

DWC 2016 Annual Conference Top Tips for Trial



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Top Tips for Trial



1. Two Types of IMR
2. Issues re Expedited Hearings
3. New Regs re MPNs
4. Attorney's Fees
5. Avoid Sanctionable Conduct
6. Make sure IW's Address is Correct on Settlement Documents
7. Orders to Dismiss
8. Misc Checklists

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1. Two Types of IMR



(1) IMR within the MPN:

SB899 (2004 reform) added LC § 4616.4 to define an IMR process for **IWs who objected to MPN's PTP MT request.**

IW is entitled to 3 opinions and then IMR.

See 8 CCR § § 9768.1 – 9768.17.

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1. Two Types of IMR



(2) IMR as Appeal from UR

SB863 (2012 reform) added LC §4610.6 to provide IMR process to be **used by all parties** as the sole appeals process from a UR decision for all MT disputes for all dates of injury.

See 8 CCR §9792.10.3 – 9792.10.9.

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2. Expedited Hearings - LC 5502(b)

Permissible Issues:

- MT except per LC 4610 & 4610.5
- MPN issues
- MT appointment or med-legal exam
- TD
- IW' s entitlement to compensation from 1 or more Ds, when 2 or more Ds dispute liability.
- Any other issues requiring an EH and per rules of the AD.**



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2. Expedited Hearings - LC 5502(b)



Eun Jae Kim v. BCD Tofu House, (2014)
79 CCC 140; **(Significant Panel
Decision - SPD)**

DOR filed by D after IW, a waitress, filed WC claim.

“Claim is in delay mode. IW has been advised of MT within the MPN...IW has selected a non-MPN physician as her PTP. D seeks an order for transfer of care into the MPN, and an order regarding no liability for non-MPN treatment.

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2. Expedited Hearings - LC 5502(b)



Eun Jae Kim v. BCD Tofu House, (2014)
79 CCC 140; **(Significant Panel
Decision - SPD)**

WCJ OTOC' d matter even though LC 5502(b)(2) includes issue as to whether IW can be required to treat within the MPN.

WCAB overturned WCJ and explained that **expedited hearings may be held on whether IW must treat within the MPN**, EVEN during the 90 day LC 5402(b) delay period.

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2. Expedited Hearings - LC 5502(b)



Eun Jae Kim v. BCD Tofu House, (2014) 79 CCC 140; (Significant Panel Decision SPD)

WCAB explained,

“LC 4616.3(a) which is one of the MPN statutes, requires a D to commence treatment within its MPN when the employer receives notice of the injury from the employee, even if the claim has not been accepted or denied and is within the 90-day delay period allowed by LC 5402(b).”

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CALIFORNIA WORKERS' COMPENSATION REPORTER

A Monthly Bulletin of Key Developments in Workers' Compensation Law / vol. 25, no. 7, August 1997

NEWS BRIEFS

WCAB RELEASES SIGNIFICANT PANEL DECISIONS FOR PUBLICATION

On July 21, 1997, Chairman Diana Marshall of the Workers' Compensation Appeals Board announced that the Board has adopted a policy of releasing for publication significant panel decisions of general interest to the workers' compensation community. Concurrent with her panel decisions that she said would provide information and guidance to practitioners in the field.

Marshall explained that publication of significant panel decisions will augment the current body of published appellate opinions and WCAB en banc decisions on novel or recurring issues about which there is little available case law. Each member of the Board believes the issue in these cases to be of general interest and has agreed that the decisions are significant and merit general dissemination. The initial four panel decisions designated to be significant cover an employer's liability to pay for more than one medical/legal evaluation under *Labor Code §4060*, the effective date of *§5813*'s sanctions provisions, how WCAB jurisdiction is invoked under the "carve out" provisions of *§201.5*, and the extent of a medical lien claimant's right to participate in discovery and trial of a workers' compensation case.

Marshall anticipates that a limited number of significant panel decisions will be submitted for publication from time to time in the future. She expects that circulation of these opinions will contribute to a more efficient processing of workers' compensation cases.

Editor's Note: In one of the significant panel decisions, Green-Brown v. Nat'l American Ins. Co., RID# 60772, July 17, 1997, a panel of Commissioners Casey, Glendon, and Heath held that §5813 sanctions can be applied only in cases where the injury occurred after 1994. The Reporter previously reported Ward v. State of Calif., Calif. Youth Authority (1996) 24 CWCR 176, in which a panel

continued on page 27.

COURT ACTIONS

COURTS OF APPEAL: KEY OPINIONS

WCAB Rejects Psychiatric AME's Opinion Against, and Neurologist's For, Compensability; Finds No Power to Develop Medical Record; Denies Claim Court Annals; Reform Laws Did Not Negate Board's Power to Obtain Further Evidence

[*Eyer v. WCAB*, Court of Appeal, 2d App. Dist., Div. 4, July 15, 1997, No. B099392, certified for publication]

The court of appeal has annulled a WCAB decision that found applicant's claim of psychiatric injury for lack of any psychiatric opinion to support the claim. The workers' compensation judge had found unimpressive the opinion of both an agreed medical examiner in psychiatry and the carrier's psychiatrist that applicant did not

HIGHLIGHTS

197 *California Courts of Appeal*: Opinions on Board's power to develop medical record, \$7,000 penalty for clerical error, failure to automatically increase untimely PD payment to one or two penalties, penalties for delay of advances and serious and willful misconduct, and more

213 *Writ Granted* on due process for medical lien claimant

214 *WCAB Decisions* on full participation for lien claimants, multiple evaluations under §4060, Board jurisdiction in §209.2 "carve out" case, failure to file lien

220 *AD Decisions* on charge of physician for conduct of interest or failure to submit treatment plan, need for QMEL to explain subjective complaints that for second objective findings

223 *Chief Managers'* Opinions on attorney fees from judgments, waiver of employer's credit

226 *1997 Legislative* New statutes, progress on bills

197 *News Briefs*: Board to designate selected panel decisions as "significant"

228 *Educational Events*

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Birth of the Significant Panel Decision: August 1997

See also Larch v. WCAB, (1999) 64 CCC 1098 (Writ Denied.)

For a list of all WCAB en banc & SPD click on:
<http://www.dir.ca.gov/WCAB/wcab.htm>

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3. Medical Provider Networks (MPN)

MPN Regs 9767.1 - 9767.19

In compliance with changes per SB863

Effective 8.27.2014

1. **Facilitate access** to MT for IWs w/in the MPN.
2. Tighten the **burden of proof** for IW' s attempting to treat o/s the MPN.



http://www.dir.ca.gov/DWC/DWCPropRegs/MPNRegulations/MPN_Regulations.htm

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3. Medical Provider Networks (MPN)

SB863 added LC 4616(a)(3)-(5):



MPNs are required to:

- **Reg. 9767.12(a)(2)(B) & (C)** - List their doctors on their website for ease of access by all.
- **Reg 9767.12 (a)(2)** - Provide MPN contacts and medical assistants to **help IWs find a doctor in the MPN** and to help them make appointments.

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3. Medical Provider Networks (MPN)



- **Reg 9767.5(f)** - For non-emergency services, the MPN shall ensure that an **appointment for the first treatment visit** under the MPN is available within 3 business days of a covered employee's notice to an MPN medical access assistant that treatment is needed.

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3. Medical Provider Networks



"MPN" must ensure MT appointment w/in 3 business days

Lim v. Torrance BCD, Inc., 2014 Cal. Wrk. Comp. P.D. LEXIS 125

“While the D did timely notify IW of their MPN and the procedures for choosing a PTP within the MPN, **they did not timely schedule an initial evaluation** for the IW within the MPN. Additionally there was no evidence presented at the EH that D directed the IW to MPN doctor when she advised the employer of her neck complaints in May and July 2013.” Therefore, IW’s SPMT costs for MT o/s the MPN were awarded and IW was entitled to continue MT o/s MPN until proper transfer of care has taken place.

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3. Medical Provider Networks (MPN)



Reg 9767.1(a)(16) - “MPN Medical Access Assistant” (MAA) person (in the US) to help IWs find Drs and schedule appointments.

Reg 9767.1(a)(20) - “MPN Contact” = responds to complaints, and answers IWs’ questions about the MPN and assists the IW in arranging for an MPN IMR per LC 4616.4.

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3. Medical Provider Networks (MPN)



- **Reg 9767.5 (h) MPN medical access assistants (MAA)** must be available, Mon – Sat (7am to 8pm) both in English and Spanish.
- **Reg 9767.5 (h) (1)** There shall be enough **MAAs** to respond to calls, faxes or messages by the next day.
- **Reg 9767.5(h)(2)** MPN **MAAs** have different duties than CS. They work in coordination with the MPN Contact and CS to ensure timely MT for IW. **If CS = MAA, the MAA contacts must be separately and accurately logged.**

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3. Medical Provider Networks (MPN)

Designation of MPN Contact Person is Mandatory

Cantabrana v. Superior Sod, 2014 Cal. Wrk. Comp. P.D.
LEXIS 47

IW treated o/s of the MPN, despite warning from D to select an MPN provider.

