ACADEMY OF FORENSIC AND INDUSTRIAL CHIROPRACTIC CONSULTANTS

Welcome AFICC Fellows and visiting Chiropractic professionals:

November 2005

The purpose of this quarterly newsletter is to inform the AFICC Fellows of the current changes and developments in the workers compensation and Personal Injury laws, rules regulations and court cases.

As the President elect of AFICC, CCA past V.P. of External Affairs, CCA board member for 6 years and an active participant, at the direction of the Industrial Medical Council for 12 years, I think it is imperative that the Fellows of AFICC and other interested Chiropractors be informed of the most current issues affecting their profession.

This Web Site and the information contained within is available for all to read. The interaction with question and answers will be privileged only to AFICC Fellows. There is nothing contained within this informational website that is not available to the general profession or public.

Please feel free to receive the information available and use this information to assist in the development of an ethical, successful, Chiropractic practice that sheds a positive light on the profession and assists in rescinding the recent political castration of our profession that resulted from a political over reaction to the many, as a result of abuse and greed of the few.

WORKERS COMPENSATION UPDATE

Craig D. Gunderson, D.C., FAFICC
Vice President of External Affairs/President Elect

UTILIZATON REVIEW "BRIEFS"

UR REPORT TIME DEADLINES: *[Labor Code: 4610(g) and 4610(g)(1)]*
The moment the insurance company receives the doctor's "medical report" or "request for authorization" or "PR-2 report" (which should request treatment and/or medical tests and/or supplies), a clock begins to tick:

LC 4610 (g)(1) states that after the PTP's request of authorization, DFR or PR-2 medical report (which better request 'something') is received by the insurance company, a 14 day time-deadline is invoked, which is termed a "Prospective Review." This 14 day time-dead line for prospective UR reviews has been tested and up-held by a recent WCAB en banc decision [Sandhagen Vs. SCIF I (69 CCC 1452 WCAB en banc, 11/16/04)]: Sandhagen Vs. SCIF further mandates that if the UR department blows the 14 day deadline, that UR report is not admissible at the WCAB and can NOT be reviewed by a Panel QME or the AME.

So, get those DFRs and PR-2s out ON TIME [5 working days per 4603.2(a)]! PR-2 reports should also be served to the insurance company within 5 working days of the examination via **Facsimile** and/or **proof of service**

If the doctor fails to get his PR-2 report in to the insurance in time, a "Retrospective UR Review" is invoked. Now, the UR doctor has a full 30 days to form his opinion. So, GET YOUR PR-2 REPORTS IN ON TIME!

TYPES OF UTILIZATION REVIEWS:

Prospective UR Review: This type of review, which is governed by 4610(g)(1), is forced upon the UR department when the doctor gets his PR-2, DFR or Request for Authorization into the insurance company within **5 working days** from the date of his/her examination. The UR team is only allowed "5 working days" or in "no event more than 14 days" to render their opinion on the doctor's requested treatment or testing. The WCAB en banc decision of **Sandhagen Vs. SCIF I (69 CCC 1452 WCAB en banc, 11/16/04)** enforces this ruling and commands any QME or AME NOT to consider any tardy UR opinions in their reports.

Retrospective UR Review: This type of review, which is also governed by 4610(g)(1), is forced upon the UR department when the doctor submits a LATE PR-2, DFR, or Request for Authorization, i.e., past 5 working days from the time of the evaluation or assessment. The UR doctors love this one, for it give them 30 days to comment upon your requests. 30 days is a LONG TIME, so get your reports in ON TIME! [See LC 4610(g)(1) here]

Concurrent UR Review: This is for patients who are in the hospital and doesn't concern us Chiropractors.

SERVICE OF YOUR REPORTS & REQUESTS FOR AUTHORIZATION:

The best method is to send PR-2, PR-3, PR-4, or DFR via "certified mail with return receipt." Per CCR 9792.9(a)(2) medical reports and/or requests of authorization are "deemed to have been received by the claims administrator on the receipt date entered on the return receipt."

Per Labor Code **4603.2(a)**, the doctor has "**5 working days**" to get that Doctor's First Report of Occupational Injury (DFR) to the Employer/Insurance Company. The fastest way is to Fax it to the Claims Department. Per CCR **9792.9(a)(1)** as long as you get the DFR faxed by 5:30pm on "working day" five, you've complied with your reporting obligation. Facsimile is the ONLY way to prove you have served the insurance company in one day. There are some required things you need on the fax cover sheet, so please read CCR **9792.9(a)(1)** carefully. If you send the DFR out "proof of service," per CCR **9792.9(a)(2)** it's deemed to be received by the insurance company "5 days after the deposit in the mail." If you don't "proof of service" you report, per CCR **9792.9(a)(2)** it's deemed to have been received by the Insurance Company the day it's "stamped as received" by the insurance company's mail room!

