Lien Statute of Limitations

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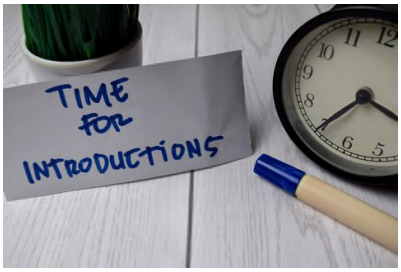

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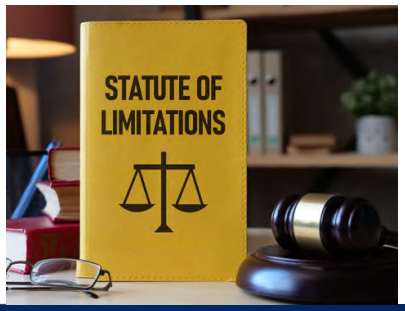
What we will cover today

- Lien SOLs
- Second bill reviews
- Essentials for every exhibit list
- Med-legal DOS and liens

Lien Statute of Limitations

- Date of Service before July 1, 2013:
  - 3 years from date of service.

- Date of Service after July 1, 2013:
  - 18 months from date of service.



Lien Statute of Limitations

Run this analysis at the start of each lien case

1. Pull up your itemized statements for liens
2. Pull up EAMS Public Lien Search for your case(s)
3. Compare the last DOS on the itemized statement to
4. The lien filing date on the EAMS Public Search tool
5. If a recent case and more than 18 months, prob barred by SOL.
6. If an older case and more than 3 years, prob barred by SOL

SOL Example #1

Lien claimant Frankenstein Chiropractic's lien

- First DOS is 2/1/12
- Last DOS is 8/10/13
- Lien filed on 2/9/15

SOL Example #1

Is Frankenstein Chiropractic's lien timely?

- Yes, because 1) the last DOS is after 7/1/13, and 2) the lien was filed 17 months and 30 days after 8/10/13
- Last DOS is 8/10/13
- Lien filed on 2/9/15
- 2/10/15 is exactly 18 months from 8/10/13, so a lien filed before that on 2/9/15 is timely

SOL Example #1

Does Frankenstein Chiropractic's lien's first DOS being before 7/1/13 matter?

- Remember, the first DOS was 2/1/12. That's before the 7/1/13 dividing line.
- Answer: No, it doesn't matter. Only the last DOS is what matters when computing SOL.

SOL Example #1

Pro tip: While we're talking about Frankenstein Chiro's itemized bill and going down our list of liens, do this quick application of the 24 visit cap:

- Count how many DOS Frankenstein had
- Check your "liens of record" list and see how many other chiros treated on your case
- If more than one, see who treated first and count up DOS.

SOL Example #1

Pro tip:

- 24 visit cap applies to any chiro DOS after 24 visits, so Chiro #2 may have a timely lien filed, but that doesn't mean that you have to reimburse them.

SOL Example #2

Lien claimant Bram Stoker's Toxicology Lab lien

- First DOS is 1/1/16
- Last treatment DOS is 8/1/16
- Lien filed on 2/26/18
- But wait, there's some shady DOS at the end for 9/1/16. It's unclear what that is for.

SOL Example #2

Is Bram Stoker's Toxicology Lab lien timely filed?

- Answer: Probably not if that last DOS of 9/1/16 is for some made-up thing. What happens sometimes is a lien claimant will realize that they filed their lien on 2/26/18, which is 18 months and 25 days after the last treatment DOS of 8/1/16.
- So on the back end, the collector fabricates DOS at the end for 9/1/16 to preserve their SOL.

SOL Example #2

Mistaek's (sic) happen …

- It's a volume business, and these liens are handled in bulk.
- So mistakes happen from time to time.
- It would be very tempting for someone shady to realize they made a filing mistake, then make up a DOS for 9/1/16 to preserve their SOL. But when you scrutinize 9/1/16, you realize that there was no medical service provided.
- Other times you'll see stuff that doesn't add up, like that the case settled before 9/1/16.
- Takeaway: scrutinize those shady last DOS!

