CIGA
Medical Provider Network and Utilization Review Update
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TOPICS

• MEDICAL PROVIDER NETWORK UPDATE
  • Valdez v. Warehouse Demo Services (2011) 79 Cal. Comp. Cases 130 (en banc)
  • Impact of Valdez on MPN Litigation
  • Transfer of Care Procedures – Evidentiary Issues
  • Changes to CIGA’s MPN and Related Issues

• UTILIZATION REVIEW UPDATE
  • Cervantes and RFAs
  • Review of CIGA’s spinal surgery objection procedures

MEDICAL PROVIDER NETWORK UPDATE
VALDEZ V. WAREHOUSE DEMO SERVICES
(2011) 79 Cal. Comp. Cases 330 (en banc)

- Applicant sustained admitted injury and commenced treatment within employer’s properly-established MPN
- Treated for approx. 3 weeks in MPN then started treatment with non-MPN doctor based on attorney referral
- Applicant claimed MPN treatment was not helping but
  - Never informed claims administrator
- At trial, applicant offered non-MPN doctor’s reports in support of TD entitlement
- WCI awarded TD relying on non-MPN doctor’s reports
- Defendant sought reconsideration

VALDEZ V. WAREHOUSE DEMO SERVICES
The WCAB Holdings...

A. Where unauthorized treatment is obtained outside a validly established and properly noticed MPN, reports from the non-MPN doctors are not admissible (Opinion p. 333)
- Applicant had right to select other MPN doctor (Reg. 9767.6(a))
- Applicant had right to 2nd and 3rd opinion MPN doctors if dispute over diagnosis or treatment under Lab. C. § 4616.3(b) or Independent Medical Review under Lab. C. § 4616.3(c)
- Lab. C. § 4616.5 precludes admissibility of non-MPN medical reports with respect to disputed treatment and diagnosis.
- Non-MPN doctor cannot become the “FDP” and therefore not authorized to report or render opinion on “medical issues necessary to determine the employee’s eligibility for compensation” under lab. C. § 4601.5 and Reg. 9785(d)
- Lab. C. § 4605 (right to consulting or attending physician of employee’s choice at his or her expense) and Lab. C. § 4606.5 (admissibility of reports of attending or examining physicians) do not alter the result.

VALDEZ V. WAREHOUSE DEMO SERVICES
The WCAB Holdings... cont’d

B. Where there has been no neglect or refusal to provide reasonable medical treatment, defendant is not liable for treatment procured outside the MPN. (Opinion, p. 338)
- Defendants are liable for non-MPN treatment if there is neglect or refusal to provide reasonable medical treatment. (Knight v. United Parcel Service (2006) 71 Cal. Comp. Cases 1423 (en banc).)
- If no neglect or refusal to provide reasonable medical treatment, applicant may treat outside of MPN at his or her own expense
- Lab. C. § 4605: “Nothing contained in this chapter shall limit the right of the employee to provide, at his own expense, a consulting or any attending physicians whom he desires.”
VALDEZ V. WAREHOUSE DEMO SERVICES

What has happened since?

• Applicant first aggrieved by the WCAB’s en banc decision and filed petition for reconsideration from the WCAB’s en banc decision
• Grant of reconsideration for further study on July 14, 2011
• Opinion and Decision After Recon on September 27, 2011
  • WCAB (en banc) rejected Valdez’ arguments
  • Affirmed its en banc decision of 4/20/11
• Petition for writ of review is likely
  • An en banc decision has immediate binding effect on WCJs and Appeals Board panels in other cases under the principle of stare decisis. (See Reg. § 10341) The en banc decision remains binding unless the appellate court expressly or implicitly overrules the en banc decision or stays or suspends its operation prior to issuance of an opinion. (See Diggle v. Sierra Sands Unified School Dist. (2005) 70 Cal. Comp. Cases 1480 (significant panel decision); Lab. C. § 5956.)

