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safetyofficerattorneys.com ★ www.law1199.com ★ SCOTT O'MARA, RICK PINCKARD & BRAD FIELDS

WAS THE PROPOSED LEGISLATION A MOVE TO CORRECT SOME OF THE WRONGS REGARDING ACCESS TO MEDICAL CARE?

This legislation was first introduced on 2/19/21 as a bill. It was amended on 4/15/21 to be a study only. It was then amended again on 4/26/21.

By Scott A. O'Mara

The proposed legislation — AB 1465 — provides *some* important corrections to SB 899 and its harmful limitations designed to restrict workers' access to medical care. AB 1465 expands access to more doctors outside the employer-controlled medical groups, and establishes the California Medical Provider Network (CMPN), allowing access to doctors outside the employer-controlled MPN. It also removes employers' ability to economically profile their selected doctors. There will be a delay to establish the CMPN program, which is very complex, but a good idea.

However, the proposed AB 1465 leaves the Utilization Review (UR)/Independent Medical Review (IMR) process fully intact. An unfortunate aspect is that the recommendations made by treating doctors with unique specialties are reviewed by UR/IMR doctors who do not necessarily possess the knowledge associated with those specialties.

The two legislative enactments — SB 899, signed by Gov. Schwarzenegger on 4/19/04; and SB 863, signed by Gov. Brown on 9/20/12, taking effect as of January 2013 — were engineered to lower the coverage available for injured workers at the expense of these workers and their families. These enactments were in some situations discriminatory in the areas of age, sex, race and even careers.

Utilization Review (UR) and Independent Medical Review (IMR) doctors never see the injured workers for whom they make important medical decisions, and they are not mandated to be licensed by the State of California as medical doctors. The UR/IMR process was designed in such a way as to encourage workers to give up their entitlement to lifetime medical care for their work injuries --- a right which otherwise would be available to these workers to protect them and their families in the future.

Furthermore, UR/IMR doctors are *not* patient advocates. As noted, they never see the injured workers for whom they make important medical conditions. In addition, they generally do not review the same records as those available to the treater.

On the other hand, an injured worker's treating doctor *is* a patient advocate. He/she sees the worker and in all likelihood reviews *all* of the patient's records. The unique knowledge of the treater provides a real and substantial understanding of the worker's medical needs and the necessity for treatment. The treater is a *real* doctor — someone who has a mandated standard of care, and is not hidden and protected from public scrutiny as is the case with UR/IMR doctors.

UR/IMR doctors do *not* have a mandated standard of care relative to the impact of their medical decisions, and they are *not* subject to medical malpractice review. With the lack of such thresholds, UR/IMR doctors function in a "cloud of protection" and essentially engage in a "catch-and-release program" which simply involves getting the limited records they are provided, reviewing those records, and then issuing their opinion based on their limited knowledge of the worker and his/her situation — and, again, they never see their patients. UR/IMR doctors have no worries related to the impact their decisions may have on injured workers and workers' families, and no worries about possibly failing to meet a proper medical standard as would normally be the case if they were not protected by the UR/IMR cloak of secrecy.

As discussed in Law1199.com Newsletter 2019 Issue #3:

"The limits imposed [by the UR/IMR process] relative to the review of medical care . . . have restricted injured workers' ability to present evidence to a judge regarding their treating doctor's opinion versus the opinions of UR and IMR doctors who don't personally know the patients because they never have had the opportunity to see them. In the past, injured workers whose medical care had been denied would appeal that decision by presenting evidence [to a trial judge] to support their treating doctor's opinions, and their appeals would be upheld because these doctors had actually seen their patients and had a better understanding as to their needs."

Injured workers deserve the ability to retain their RIGHT to present such evidence to a trial judge, as was previously the case before the enactment of the UR/IMR process. Such a right provides an opportunity for the judge to see the FULL PICTURE of an injured worker's medical situation, thereby providing SUBSTANTIAL EVIDENCE to support the treating doctor's determinations as to the worker's actual medical needs, as well as information regarding the treater's unique background when this doctor is a specialist in the area most appropriate for those needs.

Again, it cannot be emphasized enough that UR/IMR doctors never see the patients, and in many situations they lack the specialization which is often needed to make a proper medical decision. Equally disturbing is the cloak of secrecy which protects the identity of IMR doctors so their decisions cannot be challenged, they can never be accused of malpractice, and they do not even need to be licensed in the state of California. The proposed legislation set forth in Law1199.com Newsletter 2019 Issue #3 allows workers to participate in the UR/IMR process *but only if they should so choose (and this clearly is NOT a good choice)*. No one should ever be forced to engage in this process as is presently required by

SB 863, which, as stated, removed the right of injured workers to cross-examine UR/IMR doctors or present evidence supporting their treater's medical determinations to a judge.

A very simple question goes directly to the heart of problems related to the UR/IMR process: *Who is best qualified to determine an injured worker's needs and make important medical decisions based on those needs?* Obviously, the answer is an injured worker's treater. The treater sees the worker, knows the worker personally, has all of the worker's medical records, and can order additional testing as needed. On the other hand, as cannot be overstated, UR/IMR doctors never see the workers for whom they make medical decisions; they never get to know the workers personally; in many situations, they do not have all of these workers' medical records; and they often lack the specialization which injured workers' treaters have.

The impact of SB 863 is the result of an error in judgment. The parties who backed this legislation did not have — nor could they have foreseen — the full picture of the changes which would result from the passage of this legislation. Among what we have learned is the fact that SB 863 can discriminate based on age, race, sex and other factors. Workers in their 70s or 80s who have had lifetime medical care suddenly discovered that such care had been pulled away from them because of the UR/IMR process. The age of these workers creates a problem when trying to remedy this situation because they cannot go before a judge and present a full and complete picture of their situation and their medical needs.

At times, UR/IMR doctors will opine that the problems suffered by workers have resulted from age, race, sex and other factors which they will use to deny needed medical care. However, these factors should never override any work-related component which is present. An employee's injury becomes the responsibility of Workers' Compensation if their work in any way contributed to that injury, even if it was only to a very small degree. These discriminatory acts by UR/IMR doctors which have been allowed will retreat in the face of firm and substantial opinions expressed by treating doctors.

Correction should take the form of options which injured workers should have, including the opportunity to present evidence from a treating doctor to a judge.

FINAL NOTE: Once again, UR/IMR doctors are ***NOT*** patient advocates. Instead, they are economically tied to both employers and the system they function in so they can continue to receive their revenue. On the other hand, treating doctors ***ARE*** patient advocates, and the vast majority of them are very concerned about their patients, and they have more medical justification for their determinations as to their patients' medical needs because they actually see and know their patients.

AB 1465 is a good start. With additional changes, we will have a better system, which will be more functional — a system of checks and balances.

The proposed legislation set forth in Law1199.com Newsletter 2019 Issue #3 will help to rectify many of the wrongs implemented by the UR/IMR process.

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THE LAW OFFICES OF
SCOTT A. O'MARA

2370 Fifth Ave.
San Diego, CA 92101

4344 Latham St. – Ste. 250
Riverside, CA 92501

1-800-LAW-1199
(1-800-529-1199)
619-583-1199
951-276-1199
www.law1199.com

BOBBITT, PINCKARD & FIELDS, A.P.C.

8388 Vickers St.
San Diego, CA 92111

4344 Latham St. – Ste. 250
Riverside, CA 92501

858-467-1199
www.coplaw.org

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