IW's non-MPN provider (LC) argued D failed to provide MPN notices, including the name and telephone number of the MAA and MPN contact person.

The WCJ held, "The MPN pamphlet... includes a toll-free telephone number, but it appears to be the telephone number for the claims examiner, and **there is no reference to an MPN contact person**. The only means for accessing the MPN **provider** directory is a website."



MPN notice was deemed non-compliant & the LC was allowed.

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3. Medical Provider Networks (MPN)



POP QUIZ:

IW, an ironworker, has a "serious chronic back condition" after falling off a 30 foot scaffolding on 8.14.2014.

His MPN neurosurgeon has suggested IW may need back surgery.

His MPN PTP (chiro) was terminated from e'er's MPN on 10.1.2014. PTP is no longer authorized to treat IW.

IW files for EH and requests continued MT with PTP (chiro):

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3. Medical Provider Networks (MPN)



POP QUIZ:

- (a) WCJ should allow MT w/terminated chiro, since IW has established a bond with the terminated MPN chiro.
- (b) WCJ should mandate that employer follow “**continuity of care policy**” per 9767.9 & 9767.10, which allows IW to treat with terminated PTP up to 1 year.
- (c) WCJ should order the IW to select a PTP within the MPN, since he would not be able to treat with the chiro anyway, once he reaches the 24 visit cap.

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3. Medical Provider Networks (MPN)



Reg 9767.9 & 9767.10 - “Continuity of Care Policy”

Baker v. Hilton La Jolla Torrey Pines, 2014 Cal. Wrk. Comp. P.D. LEXIS 165

IW is allowed to continue MT with terminated PTP (chiro) and Employer must follow “**continuity of care policy**” and allow the PTP to complete a treatment plan.

In this case, the “PTP could not complete a ‘treatment plan’ *until* the MPN neurosurgeon determined whether or not back surgery was appropriate --- something which has not yet occurred. Once that determination has been made, the PTP can draft a treatment plan and continue MT for up to one year.”

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4. LC 5710 -Attorney's Fees

LC 5710 provides: “A **reasonable** ...attorney’ s fee for deponent if represented by member of State Bar...”

POP QUIZ: Can AA get LC 5710 fees for attending a **defense** VR expert evaluation of the IW?

- (a) Yes, if AA has properly documented the billable hours, since this situation is consistent with the established regulatory methods of discovery.
- (b) Yes, if AA has obtained an VR expert report.
- (c) No, since LC 5710 is silent regarding extending its parameters to other discovery events.

See *Fetner v. Long Beach Fire Dept*, 2014 CWC PD LEXIS 91



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5. Avoid Sanctionable Conduct

Beneficial Services v. WCAB (See), (2013) 78 CCC 219

“Under **Rule 10842(c)**, copies of documents already received in evidence... may not be submitted with a pet’ n for recon...”



Under prior **Rule 10232(a)(10)**, **(and current Rule 10205.12(a)(10)*)** no document filed with the WCAB may > 25 pages without prior permission of WCAB...”

****Always confirm you are using the most current set of WCAB Rules of Practice and Procedure.*** 22

5. Avoid Sanctionable Conduct

Beneficial Services v. WCAB (See), (2013) 78 CCC 219



“Defendant violated Rule 10842(c) because the medical evaluation reports, consisting of 97 pages, attached to Defendant’s Petition for Reconsideration, were already part of the adjudication file.

Defendant violated Rules 10232(a)(10) and 10845 since Defendant’s Petition for Reconsideration, with the attachments, was 107 pages long.”

Sanctions imposed per LC 5813 for \$500. 23

5. Avoid Sanctionable Conduct

Frivolous litigation may = sanctions



Bowlds v. SD Dev; SCIF, 2014 Cal Wrk Comp PD LEXIS 669

"Proceeding to trial without any evidence or with evidence that is utterly incapable of meeting its burden of proof is frivolous and constitutes bad faith within the meaning of LC 5813 justifying an award of **sanctions**, attorney's fees and costs against the party or lien claimant, its attorney(s) or hearing representative(s), individually or jointly and severally." (See *Torres v. AJC Sandblasting* (2012) 77 CCC 1113 WCAB en banc)

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5. Avoid Sanctionable Conduct

Callegas v. Candice, 2014 Cal Wrk
Comp PD LEXIS 671

“The record supports the WCJ's finding that the LC's pursuit of its claim through trial, more than 10 years after a C&R with a *Thomas* finding, was **"patently unmeritorious"**, since without evidence that there was an industrial injury, it could not prove compensable injury, and in turn recover anything on its claim.



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5. Avoid Sanctionable Conduct

Callegas v. Candice, 2014 Cal Wrk
Comp PD LEXIS 671

“Additionally, there was no evidence as to diligence and/or an explanation as to why LC sat on its lien for more than a decade after the matter was taken off calendar in Dec 2001, following lien proceedings subsequent to settlement of the underlying claim.

The defense of laches can apply to lien claims that are excessively delayed.”



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5. Avoiding Sanctionable Conduct

Hearing reps for LC must file letter of representation 8 CCR 10774.5(e)

Castellejos v. TeamQuest, 2014 Cal Wrk Comp PD LEXIS 674

“This court has never received a letter of representation for hearing representation as mandated by CCR § 10774.5 (e). This court also concluded that the demand for this trial was both frivolous and in bad faith.”

“On 5/7/2014, defense counsel filed a petition for \$4,686.70 in costs and sanctions. Lien claimant filed no response or opposition. Therefore, on 6/16/2014 this court served a 10 day Notice of Intention to order sanctions of up to \$2,500.00 and costs of \$4,686.70.”



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5. Avoiding Sanctionable Conduct

8 CCR 10773:

- (a) Non-attorneys may appear if:
- (1) the client has been fully informed...
 - (2) in all proceedings... the person is identified...and it is fully disclosed that the person is not licensed to practice law in the State of California;
 - (3) the attorney directly responsible... is identified.



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5. Avoid Sanctionable Conduct

De Ramos v. 99 Cents Only Stores, 2014 Cal. Wrk. Comp. P.D. LEXIS 644



“Petitioner's successive petition contains remarks that are disrespectful and impugn the integrity of the Appeals Board, the trial level Workers' Compensation Appeals Board (WCAB) and the WCJ.

“For example, petitioner accuses the Appeals Board of abuse "in the intent to avoid bad faith from defense..."

“Further, petitioner alleges game playing and "abuse and dirty tactics" on the part of the WCAB against lien claimants.

“Additionally, petitioner suggests that WCJs and the WCAB "can manipulate EAMS to justify unfair decisions."

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6. Make Sure IW's Address is Correct on Settlements

Barrett Business Services v. WCAB (Rivas),
(2012), 77 Cal Comp Cases 213 (2nd DCA)

Applicant's attorney advised defendant of IW's change of address. Defendant drafted a compromise and release and entered the old address for the IW instead of his new address. Defendant sent the settlement check of \$17,000 check to IW's old the **incorrect** address.



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6. Make Sure IW's Address is Correct on Settlements

Barrett Business Services v. WCAB (Rivas),
(2012), 77 Cal Comp Cases 213

Rivas never received the check, which was stolen and cashed by someone else. The DCA held that **since defendant prepared the C&R & entered the incorrect address** for the IW, when they were on **notice of his new** correct address, defendant remained liable to the IW for payment of the C&R amount of \$17,000.



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7. Orders to Dismiss



No Self-Destruct Orders to Dismiss a Case

8 CCR 10780 states: The Order to Dismiss can **NOT** be "...by an order with a clause rendering the order null and void if an objection showing good cause is filed."

WCJ must issue a NIT to Dismiss. If no objection filed within the time period of NIT, then WCJ may issue an Order to Dismiss.

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7. Orders to Dismiss

WCAB Must Serve Orders To Dismiss a Case



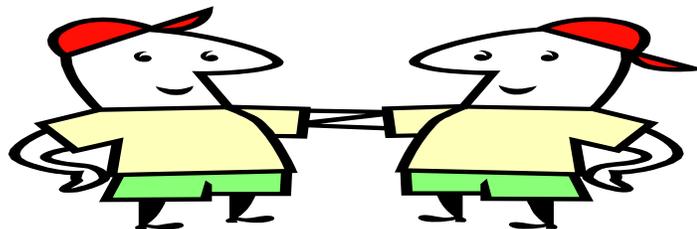
The final dismissal order needs to be served on all parties on the OAR by the WCAB, service cannot be designated.

Reg 10500(a) “WCAB may...designate a party... to make service of notices of the time and place of hearing, orders approving compromise and release, awards based upon stipulations with request for award and any interim or procedural orders.

Reg 10500(b) The WCAB shall serve all...final orders...The WCAB shall not designate (service of) any final order...”