Here's how to probably get all your 24 visits authorized, so you never have to bother with UR doctors bugging you: In your Doctor's First Report of Occupational Injury or Illness (DFR), request ALL 24 VISITS right up front and then (**here's the important part**) send that DRF "Certified Mail - Return Receipt" to the insurance company. [DO NOT FAX IT IN for then they might get to it in time!] By doing this, the UR people will rarely complete the UR review in within 5 to 14 days as mandated by CCR 9792.9(b)(1), LC 4610(g)(1) and per Sandhagen Vs. SCIF I (69 CCC 1452 WCAB en banc, 11/16/04), which makes their tardy report inadmissible in court and unreviewable by the QME or AME. Even if they make the deadline, they still probably haven't complied with the stringent UR rules per Labor Code, 4610(g)(3)(a) and/or 4610(g)(4). Per the recent WCAB en banc decision - Sandhagen Vs. SCIF I (69 CCC 1452 WCAB en banc, 11/16/04 [download Sandhagen I in .pdf]) - QME and AME doctors are **prohibited** from reviewing such tardy UR reports.

UR DISPUTES OVER MEDICAL TREATMENT:

Effective April 19, 2004, former Labor Code section 4062 was amended by Senate Bill 899 (SB899). LC 4062(a) now mandates that disputes of medical care and compensability are to be settled by the panel QME process. As opined in a recent WCAB panel decision (Casillas vs. San Luis Obispo – Case No. GRO 28418; 2005) Labor code "*section 4610 requires that disputes following a utilization review be resolved pursuant to section 4062. (Willette v. Au Electronic Corporation (2004) 69 Cal. Comp. Cases 1298 (*Appeals Board en banc)."

MERCY GUIDELINES:

(Guidelines for Chiropractic Quality Assurance and Practice Parameters)

Labor Code 4604.5(e) gives us direction in the following: For all injuries not covered by the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM)… authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based

Therefore, I shall use the " Guidelines for Chiropractic Quality Assurance and Practice Parameters' (aka: The Mercy Guidelines) (7) to support the chiropractic care that I have recommended. The Mercy Guidelines are extremely "evidence based" and are supported by numerous scientific investigations and guidelines. In fact Chapter 12 alone - which is what I am using to support my recommended care - contains over 65 footnoted investigations and guidelines to support its recommendations. Furthermore, the Mercy Guidelines have recently been accepted as a defense by a recent WCAB panel decision that over-turned an ACOEM-based WCJ's denial of a future chiropractic treatment award. [Casillas vs. The County of San Luis Obispo (08-12-2005) GRO 24818; Opinion and Order Granting Reconsideration and Decision after Reconsideration]

Chapter 8, Section Vl, Subsection E (page 125) of the Mercy Guidelines, unlike the ACOEM Guidelines, specifically addresses what type of medical treatment frequency is reasonably medically necessary to properly address "*exacerbation of a chronic condition*." More explicitly, Mercy states that following an acute exacerbation of a chronic condition, "*3 to 5 treatments per week*" should bring about "*significant improvement*" of the exacerbation within "*10 to 14 days*." For the next six to eight weeks, if necessary, a treatment frequency of "*up to 3 treatments per week*" should be sufficient to return the patient to pre-exacerbation level and free the patient from the need of professionally administered spinal manipulation and its associated therapies care. (74) This level of treatment frequency is also supported in a recent randomized controlled trial on chiropractic manipulation for chronic pain. (67)

MANIPULATION UNDER ANESTHESIA (MUA):

WORK COMP CENTRAL 9/16/05

A county prosecutor charges that chiropractors cannot perform manipulation under anesthesia even though their California licensing board is creating a certification program for the controversial procedure.
A criminal complaint filed last month by the San Joaquin County District Attorney's Office asserts that manipulation under anesthesia is a procedure "not authorized for chiropractors." Joseph Roy Ambrose of El Dorado Hills, Michael Hall Yates of Stockton, Richard Guadalupe Saucedo of Turlock and Pedram Vaezi of Modesto are charged with practicing without a license because they performed a "medical-surgical procedure" on at least 123 patients, according to court documents.

The practicing-without-a-license charge is a tiny part of a sweeping fraud case against the four chiropractors. But that portion of the criminal complaint troubles industry professionals, many of whom have been performing MUAs for years and collecting from insurance companies to do it.

"We would hate to see a legitimate clinical procedure that has some demonstrated benefit for a small, select number of patients thrown out because of, (a): the egregious behavior

of a few providers, and (b): an overzealous prosecutor," said Dr. Wayne Whalen, chairman of the national Council on Chiropractic Guidelines and Practice Parameters.

But Deputy District Attorney J.C. Weydert of San Joaquin County says state law clearly requires some involvement by medical doctors before chiropractors make decisions to put patients under anesthesia. *He said the four defendants were making those decisions without consulting physicians.*

"In this particular case, the fact that they were doing MUAs in fact triggered the criminal complaint stating that doing MUAs is outside the scope of the chiropractic practice," Weydert said. "We are going to take them on, and probably some other as-yet unnamed defendants, for conducting manipulations under anesthesia."

MUAs are typically performed on patients who cannot endure conventional chiropractic manipulation because of severe pain. Patients remain conscious, but are sedated by an anesthesiologist.

