections of the bill discuss economic profiling and what information must be provided by the carrier who sets up the network.

COMMENT: It appears that the employer might contract with an existing network such as Pacific Care or Blue Cross or Kaiser or create its own network. The statute is vague as to how diverse and large the pool of doctors must be, and regulations presumably will define this better. This may provide an opportunity for some injured workers to escape the network: Although it would be labor intensive, if one could establish that the network did not meet the legal requirements, then it would presumably be invalid. The appropriate remedy for that would seem to be allow free choice of physician to the applicant. Note that Section

4616.1(b) requires that certain information filed by the carriers in this regard must be available to the public. If a network is set up, can the carrier force an injured worker with a pre 1/1/05 injury into the network?

4616.2 This section concerns written continuity of care policies and the requirement of filing them with the Administrative Director.

4616.3 When an employer is notified of an injury, the employer shall arrange an initial medical evaluation and begin treatment. Subsection (b) requires the employer to notify the employee of his or right to be treated by a physician of his or her choice after the first visit, that the physician must be within the medical provider network established by the employer/carrier, and that the method by which by the participating doctors may be accessed by the employee.

4616.3(c) If the employee disputes either the diagnosis or the treatment proposed by the treater, he/she may seek the opinion of another physician in the medical provider network. If they are unhappy with the second physician's diagnosis or treatment, they may seek the opinion of a third physician in the medical provider network.

COMMENT: Does this mean the employee can pick the doctor, or they may seek the opinion of another physician by asking the employer and having one assigned? Presumably since liberal construction was not repealed, this means the employee can pick the doctor?

4616.3
(d) (1) The selection by the employee of a treating physician is to be based on the doctor's speciality or recognized expertise in treating a particular type of injury.

COMMENT: Does this section further limit the employee's free choice rights within the network? Are we now going to put under a microscope the motivations for switching within the network from one doctor to another?

4616.3

(d) (2) This section says that treatment by a specialist who is not a member of the network may be permitted (by whom) on a case-by-case basis if the network does not contain a doctor who can provide the appropriate treatment and the treatment is approved by the employer or carrier.

4616.4 Independent Medical Review: This section discusses what happens if the employee has gone through 3 company doctors within the network and still disputes the diagnosis and/or treatment.

4616.4(b) After exhausting 3 company doctors without satisfaction, the employee may request Independent Medical Review. This is done by submitting a one page form which the Administrative Director is going to create. (Section 4614.4(c)). The AD will then assign an independent medical review physician who will do a report. (The AD will have contracted with doctors to do this under Section 4616.4(a)(1), it is not clear who these physicians will be.) The IMR physician will review the records, examine the applicant, and prepare a report discussing whether the treatment is consistent with the ACOEM guidelines. Time constraints are established.

4616.4(i) If the Independent Medical Review doctor says the disputed treatment or diagnostic service the injured worker wanted is consistent with the ACOEM guidelines, or after they are adopted, the AD guidelines, the injured worker may obtain the disputed service or diagnostic study from a physician outside the network. However, it appears they will still have to obtain their other treatment from within the network.

4616.6 No other examinations and no other reports are admissible (regarding disputed medical treatment).

4616.7(b) This section authorizes the approval of health care service plans licensed under the Health and Safety Code to be authorized as Medical Network Providers for workers' compensation. Certain requirements and exclusions are set forth in this and subsequent sections.

COMMENTS: See also the new Section 5402(c) at page 20 of this analysis regarding "immediate" medical care.

Temporary Disability:

Section

Discussion

- 4650 This section is substantially the same with some minor changes that did not warrant much discussion.
- 4656(b) This section provides that for injuries before January 1, 1979, temporary disability shall not extend for more than 240 weeks within five years of the date of injury (this is the same rule as we had before for that date of injury).
- However, subsection (b) provides that aggregate disability payments for a single injury on or after January 1, 1979 and prior to the effective date of subdivision (c) (the date of the bill becoming effective) causing temporary partial disability are limited to 240 weeks within five years. The bill does not set forth a limitation on TTD for injuries between January 1, 1979 and the effective date of the bill.
- 4656(c) New Section 4656(c) provides that aggregate disability payments for a single injury on or after the effective date of the subdivision (presumably April 19, 2004?) causing temporary disability shall not extend for more than 104 weeks within a period of two years from the date of commencement of temporary disability. This is the so-called "hard cap" on TD.
- 4656
(c) (2) This section creates limited exceptions to two year hard-cap on temporary disability for certain conditions such as chronic Hepatitis, amputations, eye injuries, chronic lung disease and pulmonary fibrosis and HIV. In such cases the limitation on temporary disability is 240 weeks within 5 years of the date of injury.

