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WORKERS AND EMPLOYERS NEED A MEDICAL SYSTEM WHICH IS TRANSPARENT AND ACCOUNTABLE

By SCOTT O'MARA

Workers' Compensation is a system which was created to protect California workers when they sustain a job-related injury. One of the most substantial benefits injured workers are entitled to receive is medical care. The employer, through its insurance carrier or through being self-insured, must furnish all treatment reasonably required to cure or relieve the effects of the industrial injury. What makes this benefit so significant is its expansiveness.

The "treatment reasonably required" covers a wide variety of possible options, such as medications, injections, surgery, physical therapy, braces, wheelchairs, acupuncture, chiropractic care, hospitalization and nursing care, as well as surgical supplies such as crutches, orthotics and prosthetic devices. In extreme cases, this care can also cover transplants involving organs such as the liver and the heart, and house reconfiguration if a job-related injury requires modifications to enable the injured worker to perform basic activities of daily living.

The concept set forth in the California Constitution is that the care should ensure "adequate provisions for the comfort, health and safety and general welfare of any and all workers and those dependent upon them for support to the extent of . . . full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injury".

The medical care program has been subject to many revisions designed to allow further employer intervention, thereby creating obstacles to accessing medical care for many unsophisticated (and even sophisticated) workers. For instance, some employers have a medical provider network which limits the injured worker's choice of doctors to those physicians who have a contractual relationship with the employer. As discussed in previous newsletters, those doctors are held economically accountable to the employer, and their costs can be reviewed, thus profiling the doctors willing to see Workers' Compensation patients under these circumstances.

However, even with the advent of medical provider networks, many doctors remain patient advocates, recognizing that their role, first and foremost, is to provide proper care for injured workers. In the event of a conflict with the employer's lay determination as to an injured worker's need for medical care, the doctors who are patient advocates, aware of not only their advocacy role but also the fact that their performance is subject to review by the California Board of Medical Quality Assurance, have gone against the desires of the claims adjuster or employer.

To reduce Workers' Compensation costs and, in theory, to determine whether a doctor's recommended care is appropriate and necessary, the vehicle of utilization review ("UR") was established and went into effect on all cases as of 1/1/2004. This process involves a contract between the employer or its insurance carrier with an outside entity to make such determinations regarding recommended care. However, this entity's productivity will define whether its contract is renewed, thereby creating an economic dependency on its relationship with the employer or carrier.

Utilization review begins with the adjuster forwarding a doctor's treatment recommendations for an injured worker to the hired vendor for their determination on the appropriateness and necessity of the recommended care. On the surface, this process may seem reasonable enough, but it actually incorporates a very significant defect.

On the one hand, the treating doctor is making recommendations on the basis of having seen the injured worker and established a doctor/patient relationship with him or her. In addition, the treating doctor has access to all of the worker's medical records, and his/her recommendations are based upon personal knowledge derived from the established relationship and interaction with the worker. On the other hand, the UR doctor contracted by the employer has never seen the injured worker and therefore has no relationship with him or her, and any determinations made are based solely on whatever limited records the doctor has received.

According to the established time-frame, a utilization review must be completed within five days of the date of the treating doctor's request for authorization of treatment, and if additional information is needed to make a decision, the adjuster can have up to 14 days. In *certain emergency situations*, that deadline is reduced to 72 hours or less after the treatment request.

Of note is the fact that the treating doctor must make his or her recommendations on what is called an RFA ("Request for Authorization") form. Failure to use this form can jeopardize the time-line mandated upon the utilization review entity.

Recently, as many readers are aware, Senate Bill 863 was passed, resulting in further change to the Workers' Compensation system. The change created by this legislation was radical in its negative impact upon injured workers, as it removed the judicial process from the options available in particular circumstances.

Prior to the enactment of this bill, if a treating doctor's recommendations were not followed by the employer because of their UR doctor's determination, the injured worker had the right to take his/her case to a judge to settle the issue. The judge would then weigh, on the one hand, the determinations by the knowledgeable treating doctor who had established an active relationship with the worker, and, on the other, the determinations by a utilization review doctor who had no personal knowledge of the patient and also an economic contract with the employer to preserve.

The new legislation also initiated the advent of a second level of review, called Independent Medical Review ("IMR"), in 2013. Within 30 days of a utilization review denial of recommended care, the injured worker has the right to dispute that determination and take the issue through the IMR process. This process involves a vendor contracted by the State of California — currently, Maximus Federal Services, Inc. — to provide IMR services.

Very significantly, recent statistical information indicates that IMR determinations regarding the reasonableness and necessity of recommended medical care are being made not by real doctors, but by business managers functioning in the role of a doctor. Current numbers show that in about 80% of all cases which proceed to Independent Medical Review, the utilization review denial of recommended medical care is upheld. This is especially alarming in view of the fact that both the UR and IMR doctors never see the patients whose medical care they are determining, and the fact that the IMR doctor's identity is not made known to the parties.

The new law denied injured workers the right to have their day in court. In so doing, it created great harm not only to the workers themselves, but also their families. In time, also, employers would experience great harm as well because of the increase in residual disability as a result of the extensive amount of medical care which has been denied.

However, the tide may be turning at last with the issuance of a very strong and directing case which will benefit injured workers — *Jose Dubon v. World Restoration, Inc., and State Compensation Insurance Fund* — on 2/27/14. This was an *en banc* decision, meaning that it was heard by all of the judges in the court as opposed to a narrow panel of judges. This procedure is used in select cases and is reflective of the importance of the issue in question.

In the *Dubon* decision, the Workers' Compensation Appeals Board ("WCAB") made a very significant finding in that it has jurisdiction to rule on the validity of a utilization review decision, and that such decision will be deemed invalid "if it is untimely or suffers from material procedural defects that undermine the integrity of the UR decision". In this case, the insurance carrier's contracted doctor issued a report denying the recommended care and the injured worker timely requested that the matter proceed to Independent Medical Review.

At the same time, however, the worker requested that the WCAB take jurisdiction and rule as to the legality of the decision rendered by the employer's contractor's doctor. The judge determined that this doctor had failed to review all of the relevant medical records and had made a critical error in either not reviewing all of the records provided or not requesting records which were needed but not provided.

Originally, the judge considering this matter thought it would be resolved by IMR. However, that determination was overturned by the WCAB (the *en banc* panel of judges), who determined that the injured worker did not have to go through the lengthy and delayed process of IMR, and that a worker indeed does have the right to present his/her case to a judge.

This decision, the *Dubon* decision, is very powerful and will be directive for cases to follow. It restores the original concept of Workers' Compensation — the right of injured workers to access the medical care they need to cure or relieve the effects of their work-related injuries. This decision removes, in many cases, the opportunity for the employer and UR doctor to ignore substantive medical records and opinions.

The Court's power to review the adequacy of a system created to provide medical care is a constitutional right of California workers. The *Dubon* decision is reflective of the WCAB's interest in having a system which has ***transparency and accountability***. Such a system is both reasonable and necessary and will benefit not only injured workers and their families, but, as time passes, employers as well by returning injured workers to their jobs sooner and with less residual impairment.

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