Case Law – The Fight Goes On!
Litigation Post-SB 863 Year Two

presented by:

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The firm provides high-quality litigation in defense of workers’ compensation claims, employment issues and insurance litigation.

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Author of “Sullivan on Comp,” which covers the complete body of California workers' compensation law.
The firm is a recognized leader in representing injured employees in workers’ compensation and third-party civil claims.

Works closely with many of Southern California’s major labor unions to improve working conditions and champion members’ rights.

Serves on CAAA committees and is active in Sacramento, fighting for legislation benefiting injured workers.
Plan For This Session

- Discuss the most important cases in the two years since SB 863
- Hear the respective positions of the defense and applicant sides and what to expect moving forward
- Limited time, but questions are encouraged
SB 863 created the independent medical review (IMR) process to resolve medical treatment disputes when utilization review denies, delays or modifies a request for medical treatment.
The WCAB held en banc:

- Issues of timeliness and compliance with the UR statutes and regulations are within the jurisdiction of the WCAB.

- A UR decision is invalid if it is untimely or suffers from a material procedural defect that undermines the integrity of the UR decision, but minor technical or immaterial defects will not invalidate a UR determination.

- If a UR determination is invalid, the issue of medical necessity is not subject to IMR, but is to be determined by the WCAB based on substantial medical evidence. The employee has the burden of proving treatment is reasonably required.
If the UR determination is timely and valid, the issue of medical necessity shall be determined by IMR.

The WCAB further explained that a UR decision will be deemed materially defective if the UR physician does not consider all reasonably necessary medical information, and fails to list all medical records reviewed.

The WCAB remanded for the WCJ to determine whether the requested treatment was reasonable and necessary.

On May 22, 2014, the WCAB granted reconsideration to further study the factual and legal issues of the case.

The original decision remains in effect and binding.
Since *Dubon*, these panel decisions have issued:

- **Gomez v. Facilities Support Services**, 2014 Cal. Wrk. Comp. P.D. LEXIS 149 (remanded for WCJ to determine whether UR decision incorrectly stating that left knee was a denied body part was a material defect).

- **Weilmann v. United Temporary Service**, 2014 Cal. Wrk. Comp. P.D. LEXIS 163 (UR determinations invalid for failure of reviewing physicians to sign their reports, and failure to provide relevant AME reports that explained medical necessity of requested treatment).


What do we think of this decision?

- Will the WCAB rescind or modify its original decision?
- Is the original decision consistent with the intent of SB 863?
- What’s going on at the WCAB because of *Dubon*?
SB 863 made multiple changes related to home health care.

- LC 4600(h) provides that home health care shall be provided only if prescribed by a physician and surgeon.

- LC 4603.2(b)(1) requires a provider of home health-care services to submit an itemization of the services provided.

- LC 5307.8 establishes a fee schedule for home health-care services, and also provides that no fee shall be provided for any services to the extent that they had been performed regularly in the same manner and to the same degree prior to the injury.

- LC 5307.8 also allows attorneys’ fees for recovery of home health-care fees.
The WCAB held *en banc*:

- LC 4600(h), LC 4603.2(b)(1) and LC 5307.8 apply to requests for home health care in all cases that are not final, regardless of the date of injury or dates of services.

- The prescription required by LC 4600(h) is either an oral referral, recommendation or order for such services communicated directly by a physician to an employer, or a signed written referral, recommendation or order by a physician.

- Under LC 4600(h), home health-care services may be covered by the OMFS in LC 5307.1 or the home health-care schedule under LC 5307.8.
The prescription must be provided by a practitioner who is licensed by the Medical Board or Osteopathic Medical Board (M.D. or D.O.).

Whether a prescription is oral or written, an injured worker has the burden of proving that it exists and that it was received by the employer.

An employer may receive a prescription in the form of a request for authorization, a medical report or a medical record.

If an employer receives an oral communication or document that is ambiguous, it has a duty to investigate.
The WCAB noted that although the home health-care fee schedule is to be based on the IHSS regulations, those regulations themselves don’t govern home health care under LC 4600(h). (The IHSS regulations limit care to 283 hours per month or nine hours per day.)

