2017 Hot Topics in Workers' Compensation

2017 Floyd, Skeren & Kelly LLP Employment Law Conference

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QME PANELS

ENTITLEMENT TO ADDITIONAL PANEL?

ONE OR TWO PANELS?

1) NAVARRO v. CITY OF MONTEBELLO: 2 PANELS
2) PARKER v. DSC LOGISTICS: 1 PANEL

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PRACTICE HINT:

- The filing of the DWC-1 is the operative act in determining the entitlement to a second panel

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NAVARRO v. CITY OF MONTEBELLO 79 CAL. COMP. CASES 418 (2014)

- Applicant filed a CT, then saw a PQME.
- He then filed 2 additional specific injuries.
- **Holding**: Applicant was entitled to an additional panel.

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PARKER V. DSC LOGISTICS 2016 CAL. WRK. COMP P.D. LEXIS

- Applicant filed one date of injury, then two more.
- Defendant requested a panel.
- Applicant then requested 2 additional panels.
- **Holding:** the 2 additional panels were disallowed.

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ADVOCACY LETTERS: "COMMUNICATION" V. "INFORMATION"

LANGUAGE IN PQME ADVOCACY LETTERS

1) Ferniza v. Rent A Center

2) Maxham v. California Department Of Corrections & Rehabilitation

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FERNIZA v RENT A CENTER 2010 CAL. WRK. COMP P.D. LEXIS

- A defendant was precluded from sending a PQME advocacy letter to a PQME unless agreed to by applicant.

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PRACTICE HINT:

- Do not let your “advocacy” transmute from “communication” to “information”.

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LABOR CODE SECTION 4062.3 & 8 CCR 35 ET SEQ

- An opposing party can object within 10 days to non-medical records/information and this can be provided unless ordered by a WCJ.

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FERNIZA: INVOLVED A PQME

- Applicant objected to defendant's advocacy letter which was considered "information"

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MAXHAM: INVOLVED AN AME

- Defendant objected to the advocacy letters issued by applicant.
- **Conclusion**: Legitimate advocacy does not transform correspondence into "information".

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Psychiatric Permanent Disability: Post SB 863

Labor Code Section 3208.3 (d): The "Six Months" Rule Still Applies

Labor Code Section 3208.3 (d)

- Notwithstanding any other provision of this division, no compensation shall be paid pursuant to this division for a psychiatric injury related to a claim against an employer unless the employee **has been employed by that employer for at least six months.** The six months of employment need not be continuous.

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The Exception

This subdivision shall not apply if the psychiatric injury is caused by a **sudden** *and* **extraordinary** employment condition.

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SB 863: Labor Code Section 4660.1(c) [Injuries after January 1, 2013]

- Except as provided in paragraph (2), 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**. Nothing in this section shall limit the ability of an injured worker to obtain treatment for sleep dysfunction, sexual dysfunction or psychiatric disorder, if any, that are consequence of an industrial injury.

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The Exception: Labor Code Section 4660.1(c)(2)

- An increased impairment rating for psychiatric disorder shall not be subject to paragraph (1) if the compensable psychiatric injury resulted from either of the following:
- 1) Being a victim of a violent act or direct exposure to a significant violent act within the meaning of Section 3208.3.
- 2) A catastrophic injury, including, but not limited to, loss of a limb, paralysis, severe burn, or severe head injury.

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Madson v. Michael J. Cavaletto Ranches
2017 Cal. Wrk. Comp. P.D. LEXIS

- Facts: a serious truck accident of 5/17/2013 where Applicant's psychiatric permanent disability arising from his physical injuries, was still separately compensable under the "violent act" exception in Labor Code Section 4660.1 (c)

- Interpretation of Labor Code Section 3208.3(b): "Violent acts" are not limited to criminal or quasi-criminal conduct perpetrated by human beings, but also acts that are characterized and are considered threatening.

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Larsen v Securitas Services
2016 Cal. Wrk. Comp P.D. LEXIS

Facts: Applicant sustained injury as a result of being hit by a car while walking through a parking lot of 2/21/13.

Interpretation: The Applicant was hit by a car from behind with enough force to cause her to fall, hit her head and lose consciousness; as such, she was the victim of a "violent act" per Labor Code Section 3208.3(b), thereby allowing additional permanent disability for her psychological injury.

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Catastrophic Injury: Additional Considerations

- 1) Loss of a limb: complete or partial?
- 2) Paralysis: complete or partial?
- 3) Severe Burn: Nature of the Injury, % TBSA?
- 4) Severe Head Injury: Nature of the Injury, Extent of Cognitive Dysfunction?

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Labor Code Section 3202 (yes, it's still there)

- This division and Division 5 (commencing with Section 6300) shall be **liberally construed** by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment.

- Practice point: Know your WCJ & know your district WCAB Office!

