

WORKERS' COMPENSATION LIEN CLAIMANT COLLECTIONS NEWSLETTER

Utilization Review Procedures for Admitted Cases and Denied Cases Made Simple

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April 30, 2010

Utilization Review in Admitted Case

1. In admitted cases, Utilization Review must be performed whenever a request for medical treatment is made.

a. In State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (2008) 44 Cal. 4th 230, 233-234 (State Comp.), the Supreme Court clarified that when an employer is faced with deciding whether to approve or deny the treatment recommendation of an injured worker's physician, it must conduct utilization review pursuant to Labor Code section 4610.

2. Employers failure to perform a Utilization Review after request for medical treatment precludes the Employer from using the medical legal process to prove medical necessity, and the requesting medical providers reports are used to show medical necessity of the treatment.

a. In State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (2008) 44 Cal. 4th 230, 233-234 (State Comp.), the Supreme Court clarified

"Taken together, the language of sections 4610 and 4062 demonstrates that (1) the Legislature intended for employers to use the utilization review process in section 4610 to review and resolve any and all requests for treatment, and (2) if dissatisfied with an employer's decision, an employee (and only an employee) may use section 4062's provisions to resolve the dispute over the treatment request. An employer may not bypass the utilization review process and instead invoke section 4062's provisions to dispute an employee's treatment request."

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3. If the employer performs a timely utilization review and authorizes treatment it is a guarantee that the medical provider gets paid.

4. If the Carrier denies the necessity of the medical treatment through the timely utilization review process then the requesting provider may initiate the medical legal process.

a. In State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (2008) 44 Cal. 4th 230, 233-234 (State Comp.), the Supreme Court clarified

"The Legislature made clear that an employer may not use section 4062 to object to a medical determination concerning medical issues "subject to section 4610" while expressly permitting employees to use section 4062 to resolve disputes over an employer's decision not to approve treatment requests (Stats. 2004, ch. 34, § 14) — i.e., the plain language of section 4062 establishes that only employees may use section 4062 to resolve disputes over requests for treatment. This limitation is made even clearer when the current section 4062 is compared to previous versions. Former section 4062 allowed employers to object to medical determinations concerning "the extent and scope of medical treatment . . ." (Stats. 2003, ch. 639, § 17.) In Senate Bill No. 899, the Legislature deleted that phrase. (Stats. 2004, ch. 34, § 14.)"

5. If Employer fails to perform a Utilization Review or performs it untimely and the carrier then initiates medical legal procedures, the medical legal reports are inadmissible to show the reasonableness of the medical treatment requested the medical

IN THE NEWS AT:

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April 29, 2010: California Department of Insurance Uncovers Substantial Errors in Anthem Blue Cross Rate Filing; Anthem Withdraws Rate Applications

April 28, 2010: DWC States: "Unless the medical-legal provider and the payor have made a specific written agreement regarding medical-legal service payment at rates different than the MLFS, a general MPN or PPO discount does not apply."

April 22, 2010: Division of Workers' Compensation posts list of facilities using "high cost outlier" payment methodology:

April 21, 2010: Division of Workers' Compensation issues second 15-day notice of revisions to proposed medical provider network and employee information regulations

April 21, 2010: CIGA loses at trial level on issue of assigned claims. Court finds Collection Company representing medical provider is a covered claim under Insurance Code section 1063.1, subdivision (c)(9)

April 20, 2010: Insurance Commissioner Poizner Urges Californians to Be Wary of Scam Artists in the Wake of New Health Care Legislation

April 20, 2010: CIGA still refusing to pay Claims of medical providers represented by "Collection Companies" regardless if the claims have been purchased or not - Article republished.

April 15, 2010: Division of Workers' Compensation Oxnard district office moves to new location effective April 19

April 14, 2010: Insurance Commissioner Steve Poizner announced today the arrest of a San Jose man in connection with suspected workers' compensation fraud.

April 13, 2010: Effective April 12, 2010, Work Comp Insurer is changing its name from Employers Direct Insurance Company to Pacific Compensation Insurance Companies

provider.

a. State Comp. Ins. Fund v. Workers' Comp. Appeals Bd., (2008) 44 Cal. 4th 230, 244, 245; 79 Cal. Rptr. 3d 171, 181; 186 P.3d 535; 543

“Accordingly, in light of the clear statutory language and the Legislature’s purpose in enacting the utilization review process in section 4610, we conclude the Legislature intended to require employers to conduct utilization review when considering employees’ requests for medical treatment. Employers may not use section 4062 as an alternative method for disputing employees’ treatment requests.”

