Mission Impossible
Identifying Legal Trends in CA Workers’ Compensation System

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What’s Trending in Work Comp?

- A **Hard Look** at Medical Dispute “Resolution”
  - How the Treatment Process *Really Works*
  - That “Pesky” RFA Form & MPNs
  - UR and IMR Statistics and Updates
  - Judicial Intervention In the Process

- Prescription Drug & Opioid (Ab)Use
  - New Drugs and Statistics on Prescription
  - Proposition 46

- What Is Happening to Your WC Premiums?

- PD and the “**Continuous Trauma**” ~ Do They Really Get a New PQME?

- Bill and Lien Improvements & Savings

- Sanctions & a Case for 🐰 & Giggles
A Simple Request for Medical Treatment...

Step 1
- PTP (MPN), requests medical treatment.

Step 2
- Examiner authorizes or submits to UR.

Step 3
- UR authorizes, modifies or denies treatment.

Step 4
- IW accepts denial or requests IMR.

Step 5
- IMR makes final determination on treatment.

This chart shows how a basic medical treatment request is expected to be processed through the CA Workers’ compensation system. There are pitfalls throughout the process that make the chart infinitely more simplistic than the process actually is.
Easy, Right?
**STEP 1: The Request for Medical Treatment**

**Step 1**

**Problem 1:**
- What if it isn’t a PTP requesting treatment?

**Problem 2:**
- What if the PTP isn’t in the MPN and a lawful MPN is in place?

**Problem 3:**
- What if the PTP is in the MPN? Are you required to authorize?

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*Thomas Hogenson v. Volkswagen Credit, Inc.*, ADJ2145168 (Oxnard District Office)

WCJ Scott Seiden held that treatment requests submitted by Medical Provider Network (MPN) physicians are not subject to Utilization Review (UR) and Independent Medical Review (IMR) procedures, and that the UR reports obtained by the defendant in the case either fully or partially denying the MPN physician’s request for authorization (RFA) were inadmissible at trial!

Generally speaking, any treating physician request is subject to UR.

This issue really goes to Valdez and who is paying for the treatment. Is the report admissible? This is not settled, but the DIR website suggests an MPN objection is an appropriate objection for the claims examiner, but not the URO.
So we figured out who the PTP is, he’s just got to request treatment and we are off to UR ~ Step 2, right?
**STEP 1: The Request for Medical Treatment**

**Step 1**

**Problem 4:**
- What if the request is not on an RFA Form?

8 CCR §9792.9.1(c)(2)

In *Torres-Ramos v. Marquez* (ADJ982471) the WCAB held there was no obligation to perform Utilization Review under where there is no RFA form because, if there is no RFA form, no treatment request has been made and the timeframes to conduct UR pursuant to LC §4610 and 8 CCR §9792.6.1. commence only when the correct and completed form is received by the defendant.

However, in a prior case of *Musetti v. Golden Gate Disposal* (ADJ6948621) the WCAB held just the opposite! In that case, although there was no RFA, the court held that, because the defendant objected and requested a Panel QME report, it acknowledged the request for treatment and, therefore, started the UR clock.

Subsection (B) states that “The claims administrator may accept a request for authorization for medical treatment that does not utilize the RFA Form, provided that:

(1) ‘Request for Authorization’ is clearly written at the top of the 1st page of the document;

(2) all requested medical services, goods, or items are listed on the first page; and

(3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.”
Ok, so treatment has been requested, you just authorize or send to UR, *right*?
**STEP 2: Authorize or Submit to Utilization Review**

**Problem 1:**
- What if you dispute liability for the body part?

8 CCR §9792.9.1(b) – UR of a medical treatment request made on a DWC RFA Form **may be deferred** if the defendant disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on the grounds other than medical necessity.

* But when do you have to object?? If you fail to object, is the UR invalid?*

Defendants should argue LC §4610(g)(7): UR of a treatment recommendation **shall not** be required while the employer is disputing liability for injury or treatment pursuant to LC §4062.

