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The Workers' Compensation Newsletter

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In This Issue

VOLUME 26, NO. 2 JUNE 2022

Utilization Review *Denials* v. Utilization Review *Deferrals*

By Nathaly P. Martinez , LFLM Sacramento

Ever since utilization review (UR) became a mandatory requirement for all medical treatment requests, there have been numerous attempts to challenge not only individual UR determinations and the timeframes in which they have to be made, but the entire UR framework itself. Usually, these challenges came in the context of UR **denials**; however, very few if any cases have explored the idea of utilization review **deferral**. Deferral of utilization review pursuant to Labor Code §4610(l) and California Code of Regulations (CCR) §9792.9.1.(b) is an often misunderstood procedural remedy where a requested treatment is disputed on grounds unrelated to medical necessity. Conflating the two separate procedures utilized for denials on medical necessity, and deferrals on legal grounds, can have potentially disastrous outcomes, and it is important to be aware of the difference.

The UR process is used by employers and claims administrators to determine whether a request for treatment is medically necessary. Labor Code §4610 and California Code of Regulations §9792.9.1 outline the procedural requirements for UR decisions.

To ensure that benefits are provided when due, strict time constraints have been prescribed for UR decisions, and administrative penalties have been imposed for failure to comply. Many of the cases that practitioners are familiar with concerning the UR process have been particularly focused on compliance with these timeframes, and what the proper procedure is when they are not strictly followed. However, it is important to note that utilization review is a system designed to determine the **medical necessity** of a given treatment. Many practitioners will recall that the UR system was designed to remove the judicial process from decisions regarding medical necessity, thus—in theory—expediting the administration of medical treatment, and taking those decisions out of the judge's hands, except in specific scenarios.

On the question of medical necessity, it is important to remember that the UR process can function prospectively, retroactively, or concurrently to review the medical necessity of proposed treatment. Though we primarily only encounter prospective or concurrent requests, retroactive treatment authorizations can also occur. Where a requested treatment is disputed on legal grounds—such as denial of the body part for which treatment is sought—then retroactive utilization review comes into play.

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New Workers' Compensation Regulations and Guidelines: What's it Worth?

By Desiree L. Cordovadee, Orange County Office

There have been significant changes in workers' compensation regulations and guidelines recently that have arguably increased the value of claims. In April 2021, The California Department of Industrial Relations, Division of Workers' Compensation's (DWC) new medical-legal fee schedule went into effect. The new fee schedule drastically increases medical-legal costs and may prompt defendants to consider whether early settlement may be more cost-effective.

Additionally, earlier this year, version 3.5 of CMS' Workers' Compensation Medicare Set Aside Reference Guide was published including a new regulation targeted at non-submit and evidence-based Medicare Set-Aside (MSA) allocations. This new regulation creates a risk for defendants who choose to forego the Centers for Medicare/Medicaid Services (CMS) review process.

Increased Medical-Legal Fee Schedule

The amount paid by defendants to medical-legal providers for review of records has increased to $3.00 per page in excess of the first 200 pages. To put this change in context, the average cost of a medical-legal evaluation with subpoenaed records from various hospitals and/or providers may result in thousands of dollars for the record reviews alone.

The increase in amount paid for record review could make some medical-legal evaluations so expensive that it becomes cost prohibitive. It is not uncommon for an applicant to have well over several hundred pages of relevant medical records, especially if the applicant sustained (or is alleging) injury to multiple body parts. In these circumstances the parties can meet and confer in an attempt to reduce the amount of records sent to the evaluator, settle the claim, or endure an almost punitive cost.

While parties can and do meet and confer to limit the records prior to transmittal to the medical-legal evaluator, there a risk that necessary records may be omitted. The parties may also dispute which records to send. If the parties are unable to agree on what records are relevant for the medical-legal evaluation, Board intervention is necessary to resolve the dispute before the records are sent to the evaluator.