Wayne Whalen, DC (past president of the CCA) said the procedure is common throughout the country, especially in Texas and Florida. MUAs are done in California, he said, but have recently fallen out of favor with some workers' compensation insurers. Whalen said the State Compensation Insurance Fund, for one, now refuses to reimburse for the procedure, saying it has not been proven effective.

"It really wasn't an issue until a small number of providers started abusing it, then it started raising an outcry," Whalen said.

Although Whalen doesn't perform MUAs, he said he has taken a course in it. The appropriateness of the treatment is a judgment call that Whalen makes occasionally as a Qualified Medical Evaluator for the state workers' comp system. He said typically fees for the procedure run in the $2,000 to $3,000 range, but that insurers started objecting when some chiropractors began opening surgery centers and charging $12,000 and up.

According to the criminal complaint, that's exactly what Ambrose and Yates did. They were among six co-owners of the Sierra Hills Surgery & Medical Center in Sacramento, where Saucedo and Vaezi helped them perform MUAs. Prosecutors say the clinic charged approximately $37,000 for a session of three MUAs that were conducted on successive days on each patient. The clinic billed more than $4 million for the procedures from January 2002 to March 2003.

What's more, the clinic allegedly paid anesthesiologist Paul Lessler to fly up from Southern California to sedate the patients. The complaint states the clinic's billing company, Unique Healthcare Management, billed insurers $2.36 per mile for the 425-mile round trip for each patient treated, even though Lessler typically tended to nine patients per day. Lessler told prosecutors he worked as an independent contractor and was unaware of the mileage charges.

Weydert said the procedure was so lucrative for the chiropractors that they would send limousines to Modesto, about an hour south, to pick up patients.

Despite alleged abuse, the California Board of Chiropractic Examiners has determined

that MUAs have their place. Executive Officer Catherine Hayes said nothing in the law governing chiropractic care in California forbids a chiropractor from treating patients who are under anesthesia. The drugs must be administered by a medical doctor, not a chiropractor (Doctor).

What's more, proposed regulations now under final review by the Office of Administrative Law may give more legitimacy to chiropractors who perform MUAs. The regulations, which were bitterly opposed by some medical doctors, state that an MUA must be performed in an accredited hospital or ambulatory surgery center. A medical doctor would have to recommend the procedure, and chiropractors performing MUAs would be required to undergo training by an accredited educational institution.

"We've been working on this regulation for close to five years," Hayes said. "It's been a very controversial regulation."

The board ironically approved the regulations on Aug. 26, a day after the San Joaquin County District Attorney's Office filed charges against Ambrose and the other chiropractors. The proposed rules are now under final legal review by the Office of Administrative Law.

Kristine Shultz, government affairs director for the California Chiropractic Association, said she doesn't understand why San Joaquin County prosecutors are saying that chiropractors can't perform MUAs. But she isn't worried about it yet.

"It is the state board (of Chiropractic Examiners) that has authority over making the decision about what procedures are within the scope of practice of chiropractors," she said.

MUA REGULATIONS DISSAPROVED BY OAL:

WORK COMP CENTRAL 10/12/05

The Office of Administrative Law disapproves regulations submitted by the Chiropractic Board of Examiners that would allow licensed chiropractors to perform Manipulation Under Anesthesia. OAL says the submitted regulations do not comply with provisions of the Administrative Procedure Act and broaches the possibility that this procedure may not comply with the Medical Practice Act.

Although considered safe by chiropractors if performed by a licensed chiropractor, most California workers' comp carriers do not consider MUA safe or effective and will not pay for it. But according to some industry experts, some Workers' Comp Appeals Boards have been inundated with liens for this procedure.

Without a regulation in place, it may be more difficult for those who perform MUA to get a workers' comp judge to order payment for it.

According to statement by OAL director William Gausewitz, the regulations have the effect of creating two kinds of chiropractors those who may lawfully perform MUA and those who may not, making it inconsistent with APA. In addition, APA allows the Chiropractic Board to issue only one kind of license. "By adopting this regulation and

creating two categories of licenses and thus two categories of licensees , the Board has taken an action that enlarges upon its scope of power to issue "one form of license...,' " the decision says.

OAL says the regulation suffers from a number of clarity issues as well. Gausewitz would not comment on whether or not comment on whether the practice of MUA by a chiropractor is a violation of the Medical Practice Act because the record was not adequate. But he suggests that if the Chiropractic Board were to resubmit this regulation, it should include information adequate to demonstrate that chiropractors performing MUA are in compliance with both the MPA and the Chiropractic Initiative Act. In addition! , OAL says the regulation is clear in that it does not authorize chiro practors to administer anesthesia, but the decision says the record is inadequate to determine if it's appropriate within the confines of chiropractor's license to allow the use of anesthesia at all.

VOCATIONAL REHABILITATION:

NEWS DATE 9/16/05

"Employers will regret workers' comp reform " By David J. Depaolo
This article appeared in the August 16, 2005 edition of the Inland Valley Daily Bulletin. Mr. David J. DePaolo, President and CEO of WorkCompCentral, was invited to write as guest columnist. Mr. DePaolo is a trusted source of information for California business leaders.
"Employers will regret workers' comp reform"
A major flaw in the current conservative Californian's opinion that falling workers' compensation rates for employers reflect that "just about every Californian are clear winners in the effort to reform workers' compensation" (Daily Bulletin Op/Ed 8/15/05), is that there is no accounting for the demise of an important socio-legal function that the disruption of these laws will cause. Indeed, much as the abolition of mental health care under the Reagan administration simply resulted in a shift of the cost of mental illness to other social programs, the "reform" of workers' compensation will only shift liabilities to more expensive legal mandates that are less protective for the employer. This is a classic case of "be careful what you wish for" scenario, exemplified by vocational rehabilitation.