Utilization Review in Denied Case

1. If Employer fails to deny injury within the 90 days the injury is deemed admitted and the procedures to Utilization Review of admitted claim govern.

a. Cal Lab Code § 5402
(a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this

subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.

2. During one day after a claim is filed the Employer is responsible for the first \$10,000.00 in medical treatment regardless of whether they deny the injury thereafter, until the claim is denied or accepted.

a. Cal Lab Code § 5402 (c) 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 or the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).

3. Cal Lab Code § 5402 (c) applies to any date of injury – retroactive application

a. Heike M. Ruvalcaba, Applicant v. Scott Roberg, DPM, State Compensation Insurance Fund, Defendants W.C.A.B. No. OXN 0129714--Workers' Compensation Appeals Board (Panel Decision)Opinion Filed March 9, 2007

“The consequence of SB 899 as presented in the language of Section 47, noting that any amendments or additions under SB 899 are to be applied prospectively regardless of the date of injury, would make subsection (c) of 5402

applicable to any pending case. This conclusion is consistent with the appellate decisions in Kleemann, supra, Marsh, supra, and Rio Linda Union School District v. Workers' Comp. Appeals Bd. (Scheftner) (2005) 131 Cal.App.4th 517 [70 Cal.Comp.Cases 999], and thus would justify the WCJ's disposition herein...”

4. If the Employer denies treatment based on causation then the Employer must initiate the medical legal process.

a. En Banc Decision of Simmons v. California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

“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 deadlines 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); and timely initiate the AME/QME process within 20 days of the receipt of the utilization of physician’s report, if the employee is represented by an attorney, or 30 days, if the employee is unrepresented, in accordance with section 4062(a) and...”

5. Utilization Review reports are not admissible to medical causation, only the reasonableness of the medical treatment.

a. En Banc Decision of Simmons v.

California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

“A utilization review physician’s report is not admissible for the purpose of determining whether the industrial injury caused or contributed to the need for a particular treatment, i.e., a utilization review physician may address only the issue of whether a particular treatment is medically necessary;...”

6. If the Employer denies the claim based on a medical legal prior to denying the claim the Employer is not entitled to another medical unless the treating physician puts medical causation to another body part in issues, then the Carrier has 20 days to initiate the medical legal process.

a. Pursuant to 8 CCR 30 (d)(3), once a claim has been denied in its entirety, only the employee may request a Panel QME. Therefore, the Courts must look to the reports of the self-procured treating physician. 8 CCR 30 (d)(3) "Whenever an injury or illness claim of an employee has been denied entirely by the claims administrator, or if none by the employer, only the employee may request a panel of Qualified Medical Evaluators, as provided in Labor Code sections 4060(d) and 4062.1 if unrepresented, or as provided in Labor Code sections 4060(c) and 4062.2 if represented."

b. En Banc Decision of Simmons v. California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

“If in prescribing treatment for the disputed body part, the treating physician either explicitly or implicitly

determines for the first time that the injury to the disputed body part is industrial, then utilization review is not appropriate. Instead, the defendant must initiate the AME/QME process within the deadlines established by section 4062(a)."

7. If the case is denied and the Employer does not perform a medical legal and a request for treatment with a determination by provider for causation then Employer has a second chance to do medical legal.

a. En Banc Decision of Simmons v. California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

"If in prescribing treatment for the disputed body part, the treating physician either explicitly or implicitly determines for the first time that the injury to the disputed body part is industrial, then utilization review is not appropriate. Instead, the defendant must initiate the AME/QME process within the deadlines established by section 4062(a)."

8. It is the defendant's duty to object to the treating physician's causation determination and to initiate the AME/QME procedure under section 4062(a).

a. En Banc Decision of Simmons v. California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

"In essence, the defendant is objecting to the treating physician's explicit or implicit determination that the need for the prescribed treatment was caused, in whole or in part, by the industrial injury. Such an issue of causation is outside the scope of utilization review. Accordingly, it is not

the employee's responsibility either to object to the treatment denial based on causation or to initiate the AME/QME procedure established by section 4062(a). Rather, it is the defendant's duty to object to the treating physician's causation determination and to initiate the AME/QME procedure under section 4062(a)".

Related Information

a. En Banc Decision of Simmons v. California, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

"Although the ACOEM guidelines are "presumptively correct on the issue of extent and scope of medical treatment" (Lab. Code, §4604.5(c) (emphasis added)), they are not presumptively correct on the issue of whether a need for medical treatment is causally related to the industrial injury."

b. Labor Code Section 4610(a) states:

"For purposes of this section, 'utilization review' means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600."

c. In State Comp. Ins. Fund v. Workers' Comp.

