AN ANALYSIS OF THE NEW REGULATIONS REGARDING DISPUTES OVER MEDICAL-LEGAL EXPENSE AND MEDICAL TREATMENT

Effective Oct. 23, 2013, the WCAB adopted new rules of practice and procedure. Changes were made throughout the administrative regulations that alter how practitioners must act. Perhaps the most significant changes relate to what employers and insurers must do to handle disputes about medical-legal expenses and medical treatment.

Of course, SB 863 established the independent medical review (IMR) and independent bill review (IBR) processes in 2012. The bill also changed how utilization review (UR) and medical billing were to be handled. Now, new supplemental regulations present additional requirements for defendants in both areas.

The new rules regarding UR set high standards for processing, and provide for avoiding IMR should they not be met.

Those regarding medical billing require defendants to act timely in dealing with medical-legal and medical treatment bills, and establish that a defendant's failure to timely perform duties specified by the Labor Code or administrative regulations will result in a waiver of objections to the bills.

In addition, the regulations specify that attorneys' fees, costs and sanctions pursuant to Labor Code § 5813 may be imposed on a defendant that fails to comply with the statutory and regulatory requirements regarding medical-legal expenses. Defendants face serious consequences if they do not act timely and properly in dealing with medical-legal expenses and medical treatment disputes.

Do the regulations go too far? Did the WCAB exceed the scope of its authority in adopting them? Do they conflict with the statutes relating to IMR and IBR? This article discusses the procedures for disputing medical-legal and medical treatment under the new regulations, and comments on whether parts of them may be invalid.

This analysis is offered in connection with “Sullivan on Comp.” Although authored by defense attorneys and experts, that treatise is a neutral exposition of California workers’ compensation law. This paper, however, is not. It is an exposition and critique of the new rules. Many of them are invalid and conflict with the statutes. They should be challenged and thrown out.

DISPUTES OVER MEDICAL-LEGAL EXPENSES

The requirements for responding to claims for medical-legal expenses are complex and will prove to be most burdensome to the defense, and particularly to the claims adjuster.

If a medical-legal expense is at issue, the appropriate procedure for contesting a bill depends on the employer's reason(s) for disputing it. Sometimes there is a threshold issue before the parties get to the value of the services rendered. They are discussed below, and include issues such as coverage; whether the service really is medical-legal in nature; and jurisdiction.

If there is no threshold issue, the only dispute is over the value of services rendered. The bill proceeds to submission, second review and, if necessary, IBR. When there is a threshold issue, it is resolved at the WCAB. In other words, the appeals board continues to have jurisdiction over disputes related to medical-legal expenses not covered by IBR. Only after the board resolves the threshold dispute in the medical-legal provider's favor is the remaining issue of the value of services resolved pursuant to the IBR process. For a complete discussion, see “Sullivan on Comp” Section 14.65 “Payment of or Objection to Medical-Legal Expenses.”

Defining Medical-Legal Expenses

The new regulations might be somewhat esoteric because the statutory scheme creates a new environment. In particular, SB 863 eliminated liens for medical-legal expenses under Labor Code § 4903(b). Before that change, the Labor Code allowed liens for medical-legal expenses against the applicant’s claim for benefits.

The change prompts one to wonder how medical-legal billings would be processed. The regulations establish that "… medical-legal expenses may be sought through a claim of costs in the form of a lien" (Cal. Code Regs., title 8, § 10301(h)). So medical-legal expenses are to be allowed, and filing a lien is allowed. But liens are not filed against the applicant’s compensation — rather, they are costs independently allowed directly against the defendant.

Accordingly, the new regulations define exactly what is and is not a medical-legal expense. Specifically, Regulation 10451.1(b) defines a "medical-legal expense" as "any cost or expense incurred by or on behalf of any party for the purposes of proving or disproving a contested claim, including but not limited to:

(A) goods or services expressly specified by Labor Code section 4620(a);
(B) services rendered by a non-medical expert witness;
(C) services rendered by a certified interpreter during a medical-legal examination; and (D) all costs or expenses for copying and related services."

This expands the traditional definition. Labor Code § 4620(a) defines medical-legal, and includes "X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and ... interpreter's fees, …" The new regulation specifies that services by a nonmedical expert witness, including vocational rehabilitation experts, should be treated as medical-legal expenses. And all costs or expenses for copy services are considered medical-legal expenses as long as they are performed in connection with a contested claim. For a complete discussion, see “Sullivan on Comp” Section 14.64 “Defining Medical-Legal Expenses.”

