Governor Arnold Schwarzenegger signed the workers’ compensation reform package on Monday, April 19, 2004. SB 899, authored by Senator Charles Poochigian (R-Fresno), is a compromise measure that resulted from months of intense negotiations among the Governor, legislators and the interested parties. This bill is a comprehensive package addressing numerous issues from permanent disability to return to work programs.

Permanent Disability (PD)

The PD rate schedule has been based on three factors: (1) objective medical findings; (2) subjective medical findings; (3) decreased ability to compete on the open labor market.

SB 899 incorporates the AMA guidelines, 5th edition into the PD rate schedule. Further modifying the PD schedule, the term “an employee’s diminished future earning capacity” has replaced the term “an employee’s decreased ability to compete on the open market.”

For injured workers who do not receive an offer to return to work, PD is increased by 15%. For injured workers who receive an offer to return to work, PD is decrease by 15%. Small employers, defined as those employers that have less than 50 employees, are exempt from this provision.

In addition, PD is increased for injured workers who are over 70% disabled thereby providing additional assistance to those most in need. At the same time, PD is decreased for injured workers who are under 15% disabled, the area most in need of adjustment.

Report Writing and Diagnosis in PD

Under existing law PD evaluations are to be supported to the extent feasible by medical findings based on standardized examination and testing techniques generally accepted by the medical community. Existing law further specifies that measurements of the physical elements of a disability should follow the recommendations of the Joint Committee of the California Medical Association and the Industrial Accident Commission (1960).
SB 899 will require medical evaluations to be made in accordance with descriptions and measurements used in the most recent edition of the AMA guidelines, beginning January 1, 2005. This will allow time for adoption of a new PD rating schedule and AMA guides.

Procedures for determining diagnosis and treatment have to be in accordance with the American College of Occupational and Environmental Medicine (ACOEM) guidelines. In the instances where ACOEM guidelines are not applicable, a physician shall be required to utilize peer reviewed, evidence-based, nationally recognized standards of care. In addition, these new statutes restrict the admissibility of evidence of disability or reasonableness of medical treatment to reports that comply with the ACOEM guidelines.

Causation and Apportionment

Under existing law an injury is “compensable” under workers’ compensation if the workplace in any way causes the injury, i.e. a “proximate cause” standard. Psychiatric and post-termination claims have to meet a higher “predominant cause” standard. Although existing law provides that prior injuries should be taken into account when determining PD awards, case law has severely restricted such apportionment.

SB 899 requires that any compensation for a permanent disability be based on a direct causation and that the liability of the employer be limited to that which is apportioned to work-related activity. Appointment is applicable to all claims regardless of the date of injury. The employee must disclose all prior relevant compensated injuries and non-occupational labor disabling injuries. The employer has the burden of proof.

A physician shall determine the PD benefit by apportioning the percentage resulting directly from a work-related injury with those caused by other factors both before and subsequent, including prior work-related injuries.

Temporary Disability (TD)

Currently, TD is capped at 240 weeks within a period of 5 years from the date of injury.

For injuries after April 19, 2004, TD benefit payments are capped at 104 weeks within a period of two years from the first payment by an employer. TD awards may exceed the 104 week/two-year “cap” under the following conditions: acute and chronic Hepatitis A or C; HIV; amputations; severe burns; high velocity eye injuries; chemical burns to the eyes; Chronic Lung Disease; and Pulmonary Fibrosis.

Medical Care
Medical Provider Networks

Under existing law, employers are allowed to contract with a state certified health care organization (HCO) for the provision of medical care to an injured worker.

For treatment beginning January 1, 2005, SB 899 will allow employers to contract with networks of doctors as now done with group health plans. An employee will be able to see three different doctors within the network and then can seek an independent medical review (IMR), paid for by the employer. If the IMR agrees with the injured worker, the injured worker can receive necessary treatment outside the network at the employer’s expense.

The network of doctors must ensure adequate and appropriate care, including sufficient geographical coverage, an adequate number of specialists, the availability of a specified percentage of non-occupational physicians, and continuity of care, among other things.

Pre-designation of Physician

Right now, the employer has medical control for the first 30 days after the injury is reported. If the employee pre-designates a personal physician, the employee has the right to be treated by that physician from the date of injury.

Pre-designation was hotly debated until the very last, resulting in significant compromise.

Under SB 899, the injured worker is allowed to receive care from his or her group HMO or PPO or from the employer’s network if the employer provides group health insurance and the injured worker pre-designated his or her treating physician within the group. Any physician pre-designated after April 19, 2004 must agree to be designated. Workers who pre-designate their physician must not exceed 7% of the total employees. Insurers must approve referrals to specialists, and such treatments must be from within the HMO or PPO. Insurers may require prior authorization of non-emergency treatments or diagnostic services.

An employee who pre-designates a physician is bound by all the rules of group health insurance. The Division of Workers’ Compensation will study pre-designation to see whether it is cost-effective. The right to pre-designate will sunset in three years.

Immediate Medical Care

Current law allows up to 90 days to accept or deny a claim and to provide necessary medical care. This often resulted in medical treatment postponed up to 90 days.

The employer still has 90 days to determine compensability. But as of April 19, 2004, the employer is responsible to provide initial medical treatment within one working day after an employee files a claim form for a declared work-related injury until the claim is accepted or denied up to a limit of $10,000.
Standard of Care

*Existing law requires medical treatment to “cure and relieve” an injured worker.*

SB 899 now defines “cure and relieve” to be treatment in accordance with ACOEM guidelines.