* So you want some objection on record, however.*

**Problem 2:**
- How long can the examiner **delay** medical treatment?

8 CCR §9792.9.1(f)(4) – UR of a medical treatment request is only delayed until the adjuster or reviewer receives the information requested. Once the information is received, the 5 day clock starts again. AA argues:

* AA can argue the information was received sooner than the 14 days. See 8 CCR §9792.9.1(f)(1)*

* AA can argue the information was already in the adjuster’s possession. See LC §4610(g)(5) ~ “The decision must be made w/in 5 days of receipt of all necessary information by the employer.*

* AA can argue the request for more information was vague (e.g. “Provide all documentation that supports the request for authorization.”) See LC §4610(g)(4)*
Thank God! We are now on our way to UR. What could go wrong?
**STEP 3:**
UR authorizes, modifies or denies treatment.

**Problem 1:**
- UR can be untimely *(Sandhagen)*.

Propective or concurrent decisions must be made within **five business days** from the date the written RFA was first received, whether by the employer, the claims adjuster or the URO.

(Ex: Received Tue before 5:30 p.m.; Wed is Day 1)

The decision must be given, by **telephone or fax**, to the requesting physician **within 24 hours of making the decision**. If the approval is given by phone it must be followed by written notice to the requesting physician, within **24 hours of the decision**.

*State Comp. Ins. Fund v. WCAB (Sandhagen)*

*Sandhagen* only dealt with the issue of an untimely UR, but the holding was that, where defendant failed to conduct UR **timely** (properly), it loses the right to object to medical treatment.

*Sandhagen* said that invalid UR decisions were inadmissible, though subsequent case law has established the applicant must still prove the reasonableness and necessity of the treatment.

But SB 863 intended to place medical determinations in the hands of physicians.
Ok, ok. So UR just has to be *timely*, even though that’s challenging, right?
Problem 2:
- UR can be procedurally defective.

Dubon v. World Restoration, Inc; SCIF, 79 CCC 566 (5/22/14)
Originally 2/27/14
http://www.dir.ca.gov/wcab/wcab_enbanc.htm

Commissioner Caplane said 6-8 more weeks on 9/11/14.

STEP 3:
UR authorizes, modifies or denies treatment.

Holding
The board determined that it has jurisdiction to rule on challenges to the validity of a UR decision, and it said that a UR decision will be deemed invalid if it is untimely or suffers from "material procedural defects" that undermine the integrity of the decision.

Should the UR decision be invalidated, the board held en banc, that it has the authority to decide if the requested treatment is medically necessary, but if the UR decision is valid, then the issue of medical necessity must be resolved through IMR.

§10451.2(c)(1) provides that IMR applies solely to disputes about the necessity of medical treatment, and that a treatment dispute can go through IMR only when a defendant has conducted a timely and procedurally proper UR. Pursuant to the rule, a dispute about whether UR was timely undertaken or procedurally deficient is not subject to IMR.

IMR physicians are supposed to "address medical necessity issues using evidence-based medicine standards," the board reasoned, and they are not qualified to make legal determinations on whether a UR decision is untimely or procedurally deficient.

If the UR decision was timely and suffered only from minor technical or immaterial defects, any challenge to the UR decision must be resolved through the IMR process.

Medical Necessity

When Does IMR Apply?

What Can IMR Do?

Dicta
**STEP 3:**
**UR Authorizes, Modifies or Denies Treatment.**

Examples of procedural defects???

The Utilization Reviewer must be competent to evaluate the specific clinical issues involved and the treatment must be within their scope of practice. LC §4610(e).

*Ex: Chiropractor cannot evaluate the need for surgery. An orthopedist can't evaluate a treatment request for gastritis.*

The criteria for a UR determination shall follow the MTUS per LC §5307.27 and then substantial evidence-based medicine if the MTUS is silent on the treatment request.

Notification of a UR modification, delay or denial must include a one-page IMR Application Form and an addressed envelope. LC §4610.5(f).

The Utilization Reviewer’s decision has to be based on all of the relevant medical evidence (*Dubon*).
Is Utilization Review Really That Bad?

- UROs and Claims Administrators are subject to routine investigations every five years.
- Results of UR investigations are posted on the DIR website.
- As an example, in the Jan. 2014 report, 65 active URO plans were registered with the DWC:

2013 UR Investigation Results

- 54 (83%) completed investigations
- 5 are new with investigations to be conducted this year
- 6 currently in the investigation process
What Does RAND Say?