Contesting Medical-Legal Expenses Through IBR

If the only dispute over a medical-legal bill is the amount, the second review and independent bill review procedures must be followed. A defendant must issue an explanation of review (EOR) as required by Labor

Code § 4603.3 within 60 days after receipt of each separate, written billing and report (§ 4622(a)(1)). If the provider contests the amount paid, it may request a second review within 90 days of service of the EOR (§ 4622(b)(1)).

If the provider does not timely request a second review, the bill will be deemed satisfied and neither the employer nor the employee will be liable for any further payment (§ 4622(b)(2)). If the provider does make a timely request for second review, the defendant must issue a final written determination within 14 days of the request (§ 4622(b)(3)). If the provider still contests the amount paid after receipt of the second review, it must request an IBR within 30 days of receipt of the second review determination (§ 4622(b)(4)).

An aggrieved party may appeal an IBR determination within 20 days of its service. If appealed, the matter will be adjudicated by a WCJ at the trial level following the same procedures applicable to claims for ordinary benefits. Any party aggrieved by a final decision of the WCJ may file a petition for reconsideration within the same time limit and in the same manner specified for petitions for reconsideration (Cal. Code Regs., title 8, § 10957).

Non-IBR Medical Legal Disputes

As noted above, if a dispute over a medical-legal bill involves any issue other than the amount, the WCAB retains jurisdiction to resolve it. These are threshold issues. Non-IBR disputes include, but are not limited to:

(A) any threshold issue that would entirely defeat a medical-legal expense claim (e.g., employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction);

(B) whether the claimed medical-legal expense was incurred for the purpose of proving or disproving a contested claim;

(C) whether the expense was reasonably, actually and necessarily incurred;

(D) assertions by a medical-legal provider that a defendant waived any objections to the amount of the bill because it failed to comply with requirements, timelines and procedures of the Labor Code and administrative regulations;

(E) assertions by the defendant that the medical-legal provider waived any claim for further payment because it failed to comply with requirements, timelines and procedures of the Labor Code and administrative regulations;

(F) assertions by a defendant that an interpreter for a medical-legal evaluation was not certified; and

(G) assertions by a defendant that an interpreter was not reasonably required because the applicant proficiently speaks and understands English (Cal. Code Regs., title 8, § 10451.1(c)(1)).

Threshold issues, for the purposes of challenging a claim for medical-legal expenses, do not include disputes over whether an applicant sustained industrial injury or injury to particular body parts. Generally, this is what separates medical-legal expenses from medical treatment expenses. Medical-legal expenses are payable even if an injury is not compensable, because they are frequently incurred to determine the compensability of a claim.

In contrast, a medical-legal report that may not be used as proof because it is not substantial is not compensable (as discussed in depth in “Sullivan on Comp” Section 14.64 “Defining Medical-Legal Expenses”).

It would seem to follow that such a defense would be a threshold issue as well, although not specifically listed in the regulation.

Procedure for Contesting Non-IBR Issues at the WCAB

If an employer disputes a medical-legal bill and a non-IBR threshold issue is involved, the defendant still must issue an EOR defining the legal, medical or factual basis for the denial within 60 days after receipt of the bill and report (§ 4622(a)(1)).

Then, the provider must object to the denial within 90 days of service of the EOR (Cal. Code Regs., title 8, § 10451.1(c)(2)(A)). Again, if the provider does not timely object, the bill will be deemed satisfied.

If the provider timely objects to the EOR, the defendant must file a petition for determination of non-IBR medical-legal dispute and a declaration of readiness to proceed (DOR) within 60 days of the provider's service of the objection (Cal. Code Regs., title 8, § 10451.1(c)(2)).

If the defendant fails to timely file the petition and DOR, the provider may file a petition. It also may file a petition if the defendant breaches its duty at an earlier stage of the non-IBR dispute (Cal. Code Regs., title 8, § 10451.1(c)(3)(A)).

The medical-legal provider is not required to file a DOR with its petition. Nor is the provider required to file a lien in conjunction with its petition (Cal. Code Regs., title 8, § 10451.1(c)(3)(B) and (D)).

Even if a DOR is filed by either the defendant or the medical-legal provider, if there is a threshold issue, the WCAB may defer hearing and determining the issue until either the issued is presented for determination in the underlying claim of the employee, or the underlying claim has been resolved by a compromise release agreement or has been abandoned (Cal. Code Regs., title 8, § 10451.1(c)(4)). One has to think that the WCJ almost always will take advantage of this rule and defer the issue. Otherwise, there’s a bifurcated trial on the issue of this one medical-legal billing.

