



Medically Speaking



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The Council's Clean Sweep

California Adopts IMC Treatment Parameters

The IMC Treatment Guidelines for the low back, knee, shoulder, elbow, neck, and hand and wrist, adopted by the Council, have been approved by the Office of Administrative Law.

Although the Guidelines have been approved as regulatory in nature, the Council is advising that they are intended as educational and should be utilized as parameters or guideposts for treating common industrial injuries.

The guidelines are required to comply with the Administrative Procedure Act which provides that any rule or standard adopted by any state agency to implement, enforce or make specific the law enforced or administered by that agency must comply with the APA. Since the Council was carrying out the legislative mandate given to it under Labor Code §139(e), the Council was clearly drafting what the law recognizes as "regulations."

In order to comply with this mandate, and yet allow for reasonable treatment under Labor Code § 4600 ("cure or relieve") and potential scope of practice considerations, the Council added language to make it clear that they are advisory and are to be viewed as practice parameters - not practice requirements.

The guidelines committee was co-chaired by Dr. Ira Monosson and Dr. Larry Tain. Councilperson Dr. Alicia Abels said the most important aspect of the guidelines would be their effect on injured workers.

"It's been a long road and I think everyone would agree there are some controversial provisions," said Dr. Abels. "We have made some hard decisions but I believe the choices we have made will benefit injured workers. What we need to do now is gauge the effect on the provider community as it relates to providing the most efficacious forms of treatment".

Concern has been expressed by some that the guidelines will somehow affect the burden of proof before the Appeals Board. Executive Medical Director Dr. Allan

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New Rating Schedule Implemented

A new rating schedule for permanent disability has been implemented by the Division of Workers Compensation. The schedule will be effective for injuries which occur on or after April 1, 1997.

The new schedule amends the age and occupation adjustment sections; schedules new ratings and eliminates unused provisions. New examples and instructions have also been added. However, no change has been made to the occupational adjustments.

For more information on the new schedule contact DWC (415) 975-0700 or e-mail (www.dir.ca.gov)

Oh, My Aching Low Back Guidelines

by DA MacKenzie, MD, FAAOS

The deed is done! That most contentious of California WC treatment guidelines, the low back treatment guideline has been adopted by the State. At the IMC April meeting the vote was a unanimous expression of the full Council: 16-0 in favor. However, do not be deceived by the vote count. This was never a simple nor seamless guideline-writing experience.

The Council struggled through the end of the first quarter of 1997 trying to develop a final version of the treatment guideline which would be acceptable to the main stakeholders in the WC community - payers, providers, and injured workers. Looking over their shoulder were the Legislature and the major players in this community. They were impatient because they had been waiting 2.5 years for this product. On a personal and professional level, I can tell you that it has been an experience.

History

The paper trail, or saga, of IMC's guideline experience began in the 1993-94 legislative session. During that session, the legislature mandated the Council to "adopt guidelines for the treatment of common industrial injuries on or before 1 July 1994" [LC § 139 (e)(8)]. Further instruction advised the Council that, "The guidelines shall reflect practices as generally accepted by the health care community, and shall apply the current standards of care including but not limited to, appropriate and inappropriate diagnostic techniques, treatment modalities, adjunctive modalities, length of treatment and inappropriate specialty referrals".

Concurrently, the Administrative Director was instructed to develop model utilization protocols in order to provide parallel UR standards. Insurers were mandated to comply with this UR protocol by 1 July 1995.

This was obviously a highly specialized complex task for which the Council needed sophisticated assistance. In Fall 1993, the Council initially contracted with UC San Francisco to produce treatment guidelines which were completed in the Spring of 1994. The Council however, had serious concerns with the final product and could not recommend its adoption. Although they were evidence-based on the medical literature, they could not be cross-referenced with the chiropractic and acupuncture literature. The Council's sense was that if the guideline had been adopted "As Is", the Council would have compromised the statutory right of California's injured workers to receive appropriate treatment to 'cure or relieve' from the effects of the work injury (LC § 4600).

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MacKenzie has repeatedly pointed out that this is simply not the case. Under the Scope of Guidelines, the language emphasizes that they are not substitutes for scope of practice or malpractice issues, nor are they intended to replace clinical judgment, he said.

"Our goal from the beginning of this process was to help providers give appropriate care at a reasonable cost Dr. MacKenzie said. "Some may argue the point, but the legislature wanted reasonable parameters and we have accomplished this task".

The Guidelines include 'red flags' in areas where indications may prove to be more of a complex nature. "The red flags are there to advise the physician that there are more serious pathologies. Therefore, the condition would fall outside the treating guidelines and require more extensive diagnostic and treatment considerations", said Dr. Gayle Walsh.