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MEDICARE SECONDARY PAYER ACT

Overview

- Enacted in 1981
  - Medicare is secondary payer
- Amended in 2007
  - Imposed Mandatory Insurer Reporting (MIR) to identify secondary payers
  - Ability to recover for Conditional Payments
  - Protect Medicare's interest through **MSA allocation**

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Medicare Set Aside

- An MSA is an amount included in a settlement that are set-aside for the Medicare Beneficiary to pay for medical benefits.

- WCMSA
  - ✓Standard practice, guidelines and policy established for WC claims settlement.
  - ✓Medicare, as a secondary payer, may not make a payment if payment has been made or can reasonably be expected to be made under a workers' compensation plan.
  - ✓ALL beneficiaries and claimants must consider and protect Medicare's interests when resolving workers' compensation cases that include future medical expenses.

- LMSA
  - ✓CMS has no formal policy or guidance from CMS on how to satisfy the requirement to protect Medicare's interest.
  - ✓Feb 3, 2017 – Change Request 9893 released by CMS to establish LMSA Guidelines to comply with Government Accountability Act.

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RRE's Obligation

- What is the Rule?

  RRE Obligation to Protect Medicare's interest

  a. Identify individuals in your plan to whom MSP requirement applies – MMSEA Section 111
  b. Provide proper primary payment where Medicare is secondary payer.
  c. Accurately complete and submit data match – MMSEA Mandatory Insurer Reporting

- Prior to settling a workers' compensation case, parties to the settlement should consider Medicare's interest related to future medical services and whether the settlement is to include a WCMSA Arrangement.
  - Is this required on all settlements?
  - Is there a requirement to obtain CMS approval for MSA?

Note: When there is evidence that the workers' compensation plan will not pay promptly, Medicare may make a conditional payment. A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so that the beneficiary won't have to use his own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a settlement, judgment, award or other payment is made.

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WC MSA Process

- Set aside the portion of the settlement that applies to Medicare-covered items and services.
- If a component of a settlement is a commutation, Medicare payments are excluded until medical expenses related to the injury equal the amount of the lump sum payment.
- The computation of the total settlement amount includes wages, attorney fees, all future medical expenses (including prescription drugs), and repayment of any Medicare conditional payments.
- Caution – in WC cases, the RRE's obligation to continue payment exists for as long as the medical condition is still present.

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When does a WCMSA meet CMS' Criteria for Review?

- The Claimant is currently a Medicare beneficiary and the total settlement value is greater than $25,000.

  Or

- The Claimant has a "reasonable expectation" of Medicare enrollment within thirty (30) months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

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Reasonable Expectation of Enrollment:

1. The claimant has applied for Social Security Disability Benefits.
2. The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision.
3. The claimant is in the process of appealing a denial of or re-filing for Social Security Disability benefits.
4. The claimant is 62 years and 6 months old.
5. The claimant has an End-Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

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MEDICAL PROVIDER NETWORK

INTRODUCTION

- An MPN is a group of health care providers set up by an insurer or self-insured employer and approved by DWC's Administrative Director to treat workers injured on the job.
- Under California state regulations, each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.
- MPNs are required to meet access to care standards for common occupational injuries and work-related illnesses.
- The regulations also require MPNs to follow all medical treatment guidelines established by the DWC and allow employees a choice of provider(s) in the network after their first visit.
- MPNs must offer an opportunity for second and third opinions if the injured worker disagrees with the diagnosis or treatment offered by the treating physician. If a disagreement still exists after the second and third opinion, an injured worker in the MPN may request an independent medical review (IMR).
- All medical care for workers injured on the job whose employer has an approved MPN will be handled and provided through the MPN except:
  - Those employees who properly pre-designate a physician any time before an injury occurs, even if the pre-designated physician is a provider in the MPN's network;
  - Those employees with injuries prior to the effective date of the MPN whose care has not been transferred into the MPN; and
  - Those employees who are otherwise exempted from the MPN by the MPN insurer or employer.

Rivas vs. North American Trailer

- Rivas sustained a significant skull fracture and lost consciousness when a chain and hook struck him on the head at work. Medical treatment included 5 days of hospitalization and surgical installation of titanium plate.
- Carrier's MPN included Casa Colina Transitional Living Center in multiple specialties. However, occupational therapy and physical therapy were marked with an asterisk (*) – indicating "by referral only".
- Rivas designated Casa Colina and selected a physician. The physician was not specifically listed on the MPN.
- The physician issued an RFA for 60 days of in-house post-op physical rehab.
- The carrier's adjuster decided not to respond to the RFA because the physician is not in the MPN and sent a a letter to Casa Colina denying treatment based solely on the physician not being on the MPN.
- WCJ determined that LC 4616(a)(3) and Title 8 of CCR subsection 9767.5.1 provide for physicians designation of a physician acting on behalf of the medical group and duly included in an MPN, despite not being listed individually on the MPN list. Defendant was ordered to provide treatment through Casa Colina.