If the appeals board resolves a non-IBR medical-legal expense dispute in the medical-legal provider’s favor, any outstanding issue over the amount payable must be resolved through IBR, if applicable (Cal. Code Regs., title 8, § 10451.1(d)).

Waiver of Medical-Legal Expense Issues

As outlined above, the Labor Code and the new regulations establish requirements, timelines and procedures that both defendants and medical-legal providers must comply with. Prior to their enactment, there was no question that a provider's failure to comply with requirements would result in a waiver of its claim to additional payment.

Labor Code § 4622 expressly states that a provider's failure to timely request a second review or object to a defendant's denial of a bill on a threshold issue will result in the bill deemed satisfied, leaving neither the defendant nor the applicant with any liability for it (§ 4622(b)(2) and (c)). Labor Code § 4603.6(a) expressly states that a provider's failure to timely request an IBR following a second review will result in the bill deemed satisfied. These situations are codified in the regulations (Cal. Code Regs., title 8, § 10451.1(f)(2)).

But the new regulations go even further; they provide that a defendant will waive objections to a medical-legal provider's bill if it fails to comply with the statutory and regulatory requirements. Needless to say, this is an unwelcome surprise for defendants.

Regulation 10451.1(f)(1)(A) provides that a defendant will be deemed to have waived all objections to a medical-legal provider's billing, other than compliance with Labor Code § 4620 (requirement of a contested claim) and § 4621 (requirement that the expenses be reasonably, actually and necessarily incurred) if either:

1. the provider submitted an properly documented bill and the defendant either failed to issue an EOR in compliance with § 4603.3 and/or failed to make payment consistent with the EOR within 60 days; or

2. the provider submitted a timely request for second review, and the defendant failed to serve a final written determination that complies with the regulations and/or failed to make payment consistent with the final determination within 14 days.

So on receipt of a medical-legal billing, the claims adjuster must object on time or pay on time. If there is second review, the adjuster must respond within 14 days or make payment. Failure to do either means that all objections have been waived, and the bill must be paid.

The only exception to waiver is the argument that there was no contested claim to warrant the medical-legal expense, or that it was unreasonable or unnecessary. These situations have been carved out in line with the well-known case of *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal.Comp.Cases 1598. In that case, it was reasoned that the existence of a contested issue and the reasonableness or necessity of obtaining evidence to speak to the issue are preconditions to the existence of medical-legal evidence. As such, failure to object would be forgiven, as there was no proper medical-legal charge in the first place.

The same sort of rule applies if there is a threshold issue that would force the billing to the appeals board before IBR. Recall that in these instances, the defendant objects within 60 days, and the provider, to avoid waiver, must respond to the objection within 90 days. Then the defense must issue a DOR and petition.

If the defense fails to do so, the statute entitles the provider to file a petition of its own. But the regulations go further. Regulation 10451.1(f)(1)(B) provides that a defendant will be deemed to have waived all objections to a medical-legal provider's billing, other than the amount pursuant to the fee schedule, if it fails to timely file a petition for determination of non-IBR medical-legal dispute and a DOR. Again, the only exception is that there was no contested claim or that the medical-legal expense was unreasonable or unnecessary under Labor Code § 4620 or § 4621.

So even if a defendant appropriately denies a medical-legal bill based on a threshold issue, if, after receiving the provider's timely objection, the defendant fails to file both a petition and a DOR, it loses the right to challenge the bill based on the threshold issue; it may dispute only the amount to be paid.

Therefore, if a defendant violates the time limits of the statute, the following rules regarding waiver apply:

1. An objection on the grounds of Labor Code § 4620 (requirement of a contested claim) and § 4621 (requirement that the expenses be reasonably, actually and necessarily incurred) will survive a late action by the defense.
2. If the defense simply does not object to a medical-legal billing within 60 days, it waives all objections and must pay the bill.
3. If the defense does not respond to a request for second review within the 14 days allotted, it has waived all defenses.
4. If there is a threshold issue, an objection is made within 60 days, and the provider makes a timely reply to the objection in 90 days, the defense must file its DOR and petition. If it does not, it may contest the value of services, but the threshold issues are waived.

Are the New Waiver Regulations Valid?

