## ANOTHER INSTALLMENT IN THE *GEORGE THE BARTENDER* SERIES

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## RE: GEORGE THE BARTENDER AND THE GOLDEN FLEECE OR IS THE TAIL WAGGING THE DOG?

**FROM THE LOBBY BAR AT THE HYATT**

After a hard day denying benefits I was greeted at the lobby bar by Kim, the Hyatt's breathtakingly beautiful cocktail waitress, with my Beefeater's martini in tow.

George the Bartender was at his customary spot behind the lobby bar polishing martini glasses with the expectation that I would be requesting refills.

All was right with the world . . . or so I thought.

The raucous laughter and merriment of George's primary treating physicians, Dr. Nickelsberg and Dr. Ratbar, began to fill the air.

If these two docs are this elated, I reasoned, then mischief is afoot in the world of workers' compensation.

As curiosity got the better of me, I offered free cocktails to the good doctors to learn the source of their joy and merriment.

As I suspected it had to do with the use, or I should say non-use, of the industry's strongest weapon in combating wasteful treatment programs, Utilization Review pursuant to Labor Code §4610.

After accepting his free cocktail, Dr. Ratbar explained to me that their lien claim collection representatives, Larry and Lenny Lien of the 8600 Group, had just reimbursed Dr. Nickelsberg and Dr. Ratbar with the settlement proceeds on their denied cases over the past six months.

Dr. Ratbar told me that the recovery was a veritable bonanza!

At this point I wanted to know how applicants' treating doctors could get so excited over a recovery on their lien claims on denied cases, especially when the subject cases usually settled for a very low amount plus a special finding pursuant to *Thomas v. Sports Chalet.*

Dr. Nickelsberg explained to me that his billings did not adhere to the fee schedule, but represented what he referred to as his "usual and customary charges." As soon as he learned the case had been denied, usually by reason of an objection from the claims adjuster, he would ratchet up his treatment program, which would include endless physical therapy, acupuncture, chiropractors, etc.

Dr. Nickelsberg and Dr. Ratbar estimated that billings for procedures on denied cases usually came in between $15,000.00 and $20,000.00 and in many cases more.

When the case in chief was settled, even if the settlement was only $1,000.00, plus a special finding pursuant to *Thomas v. Sports Chalet*, Dr. Ratbar and Dr. Nickelsberg would send Larry and Lenny Lien down to the Board. According to Dr. Nickelsberg, after smiling broadly at Dr. Ratbar, the settlement of their liens would be between 30% and 40%, thereby netting what they would have received had the case been an admitted industrial injury without the benefit of that pesky Utilization Review pursuant to Labor Code §4610.

At this point Dr. Ratbar confided that his son-in-law worked for a major insurance carrier that had their own internal Utilization Review Department. This UR Department, like UR Departments across the State, had taken the position that Utilization Review was not necessary in denied cases or even cases involving a denied body part.

Distressing as it was to hear this, I knew that Dr. Nickelsberg and Dr. Ratbar had a point- Utilization Review Departments across the state had decided, contrary to law, that denied cases or contested body parts were not subject to Utilization Review.

This assumption, of course, is false and incredibly enough our defense industry has routinely ignored the amendment to Labor Code §4600, which was part of the SB-899 reform package effective April 19, 2004.

I am still astonished that even though we are more than five years post reform our industry has not bothered to read and digest Subsection (b) of Labor Code §4600 which provides that all medical treatment (when I say all, I mean all) is subject to Utilization Review pursuant to Labor Code §4610.

Labor Code Section 4600 (b) provides in relevant part as follows:

> "As used in this division . . . medical treatment that is reasonably required to cure or relieve the injured worker from his or her injuries <u>means</u> treatment that is based upon the guidelines adopted by the Administrative Director pursuant to Section 5307.27 or, prior to the adoption of these guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines."(emphasis added)

What a great statute! Read it! The Administrative Director has now adopted the ACOEM Guidelines.

Did I happen to mention that all treatment, including treatment on denied cases, is subject to Utilization Review?