Saldana vs Dirt Cheap

- Lorena Saldana sustained an admitted industrial injury to her neck and upper extremities on 4/1/2013. Her employer sent her to US Healthworks – a provider in the employer's MPN.
- She treated with US Healthworks for a period of time eventually seeking treatment from a doctor outside the MPN because she was not satisfied with her care at US Healthworks.
- The carrier sent all the proper MPN notices including information on what she needs to do if she disagrees with the MPN doctor.
- Is Ms. Saldana entitled to treat outside the MPN?
  - The trial judge found in favor of Ms. Saldana and awarded her the costs of her self-procured medical treatment in English and Spanish.
  - WCAB reverse the decision and determined that Ms. Saldana should have changed doctors within the MPN or take advantage of the MPN's IMR process which provides that the IW must first seek a second and third opinion from an MPN provider and then request an IMR if the service is still in dispute.

Escobar vs PRN Ambulance

- Mr. Escobar sustained an injury to his neck and spine on 7/20/14 that was admitted by the carrier. He promptly sought treatment through the MPN but he had difficulty locating a chiropractor for PTP.
  - Note – a chiro can be designated as PTP up to 24 cap.
- The case was heard for an expedited hearing in Jan 2015. WCJ ordered defendant to provide IW with a choice of 3 chiro within 60 min/30 miles of his home/work based on the "specialist access standard" per the MPN regs.
- IW filed a Pet for Recon based on the following arguments:
  - He was entitled to designate a chiro as PTP using the access standard per the MPN Regs - 3 PTP's within 30 min/15 miles of his home or work; and
  - He was entitled to treatment outside the MPN since defendant was not able to meet the PTP access standard timely.
- WCAB agreed with Escobar and ordered defendant to authorize IW to select a Chiro as his PTP outside the MPN.

IBR VS. LIEN

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IBR

- Date of service on or after 1/1/2013
- Issue is only about how much should be paid
- There is a fee schedule
- Claims responded timely to both the initial bill and the Request for Second Review
- EOR is compliant
- Covers treatment, facilities, DME, drugs, interpreters and Medical-Legal bills

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IBR

- Statutorily mandated IBR
- IBR provided by Maximus Federal Services
- Medical Provider must pay $195.00 up front
- IBR decision is final
  - Limited appeal rights
- If additional payment is found, defense must pay owed amount plus the $195.00

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IBR Process

- If provider is dissatisfied with level of payment, including line items paid at zero, they must request Second Review.
  - Second Review must be requested within 90 days of the receipt of the EOR from the payer.
  - If no request, payment amount is final, with no recourse.
  - Claims must respond with a second EOR within 14 days.
  - Providers are not entitled to file a lien, but if they do, DWC will happily take their money.

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IBR Process (cont'd.)

- If the provider is dissatisfied with the Second Review, they can file for IBR.
  - IBR must be requested within 30 days of receipt of the Second Review EOR.
  - If no request, payment amount is final, with no recourse.
  - They are not entitled to file a lien, but if they do, DWC will happily take their money.

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IBR Appeal

- (1) The administrative director acted without or in excess of his or her powers.
- (2) The determination of the administrative director was procured by fraud.
- (3) The independent bill reviewer was subject to a material conflict of interest that is in violation of Section 139.5
- (4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.
- (5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review and not a matter that is subject to expert opinion.

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Lien

- Any date of service for treatment prior to 1/1/2013
- Dates of service after 1/1/2013 if there is a threshold issue
  - Injury AOE/COE
  - Body Parts
  - Treatment outside of MPN
  - UR denial (but only after IMR process has been completed)
  - Other
- Party breached a duty

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Jurisdiction

- Judge has no jurisdiction to determine level of payment for Post 2013 dates of service for anything that is covered by a fee schedule.
- Judge can determine threshold issues.
  - Injury AOE/COE
  - Validity of UR
  - Right to treat outside MPN
  - Disputed Body Parts
- Judge can also determine if claims breached a duty.

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Jurisdiction (cont'd.)

- If threshold issue is found in favor of lien claimant, defense should pay the bill per fee schedule and issue an EOR.
- Once payment is made and EOR provided, Second Review and IBR process should be followed.

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PROPER OBJECTIONS TO BILLS

What Types of Bills are Covered?

- Medical Treatment LC 4600
- Medical-Legal LC 4620
- Copy Service – depends on what the copies are for which bucket it falls into
  - If medical-legal under 4620
  - If treatment related under 4600
- Interpreters – depends on type of service
  - If for Court Hearing or Depo doesn't go to IBR, disputes go to WCAB via Petition for Costs
  - If for treatment or medical-legal goes to IBR

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Must Object Using an Explanation of Review (EOR)

- LC 4603.2 (b) - requires EOR for treatment bills
- 4603.3 (a) – defines elements of an EOR. See also Medical Billing and Payment Guide
- 4622(a)(1) – requires EOR for medical-legal bills
- CCR 9792.5.4 – defines an EOR for treatment
- CCR 9795.4 – defines an EOR for medical-legal

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UR/IMR

2017 Changes

- The option to delay a UR decision is removed from the statute.
- Minor rewording that doesn't change the rule.
- Unless otherwise indicated, a physician providing treatment under 4600 RFA's to the claims administrator.

