Contra Costa County Schools Insurance Group

Important Overview on SB 863
Workers' Compensation Reform

Gov. Jerry Brown signed SB 863, the 2012 workers' compensation reform bill designed to increase permanent disability benefits, reduce frictional costs, expedite medical treatment for injured workers, and address other California workers' compensation cost drivers. Details were negotiated by representatives of labor, major employers, the legislative leadership and the Brown Administration during closed door sessions over several months. Applicants' attorneys, medical provider lobbyists and some labor unions vehemently opposed the bill, but following intense lobbying by the governor, the State Assembly passed the final version of SB 863 on a vote of 66-4, while the State Senate passed the measure on a 34-4 vote. Among the key issues addressed:

Permanent Disability (PD):

- Sets new minimum/maximum weekly PD payments
  - For workers injured on or after 1/1/13:
    - PD ratings below 55%: minimum $160/maximum $230
    - PD ratings of 55% or greater but less than 70%: minimum $160/maximum $270
    - PD ratings of 70% or greater but less than 100%: minimum $160/maximum $290
  - For workers injured on or after 1/1/14: minimum $160/maximum $290
- Revises the permanent disability rating formula
  - Removes the diminished future earning capacity modifier
  - Requires all AMA Guides impairment ratings to be multiplied by a 1.4 whole person impairment modifier
  - Deletes psych, sleep and sexual dysfunction add-ons except for victims of violent acts or catastrophic injury (though employers remain liable for medical care related to these conditions)

Return to Work:

- Eliminates the 15% PD bump up/bump down return-to-work (RTW) incentives
- Calls for a $120 million RTW fund through Division of Industrial Relations for workers suffering disproportionate loss of earnings
- Repeals PD advances if employer offers RTW at 85% of prior wage or worker has a job making his prior pay

Supplemental Job Displacement Benefit (SJDB):

- Provides an SJDB voucher of up to $6,000 for qualifying PD claims with injury dates on or after 1/1/13
- Requires SJDB to be offered earlier (within 20 days after the time for making an offer of regular, modified or alternative work expires)
- Establishes that if vouchers issued on or after 1/1/13 are not used, employer's SJDB liability terminates 2 years after the voucher issue date or 5 years after the injury date, whichever is later
- Prohibits settlement or commutation of a claim for SJDB

Official Medical Fee Schedule (OMFS) / Medical Payments:

- Mandates adoption of Medicare's Resource-Based Relative Value Scale (RBRVS) Schedule for physician services, to be phased in over 4 years beginning in 2014, and to remain in effect until the Division of Workers' Compensation adopts an RBRVS schedule that allows no more than 120% of the aggregate fees allowed by Medicare
- Reduces time frames for contesting and paying paper medical bills from working days to calendar days

Other Fee Schedules: Requires new fee schedules for home health care, certified interpreters and copy services; modifies the Ambulatory Surgery Center fee schedule and the requirements for a vocational expert schedule

Independent Medical Review (IMR): Calls for creation of a 30-day IMR process for medical treatment disputes. IMRs will not involve a physical exam of the worker, but decisions must be supported by evidence-based guidelines or specified standards. Employers will pay a flat IMR fee of under $500, and will not be liable for self-procured treatment prior to the IMR. Also limits grounds for appealing IMR decisions

Medical Provider Networks (MPNs): Deems DWC-approved MPNs to be valid and sets forth new MPN rules:

- Failure to provide MPN notice is not an adequate basis for workers to seek non-MPN care unless it led to denial of care
- Employers are not liable for the cost or consequences of non-MPN treatment if the employee was not entitled to out-of-network care
- Self-procured, non-MPN medical reports cannot be the sole basis of an award, but issues raised in such reports must be addressed by the primary treater or a qualified medical evaluator
- Employers must be granted an expedited hearing within 14 days if an employee seeks non-MPN treatment
- MPNs must provide medical access assistants to help injured workers get treatment and make appointments

Medical Care:

- Repeals LC §5318 duplicate payment allowances for spinal surgery hardware, but calls for the DWC Administrative Director to adopt a regulation by July 2013 specifying additional fees to sufficient to cover costs that include surgical hardware for some spinal surgery diagnostic groups
- Eliminates the spinal surgery second opinion process
- Reduces ambulatory surgery center fees from 120% to 80% of Medicare's hospital outpatient surgery department facility fee schedule
- Requires an RBRVS fee schedule that sets physician fees in proportion to the cost of providing the service
- If necessary, requires employer-paid, certified interpreters, at medical treatment visits

Med-Legal Process:

- Eliminates the "the AME/QME dance" [i.e., the requirement to seek an Agreed Medical Evaluator (AME) before obtaining a Qualified Medical Evaluator (QME) panel]
- Prohibits chiropractors from serving as a primary treating physician beyond the 24-visit treatment cap
- Limits QMEs to 10 office locations to prevent "phantom QMEs" operating out of hundreds of offices

Independent Bill Review (IBR): Calls for an independent bill review process to handle medical billing disputes

- Requires the employer to make the payment with an Explanation of Review (EOR)
- If a provider disputes the amount paid, they may request a second review within 90 days of service of the EOR
- The payor has 14 days from the request for a second review to respond on each item or amount in dispute, and 21 days from the receipt of the request for a second review to pay any undisputed amounts
- A provider who contests the amount paid after the second review has 30 calendar days from the service of the second review to request an IBR and submit an IBR fee to the DWC
- DWC will contract with independent bill reviewers to review the disputed bill and issue an opinion within 60 days. IBR fees will be reimbursed to the provider if any additional amount payment is due
- IBR determinations are considered binding, with both parties given limited opportunity to appeal within 20 days

Liens:

- Effective 1/1/13, requires a $150 lien filing fee for new liens and a $100 lien activation fee for existing liens
- Liens for services provided on or after 1/1/13 must be filed within 3 years of the service date, and within 18 months of the service date for a service provided on or after 7/1/13
- Liens may not be filed for unbilled services, fee schedule bill disputes, or before payment is dueWith limited exception, only the person entitled to payment (not an assignee) may be awarded payment of a lien

Some elements of SB 863 will be phased in during 2013 and 2014, but many provisions take effect in January 2013, so the workers' compensation community must gear up quickly.

Information compiled from California Workers' Compensation Institute bulletins.