ANOTHER INSTALLMENT IN THE *GEORGE THE BARTENDER* SERIES

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RE: GEORGE THE BARTENDER AND THE $25,000 LOOPHOLE IN UTILIZATION REVIEW – OR IS IT?

FROM THE LOBBY BAR AT THE HYATT:

After a hard day denying benefits I arrived at the lobby bar looking forward to my cocktail of choice, a Beefeater's martini with two olives, served by Kim, the Hyatt's breathtakingly beautiful cocktail waitress.

After my first sip I let out a sigh of contentment. All was right with the world - that is until I saw the gathering of storm clouds down at one end of the bar.

By storm clouds I meant that there was a conference involving Ron Summers, George the Bartender's workers' compensation attorney, Dr. Nickelsberg, George's primary treating physician, Dr. Ratbar (his secondary treating physician), Larry and Lenny Lien (of The 8600 Group) and a person who I did not know.

Knowing that this counsel of war bode no good for the defense I motioned to George to buy a round of cocktails for Ron and company as an entrée to find out what was going on.

After receiving his complimentary drink Ron was more than happy to fill me in. Apparently, Dr. Nickelsberg and Dr. Ratbar were feeling the financial pinch of Utilization Review as Ron was forced to admit that most insurance carriers and third party administrators had finally learned how to apply both perspective and retrospective Utilization Review.

Ron then introduced me to the mystery person that I did not know in this gathering, a young chiropractor by the name of Abel Adjustment.

Dr. Adjustment had just been hired by Dr. Nickelsberg to explore what Dr. Adjustment discovered: a loophole in the implementation of Utilization Review pursuant to Labor Code §4610.

It took me the monetary cost of two more rounds of cocktails but Ron and Dr. Adjustment finally filled me in on the so called "loophole" in the practice of Utilization Review by many carriers and some self-insured employers.

At my quizzical look Dr. Adjustment told me that his brother works as an adjuster for a major insurance carrier that has its own Utilization Review Department headed by a Utilization Review manager.

Dr. Adjustment told me that his brother confided in him that when he made a referral to the Utilization Review Department the manager would make an independent decision as to whether or not his department would perform Utilization Review on a specific medical modality.

At this point Dr. Nickelsberg broke in to tell me the good news as far as he was concerned was the possibility that the Utilization Review manager would make the determination that denied body parts or treatment in denied cases were not subject to Utilization Review.

At this point Ron interjected that this was true with a number of large TPA's and carriers and constituted the "loophole" that he and his doctor friends would drive a Mack truck through.

Ignoring my dumbfounded look Ron continued. Once a case has been denied or a body part has been denied Dr. Nickelsberg and Dr. Ratbar would begin treating up a storm knowing that they had free reign as their charges would not be denied by Utilization Review. Dr. Adjustment was hired by Dr. Nickelsberg to up the ante by starting a course of chiropractic treatment, then physical therapy, then acupuncture, etc., three to four times per week at their usual and customary rate until the bills hit $25,000.00.[1]

As the Supreme Court in the *Sandhagen* case found that we can only contest the necessity of medical treatment by referral to Utilization Review all services become immediately payable if even 1% of industrial causation is eventually found.

At this point Larry and Lenny Lien, who had been listening to our conversation with interest, broke in and advised me that once causation was found the $25,000.00 bill for treatment that might be considered unnecessary by reason of the ACOEM Guidelines becomes payable at at least fee schedule.

In ordering another Beefeater's martini from Kim I thought to myself that even if we reduced the $25,000.00 of unnecessary treatment by fee schedule we would still be paying fee schedule prices for treatment that was still unnecessary pursuant to the ACOEM Guidelines.

WHO IS THE MOST IMPORTANT PERSON IN THE WORKERS' COMPENSATION SYSTEM?

In my various seminars I give on Utilization Review I pose the above question to the audience.

The answer is contained in the Labor Code. The most important individual in our system is the one that makes the determination as to whether or not benefits will be provided to the injured worker so the answer is: "the adjuster."

[1] The figure $25,000 came to mind because this is the usual charge that I have encountered with self-procured chiropractors, acupunctures, etc., on denied cases. However, the ante has now been raised as I have just received a lien claim on a case for which a chiropractor has billed over $45,000 for self-procured medical treatment. Inflation is lovely!

The Labor Code and the Rules of Practice and Procedure of the Administrative Director refer to the "adjuster" as the claims administrator.

Ever wonder why our adjudication system is referred to as the Workers' Compensation Appeals Board?

The theory is that an injured worker who disagrees with the determination made by the claims administrator can then file an Application and appeal his case to the Workers' Compensation Appeals Board.

The claims administrator, or adjuster, is the one authorized by the Labor Code to make all decisions regarding the provision of benefits, including medical benefits.

The Utilization Review Department is supposed to be an aid to the adjuster not vice versa. In the example above the hypothetical Utilization Review manager should not be making any decisions with respect to the provision of benefits as this is the duty and obligation of the claims administrator.

