STATE EMPLOYMENT LAWS

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Workers' Compensation Changes for 2013

Due to a projected increase of 12.6 percent on the cost of workers' compensation insurance (from $14.8 billion to $19 billion), Governor Jerry Brown signed into law significant changes to the California workers' compensation system on Sept. 18, 2012. The changes became effective on **Jan. 1, 2013**.

According to a statement from Governor Brown, the changes will reduce systemic inefficiencies and unnecessary expenses and are projected to save businesses $1 billion in 2013, increase payments to disabled workers by 30 percent and improve the delivery of medical treatment, retraining and other benefits.

The legislation was supported by both Democrats and Republicans and is intended to benefit employers and employees in California by reducing costs, increasing benefits and improving the system overall. Below is a brief overview of the major changes in this workers' compensation reform.

PERMANENT DISABILITY BENEFIT CHANGES

Increased Benefits

The amended statutes enable injured employees who are permanently disabled to receive higher benefits by increasing impairment ratings by 40 percent and raising the amount of weekly benefits over a two-year period. Some estimate that these changes translate into $860 million in additional benefits for injured employees. The new law aims to finance this increase in benefits by relying on savings derived from a leaner and more predictable system, rather than increasing employer contributions.

Delayed Payment

Under the amended statutes, an employer is not obligated to provide wage replacement benefits for a worker with a permanent disability if:

- An award for permanent disability has not yet been issued; and
- The employer has offered the employee a position that pays at least 85 percent of his pre-injury average wages or the employee already works in a position that pays at least 100 percent of his pre-injury wages.

However, once an award for permanent disability is authorized, an injured employee is entitled to receive these benefits retrospectively from the date the last benefit for temporary disability was paid or the date the employee's disability became permanent and stationary, whichever is earlier.

INDEPENDENT MEDICAL REVIEW (IMR)

Process Prior to 2013

Under the system in place prior to 2013, injured workers are required to receive an initial evaluation of their injury from a physician that belongs to the Medical Provider Network. The network physician also determines the extent of disability caused by the injury and proposes a medical treatment plan. The plan then goes through utilization review.

Employers and insurance carriers use the utilization review process to evaluate whether treatment plans follow authorized medical standards. The utilization review also

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determines how much of the treatment will be covered by the employer's workers' compensation insurance policy.

In theory, employers that disagree with a treatment plan can contest it through an IMR system. In practice, however, parties usually bring their medical treatment issues to the California Workers' Compensation Appeals Board (WCAB) for hearings, using judicial appeal mechanisms as necessary.

Process for 2013 and Beyond

For any occupational injury or illness occurring on or after Jan. 1, 2013 and for any utilization review decision communicated to a requesting physician on or after July 1, 2013 (regardless of the date of injury), the amended statutes force disputing parties to resolve their disputes through the IMR process (including whether their employees are adequately released from care). This change is intended to help employers, injured workers and physicians avoid litigation costs and provide a faster determination on treatment for injured workers.

The IMR is limited to an examination of whether the proposed medical treatment is a medical necessity. A **medical necessity** is a treatment that is "reasonably required to cure or relieve the injured employee of the effects of his or her injury." This process must be used even when considering a dispute regarding spinal surgery, a dispute process that follows an entirely different medical dispute resolution track under the pre-2013 system. The physician who conducts an IMR must be an uninterested third party. The new laws set detailed parameters to ensure that the IMR physician conducts an independent and uninterested review. A physician who has a financial interest in a particular case may not participate in the case review.

IMR physicians must use a specific hierarchy of medical authorities to render his or her evaluation. If the case is reviewed by a panel of physicians, the majority's decision prevails.

IMR physicians must render their decisions in writing **within 30 days** and must use plain and simple language so a layperson may understand, as much as possible, the reasoning used for the decision. The review process can be expedited to **three days** if there is an imminent and serious threat to the health of the employee.

Appealing an IMR Decision

Appealing an IMR decision is difficult under the amended statutes. A party can appeal an IMR only if it can prove with clear and convincing evidence that:

- The decision was made without or in excess of the reviewer's authority;
- The decision was procured by fraud;
- The IMR physician was subject to a material conflict of interest;
- The decision was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability; or
- The decision was the result of a plainly erroneous express or implied finding of fact (the fact must be based on ordinary knowledge, not subject to expert opinion).