California Code of Regulations Section 9795 has been updated as well. A medical-legal evaluation will include all subsequent evaluations that do not qualify as a follow-up or supplemental and be billed at the flat rate of $2,015.00. This flat fee is subject to the increase discussed above for record review ($3.00 per page over the first 200 pages of record review), a 10% increase if an interpreter is used, and a 35% increase if the doctor is serving as an Agreed Medical Examiner (AME). Additionally, increases apply to several specialties such as, psychiatry, psychology, oncology and toxicology. Re-evaluations will be billed at the flat fee of $1,316.35 with the above discussed increase in record review, but only if they take place within 18 months of the original examination.

The cover letter to the medical-legal evaluator prior to the initial evaluation has now become even more important and must be carefully drafted. If the doctor omits an issue discussed in the cover letter in his initial report, and a supplemental report is requested on that issue, that doctor cannot bill for drafting the supplemental report.

These increased medical-legal costs provide a strong incentive for defendants to avoid the medical-legal examination process where extensive record review is required, and explore the potential for early resolution.

Medicare Set Aside Approval is Recommended

CMS clearly stated its intentions when drafting section 4.3 by specifying that it is meant to target non-submit and evidence-based MSA allocations. The new policy essentially states that CMS cannot guarantee that Medicare's interests are adequately protected unless an MSA is submitted to and approved by CMS. CMS will consider any non-CMS-approved MSA as a possible attempt to improperly shift the financial burden to Medicare by denying payment for medical services related to the

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NEW WC REGULATIONS & GUIDELINES

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workers' compensation injury and/or illness until the injured worker can prove the entire net settlement amount has been exhausted – regardless of how much was contemplated for the cost of medical expenditures.

This new guideline means that if the MSA was not submitted to CMS for approval, Medicare will not provide financial assistance until the applicant can adequately demonstrate that their entire, net settlement amount was spent on medical treatment. For many applicants this functionally means that they will not receive the care that they need because they cannot afford to shoulder the financial burden without Medicare's assistance. The need to exhaust the entire settlement amount is especially problematic for injured workers with structured settlements. If the injured worker has a structured settlement, they must wait until all payments have been made before Medicare will assist. If the settlement is structured to provide the injured worker with funds for the remainder of his life, with a non-submit MSA, Medicare may never assist because the net settlement amount will not be exhausted.

Defendants are encouraged to seek the advice of counsel, in conjunction with their Medicare vendors, to ensure that they have the most up-to-date information regarding CMS' requirements, to avoid potential pitfalls. ⌘

UTILIZATION REVIEW

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When Deferral of Utilization Review is Appropriate

Issues can arise where a requested treatment is denied by a claims administrator for reasons related to legal disputes. Sometimes requests for authorization of treatment will be sent to the claims administrator when a claim is denied, or for treatment related to a body part which is currently disputed as industrial. Such requests are not put through UR, as, pursuant to §4610(l), UR "shall not be required" where there are disputes as to liability. One could reasonably conclude that this means the treatment must be "denied." However, the inquiry does not stop there.

If the claims administrator disputes liability for either 1) the occupational injury for which the treatment is recommended or 2) the recommended treatment itself on the grounds **other than medical necessity**, the medical treatment request made on the DWC Form RFA may be **deferred**. The permissive "may" is used here by the code to indicate that the treatment need not be deferred in all situations, as it may also be approved by the claims administrator. However, this does not suggest that the claims administrator may do nothing, or may deny the treatment, as the later sections make clear. Indeed, a written decision deferring utilization review of the requested treatment **must** still be issued no later than 5 days from receipt of the RFA. In other words, the timeframes that apply to utilization review determinations on medical necessity grounds are equally applicable to deferrals based on disputes regarding liability or other legal issues. Additionally, the written decision must be sent to the requesting physician, the injured worker, and applicant attorney. (Title 8, CCR Section 9792.9.1(b)(1)).

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The Workers' Compensation Newsletter is published by Laughlin, Falbo, Levy & Moresi LLP. Contributors to this issue include Nathaly Martinez (LFLM Sacramento) and Desiree Cordovadee (LFLM Orange County).