The regulations establish waiver of a defendant's objections to medical-legal bills for failing to comply with the statutory and regulatory requirements, timelines and procedures. Unlike for medical-legal providers, however, these waiver rules do not exist in the Labor Code. So, are they valid?

If the Legislature had intended for defendants to waive objections to medical-legal expenses by failing to comply with the relevant timelines and procedures for payment of them, it would have done so. But the Legislature did not enact any waiver provisions for defendants.

The only penalty specified in the Labor Code for failing to timely pay a bill is that "the portion of the billed sum then unreasonably unpaid shall be increased by 10 percent, together with interest thereon at a rate of 7 percent per annum retroactive to the date of receipt of the bill and report by the employer" (§ 4622(a)(1)). (See "Sullivan on Comp" Section 13.30 Unreasonable Delay – Failure to Pay Medical-Legal Benefits.) The additional waiver penalty is an unwarranted imposition on a deliberate statutory scheme — a scheme explicitly devised to curb billing in the system.

Furthermore, in adopting the new procedures for payment of medical-legal expenses, the Legislature left the language in Labor Code § 4622(f) unchanged. That subsection states:

> Nothing contained in this section shall be construed to create a rebuttable presumption of entitlement to payment of an expense upon receipt by the employer of the required reports and documents. This section is not applicable unless there has been compliance with Sections 4620 and 4621.

So subsection (f) expressly states that nothing in § 4622 creates a rebuttable presumption of entitlement to payment when a defendant receives a bill for medical-legal expenses. In the aforementioned *Kunz v. Patterson Floor Coverings, Inc.*, the WCAB held *en banc* that "under sections 4620 et seq., a defendant now can raise (and the Board can consider) certain objections to a medical-legal billing, even if those objections were *not* specifically raised within 60 days of the receipt of the billing."

Nevertheless, in adopting the waiver provisions outlined in Regulation 10451.1(f), the WCAB explained on page 11 of the Initial Statement of Reasons for Rules of Practice and Procedure[1] that:

> [S]ection 4622(f) allows a defendant to raise section 4620 and 4621 issues even if it does not raise those objections through an EOR within 60 days of receipt of the medical-legal provider's billing, if it does not respond to a provider's request for second review of an amount payable dispute within 14 days, or if it fails to file a petition and DOR regarding a non-amount payable dispute within 60 days of a timely objection to an EOR.

But the WCAB concluded that:

> [T]he language of section 4622(f) does not permit a defendant to ignore or violate its duties under sections 4622 and 4603.3 without any adverse legal consequences. [Citation.] That is, if the WCAB determines that a medical-legal cost is in compliance with sections 4620 and 4621, a defendant that failed to comply with its obligations under sections 4622 and 4603.3 will run the risk of waiving all other objections and of becoming liable for the full amount of the medical-legal bill.

[1] A copy of this document may be obtained at: http://www.dir.ca.gov/WCAB/WCABRulesofPracticeProcedure2013/WCABRulesofPracticeProcedure2013_ISOR.pdf.

The WCAB relies solely on the language of § 4622(f) referring to Labor Code § 4620 and § 4621 to carve out limitations on waivers for objections under those sections. The WCAB, however, ignores the language in § 4622(f) establishing that "Nothing contained in this section shall be construed to create a rebuttable presumption of entitlement to payment of an expense upon receipt by the employer of the required reports and documents."

In adopting the waiver provisions, the WCAB created more than just a rebuttable presumption against defendants; it created conclusive presumptions. Under Regulation 10451.1(f), defendants who have failed to timely serve an EOR or a final written determination following a second review to waive all objections, other than compliance with § 4620 and § 4621. So as long as a medical-legal provider establishes that the expense was procured for a contested claim and was reasonably, actually and necessarily incurred, the regulation establishes not only a conclusive presumption of entitlement to payment, but a conclusive presumption that the bill is reasonable. A defendant has no defense regardless of the amount of the bill.

Furthermore, if a defendant disputes a medical-legal bill on grounds other than the amount to be paid, but fails to timely file a petition and a DOR following the provider's objection to an EOR, the regulation establishes that the defendant may not challenge the charges on the grounds stated in the EOR, but may dispute only the amount payable. It creates a conclusive presumption that the provider is entitled to payment subject only to a dispute regarding the reasonableness of the charges.

Accordingly, there are valid questions as to whether the waiver provisions under Regulation 10451.1(f) contravene the language in § 4622(f).