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2018 Changes

- (b) For all dates of injury occurring on or after January 1, 2018, ER services and medical treatment rendered for a body part or condition *that is* accepted as in the by a member of the MPN or HCO, by a physician predesignated pursuant to subdivision (d) of Section 4600, or by an employer selected physician within the 30 days following the initial date of injury, shall be authorized without prospective UR, except specific requests.

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2018 Changes (cont'd.)

- The services rendered under this subdivision shall be consistent with the MTUS.
- For treatment rendered by a MPN physician, HCO physician, a predesignated physician, or an employer-selected physician, the report required under Section 6409 and a complete RFA shall be submitted by the physician within five days following the employee's initial visit and evaluation.

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Still Require Authorization

- (1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary.
- (2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
- (3) Psychological treatment services.
- (4) Home health care services.
- (5) Imaging and radiology services, excluding X-rays.

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Still Require Authorization (cont'd.)

- (6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the OMFS.
- (7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
- (8) Any other service designated and defined through rules adopted by the administrative director.

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- Must submit the bill within 30 days
- Failure to submit the report and RFA within 5 days may result in losing the ability to be exempt from UR.
- An employer may perform retrospective UR for any treatment provided solely for the purpose of determining if the physician is prescribing treatment consistent with the MTUS, including, but not limited to, the drug formulary.

- If it is found after retrospective UR that there is a pattern and practice of the physician or provider failing to render treatment consistent with the MTUS, including the drug formulary, the physician lose the exemption from prospective UR. The employer shall notify the physician or provider of the results of the retrospective UR and the requirement for prospective UR for all subsequent medical treatment.
- The results of retrospective UR may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the MPN or HCO.

IMR Determinations

- Maximus shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, and the determination shall be issued, as follows:
- For a dispute over medication prescribed pursuant to the drug formulary, within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the AD.
- For all other medical treatment disputes submitted for review, within 30 days of receipt of the request for review and supporting documentation, or within less time as prescribed by the AD.

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IMR Determinations (cont'd.)

- If the disputed medical treatment has not been provided and the employee's provider or the AD certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.

