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MORE DEVELOPMENTS AFFECTING CALIFORNIA INJURED WORKERS

By Scott O'Mara

The complexity of the process involved for injured workers and their doctors to obtain approval for much-needed medical care to cure or relieve the effects of a job-related injury continues to be a pinnacle of concern for injured workers and their families, as well as a vehicle for employers and carriers to minimize their costs. There should be a common road for injured workers and employers/carriers to follow to ensure appropriate care is provided on a timely basis so that the workers are able to return to their jobs with a high level of function and continue their employment.

The maturation of the present Workers' Compensation system unfortunately has created paths to misadventure for the parties involved. The 2012 legislation which set forth the map for this system — Senate Bill 863 — was intended to provide quicker access to medical care for injured workers to cure or relieve the effects of their job-related injuries. In reality, however, the new system actually was intentionally designed to create major encumbrances for injured workers attempting to obtain the medical care they need. The encumbrances clearly are greatest for those injured workers who do not have legal representation, as well as those who have been receiving approved treatment for long periods — some as much as 30 years or more — but now are being denied that care because of the present system and the two very limiting filters of its review process — Utilization Review (UR) and Independent Medical Review (IMR).

Recognition of the failure of the present system is reflected in the court challenges to the timeline involved in obtaining care. Most recently, the Second Court of Appeal, on June 22, 2016, made a finding that the 30-day time limit for completing IMR reviews was not a mandate, and was only meant to provide direction to IMR as to a timeline — *a finding absolutely contrary to the marketing and selling which occurred when SB 863 was passed and signed off by the various parties*. The marketing pitch was that this legislation would create a system for obtaining medical care which would be less time-consuming and less costly through the utilization of a review process which would be independent, unbiased and professional.

The 30-day timeline for IMR to complete its reviews gave California workers assurance that they would receive a decision regarding their medical care within that time-frame. However, this assurance has been undermined by the recent decision which found that an untimely IMR determination is not invalid, because the legislative intent was not to mandate a strict time limit, but only to provide direction. This is very disturbing because something which is mandatory creates a standard of practice to be observed; on the other hand, something which is merely directive creates no such standard, and provides no boundaries whatsoever. This decision removes the urgency for IMR having to complete its determinations in a timely fashion, as there is no standard for timeliness.

Therefore, IMR can render its decisions any time, completely defeating the marketing concept that SB 863 would result in injured workers receiving a more timely decision regarding the medical care they need. This interpretation also defeats the basic Workers' Compensation concept that injured workers are to receive the medical care they need to cure or relieve the effects of their job-related injuries.

The failure of the current Workers' Compensation system, as further emphasized by this recent Court of Appeal decision, has been recognized by numerous participants, but this recognition has been unable to offset the tremendous economic gain employers and carriers receive from shifting the responsibility for providing medical care to injured workers' private insurance or personal savings.

Christine Baker, the current Acting Director of the Work Comp system, has, in her position, issued some proposals which deal in a small way with the denial of medical care. Her thought is to prohibit Utilization Review for 30 days with respect to work-related injuries for which workers are receiving treatment provided by the employer's or carrier's Medical Provider Network (MPN) doctors. In other words, if an injured worker is treating with an employer's MPN doctor or the worker's pre-designated doctor, the medical treatment for accepted injuries or medical conditions provided within 30 days would automatically be authorized without the need to go through either the UR or IMR process.

Ms. Baker is to be commended for her recognition of the problems which currently exist in the California Workers' Compensation system and her attempt to deal with some of its ongoing failures. She also has identified other areas of change. For instance, if a treating doctor fails to provide, within five days of seeing an injured worker, a report which details the worker's view as to how the injury occurred, explains all diagnoses, specifies the treatment rendered, and identifies the treatment plan and any restrictions imposed, the employer/carrier would then have the authority to revoke the treating physician's ability to continue to provide treatment.

Ms. Baker also determined that the Utilization Review process would have the ability to review retrospective treatment provided during the 30-day period and determine whether it was provided in accordance with the treatment guidelines. She addresses the fact that this retrospective review, in certain situations, might develop a showing of good cause which would allow the employer/carrier to force a change of physician or provider for the injured worker, and remove the doctor in question from the employer/carrier's Medical Provider Network list.