Appeals Bd. (2008) 44 Cal. 4th 230, 233-234 (State Comp.), the Supreme Court clarified

"The Legislature made clear that an employer may not use section 4062 to object to a medical determination concerning medical issues "subject to section 4610" while expressly permitting employees to use section 4062 to resolve disputes over an employer's decision not to approve treatment requests (Stats. 2004, ch. 34, § 14) — i.e., the plain language of section 4062 establishes that only employees may use section 4062 to resolve disputes over requests for treatment. This limitation is made even clearer when the current section 4062 is compared to previous versions. Former section 4062 allowed employers to object to medical determinations concerning "the extent and scope of medical treatment . . ." (Stats. 2003, ch. 639, § 17.) In Senate Bill No. 899, the Legislature deleted that phrase. (Stats. 2004, ch. 34, § 14.) "We presume the Legislature intends to change the meaning of a law when it alters the statutory language [citation], as for example when it deletes express provisions of the prior version . . ." (Dix v. Superior Court (1991) 53 Cal.3d 442, 461.) State Fund would have us read "the extent and scope of medical treatment" back into the statute as one of the matters employers may object to under section 4062. We decline to do so.

Accordingly, in light of the clear statutory language and the Legislature's purpose in enacting the utilization review process in section 4610, we conclude the Legislature intended to require employers to conduct utilization review

when considering employees' requests for medical treatment. Employers may not use section 4062 as an alternative method for disputing employees' treatment requests."

En Banc Decision on Request for Spinal Surgery: Cervantes v. Workers' Comp. Appeals Bd., (En Banc) (2009)74 Cal. Comp. Cas. (MB) 1336 is as follows:

"The Appeals Board held that the procedures and timelines governing objections to a treating physician's recommendation for spinal surgery are contained in Labor Code sections 4610 and 4062 and in Administrative Director (AD) Rules 9788.1, 9788.11, and 9792.6(o) and are as follows:

(1) when a treating physician recommends spinal surgery, a defendant must undertake utilization review (UR);

(2) if UR approves the requested spinal surgery, or if the defendant fails to timely complete UR, the defendant must authorize the surgery;

(3) if UR denies the spinal surgery request, the defendant may object under section 4062(b), but any objection must comply with AD Rule 9788.1 and use the form required by AD Rule 9788.11;

(4) the defendant must complete its UR process within 10 days of its receipt of the treating physician's report, which must comply with AD Rule 9792.6(o), and, if UR denies the requested surgery, any section 4062(b) objection must be made within that same 10-day period; and

(5) if the defendant fails to meet the 10-day timelines or comply with AD Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery.

The Appeals Board also disapproved of Brasher v. Nationwide Studio Fund (2006) 71 Cal.Comp.Cases 1282 (Appeals Board significant panel decision) (Brasher) to the extent it holds:

(1) a defendant may opt out of UR and instead dispute the requested spinal surgery using only the procedure specified in section 4062(b); and

(2) if a defendant's UR denies spinal surgery, it is the employee that must object under section 4062(a)."

End of Article

April 2010: Work Comp Issues

[April 27, 2010: Daily WC Issues:](#)

→ Utilization Review

Cases you must know on the issues of utilization review and medical necessity.

[April 26, 2010: Daily WC Issues:](#)

→ Causation

It is the defendant's duty to object to the treating physician's causation determination and to initiate the AME/QME procedure under section 4062(a)."

[April 25, 2010: Daily WC Issues:](#)

→ Pain Management

Psychic treatment for pain from physical injury does not require that a "psychic claim" be pled.

[April 24, 2010: Daily WC Issues:](#)

→ ACOEM guidelines

Although the ACOEM guidelines are "presumptively correct on the issue of extent and scope of medical treatment" (Lab. Code, §4604.5(c) (emphasis added)), they are not presumptively correct on the issue of whether a need for medical treatment is causally related to the industrial injury.

[April 24, 2010: Daily WC Issues:](#)

→ Postsurgical physical medicine

After the postsurgical physical medicine treatment period ends, additional

therapy visits will come from any visits remaining under the 24-visit cap. (From DWC FAQ)

[April 23, 2010: Daily WC Issue:](#)

→ Scope of medical treatment

The Legislature amended section 4062, subdivision (a), eliminating "the extent and scope of medical treatment" from the list of things to which an employer may object. (Stats. 2004, ch. 34, § 14.) Subdivision (a) of section 4062 now permits an employer to object only to medical determinations regarding "any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610

[April 22, 2010 Daily WC Issues:](#)

→ Fictitious Business Name

[Download an additional panel decision on FTBN](#)

[April 21, 2010 Daily WC Issue: Comments](#)

→ When Stay Exceeds Average Length of stay of DRG

The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §9789.22(a) by the average length of stay for that specific DRG.