VALDEZ’ IMPACT ON MPN LITIGATION

• HUGE – IF THE DECISION STANDS
• APPLICANT FIRMS AND NON-MPN PROVIDERS SCRAMBLING!
• VALDEZ REMOVES INCENTIVE TO TREAT OUTSIDE OF MPN
  • Non-MPN treating doctors opinions inadmissible to prove right to compensation
  • No liability for non-MPN treatment
• APPLICANTS FOCUS ON ESTABLISHING
  • Non-compliance with requirements for creation of MPN (not validly established MPN)
  • Non-compliance with notice requirements
  • Non-compliance with access standards under Reg. § 9767.5
  • Inability to access to MPN (applicant’s claiming inability to access MPN web site)

TRANSFER OF CARE

Revisiting the procedure (Reg. § 9767.9)

• Isn’t Transfer of Care (TOC) old news? No.
  • Most applicants will enter CIGA’s MPN through TOC
  • Some applicants continue to resist transfer
  • Some attorneys are still unclear on TOC procedure
    • TOC is primarily a claims function
    • TOC may occur less frequently with some other defendants
    • Some attorneys have not dealt with TOC disputes
    • Leads to acceptance of other side’s or WCJ’s pre-trial “suggestions” that are not always correct
TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9)
(PTPs already in MPN)

• If PTP is member of MPN, send MPN letter 1 which advises the injured employee that he/she is now treating within the scope of the MPN.
  • MPN letter 1 is copied on:
    • PTP
    • Defense and applicant’s attorney.
  • Enclose MPN Handbook for Claimant
  • Letters will be sent in both English and Spanish.
  • All MPN Letters must be sent with Proof of Service.
  • Letter signature includes 800 number

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9)

• Adjuster determines if one of the four conditions specified in Reg. § 9767.9(e)(1)-(4) exists
  • Acute? (Sudden onset of symptoms requiring prompt medical attention that last less than 90 days.)
  • Serious chronic? (Condition that is serious in nature that persists without full cure or worsens over 90 days and requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment up to one year.)
  • Terminal illness? (Incurable or irreversible condition that has high probability of causing death within one year or less. Completion of treatment for duration.)
  • Performance of surgery or other procedure? (Surgery or other procedure authorized by employer or insurer as part of documented course of treatment and recommended and documented by provider to occur within 180 days from MPN coverage date.)

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d
Exceptional medical condition

• If adjuster determines that one of four exceptional conditions under Reg. § 9767.9(e)(1)-(4) exists (acute, serious chronic, terminal or surgery within 180 days)
  • Completion of treatment will be authorized for the period specified in the regulations
TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

There Is No Exceptional Medical Condition

- If no exceptional medical condition applies, send **MPN letter 3**, requesting claimant transfer to MPN provider.
  - Must include Panel/list of at least 3 appropriate treaters.
  - Enclose MPN Handbook
  - This letter includes dispute procedures.
  - Must copy non MPN PTP applicant’s atty & defense atty.
- If there is no response from the claimant after sending MPN 3 in 30 days, send MPN 12 with another MPN Panel.
  - 12b and 12c advise the non MPN PTP and secondary treaters that payment will no longer be made for treatment provided by them.
  - Letters 12b and 12c need an effective date entered.
- Effective date is 30 days after the date of the MPN 12.

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

- Time frames for acute and serious chronic run from date of noticed transfer (if applicant continues to treat with non-MPN doctor)
  - Not the date applicant or their attorney chooses
  - Not the date the PTP prepares the requested report
  - Not the date of AME/QME report under §4062
  - Not the date of a WCJ’s determination that one of the four conditions exist
  - Not any other date
- Note – surgeries or other procedures to take place within 180 days
  - Does not expressly limit surgical treatment to 180 days
  - Does not expressly state whether post-surgical care must be permitted outside MPN

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

- Applicant objects:
  - Must request report from non-MPN PTP re: condition
  - If non-MPN PTP fails to issue report with 20 calendar days of the request, CIGA’s determination “shall apply.” (Reg. § 9767.9(g))
  - Report request “loophole” under Reg. § 9767.9 (Reg. only specifies time for doctor to produce report not time to request.)
- Disputes over PTP’s determination shall be resolved pursuant to Lab. C. § 4062 (Reg. § 9767.9(h))
TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

- Where non-MPN PTP issues report
  - PTP agrees with CIGA’s determination
    - “The transfer of care shall go forward during the dispute resolution process.” (Reg. § 9767.9(i))
    - Injured worker has no right to treat outside CIGA’s MPN until dispute resolved and condition delaying transfer is established
  - PTP does not agree with CIGA’s determination
    - “The transfer of care shall not go forward until the dispute is resolved.” (Reg. § 9767.9(j))

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

- General Rule: CIGA will not object to PTP’s report disagreeing with adjuster’s determination so long as the report is substantial evidence
  - Cost
    - The dispute resolution process may take as long or longer than the permitted period of non-MPN treatment
- Most often it will be the applicant who objects
- AME/QME dance – the chips will fall where they may

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

- Often applicants will litigate the transfer without having followed the required procedure
  - Applicant requests MSC or Expedited Hearing in response to transfer notice
  - Applicant has not requested report or doctor has not provided report or not provided timely
  - Yet applicant maintains that he or she has one of the four conditions specified in Reg. § 9767.9(c)(1)-(4)