Permanent Disability Changes:

Section

Discussion

- 4658 This section remains the same as before except a new subsection (d) (1) is added. This subdivision applies only to injuries on or after the date of the revised permanent disability schedule. It effectively reduces the weeks of permanent disability for ratings under 15% and increases the weeks of permanent disability for ratings over

70%. Since the weeks above 15% are cumulative, this reduces the weeks of permanent disability for all ratings under 70%.

COMMENT: Since, as we will see later on, we are going to change the whole rating schedule, one wonders if the difficulty of getting a rating of 70% or more will be even greater than it is now. Most cases are under 25%.

4658

(d) (2)

Subsection (d) discusses return to work offers and their effect on permanent disability. Note this only applies to injuries after the date of the new rating schedule since it is part of Section 4658(d). If within 60 days of applicant becoming permanent and stationary, the employer has not offered modified or alternate work lasting at least a year, then permanent disability payments after that date are increased by 15%, unless the employer has less than 50 employees in which this does not apply.

If the employer makes an offer of modified or alternate work lasting at least one year, regardless of whether the employee accepts it, subsequent permanent disability payments are all decreased by 15%.

4658

(d) (4)

This section provides that for compensable claims arising before April 30, 2004, the schedule provided in this subdivision shall not apply to the determination of permanent disability when there has been either a comprehensive medical-legal report or a report by a treating doctor indicating the existence of permanent disability or when the employer is required to provide the notice set forth in Section 4061 to the injured worker.

COMMENT: How does this interact with Section 4658(d) (1) discussed above? That section says that the reduction of the weeks of PD payable for ratings under 15% and the increase for ratings over 70% only applies to injuries occur after the effective date of the new PD schedule. However, this section seems to say that the same subsection does not apply to claims arising before April 30,

2004 if there is a medical report demonstrating permanent disability. Actually, the language is not inconsistent because this later section does not say that if there is no such report, the schedule applies; it only says that if there isn't such a report, it does not apply. But it would not apply anyway by virtue of Section 4658(d)(1) discussed above. This is what happens when you vote on bills at 3:38 a.m. in conference committees.

4658.1 This section includes the definitions of regular work, modified work and alternate work to be used in conjunction with whether the employer offers it. These are important definitions to review.

4660(a) This section involves a very radical change. In determining permanent disability account shall be taken of the physical injury or disfigurement, the occupation of the injured worker and their age, but instead of giving consideration to their diminished ability to compete in the open labor market, we are directed to consider their diminished future earning capacity. In other words, we are substituting future earning capacity for diminished ability to compete in the open labor market.

4660
(b) (1) This section mandates that the nature of physical injury or disfigurement component of permanent disability shall incorporate the descriptions and measurements of physical impairments and the correspondence percentages of impairments published in the AMA Guides, 5th Edition.

4660
(b) (2) This section mandates that the employee's diminished future earnings capacity shall be a numeric formula based on empirical data and findings aggregating the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees. The AD is directed to formulate the adjusted rating schedule based on the RAND study and interim report (December 2003) and upon data from additional empirical studies.

COMMENT: While it sounds at first like we might be going to a system of wage loss where we can bring in an economist to talk about our client's future lost earnings, subsection (2) pretty clearly states that this is to be a numeric formula based on an average percentage. This is probably an attempt to preclude any sort of an individual consideration of earnings loss. However, if the schedule remains prima facie evidence and rebuttable, the fact that Section 4660(a) mandates future earning capacity be considered combined with liberal construction suggests that we may be able to bring an economist to discuss lost future wages.

4660(c) The AD shall amend the schedule for rating PD at least once every 5 years. Without formal introduction into evidence, the schedule shall be prima facie evidence of the percentage of permanent disability attributable to each injury covered by the schedule.

4660(d) The schedule is prospective only and applies only to injuries occurring after the date of adoption of the schedule. Interestingly, subsection (d) provides that for compensable claims arising before January 1, 2005 the schedule as revised applies to the determination of permanent disability if there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of PD or where the employer is not required to provide Section 4061 notice to the injured worker.

COMMENT: This language only further muddies the water regarding the conflicting language discussed above in Section 4658. Section 4658(d)(1) states the subdivision applies only to injuries after the effective date of the revised schedule, however, that subsection also states that it does not apply where there has been a report (treater or QME) indicating the existence of PD where the employer was required to issue the 4061 notice. So, what happens if applicant becomes P&S in a claim arising before April 30, 2004 in September 2004 and there is no new schedule yet? As a

practical matter, it would seem that the old schedule would have to apply, but the statutory language is confusing.