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8. Checklists

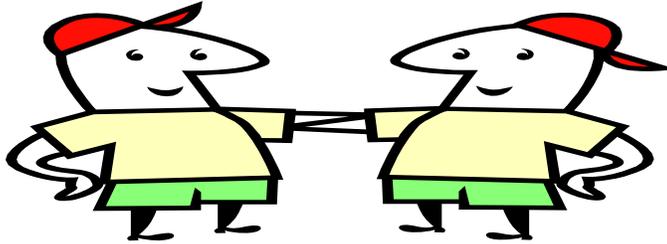


Issues to consider before submitting a settlement doc:

- Are medical reports in file? Bring extra copies of P&S report, and the one that supports the settlement
- Is PD indicated and accurate
- If no QME, include proof that IW got notice of QME option
- Extent of FMT? Is surgery recommended?

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8. Checklists



Issues to consider before submitting a settlement doc:

- If C&R – Is amount sufficient for FMT?
- If Stip – has FMT box (yes or no) been checked?
- Has IW RTW? w/ or w/o restrictions?
- Document – properly signed? (See *Marchese v. Home Depot*, (2009) 37 CWCR 282.)

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LIEN CLAIMS,
PETITIONS FOR COSTS AND
PETITIONS FOR
DETERMINATION OF NON—IBR
MEDICAL-LEGAL DISPUTES

Francie R. Lehmer

Workers' Compensation Judge

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Medical Treatment and Medical-Legal Expense Disputes Post January 1, 2013 (Cliff Levy, PWCJ, San Diego WCAB)

Overview

Senate Bill 863 (effective January 1, 2013) created Independent Medical Review (IMR), and Independent Bill Review (IBR). When the only dispute is whether requested medical treatment is reasonably medically necessary, the dispute must be resolved by IMR. When the only dispute is how much should be paid pursuant to fee schedule for medical treatment or for medical-legal expenses, the dispute must be resolved by IBR. The WCAB is authorized to hear “non-IMR/non-IBR” medical treatment and medical-legal expense disputes, also known as “threshold” disputes.

“Threshold” disputes are resolved before IMR and/or IBR come into play. Two new pleadings have been created to advance these disputes at the WCAB: the Petition for Costs, and the Petition for Determination of Non-IBR Medical-Legal Dispute.

Petition for Costs (CCR 10451.3)	Petition for Determination of Non-IBR Medical-Legal Dispute (CCR 10451.1)	Lien Claim
<p>May be filed <u>only</u> by an <u>employee</u> or dependent of a deceased employee, a <u>defendant</u>, or an <u>interpreter</u>(for services rendered at a WCAB proceeding or deposition);</p> <p>A petition for costs filed by anyone else is deemed dismissed by operation of law and does not toll the statute of limitations;</p> <p>Can be used by the employee to seek reimbursement of payments made to a medical-legal provider.</p>	<p>Medical-Legal providers are no longer required to file a lien;</p> <p>Petition may be filed for any dispute concerning payment of medical-legal expenses other than the amount payable pursuant to fee schedule (which goes to IBR);</p> <p>Can be filed by any provider of medical-legal goods or services, including copy services and vocational experts;</p> <p>Can be filed by an interpreter for services rendered at a medical-legal exam.</p>	<p>Medical treatment providers must file a lien;</p> <p>An interpreter must file a lien for services rendered at medical treatment appointments;</p> <p>Lien claimants can use CCR 10451.2 to adjudicate compliance with the post January 1, 2013 bill payment protocols.</p>

A Word About IMR and IBR

Independent Medical Review (IMR) was implemented on January 1, 2013 (Labor Code 4610.6). For dates of injury on or after January 1, 2013, and for all dates of injury where a Utilization Review decision is communicated to the requesting physician on or after July 1, 2013, if the UR decision denies, modifies, or delays a treatment recommendation, and the only dispute is whether the requested treatment is reasonably medically necessary, the dispute must be resolved by use of independent medical review (Labor Code 4610.5). “In no event shall a workers’ compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization” (Labor Code 4610.6(i)).

Independent Bill Review (IBR) went into effect on January 1, 2013 (Labor Code 4603.6). When the only dispute is how much should be paid pursuant to a fee schedule for medical treatment or for medical-legal goods and services, the dispute must be resolved by way of independent bill review.

Unlike IMR, the statues implementing IBR are ambiguous about whether IBR applies prospectively only, or has retrospective application. Labor Code 139.5 suggests that IBR pertains only to injuries occurring on or after January 1, 2013, however section 84 of SB 863 (found at the end of Labor Code 62.5) provides that “this act shall apply to all pending matters, regardless of date of injury, unless otherwise specified in this act...” The Administrative Director decided that IBR should apply to medical treatment rendered on or after January 1, 2013 and to medical-legal expenses incurred on or after January 1, 2013 (CCR 9792.5.5).

The WCAB is authorized to hear and decide all other disputes relating to medical treatment and to medical-legal expenses. Even when IMR and IBR are necessary, there can be a host of disputes that must first be determined by the WCAB. These disputes are known as “threshold” disputes.

Threshold Disputes

Traditional threshold disputes are those that if resolved against the injured worker completely absolve the employer from any liability to pay for medical treatment expenses and/or for medical-legal expenses. These disputes are typically litigated by the injured worker and the employer and are only brought forward by a provider when the injured worker has settled or abandoned the underlying case:

Threshold Medical Treatment Expense Disputes	Threshold Medical-Legal Expense Disputes
Injury AOE/COE Employment Statute of Limitations Insurance Coverage Jurisdiction Whether the treatment was for an industrially injured body party	Employment Statute of Limitations Insurance Coverage Jurisdiction Whether the medical-legal expense was reasonably incurred to prove a contested claim

Examples of more recent threshold disputes within the domain of the WCAB include those resulting from the creation of Utilization Review, effective January 1, 2003 (Labor Code 4610), and the creation of Medical Provider Networks following passage of SB 899 on April 19, 2004, which went into effect for MPNs on January 1, 2005 (Labor Code 4616):

Threshold Medical Treatment Expense Disputes		Threshold Medical-Legal Expense Disputes
<p>The timeliness of the UR decision</p> <p>Whether the UR decision was communicated to the requesting physician in a timely manner</p> <p>Whether the requested treatment is consistent with the Administrative Director’s Treatment Guidelines</p> <p>Whether the employer has liability for medical treatment rendered outside of the employer’s Medical Provider Network</p>		<p>Whether the medical-legal exam was properly obtained pursuant to Labor Code Sections 4060, 4061, and 4062</p>

Following the enactment of SB 863, Labor Code 4603.2 was amended and Labor Code 4603.3 was implemented to create a highly detailed set of bill payment protocols for medical treatment expenses.

For medical-legal expenses, Labor Code 4622 was amended to create a highly detailed set of bill payment protocols.

The WCAB enacted rules of practice and procedure to give the new laws practical effectiveness (CCR 10451.1 and 10451.2, effective October 23, 2013), thus creating new “threshold” disputes for resolution by the WCAB:

Threshold Medical Treatment Expense Disputes		Threshold Medical-Legal Expense Disputes
<p>Did the defendant <u>waive any objection to the amount of the bill</u> for failing to follow treatment bill payment protocols established in Labor Code 4603.2 or 4603.3? (CCR 10451.2(c))</p> <p>Did the <u>provider waive</u> any claim to payment for failure to follow the bill payment and objection protocols contained in Labor Code 4603.2?</p> <p>Was an interpreter reasonably required at a medical treatment appointment? (CCR 10451.2(c))</p>		<p>Did the <u>defendant waive any objection to the amount of the bill</u> by failing to comply with the bill payment procedures and timeliness set forth in Labor Code 4622? (CCR 10451.1(c))</p> <p>Did the <u>provider waive</u> any claim to payment by failing to comply with the timelines and procedures set forth in Labor Code 4622? (CCR 10451.1(c))</p> <p>Was it necessary to have an interpreter at a medical-legal examination? (CCR 10451.1(c))</p>

<p>Was the interpreter at a treatment appointment properly certified? (CCR 10451.2(b))</p>	<p>Was the interpreter properly certified? (CCR 10451.1(c))</p> <p>Was it necessary to incur copy service costs? (CCR 10451.1(c))</p> <p>Was it necessary to incur vocational expert witness costs? (CCR 10451.1(c))</p>
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Post January 1, 2013 medical treatment and medical-legal bill payment protocols are highly detailed. In order to implement CCR 10451.1 (for medical-legal expenses) or CCR 10451.2 (for medical treatment expenses), it is necessary to be familiar with the following:

Medical Treatment Expenses	Medical-Legal Expenses
<p>1. The medical treatment provider serves the itemized bill, report and related documentation on the claims adjuster. (Labor Code 4603.2, CCR 9792.5.0)</p> <p>2. If the claims adjuster contests any portion of the bill, an “Explanation of Review” (EOR) must be served on the provider within 30 days of receipt of the bill setting forth each and every objection. (Labor Code 4603.2(b)(2))</p> <p>3. If the claims adjuster fails to timely serve the EOR, the provider can assert that the defendant has waived any objection to the amount billed. (CCR 10451.2(c)(1)(D))</p> <p>4. If the only objection in the EOR is the amount payable pursuant to a fee schedule, the medical treatment provider has <u>90 days</u> to request a <u>second review</u>. (Labor Code 4603.2(e), CCR 9792.5.5(a))</p> <p>5. If the only dispute is the amount to be paid pursuant to a fee schedule, and the medical treatment provider does not request a second review within 90 days, the bill is deemed satisfied. (Labor Code 4603.2(e)(2), CCR 9792.5.5(e))</p> <p>6. If the employer denies payment for any</p>	<p>1. The medical-legal provider serves the bill, report, and related documentation on the claims adjuster. (Labor Code 4622, CCR 9793)</p> <p>2. Unless the bill is paid in full, within <u>60 days</u> of receipt of the bill the claims adjuster must serve an “Explanation of Review” (EOR) on the provider, setting forth all objections. (CCR 9794(b))</p> <p>3. If the claims adjuster fails to timely serve the EOR, the provider may assert that the defendant has waived any objection to the amount of the bill. (CCR 10451.1)</p> <p>4. If the only objection raised in the EOR is the amount payable pursuant to a fee schedule, the med-legal provider has <u>90 days</u> to request a <u>second review</u> by the claims adjuster. (Labor Code 4622(b), CCR 9794(b), CCR 9792.5.4(i), CCR 9792.5.5)</p> <p>5. If the only dispute is the amount to be paid pursuant to a fee schedule, and the med-legal provider does not request a second review within 90 days, the bill is deemed satisfied. (Labor Code 4622(b)(2) CCR 9792.5.5(e))</p> <p>6. If the employer denies payment for any reason other than the amount to be paid pursuant to a fee schedule, the med-legal</p>

<p>reason other than the amount to be paid pursuant to a fee schedule, the need to request a second review is deferred until the threshold issues are resolved at the WCAB. (Labor Code 4603.2(e)(1))</p> <p>7. Where the only dispute is the amount billed, if the medical treatment provider requests a second review, the claims adjuster has <u>14 days</u> to serve a final written determination on the provider. (Labor Code 4603.2(e)(3), CCR 9792.5.5(g))</p> <p>8. If the medical treatment provider contests the amount paid after receipt of the final written determination following the second review, the provider may request IBR. (CCR 9792.5.5(i))</p> <p>9. The time limit for the provider to request IBR is <u>30 calendar days</u> from service of the final written determination. (Labor Code 4603.6(a))</p>	<p>provider has <u>90 days</u> from service of the EOR to <u>object</u>. (Labor Code 4622(c), CCR 9794(g))</p> <p>7. If the med-legal provider timely objects to an EOR that denies payment for reasons other than the amount to be paid per fee schedule, the <u>defendant must file a “Petition for Determination of Non-IBR Medical-Legal Dispute,”</u> along with a DOR, within <u>60 days</u> of service of the providers objection. (CCR 10451.1(c)(2)(A), CCR 9794(g))</p> <p>8. If the defendant fails to file a Petition for Determination of Non-IBR Medical-Legal Dispute, the provider may file it, with or without a DOR. (CCR 10451.1(c)(3))</p> <p>9. If it is determined that either the defendant or the med-legal provider engaged in bad faith tactics, the WCAB may award attorney fees, costs, and sanctions under Labor Code 5813. (CCR 10451.1(g))</p> <p>10. Any dispute requiring IBR is suspended while the WCAB resolves the threshold dispute. (CCR 10451.1(d))</p> <p>11. The med-legal provider has 90 days from the date of service of an order of the WCAB resolving any threshold dispute to request a second review of the bill, if the amount of the bill is in dispute. (CCR 9792.5.5(b)(2))</p>
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The Dispute Resolution Process (CCR 10451.1 – 10451.3)

I. CCR 10451.1 (Determination of Medical-Legal Expenses Dispute)

WCAB Rule of Practice and Procedure, section 10451.1, applies to the adjudication of threshold medical-legal disputes between the employer and medical-legal provider:

1. A “Petition for Determination on Non-IBR Medical-Legal Dispute” can be filed instead of a lien (10451.1(c)(3)(D)); the defendant has the primary duty to file it (10451.1(c)(2)(A));
2. The petition can be filed by the med-legal provider if the employer fails to file it;
3. The medical-legal provider becomes a “party” when the petition is filed (CCR 10301(dd)). The provider is added to the WCAB official address record;
4. Threshold issues are those that are determinative of whether the employer has liability for the medical-legal expense. Threshold issues include employment, statute of limitations, insurance coverage, jurisdiction, whether the expense was reasonably incurred to prove a contested claim, and whether a party waived any objection for failure to comply with the billing and objection timelines and procedures set forth in Labor Code Section § 4622(10451.1(c)(1)(A), CCR 10451.1(c));
5. A threshold dispute can be adjudicated before the case in chief is settled or decided, however the judge may defer hearing the threshold dispute if appropriate (CCR 10451.1(c)(4));
6. IBR is put on hold until the threshold dispute is resolved (CCR 10451.1(d)(2));
7. A medical-legal provider can elect to file a lien, rather than a petition under CCR 10451.1(CCR 10451.1(c)(3)(D)), however, the lien must be filed electronically (Labor Code 4903.05(b), CCR 10207(b), CCR 10770(b)(1)(A)), and the provider must pay the \$150 lien filing fee (Labor Code 4903.05(c)), CCR 10207(d), CCR 10207(m), CCR 10451.1(c)(3)(D), CCR 10770(a)(3));
8. Medical-legal liens filed prior to January 1, 2013 are subject to regular lien procedures, and payment of the lien activation fee (CCR 10451.1(e));
9. When the employee or his/her attorney directly pays for the medical-legal goods or services and seeks reimbursement from the employer, the employee cannot file a “Petition for Determination for Non-IBR Medical-Legal Dispute” because the employee is not a “medical-legal provider” (CCR 10451.1(b)(2)). Instead, a Petition for Costs can be filed (CCR 10451.3);
10. “Medical-Legal expenses” include vocational expert fees, interpreters fees for services rendered at a medical-legal exam, copy service fees, and goods and services specified in

Labor Code § 4620(a) (e.g. x-rays, diagnostic tests, medical reports, medical testimony...) (10451.1(b)(1));

11. The defendant is obligated to file the Petition and a Declaration of Readiness if the defendant has denied payment of the med-legal bill for any reason other than the amount to be paid per fee schedule and the medical-legal provider has objected to the denial within 90 days of service of the denial on the provider. The denial letter is known as the “Explanation of Review,” or EOR. The defendant must file the petition along with a DOR within 60 days of the date of service of the provider’s objection to the EOR (CCR 10451.1 (c)(2)(A));
12. The EOR must set forth each and every reason for the denial of payment and the basis for any adjustment or partial payment, and advise the provider of the 90 day time limit to request a second review (Labor Code 4603.3, 4622, CCR 10451.1(c)(D));
13. Failure by the defendant to timely serve the EOR or to comply with any of the relevant requirements and timeliness set forth in Labor Code sections 4622, 4603.3 and 4603.6 operates as a waiver of any objection to the amount of the bill (CCR 10451.1(c)(1)(D)). Failure of the medical-legal provider to follow the procedures and timelines operates as a waiver of any claim to further payment (CCR 10451.1(c)(1)(E));
14. If the defendant fails to file the petition and DOR, the medical-legal provider may do so, with or without a DOR (CCR 10451.1(c)(3));
15. If the defendant engages in bad faith action or tactics, the judge can award reasonable attorney fees and costs to the med-legal provider, and issue sanctions not less than \$500. Bad faith actions include failing to timely pay any uncontested portion of the bill, and failing to timely comply with the Labor Code 4622 procedures to object to the bill. The defendant can also seek payment of attorney fees and cost from the provider, and sanctions (10541.1(g)).

Note: A “Petition for Determination of Non-IBR Medical-Legal Dispute” is a non-action document, meaning the WCJ does not take any action until a party files a DOR and the matter is on-calendar. The medical-legal provider is a party, and can be heard at any proceeding.

Procedurally, some providers have reported that their DORs for lien conference have been rejected because they do not have a lien on file, even though no lien claim is required. And it’s not unusual for parties to instinctively object to a lien conference being set before the case in chief is concluded, even though this may or may not be good cause to defer the medical-legal cost issue.

Hopefully most medical-legal expenses are being timely and properly paid. But if not, CCR 10451.1 provides an excellent mechanism for the judge to expeditiously determine liability for medical-legal expenses, especially where the claims adjustor or medical-legal provider has failed to follow the highly detailed bill pay/objection timelines and procedures set forth in Labor Code Section 4622.