"BUT I REALLY AM SERIOUS CHRONIC!!!"
TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

• Not substitutes for PTP report:
  • AA objection letters declaring existence of one of the four conditions – “My client’s condition is serious chronic!”
  • Applicant’s declaration of the existence of one of the four conditions
  • Lots of P0 – therefore the applicant must have one of the four conditions, namely “serious chronic”
  • Statements by WCIs that the WCI thinks the applicant has one of the four conditions (without any medical evidence)
  • Report obtained outside of the established procedure
  • A note from the applicant’s mother...

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

• Applicant does not request PTP report or report not provided timely
  • CIGA’s transfer of care determination “shall apply”
  • No need to file a petition to transfer care and
    • Cannot force an applicant to treat within MPN
    • L.C. §4605 permits treatment outside MPN at applicant’s own expense
  • Untimely report (as opposed to no report) may ultimately be within WCI discretion to excuse
    • Raise 4062 objection and follow procedure
    • Make it clear that CIGA’s following of 4062 procedure is not a waiver of the defense

TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

• Some WCIs still unfamiliar with transfer procedure
  • Some will admit evidence obtained outside of the procedure
  • Some will make medical determinations in absence of evidence regarding the existence of one of the four conditions – usually “serious chronic”
  • Some will find that a significant level of PD = “serious chronic”
  • Some will make up new access standards to avoid transfer
TRANSFER OF CARE
Revisiting the procedure (Reg. § 9767.9) cont’d

• Where applicant fails to follow established procedure under Reg. § 9767.9 CIGA’s position is
  • CIGA’s determination “shall apply”
  • Grounds for waiver of dispute over determination
  • Object to medical evidence obtained outside of the established procedure

CHANGES TO CIGA’S MPN

• CIGA’S MPN CHANGES
  • 9-16-2005 CIGA’s initial MPN approval
  • 1st amendment 2-19-2008 Changes – Custom MPN
  • 2nd amendment 5-20-2011 changes – Tallpoint
    (tallpoint.com/cvty/cigmpn)
  • Documentary changes

• STATE PROVIDERS
  • Obligations to state treatment providers are not “covered claims” under Ins. C. § 1063.11(4)
    • All states
  • CIGA has removed state providers from MPN (e.g. UC medical providers)
  • What to do when state provider was selected prior to MPN list changes and care authorized

UTILIZATION REVIEW UPDATE
CERVANTES & SPINAL SURGERY PROCEDURES

• In 2009 WCAB (en banc) issued decision in
• Importance
  • Interplay between UR under Lab. C. § 4610 and spinal surgery objection procedure under Lab. C. § 4062(b)
  • Comments regarding what constitutes an “RFA”
  • UR and Lab. C. § 4062(b) are no longer either-or
  • Brasher permitted defendant to opt out of UR and resolve spinal surgery dispute only under Lab. C. § 4062(b)

CERVANTES & SPINAL SURGERY PROCEDURES cont’d

• Spinal surgery requests are subject to UR
  • “[W]e conclude that when a treating physician requests authorization to perform spinal surgery, a defendant must assess that request through UR.” (p. 1341)
• UR denial is prerequisite to initiation of 4062(b) process
  • “[S]ections 4062(a) and 4610(g)(3)(A) both plainly and unequivocally provide that the spinal surgery second opinion process of section 4062(b) cannot be initiated unless and until the UR process of section 4610 has denied the requested spinal surgery.” (pp. 1352-1353. Italics supplied.)
  • “Denial” on spinal surgery cases is any UR decision that does not fully approve the specific spinal surgery recommended. (Cervantes, p. 1352)
    • Modifications and delays are considered “denials”

CERVANTES & SPINAL SURGERY PROCEDURES cont’d

• Effect of UR decision
  • UR approval or untimely UR – must authorize (pp. 1342-1344)
  • UR denial – defendant may object under Lab. C. § 4062(b) and seek second opinion (pp. 1352-1353)
  • UR must deny within 10 days so that timely 4062(b) objection can be issued (p. 1353)
CERVANTES & SPINAL SURGERY PROCEDURES cont’d

- Lab. C. § 4062(b) objection
  - Within 10 days of receipt of report
  - Must comply with Reg. § 9788.1 (as to use of form 233 and declaration re: receipt of report)
  - No timely 4062(b) objection – must authorize (p. 1354)
  - Failure to comply with Reg. § 9788.1 – must authorize (p.1354)