A fundamental change to the workers' compensation system was the abolition of vocational rehabilitation (which met its demise in the 2003 "reform" legislation AB 227/228). While vocational rehabilitation as a program had questionable success, it provided a very significant legal protection for the employer because the mandates inherent in vocational rehabilitation fulfilled the mandates of the Fair Employment and Housing Act (FEHA).
The expense of vocational rehabilitation was limited to $16,000. Once the $16,000 cap was reached the employer's liability stopped, both financially and legally. There is no limitation on the liability or financial exposure under the FEHA. In addition, the cost of vocational rehabilitation was financed through the employer's workers' compensation policy premium. There is no insurance for FEHA violations.

USING OUT OF STATE DOCTORS FOR UTILIZATION REVIEW:

WORK COMP CENTRAL 9/30/05

OAL: Using Out-of-State Docs Complies with Law

The Office of Administrative Law says that using out-of-state doctors to review treatments does not violate California state law. The statement clearly affirms the legislative intent of SB 228, and for the sake of the market, keeps the costs of medical utilization down.

The Utilization Review regulations which were finalized for compliance by OAL last week are stirring up controversy among doctors and applicants' attorneys alike for the provision allowing carriers to use out-of-state doctors to review treatment requests. The California Medical Board says the practice is illegal.

According to OAL Director William Gausewitz, the language of the statute does not limit treatment reviewers to California licensed physicians. The statement reads in pertinent part:

"The Section 3209.3 definition of physician is not exhaustive-it does not list every possible provider who could qualify as a physician. Case law interpreting this section has held that a treating physician in workers' compensation, although subject to the Section 3209.3 definition of 'physician' is not required to be licensed in California. The meaning of 'physician' must be evaluated in the context of the whole workers compensation system."

Citing legislative history, OAL could find no evidence to suggest that the legislature intended to establish a utilization process that allowed only California-licensed physicians to be reviewers. The statement says that the legislature intended that the term utilization be interpreted as commonly understood and that which is used by Health Care Service Plans and health insurance programs regulated by the Department of Insurance, both of which do not limit reviewers to California-licensed doctors.

But employers and carriers should not rest easy yet. Applicants' attorneys have long resented the fact that medical doctors in other states can nix treatments that their clients have been receiving for years. Challenges may very well be on the horizon.

PREDESIGNATION OF PHYSICIANS:

WORK COMP CENTRAL 9-23-05

The Administrative Director has submitted emergency regulations for Predesignation of a Personal Physician to the Office of Administrative Law for approval. The OAL has ten days to respond to the request for approval but may approve the regulations in advance of that time. Once approved the regulations are effective for a period of 120 days after which the Administrative Director may reissue the rules (one time) or adopt final rules after public hearing and comment.

These rules are certain to generate controversy as they answer many questions regarding not only Predesignation but other issues of interest regarding receipt of medical care and

selection of treating physicians. Among other issues addressed by these regulations are the following items:

1. A predesignated personal physician must agree to be pre-designated prior to an injury but not necessarily on the predesignated form. [ADR 9780.1(a)(3)] *This is significant as several employee representative groups have argued that a physician may agree to be predesignated subsequent to an industrial injury.*

2. The employer's provision of group health insurance is sufficient to allow predesignation regardless of whether the employee accepts or participates in the group health plan or not. [ADR 9780.1(a)(2)] *Considerable speculation has occurred over whether an employee actually had to participate in the group health benefit in order to predesignate a personal physician.*

3. Where an employee has validly predesignated a personal physician, the employee is not in the MPN for any reason and the personal physician cannot be required to refer to physicians or facilities within the MPN. [ADR 9780.1(d) &(e)].

4. The employer may not, without consent of the injured worker, contact the predesignated personal physician to confirm the consent to be predesignated. [ADR 9780.1(f)]

5. The request for a change of treating physician by an employee pursuant to Labor Code section 4601 does not apply to any employee whose employer had a MPN. [ADR 9781(a)] *One of the tactics that has been suggested by applicant attorneys to get their employees out of MPNs was to demand a change of treating physician pursuant to Labor Code 4601 and if the defendant failed to respond within the 5 day time limit, argue that the employee had regained control of medical care. Given the employee's complete freedom to change treating physicians within the MPN it makes no sense for Labor Code 4601 to apply within the network.*

6. The rules make it clear that the predesignation of a personal physician does not apply to any specialty other than physicians defined in Business and Professions Code sections 2000 et. seq. and is limited to physicians and surgeons. This excludes chiropractors or acupuncturists from being predesignated under Labor Code section 4600 and allowing the employee to treat outside the MPN. [ADR 9781(a) & ADR 9780(f)]