II. CCR 10451.3 (Petition for Costs)

WCAB Rule of Practice and Procedure, section 10451.3 essentially allows the attorney for the injured worker to file a petition instead of a lien to seek reimbursement from the employer and for payments made directly to a medical-legal provider. It also allows an interpreter to file a petition, instead of a lien, to collect payment for services rendered at a deposition or at a WCAB proceeding:

1. A “Petition for Costs” can be filed instead of a lien to litigate threshold disputes concerning the employer liability for the medical-legal expense (CCR 10451.3(a));
2. Only the employee, the defendant, or an interpreter is allowed to file a Petition for Cost, and no one else (10451.3(f)); Question – can you think of a circumstance where the defendant would file a petition for costs?
3. An employee can file a Petition for Costs to seek reimbursement for payments made directly to a medical-legal provider, including payments made to a copy service, vocational expert, or to a physician for medical testimony or for a report. If it is determined that the employer has liability to reimburse the expense, the amount to be paid is still subject to IBR if there is an applicable fee schedule (10451.3(c));
4. An interpreter can file a Petition for Costs only for services rendered at a deposition or at a WCAB proceeding, and subject to any applicable official fee schedule. The interpreter becomes a “party” to the case (CCR 10301(dd)), and is added to the Official Address Record;
5. A Petition for Costs filed by an interpreter must contain the name and certification number of the interpreter who performed the service along with a statement of what services were performed (10451.3(d));
6. A Petition for Costs shall not be filed or served until at least 60 days after a written demand for payment, a copy of which must be attached to the petition along with a copy of its proof of service and any response. A Petition for Costs may be dismissed for failure to comply (10451.3(e));
7. Medical-legal costs that can be claimed by filing a petition can also be claimed by filing a lien (Labor Code 4903.05(b), CCR 10301(h), 10301(v), 10770(a)(3)).

However, after January 1, 2013, if a lien is filed instead of a petition, the person filing the lien is deemed to be a “lien claimant” (CCR 10301(x)), and must file the lien electronically (Labor Code 4903.05(b), CCR 10207(b), 10770(b)(1)(A)), unless the lien is filed by an unrepresented employee or uninsured employer (CCR 10206.2), and the filer must pay the lien filing fee (Labor Code 4903.05(c), CCR 10301(Y), 10770(c)(6)).

8. A “Petition for Costs” is an “action” document, meaning the judge may act on the petition with or without a DOR being filed. The judge can issue a 15 day notice of intention to allow or to disallow the cost, and issue an order if no timely objection is

filed. The matter can be set on-calendar on the judge's own motion, or action can be deferred on the petition if appropriate (CCR 10451.3(g)).

Note: All petitions (and answers) must be verified under penalty of perjury. Failure to comply constitutes a valid ground for dismissing or denying the petition or summarily rejecting the answer (CCR 10450(e)).

Caveat!

Labor Code Section 4903 (Determination of liens payable against compensation) was amended by SB 863 (effective January 1, 2013) to remove medical-legal costs from the list of expenses allowable as a lien against compensation. This makes sense because medical-legal expenses, when valid, are assessed against the employer. They are not deducted from the employee's compensation benefits.

The WCAB implemented CCR 10451.3 to allow a broad range of litigation related medical-legal costs to be claimed by way of a petition for costs, rather than a lien, when these costs are directly paid for by the attorney for the applicant, or claimed by an interpreter for service rendered at a deposition or WCAB proceeding. However, by its terms, CCR 10451.3 specifically limits the expenses that can be claimed by a "Petition for Costs" to those that are "not allowable as a lien against compensation under Labor Code section 4903" (10451.3(a)).

Here is the problem: effective August 19, 2014, Assembly Bill 2732 amended Labor Code 4903 and reinstated medical-legal expenses to the list of expenses allowable as a lien against compensation (4903(b)). This is not a problem for petitions for costs filed prior to August 19, 2014. But what about petitions for costs filed on and after August 19, 2014?

There is regulatory authority in the Administrative Director Rules, section 10205 (Definitions and General Provision), and in the WCAB Rules of Practice and Procedure, section 10301 (Definitions) for the proposition that the employee, the defendant and an interpreter may claim medical-legal expenses by filing a Petition for Costs even after the August 19, 2014 amendment of Labor Code section 4903(b):

1. CCR 10770(a)(3) provides that "claims for medical-legal costs and other claims of costs are not allowable as a lien against compensation";
2. CCR 10301(ii) defines a Labor Code 4903(b) lien to mean a lien for medical treatment expenses, (not medical-legal expenses);
3. CCR 10205(hh) also defines a Labor Code 4903(b) lien to mean a lien claim for medical treatment expenses;
4. CCR 10205(h) defines a "cost" to include medical legal expenses (10205(h)(3));
5. CCR 10301(h) also defines "costs" to include medical-legal expenses, and specifically authorizes the employee, the defendant and an interpreter to seek payment of medical-legal costs by filing a petition for costs pursuant to CCR 10451.3.

The fact remains that this may be a point of contention until Labor Code 4903(b) is amended, once again, to remove medical-legal expenses from the list of expenses allowable as a lien against compensation.

Incidentally, there is also authority for the proposition that when a lien is filed by the employee for medical legal costs the employee is exempt from paying the \$150 lien filing fee. CCR 10207(c)(2)(H) specifically exempts a “lien claimant or party” from paying the lien filing fee if the filer is “a party who is not a lien claimant,” and the lien is not for medical costs.”

However, note CCR 10770(c)(6): “Any person or entity filing a section 4903(b) lien and/or a claim of costs lien shall not file any such lien unless it has paid the requisite lien filing fee.”

Also, 10770(c)(6): “Any lien claim filed in violation of this provision shall be deemed dismissed by operation of law.”

III. CCR 10451.2 (Determination of Medical Treatment Disputes)

Prior to January 1, 2013, the WCAB had authority to weigh the evidence and make determinations whether recommended medical treatment was reasonably necessary. Labor Code section 4610.5 (Review of utilization review decision) changed this.

For dates of injury on and after January 1, 2013, and for all dates of injury where the UR decision is communicated to the requesting physician on or after July 1, 2013, medical necessity disputes must be resolved by “Independent Medical Review” (Labor Code 4610.5, 4610.6; CCR 9792.10.1 through 9792.10.9). Labor Code 4610.5(i) prohibits a workers’ compensation judge, the Appeals Board, or any higher court from making a determination of medical necessity contrary to the determination of the independent review organization. The determination of the IMR organization (Maximus Federal Services, Inc, a private contractor), is deemed to be the determination of the state agency, DWC, by the DWC Administrative Director (Labor Code 4610.5(g)).

IMR is a “new state function” pursuant to Gov. Code section 19130(b)(2). The state defines what treatment is appropriate for employees injured at work (Labor Code 4600(b)), and the frequency, duration and intensity of the treatment available to them (Labor Code 5307.27; CCR 9792.20-9792.26). Medical treatment disputes are no longer resolved by “the often cumbersome and costly court system” (DIR, DWC, IMR Home Page, www.dir.ca.gov).

CCR 10451.2

There are many disputes that relate to medical treatment other than those subject to Independent Medical Review and/or Independent Bill Review. CCR 10451.2, effective October 23, 2013, sets forth the procedures to resolve these disputes:

1. If the medical treatment dispute is between the employer and the employee, the procedures for claims for ordinary benefits are used, including Expedited Hearing (10451.2(c)(2)(A));
2. If the medical treatment dispute is between the employer and the medical provider, the procedures for lien claims are used, including filing of a lien claim and payment of applicable lien filing or lien activation fee (10451.2 (c)(2)(B));
3. If the employer is disputing liability for medical treatment for any reason other than medical necessity, the time to request IMR is extended to 30 days after service of notice to the employee that the liability dispute has been resolved (Labor Code 4610.5(h)(2));
4. If the employee is disputing liability for payment of a medical treatment bill for some reason other than the amount charged, the reason for denial of payment must be set forth in the EOR (Labor Code 4603.3(a)(5)). If the EOR sets forth a threshold dispute that must be resolved by the WCAB prior to Independent Bill Review, the time to request a “second review” of the bill is within 90 days of service of an order of the appeals board resolving the threshold dispute (Labor Code 4603.2(e)(1), 4603.3, CCR 10451.2(c)(3)).