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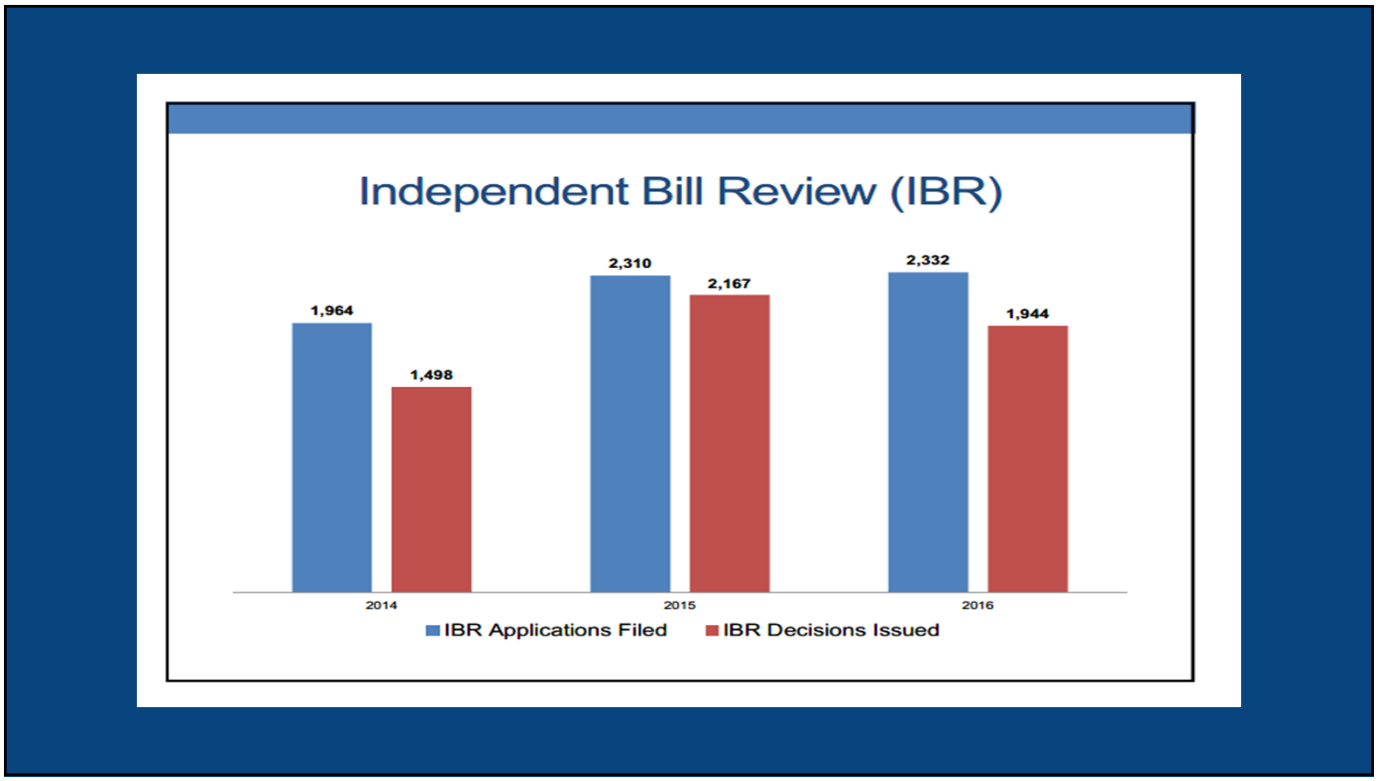
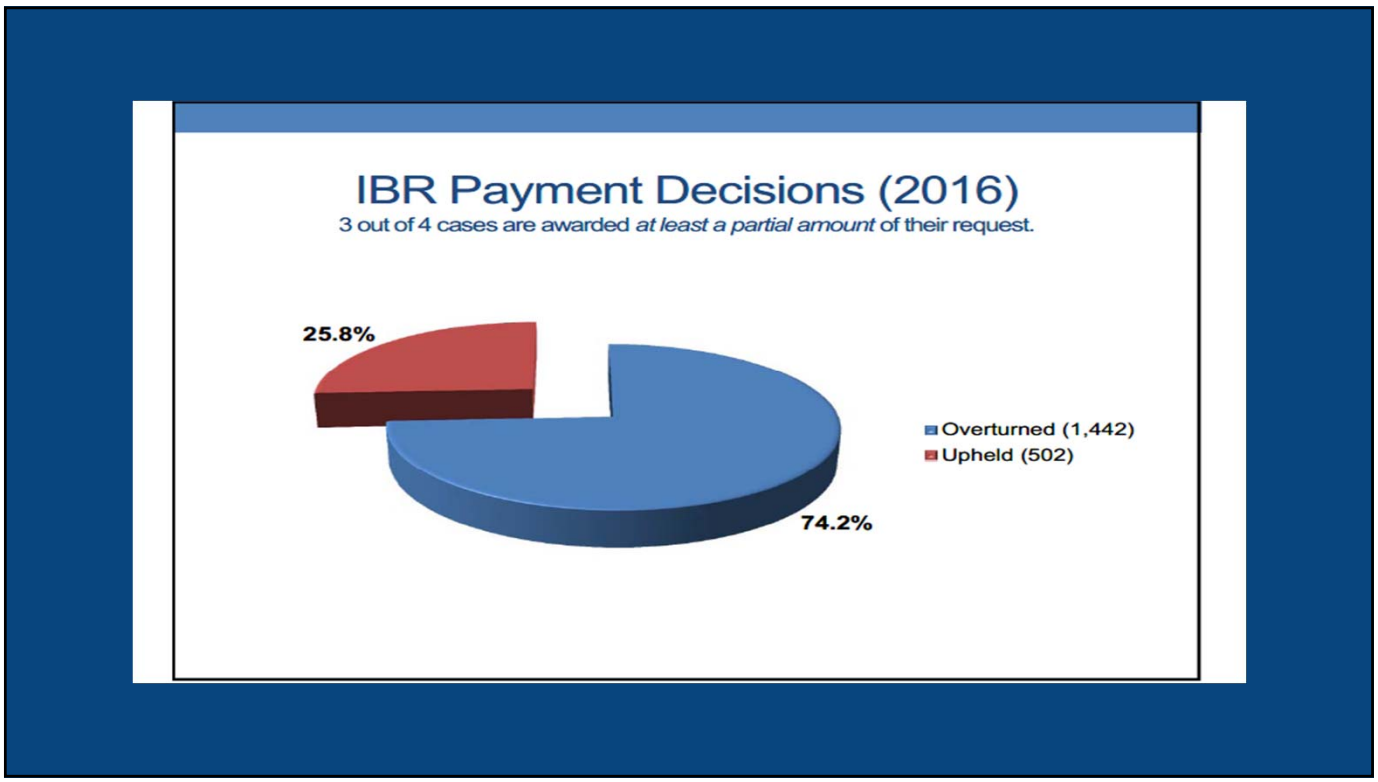
Court Cases

- *Ramirez v. WCAB.* Court of Appeal, 4th Appellate District. Constitutionality of IMR process. Oral argument set for 3/14/17.
- *Zuniga v. WCAB.* Court of Appeal, 1st Appellate District. Constitutionality of IMR process.
- See *Stevens v. WCAB, et. al.* (2015) 241 Cal.App.4th 1074.
- *King v. Comppartners.* Court of Appeal, 3rd Appellate District. On appeal to CA Supreme Court.
- District Court of Appeal held injured worker could assert civil tort claim against UR doctor for failing to warn about the potential consequences assoc. with abrupt withdrawal of psychotropic meds. Found a Dr.- patient relationship existed.