"We feel that the guidelines certainly reflect the passion of the workers compensation community and the council has every reason to be proud of its work", said Dr. Tain.

The sections on tertiary care were removed in earlier versions of the guidelines and may be addressed by the Council in the future.

"The next step in the evolution of this process is to track the practical impact of the guidelines on Utilization Review and how they can best interface with injured workers 'constitutional rights to prompt and proper treatment', MacKenzie said. "This is just a first step. Medicine changes rapidly as new technologies and advancement occur. We will ensure that the guidelines are consistent with this change", he said.

Copies are available for free from the IMC.

IMC To Hold Educational Conference To Help Assist Treating Physicians

The Council has announced that, in lieu of its November monthly meeting, it will hold a one day educational conference for treating physicians on Thursday November 20 to help educate treating physician regarding the many complex issues they confront as they become a more integral part of the compensation system.

It is now accepted that, with the presumption of correctness of the treating physician's report, that the primary treating physician has taken on a critical role in the workers compensation system. Yet most treating physicians have not had much contact with such concepts as subjective factors of disability or work preclusions.

As the medical branch of the Workers' Compensation System, the IMC hopes to fill this void by providing more educational outreach. The Council will conduct the conference in Northern California one day prior to the summit put on by the Commission on Health and Safety in Workers' Compensation to address a RAND study on California's Permanent Disability System.

The Council financially sponsored the study which will include public comment from the workers' compensation community.

The educational conference will

address a variety of issues facing treating physicians including report writing, regulations, utilization review, and treatment guidelines.

For more information call the IMC at (800) 794-6900. Seating will be limited.

Conference Agenda

- ◆ **Segment I : Workers Comp. Fundamentals**
 - Overview of WC Laws
 - Responsibilities of the Primary Treating Physicians
 - Writing Final Disability Reports
- ◆ **Segment II : Case Management Issues**
 - Utilization Review, Disability & Case Mgmt
 - Practice Mgmt Software
- ◆ **Segment III : Treatment Considerations**
 - IMC Treatment Guidelines
 - Appropriate Physical Medicine Referrals
- ◆ **Segment IV : Caveats for Report Writing**
 - Causation/Appointment
 - Sensitizing the Treating Physician to Psychosocial Issues/Confidentiality

IMC Studying Confidentiality Issue

Dr. Robert Larsen has been appointed to chair a subcommittee for the Council to address some of the confidentiality issues raised by the recent *Pettus v Cole* decision (49 Cal. App. 4th 402; 61 CCC 975). In that decision, the court of appeal held that in a non-workers compensation case, the physicians who conducted a psychiatric evaluation of an employee under an employer's disability leave program had violated the employee's right to confidentiality under the Confidentiality in Medical Practices Act (Civil Code § 56 et seq).

The Council's legislative mandate under Labor Code § 139 (e) (1) directs the Council to maintain liaison with the medical, osteopathic, chiropractic, and psychological community. Dr. Larsen notes that since the decision potentially applies to different kinds of cases — not just psychiatric — all physicians should know about *Pettus*.

Dr. Larsen indicated that the role of the committee is not to write regulations or put forth the "definitive instruction" to examining physicians, but he does hope to elicit some ideas from the community and produce something in the way of educational material.

"We don't want to advise physicians how to conduct or not conduct their examinations," he said, "but at the same time, offering practical examples of potential problem areas may help someone along the way."

The Committee will eventually make a full report to the council and possibly add its work to the IMC Physicians' Guide. The Committees' conclusions will also be made available to professional associations, malpractice carriers and other interested parties.

Newsletter Staff

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The Federal Treatment Guidelines

Recall that the Agency for Health Care Policy and Research (AHCPR) established by Congress in 1990, convened panels of experts to create treatment guidelines. The stated reasons for doing this was to reduce treatment uncertainty, eliminate inappropriate choices, and to improve patient outcomes. By the time the AHCPR guidelines were released, the question being asked was whether they should just simply adopt the Federal guideline rather than their own 'home grown'. Easier said than done!

The Council's reservations with the Federal Treatment Guidelines were valid. They were not intended to be used in a Workers' Comp. (WC) setting, they were only meant to deal with acute injuries, and most importantly, they did not consider the variety of physician provider groups already providing treatment under the California Labor Code (LC §4600).