LABOR CODE §4600(b)

This code mandates that all medical treatment, even treatment on denied cases, is subject to Utilization Review.

The delivery of medical treatment to the injured worker or to those claiming to be injured is mandated by Labor Code §4600 which has been amended several times over the years.

The major cost driver in our system has been and still is the cost of medical treatment. Senate Bill 899 was truly emergency legislation to provide a remedy to a system in which costs had escalated to over 30 billion dollars annually, with runaway medical treatment leading the way.

Prior to SB899 and Utilization Review medical treatment was guaranteed in a litigated case to be ongoing- until the case settled.

THE CURE OR RELIEVE DILEMMA

In crafting the SB899 reform, Labor Code §4600 was closely analyzed.

As I alluded to earlier, Labor Code §4600 has provided that injured workers are entitled to the delivery of medical treatment which either "cures" or "relieves" from the effects of the industrial injury.

The "cure" requirement has never been a problem but no one could quite get their hands around the "relieve" component.

For years a standard question in depositions to injured workers was whether or not passive modalities such as "massage," "diathermy," "acupuncture," etcetera, were reasonable.

The universal answer was that these passive modalities provided temporary relief, and after a short period of time the applicant's condition reverted to its "pre-massage" condition.

Prior to the implementation of SB899 it was suggested that the "relieve" component should be deleted from Labor Code §4600 but it was quickly determined that this would not be practical in light of our mandate to provide medical treatment to injured workers.

Therefore, SB899 did the next best thing by amending Labor Code §4600 with sub section B which provides in relevant part as follows:

> . . . 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 pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines

Therefore, ever since the adoption of SB899 on April 19, 2004 the word "relieve" has a definition: medical treatment that meets the guidelines of the Administrative Director or "ACOEM."

It should be noted that this section does not just refer to treatment in admitted cases or admitted body parts but applies to *all treatment.*

IS MEDICAL TREATMENT IN DENIED CASES SUBJECT TO UTILIZATION REVIEW?

The answer to this question varies, depending on who you ask. According to the Appeals Board it's "yes." Some Utilization Review Departments, as crazy as it might seem, would disagree.

Although the amendment to Labor Code §4600 has been the law for over five years we still inexplicably have some Utilization Review Departments contending that treatment in denied cases (or a denied body part) is not subject to Utilization Review.

In a recent Panel decision dated June 2, 2010, the Board once again affirmed that Utilization Review can be applied to denied body parts. In so doing the Board referred to its *en banc* decision in *Simmons v. State of California (2005)* 70 Cal Comp Cases 866.

In *Simmons* the Board held as follows:

> Where a utilization review physician finds that a treatment is medically necessary but questions whether the need for that treatment is causally related to the

> industrial injury, the defendant must either: (a) authorize the treatment; or (b) timely deny authorization based on causation within the deadline set forth in Section 4610(g)(1); timely communicate the denial based on causation to both the treating physician and the applicant within the deadlines set forth in section 4610(g)(3)(A).

In citing Simmons the Board in *Martha Zamora*[2] confirmed that the defendant may contest causation in a case that is sent to Utilization Review as follows:

> As was held by the Appeals Board in *Simmons*, a defendant may contest the issue of causation of the need for the medical treatment if the UR physician identifies that as in issue in the UR Report.

However, in referring a request for treatment to Utilization Review there must be communication between the third party administrator (adjuster) and the UR physician so that the UR physician is aware that there is an issue as to medical causation so this can be incorporated in the UR determination.

THE $25,000.00 LOOPHOLE

We all have cases on our diary involving denied claims of orthopedic injury in which doctors such as Dr. Adjustment referred to earlier treat with abandon and run up some $25-$30,000.00 in medical bills.

The ACOEM Guidelines provide that one or two passive modalities may be certified as medically necessary and more if the therapy and/or chiropractic treatment and/or acupuncture results in actual functional improvement. However, this almost never happens as in these cases each medical report indicates no functional improvement but a need for continued treatment. Therefore, of the hypothetical $25,000.00 of treatment perhaps only $1,000.00 would be medically necessary pursuant to the ACOEM Guidelines.

However, if the case has not been subject to Utilization Review and was later found to be compensable, even 1%, the other option is to reduce the $25,000.00 lien to fee schedule but the fact remains that we would still be paying the fee scheduled amount for unnecessary medical treatment.

DISCLAIMER:

All characters of the lobby bar with the exception of Kim, George and myself are imaginary and a product of my imagination.

Unfortunately the storyline is not. Many Utilization Review Departments are taking the position

[2] Anyone wishing a copy of the Zamora case, please request via e-mail.

that denied body parts or medical treatment on denied cases are not subject to Utilization Review.

I have long felt that all decisions effecting cost containment and the providing of benefits should be left to the expert discretion of the person who is paid to make these decisions, the claims administrator.

Make mine a double, George.

-Joe Truce