Should you have any questions or comments regarding the Laughlin, Falbo, Levy & Moresi newsletter, or would like to suggest a topic or recent case you think would be of interest, please contact:

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UTILIZATION REVIEW

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This, again, mirrors the requirements that have been held to render utilization review determinations invalid where the decisions are not served to all of the above individuals.

In order to be valid, the UR deferral letter must include the following language and information per Title 8, CCR 9792.9.1(b)(1)(A-E):

> "1) The date on which the RFA was first received; 2) A description of the specific course of proposed medical treatment for which authorization was requested; 3) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part, or parts, or the recommended treatment; 4) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' compensation Appeals Board; and 5) Mandatory language indicating "you have a right to disagree with decisions affecting your claim…..".

If UR is deferred pursuant to this section, and it is later determined that the claims administrator is liable for the requested treatment, either by decision or by agreement, then retrospective UR is applied to the deferred requests (30-day rule). Under these circumstances, UR begins on the date it is determined that the claims administrator's liability is final. For prospective and concurrent UR, the claims administrator must issue a UR decision from the date of the receipt of the RFA after the final determination of liability.

This distinction between deferral and denial was made painfully apparent in the case of *Rosenblum v. Lompoc Unified School District* (2019) Cal. Work. Comp.P.D. LEXIS. There, the defendant failed to timely defer a request for treatment on a disputed body part, and instead sent the request through utilization review, where it was approved. The defendant wrote to the primary treater several days after the approval, objecting to the treatment on the grounds that it was for a body part which was not accepted, and exercising the right to have the liability for the same determined by a QME. The issue was activated by applicant's attorney to an expedited hearing, where the judge indicated it lacked jurisdiction to try the issue where there was a timely utilization review approval. The WCAB, on petition for removal, reversed, and not only held that defendant's retroactive deferral was untimely, but that the treatment **must** be authorized over defendant's belated objection.

Furthermore, the court in *Milette v. 81 Grand Holdings, Inc.*, held that utilization review deferrals must provide a "clear, concise, and appropriate explanation of the reason for the…dispute of liability." In that case, the court held that simply stating "causation is in dispute" was not sufficient justification for deferral of utilization review.

To prevent the unfortunate authorization of treatment which may or may not be related to an industrial condition, proper care should be taken to note the distinction between denial and deferral, and where deferral is appropriate, proper steps taken to ensure that the deferral is above reproach. Decisions to defer should also be revisited if and when a determination as to causation is made pursuant to the proper timeframes, to ensure that utilization review remains a backstop for treatment that is otherwise not medically necessary. ⌘

UPCOMING CONFERENCES & EVENTS

CCWC Conference
June 8 - 10, 2022
Disneyland (Anaheim, CA)
Platinum Sponsor
Demetra Johal, Managing Partner of LFLM Los Angeles, will be presenting "It's Your Turn: Ask the Legal Experts" on Thursday June 9 at 1:45pm.

WCI Conference
August 21 - 24, 2022
Florida
Michelle Sebring, Partner in LFLM San Diego, will be presenting "Late Night!... with Workers' Comp". Date & Time TBD

CAJPA Conference
September 13 - 16, 2022
Lake Tahoe
Vicki Lindquist, Partner in LFLM Oakland, will be presenting "Blast Off into Discussions of Rebutting and Defending Against PTSD Claims". Ms. Lindquist will be presenting with Dr. Tyrone Spears, Division Cheif, City of Los Angeles and Dr. Ron Heredia, Director, Good Mood Legal. Date & Time TBD

LAUGHLIN, FALBO, LEVY & MORESI PUBLICATIONS

Laughlin, Falbo, Levy & Moresi LLP offers a variety of publications, including the WCAB & DOL Directory, Workers' Compensation Flow Chart, PD Indemnity Chart, Public Agencies Guidebook, Educational Entities Guidebook, Schedule for Rating Permanent Disabilities, and others.

If you would like copies of any of the Laughlin, Falbo, Levy & Moresi LLP publications, please email us at info@lflm.com. Include number of copies you want and your street address.

Thank you!

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