Non-IMR/Non-IBR Medical Treatment Disputes

The WCAB is authorized to hear and decide the following medical treatment disputes:

1. Disputes over the timelines of a UR decision are resolved by the WCAB (Dubon v. World Restoration, Inc (Dubon II) en banc decision, 79 Cal. Comp. Cases 1298, CCR 10451.2(c)(1)(C));
2. Any threshold issue that would entirely defeat a medical treatment claim (e.g. injury AOE/COE, parts of body injured, employment, statute of limitations, insurance coverage, jurisdiction...) (CCR 10451.2(c)(1)(A)) are heard by the WCAB;
3. UR disputes for dates of injury prior to January 1, 2013 where the UR decision was communicated to the requesting physician prior to July 1, 2013 (CCR 10451.2(c)(1)(B)) are determined by the WCAB;
4. An assertion by the medical treatment provider that the defendant waived any objection to the amount of the bill because of failure to follow the bill paying procedures or timeliness contained in Labor Code 4603.2 and 4603.3 (CCR 10451.2(c)(1)(D)) are decided by the WCAB;

5. An assertion by the defendant that the medical treatment provider waived any claim to further payment because the provider failed to follow the bill paying procedures or timeliness contained in Labor Code 4603.2 (CCR 10451.2(c)(1)(E)) are decided by the WCAB;
6. A dispute over whether the employee was entitled to select a treating physician outside of the defendant's MPN (CCR 10451.2(c)(1)(F)) are decided by the WCAB;
7. A dispute whether an interpreter who rendered services at a medical treatment appointment was properly certified (CCR 10451.2(c)(1)(G)) and/or needed (CCR 10451.2(c)(1)(H)) are decided by the WCAB.

QUESTIONS

If you can answer these questions, you have an advanced understanding of the post 1/1/2013 laws.

1. A copy service files a Petition for Costs for services rendered in 2013. Two years later the case in chief resolves. The defendant files a DOR for a lien conference. Is the copy service a party? What if the copy service files a lien after the DOR is filed? (See Labor Code 4903.5 and CCR 10451.3(f)).
2. The attorney for the injured worker files a Petition for Costs to recover the money he paid to the PQME to take the doctor's deposition. He paid \$800 to the QME, and \$350 to the court reporting service. What would you need to know in order to determine whether the costs are reimbursable?
3. Assume the facts above, and that the defendant files a timely objection to the judge's notice of intention to order payment. The defendant claims that a check was previously sent to counsel for applicant to reimburse him in accordance with fee schedule. Does this alter the result?
4. An AME files a Petition for Determination of Non-IBR Dispute seeking payment of his fee for an exam and report prepared in 2014, and he files a DOR for a lien conference. The defendant objects that the case in chief is not resolved, and requests that the lien conference be taken off calendar. Furthermore, the defendant represents that a timely objection letter was sent to the AME informing him that the injury has been denied and/or there is a dispute concerning which parts of the body were injured. Did both the AME and defendant follow the proper procedure?
5. An interpreter files a Petition for Costs for services rendered at medical treatment appointments. The interpreter is charging \$70 per appointment for Spanish language interpreting services rendered in early 2015. Is the interpreter entitled to reimbursement?
6. An attorney for the injured worker files a Petition for Costs requesting an order that the defendant pay his vocational expert the sum of \$1,250 for the exam and report and trial testimony of the vocational expert. What arguments can defendant make?

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

PRE-TRIAL CONFERENCE STATEMENT

V.	APPLICANT
	DEFENDANT(S).

CASE NO. ADJ _____

PRE-TRIAL CONFERENCE STATEMENT §5502 (d) (3)
 NOTICE OF HEARING

LOCATION: _____ DATE: _____ TIME: _____

SETTLEMENT CONFERENCE JUDGE: _____

APPEARANCES

INJURED WORKER: _____

INJURED WORKER'S ATTORNEY: _____

ATTY HRG REP

(FIRM NAME AND PERSON APPEARING)

DEFENDANT'S ATTORNEY: _____

ATTY HRG REP

 ATTY HRG REP

 ATTY HRG REP

 ATTY HRG REP

(FIRM NAME AND PERSON APPEARING)

(DEFENDANT)

OTHERS APPEARING: _____

(L.C., INTERPRETERS, ETC.) _____

ADDRESS RECORD CHANGES: _____

BOX BELOW TO BE COMPLETED ONLY BY WORKERS' COMPENSATION JUDGE

DISPOSITION: SET FOR REGULAR HEARING:		<input type="checkbox"/> WCAB NOTICE	<input type="checkbox"/> NOTICE WAIVED	
<input type="checkbox"/> 1 HOUR	<input type="checkbox"/> 2 HOURS	<input type="checkbox"/> ½ DAY	<input type="checkbox"/> ALL DAY	<input type="checkbox"/> LIEN TRIAL
<input type="checkbox"/> BEFORE ANY WCJ	<input type="checkbox"/> BEFORE WCJ _____	<input type="checkbox"/> BEFORE ANY WCJ OTHER THAN _____		
<input type="checkbox"/> CASE(S) SET ON _____	AT _____	WCJ _____	IN _____	
	(DATE)	(TIME)	(LOCATION)	
<input type="checkbox"/> OTHER DISPOSITION AND ORDERS: _____				

SERVICE AS ORDERED ON PAGE 4

WORKERS' COMPENSATION JUDGE

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

PRE-TRIAL CONFERENCE STATEMENT

CASE NO. _____

ISSUES

- EMPLOYMENT: _____
- INSURANCE COVERAGE: _____
- INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT: _____
- PARTS OF BODY INJURED: _____
- EARNINGS: EMPLOYEE CLAIMS _____ PER WEEK, BASED ON _____
EMPLOYER/CARRIER CLAIMS _____ PER WEEK, BASED ON _____
- TEMPORARY DISABILITY, EMPLOYEE CLAIMING THE FOLLOWING PERIOD(S): _____

- PERMANENT AND STATIONARY DATE:
EMPLOYEE CLAIMS _____, BASED ON _____
EMPLOYER/CARRIER CLAIMS _____, BASED ON _____

- PERMANENT DISABILITY APPORTIONMENT
- OCCUPATION AND GROUP NUMBER CLAIMED: BY EMPLOYEE _____
BY EMPLOYER/CARRIER _____

- NEED FOR FURTHER MEDICAL TREATMENT: _____
- LIABILITY FOR SELF-PROCURED MEDICAL TREATMENT: _____

LIENS:

<u>LIEN CLAIMANT</u>	<u>TYPE OF LIEN</u>	<u>AMOUNT AND PERIODS PAID</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- ATTORNEY FEES
- OTHER ISSUES: _____

APPLICANT

DEFENDANT

LIEN CLAIMANT/OTHER

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

PRE-TRIAL CONFERENCE STATEMENT

CASE NO. _____

THIS PAGE FOR JUDGE'S USE ONLY

JUDGE'S CONFERENCE NOTES: _____

ORDERS

IT IS ORDERED PURSUANT TO WCAB RULE 10500, THAT DEFENDANT APPLICANT LIEN CLAIMANT SERVE FORTHWITH THIS PRE-TRIAL CONFERENCE STATEMENT NOTICE OF HEARING ON ALL PARTIES OR THEIR REPRESENTATIVE SHOWN ON THE OFFICIAL ADDRESS RECORD AND ANY ADDITIONAL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER **ISSUES** (PAGE 3).

IT IS FURTHER ORDERED THAT DEFENDANT APPLICANT LIEN CLAIMANT SERVE TIMELY NOTICE OF THE TIME AND PLACE OF ALL REGULAR HEARING SESSIONS ON ALL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER ISSUES, TOGETHER WITH THE **FOLLOWING NOTICE: YOUR LIEN IS AT ISSUE AND WILL BE ADJUDICATED AT REGULAR HEARING.**

IT IS FURTHER ORDERED THAT THE PROOF OF SERVICE ORDERED ABOVE BE FILED WITH THE WCAB **ONLY** ON REQUEST OF THE ASSIGNED WORKERS' COMPENSATION JUDGE.

OTHER DISPOSITION AND ORDERS:

SERVICE OF THIS DOCUMENT WAS MADE PERSONALLY UPON _____ BY WCJ.

DATE _____

WORKERS' COMPENSATION JUDGE

1. APPLICANT, BORN _____, SUSTAINED OR CLAIMS INJURY AS FOLLOWS:

	(1)	(2)	(3)	(4)
CASE NO.				
DOI				
	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>			
BODY PARTS				
JOB TITLE(S) OCCUPATIONAL GROUP NO(S).				
EARNINGS & TD/PD RATES				
EMPLOYER				
CARRIER ADJUSTED BY				
WORK COMP SECURED BY	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>			
COVERAGE DATES				

2. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS:

<u>TYPE</u>	<u>WEEKLY RATE</u>	<u>PERIOD</u>	<u>PAID BY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF TEMPORARY DISABILITY CLAIMED THROUGH _____.