The current template allows injured workers to challenge UR denials of medical care and seek IMR review of a denied treatment determination. Ms. Baker thought the IMR process could be avoided by allowing injured workers a second review as to the appropriateness and necessity of their treater's recommended medical care which has been denied by Utilization Review. This second request would be made by the injured worker within 10 days, forcing a second UR review as to the need for medical care.

In the LAW1199.com Newsletter series, 2015 Issue #5 offers solutions to these problems. The largest challenge is the failed UR/IMR system. The way to correct it is to amend Labor Code §4616 to state as follows:

"4616. (a) (6) Injured workers have the right to predesignate a treating physician prior to sustaining a work injury. Upon sustaining an industrial injury, workers then have the right to treat either with their predesignated doctor or a doctor on the employer's Medical Provider Network list (if the employer has created an MPN). If the latter option is selected, the worker is entitled to treat with the MPN doctor without having to go through either Utilization Review and/or Independent Medical Review.

(7) Injured workers also have the right subsequent to sustaining a work injury to select a treating physician who is on the health plan in which they are enrolled."

Amending Labor Code §4616 as above would negate the ability of UR and IMR to limit injured workers' access to medical care.

According to newly proposed legislation, Assembly Bill 1244 by Assembly Adam Gray, employers would not be liable for medical care provided in relation to a cumulative trauma or occupational disease claim which has yet to be accepted or denied, unless the injured worker is being treated by a doctor in the employer's MPN or the worker's predesignated personal physician. This portion of AB 1244 is of questionable merit as it causes harm to injured workers.

This amendment limits access to care per Labor Code §5402, which requires employers to pay up to $10,000 during the period of time (90 days) when they are making their decision as to whether to accept or deny a claim. The current law does not separate a specific injury from a cumulative injury. Most workers and many doctors do not understand what a cumulative injury is until they have spoken either to an educated doctor or an attorney. Therefore, the denial of benefits available per Labor Code §5402 for a cumulative injury is harmful without a rationale other than shifting economic responsibility from the employer to the worker.

AB 1244 has now been amended to address additional questionable issues. Assemblyman Gray added an amendment which addresses the attorney fees which can be charged to injured workers and attempts to revamp some of the mandates currently in place. Of note, however, this proposed legislation does not require review of fees charged by defense attorneys. Therefore, while the limits placed by this bill may have impact on some applicant attorneys representing injured workers, the legislative branch apparently does not reflect any concerns or thoughts regarding fees which can be charged by defense attorneys.

The concern expressed by the parties regarding the costs of Workers' Compensation might need to be expanded to ensure that the attorney fees charged by defense attorneys are reasonable.

Assembly Bill 1244 does not resolve issues, but instead creates limits which take away from the injured worker's ability to receive care for cumulative trauma injuries which have yet to be accepted. In addition, this legislation may limit legal representation.

On July 22, 2016, Gov. Brown signed Senate Bill 914 by Senator Tony Mendoza This legislative enactment provides some clarity as to the avenues injured workers have to challenge a denial of medical care, testing or other needs related to industrial injuries when their employer has a Medical Provider Network list. This vehicle for review is separate from the IMR process created by Senate Bill 863, which created havoc.

The review allowed pursued to Labor Code §4616 is one initiated by the injured worker. If the worker disputes the diagnosis and/or recommended treatment, he/she may seek a second opinion regarding the disputed issues from another provider on the employer's MPN list. The injured worker may seek up to three opinions from MPN doctors in the course of this review process.

Of great significance is the fact that Labor Code §4616 specifically states that the doctors in an employer's Medical Provider Network, whether they be treaters or reviewers, may not receive additional compensation for their services, or a reduction in same for not following an adjuster's wishes. The law states:

"Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment."

As many readers are aware, Sen. Pan has drafted specific legislation which removes the award process for UR doctors. Such practice obviously has medical consequences affecting injured workers. Labor Code §4616 identifies and deals with this problem, and its verbiage should be embraced within the UR/IMR protocol if this failing system is allowed to continue.

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NOTICE

Making a false or fraudulent Workers' Compensation claim is a felony subject to up to 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.

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