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REVIEW OF MEDICAL CARE

By Scott O'Mara

The California Workers' Compensation system developed as a result of a bargain entered into between employers and employees in the early 1900s. The bargain was that employers would provide medical care for injured workers to cure and relieve the effects of their injuries in exchange for some limitations on the compensation for loss of earning capacity.

The California Constitution, Article 14, Section 4, specifically delineates that the Workers' Compensation system is to be a "complete system" which will "create and enforce a liability on the part of any or all persons to compensate any or all of their workers for injury or disability, and their dependents for death incurred or sustained by the said workers in the course of their employment, irrespective of the fault of any party . . . [with] 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 verbiage "cure and relieve from the effects of . . . injury" means that Workers' Compensation medical care is intended not only to "cure" the injuries sustained by an injured worker, but also to "relieve" the worker of pain and discomfort or other limitations imposed by the job-related injury. In exchange for this benefit, California workers agreed to limit the amount of money damage they could receive from the employer for such injury.

These provisions in the California Constitution were supplemented by the enactment of Labor Code §4600, which states that employers are required to provide for injured workers the medical care "that is reasonably required to cure or relieve the injured worker from the effects of his or her injury", and "the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing [such] treatment".

However, on 4/19/04, Gov. Schwarzenegger signed Senate Bill 899, which created the Medical Provider Network (MPN) system. Prior to the enactment of this legislation, California workers had the right to select any physician of their choosing to provide treatment 30 days after their injury was reported. With the enactment of SB 899, however, those companies using the MPN system could hand-pick the doctors and medical facilities they wanted to provide care for injured workers, selecting only those physicians and companies who met their economic profiling requirements — *i.e.*, those doctors and facilities which would help to keep their costs down. Labor Code §4616.1 supported

this economic profiling, thereby allowing employers/carriers to unilaterally remove doctors from their MPN list if they failed to meet the cost-savings goal of the profiling.

Even with the implementation of the MPN system, workers still retain one option they can use to avoid doctors and medical facilities subject to the economic profiling — *if they predesignate a treating physician (a doctor who has treated them previously) prior to sustaining a work-related injury*.

The Medical Provider Network system has created many hurdles for injured workers, and doctors on this list frequently appear to forget they are first and foremost patient advocates who are trained to uphold Medical Quality Control Board standards, and their responsibility is to "cure and relieve" injured workers from the effects of their injuries.

As a result of these developments, some injured workers have chosen not to be part of the MPN system by never filing claims for their work-related injuries. This, of course, shifts the economic burden for such injuries from those rightfully responsible for this burden — employers and insurers — to the workers themselves and their private health plans. In turn, this has resulted in cost increases for individual health plans, which are borne in whole or in part by the injured workers.

The next change impacting the California Workers' Compensation system came with the enactment of Senate Bill 863, signed by Gov. Brown on 9/19/12. The impact of this legislation was not fully understood at the time of its passage. It was marketed as a means of increasing the level of permanent disability payments, which had been reduced by Senate Bill 899. It also was marketed as a means of expediting injured workers' access to medical care.

However, SB 863 embraced the previous legislation which allows employers to use the Utilization Review (UR) process. This process allows an employer to send a treating doctor's recommendations for medical care to a vendor contracted by the employer for a determination as to the appropriateness and necessity of the recommended care. Thus, before SB 863, employers had two points of control over injured workers — through Medical Provider Network lists and Utilization Review.

In the UR process, although the doctors involved never see the injured workers, the parties are at least aware of the doctors' identity and credentials, and the fact that they are employed by the employers/carriers. Prior to the enactment of SB 863, if a UR doctor denied the treatment recommended for an injured worker, the worker had the absolute right to take the matter before a Workers' Compensation Appeals Board judge and present evidence substantiating the need for the recommended care. This need would be based on the opinion of a doctor who has seen the injured worker many times and has unique personal knowledge of his/her case, as opposed to the opinion of a doctor who has never seen the worker and is basing his/her opinion solely on the medical documentation provided to him/her. In a vast majority of situations, the opinion of the UR doctor was found to be inadequate, and medical care was granted by the judge

based on the strength of the treating doctor's report and perhaps additional evidence. Thus, prior to SB 863, the element of judicial review provided a means of checks and balances within the Workers' Compensation system.

However, this situation changed dramatically with the passage of Senate Bill 863, which introduced an additional process — Independent Medical Review (IMR). If Utilization Review denied a doctor's treatment recommendations, that decision — instead of going before a judge, as had been the case prior to SB 863 — would now be appealed through the IMR process. This process created an additional step in which a treating doctor's recommendations would be reviewed once more by another non-treating doctor, a doctor paid for by the State of California, and whose identity is not made known to the parties, and whose determination has finality and is not subject to judicial review, except in very rare situations which would be virtually impossible to prove, including the following, as outlined in Labor Code §4610.6:

(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 §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 §4610.5 and not a matter that is subject to expert opinion.

This section of Labor Code §4610.6 provides remedies which cannot work simply because the identity of the Independent Medical Reviewer is veiled in a cloak of secrecy, thereby defeating any attempts to challenge an IMR determination.

After the enactment of Senate Bill 863 came the *Dubon* cases — *Dubon I* and *Dubon Ii*. In *Dubon I*, it was established that the adjuster had not provided the Utilization Review doctor with all the medical documentation necessary to make a fair determination regarding the medical treatment which had been recommended, thereby invalidating the UR determination and voiding the need for IMR review. However, *Dubon II* subsequently overturned that decision, stating that the only valid reason for invalidating a UR determination is untimeliness — not a failure to provide all the appropriate medical records.

The legislative changes which have occurred pursuant to SB 899 in 2004 and SB 863 in 2012 have limited the courts' ability to weigh and measure the evidence in a given case and make an independent determination regarding the need for medical care. These changes also have dramatically impacted injured workers' ability to receive the medical

care they justly need to "cure and relieve" the effects of their injuries, as set forth in the California Constitution. Moreover, these changes have forced many injured workers to either not file a Workers' Compensation case or enter into a agreement to "sell" their medical care for a lump sum payment, and the more this occurs, the more the cost of private health coverage will increase.

A brief moment of perceived change benefitting injured workers occurred recently when Sen. Richard Pan sponsored Senate Bill 563. This bill addressed some of the changes needed to right the wrongs created by SB 899 and SB 863. Unfortunately, however, this bill apparently has died in committee.

The citizens of California — California workers and their families — need to examine the failure of the current medical system in Workers' Compensation and recognize that the system as it presently exists delays injured workers' recovery, keeping them off work longer, and in many cases increases their level of permanent disability. In addition, the current established system has unfairly caused a shift in economic responsibility for work injuries from employers and insurers — whose burden for such responsibility is clearly outlined in the California Constitution, Article 14, Section 4 — to injured workers and their families.

Changes are seriously needed to remedy the California Workers' Compensation system — and they are needed NOW.

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