Sanctions for Bad-Faith Actions or Tactics

In addition to waiving potential objections, the new regulations establish that if the WCAB determines that a defendant, as a result of bad-faith actions or tactics, fails to comply with the requirements, timelines and procedures defined in the statutes and regulations regarding payment of medical-legal fees, it will be liable for the medical-legal provider's reasonable attorneys' fees and costs and for sanctions under Labor Code § 5813 and Regulation 10561. For bad-faith actions or tactics occurring on or after Oct. 23, 2013, the sanctions will not be less than $500 (Cal. Code Regs., title 8, § 10451.1(g)(1)).

The regulations provide that bad-faith actions or tactics include, but are not limited to:

(A) failing to timely pay any uncontested portion of a medical-legal provider’s billing; (B) failing to make a good-faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; or (C) contesting liability for the medical-legal provider’s billing based on a dispute over injury, or injury to a particular body part (Cal. Code Regs., title 8, § 10451.1(g)(1)(A)-(C)).

What these standards actually mean is difficult to discern. It’s not clear whether every failure to timely pay an uncontested bill will result in sanctions. It’s also not clear how the WCAB will determine whether an employer has made a good-faith effort to comply with the applicable statutory or regulatory requirements. These issues need to be clarified by the courts.

Nevertheless, the regulations explain that if sanctions under § 5813 are awarded, the attorneys’ fees, costs and monetary sanctions will be in addition to any penalties and interest payable under § 4622 or other applicable provisions of law. Also, the sanctions are in addition to any lien filing fee, lien activation fee or IBR fee that, by statute, the employer might be obligated to reimburse to the medical-legal provider.

The regulations also provide that sanctions may be imposed on the medical-legal provider if the WCAB determines that it improperly asserted that a defendant failed to comply with the relevant requirements, timelines and procedures. The amount of such fees, costs and sanctions must be determined by the appeals board, but the monetary sanctions will not be less than $500 for bad-faith actions or tactics occurring on or after Oct. 23, 2013 (Cal. Code Regs., title 8, § 10451.1(g)(2)). This provision, however, does not add much to the law as 10561 already allows for sanctions for making assertions that are substantially false, substantially misleading or contain substantial misrepresentations of fact.

As described above, whether sanctions apply is an issue for the appeals board. Because attorneys' fees are an issue, one might think that providers have every incentive to file for these penalties if they perceive that the defense has made a mistake or been neglectful.

DISPUTES OVER MEDICAL TREATMENT

As with medical-legal expenses, the regulations establish different procedures for dealing with medical treatment disputes depending on whether they are subject to IMR or IBR. Regulation 10451.2(c)(1) provides that:

(1) Disputes solely over the necessity of medical treatment if a defendant has conducted a timely and otherwise procedurally proper utilization review are subject to IMR.
(2) Disputes related to the amount payable to a medical treatment provider under an official fee schedule in effect on the date the medical treatment was provided are subject to IBR.
(3) All other disputes — threshold disputes — are subject to the jurisdiction of the WCAB.

Contesting Medical Treatment Through IMR

If a medical treatment dispute concerns only the medical necessity of the request for treatment, it must be resolved through the UR and IMR process. It is largely unchanged by the regulations. The process is discussed in depth in "Sullivan on Comp" Section 7.40 Independent Medical Review — Process and related sections.

The physician must issue a request for authorization for treatment on the request for authorization (RFA) form. If the form is not completed properly, the defendant may treat it as complete and comply with the time limits for UR, or return it to the requesting physician marked "not complete" no later than five business days from receipt (Cal. Code Regs., title 8, § 9792.9.1(c)(2)).

Under Labor Code § 4610(g)(1), on receipt of a proper request for treatment, the defendant must conduct a prospective or concurrent UR "in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from receipt of the information reasonably necessary to make the determination, but in no even more than 14 days from the date of the medical treatment recommendation by the physician." The regulations establish that a defendant must complete UR within five business days of receipt of the completed RFA, but no more than 14 calendar days from receipt of the completed form (Cal. Code Regs., title 8, § 9792.9.1(c)(3)).

The applicant must request an IMR no later than 30 days after the service of a UR decision (§ 4610.5(h)(1)). For a regular review, the defendant must provide records to the independent medical review organization (IMRO) within 15 days of receipt of the mailed notification (Cal. Code Regs., title 8, § 9792.10.5(a)(1)).

Following the IMR determination, § 4610.6(h) allows a party to file an appeal with the WCAB "within 30 days of the date of the mailing of the determination." But Regulation 10957.1(c) requires a petition to be filed within

"20 days after service of the IMR determination." The regulation is at odds with the statute, so it's probably invalid.