SOL Example #3

Lien claimant Frankenstein Chiropractic's lien

- First DOS is 12/1/12
- Last DOS is 7/10/13
- Lien filed on 10/9/15

SOL Example #3

- We tell lien claimant Frankenstein Chiropractic that their lien is untimely because 10/9/15 is more than 18 months after last DOS.
- Frankenstein replies that the lien is filed three years from first DOS, argues that's ok.
- No, that doesn't fly – numerous WCAB panel decisions have said you can't use the first DOS like that to try and get the three-year statute of limitations. Last DOS is what controls.

SB 863 did away with "lack of service" arguments

- Prior to SB 863 becoming law in 2012, lien claimants could argue that the SOL was tolled until defendants served settlement docs on the lien claimant.
- However, SB 863 amended LC 4603, and tied a statute of limitations argument to the last DOS. This simplified the SOL analysis.
- Occasional lack of service arguments do not fly, they do not toll the SOL.

Group Health Lien Statute of Limitations

- Group health liens enjoy an entirely different SOL
- LC 4903.5(b) gives group health plans one year after "the entity first knew or in the exercise of reasonable diligence should have known that an industrial injury is being claimed, but in no event later from the date the services were provided to the employee."
- TL,DR: One year from when they should have known.

Group Health Lien Statute of Limitations

When should they have known? When:

- An applicant wrote down on intake forms that this is for a work injury
- Telling their group health personal physician about how this injury is work-related
- This last one is arguable: I, the defense attorney, send the group health a subpoena for a workers' compensation case. That arguably puts them on notice of "hey there's this legal proceeding with your guy over here. Can you respond to this official subpoena from this work comp case?"

Group Health Lien Example #1

- Harvey Dent, the applicant, goes to see his dermatologist and plastic surgeon at the group health plan.
- While filling out intake forms on 7/18/08 he checks "yes" in response to the "Are you here for a work-related injury?"
- He has effectively put them on notice of his work-related injury. They have until 7/18/09 to file their lien.

Delving into the group health lien a little more

- Lets say Harvey's group health plan does file a timely lien before 7/18/09. What next?
- OMFS is probably not your ticket to victory. Why? Group health's "web of contracts" often create discounts that make their billing for each DOS lower than OMFS. If things are being done correctly, your work comp bill review expert's OMFS valuation will usually be higher than the bill the group health guys are asking you to pay.

Delving into the group health lien a little more

- Check which body parts they're treating. If Harvey's face was the only industrial body part, and group health is treating (and billing you) for a nonindustrial broken knee – then that is nonindustrial treatment.

Activation fees

- Back in 2014-2016 this came up: Liens with DOS after 7/1/13 suddenly had to pay an activation fee of $150.
- There was some litigation, but eventually they had until 12/31/15 to pay that fee.
- If they didn't pay that fee, they were dismissed by operation of law.
- So if you have liens from that 2014-2015 timeframe that never paid their fee, they are dismissed by operation of law. Many have already been purged from EAMS.

Second Bill Reviews

- On your PTCS, list: Second bill review, or LC 4603.2(e) and CCR 9792.5.5
- In situations where the only dispute is the amount of payment, a provider with DOS on/after 7/1/13, must request a second bill review within 90 days of receiving an EOR they disagree with.
- They have to send it back to the TPA along with a longer list of things.

Second Bill Reviews

Request for second bill review must include:

1. the original DOS and the same itemized services rendered as the original bill (no new DOS or additional billing codes may be included);
2. the date of the EOR and its claim number or other identifying number;
3. the item and amount in dispute;
4. the additional payment requested and reason for it; and
5. the additional information provided in response to a request in the first EOR or any other additional information provided in support of the additional payment requested.

Second Bill Reviews

- Some medical office managers are really good about this. So if you see they made a valid request, then it goes back to a dispute.
- But some are not so good, and if they didn't request it in an accepted case, then their DOS are effectively knocked out.
- Second bill review process only applies to OMFS disputes.

EORS/EOBS on denied cases

- Often we have a denied case, and client's reviewers issue EORs zeroing out everything because it's a denied case.
- If case later becomes compensable, those EORs are essentially worthless.
- Second bill review doesn't apply because second bill review only applies when it's solely a fee schedule (OMFS) dispute.
- Takeaway: in these situations, get them reviewed again.

