

ANOTHER INSTALLMENT IN THE *GEORGE THE BARTENDER* SERIES

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RE: **GEORGE THE BARTENDER AND THE SANDHAGEN DECISION: WAS IT A DEFEAT OR A WAKE-UP CALL?**

FROM THE LOBBY BAR AT THE HYATT:

In light of the decision of the Supreme Court in *State Compensation Insurance Fund v. Workers' Compensation Appeals Board and Brice Sandhagen*, published on July 3, 2008, I was not surprised by the ongoing celebration by George the bartender's attorney, Ron Summers, and his always present treating physicians, Dr. Nickelsberg and Dr. Ratbar.

Slipping into my seat at the lobby bar and dodging the balloons proclaiming, "**We won**" I ordered my usual Beefeater's Martini, straight up with two olives.

After suffering so many defeats in their battle against the needed reforms of SB899 and 228 Ron, Dr. Nickelsberg and Dr. Ratbar could not wait to come over and "**gloat**" and tell me what was in store for me and other defense attorneys in light of the **Sandhagen** decision.

Although I already knew the history of **Sandhagen I** and **Sandhagen II**, Ron, without invitation to sit down, gave me a brief overview.

In **Sandhagen I**, the Court of Appeal upheld the strict timelines for utilization review as set forth in Labor Code §4610.

The Board's en banc decision in **Sandhagen I** spawned **Sandhagen II**, as in its initial decision the Board commented that even if the State Fund had not timely submitted the treatment authorization to utilization review pursuant to the time limits as set forth in Labor Code §4610 they can still challenge the treatment request by the expanded time limit in Labor Code §4062 by going through the AME/QME process.

The applicant's attorney in **Sandhagen** objected, claiming that this gave the defendant "two bites of the apple" and in said decision in **Sandhagen II** the Board and eventually the Court of Appeal confirmed that after blowing the time limits for utilization review a defendant could also challenge the treatment request by utilizing the Labor Code §4062 AME/QME process.

The California Supreme Court has now ended this dispute by indicating that utilization review only gives us "one bite of the apple" **for prospective Utilization Review** and therefore requests for medical treatment can only be challenged through the provisions of Labor Code §4610.

After explaining to me what I already knew about the history of **Sandhagen** Ron briefly told me that the lengthy treatment programs by Dr. Ratbar and Dr. Nickelsberg were back "**in vogue**," as third party administrators and insurance carriers **NEVER** conduct **retrospective utilization review** on a timely basis pursuant to the guidelines as set forth in Labor Code §4610.

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At this point Dr. Nickelsberg explained to me that he, Dr. Ratbar and their friends had found a foolproof way around prospective utilization review.

Both he and Dr. Ratbar used to call the carrier's utilization review department and request authorization for ongoing therapy, epidural injections, etc., and these procedures were always denied on a timely basis.

Dr. Nickelsberg explained to me that it took claims administrators approximately one to one-and-a-half years to develop their prospective utilization review techniques, but once they did so a very high percentage of prospective utilization review treatment requests were being denied on a timely basis.

Therefore, Dr. Nickelsberg consulted with Ron and, after studying Labor Code §4610, finally hit on a foolproof plan to avoid what they referred to as the "**Draconian**" effects of prospective utilization review.

They NEVER call for authorization, as this would be a red flag for utilization review but simply continue their lengthy treatment programs, including ongoing therapy visits, acupuncture, chiropractic manipulations and, of course, all sorts of injections.

Sadly, this is an almost foolproof way of getting around utilization review as we, in this industry, have failed to embrace the concept of "**retrospective**" utilization review as contained in the Labor Code §4610.¹

The legislature, in creating time frames for prospective and retrospective utilization review, mandated a shorter time frame for prospective **UR**, as a request for medical treatment is time sensitive and making a quick decision is essential.

However, in retrospective utilization review the injured employee has already received the treatment and therefore **UR** is no longer time sensitive so the time frames are longer (30 days).

At this point Dr. Ratbar broke in to tell me that his office manager used to work for a large insurance company and confided to him that few carriers were set up to perform "**retrospective**" utilization review, as this process required coordination and/or communication between the claims administrator (adjuster) and the utilization review department.

Many utilization review departments and/or companies are off site or even out of state so it is difficult for there to be coordination between the claims administrator and the utilization review department.

The key in Labor Code §4610 as to when the 30 days commences to run as to retrospective utilization review is contained in the phrase: "within 30 days of receipt of information that is reasonably necessary to make this determination. . ."