If appealed, the matter will be adjudicated by a WCJ at the trial level following the same procedures applicable to claims for ordinary benefits. Any party aggrieved by a final decision of the WCJ may file a petition for reconsideration within the same time and in the same manner specified for petitions for reconsideration (Cal. Code Regs., title 8, § 10957.1).

If the IMR determination is reversed, the dispute must be returned to the administrative director for another IMR. If IMR approves the treatment in cases of services not yet rendered, the defendant must authorized them within five working days of receipt of the IMR determination, or sooner if appropriate for the applicant's medical condition (§ 4610.6(j)).

Contesting Non-IMR/IBR Medical Treatment Disputes

If a medical treatment dispute is not subject to IMR or IBR, it falls within the jurisdiction of the WCAB. Regulation 10451.2(c)(1) specifies that non-IMR/IBR disputes include:

(A) any threshold issue that would entirely defeat a medical treatment claim (e.g., injury, injury to the body part for which treatment is disputed, employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction);

(B) a dispute over a UR determination if the employee's date of injury is before Jan. 1, 2013, and the decision is communicated to the requesting physician before July 1, 2013;

(C) a dispute over whether UR was timely undertaken or was otherwise procedurally deficient;

(D) an assertion by the medical treatment provider that the defendant has waived any objection to the amount of the bill because it allegedly breached a duty prescribed by Labor Code § 4603.2 or § 4603.3 or the related administrative rules;

(E) an assertion by the defendant that the medical treatment provider has waived any claim to further payment because it allegedly breached a duty prescribed by Labor Code § 4603.2 or the related administrative rules;

(F) a dispute over whether the employee was entitled to select a treating physician not within the defendant's medical provider network (MPN);

(G) an assertion by the defendant that an interpreter who rendered services at a medical treatment appointment was not appropriately certified; and

(H) an assertion by the defendant that an interpreter was not reasonably required because the employee proficiently speaks and understands the English language.

If a defendant defers UR because it is disputing liability for the injury or on grounds other than medical necessity, it must give notice of its intent to do so. The defendant must issue a written decision deferring UR within five days of receipt of the RFA form (Cal. Code Regs., title 8, § 9792.9.1(b)(1)).

If a non-IMR/IBR dispute is between the applicant and a defendant, the WCAB's procedures for ordinary benefits must be employed, including the procedure for expedited hearing. If the dispute is between a medical

treatment provider and a defendant, the procedures applicable to lien claimants must be employed (Cal. Code Regs., title 8, § 10451.2(c)(2)).

If the non-IMR/IBR dispute is resolved in favor of the employee or the medical treatment provider, any applicable IMR and/or IBR procedures must be followed (Cal. Code Regs., title 8, § 10451.2(c)(3)).

Is the WCAB's Jurisdiction Over "Procedurally Deficient" Utilization Review Valid?

Generally, the IMR process applies only if there is a utilization review decision. So if a defendant fails to conduct UR, the IMR process would not apply. The Court of Appeal in *SCIF v. WCAB (Sandhagen)* (2008) 44 Cal. 4th 230 held that its failure to comply with the UR deadlines precluded a defendant from using the UR process to deny a request for treatment, and this issue was not appealed to the California Supreme Court. So it's likely that if a UR decision was not timely issued, the IMR process also will not apply. Accordingly, medical treatment disputes when the defendant fails to timely conduct UR are subject to the WCAB's jurisdiction. (UR timelines are discussed in depth in "Sullivan on Comp" Section 7.35 Utilization Review — Time Limits. The consequences for failing to comply with the UR timelines is discussed in Section 7.36 — Utilization Review Procedures.)

The new regulations expand the jurisdiction. Regulation 10451.2(c)(1)(C) provides that the WCAB has jurisdiction over a medical treatment dispute if there is "a dispute over whether UR was timely undertaken or was otherwise *procedurally deficient*," although the employee "still has the burden of showing entitlement to the recommended treatment" (emphasis added). So even if a UR decision is timely, if the WCAB finds that the decision was procedurally deficient, the deficiency would not be corrected by the IMR process. Instead, the WCAB would decide the treatment dispute.

Naturally, applicant attorneys will be big fans of this rule, seems to keep cases out of IMR if a procedural deficiency can be found in the UR process. Applicants generally believe that their claims for medical care will fare better before the WCAB than IMR. The defense, of course, does not like this rule, as it seems to allow applicants to avoid IMR on a technicality.