Most medical treatments approved on 1st request.
Based on UR investigations 2007 - 2011

*Item 1* 70 - 75% requested medical services **approved**

*Item 2* 22% requested medical services **denied**

*Item 3* 6% requested medical services **modified**

*Item 4* 2% requested medical services **delayed**

*Item 5* Of those treatment requests that are denied, 19% are elevated to additional UR review (appealed).

*Item 6* Of those treatment requests that are denied, only 6% are eligible for IMR.

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What Does CWCI Say?

Most medical treatments approved on 1st request.
Based on UR investigations 2007 - 2011
What Happens with IMR?

STEP 4: Injured Worker Accepts Denial or Requests IMR

STEP 5: IMR Makes Final Determination on Treatment.

- According to Christine Baker on 9/11/14, 50% of the IMR denials are for pharmaceuticals.

- *Stevens v. SCIF, 2014 Cal. Wrk. Comp. LEXIS 82*

- Applicant is asserting that IMR procedures in LC §4610.6 violate *due process* because they provide for review of medical necessity recommendations by anonymous, non-treating and non-examining physician, prevent cross-examination of independent medical review physician, and specifically prohibit appellate review of independent medical review decisions.
Is the Problem Drugs?

Here is a CWCI graphic description of the UR determinations of various treatment decisions.

Clearly, the number one item that is sent through UR is prescription drug requests.

Why??? They are expensive and overprescribed!!!
Are Drugs the Problem?

According to the CDC Policy Impact Statement, drug overdose rates in the US have more than tripled since 1990.

The rise in overdose deaths in the US parallels a 300% increase since 1999 in the sale of these strong painkillers.

These drugs were involved in 14,800 overdose deaths in 2008, more than cocaine and heroin combined!

The misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years!

Why Opioids Are a Problem in CA Work Comp:

#1 COST DRIVER ~ TREATMENT

Countrywide Incurred Indemnity Benefits per Claim

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Why Opioids Are a Problem in CA Work Comp:

#1 COST DRIVER ~ TREATMENT

Countrywide Incurred Medical Benefits per Indemnity Claim

$46,054

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### DEA Drug Schedules

Unscheduled drugs are legal/over the counter

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Drugs</td>
<td>Schedule I</td>
<td>High potential for abuse, no currently accepted medical use in U.S., lack of accepted safety for use under medical supervision</td>
</tr>
<tr>
<td>II Drugs</td>
<td>Schedule II</td>
<td>High potential for abuse, currently accepted medical use in U.S., abuse may lead to severe psychological or physical dependence</td>
</tr>
<tr>
<td>III Drugs</td>
<td>Schedule III</td>
<td>Potential for abuse less than schedule I and II drugs, currently accepted medical use in U.S., abuse may lead to moderate or low physical dependence or high psychological dependence</td>
</tr>
<tr>
<td>IV Drugs</td>
<td>Schedule IV</td>
<td>Lower potential for abuse less than schedule III drugs, currently accepted medical use in U.S., abuse may lead to limited physical or psychological dependence relative to schedule III substances</td>
</tr>
<tr>
<td>V Drugs</td>
<td>Schedule V</td>
<td>Low potential for abuse relative to schedule IV substances, currently accepted medical use in U.S., abuse may lead to limited physical or psychological dependence relative to schedule IV substances</td>
</tr>
</tbody>
</table>

- Heroin, Ecstasy, LSD, Marijuana
- Cocaine, methamphetamine, methadone, Dilaudid, Demerol, Percocet, oxycodone (OxyContin), fentanyl, Adderall, and Ritalin
- Tylenol w/Codeine, anabolic steroids; Tramadol (6/10/14)
- Xanax, Soma, Ambien, Darvocet, Valium, Ativan
- Lyrica, Lomotil, limited Codeine

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Scheduled Drugs in Work Comp

The Opioid Drug Crisis in California

In the first half of 2013, Schedule II opioids, which include OxyContin, fentanyl and morphine, have grown to 7.3% of California workers’ compensation prescriptions ~ nearly 6 times the proportion noted in 2002.

Over the same period, payments for these drugs have increased from 4.7% to 19.6% of California workers’ compensation prescription dollars.

CWCI reports that 1 out of every 5 dollars paid for workers’ compensation prescriptions in California is for Schedule II opioids!