7. The definition of a "personal physician" that can be predesignated, in addition to having to be a physician or surgeon, is limited to a "primary care physician" who is defined as one who "has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. A primary care physician shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner." [ADR 9780(g)]. *This would eliminate prior treating physicians for industrial injuries who did not meet the definition of "primary care physician" in the regulations from being predesignated as a personal physician. This language would also eliminate selection of a "Facility" to serve as Predesignated personal physician and limit selection to an individual physician within a facility to act in that capacity.*

8. As has been suggested by this and many other authors and commentators, the process for getting to a predesignated chiropractor or acupuncturist requires the employee to initiate treatment with an employer-designated physician and then make a request for a change under Labor Code section 4601. The employer is then required to allow the employee to go to their predesignated physician [ADR 9783.1 - Notice of Personal Chiropractor or Personal Acupuncturist - see Instructions].

Assuming that the OAL finds no problems with these regulations (and they appear to closely conform to the statutory language) these regulations will become effective around the beginning of October. The requirements to provide notice to employees is contained in ADR 9880 (new hire information) and ADR 9881 (Posting requirements). There does not appear to be any requirement to provide any specific notification of these requirements to employees at any other time. The exception of course is with the implementation of an MPN where employees are required to receive notices as required by the MPN regulations and the individual MPN applications.

LC 4663 APPORTIONMENT:

WORK COMP CENTRAL9/11/2005 and 9/24/2005

Article: Substantial Evidence of Causation Apportionment posted on 08/28/2005, on Workcomp Central

California Evidence Code section 140 defines the term, *evidence*, as "testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact." The phrase, *substantial evidence*, does not appear in the Evidence Code but definitions can be found in the case law. Probably the most widely accepted definition of substantial evidence is *relevant evidence that a reasonable person might accept as adequate to support a conclusion*.

Of course, there is a lot of subjectivity in this definition because reasonable people can differ and what may convince one person may not be persuasive to another. Notwithstanding these considerations, substantial evidence is simply evidence that is believable. At the extreme ends of the spectrum, the concept will be easy to apply. If any reasonable person could read a medical report and find the doctor's conclusion to be persuasive, that's substantial evidence, assuming the report is based on accurate facts. On the other hand, if the doctor's opinion would insult the intelligence of any reasonable person or elicit the reaction that it could only happen this way on a cold day in hell, the report is not substantial evidence.

In *Escobedo*, the Board listed certain requirements that a medical opinion must fulfill in order for an apportionment determination to be based on substantial evidence:

* it must be framed in terms of reasonable medical probability
* it must not be speculative
* it must be based on pertinent facts
* it must be based on an adequate examination and history, and
* it must set forth reasoning in support of its conclusions.

The Board also made it clear that it is not good enough to just address the nonindustrially

caused portion of the disability and assume that the balance must be industrial. It must be stated specifically why the doctor believes a given percentage of the disability was the direct result of the industrial injury and why a given percentage was caused by other factors.

These criteria are consistent with from the topics to be addressed in medical-legal reports listed in Title 8, California Code of Regulations, section 10606, although the Escobedo criteria are more general and section 10606 is more specific. Each of these requirements will be analyzed to see what they really mean.

1. The opinion must be framed in terms of reasonable medical probability

The problem with requirements such as this one is that they end up being the subject of "boilerplate" that is routinely inserted into every report as a matter of course, whether or not the statement is true. It will be easy for the physician to meet this requirement.

2. The opinion must not be speculative

This requirement must be interpreted to mean that the opinion must not be *significantly* speculative because every apportionment determination is going to involve a certain degree of speculation unless the disability is clearly all industrial or clearly all nonindustrial. Thus, there will always be an element of subjectivity in determining whether the doctor engaged in speculation. Physicians should expect to be deposed and asked such questions as, "If 50 percent of the disability was caused by nonindustrial factors, why not 60 percent or 40 percent?"

Claims that an apportionment determination is speculative can be minimized by assigning the lowest percentage to the nonindustrial component that can be supported by the facts. That way, when asked why a 50 percent apportionment couldn't just as well be a 40, the doctor can respond that while it might be 60 percent, it couldn't be 40 percent because the applicant was given the greatest possible benefit of the doubt. On the other hand, if the doctor has no reason for selecting the percentages in his report over any other two numbers that might add up to 100, the opinion is clearly speculative.

3. The opinion must be based on pertinent facts.

This means the doctor must be able to isolate all of the relevant information that suggests the existence of both industrial and nonindustrial causes and that he must be able to use those facts to form his opinion. In *Escobedo*, the treating physician based his opinion on one fact alone: that Ms. Escobedo denied prior symptoms or disability. This was simply not good enough. There were many other pertinent facts that should have been taken into consideration no matter what the doctor might have concluded in the final analysis. In contrast, the QME also considered the fact that she denied prior disability or symptoms, but then he went on to examine other pertinent facts such as the trivial nature of the injury, the substantial disability, and the rapid onset of the pain in the noninjured knee, facts that the treating physician neglected to consider and address.