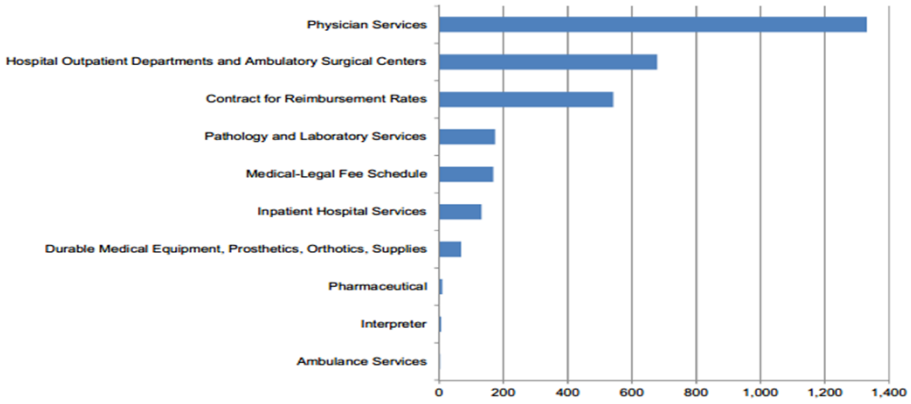
Court Cases Continued
IMR Deadline to Issue Determination

- *CHP v. WCAB (Margaris).*248 Cal.App.4th 349 (2016). Court of Appeal, 4th App. District.
  CA. Supreme Court den. rev. on 9/14/16. Labor Code §4610.5.
  Held: IMR deadline to issue determination is directory, not mandatory.
- *Hallmark Marketing v. WCAB (Southard).* Court of Appeal, 3rd App. District. Oral argument set for 4/17/17. WCAB panel concluded IMR deadline to issue determination is mandatory, not directory.
- *Baker v. WCAB.* Court of Appeal, 3rd App. District. Oral argument set for 4/17/17. WCAB panel concluded IMR deadline to issue determination is directory, not mandatory.

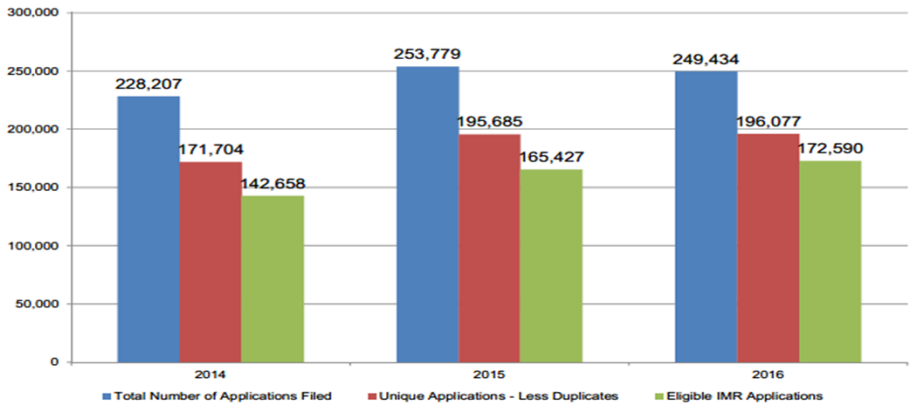




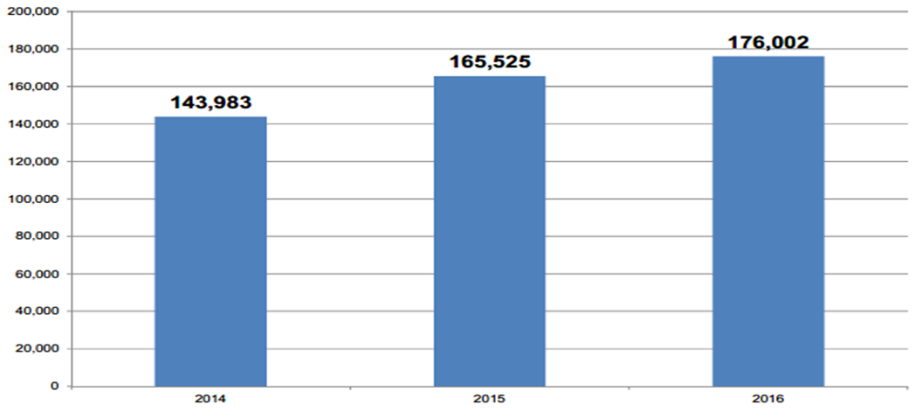
IBR Fee Schedule Categories (2016)