Apportionment:

Section

Discussion

- 4663 In what is perhaps intended to be a radical change, Section 4663 is amended to read: "Apportionment of permanent disability shall be based on causation". This section goes on to detail various requirements for physicians' reports and to require employees who claim industrial injuries to disclose on request all previous permanent disability or physical impairments. (Does this conflict with the ADA or FEHA?)
- 4664(a) This section provides the employer is liable only for the percentage of permanent disability directly caused by injury AOE/COE.
- 4664(b) Prior permanent disability awards are conclusively presumed to still exist.
- COMMENT: If the old award is based upon diminished ability to compete in the open labor market, and the new award is based upon the AMA Guides, how do we subtract oranges from apples? Is the old award even relevant since it is a different index of disability? What does it mean that it "still exists"?
- 4664(c)
(1) & (2) This section discusses the accumulation of permanent disability awards providing that with respect to any one region of the body they shall not exceed 100% over the employee's lifetime except where the injury or illness is conclusively presumed to be total under Section 4662. This section defines what different parts of the body are. Furthermore, it provides that nothing in the section shall be construed to permit the PD rating for each individual injury sustained by an employee arising out of the same accident when added together to exceed 100%.
- 4750 Repealed.

4750.5 Repealed.

COMMENT: Clearly the authors were trying to change the apportionment rules to make them more favorable to the employer. How this will play out in practice remains to be seen. Does the repeal of Section 4750 undermine Fuentes (1976) 16 Cal. 3d 1, 41 CCC 42?

4706.5 This section concerns death benefits. I can discern no significant major changes from the applicant's practice point of view.

4903.05 This section primarily involves filing fees for liens on behalf of medical providers.

Presumption of Injury:

Section

Discussion

5402 We still have a presumption of injury AOE/COE where the claim is not denied within 90 days of the DWC-1.

Immediate Medical Treatment:

Section

Discussion

5402(c) Within one day of filing a DWC-1, the employer shall authorize provision of all treatment for the injury. The treatment shall be pursuant to the ACOEM guidelines or once adopted the AD guidelines. This goes on until liability is accepted or rejected, but prior to that time, the employer is not required to pay more than \$10,000 in treatment.

COMMENT: This was the fig leaf many Democrats and others use when they voted for this atrocious bill. Most union employees have group health insurance anyway and if the claim is put on a delay status or rejected, they get treatment through their private health plan while their claim is litigated. This provision will however benefit those employees who have no alternative health insurance while their claim is on a delay status. This minor improvement certainly does not

justify the massive take backs contained in this bill.

Admissibility of Evidence:

<u>Section</u>	<u>Discussion</u>
5703	This section sets forth what the Appeals Board may receive as evidence.
5703(h)	Medical treatment protocols under certain conditions may be admissible. However, a very high standard is set for the party offering into evidence treatment protocols: You must demonstrate information regarding how the protocol was developed, to what extent it is evidence based, peer reviewed and nationally recognized. This seems designed to make it difficult for those challenging the treatment guidelines and offering an alternative set of guidelines to get their guidelines into evidence.
5703(i)	This section provides that the official medical treatment guidelines and ACOEM guidelines are admissible automatically.

Penalties:

<u>Section</u>	<u>Discussion</u>
5814	The bill reiterates Section 5814 but then adds a subsection (b) providing that Section 5814 as we know it becomes inoperative on June 1, 2004 and as of January 1, 2005 is repealed.
5814	<p>This is the new and very unattractive Section 5814. When payment of compensation is unreasonably delayed or refused, the amount of the payment unreasonably delayed or refused is increased by 25% or \$10,000 which ever is <u>less</u>.</p> <p>In addition, if the employer discovers a potential violation prior to the employee claiming a penalty and within 90 days of the date of discovery pays a self-imposed penalty of 10% of the amount unreasonably delayed or refused along with the amount that was delayed or refused, this wipes out the penalty under 5814.</p>

COMMENT: In other words, if the employer complies

with Section 4650, they don't have to pay a 5814 penalty.

- 5814(c) This section provides that upon approval of a C&R or Stipulation or upon issuance of an F&A, it is conclusively presumed that any accrued claims for penalties are resolved unless they are expressly excluded.
- 5814(d) Section 5814 penalties are reduced by any 4650 increase paid for the same delay.
- 5814(g) There is a two year statute of limitations on penalty claims.
- 5814(h) The new section applies to all injuries without regard to date of injury.
- 5814(i) The new section is effective June 1, 2004.
- 5814.6 This section provides that if an employer knowingly violates Section 5814 with a frequency indicating a general business practice, it may have to pay some administrative penalties not to exceed \$400,000.

COMMENT: This is a poor substitute for allowing the workers to enforce their own rights. Who is going to enforce this. How do you show an employer knowingly violated Section 5814? What is a frequency that indicates a general business practice?

Injury Prevention:

Section

Discussion

6401.7 This sets forth and creates a so-called injury prevention program.

General Provisions:

Discussion

General provisions at the end of the bill repeal the primary treating physician presumption for all cases and all dates of injury but provides that this shall not be good cause to reopen. The bill

provides that its provisions apply prospectively from the date of enactment, April 19, 2004(?), unless specified otherwise.

The bill states that it is an urgency statute and therefore shall take effect immediately.