Because a fee schedule hasn’t been adopted, the applicant bears the burden to demonstrate a reasonable hourly rate for the type of services provided, and the number of reasonably required hours.

An injured worker may seek reimbursement for home health-care services or an award of future medical care in the form of home health care.
A provider of home health-care services must comply with LC 4603.2(b)(1) in order to be paid.

The WCAB remanded because there were issues as to prescription requirement, what services actually were needed and what services actually were performed before and after the injury.

The WCAB added that any award of reimbursement would be based on an appropriate rate for a similar caregiver, not on the spouse’s loss of earnings from previous employment.

What do we think of this decision?

- What does this mean for existing home health-care liens?
- What must an employee prove to be awarded and paid for home health care?
- How can an employee prove the reasonable value of home health-care services without the fee schedule?
SB 863 amended LC 5502(b) to provide for an expedited hearing to address the question of whether the injured worker is required to obtain treatment within an MPN.

CCR 10252 still states that an expedited hearing is permitted “[w]here an injury to any part or parts of the body is accepted.”

**Issue:**

During the 90-day investigation period described in LC 5402(b), is a party entitled to an expedited hearing pursuant to LC 5502(b) to address the provision of reasonable medical treatment through an employer’s MPN?
The WCAB held in a significant panel decision:

- A party is entitled to an expedited hearing to address the provision of reasonable medical treatment through the employer's MPN during the 90-day investigation period.

- It explained that CCR 10252 preceded the amendments to LC 5502(b) by SB 863, and was invalid to the extent it was inconsistent with the statute.

- It also explained that LC 4616.3(a) requires a defendant to commence treatment within its MPN when it receives notice of the injury, even if the claim has not been accepted or denied.
What do we think of this decision?

- What does this mean for attempts to treat outside of the MPN during the delay period?

- What must an employer do to maintain treatment within the MPN during the delay period?
Navarro v. City of Montebello (2014) 79 CCC 418 (WCAB en banc)

- CCR 35.5(e) provides that, in the event of a new injury involving the same body part or body system and the parties are the same, the parties shall utilize the same evaluator who previously reported.

- This regulation was adopted in 2009, before SB 863.

- Is the regulation valid?
The WCAB held *en banc*:

- The Labor Code does not require an employee to return to the same panel QME for an evaluation of a subsequent claim of injury.

- CCR 35.5(e) is inconsistent with the Labor Code and is invalid.
There is no reference in the Labor Code to same or different body parts. So, CCR 35.5(e) imposed an unwarranted limitation on the Labor Code.

Parties are not precluded from returning to the same evaluator for subsequent claims of injury; an employee may be evaluated by a new evaluator for each injury or injuries reported on a claim form after an evaluation has taken place.

The evaluator shall consider all issues arising out of any claims that were reported before the evaluation. If several subsequent claims of injury are filed before the evaluation by the new evaluator takes place, the new evaluator must consider all of them.
Navarro v. City of Montebello (2014) 79 CCC 418 (WCAB en banc)

What do we think of this decision?

- Does this decision favor one side or the other?
- Does this change how claims are defended or pursued?
- Are we back to dueling QMEs in cases of multiple injuries?
SB 863 adopted a lien activation fee of $100 for medical treatment liens filed before Jan. 1, 2013.

Lien claimants have challenged the constitutionality of the lien activation fee.

On Nov. 12, 2013, the U.S. District Court for Central District of California determined that the fee was unconstitutional and issued a preliminary injunction restraining the Department of Industrial Relations from enforcing and collecting the lien activation fee.
What do we think of this decision?

- How does this decision affect liens that should have been dismissed by operation of law as of Jan. 1, 2014?

- How does the U.S. District Court’s injunction affect liens that have been dismissed for failure to pay the lien activation fee?

- Does this have any effect on the lien filing fee?
Thanks for listening!!

- Questions?

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