Most of us are familiar with the amendment to Labor Code §5402 which provides that a defendant must authorize up to $10,000 of medical treatment from the date the claim form was filed to the date when the case is denied. How many of us though have read further to note that we only have to authorize treatment that complies with ACOEM Guidelines?

Specifically, Labor Code Section 5402(c) provides:

> "Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment consistent with Section 5307.27 of the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines...and shall continue to provide the treatment until the date that liability for the claim is...rejected… liability for medical treatment shall be limited to ten thousand dollars ($10,000)."

You will note that our only obligation is to provide treatment that complies with the ACOEM Guidelines, so this statute literally cries out for Utilization Review.

How many suspect orthopedic cases do we have in which medical treatment runs rampant, then following the nominal settlement of such case the file remains open for another six months to a year with corresponding legal and investigation expenses as no one thought to have the defense of a Utilization Review denial?

As most passive modalities for orthopedic injuries (acupuncture, chiropractic treatment, and therapy) are limited to two or three treatments, unless definite functional improvement is shown, the $20,000.00 plus lien can easily be cut down to less than $2,000.00. The beauty of using Utilization Review in a denied case is that ***only the applicant***, not the provider or lien claimants, can appeal. Therefore, in the event of a timely Utilization Review denial, these lien claims should be thrown out at the first hearing.

One *caveat* here is that the physicians on a denied case seldom call the carrier and/or claims administrator for authorization but simply go ahead and treat the applicant without authorization. In such a case prospective Utilization Review is out and our remedy is retrospective Utilization Review. Unfortunately, in our industry we have a real problem with this as it takes a genuine partnership between the claims administrator and the Utilization Review Department.

When authorization is not requested, we have 30 days (as opposed to five working days not to exceed 14 calendar days) to send out our Utilization Review determination and the 30 days start from the date that the claims administrator is reasonably certain that the treatment has been given to the applicant. That means the claims administrator must advise Utilization Review as to the date on which he became reasonably certain that the treatment had been done, which is usually the date that the bill and/or report is date stamped into the insurance carrier and/or claims administrator.

Remember, the most important person in our system, per the Labor Code, is the claims administrator. The claims administrator has the ultimate responsibility of delivering workers' compensation benefits including the medical benefit to injured employees.

With the incredible expansion of our system and the issues involved, claim administrators are now assisted in their decision-making process by bill review companies, medical management nurses and Utilization Review companies.

However, the claims administrator remains the focal point of the decision-making process. Utilization Review physicians should never approve a specific treatment but only issue a certification as to whether or not the requested treatment is within evidence-based guidelines. In California that primarily means the ACOEM Guidelines. Once the claims administrator receives a copy of a non-certification from UR, the claims administrator is empowered to overrule the non-certification and approve the treatments if, in their judgment, said decision is warranted given the facts and circumstances of the specific case.

All Utilization Review certifications as to treatments should contain the disclaimer that a certification is not an approval of treatment.

**DISCLAIMER:**

The above story line and characters at the lobby bar are not real but are a product of my warped imagination, with the exception of myself, George and Kim, the Hyatt's breathtakingly beautiful cocktail waitress (thank God for that).

A great deal of the litigation at the various Appeals Boards involves so-called "lien negotiations" on cases that were denied and settled for a nominal amount years ago. Although the applicants usually settle by the first trial date (if not at the Conference or deposition) for a nominal amount, these cases are kept alive (sometimes for another year or so) by the multitude of medical providers who have lien claims for durable goods, pharmaceutical products, acupuncture treatments, chiropractic treatments, physical therapy treatments, etc.

The real irony is that these liens represent a value many times in excess of the actual settlement of the case and at the first hearing they would all go away assuming timely Utilization Review denials. Otherwise, the litigation goes on and on and the ultimate settlement of these liens produces delight in the above fictional characters, Lenny and Larry Lien of the 8600 Group.

The reform laws of 2004 have given us the weapons. Let's use them! It reminds me of the old adage: "We have met the enemy and he is us."

Make mine a double, George.

– Joe Truce