



CWCI Details Calif. Workers' Comp Reform Overhaul

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Governor Schwarzenegger fulfilled one of his most ambitious campaign promises April 19 signing Senate Bill 899 (Poochigian), a comprehensive workers' compensation bill that addresses many of the major cost drivers and problems that have plagued the system and driven employers out of the state, according to the California Workers' Compensation Institute (CWCI).

Capping several weeks of negotiations, including a final session that ran into the wee hours of last Thursday morning, state lawmakers passed Senate Bill 889 by Senator Charles Poochigian on Friday afternoon. The vote was 77-3 in the State Assembly, and 33-3 in the State Senate. Schwarzenegger, who had made overhauling the state's troubled workers' compensation program a centerpiece of his recall election campaign and a top priority of his administration, signed the bill at a ceremony at a Boeing plant in Long Beach.

Among the bill's key provisions:

First-Day Medical Treatment: Employers still have 90 days to investigate and determine compensability of a work injury claim, but effective immediately, within one working day of the filing of a claim form, and until the claim is accepted or rejected, they must now authorize all necessary treatment – up to \$10,000 in medical fees -- consistent with evidence-based medical utilization guidelines developed by the American College of Occupational and Environmental Medicine (ACOEM)/treatment utilization schedule adopted by the Administrative Director of the state Division of Workers' Compensation.

Strengthening of Utilization Review Guidelines: The bill redefines the Labor Code's threshold for what constitutes "medically necessary" treatment, making it consistent with the ACOEM guidelines/ Administrative Director's adopted treatment utilization review guidelines. The bill also grants the presumption of correctness to these guidelines, regardless of the date of injury, and clarifies that the presumption is one affecting the burden of proof. It requires a preponderance of scientific medical evidence and guidelines accepted by the national medical community to overcome the presumption.

Medical Control/Independent Medical Review: For treatment on or after 1/1/2005, SB 899 allows employers and insurers to establish or modify medical provider networks. The networks will be primarily composed of occupational medicine specialists, but will have a goal of at least 25 percent physicians who primarily treat non-occupational injuries. All care provided by the network must be consistent with the ACOEM/Administrative Director-adopted treatment utilization schedule. Under the new law, employers with a provider network will arrange the injured worker's initial medical evaluation, after which the employee may choose another network physician. If the employee disputes the provider's diagnosis or treatment, they must obtain a second and third opinion from within the network. If a dispute exists after that, the worker may appeal to an Independent Medical Reviewer appointed by the Administrative Director, who will issue an opinion on whether the disputed medical services meet the ACOEM/Administrative Director guidelines. If so, the worker may receive those services from either within or outside the network.

Medical Disputes: The bill creates new medical-legal processes for resolving disputed medical issues of both unrepresented and represented workers:

Unrepresented Workers: Allows either party to request a med-legal evaluation and to choose the Qualified Medical Evaluator's (QME) medical specialty (employers may only submit a request if the employee fails to submit the required form within 10 days of receiving it). The employee will be sent a list of three QMEs and has 10 days to select one, schedule an appointment and inform the employer. If they fail to do so, the employer selects a QME.

Represented Workers: For injuries on or after 1/1/05, either party may request a med-legal exam by sending the name of at least one physician to act as an agreed medical evaluator. If there is no agreement within 10 days (or 20 days if agreed), either party may request a QME panel. The requesting party notifies the Administrative Director of their preferred specialty, the other side's preferred specialty (if known) and the treater's specialty. The DWC medical director will assign a panel of three QMEs, and the parties have 10 days to agree on a QME. If they fail, each party strikes one name from the panel.

For both unrepresented and represented workers: Additional medical-legal exams are prohibited if the worker's representation status changes.

Temporary Disability Caps: The legislation sets a limit of 104 weeks of paid TD within 2 years of the first TD payment, except for specified injuries that typically require extended recuperation (e.g., severe burns and amputations), which are capped at 240 weeks within 5 years of the first TD payment.

Return-to-Work Incentives: The measure modifies the return-to-work program created by AB 749, specifying that employers with fewer than 50 full-time employees will be reimbursed for workplace modifications that allow workers injured on or after 7/1/04 to return to work. Other incentives designed to encourage employers to offer return-to-work programs include a 15 percent reduction in the amount an employer has to pay in permanent disability if they offer an injured worker their pre-injury job at the same pay (or provide them a modified or alternative job paying at least 85 percent of their pre-injury wage) for at least one year; and a requirement that injured workers who do not receive a suitable return-to-work offer will be given a 15 percent increase in their permanent disability payments.

Permanent Disability Determination: The Administrative Director of the Division of Workers' Compensation is required to adopt a new, objective, uniform Permanent Disability Rating Schedule by 1/1/05. PD determinations will be based on a formula that reflects the injured worker's future loss of earning capacity rather than their ability to compete in the open labor market. The formula will incorporate results of research by the RAND Corporation and other studies showing the average percentage of long-term income loss by injury type. The new law also requires that determinations of physical injury or disfigurement must incorporate descriptions, measurements and percentages of impairment based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition.

Permanent Disability Benefits: For injury dates on or after the effective date of the revised PD schedule (due 1/1/05), PD benefits to severely injured workers will be increased, while awards for minor PDs will be reduced. Specifically, the legislation provides that the most severely injured workers – those with permanent disabilities rated 70 to 99.75 percent -- will receive 16 weeks of payments for each 1 percent of PD – up from 9 weeks under the old system; while workers with minor permanent disabilities -- those rated 0.25 percent to 15 percent -- will receive 1 less week of payments for each 1 percent of PD.

Apportionment: Under the new law, an injured worker's disability will be based on causation, and all permanent disability reports must consider what portion of the disability is attributable to work. The employer's liability will be limited to the percentage of PD directly caused by the work injury. The statute 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.

Penalties: The old system allowed claims administrators to be assessed a 10 percent penalty on an entire specie of benefit (e.g. all medical costs – past, present, and future) if it was found that there had been an unreasonable delay or refusal to pay a benefit (LC Section 5814). The new law, effective 6/1/04, bases the penalty on the amount of the late payment and caps the penalty at 25 percent of the late payment or \$10,000, whichever is less, and claims administrators who discover a potential violation before the employee claims a penalty will be allowed to correct the error by paying the amount owed plus a 10 percent self-imposed penalty. The law also reduces the amount of the 5814 penalty by the amount of any self-imposed penalty paid under Labor Code Section 4650, and sets a 2-year statute of limitations from the date payment of compensation was due. In addition, SB 899 establishes a new penalty of up to \$400,000 for any employer or insurer who is found to knowingly incur 5814 penalties with such frequency as to indicate a general business practice.

SB 899 also added clean-up language to address some of the drafting problems in the 2003 workers' comp reforms (AB 227 and SB 228), including removal of duplicative voc rehab provisions; reinstatement of 100 percent user funding for DWC; parameters for the mandatory injury illness and prevention programs; and modifications to allow claims administrators to authorize more than 24 visits for chiropractic care, physical therapy or occupational therapy without losing other utilization review controls.

Institute staff continues to analyze the bill and plans to post a more detailed summary under "Policy Issues" in the Newsroom on the CWCI Web site (www.cwci.org). CWCI also will conduct a seminar in early June to educate the community about the changes, as the bill was enacted as emergency legislation, so many elements take effect immediately. Seminar details and registration information will be posted under "Upcoming Events" in the Newsroom. In the meantime, copies of SB 899 can be downloaded from www.leginfo.ca.gov/bilinfo.html.

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