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THE CURRENT WORKERS' COMPENSATION SYSTEM VIOLATES THE BARGAIN BETWEEN EMPLOYERS AND WORKERS AND CREATES A BURDEN ON SOCIETY

By Scott O'Mara

The California Workers' Compensation system is reflective of systems which developed in Europe and throughout the United States in the late 1800s and in the 1900s. The Federal Government also reflected this awareness and in 1906 President Theodore Roosevelt stated:

> *Industrial accidents are a risk of trade which the law must place on the employer who alone is able to pass it on to consumers, upon whom in justice all costs incident to the manufacture of a commodity should fall.*

In 1989, the California Supreme Court again reflected this principle in the case of *S.G. Borello & Sons, Inc. v. Dept. of Industrial Relations*, stating that the Workers' Compensation system has the responsibility "to ensure that the cost of industrial injuries will be part of the cost of goods rather than a burden on society". This decision also went on to state that this system must "guarantee prompt, limited compensation for an employee's work injuries, regardless of fault, as an inevitable cost of production".

It should be noted that the California Supreme Court reflected that the bargain into which the parties entered in the early development of the Workers' Compensation system placed some limitations on the compensation for loss of earning capacity, *but no limitations on injured workers' access to medical care to cure or relieve the effects of their industrial injuries*.

The Workers' Compensation system has been subject to numerous changes since its implementation in 1913 and 1917. Nevertheless, the structural integrity of the system returns back to the bargain entered into by employers and employees with the guarantee of certain basic benefits for injured workers, including medical care to cure or relieve the effects of their industrial injuries.

The Workers' Compensation laws were enacted by the California legislature to ensure fair treatment of workers who incur injuries in the course of their employment. The resulting Workers' Compensation system was designed to settle many contested issues without a jury trial and thereby avoid costly civil litigation. Unfortunately, with recent

changes in the law, the current system provides employers distinct advantages over injured workers — particularly when it comes to medical treatment.

The Labor Code changes now allow employers to measure the costs engaged in by Medical Provider Networks (MPNs) by profiling doctors (Labor Code §4616.1). This profiling potentially allows MPNs and/or employers to remove doctors who are unwelcome costwise. However, while profiling allows a measurement of costs, it does not ensure the best medical care. California workers still have the right to predesignate a doctor who meets certain qualifications so they can utilize a physician with whom they are familiar, but even this process is not without significant limitations.

The 2004 legislation — Senate Bill 899 — created the provision allowing each employer to establish a Medical Provider Network of specific doctors or medical facilities to treat injured workers. The legislation also set forth guidelines for reviewing treatment recommendations and either approving or denying injured workers' access to medical care through implementation of the Utilization Review (UR) process. This process allows adjusters to send a treating doctor's recommendations for care and treatment to a company which has contracted with either the carrier or the employer to review such recommendations and then make a determination as to the appropriateness and necessity of the care recommended. If the UR doctor embraces the treating doctor's recommendations, the injured worker has access to same.

The 2004 legislation which created the provision for Medical Provider Networks (SB 899) is restrictive and failed to anticipate the challenges which have resulted. It set forth that MPNs must provide a hospital, emergency health care services, or a physician who is within 30 minutes or 15 miles of an injured worker's primary residence or place of employment.

SB 899 also created a threshold as to medical treatment. The theory was that the threshold necessitating medical care would be determined by evidence-based or peer-reviewed standards which had national recognition and were recommended by the Commission on Health and Safety in Workers' Compensation. Determinations would be made regarding the frequency, duration, intensity and appropriateness of recommended care and would have the benefit of a presumption of correctness. Recognizing that such presumptions are not perfect, these enactments allowed challenges through a preponderance of evidence which was scientifically-based.