In adopting the rule, the WCAB explained, "Consistent with *Sandhagen,* where a defendant fails to comply with the UR timelines and procedures of section 4610, it's UR denial is not valid. Therefore, in legal effect, there is no 'utilization review decision' that can be subject to IMR" (Supplemental Statement of Reasons for Rules of Practice and Procedure, p. 12).[2] It further explained that "IMR cannot determine whether a defendant's UR determination was untimely or procedurally deficient. To the contrary, this question falls within the exclusive jurisdiction of the WCAB" (Final Statement of Reasons for the Rules of Practice and Procedure, p. 5).[3] It concluded that if "the WCAB finds that UR was untimely or otherwise procedurally deficient, then IMR does not come into play" (*Ibid*).

Without clarifying what it means for a UR decision to be "procedurally deficient," the regulations have crafted a broad exception that potentially subverts the IMR process established by SB 863. The question naturally arises: Has the WCAB improperly assumed jurisdiction over a dispute that should be resolved by IMR? A good case can be made that it has.

The legislative history of SB 863 shows that the IMR process was adopted because the system of "lawyers/judges making medical decisions ... resulted in an extremely slow, inefficient process" (Sen. Rules. Com., Off. of Sen. Floor Analyses, on Sen. Bill No. 863, 2011-2012 Reg. Sess., Aug. 30, 2012, p. 16). The IMR

[2] A copy of this document may be obtained at: http://www.dir.ca.gov/WCAB/WCABRulesofPracticeProcedure2013/WCABRulesofPracticeProcedure2013_Sup_SOR.pdf.
[3] A copy of this document may be obtained at: http://www.dir.ca.gov/WCAB/WCABRulesofPracticeProcedure2013/WCABRulesofPracticeProcedure2013_FSOR.pdf

system was adopted because it "would result in a faster and better medical dispute resolution than existing law" and the IMR system was designed "to ensure that medical expertise is used to resolve medical disagreements" (*Id.* at pp. 16-17).

These goals would not be advanced by allowing medical treatment disputes to be resolved by the WCAB following a procedurally deficient UR. Allowing the appeals board to assume jurisdiction over a medical treatment dispute solely because of an allegation that the defendant's UR decision was procedurally deficient would not speed up the resolution process and would leave medical treatment disputes in the hands of judges, rather than doctors. The regulations appear to contravene the Legislative intent of the IMR process.

Furthermore, the regulation appears to contradict the statutes themselves. Labor Code § 4610(g)(3)(A) provides that if a treatment request is not approved in full, "disputes *shall* be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062" (emphasis added). Per § 15, "shall" is mandatory language. So, if Labor Code § 4610.5 is applicable, it "shall" be used to resolve the dispute.

Section 4610.5(a) states that it applies to: (1) "*Any dispute* over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013," and (2) "*Any dispute* over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury" (emphasis added). Subsection (b) adds, "A dispute described in subdivision (a) *shall* be resolved only in accordance with this section" (emphasis added). Subsection (e) then states, "A utilization review decision may be reviewed or appealed *only* by independent medical review pursuant to this section" (emphasis added). The remainder of § 4610.5 outlines the IMR process.

So, under the terms of the statute, the IMR process "shall" apply to "any dispute" over a UR decision for an injury occurring on or after Jan. 1, 2013, or any injury if the UR decision was communicated on or after July 1, 2013. The language allows no exception to an IMR if the UR was procedurally deficient. The regulations create an exception to the IMR process where one does not exist.

The regulation is potentially inconsistent regarding whether the WCAB has jurisdiction even if it finds that the UR decision was untimely or procedurally deficient. While Regulation 10451.2(c)(1)(C) provides that a dispute over whether UR was timely undertaken or was procedurally deficient is not subject to IMR, subsection (c)(3) states, "If a non-IMR/IBR dispute is resolved in favor of the employee or the medical treatment provider, then any applicable IMR and/or IBR procedures established by the Labor Code and the Rules of the Administrative Director shall be followed."

So this provides that if a non-IMR dispute is resolved in the applicant's favor, IMR still must be employed, if applicable. Again, the IMR process applies to "any dispute" over a UR decision. So, pursuant to the regulation, it may be argued that IMR does not lose jurisdiction, even if it is determined that the UR decision is procedurally deficient.

Because the language in the regulations giving the WCAB jurisdiction over a medical treatment dispute if it finds a procedurally deficient UR appears to conflict with the Labor Code and the legislative intent of SB 863, challenges to it should be anticipated.