Limits on Occupational Therapy

Existing law generally limited chiropractic and physical therapy treatments to 24 visits for injuries after January 1, 2004.

SB 899 amended this to include occupational therapy within the 24-visit limitation. The requirement of written authorization for treatments beyond 24 visits has been clarified.

Carve-out Programs and 24-hour Pilot Programs

*Last year, AB 227 (Vargas) and SB 228 (Alarcon) provided for carve-out programs in unionized construction trades permitting benefits to be determined in their collective bargaining agreements that include an alternative dispute resolution (ADR) process.*

This bill expands carve-out programs to other unionized industries to allow a seamless 24-hour health and disability system, without regard to causation, provided that statutory minimum PD benefits are met. SB 899 also provides an option for 24-hour integrated coverage to be included within the existing carve-out programs.

Repeal of the Treating Physician Presumption of Correctness

*Under current law, if a physician is pre-designated by an injured worker, the opinion of that treating physician is presumed to be correct.*

Although the presumption was originally a rebuttable one, over time, courts treated it as a conclusive presumption, which was a major cost-driver in the system.

Effective on signature SB 899 repeals the treating physician presumption of correctness for pre-designated physicians, completing the job begun in last year’s reform package. The repeal applies in all cases, regardless of the date of injury; but it shall not constitute good cause to reopen or rescind, alter, or amend any existing order, decision, or award of the Workers' Compensation Appeals Board.

Medical Disputes

*Current law provides unwieldy and expensive medical-legal processes for resolving disputed medical issues.*
SB 899 creates new medical-legal processes for resolving such disputes for unrepresented and union workers.

For unrepresented workers, SB 899 allows either party to request a med-legal evaluation and to choose the Qualified Medical Evaluator's (QME) medical specialty. If they can’t agree on a physician, the employee has ten days to select a QME from a list of three, schedule an appointment and inform the employer. Otherwise, the employer selects a QME.

For union workers, applicable to injuries after January 1, 2005, either party may request a med-legal exam and suggest a physician to act as the QME. If they can’t agree on the physician, either party may request a QME panel. Selection of the panel follows a procedure overseen by the Department of Workers’ Compensation (DWC) medical director.

For both unrepresented and union workers, additional medical-legal exams are prohibited if the worker’s representation status changes.

**Vocational Rehabilitation:**

Effective on signature SB 899 reinstates old Labor Code Section 139.5, specifically providing that employees injured prior to 1/1/04 are eligible for rehabilitation benefits. The rehabilitation must be completed no later than 12/31/2009, at which time Labor Code Section 139.5 expires.

**Penalties arising from Labor Code Section 5814**

*Under existing law, when payment of compensation is unreasonably delayed or refused, the entire species of benefits, including temporary disability (TD), PD, and medical treatment, not just the late payment, is increased by 10%.*

SB 899 substantially amends this section effective June 1, 2004. After that date, should a payment of compensation be unreasonably delayed or refused to an injured worker, the penalty will be 25% of the late payment, up to $10,000. This penalty will not apply to late payments to physicians unless significant harm to an injured worker resulted. However, there is a new penalty up to $400,000 for a pattern or practice of such conduct. A new two-year statute of limitation will apply to 5814 penalty claims. Section 5814.5 has been reinstated to allow recovery of attorney’s fees.

**User Funding**

*Prior to last year’s workers’ compensation reform package, 80% of the funding for the Division of Workers’ Compensation came from the State General Fund and 20% derived from “user funding.”*
Last year’s workers’ compensation reform package included provision for 100% user funding of the Division of Workers’ Compensation. Unfortunately, subsequent passage of the Budget Act “chaptered-out” or nullified the user funding provision.

SB 899 restores the 100% user funding of the Division of Workers’ Compensation.

**Return to Work Program**

*Existing law enacted in AB 749 (Calderon) in 2002, provided for, but never funded, a return to work program for small and medium-sized employers.*

This bill establishes and funds a return to work program that provides up to $2500 to small employers who need to make workplace improvements or modifications in order to return injured workers to their jobs.

**Statutory Construction**

*Existing law requires that workers’ compensation provisions be liberally construed by the courts and prohibits this provision from relieving a party or a lien claimant from meeting the evidentiary burden of proof by a preponderance of the evidence.*

The term “liberal construction” now is to be interpreted in an impartial and balanced manner in order that all parties are considered equal before the law. While SB 899 does not alter Labor Code Section 3202, it makes clear that the courts now are to interpret evidence in an equally balanced fashion and not construe with the intent to expand benefits, as they were required under Section 3202.

**Injury and Illness Prevention Program (IIPP)**

SB 899 reduces the scope of IIPP requirements in AB 227 and SB 228 enacted last year. Specifically, the requirement that every workers’ compensation insurer conduct a review of the injury and illness prevention program of each insureds within four months of the initial insurance policy term is restricted to employers with an experience modification factor of 2.0 or greater and is extended to within six months of the initial policy term. The review may be done by a licensed California professional engineer, certified safety professional, certified industrial hygienist, or another person working under the direction of such a professional.

**Insurance Rate Study**

After intense months-long debate in and out of the media spotlight, SB 899 requires the Division of Workers’ Compensation in consultation with the Department of Insurance to contract for a report on the impact that the cost savings from this bill and AB 227 and SB 228 of last year have on rates. This bill also requires the study to address the appropriateness of rate regulation. The
insurance industry will pay for the study, up to $1,000,000, proportionately allocated by each insurer’s share of the California workers’ compensation market.