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Speaking of denied cases that become compensable …

- When you have a denied case with UR deferrals of RFAs
- And later on you decide to accept the case
- You have up to 30 days from the determination of compensability to submit those to retrospective UR

Speaking of denied cases that become compensable …

Retrospective UR will weed out the frivolous things that lien claimants are billing for, such as:

- Services that are not reasonable or necessary under the MTUS/ACOEM Guidelines.

Authority: CCR 9792.9.1, LC 4610

Essentials for your exhibit list

When preparing for a lien conference, I will try to list all of the following on my exhibit list:

- delay/denial,
- EORs/EOBs,
- URs/IMRs,
- QME reports,
- SDT records,
- Evidence of other chiro/PT/acupuncture if arguing 24-visit cap
- sub rosa if you have it,
- applicant depo
- Witnesses: ER witnesses, OMFS experts
- I may not actually use all of that stuff, but it's hard to tell what will become relevant. Therefore I overlist and actually use only some of this stuff.

Alternative "less is more" theory of exhibits: Denied cases

Sometimes you have a denied case and lien claimants have a struggle against AOE/COE. If that's the case, then the alternative theory is to only list a few things, like:

- delay/denial
- EORs/EOBs (ie more recent ones showing OMFS valuation)

Alternative "less is more" theory of exhibits

The "less is more" approach puts the burden on the LC to prove the case. Have heard many judges say defendants can shoot themselves in the foot by including QME reports.

That's a case-by-case consideration – don't want to shoot yourself in the foot, but on the other hand, the QME report can help you nuke frivolous treatment by PTPs.

Still need your denial, and want to list something with base OMFS valuation so if you lose you don't get hit with the full balance.

Theory toward the order of lien settlements

There is sometimes value in settling liens in a particular order. For instance, one can create a strategic disadvantage with exhibits in this scenario:

- Case is set for lien trial with multiple LCs, including: PTP, toxicology, secondary treater, DME, interpreting, med-legal services, nonphysician LCs.
- Often, the PTP is the one with the best exhibit list. The other LCs may be missing a plethora of reports on their exhibit lists.

Theory toward the order of lien settlements

- Because case is set for trial and PTCS is complete, no more new exhibits.
- Settle the PTP first. It removes their exhibits from evidence. The other lien claimants who have flawed exhibits suddenly don't have all those great things the PTP has listed.
- If you have settled the PTP for a lower rate, then you can brag to the other LCs "Hey the PTP settled for 25%. Tells you a lot about the case, doesn't it?"
- If having difficulty, can make sure the LC's supervisor is aware of what the PTP settled for.

Med-legal services

One question that pops up is what is, and what are not, med-legal services.

- What is med-legal? Basically:
- when a service helps prove/disprove a disputed issue or fact in a contested case

Med-legal services

Per CCR §9793(h) a Medical-Legal Expense means:

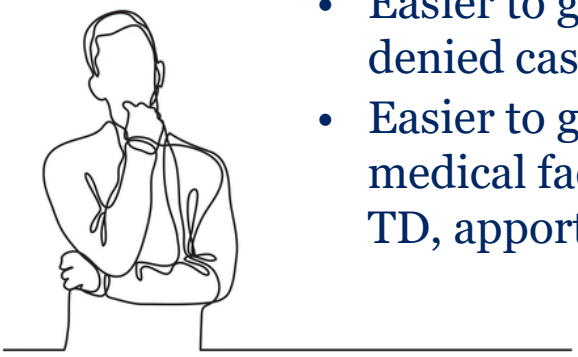
"Any cost or expenses incurred…for x-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter fees, for the purpose of proving or disproving a contested claim."

What is a contested claim?

CCR §9793(b) defines a Contested Claim:

1. **Where the administrator has rejected liability for a claim benefit.**
2. Where the claims administrator has failed to accept liability for a claim and the claim has become presumptively compensable under Section 5402 of the Labor Code.
3. Where the claims administrator has failed to respond to a demand for payment.
4. **Where the claims administrator has accepted liability for a claim and a disputed medical fact exists.**

TL,DR: Boooooooring, what does all that mean?