Statistics from the Prescription Drug Monitoring Program Center for Excellence:

- Emergency room visits related to the abuse of oxycodone rose 242%;
- Emergency room visits related to the abuse of hydrocodone rose 125%; and
- Emergency room visits related to the abuse of all pharmaceuticals rose 98%.
A “Doctor” Problem

A relatively small percentage of providers continue to account for the vast majority of these prescriptions in California workers’ compensation:

- In 2010, the top 10% of doctors who prescribed Schedule II opioids to California injured workers accounted for 79% of all workers’ compensation prescriptions for these drugs.

- In 2012/13, the top 10% of the doctors who wrote these prescriptions accounted for 82% of the prescriptions.

- Half of all Schedule II prescriptions dispensed to injured workers in the 2012/13 sample were for relatively minor injuries for which the use of these drugs is not supported by evidence-based medicine.

- There have been ongoing calls for the state to strengthen its prescription drug monitoring program (PDMP) to better monitor when these drugs are dispensed, and to provide a tool for doctors and pharmacists to readily obtain a patient’s prescription drug history so they can identify and stop prescription drug seekers from doctor shopping and abusing prescription drugs.
Prescription Drug & Opioid (Ab)Use

Despite a 2013 legislative proposal, under current law, medical providers are not required to check CURES before writing prescriptions for controlled substances, and third parties— including workers' compensation payors—are not allowed access to CURES data to better manage the use of these drugs, even though WCIRB research has shown that third party access could save millions of dollars a year in workers' compensation prescription costs.

The CURES program has had its limitations as the state only requires doctors and pharmacies to report to CURES upon dispensing a controlled substance.

California's PDMP, first introduced in 2009, is an internet-based tracking system known as the Controlled Substance Utilization Review and Evaluation System (CURES).

"Estimated Savings from Enhanced Opioid Management Controls Through Third Party Payer Access to CURES," published in January 2013, estimated that for accident year 2011 claims alone, allowing workers' compensation payors access to CURES data would have reduced paid losses by $57.2 million.

Proposition 46: Requires CURES review; but requires annual doctor drug testing; lifts the 1975 cap of $250,000 on med mal to $1 million, etc.
MISSION IMPOSSIBLE REPORTING PROGRESS ON SB 863
Work Comp Premiums

Costs Rising at a Lower Rate?

Even though SB 863 successfully trimmed three percentage points off the rate increase, employers still had to endure an increase of more than 10% in their workers’ compensation costs.

As a result, even though an increase in workers’ compensation costs has been projected for 2013 and 2014, it is estimated that costs would have risen even more without SB 863.

So, your premiums are rising, but at a slower rate????

Insurance prices had already begun to rise in 2012. After SB 863 was passed, the Department of Insurance adopted an advisory pure premium rate for January 1, 2013, which was up 11.3% from the rate one year earlier.

If SB 863 had not been enacted, indications are that the increase would have been 14.3%.
Permanent disability (PD) benefits increases are now in effect. It is too soon to determine the net effects, primarily because it takes up to two years or more for permanent disability to be determined.

But now we have a new problem for additional permanent disability, thanks to Navarro, currently under review - the new continuous trauma for a better PQME and greater PD.
Bills and Liens

SB 863 reduced ASC facility fees from 120% to 80% of Medicare’s hospital outpatient fee schedule. The average amount paid per ASC episode in the first six months after the change in fee schedules was 26% lower than in the year before the change took effect.

SB 863 amended the inpatient fee schedule by repealing the separate reimbursement for spinal hardware. The average amount paid per episode of the spinal surgery involving implantable hardware declined by 56% after the separate reimbursement (duplicate payment) for spinal hardware was repealed.

The lien filing fee halved the number of liens being filed. In the first year the filing fee was in effect, 213,092 liens were filed, down from 469,190 in 2011; a greater than 50% reduction.
Sanctions & a Case for and Giggles

The WCAB sanctioned an AA under LC §5813 and reduced an award of fees when the attorney filed a frivolous petition for recon seeking 20% fees instead of the 15% awarded.

The WCAB ordered sanctions of $750 against the attorney for filing a frivolous petition, and also found nothing in the record to establish that the case was other than of average complexity. It reduced the fee award to 9 percent!

Upset, the WCAB found AA failed to provide applicant with notice of an adverse interest and of her right to seek counsel as required by CCR 10778. It also found that AA failed to provide a coherent basis for asserting that she was entitled to an additional fee and that, per CCR 10842, she attached impermissible exhibits.


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Questions? Comments?

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