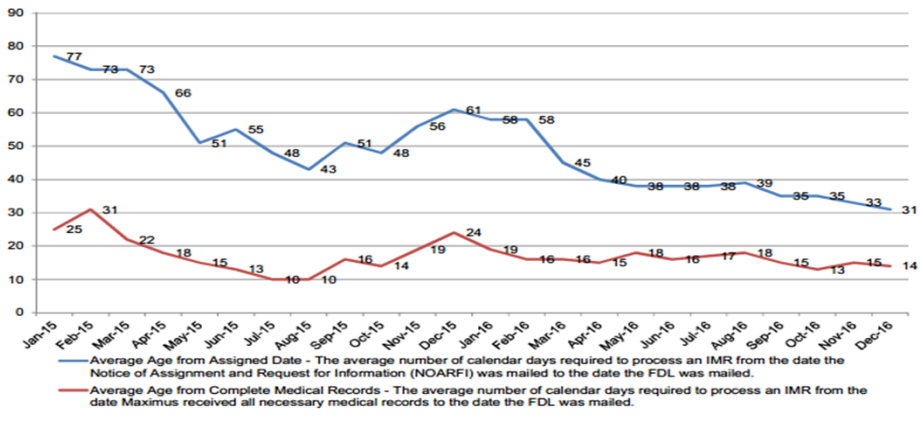
IMR Application Filings



IMR Final Determination Letters (FDL's) Issued

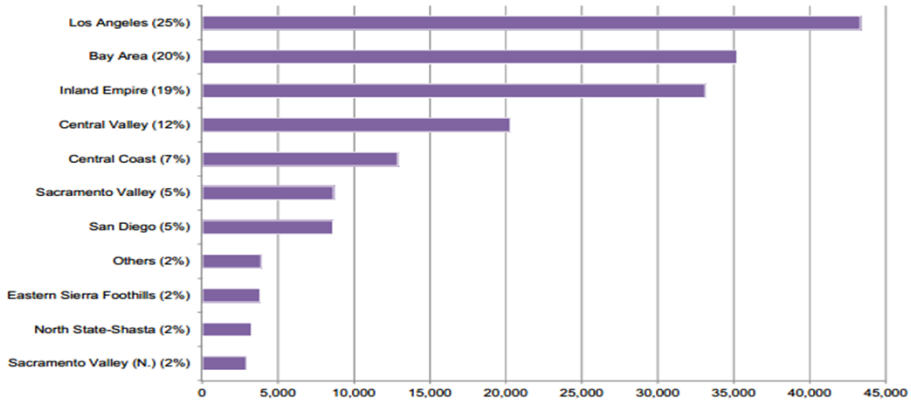


IMR – Timeliness of Decisions

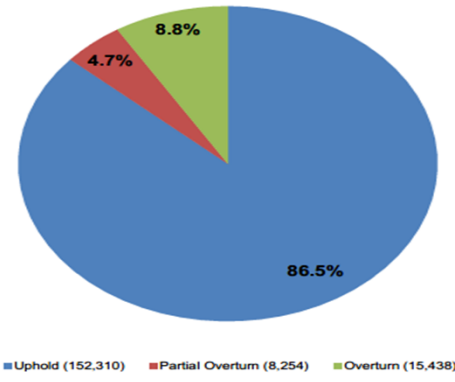


IMR – Geography of Injured Workers

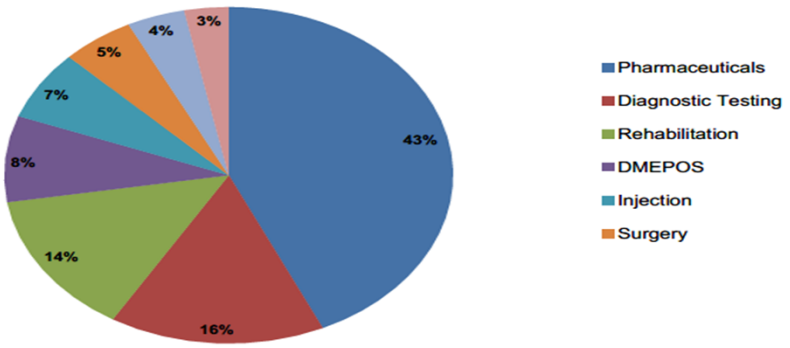
(2016 Case Decisions)



IMR – Case Decisions (2016)



IMR – Treatment Categories (Q4 2016)



IMR – Most Requested Pharmaceuticals by Drug Class (2016 Decisions)

Drug Class	Total	% of All Pharma Requests
Opioids	44,981	30%
NSAIDs	20,768	14%
Muscle Relaxants	20,393	14%
Topical Analgesics	11,259	8%
Proton Pump Inhibitors	9,627	6%
Total	**107,028**	**72%**

LIENS – SB 1160 AND AB 1244

New Labor Code 4615

- Covers liens filed under both 4600 and 4621 (doesn't mention Petitions under 10451.1)
- Covers interest on the charges covered under those liens
- Stays any action upon filing of criminal charges against a
- physician or provider for an offense involving fraud against the workers' compensation system, Medicare or Medi-Cal.
- Stay remains in place until resolution of the criminal proceedings.
- AD has posted the names of physicians or providers whose liens are stayed.

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New Labor Code 139.31

- (a) (1) The AD shall promptly suspend, pursuant to subdivision (b), any physician, practitioner, or provider from participating in the workers' compensation system as a if the individual or entity meets any of the following criteria:

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New Labor Code 139.31 (cont'd.)

- The individual has been convicted of any felony or misdemeanor:
  - (i) Fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient.
  - (ii) It relates to the conduct of the individual's medical practice as it pertains to patient care.
  - (iii) It is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system.
  - (iv) It is otherwise substantially related to the qualifications, functions, or duties of a provider of services.