4. The opinion must be based on an adequate examination and history.

The physician will not be able to identify the pertinent facts without making an inquiry

into the circumstances of the injury and the injured worker's physical condition, both before and after the injury. This can only be accomplished by taking a comprehensive history from the applicant, performing a thorough physical examination, obtaining the necessary diagnostic testing, and reviewing the content of relevant medical records.

5. The opinion must set forth reasoning in support of its conclusions.

Determining medical causation issues requires a combination of medical judgment and scientific analysis. The physician must analyze all of the pertinent facts and reach a conclusion that is as much a function of experience and insight as it is based on medical knowledge. Then, however, the doctor must be able to translate his thought processes into a written explanation that a person with no formal medical training will be able to understand. It will not be good enough for the physician to simply remind the reader that he is an expert who knows what he's talking about and therefore his opinion should be taken on faith.

In appellate opinions interpreting the former apportionment statutes, the courts rejected medical opinions that were based on the doctor's belief that the apportionment determination was "fair" or "reasonable" On the other hand, there may be cases in which it would be impossible to assign percentages of causation without resort to speculation. Since the statute essentially provides that the physician must make an apportionment determination in order to validate the opinion on permanent disability, the only possible reasoning in support of a speculative conclusion may be that the doctor was complying with the law.

What is a direct result of an industrial injury?

In its opinion in *Escobedo*, the Appeals Board specifically stated that Labor Code section 4663 not only requires substantial evidence of the nonindustrial component of the apportionment determination, but also substantial evidence of the industrial portion. These two factors are described in new Labor Code section 4663 as follows:

"A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries"

Logically, a *direct result* would be the effect of a *direct cause* which in turn, is a synonym for *proximate cause*. It is a statutory condition of compensation that an injury be "proximately caused by the employment, either with or without negligence." In workers' compensation law, the term *proximate cause*, as it relates to causation of the injury rather than causation of the disability, has generally been defined as *a substantial cause without which the injury would not have occurred*.

If an injured worker tears a ligament in his knee while performing his job duties, the disability resulting from the torn ligament is clearly a direct result of the industrial injury. However, it is unclear how the term *direct result*, as it is used in the statute, might impact on compensable consequence injuries. The Board obviously found the disability arising out of the compensatory injury in *Escobedo* to have been "caused by the direct result of

[the] injury." However, what if Ms. Escobedo had sustained additional permanent disability to her knees in an automobile accident on her way to therapy? Would the disability arising out of the auto accident still be considered the "direct result" of the industrial injury?

Liability for compensable consequence injuries, in general, was unchanged by SB 899 because Labor Code section 4663 governs apportionment of permanent disability; not apportionment of injury. The Appeals Board made this clear in its opinion in *Escobedo*. Therefore, it is difficult to understand how an injured worker's temporary disability and need for medical treatment caused by a secondary injury could be industrially related, but not his permanent disability because it was not "the direct result of injury arising out of and occurring in the course of employment." However, a definitive answer will have to await interpretation by the Appeals Board and the appellate courts.

Is the applicant's history credible?

When a new patient comes to a doctor with a medical problem, there is generally little incentive for the patient to misrepresent his symptoms or past history because he wants the doctor to diagnose his condition and hopefully provide him with a cure. When an injured worker comes to a doctor for the purpose of obtaining evidence in connection with litigation of an injury claim, there is often an incentive to be less than candid. The doctor cannot simply accept every story at face value. Yet doctors are often hesitant to question an applicant's history or complaints even where it is highly unlikely that the reported information is accurate.

If the degree of degenerative arthritis shown on x-rays taken on the day of the injury is such that the individual almost surely must have had some physical limitations if not subjective complaints, the doctor should say so. If the physical findings clearly do not support the degree of pain and physical limitations that the applicant reports after the condition has become permanent and stationary, the doctor should say so. Where litigation is involved, misrepresentations concerning past or present physical condition are often easy to rationalize. In fact, an individual who admits to prior problems where there are no medical records or other means of proving it would be considered by many to be a fool.

In these situations, it is up to the physician to try to separate the wheat from the chaff. While injured workers should be given the benefit of the doubt, this rule does not apply where there is no reasonable room for doubt. A sympathetic physician should avoid the temptation to make workers' compensation the Band-Aid for all the ills of society by helping an injured worker to reap a windfall or to retire with a higher pension.

NATIONALLY RECOGNIZED EVIDENCE BASED GIDELINES:

It started with 73 guidelines, and it concluded ACOEM, McKesson, AAOS, IntraCorp, and ODG met the AD's criteria. However, some of the AD's criteria went beyond "recognized by the national medical community and are scientifically based" e.g. the criterion for the guides to cost less than $500. Thus, there probably are other EBM Guidelines which are "recognized by the national medical community and are scientifically based" in addition to ACOEM, McKesson, AAOS, IntraCorp, and ODG.

GOOD LABOR CODES TO KNOW:

4062(a): If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

4062.1(b): If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may submit the form prescribed by the administrative director requesting the medical director to assign a panel of three qualified medical evaluators in accordance with Section 139.2. However, the employer may not submit the form unless the employee has not submitted the form within 10 days after the employer has furnished the form to the employee and requested the employee to submit the form. The party submitting the request form shall designate the specialty of the physicians that will be assigned to the panel.