A Fresh Approach

What was the Council to do? After much deliberation, they decided to choose a 'fresh horse'. Cooperative Personnel Services (CPS) of Sacramento had just enjoyed remarkable success in accomplishing the seemingly impossible task of creating and administering a Qualified Medical Evaluator (QME) competency exam in about nine months. Accordingly in Fall 1994, they were chosen to convene consensus panels to "...reflect the practices of the health care community" as per LC §139(e)(8) and to expand the guidelines for current standards of care by grading into four levels of appropriateness.

The significance of this move was two-fold. First, it recognized that it was extremely important that the guideline reflect *all* of the important groups who had been defined as physician and/or provider by the Legislature who were already providing care under the California Labor Code. Secondly, it recognized the philosophical difficulty of grading the evaluation and management components in the guidelines into only 2 levels of appropriateness - appropriate or inappropriate. As Yogi Berra might say - *the art of medicine is not an exact science*.

This avenue also made a significant move away from strict scientifically based evidence guidelines toward guidelines in which there was an increased importance placed upon local consensus from the major provider groups in the WC community. Dr. Richard Deyo, one of the founding fathers of the AHCPR Low Back Guideline, stated at a WC Convention in June 1996 that this appeared to be a reasonable *modus operandi*. Moreover, this was the legislative mandate given to the IMC.

Methodology

Individuals from the WC community were nominated by their professional associations to serve on either the consensus or evidence review panels. The nominees included representatives from all specialties.

The function of the consensus panels was to measure the degree of consensus for the various treatment modalities as described in the proposed IMC document. The Federal guidelines were made an essential reference source and were referred to frequently. The panels rated on a 5 point mapping gradient scale. To facilitate the consensus evaluation process, health care professionals representing the entire spectrum of practitioners and specialists who had 5 or more years of experience treating industrial low back injuries were selected to serve.

The evidence panels were comprised of physicians

with knowledge and expertise in research critique, biostatistics, or epidemiology. The panels evaluated research articles submitted along with the comments to determine the scientific rigor of each reference. The panel then rated these on a 4 point (A-D) scale and delivered their findings to the consensus panels.

The Appropriateness Level Scale

The last CPS consensus panel met to determine the appropriateness levels for each of the low back clusters. The IMC devised a 4 point appropriateness level scale. In response to public comments about some perceived ambiguity in the descriptions of the appropriateness level chart, the IMC modified the wording. The chart explains that a level 4 was the 'gold standard' and implies that there is good research based evidence, good clinical evidence, has the consensus of the health care community and is an appropriate consideration for the management and evaluation of common low back problems.

An appropriateness level 3 does not have good research based evidence but has good clinical evidence, has the consensus of the health care community and was acceptable and appropriate in most cases for the evaluation and management of low back problems.

An appropriateness level 2 has no good research based evidence but does have some clinical evidence, has partial consensus and is 'appropriate in uncommon individual cases'. The user is advised to document the case specific clinical factors or circumstances which make this procedure reasonable and necessary for this injured worker. An appropriateness level 1 is deemed to be inappropriate in the evaluation and management of the low back injury. It has neither research based evidence, clinical evidence nor consensus in the health care community to support it.

The Impact of The Guidelines on The WC Community

The IMC has purposely understated the impact of these guidelines by noting that they are simply a public statement that the California WC Community has joined the rest of North America in the new mentality of the 90's regarding the evaluation and management (E & M) of low back problems.

It is generally conceded that there may well be an increased general compliance by providers, resulting from the knowledge that specific E & M criteria have been set in writing and will be observed by 'someone'. This 'guideline observation effect' could be comparable to the often cited "Hawthorne Effect", noted when a U.S. industrial study of worker performance resulted in a significant increase in worker output presumably resulting from the mere awareness that their performance was being observed and studied.

A constant concern of all the providers involved in the development of the IMC guidelines was - what would the insurers, payers, and third party administration (TPAs) do with IMC's treatment guidelines? Would they, as some suggested, use these guidelines to serve as the sole basis for refusing payment for treatment deemed to be inappropriate?

The IMC tried to counteract this concern by advising that these guidelines were educational and descriptive only and did not purport to be the 'standard of care', and by making the guidelines as clear and unambiguous as possible and finally by carefully crafting provisions for variance from the guidelines.

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Good Faith Personnel Action? Or Bad Faith?

Some Important Points To Keep In Mind With The Medical-Legal Psychiatric Exam

by: Glenn R. Repko, Ph.D.

I. Introduction

When is a personnel action a good faith personnel action and when is personnel action not a good faith action? This is a very important question in the California Workers' Compensation system today because in July 1993, Assembly Bill 119 became law. This article focuses specifically on Section 3208.3(h) which pertains to the subject of a good faith personnel action.

