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CURRENT STATUS OF WORK COMP SYSTEM UNFAIR TO WORKERS

By Scott O'Mara

The history of Workers' Compensation has evolved from European concepts to the acceptance by the State of California of its need to provide benefits to its injured workers. In 1911, the California Legislature enacted the Roseberry Act, which provided a voluntary plan of compensation. Two years later, in 1913, passage of the Boynton Act created a compulsory program mandating that California workers be protected.

A bargain between employers and employees occurred at that time. The bargain was that injured workers would have limits as to their access to monetary damages in the event they sustained a job-related injury, and employers could not raise the specter of negligence on the part of injured employees to preclude their right to receive benefits. The substance of this bargain was the provision for medical care to cure or relieve the effects of a job-related injury, with supplementation for lost wages and, depending upon the extent of injury, the potential to receive permanent disability payments.

Until September 2012, the evolution of Workers' Compensation benefits continued. While the access to medical care could be challenging, it still could be accessed.

However, on 9/18/12, Gov. Brown signed Senate Bill 863, which was an attempt to correct the errors made in 2004 with the passage of Senate Bill 899. The irony is that the 2012 legislation has actually eviscerated the bargain entered into by California employers and employees. This erosion has created limits in the access to medical care and has placed California workers at the risk of not receiving proper medical care, or not receiving it in a timely manner, thereby extending their period of time off work and potentially increasing their level of disability — both of which constitute additional costs for employers.

Another significant concern is that the artificial barriers created by Senate Bill 863 have created a shift in economic responsibility relative to industrial injuries.

Again, the concept of Workers' Compensation was that employers through their insurance carrier or self-insured fund would provide medical care to cure or relieve the effects of work-related injuries and the costs would be borne by Workers' Compensation.

However, the 2012 legislation has, in many situations, made it impossible for injured California workers to receive benefits under the Workers' Compensation system, as the denial of medical care — or the delay in receiving same — forces these workers to use their own health plans (*e.g.*, Kaiser, Blue Cross, Aetna, etc.) to access medical care. The shift in liability for the medical care necessary to cure or relieve the effects of job-related injuries from the employers responsible for these injuries to private health plans will raise the cost of the health plans, thereby also increasing costs for injured employees, who in many situations pay a substantial portion of the premium or are responsible for co-payments.

In addition, the new system created in 2012 involves a process which is shrouded in a cloak of secrecy. The process begins with Utilization Review (UR), which is conducted through a business entity which has a contract with the employer or the employer's self-insured administrator or their insurance company. The function of UR is to review the treating doctor's recommendations, and if they do not embrace those recommendations, the injured worker has a limited time to appeal the denial through what is called Independent Medical Review (IMR).

However, the identity of the doctors used by IMR to review the recommendations which have been denied by UR remains unknown, thereby removing any possibility for cross-examination of the IMR doctors as to their credentials and their understanding — or lack thereof — of the appropriateness and necessity of the recommended treatment.

The doctors used in the first stage of the review process — the UR doctors — are made known to the parties, and they can receive supplemental information to enhance their understanding of a given worker's situation. They can also have direct communication with treaters and obtain additional records. However, the IMR portion of the review process has removed the judicial process.

Prior to the implementation of Senate Bill 863, if a UR doctor — who does not see the injured worker — did not embrace the recommended medical care, the worker had the absolute right to present evidence to a judge, and this evidence typically would be comprised of the opinion of the treating doctor, the worker's past medical history, and the worker's current subjective complaints. However, the institution of the IMR process — which currently rubber-stamps 84% of the denials

made by UR — has resulted in very limited opportunities for injured workers to take their treatment denials before a judge.

A recent development in the Workers' Compensation arena is a significant case called *Dubon*, which reflected a manipulation of facts by the insurance carrier. The manipulation took the form of a unilateral determination to limit the medical information provided to the UR doctor. The injured worker had sought medical care, and the carrier had sent the treating doctor's recommendation to Utilization Review, which then denied the recommended care. The worker then followed the mandated appeal process to submit the matter to Independent Medical Review, which upheld the UR denial.

However, it was later discovered that the adjuster was selective with the information provided to Utilization Review, and had not submitted the complete medical records for their consideration. The withholding of key medical records was a substantial manipulation of the review system, enhancing the likelihood of a narrow interpretation (*i.e.*, a denial) by the IMR doctor(s).

As stated above, before the implementation of the IMR process in September 2012, a worker could present evidence to a judge, who could then weigh all the evidence fairly and make an unbiased decision regarding the appropriateness and necessity of the treating doctor's recommendations, thereby enabling justice to prevail.

When the *Dubon* case went to trial, two decisions ultimately were rendered. In the initial decision on 2/20/14, the *Dubon* Court acknowledged that the adjusting agency had not provided all the necessary medical records for consideration by the UR doctor. In this decision (which occurred in the form of a trial), the WCAB, in essence, determined that the artificial standards and secrecy established by Senate Bill 863 — which does not provide the injured worker with the right to litigate UR/IMR issues before a judge — should not have application.

The WCAB (Workers' Compensation Appeals Board), in reviewing the *Dubon* case, determined that the carrier, by not sending all the proper medical documentation to the UR/IMR doctors, had eviscerated the ability of the reviewing doctors to give adequate consideration to the matter and make appropriate decisions. Therefore, the WCAB felt it had the ability to overturn the IMR decision.

Ultimately, however, a new decision was issued on 10/6/14. In the interim between the first and second rulings, the WCAB panel changed membership, and the new Board stated that the ability to litigate access to medical care is not based upon

material procedural defects, such as what occurred in *Dubon*. The Board felt that the IMR process is the sole way California injured workers can access medical care, and the only way a worker may litigate denial of medical care by UR/IMR is on the issue of timeliness. If in fact a UR review is not timely, or an IMR review is not timely, the worker may challenge it.

The second decision in *Dubon* ignores the first decision made on 2/20/14, which stated that the bulk of pertinent medical records had not been submitted to UR. The 10/6/14 decision shifts the economic responsibility for medical care from the Workers' Compensation system to private health care programs, such as those noted above — Kaiser, Blue Cross, Aetna, etc. The immediate effect of this decision is that it allows employers and carriers to manipulate the review process by providing only selective medical records to UR and IMR. Thus, UR doctors — who already are contracted and paid by employers — will see only the records the employers want them to see.

This unfair game is very powerful and destructive, and it will continue to increase employees' time off work — and their levels of disability — and shift more and more economic responsibility for medical care to workers and their private health plans. *In its current state, the California Workers' Compensation system is in direct conflict with its original intent to benefit injured workers — an intolerable situation which is unjust and must be changed.*

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