Criticisms of the IMR System

Opponents of the revised IMR system argue that it does not allow for an accurate review of an injured worker's condition, substantially decreases individual access to treatment and jeopardizes the quality of care available to injured workers. They believe that the new IMR system is a paper review process that deprives injured workers of a face-to-face medical re-evaluation and compromises constitutional due process rights.

TREATMENT RESTRICTIONS

Psychiatric, Sleep and Sexual Disorders

Under the amended statutes, treatment for psychiatric disorders, sexual dysfunctions and sleep dysfunctions will be paid for through workers' compensation only if the disorder or dysfunction is the direct result of an industrial injury. In other words, treating physicians generally cannot increase a disabled worker's impairment rating to accommodate for these conditions when the conditions are not the direct result of an accident but develop because of a compensable physical injury.

However, the amended statutes do allow physicians to increase an impairment rating when psychiatric injury is the result of direct exposure to a significant violent act or a catastrophic injury. The definitions of violent act, significant violent act and catastrophic injury remain unchanged in the amended statutes.

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Chiropractic Treatment

The amended statutes restrict a chiropractor's status as a treating physician in the Medical Provider Network. As of Jan. 1, 2013, a chiropractor is a treating physician to an injured worker only during the number of visits allowed by the Medical Treatment Utilization Schedule.

Home Health Care Services

The amended statutes place additional restrictions on covered home health care services. These services can be provided as medical treatment only if they are reasonably required to cure or relieve the injured employee from the effects of his or her injury, and they are prescribed by a licensed physician.

These services do not have to be covered if they are provided **more than 14 days before** the employer receives the physician's prescription.

Criticism of Treatment Restrictions

Some health care providers also oppose the treatment restrictions. They claim that standardized, prescribed procedures are not always in the best interest of injured workers and that increased Medical Provider Network oversight on the workers' compensation system will increase treatment costs and cause delays in delivering adequate care.

MISCELLANEOUS CHANGES

Interpreters

The amended statutes give employees the right to have access to certified interpreters during administrative hearings, medical treatment appointments and other proceedings at their employer's expense. The Division of Worker's Compensation (DWC) determines the qualifications interpreters must meet to provide their services and the fees they can collect.

Independent Bill Review

Under the amended statues, medical service billing disputes for injuries on or after Jan. 1, 2013, will be resolved through non-judicial, independent bill review (IBR). The IBR applies to any medical service bill if the fees were determined by the DWC's fee schedule.

Burial Expenses

Under the amended statutes, burial expenses increase **from $5,000 to $10,000** for injuries occurring on or after Jan. 1, 2013.

SELF-INSURED EMPLOYERS

Beginning in 2013, additional restrictions will be placed on employers that self-insure workers' compensation benefits. Certain types of employers will not be permitted to self-insure these benefits and those that do will be subject to revised deposit requirements.

Self-Insurance Restrictions

Under the amended statutes, an employer must have the Department of Industrial Relations' (DIR) authorization to self-insure if it has previously allowed its workers' compensation coverage to lapse.

In addition, starting on Jan. 1, 2013 new authorization to self-insure will not be issued to certain employers. Moreover, under the amended statutes, all self-insurance authorizations issued to these employers prior to Jan. 1, 2013 will be revoked or phased out by Jan. 1, 2015.

Affected employers include:

- Professional employer organizations;
- Leasing employers;
- Temporary service employers; and
- Any employer in the business of providing employees to other employers.

Deposit Requirement Changes

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Prior to 2013, the DIR required a deposit equal to 125 percent of the employer's estimated future liability for compensation plus 10 percent of the employer's estimated liability relating to the administrative and legal costs associated with the payment of benefits.

The amended statutes require a deposit equal to the sum of the following figures, as they are calculated on Dec. 31 of each year:

- The employer's projected losses;
- Net of specific excess insurance coverage;
- Incurred but unreported liabilities (IBNR);
- Allocated loss adjustment expense; and
- Unallocated loss adjustment expense.

The deposit must be paid by May 1 of each year, as with the previous formula. An employer that overpays its deposit will be able to receive a refund only if it receives the consent of the Self-Insurer's Security Fund, if there has not been an order of default or if the funds are not part of the composite deposit.