II. The Meaning Of Good Faith

Sections 3208.3(h) reads as follows: *"No compensation shall be paid by an employer if the psychiatric injury was substantially caused by a lawful, nondiscriminatory, good faith personnel action. The burden of proof shall rest with the party asserting the issue.*

This section of the statute was originally created to curb the rampant abuses that were found in post-termination stress claims. Recent statistics have shown a dramatic drop in the number of psychiatric stress cases. However, what was originally conceived of as an attempt to cut down on litigation may, in fact ultimately become the source of almost endless litigation.

The heart of the problem is that the words "good faith" are legal words of art. Psychiatrists and psychologists writing evaluation reports are expected now, in a sense, to become management and human resource specialists. Attorneys representing employees and employers must now become familiar with a whole body of law that pertains to labor law.

The concept of good faith has an intangible and abstract quality. It does not have a single, well defined, absolute definition. There is no statutory definition. Good faith includes among other things: the absence of malice, the absence of design to defraud, the absence of any attempt to seek an unconscionable advantage. Boiled down, good faith means an honest intention to abstain from taking advantage of another person. There must be fair dealing¹.

The question of good faith is ultimately a question of fact and only a Workers' Compensation Judge can make the final determination. But the determination of good faith or lack of it is made on all the facts of the case that form the evidence for the decision.

It has been pointed out that, in arriving at a determination, it is necessary to examine and evaluate the facts and surrounding circumstances that existed prior to the alleged good faith personnel action that is complained about or raised².

There is often no debate about what a personnel action is. An employee promotion is a personnel action. A job transfer is a personnel action. An employee performance review is a personnel action. But what is a "good faith" personnel action? The words personnel action have an objective quality to them, but the words 'good faith' have a subjective quality to them.

It can be argued that there is a point at which a good faith personnel action departs from and goes beyond the realm of good faith. Here the focus becomes the nature of the employer-employee relationship. The subject starts to encompass the area of personality. The issue becomes more about quality rather than quantity. An employer or supervisor may protest that their action or actions were

well intentioned and therefore in good faith, but upon closer scrutiny, the actions may have an unfair or even abusive quality to them. Is the employer or supervisor acting in good faith if they take a harsh approach to the employer-employee relationship?

III. The Notion Of The Simple Versus The Complicated Good Faith Personnel Action

When entering the potential nightmare of the good faith personnel action, it might be helpful to differentiate between a simple and a complicated case. The new legislation has actually functioned quite well in what might be labeled a "simple" case: the personnel action is a singular action, not extensive and not debated in its quality of being administered. If a worker suffers stress from being passed over for a promotion or suffers stress from being transferred to another department or location, the employee may not have a case. These simpler cases might have been picked up and, in fact, promoted or nurtured in the years preceding AB 119 when Workers' Compensation "mills" flourished. But these mills are now defunct and the number of superficial or even bogus cases has dramatically dropped. However, those evaluating physicians doing Workers' Compensation stress cases today, in 1997, will attest to the fact that the cases that are emerging are far from simple and require considerable energies and expertise to handle. These are the "complicated" cases where the complaint in scope goes beyond an isolated action or entails a quality of interaction that questions fairness.

IV. The Supervisor-Supervisee Relationship

This is where many cases involving the issue of good faith emerge. What if the supervisor is rough around the edges? What if they are really not a 'people person'?

A supervisor may be doing their best as they see it in dealing with a supervisee. A well intentioned supervisor may nevertheless come across quite harshly while a specific employee may have personality vulnerabilities. These specific supervisor-supervisee interactions can be viewed as actual employment events that can trigger emotional reactions in people. Poor people skills that lead to negative interactions, particularly when repeated over time, can lead to psychiatric disabling conditions. This is the area where the medical-legal exam becomes extremely important.

One area of work where the supervisor-supervisee interaction is particularly prone to possible difficulty is the area of employee performance evaluations. Care must be exercised by supervisors in the manner in which the evaluations are performed. A recent Wall Street Journal article pointed out how both parties, supervisor and supervisee dislike the process. Annual reviews were viewed by some as a deadly disease. In the Journal survey, less than 10% of persons surveyed judged reviews as effective and 70% of the individuals said they were more confused than enlightened. Fortunately, many companies are becoming aware of the problems and are attempting to overhaul their systems. Performance management businesses are springing up to help companies make these changes.

Nevertheless, the employer-employee relationship
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encompasses all of the interactions between the supervisor and supervisee, and in fact, all of the actions and interactions in the workplace. One often finds that an employee will catalog multiple events in the workplace that led to the filing of the workers' compensation claim.