CERVANTES & SPINAL SURGERY PROCEDURES cont’d

- UR decision and § 4062(b) objection must be done within the same 10 day period
  - No UR extension to 14 days based on lack of required information normally available under Lab. C. § 4610(g)(5)
  - Grounds for UR denial if defendant does not have all necessary information within 10 days (p. 1353)

CERVANTES & SPINAL SURGERY PROCEDURES cont’d

- RFAs must satisfy the requirements in Reg. § 9792.6(o) to trigger UR and 4062(b) time frames (pp. 1353-1354)
  - Doctor’s First Report of Occ. Inj. or Illness (DLSR 5021)
  - Primary Treating Physician’s Progress Report (PR-2)
  - Narrative report
    - Containing same information required in PR-2
    - “[C]learly marked at the top that it is a request for authorization”
    - “Narrative report” means any report other than 5021 or PR-2 (p.1353)
  - This discussion has application to all RFAs
CIGA's Spinal Surgery Objection Procedures
Putting It All Together

All RFAs Must Go to UR

- All RFAs for spinal surgery must go to UR for a timely proper
  UR determination.
- UR of RFAs for spinal surgery must be completed in 10 days
  even if additional information is requested.
- Without a request for additional information the UR must be
  completed in five working days.
- 9792.9

If UR Approves the Surgery, or if UR Is Not Completed Timely, and there are no other defenses to
CIGA's Liability, the Surgery Must Be Authorized.
IF UR Denies/Modifies the Request, Requirements of 4062(b) and 9788.1 Must Be Satisfied to Preserve CIGA's Right to Challenge the Recommended Spinal Surgery.

10 Days  10 Days  10 Days

Labor Code 4062(b)

• Adjuster must object in writing to the request within 10 days of receipt of the RFA by completing and serving DWC form 233.
  • Original to Administrative Director
  • Copy to applicant
  • Copy to applicant's atty
  • Copy to treating physician recommending surgery
• And, Adjuster must contact Applicant's attorney to seek agreement on orthopedic surgeon or neurosurgeon to resolve disputed surgical recommendation.
  • Use 4062(b) letter or
  • Phone

More on 4062(b)

• Adjuster must notify AD within one working day if:
  • Agreement is reached with applicant's attorney.
  • CIGA withdraws its objection to the surgical request.
• If no agreement is reached within 10 days an orthopedic surgeon or neurosurgeon will be randomly selected by the Administrative Director.
• If applicant is unrepresented, the second opinion physician will be selected by the Administrative Director.
Adjuster Receives Notification of DWC Selected Second Opinion Doctor:

- Notification will be by regular mail.
- Immediately, (don’t wait for appointment to be set),
  - Furnish the second opinion physician with medical records and medical reports relevant to the spinal surgery decision including:
    - X-rays, MRI, CT and other diagnostic films.
    - Any medical reports describing the applicant’s current spinal condition and recommended treatment.
  - Adjuster must serve copies of all reports and records, except X-rays, MRI, CT and other diagnostic films, on the applicant or his or her attorney if represented.
  - The DWC will only send the RFA report to the second opinion physician.
  - We do not want the second opinion physician making an opinion and writing a report based only on the RFA report.

Why Not Wait Until Notice of Appointment Received

- Report, with or without an exam, must issue not later than 45 days from the date the RFA was received by the claims administrator.
  - An examination is not necessary if:
    - Second opinion doctor agrees with physician recommending spinal surgery.
  - An examination is necessary if:
    - Second opinion doctor determines physical examination is necessary.
    - Second opinion doctor disagrees with the treating physician who requested procedure.
  - We do not want the second opinion physician writing the report based solely on the RFA

Scheduling the Physical Examination

- Second opinion physician shall schedule the examination.
- Second opinion physician shall send written notice to:
  - the applicant,
  - the applicant’s attorney and
  - to the party objecting to the recommended surgery.
After Receipt of the Second Opinion Report

- If Second opinion physician agrees with the treating physician:
  - Authorize the Surgery
  - Communicate the authorization to the treating physician within three working days of receipt of the second opinion physician's report. 9788.91

- If the second opinion physician disagrees with the treating physician:
  - Disagreement includes where the second opinion physician offers a modified or alternate surgical procedure (does not “rubber stamp” the requesting doctor)
  - Adjuster or DA must file DOR within 14 days of receipt of the second opinion physician’s report.

Exception to DOR Requirement

- Parties agree with determination of second opinion physician; or
- Surgery has been authorized.
- Why:
  - Not a strong report

Questions and Ideas