However, there are several problems with this current system. First, as Utilization Review (UR) doctors are contracted by carriers or employers, their built-in allegiance is not first and foremost to the injured workers they treat, as their financial interests are best served by minimizing the care they approve. Secondly, the medical documentation on which the UR doctors make their decisions is supplied by the carrier's adjusters, thereby allowing the adjusters the unique opportunity to forward to the doctors only the

documentation most favorable to their cause — as was discovered recently in a 2014 case called *Dubon I*. In this case, the adjuster — either intentionally or unintentionally — restricted the medical records provided to the Utilization Review doctor, thereby skewing in the insurance carrier's favor the doctor's determinations regarding the treating physician's recommendations for care. Unfortunately, in *Dubon II*, the Court said that under the current law, the lack of an adequate review of records was not a basis to invalidate the UR determination.

In the vast majority of all situations, treating doctors (in contrast to Utilization Review doctors) have greater insight and knowledge as to injured workers' needs because of having interacted directly with the workers and reviewed all documents relative to their injuries — not just those selectively chosen by an adjuster for presentation to the UR doctor, who has no interaction with the injured workers whose course of treatment they are determining based solely upon the limited reports provided to them by adjusters.

The fact that Utilization Review doctors never see their "patients" is very significant. That in itself creates a conflict with the California Constitution. Further conflict exists when California injured workers are placed in the wrongful position of being financially responsible for the treatment they receive for those injuries, as set forth in 1976 by *Bell v. Samaritan Medical Clinic, Inc.*.

When the additional element is added to the equation — *i.e.*, failure of the carrier to provide all relevant documentation to the UR doctor, as in *Dubon I* and *II* — it becomes very clear that the Workers' Compensation medical system, as it currently exists, violates the bargain entered into by employers and injured workers in the early 1900s to ensure that workers receive the medical care needed to "cure or relieve" the effects of their injuries.

The California Constitution, Article 14, Section 4, states:

> The Legislature is hereby expressly vested with plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers' compensation . . .. A complete system of workers' compensation includes 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 relieving from the consequences of any injury or death . . . [and] full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injury . . ..

Moreover, Labor Code §4600, which delineates "medical treatment provided by employer", states under subsection (b) the employer's obligation to provide "medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury".

It is very clear that the new system for reviewing treatment recommendations established by Senate Bill 863 (signed by Gov. Brown on 9/18/12) — Independent Medical Review (IMR) — is in direct violation of both the California Constitution and the California Labor Code because it has eliminated the previous right injured workers had to appeal denied treatment recommendations by taking their case before a judge where they could present documentation and testimony supporting the rationale for the recommended medical care and the judge could make an informed impartial determination as to whether the recommended treatment was "reasonably required to cure or relieve the injured worker from the effects of his or her injury". With that right removed, California injured workers at every stage of the evaluation and review process are now facing a "stacked deck"— from seeing doctors hand-picked for inclusion in the employers' Medical Provider Networks, to having the reasonableness and necessity of treatment recommendations determined by Utilization Review doctors who are hired by the employers or carriers and never see their patients, to the last unfair phase of having unidentified and unchallengeable IMR doctors make final decisions regarding treatment denials.

In addition, the legislative change produced by SB 863 with the creation of Independent Medical Review, combined with the restrictions placed on the Court's ability to review treatment denials by the decision in *Dubon II*, has shifted economic responsibility for industrial injuries from the employers — who should rightfully bear this burden — to the injured workers themselves.

Recently, because of the continued failure of the existing system (with particular emphasis on the negative impact of SB 863), the Department of Industrial Relations (DIR) stated in their 11/25/14 *Newsline* (No. 2014-110) that pursuant to California Code of Regulations, Title 8, §9792.12(c)(6), if a claims adjuster fails to provide appropriate records to IMR within a set time limit — *i.e.*, within 15 days from the adjuster's receipt from the IMR reviewing agency of a document called a "Notice of Assignment and Request for Information (NOARFI)" — the Administrative Director may impose a $500 penalty for each day the records in question have not been provided to IMR (up to a maximum of $5,000).