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New Labor Code 139.31 (cont'd.)

- Has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.
- The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

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New Labor Code 139.31 (cont'd.)

- The AD has adopted regulations for suspending a provider from participating in the workers' compensation system
- The AD must send written notice to the provider about the right to a hearing regarding the suspension and the procedure to follow to request a hearing.

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New Labor Code 139.31 (cont'd.)

- AD is required to suspend the provider pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the provider requests a hearing and, in that hearing, the provider provides proof that paragraph (1) of subdivision (a) is not applicable.
- The provider may request a hearing within 10 days from the date the notice is sent by the AD.

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New Labor Code 139.31 (cont'd.)

- A request for a hearing stays the suspension.
- A hearing will be held within 30 days of the receipt of the request.
- After the hearing, if the AD finds that paragraph (1) of subdivision (a) is applicable, the AD will immediately suspend the provider.
- The AD will notify the provider's state licensing, certifying, or registering authority of a suspension imposed and shall update the division's QME and MPN databases.

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New Labor Code 139.31 (cont'd.)

- After suspension of a provider, the AD will notify the chief judge of the DWC who will provide written notification of the suspension to district offices and all WCJ's.
- The AD shall also post notification of the suspension on the DWC's Internet Web site.
- These procedures will apply to the adjudication of any liens of a suspended provider suspended including any liens filed by or on behalf of the provider or any clinic, group or corporation in which the suspended provider has an ownership interest.

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New Labor Code 139.31 (cont'd.)

- If the disposition of the criminal proceeding provides for or requires dismissal of liens and forfeiture of sums claimed, all of those liens shall be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding, and orders notifying of those dismissals may and shall be entered by WCJ's.
- If the disposition of the criminal proceeding fails to specify the disposition to be made of lien filings in the workers' compensation system all liens pending in any workers' compensation case in any district office within the state shall be consolidated and adjudicated in a special lien proceeding.

82

New Labor Code 139.31 (cont'd.)

- After notice of suspension, the AD will appoint a special lien proceeding attorney. This attorney will identify liens to be consolidated, and workers' compensation cases in which those liens are pending, and shall notify the chief judge regarding those liens. Based on this information, the chief judge shall identify a district office for a consolidated special lien proceeding to adjudicate those liens, and shall appoint a WCJ to preside over that proceeding.

83

New Labor Code 139.31 (cont'd.)

- There is a presumption that all liens to be adjudicated in the special lien proceeding, and all underlying bills for service and claims for compensation arise from the conduct subjecting the physician, practitioner, or provider to suspension, and that payment is not due and should not be made on those liens.
- A lien claimant shall not have the right to payment unless he or she rebuts that presumption by a preponderance of the evidence.

84

New Labor Code 139.31 (cont'd.)

- The special lien proceedings shall be governed by the same laws, regulations, and procedures that govern all other matters before the appeals board. The AD shall promulgate regulations for the implementation of this section.
- If it is determined in a special lien proceeding that a lien does not arise from the conduct subjecting a provider to suspension, the WCJ shall have the discretion to adjudicate the lien or transfer the lien back to the district office having venue over the case in which the lien was filed.

85

New Labor Code 139.31 (cont'd.)

- At any time following suspension, a provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice, which shall constitute a final disposition of the claim for compensation asserted therein.

86

4903.05 Amendments

- **For liens filed on or after January 1, 2017**
- Must file a copy of the original bill along with the full statement or itemized voucher when filing the lien.

87

New Declaration

- Must submit a declaration, stating under penalty of perjury, that the dispute is not subject to IBR and IMR under 4603.6 and 4610.5.
- Must satisfy one of the following:
  - Treating physician is in the MPN
  - Is the QME or the AME in the case
  - Has provided treatment authorized under 4610

88

New Declaration (cont'd.)

- Has made a diligent search and determined that the employer doesn't have an MPN
- Has documentation to support that medical treatment has been neglected or unreasonably refused.
- Is for an emergency medical condition (HS 1317.1)
- Is a certified interpreter providing a med-legal eval, a copy service providing med-legal services or has an expense allowed as a lien

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Declaration Deadline

Only Liens Required to Pay a Filing Fee

- Must file along with liens filed on or after 1/1/2017
- For liens filed prior to 1/1/2017, must file by 7/1/2017.
- Failure to file the declaration shall result in the lien being dismissed with prejudice by operation of law.
- Filing of a false declaration are grounds for dismissal with prejudice with notice.

90

Assignments

- For liens filed on or after 1/1/2017, liens shall not be assigned unless the person ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title and interest in the remaining accounts receivable to the assignee.
- The assignment of the lien in violation of this law is invalid by operation of law.

91

Medical bills – SB 1175

Addition to LC 4603.2 (b)

- Effective for services provided on or after January 1, 2017, bills must be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services.
- The AD shall adopt rules to implement the 12-month limitation period, including good cause for an exemption.
- The request for payment is barred unless timely submitted.
- Applies to electronic and Medical-Legal bills as well.

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