Waiver of Medical Treatment Objections?

Regulation 10451.2(c)(1)(C) identifies a threshold issue not subject to IBR. Specifically, it provides for WCAB jurisdiction if the issue is whether the defendant has waived any objections to the amount of a bill because it breached a duty prescribed by Labor Code § 4603.2 (time limits and procedures for payment of medical bills) or § 4603.3 (EOR requirements) and the related administrative rules.

The clear implication is that when a defendant breaks any rules regarding objection to or payment of medical treatment billing, it waives its defenses and must pay the bill. And, the issue of waiver is to be decided by the WCAB, not IBR.

This provision was included because, according to the WCAB, "the law establishes that where a party has a duty to take a particular action to preserve a claim or defense, it must timely undertake that action and cannot bypass it; otherwise, the party waives that claim or defense" (Supplemental Statement of Reasons for Rules of Practice and Procedure, p. 14).

As with its medical-legal cousin, however, the regulation appears to be inconsistent with the law. The Labor Code specifies the penalties for failure to timely pay a bill.

Section 4603.2(b)(2) provides, "Any properly documented list of services provided and not paid at the rates in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization."

So if a defendant fails to timely pay a bill or issue an EOR, in addition to a 15 percent penalty and interest, it must pay "at the rates then in effect under Section 5307.1," which establishes the Official Medical Fee Schedule (OMFS). The defendant, however, does not waive all objections to the amount of the bill, and may contest whether the amount is reasonable under the OMFS.

The regulation appears to be inconsistent with *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal.Comp.Cases 1588. In that case, the WCAB held *en banc* that "a defendant's failure to specifically object to a lien on a basis of reasonable medical necessity (or on any other basis) does not result in waiver of that objection under section 4603.2" (*Id.* at 1592). *Kunz* added that "nothing in section 4603.2 states or implies that the consequence of a defendant's failure to make any particular specific objection is that the defendant is thereafter precluded from raising that objection, or that the lien claimant is relieved of any portion of its obligation to prove by a preponderance of the evidence all of the elements necessary to the establishment of its lien" (*Ibid*).

The regulation also appears to be inconsistent with *Sandhagen*, in which the California Supreme Court explained that "notwithstanding whatever an employer does (or does not do), an injured employee must still prove that the sought treatment is medically reasonable and necessary" (*Sandhagen, supra,* 44 Cal. 4th at 242). The Supreme Court explained that even if a defendant fails to conduct a timely UR, it does not relieve an applicant of the burden of proving that his or her recommended treatment is reasonable and necessary. So it makes little sense that a defendant's failure to object to a medical treatment bill would result in a waiver of all objections to the bill when a defendant's failure to timely dispute a request for medical treatment using the UR process does not result in a waiver of a defendant's objections to the treatment.

Furthermore, it must be noted that the regulation pertaining to medical-legal billing went out of its way to devise specific rules regarding waiver, and the clear penalties that applied, including mandatory payment of the billing. Regulation 10451.1, as discussed earlier, specifies that failure to timely object to a medical-legal bill results in waiver of all objections to the provider's billing. But there is no language in Regulation 10451.2 specifying whether a waiver applies if the employer does not timely object to a medical treatment bill. That is, Regulation 10451.2 allows a medical treatment provider to raise waiver based on a defendant's failure to properly object to a medical treatment bill, but does not specify whether failure to properly object will result in waiver of all objections to the bill.

Because waiver is not specified in the statute or regulations as a consequence for failure to timely object to a medical treatment bill, it is arguable that such a consequence does not exist. Nevertheless, whether failure to properly object to a bill will result in waiver of any objections to the bill will need to be clarified by the courts.

Conclusions

The new regulations adopted by the WCAB will require all defendants to change how they manage medical bills and requests for treatment. The regulations require defendants to take different actions depending on whether the disputes are subject to IMR or IBR, or to the WCAB's jurisdiction, and establish consequences for defendants who fail to act properly.

Defendants who fail to comply with the duties specified in the Labor Code or the administrative regulations may waive objections to medical-legal and medical treatment bills. Furthermore, providers may seek attorneys' fees, costs and sanctions under § 5813 if a defendant's failure to pay a medical-legal expense was a result of bad-faith actions or tactics.

There is no question that some of the new regulations will be challenged as exceeding the scope of the IMR or IBR statutes. But until those issues are decided by the courts, defendants would do well to change their practices to conform to the requirements of the regulations.