¹ Labor Code §4610 provides in relevant part as follows: "In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designatee within 30 days of receipt of information that is reasonably necessary to make this determination." (emphasis added)

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Dr. Nickelsberg chimed in to indicate that as soon as he sends his report and billing to the adjuster indicating that he has performed treatment on the applicant, such as an epidural injection, the 30-day time limit for retrospective utilization review starts to run and that unless the adjuster reviews the billing and report, decides that the treatment might not be appropriate, and immediately sends the report and bill to utilization review to make a determination pursuant to retrospective utilization review then said treatment must be paid for as it is authorized treatment. **Dr. Nickelsberg gleefully told me that he has never had any of his treatment denied by utilization review.**

Sadly, Dr. Nickelsberg is correct, **but only in part.** I have given numerous seminars on utilization review to insurance carriers and third party administrators and one of the most frequent comments I hear from adjusters is as follows: "Well, since the treating doctor did not call for authorization I filed an objection to his lien."

Remember, in the case of an admitted injury the authorized treating physician is not obligated to call and/or request authorization for treatment to an admitted body part as they are authorized to treat as they see fit pursuant to Administrative Rule 9785.

In the case of a medical provider physician who is not in our Medical Provider Network our remedy is to file a Petition for Change of Primary Treating Physician pursuant to Administrative Rule 9786 but while our Petition for a new treating physician is pending Labor Code §9786 clearly mandates as follows:

"The claims administrator's liability to pay for medical treatment by the primary treating physician shall continue until an order of the Administrative Director issues granting the Petition. . ." (emphasis added)

Remember, I said that Dr. Ratbar was only partly right in his comments on the adjuster missing the time limits for **Retrospective Utilization Review.**

In **Sandhagen** the Supreme Court addresses a very narrow issue: prospective UR versus the L.C. §4062 AME/QME procedure.

The Court made it quite clear that when authorization is requested we must address this request through the UR process and not L.C. §4062.

However, what if the physician never requests authorization and goes ahead with the treatment which is not denied on a timely basis thru retrospective UR—what then?

The answer is contained in the subsequent enactment of L.C. §4600(b), courtesy of SB 899, which provides a statutory definition for the term "relieve" in that famous phrase to "cure or relieve."

L.C. §4600(b) mandates that the applicant or lien claimant has the evidentiary burden (not us) of establishing that the medical treatment received by the applicant complies with the medical protocols of the American College Occupational and Environmental Medicine (ACOEM), which has now been confirmed by the published decision of the Court of Appeal in the **Sierra Pacific Industries v. Workers' Compensation Appeals Board**, 71

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CCC 7142.²

The **Sierra Pacific** decision allows us to challenge medical treatment liens on the basis that said treatment does not comply with newly enacted L.C. §4600(b).³

I refer to this as retroactive (as opposed to retrospective) Utilization Review.

However the irony of all of this is that the defendant in **Sandhagen**, State Fund, could have avoided an incredible proliferation of litigation and expense by simply denying the bills at issue in **Sandhagen** on a timely basis through Utilization Review.

Can you imagine the legal expense involved in the **Sandhagen** litigation (hmm. . .what am I saying. . .maybe this is a good thing) for all of the appeals, legal research and court appearances? The legislature, in enacting L.C. §4610, has given us all the weapons we need to resolve medical issues on a timely basis and regrettably we are only partially using this statute.

DISCLAIMER:

The above hypothetical story and the tortuous history of **Sandhagen I** and **Sandhagen II** is, of course, based on my imperfect memory, which has been experiencing a rash of senior moments. However it would seem that the Supreme Court decision in **Sandhagen** is a wake-up call to all of us in the defense community as to the legislative intent as contained in the workers' compensation reforms per SB228 and SB899.

Coordination between the claims administrator and the utilization review department is paramount in the case of retrospective utilization review and in the case of prospective utilization review is no less important.

In some cases utilization review is simply being "**over utilized.**"

From the onset, the legislature has conveyed great responsibility on the claims administrator who is responsible for all aspects of the workers' compensation delivery system and this includes the concept of utilization review.

Utilization review is simply another tool to be analyzed by the claims administrator who can elect to modify and/or overrule a utilization review decision and in some cases this could be the best way to deliver the

² Anyone wishing copies of the Court of Appeal decision in **Sierra Pacific** or the Supreme Court's decision in **Sandhagen** should request copies by email.

³ Labor Code §4600 was amended on April 19, 2004 by SB899 to provide that medical treatment that is reasonably required to cure or relieve the injured worker ". . .from the effects of his or her injury means treatment that is based upon the guidelines adopted by the Administrative Director. . .or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines. . ." The Administrative Director has now issued her own guidelines pursuant to the mandate of Labor Code §4600 and has adopted the ACOEM Guidelines in full.

KEGEL, TOBIN & TRUCE

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appropriate medical benefits and get the employee back to work.

Make mine a double George.

Joe Truce