4. THE EMPLOYER HAS FURNISHED ALL SOME NO MEDICAL TREATMENT.
THE PRIMARY TREATING PHYSICIAN IS _____.

5. NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE AGREEMENTS HAVE BEEN MADE.

6. OTHER STIPULATIONS: _____

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

ORDER RE: FILING EXHIBITS

_____, *Applicant* v. _____, *Defendant(s)*

ADJ No(s). _____

Good cause appearing, IT IS ORDERED THAT:

1. **ALL PARTIES** (including e-filers) are to file a **courtesy paper copy of all exhibits** with the trial judge at least 20 days prior to trial. These are to be **indexed, tabulated and bradded** (for the judge's use during trial). Place courtesy copy of exhibits in trial judge's in-box in courtroom. If filing by mail, mark the Exhibits to the Judge's attention, personal and confidential. **No exhibits are to be uploaded prior to trial**, but must be listed, applicant using numbers and defendant using letters. **Do not include any EAMS forms (cover and separator sheets)**. If there are **several reports from a medical practitioner**, they should be grouped as one exhibit in **reverse chronological order** (latest listed first). If there is a particular report of significance to an issue for trial, it should be listed as a separate exhibit from the group reports. Any **briefs** the parties wish the trial judge to read should be filed with the exhibits. The courtesy paper copy for the judge should include joint exhibits, defendant's exhibits and applicant's exhibits as described below.
2. **ALL PARTIES** (including e-filers) should list but need not serve exhibits that have been previously served. The index should include a description of the exhibits, its author and its date. (Applicant's exhibits are numbers; defendant's exhibits are letters).
3. **DEFENDANTS** are to file all joint exhibits, such as AME/PQME reports and deposition transcripts (except of the applicant). Joint exhibits are to be numbered, beginning at 101, 102, etc. **Applicants should not file duplicates of joint exhibits.**
4. **AFTER TRIAL:** E-filers are to e-file exhibits within five business days after trial. Non-e-filers will reply to an e-mail from the court reporter by attaching the exhibits within five business days with a copy to all other parties. Each designated exhibit is to be separately labeled and separately scanned as it own PDF file. Neither a cover sheet nor a separator sheet is required.

Date: _____

Workers' Compensation Judge

Notice to: _____

Pursuant to Rule 10500, you are designated to serve the attached document(s) forthwith on all parties shown on the Official Address record along with a proof of service. You shall maintain the proof of service, *which shall not be filed with the W.C.A.B. unless a dispute arises regarding service of the document(s)*.

Served on parties present designated party on: _____ By: _____

**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD**

<p><i>Applicant,</i></p> <p style="margin-left: 100px;">vs.</p> <p><i>Defendants.</i></p>
--

Case No(s). ADJ _____

**STIPULATIONS AND ISSUES
FOR EXPEDITED HEARING**

INJURED WORKER'S ATTORNEY: _____

(firm): _____

DEFENDANT'S ATTORNEY: _____

(firm): _____

INTERPRETER: _____ **Lic. No.** _____

EDD REPRESENTATIVE: _____

I. Is there a prior Award in this case? Yes _____ No _____

If not, proceed to Section II.

If yes, provide date: _____ and **SKIP** to Section III

II. STIPULATIONS

**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD**

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(firm): _____

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(firm): _____

INTERPRETER: _____ **Lic. No.** _____

EDD REPRESENTATIVE: _____

I. Is there a prior Award in this case? Yes _____ No _____

If not, proceed to Section II.

If yes, provide date: _____ and **SKIP** to Section III

II. STIPULATIONS

THE FOLLOWING FACTS ARE ADMITTED:

1. _____, born ___/___/_____, while employed by _____ on ___/___/_____, (or) during the period through ___/___/_____, as a(n) _____, at _____, California, sustained injury arising out of and occurring in the course of employment to _____ and claims to have sustained injury arising out of and occurring in the course of employment to _____.
2. At the time of injury, the employer was ___ permissibly self-insured ___ legally uninsured, insured by _____.
3. At the time of injury, the employee's earnings were \$_____ per week, warranting a temporary disability indemnity rated of \$_____ per week.

III. IS THERE A DISPUTE OVER T.D.?

Yes _____ No _____

If not, proceed to Section IV.

TD RATE: Applicant's contention: \$_____ Defendant's contention: \$_____

Applicant's contention as to TD period: _____

Defendant's contention why TD not due: P&S _____ Mod work offered _____

Termination for cause _____

Did EDD provide benefits? Yes _____ No _____

If so, period of payment: _____ Rate: \$_____

Does Applicant's attorney request a fee? Yes _____ No _____

IV. IS THERE A DISPUTE OVER BODY PARTS?* Yes _____ No _____
If not, proceed to Section V.

Applicant's contends (and Defendant disputes) injury to: _____.

* Policy and Procedure Manual 1.20 allows disputed body parts to be tried at Expedited Hearing where treatment for the body part is at issue.

V. IS MEDICAL TREATMENT AT ISSUE? Yes _____ No _____
If not, proceed to Section VI.

Medical treatment sought by Applicant: _____

Does Applicant contend that no Utilization Review was done [Title 8, Calif. Code of Regs., Sec. 10451.2(c)(1)(C)]? Yes _____ No _____

Does Applicant contend that Utilization Review, if done, was untimely [Title 8, Calif. Code of Regs., Sec. 10451.2(c)]? Yes _____ No _____

Date RFA transmitted: _____ Date of denial: _____

Date of request for additional information: _____

Does Applicant contend that all relevant documents were not received by the IMR organization timely [Title 8, Calif. Code of Regs., Sec. 9792.10.5(a)(1)]? Yes _____ No _____

Does Applicant contend that the IMR decision was untimely [Labor Code Section 4610.6(d)]? Yes _____ No _____

Does Defendant contend that the WCAB lacks jurisdiction to hear this matter [Labor Code Sec. 5502(b)(1)]? Yes _____ No _____

VI. IS TREATMENT WITHIN AN MPN AT ISSUE? Yes _____ No _____
If not, proceed to Section VII.

Identification of MPN: _____

Basis of Applicant's objection to MPN: _____

VII. IS A MEDICAL TREATMENT APPOINTMENT AT ISSUE? Yes _____ No _____
If not, proceed to Section VIII.

Date of Appointment: _____ Doctor: _____

Party Requesting: _____

III. IS A MED-LEGAL EVALUATION AT ISSUE? Yes _____ No _____
If not, proceed to Section IX.

Date of Appointment: _____ Doctor: _____

Party Requesting: _____

IX. IS THERE A NEED FOR TESTIMONY? Yes _____ No _____

Witnesses: _____

(Have you considered an Offer of Proof?)

WAIT! YOU ARE NOT DONE!

LIST ALL EXHIBITS ON SEPARATE SHEETS.

Applicants' Exhibits are designated by numbers; Defendant's Exhibits are designated by letters.

THE FOLLOWING FACTS ARE ADMITTED:

1. _____, born ___/___/_____, while employed by _____ on ___/___/_____, (or) during the period through ___/___/_____, as a(n) _____, at _____, California, sustained injury arising out of and occurring in the course of employment to _____ and claims to have sustained injury arising out of and occurring in the course of employment to _____.
2. At the time of injury, the employer was ___ permissibly self-insured ___ legally uninsured, insured by _____.
3. At the time of injury, the employee's earnings were \$_____ per week, warranting a temporary disability indemnity rated of \$_____ per week.

III. IS THERE A DISPUTE OVER T.D.? Yes _____ No _____
 If not, proceed to Section IV.

TD RATE: Applicant's contention: \$_____ Defendant's contention: \$_____

Applicant's contention as to TD period: _____

Defendant's contention why TD not due: P&S _____ Mod work offered _____

Termination for cause _____

Did EDD provide benefits? Yes _____ No _____

If so, period of payment: _____ Rate: \$_____

Does Applicant's attorney request a fee? Yes _____ No _____

IV. IS THERE A DISPUTE OVER BODY PARTS?* Yes _____ No _____
If not, proceed to Section V.

Applicant's contends (and Defendant disputes) injury to: _____.

* Policy and Procedure Manual 1.20 allows disputed body parts to be tried at Expedited Hearing where treatment for the body part is at issue.

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Does Applicant contend that Utilization Review, if done, was untimely [Title 8, Calif. Code of Regs., Sec. 10451.2(c)]? Yes _____ No _____

Date RFA transmitted: _____ Date of denial: _____

Date of request for additional information: _____

Does Applicant contend that all relevant documents were not received by the IMR organization timely [Title 8, Calif. Code of Regs., Sec. 9792.10.5(a)(1)]? Yes _____ No _____

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If not, proceed to Section VIII.

Date of Appointment: _____ Doctor: _____

Party Requesting: _____

III. IS A MED-LEGAL EVALUATION AT ISSUE? Yes _____ No _____
If not, proceed to Section IX.

Date of Appointment: _____ Doctor: _____

Party Requesting: _____

IX. IS THERE A NEED FOR TESTIMONY? Yes _____ No _____

Witnesses: _____

(Have you considered an Offer of Proof?)

WAIT! YOU ARE NOT DONE!

LIST ALL EXHIBITS ON SEPARATE SHEETS.

Applicants' Exhibits are designated by numbers; Defendant's Exhibits are designated by letters.