[April 21, 2010 Daily WC Issue:](#)

→ Medicare Severity DRG

If an admission for

Medicare Severity DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (f). [MS-DRG Reimbursements](#)

[April 21, 2010 Article](#)

The ACOEM Guidelines indicate (page 391) that the initial assessment of patents by the primary treating physician ("PTP") "...should screen for potentially serious psychiatric disorders,

[April 20, 2010 Daily WC Issue:](#)

→ Inpatient Rehab

Physical Therapy / Rehabilitation services performed at a distinct part rehabilitation unit of an acute care hospital are exempt from the fee schedule and paid at usual and customary fees.

[April 20, 2010 Download](#)

Sample Points and Authorities on Issue of CIGA and Assigned Claims

[April 19, 2010: Daily WC Issue:](#)

→ Evidence

The parties' specific duty to disclose all available evidence at the time of the MSC superceded the WCAB's general duty to supplement the record.

[April 17, 2010 Daily WC Issue:](#)

→ Billing Injured Worker

Unless the medical

provider has received written notice that liability for the injury has been rejected

[April 17, 2010:](#)

→ **Aggravation of a preexisting**
Lighting up or aggravation of a preexisting condition by an industrial injury

[April 16, 2010: Daily WC Issue:](#)

→ **Outpatient Services -**
If it is claiming to have provided services only as an "outpatient setting," it is not required to have a license or fictitious-name permit from the Medical Board if it is properly accredited by an agency recognized by the Medical Board.

[April 15, 2010:](#)

→ **Silent PPOs**
a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract..."



[Flowchart Silent PPO](#)

[April 14, 2010: Daily WC Issue:](#)

→ **Treating Non-Industrial Injury**
Treatment for nonindustrial conditions may be required of the employer where it becomes essential in curing or relieving from the effects of the industrial injury itself.

[April 13, 2010: Daily WC Issue:](#)

→ **Laches**
Equity aids the vigilant and

not those who procrastinate regarding their rights; Neglect to assert a right or claim that, together with lapse of time and other circumstances, prejudices an adverse party.

[April 12, 2010 Daily WC Issue:](#)

→ **QME Procedures**
The Board held that for injuries occurring prior to January 1, 2005, section 4062, as it existed before its amendment by SB 899, continues to provide the procedure by which Agreed Medical Evaluation (AME) and QME medical-legal reports are obtained in cases involving represented employees.

[April 11, 2010 Daily WC Issue:](#)

→ **Success of Self-procured treatment**
is a factor in determining the necessity of that treatment. However, reimbursement for treatment procured by the employee will not be denied automatically solely on the basis of an unsuccessful result.

[April 10, 2010: Daily WC Issue:](#)

→ **Denied Claim and Utilization Review**
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[April 09, 2010: Daily WC Issue:](#)

→ **Fictitious-name permit.**
"Here, it cannot be determined that compensation for all of the lien claims should be barred because of lack of a fictitious-name permit."

[April 08, 2010: Daily WC](#)

[Issue:](#)

Doctor-patient relationship

A carrier may lose control over medical treatment by continually referring the injured employee for treatment to doctors who indicate that no treatment is necessary since such action on its part is tantamount to a denial of medical treatment.

[April 07, 2010: Daily WC Issue:](#)

Usual and Customary Charges

Lien Claimant is entitled to payment of its reasonable, usual and customary *charges* (not exceeding what is charged non-industrial patients) (Valdez)
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[April 03, 2010: Daily WC Issue:](#)

24 visit limitation.

Even though massage therapy is utilized as physical therapy, it was not prescribed as medical treatment for this purpose and therefore, should be considered as physical therapy and not subject to the 24 visit limitation.

[April 02, 2010: Article:](#)

SELF-PROCURED MEDICAL TREATMENT AND GETTING PAID USUAL AND CUSTOMARY FEES.

[April 01, 2010 Article and Daily WC Issue:](#)

Fees Above Fee Schedule
Robert Klittich, Applicant v. Green Thumb International, State Compensation Insurance Fund, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 866, Opinion Filed August 11, 2008

Dr. Bresler appeared and testified on his own behalf. His services were found to involve extraordinary

circumstances justifying fees above the Official Medical Fee Schedule as follows:

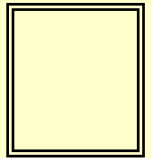
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