- Easier to get med-legal distinction in denied cases
- Easier to get med-legal if disputed medical fact, such as body parts, PD, TD, apportionment, etc.

En banc WCAB: Colamonico

- *Ashley Colamonico v. Secure Transportation 11/14/19*

Takeaways:

- Copy service LCs must establish that:
  - There is a contested claim
  - Services were incurred for proving/disproving contested claim
  - Expenses were reasonable and necessary
- Defendant's failure to issue EOR does not constitute a waiver of objections. Still, we recommend issuing EORs or some kind of objection to copy service liens.

What services are med-legal expenses?

- Definitely: QME/AME reports
- Definitely: interpreters at court hearings
- Most of the time: Copy services in cases with any disputes (per a review of recent WCAB panel decisions). Even ancient copy service DOS that they waited 10 years to pursue, WCAB is handing them wins too.
- Sometimes: PTPs narrative reports that comment in great detail on disputed issues. (Often the initial evaluation report and the final MMI/P&S report.)

Contribution: Keep those med-legal categories in mind for contribution

- In contribution/reimbursement, can get back pro rata shares for treatment.
- But in contribution/reimbursement, can split med-legal costs 50/50 with codefendant.

Takeaway: Copy services

- I recently had a decade old lien from a copy service.
- They filed timely as a LC of record and paid their fee, but waited 8 years to the detriment of me and my client.
- I did a deeper dive on WCAB panel decisions, and unfortunately discovered that the WCAB has made it so easy for copy services to prevail as med-legal services, even in situations like this.

Takeaway: Copy services

- These panels absolve/ignore threshold arguments, such as whether the copy services' subpoenas were defective.
- For example, defective service deprives a defense attorney from being able to object. Does that defeat their lien? No, not according to the WCAB.
- Does failing to prosecute their timely-filed lien bar them from recovery? No, not according to a recent review of WCAB decisions on copy services.
- Do I agree with these results? No, I disagree. Flawed subpoenas should not be reimbursable.

Takeaway: Med-legal services petitions for non-IBR

- We are happy to fight the good fight and make arguments against these. Usually the best ones to fight are the PTPs, the ones that are often not worth fighting are the copy services.
- We have won at trial on interpreters med-legal services, only to be overturned at the WCAB.
- Have seen multiple decisions involving copy services where defendants won at trial, only to be overturned at WCAB level.

Takeaway: Med-legal services petitions for non-IBR

This area is currently rife with abuse. Examples of abuse:

- Getting 3 subpoenas for the same location in one month from an AA's copy service, where the AA didn't request them first.
- Have had a case where AA and I have a settlement agreement, just waiting on CMS to approve. No treatment, no nothing during waiting period. Receive a new SDT for an old facility that applicant hasn't treated at in years. AA didn't request it.

Multiple subpoenas for one location?

Question: What produces this fact pattern?

- Getting 3 subpoenas for the same location in one month from an AA's copy service, where the AA didn't request them first.

Answer: AAs have allowed copy services to use bots to scan their file management software. Anytime defendant subpoenas something, copy service automatically orders it up without AA actually requesting it.

Copy services abusing the system

Other examples of abuse by copy services:

- There are former AAs out there who have been indicted for pay-for-play arrangements. Talk to them and they will tell you that they swear other AAs are getting paid referral fees by copy services. In other words, every time a new subpoena issues, the AA gets a fee.
- This is outright fraud and is illegal. It is difficult to document and prove, but keep an eye out for it.

Solution: The Legislature

1. We have PTPs who are claiming all treatment is med-legal (false).
2. We have copy services who are ordering up subpoenas despite AA never asking for them.
3. We have interpreters billing exorbitant amounts for med-legal, when we know that same interpreter had 30 appearances that same morning. (30 x 4 hours of billing = 120 hours for a single weekday morning).
4. All are filing petitions for non-IBR.

Solution: It has reached the level where the lobbyists need to show lawmakers that it is rife with abuse and is reaching unacceptable costs.

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