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Bill Would Limit Employer Liability for CT and Disease Claims

- *By Greg Jones*
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California employers would not be liable for medical treatment provided before they accept or deny a cumulative trauma or occupational disease claim unless the injured worker was treated by a doctor in the employer's network or his or her personal physician, under recent amendments to a bill that could also be a vehicle for reforms being drafted by the Department of Industrial Relations.

Assemblyman Adam Gray

Assemblyman Adam Gray, D-Merced, on Monday amended AB 1244 to add language limiting employer liability for medical and legal costs incurred in the early stages of a claim.

One change would add a provision limiting employer liability for cumulative trauma and occupational disease claims under Labor Code 5402, which requires

employers to pay up to $10,000 for medical treatment during the 90-day period they're allowed to investigate and accept or deny a claim.

Under the amendments, employer liability for medical payments under this section of the Labor Code would not apply to occupational disease and cumulative injury claims filed on or after Jan. 1, 2017, unless treatment is provided by a physician in the employer's medical provider network or the worker's predesignated physician, or if a Taft-Hartley trust fund would be liable for payment if the employer were not. Taft-Hartley funds are typically multi-employer plans negotiated by unions.

Gray also added language that would revise the attorney fee disclosure form represented workers have to sign, and eliminate employer liability for legal and medical services provided before the form is filed with the Workers' Compensation Appeals Board.

The amended bill would require adding to the attorney fee disclosure form a paragraph identifying the WCAB location where the case will be filed. And the injured worker would not be allowed to sign the fee disclosure form until it includes information about where the case will be heard.

The WCAB would be prohibited from ordering payment for legal services, medical and medical-legal costs or deposition expenses incurred before the signed disclosure form is filed and also sent to the employer or the insurer, under the amended bill.

Gray on Monday also revised the language for a proposed new Labor Code section requiring the Division of Workers' Compensation to revoke the ability of criminally convicted doctors to treat injured workers.

The latest amendments would require the DWC to suspend any doctor from participating in the comp system in any capacity if that doctor has been convicted of fraud or abuse of a patient, or any misdemeanor or felony involving fraud or abuse of the work comp system, Medi-Cal or Medicare.

The amendments eliminate an earlier proposal that would have required the DWC to suspend any doctor who has ever been convicted of any felony, regardless of whether that felony was related to his or her professional practice.

Gray's office would not comment on the record about the latest amendments to bill Wednesday.

During a June 29 hearing of the Senate Committee on Labor and Industrial Relations, Gray said he introduced the bill in response to reports of widespread fraud in the state's comp system, including allegations of widespread capping and steering schemes in Southern California in which applicants' attorneys were allegedly receiving kickbacks for referring injured workers to certain providers.

The California Applicants' Attorneys' Association is still reviewing the amendments, according to spokesman John de los Angeles. He also said every dollar taken by "fraudsters" is a dollar that doesn't go to injured workers or the honest providers who treat them.

Alan Gurvey, managing partner of applicants' firm Rowen, Gurvey & Win, said he thinks there could be equal-protection issues or other constitutional concerns relating to the proposal to limit liability for cumulative trauma and occupational disease to treatment provided by MPN doctors. He said the proposal would effectively allow employers to control liability without the intervention of a court.

"Just because an employer denies liability does not mean that the injured worker should have been left in the cold," he said.

He also said the proposal could create hardships for doctors in the MPN, who might have to choose between practicing medicine and following orders from insurance companies to stay in the network. And if the MPN doctors won't treat cumulative trauma or occupational disease claims, injured workers might have to go without treatment.

"No doctor will treat on a lien under these circumstances and the injured worker will not get the benefit of due process," Gurvey said.

Because AB 1244 has some overlap with legislative proposals being drafted by the Department of Industrial Relations, the measure is one possible vehicle to carry the administration's proposed changes.

The DIR held a series of meetings with system users on Tuesday and Wednesday to discuss its legislative proposal, which would prohibit doctors convicted of defrauding work comp, another insurer, Medicare or Medi-Cal from pursuing recovery of liens or treatment bills. The department is also proposing to automatically stay any liens and stop interest from accruing on those liens starting on the date that criminal fraud charges are filed against a provider and ending when the case is resolved.

The DIR draft legislative proposal, which a spokeswoman said is still a work in progress and "changing as we speak," would also prohibit prospective utilization review during the first 30 days following an injury for most treatment provided by an MPN doctor or an injured worker's predesignated treating physician. Services for conditions not addressed in the Medical Treatment Utilization Schedule, pharmaceuticals, surgery, psychological treatment, home health care, imaging and radiology, and durable medical equipment exceeding $250 in total value would still be subject to UR under the department's proposal.

The department is also contemplating a second review process that would allow an injured worker to appeal a UR denial without applying for independent medical review.

The proposals relating to utilization review could also fit into Senate Bill 1160, which may be the odds-on favorite for a last-minute amendment, especially after a lobbyist for the bill's sponsor in June said the measure probably won't be finished until the final days of the session, which ends Aug. 31.

SB 1160, by Sen. Tony Mendoza, D-Artesia, would require, starting in 2018, accreditation of UR firms. It would also increase penalties for claims administrators who don't report claim data to the Workers' Compensation Information System.

Lawmakers have until Aug. 19 to amend bills, but leadership can allow them to make changes after that date.

In addition to fighting work comp fraud, Gray's recently amended bill and the DIR's final legislative recommendation would also address what the Workers'

Compensation Insurance Rating Bureau in its latest system report identified as they key drivers of high loss-adjustment expenses in California.

In a 2016 state of the system report published Tuesday, the WCIRB noted that most of its projections for the 2012 reforms in Senate Bill 863 are developing as expected. But while medical costs have dropped more than expected, possibly as a result of the new Resource-Based Relative Value Scale Fee Schedule, reduced fees for ambulatory surgical centers, IMR and independent bill review, the cost of administering claims has not dropped as had been projected.

The WCIRB estimated the average allocated loss adjustment expense per indemnity claim increased to $14,009 in 2015 from $11,295 in 2012.

“Among the factors believed to be impacting the higher-than-expected loss adjustment expenses, or frictional costs, are more IMRs than anticipated, increased frequency of cumulative trauma injury claims, increased rates of injured workers being represented by attorneys and, despite the creation of the IMR process, a greater-than-expected number of expedited hearings on medical issues,” the WCIRB said in its report.