Expedited Hearing Set-Up Sheet

Date: _____ Reporter: _____

Case Name: _____

Case Number[s]: _____

App. Atty: _____ Def. Atty [ies]: _____

Other appearances: _____

STIPULATIONS

Applicant, _____, born _____, while employed on _____
or during the period _____ in: _____, California, as
a[n] _____ by _____, insured for workers'
compensation by _____, sustained injury arising out of and
in the course of employment to _____

_____. Applicant also alleges injury to _____

At the time of the injury, AWW was \$ _____; TTD rate: \$ _____.

TTD was paid: _____

ISSUES

Medical treatment: _____

TTD: _____

_____ Atty. fee: _____

Stipulation

- Occupational Group

Job description/job duties and work function

Utilize Schedule for Rating Permanent Disability Section 3

- Coverage

EAMS party designation not coverage

8 CCR 19550-carrier includes high self-insured retention, large deductible or any provision that effects identity of entity or entities actually liable for payment of compensation. Carrier discloses whether appearing on its own behalf or on behalf of the employer.

Colderon 67 Cal. Comp. Cases 2899en banc-failure to disclose the proper carrier may subject third party administrator to sanctions per Labor Code 5813

- Earnings

Earning statement prepared by employer/record of earnings

Earning capacity-past employment

Garcia 2015 Cal. Wrk. Comp. P.D. LEXIS 492- Brd panel found mistake by defendant on the gross amount of permanent disability payable was a unilateral mistake. Defendant put that amount on assumption payable at maximum weekly rate even though stipulations set forth a weekly rate of \$188.40 per week with 15% reduction. The difference of approximately of \$11,000 resulted. The defendant bound by the stipulation.

- Temporary disability

Benefit notices/benefit print-out with designation code, medical basis, offer of modified work and job description of work

8 CCR 10607 requires the benefit print-out to be provided if requested w/I 20 days and this request may be made every 120 days unless there is a change in indemnity payments

- Other Stipulation

Further med. Treatment

Trial Exhibits

- 8 CCR 10629(d)

List author/provider and date

Different author and/or different date listed as separate exhibit unless physician notes, hospital or dispensary records; personnel wage record/statements, job description and other business record and EOB may be group exhibit

Each exhibit must specify number or initial (letters)

- Prepare index of exhibits
- 8 CCR 10393(b)(1) and (2)

When filing D/R, AME, QME or PTP report relevant to issue raised which are in possession of declarant not previously filed should be filed. Unless ordered by WCAB, no other medical reports, medical records, medical-legal reports or other documents shall be filed.

EXPEDITED HEARINGS

Issues determined (Labor Code §5502(b)(1)-(6)):

- MPN dispute
- Entitlement to medical treatment (UR and IMR)
- Medical appointment or medical-legal examination
- Entitlement to temporary disability
- Entitlement to compensation where two or more employers dispute liability

UR

Jurisdiction to hear

- Timeliness (Dubon II(en banc) 79 Cal. Comp. Cases 1298)
- Timeframes to act (Labor Code §4610(g), 8 CCR §9792.9-injuries pre 01/01/2013 and request for authorization rec. prior to 07/01/2013, 8 CCR §9792.9.1-injuries post 01/01/2013)

For concurrent or prospective review (defined 9792.6.1(d) and (p) respectively)

- RFA rec. on date transmitted if by fax if before 5:30 p.m. PST.
- RFA by mail rec. 5 days post proof of service date, date stamped on return receipt, date stamped received on document.
- Have 5 business days to defer UR if dispute liability, 5 working days to deny, modify or delay, 14 days from date of medical recommendation if delay notice issue or have no more than 72 hours after receipt of information support finding the applicant

For expedited review (defined 9792.6.1(j))

- No more than 72 hours after receipt of information necessary to decide where applicant faces imminent and serious threat to his or her health, potential loss of life, limb or other major bodily function
- Where time of compliance is in hours the time for compliance is counted from time of receipt of RFA (9792.9.1(c)(1))

For concurrent, prospective or expedited review, decision shall be communicated to requesting physician within 24 hours initially by telephone, fax or electronic mail followed by written notice to requesting physician, applicant and applicant's attorney if represented within 24 hours for concurrent review, within 2 days for prospective review and within 72 hours of receipt of the request for expedited review. (9792.9.1(c)(3))

Bodam(significant panel decision) 79 Cal. Comp. Cases 1519

Must comply with all time requirements when conducting UR. Where decision timely made but not communicated, the decision is invalid and necessity of medical treatment may be determined by WCAB based on substantial evidence.

Keller v. No. Calif. Med. Asso.(2015) 2015 Cal. Wrk. Comp. P.D. LEXIS 594

Board panel determined timely service of medical records is not part of the UR process set forth in Labor Code §4610. The finding of an untimely UR was reversed.

For retrospective decisions (defined 9792.6(r))

- Decision to approve, modify or deny made with 30 days of receipt of RFA and medical information reasonably necessary to render decision.

When liability is disputed, decision deferring utilization review must provide date RFA first received, description of treatment proposed, clear explanation for placing liability, advising clearly dispute resolved either by agreement or determination by WCAB and mandatory language (9792.9.1(b)(1))

Beiling v. UPS 2015 Cal. Wrk. Comp. P.D. LEXIS

Per Labor Code §4610(g)(8), retrospective utilization review commences when liability for treatment is finally determined and prospective utilization commences upon receipt of the treatment recommendation after the determination of liability.

King v. Comp. Partners (decided 01/05/2016)- Court of Appeal held that a UR doctor has a doctor/patient relationship and has a duty of care. The UR doctor may be subject to being sued (medical malpractice) and not barred by workers' compensation exclusive remedy.

IMR

Labor Code §4610.5 and §4610.6 set forth the IMR requirements. IMR appeals are either appeal of the AD ineligibility determinations and appeals of the AD final determination.

- 8 CCR 9792.10.3 sets forth the following eligibility issues
 - (a) Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. In making this determination, the Administrative Director shall consider:
 - (1) The timeliness and completeness of the Application;
 - (2) Any previous application or request for independent medical review of the disputed medical treatment;
 - (3) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.
 - (4) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician.

(5) The employee's date of injury.

(6) The failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation.

(b) The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, if the employee is represented by counsel, the employee's attorney, and the requesting physician, as appropriate, by the most efficient means available.

(c) The parties shall respond to any reasonable request made pursuant to subdivision (b) within five (5) business days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review under section 9792.10.4.

(d) If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the claims administrator agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

(e) The parties may appeal an eligibility determination by the Administrative Director that a disputed medical treatment is not eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board.

(f) The Administrative Director shall retain the right to determine the eligibility of a request for independent medical review under this section until an appeal of the final independent medical review determination issued under section 9792.10.6(e) that determines the medical necessity of the disputed medical treatment has been filed with the Workers' Compensation Appeals Board, or the time in which to file such an appeal has expired.

The applicant has 30 days from service of the UR determination to submit a request for IMR (Labor Code §4610.5(h)(1)).

- Final determinations by AD are presumptively correct and is rebutted by clear and convincing evidence is established on the following grounds per Labor Code 4610(h)

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

The IMR reviewer has 30 days from receipt of the Application for IMR and supporting documentation to complete its review and supporting documentation and information for regular review. (Labor Code § 4610.6(d); 8 CCR 9792.10.6(g)(1)). Labor Code §4610.5(l) requires the employer to forward all relevant medical record to IMR for review within 10 days of the notice of assignment for review by AD. If the applicant's provider or AD certifies in writing that an imminent and serious threat to health may exist, the review is expedited and a final determination is made within 3 days of receipt of the information.

If the IMR determination is reversed, the matter is remanded back to AD for another review by different reviewer. Medical necessity shall not be determined by WCJ, Appeals Board or any higher court.

Garibay-Jimenez 43 CWCR 92- failure of defendant to provide AME reports for review was enacted without or in excess of AD powers.

Arredondo 80 Cal. Comp. Cases 1050- Board panel found the time frames for IMR decision are directory and not mandatory. An IMR determination not made in 30 days was not invalid.

Saunders 43 CWCR 145- Board panel found the time frames for IMR decision were mandatory and not directory and ruled a late IMR was invalid and that the determination of medical necessity is addressed by the WCJ.

Southard panel reached the same conclusion as Saunders. Court of Appeal has granted review.

Stevens v. WCAB(2015) 241 Cal. App. 1074, 80 Cal. Comp. Cases 1262

Court held the IMR process did not violate Cal. Const. separation of powers and due process clause; lack of process to enforce time limit (30 days to make determination) did not affect constitutionally.

Matute 2015 Cal. Wrk. Comp. P.D. LEXIS 126- en banc decision found appeal of IMR determination is extended 5 days because service by mail.

Hacker 2015 Cal. Wrk. Comp. P.D. LEXIS 415- Brd panel determined nothing statutorily or regulatory requiring the IMR determination to provide the author and specific date of each report it reviewed and 8 CCR9792.10.6(d) requires only a list of documents reviewed. WCJ finding the IMR determination was not substantial evidence was not a determination of plainly erroneous finding and that such a finding was prohibited by Labor Code §4610.6(i).