While this "band-aid measure" constitutes a partial recognition of the failure of Senate Bill 863, it clearly does not solve the existing problem. The impact on the employee is delayed medical care, which in turn can result in increased permanent disability, as well as increased costs because of the worker's extended temporary disability status and the increase in permanent disability, along with the potential inability of the worker to return to his/her employment.

Therefore, the new UR/IMR process and the relevant case law which has evolved — specifically, *Dubon I* and *II* — inevitably will result in increased costs. Also, injured workers seeking maximum recovery and the ability to return to work will, in many

situations, elect not to receive benefits through the Workers' Compensation system, choosing instead to use their private health insurance so they can select their own doctors — physicians who are patient advocates not controlled by an employer's medical network — to access more quickly the medical care and treatment they need to recover.

In so doing, injured workers can avoid all the delays and frustrations associated with the UR/IMR process, including having determinations regarding their medical needs made by doctors who never see them — UR doctors whose impartiality is questionable because of their economic ties to the carriers who hire them; and IMR doctors who are paid a flat fee by the State of California to make medical determinations regarding injured workers they have never seen based on selective records provided to them by employers/ carriers, and whose determinations cannot be challenged because their identity remains unknown. The flat fee paid to IMR doctors — along with their immunity to being challenged — clearly encourages a "catch-and-release" approach to their review of medical records.

Recent statistics released by the DIR's Division of Workers' Compensation indicate that Maximus Federal Services — the vendor contracted by the State of California to conduct IMR reviews — recently determined that 84% of the treatment recommendation denials made by Utilization Review were upheld by IMR doctors. Thus, to a large extent, IMR is essentially "rubber-stamping" UR denials, and the so-called "appeal" process has little substance.

The amount of control given to employers relative to the major issue of medical care is very significant. First of all, employers have the advantage of being able to profile doctors selected to be in their Medical Provider Networks, with the selected doctors being contracted by each employer or their adjusting agency. Then, if an employer disputes their own MPN doctor's treatment recommendations, those recommendations are forwarded to Utilization Review, where another doctor contracted by the employer/ carrier reviews the recommendations (without ever seeing the injured worker) and, in a very high percentage of cases, denies them.

Finally, as explained above, the injured worker can appeal the UR decision through the IMR process, but with only about a 16% chance of having that decision overturned by a State-contracted doctor who again never sees the worker and makes important medical decisions based solely upon the limited information provided to him/her.

Thus, California injured workers are facing a "stacked deck" and being denied their Constitutional rights to appropriate medical care, resulting in an unfair shift in the responsibility for that care to the workers themselves. Yet, the current protocol is harmful to employers as well. In essence, the only real "winners" in the present system are the MPN, UR and IMR doctors who benefit from their established contractual rela-

tionships with the employers and carriers. The time has definitely come for restoration of the California Workers' Compensation system to its original purpose and intent.

The bargain entered into by injured workers and employers in the early 20th Century has been damaged and potentially destroyed by allowing the costs of industrial injuries to be a burden on society. The Utilization Review (UR) process, which utilizes doctors who never see their patients (the injured workers), and the Independent Medical Review (IMR) process, which utilizes doctors who not only never see the injured workers but also whose identities are never revealed — and who make their determinations regarding medical care based on whatever limited records are provided to them by adjusters — have allowed and continue to allow a disintegration of the Workers' Compensation system, such that the costs for industrial injuries have now been shifted back to workers and their families, as demonstrated strongly in the *Dubon I* and *Dubon II* cases. The attempt by the Division of Industrial Relations to correct this problem by placing a $500-per-day penalty on employers for untimely action is weak and will have little impact.

The real corrective action is to allow an injured worker to present objective medical information to a doctor who does not have an economic tie or bond to the employer — a doctor who is a treater and knows an injured worker's complete medical history, so all the relevant information can be weighed and measured by a judge who will reach an impartial decision. Without this solution, the Workers' Compensation system will fail to meet the standards set forth in the bargain entered into by the parties.

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