4062.1(c): Within 10 days of the issuance of a panel of qualified medical evaluators, the employee shall select a physician from the panel to prepare a medical evaluation, the employee shall schedule the appointment, and the employee shall inform the employer of the selection and the appointment. If the employee does not inform the employer of the selection within 10 days of the assignment of a panel of qualified medical evaluators, then the employer may select the physician from the panel to prepare a medical evaluation. If the employee informs the employer of the selection within 10 days of the assignment of the panel but has not made the appointment, or if the employer selects the physician pursuant to this subdivision, then the employer shall arrange the appointment. Upon receipt of written notice of the appointment arrangements from the employee, or upon giving the employee notice of an appointment arranged by the employer, the employer shall furnish payment of estimated travel expense.

4603.2(a): Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. The physician shall submit a report to the employer within **five working days** from the date of the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

4610(g)(1): Prospective or concurrent decisions shall be made in a timely fashion that is

appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

4610(g)(3)(a): Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

4610(g)(4): Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

GOOD REGULATIONS TO KNOW (TITLE 8 CCR):

9792.9(a)(1): For purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was transmitted. A request for authorization transmitted by facsimile after 5:30 PM Pacific Standard Time shall be deemed to have been received by the claims administrator on the following business day as defined in section 9 of the Civil Code. The copy of the request for authorization received by a facsimile transmission shall bear a notation of the date and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted.

9792.9(a)(2): For purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was transmitted. A request for authorization transmitted by facsimile after 5:30 PM Pacific Standard Time shall be deemed to have been received by the claims administrator on the following business day as defined in section 9 of the Civil Code. The copy of the request for authorization received by a facsimile transmission shall bear a notation of the date and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted.

9792.9(b)(1): Prospective (your request for all 24 chiropractic visits) or concurrent (for inpatient services only) decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for authorization.

9792.10(a)(2): An objection to a decision disapproving in whole or in part a request for authorization of medical treatment, must be communicated to the claims administrator by the injured worker or the injured worker's attorney in writing within 20 days of receipt of the utilization review decision. The 20-day time limit may be extended for good cause or by mutual agreement of the parties. (NOTE: if the injured worker is NOT represented by an attorney, this time deadline is extended to 30 days per LC 4062(A). [labor codes always trump regulations.]

To be continued next quarter;

PERSONAL INJURY UPDATE

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In most doctors' practices, there is a mix of personal injury patients with most being those involved in motor vehicle accidents. This is a very complicated topic that includes subjects such as injury thresholds, appropriate treatment plans, the Colossus defense assessment program, fraud, over treatment, under treatment, personal injury lawyers and the different types, med-pay, liens, defense experts, plaintiff experts, eggshell testimony, malingering, property damage, occupant damage, accident reconstruction, etc.

With the recent legislative changes in the California workers' compensation system that include a somewhat "managed care" program with networks, many doctors are desiring to see more personal injury patients in their practice.

Following is a summary guideline of topics that you should be aware of when treating personal injury patients.

MEDICAL PAYMENTS

Med-pay, as it is commonly referred to, is a relatively inexpensive insurance that one can add to their car insurance policy. The discount carriers will generally limit the coverage to $2000.00 or $5000.00, while premium carriers will commonly offer up to $100,000.00 of coverage. When possible, recommend that patients carry at least $25,000.00 of med-pay, even if they do have a good group health policy to back them up. This will often give them choice of additional providers to treat their injuries and eliminate any co-pays that may be in effect with their group health insurance.

All parties should know that some carriers have subrogation clauses and some do not. For example, if AAA pays $2000.00 of medical payment to a doctor for treatment, you never have to pay them back from the third party settlement since they sell a no fault, no subrogation med-pay policy. Conversely, if Farmers or State Farm pays out $2000.00 for treatment, they expect to have this reimbursed via a third party lien against the responsible party.

ATTORNEYS

In today's legislative environment, many patients will be well served by having a competent and ethical attorney representing them. Although some adjusters and company policies and quite ethical, some are not. Since the carrier has attorneys working for them and advising them, an most patients know little if anything about their rights when injured in a motor vehicle accident, this will serve to level the playing field to assure a fair settlement of the claim. Statistics show that the patient will end up with only a small financial advantage by having an attorney, but they will buy peace of mind. Once the patient is represented, the carrier must communicate through the attorney and not contact the patient. These cases will settle for higher amounts with an attorney, but often the increased amount is approximately close to one third, or the amount that the attorney will withhold from the settlement for fees.

Essentially, there are two types of attorneys. There are the "mills" that characteristically advertise a lot and close cases quickly at any cost and those that will take the time to analyze each case individually and make reasonable demands based on the merits of the specifics of the case. The mills will often ask the doctor to keep their billed amounts at a certain price "range", seemingly regardless of patient need, with bills that are too low or too high causing interference to their streamlined settlement process. They will often propose "deals", such as the common 1/3,1/3,1/3 proposition, where the attorney will suggest a distribution of the settlement amount with 1/3 going to the patient, 1/3 to the doctor, and the attorney keeping 1/3. It is suggested that you avoid these scams and submit billings for services reasonably required to address the patient's injuries appropriately and cost-effectively. There are times when it may be appropriate to reduce a lien in order to facilitate a settlement in a particularly difficult case, but this should be a rare event.

FACTORS THAT MAKE CASES DIFFICULT TO SETTLE

1. Delay of treatment. The longer the patient waits to get treatment after a motor vehicle accident.

2. Low property damage. Generally speaking, when the damage to the vehicle requires less than $1000.00 to repair, the defense will question whether injury threshold was reached. Although from a scientific standpoint there is no linear relationship between property and occupant damage, and often an inverse relationship exists, defendants have been successful selling the idea to juries that relatively low property damage is somehow related to occupant injury. Therefore, the fact remains that low property damage makes cases harder to settle. Some companies, including large ones like State Farm, will commonly send all cases with less than $1000.00 dollars of property damage to their "fraud investigation unit".

3. SOAP notes, re-examinations and guideline-based supportable treatment, with appropriate documentation of such will add value to a case.

4. Diagnostic testing/treatment costs. Generally speaking, the treatment should cost more than the diagnostic testing. Formulas for "case values" that are often largely based on medical treatment will often eliminate testing costs in order to only consider direct treatment costs for the injury. While an MRI may boost the value of a case when positive, multiple negative testing of any type will clearly hurt a case. Carriers especially hate seeing multiple sEMGs, computerized ROM or muscle testing, nerve conduction tests, radiographs, thermograms, etc. If your patient needs any of these tests, only provide them when required to appropriately treat the patient's injuries and be ready to justify your position.

5. Total bills. Although the patient's billings may vary substantially depending on their specific injuries and need for care, chiropractic bills that exceed $5000.00 make it more difficult to settle a chiropractic-only case. If an orthopedic surgeon co-manages the patient and prescribes or requests a substantial amount of treatment, a larger threshold is allowed before the case if compromised. This amount assumes substantial automobile damage and clear evidence of injury.

6. Document factors of complexity. Include significant injury threshold factors by documenting prior DJD, head rotation during a rear-end collision, a non-expecting occupant (didn't see it coming), or a headrest set too low during impact. Document what body parts where injured and exactly how. Have the patient describe exactly what happened to their body at the time of the impact. Although a defendant will argue that prior injuries or DJD are a contributing factor to a patient's need for treatment, the applicant will argue that the DJD or prior injury made the patient more susceptible to more serious injury. This is the "eggshell" argument that relies on the fact that insurers must accept clients in the condition that they are in when they sell them a policy.

LIENS

When establishing working relationships with attorneys, they will expect the doctor to accept liens on occasion. If the patient has med-pay or group health insurance, you may bill them as you treat and collect money from those carriers. Be sure to disclose that the patient was injured in a motor vehicle accident, since some carriers will file a lien with the attorney against the settlement. I recommend that if a patient does not have any med-pay or other insurance coverage that pays for your services, or if this amount has been exhausted, that you have the patient make monthly payments towards their account. I request $100.00 per month payments towards their account in these cases. Be sure that the patient and attorney both sign the lien to protect your interests in the case.

TREATMENT GUIDELINES

All treatment offered must be reasonable and well documented. A doctor should prepare every PI patient's file for court, since some will end up that way. IMC guidelines, Mercy, Glenerin, or other reasonable guidelines should be followed closely. Re-examinations should be performed at no more that six-week intervals and the patient should be declared maximally medical improved as appropriately determined during one of these re-evaluations.

DEPOSITIONS

As one enters the field of PI more seriously and aggressively, be prepared to give depositions. These will be more common in larger cases with larger bills and more diagnostic testing. This is another reason why each PI file must be prepared for trial. Prepare thoroughly for depositions and answer each question accurately and succinctly. Be sure to demand a reasonable fee for your time. Deposition fees typically vary from $200.00 to $1000.00 per hour amongst different doctors and depend on your experience, expertise, and current income. Common fees for chiropractors range between $250.00 to $500.00 per hour and the law mandates that these fees be paid at the time of the deposition for the first hour, and within five days of receipt of a statement for any time owed beyond the first hour. Most attorneys come prepared to pay the entire deposition fee at the time of service.

SUMMARY

I recommend that doctors attempt to increase their personal injury practices at this time of change in chiropractic. In personal injury, an ethical and reasonable doctor can still get paid usual and customary fees in a world of managed care in the private sector and boundless paperwork, visit restrictions, and U.R. delays in the workers' compensation system. This is a time for practice diversity, where one should maximize their cash, PI, Group Health, and Workers' Compensation practices. Workers' Compensation is still in a very transitional phase with nobody really knowing what the future holds for insurance companies, doctors, and injured workers. So while increasing your knowledge in the fields of PI through programs taught by experts like Charles Davis, DC (cdavisdc@gmail.com) Arthur Croft, DC (info@srisd.com), and Dan Murphy, DC (danmurphydc.com), doctors should continue to maintain expertise in Worker's Compensation so that they can re-enter the arena enthusiastically when and if the problems are "ironed out".

To be continued next quarter;