V. What Should The Evaluator Look For During The Exam?

A. The Extent Of The Complaint

This is a very important consideration. Considering the *extent* of the complaint is in keeping with the notion that determining good faith necessitates the examination and evaluation of the facts and surrounding circumstances that preceded the action in question. An employee may have a negative performance review which precipitates his or her emotional breakdown, but, a careful analysis of the facts of employment preceding the negative performance review may reveal a much more complicated scenario that prevents the use of a good faith personnel action argument. A defense attorney may narrowly focus a negative performance review as the sole source of the employee's problem, despite the fact that some employees have a litany of complaints about their work. These complaints may be verifiable. There may be excessive workloads, long work hours, short staffing, or embarrassments experienced in front of co-workers when criticized publicly.

B. Collateral Information

Another important area is that of additional or collateral information. Good examples of additional information are the investigative report and the personnel file. The investigative report can help verify that an employee may have had significant work-related distress prior to the good faith action in question and other employees may confirm this. Also, when an employee alleges that a particular supervisor is the problem, it may be discovered that, in fact, this particular supervisor has a history of problem interactions with other employees. These sources of the investigative report and personnel file should be made available and should be reviewed before the evaluator renders their final opinion. Careful scrutiny of collateral information allows the evaluator to go beyond the area of self-report on the part of the employee and supervisor.

C. Credibility Of The Employee

Another important area for the evaluator to consider is that of the credibility of the employee. Is the employee a credible individual? Does the employee tend to exaggerate? A thorough clinical interview with supportive psychological testing is invaluable in cases such as these. Other questions the evaluator should consider are: What is the employee's prior work record with the company in question? Have previous performance reviews been favorable or unfavorable?

D. The Personality Of The Employee And Supervisor

The area of personality is also very important. This includes the personality of the employee and by clinical inference the personality of the supervisor. Is the employee overly dependent? Passive-aggressive? Suspicious? Is the supervisor autocratic? Cold? The key of personality analysis often unlocks the most complicated or confusing of cases. Unfortunately, personality clashes are quite common in the workplace. An employee la-

beled as incompetent by a supervisor may not reflect the true or the complete story.

The issue that emerges is: does perception lead to or equal disability. The well known *Albertson's* case and following cases may be applicable here³

But without going too far astray from the good faith issue, it should be said that, though the applicant's perception of the stress is what counts, the perception must be sincere and based on actual events of employment that must be documented in detail in the evaluation report.

VI. Other Important Aspects Of LC Section 3208.3(h)

A. There Must Be A Psychiatric Injury

In some instances, though an employee may be emotionally distressed or disgruntled over a specific personnel action, the distress or anger does not rise to the degree to meet the level of a psychiatric disorder as defined by DSM-IV⁴. DSM-IV has a section that identifies what are called V code conditions where the symptoms do not meet the criteria for a mental disorder. Not uncommonly, a V code diagnosis is appropriate where the employee is upset but the reaction is not in excess of what would be expected given the nature of the stressor.

B. The Psychiatric Injury Must Be Substantially Caused By The Good Faith Personnel Action

The threshold of compensability in establishing the issue of a good faith personnel action is substantial, 35-40%. The 1993 legislation changed the threshold of compensability for psychiatric cases from 10% to predominant, 51%. However, good faith personnel actions, like industrial injuries resulting from violent acts are exceptions to the rule of 51%. In other words there is a lower threshold of causation for good faith cases.

C. The Good Faith Personnel Action Must Be Non-discriminatory

This article has not focused on issues of age, race or sexual discrimination. If discriminatory allegations are made, certainly these allegations should be considered. Nevertheless, employees often complain of being treated unfairly without raising issues of discrimination.

D The Burden Of Proof Rests With The Party Asserting The Issue

It is the employer who has the burden of proof here since the employer will be asserting the good faith issue as a defense against a psychiatric claim. This puts considerable demands on the employer. The entire employee file is important.

Dr. Repko is a QME and serves as a member of the Industrial Medical Council.

References:

1. *Black's Law Dictionary*, 6th Edition.
2. *Doyle v. Gordon*, 158 N.Y.S. 2nd 260.
3. *Albertson's Inc. v. WCAB* (1982) 47CCC 460
4. *Diagnostic and Statistical Manual*, 4th Edition

This article is intended as information to interested parties. It is hoped that this article will stimulate thought and discussion on this important area of the good faith personnel action. Many of the areas covered in this article are debatable areas. At this point in time, there is no solid case law explicating some of these areas.

Continuing Education Providers' List.

- #570 Dean Falltrick, D.C.
5670 Bell Road
(Auburn, CA 95602)
(916) 269-1127
- #580 Industrial Medicine Seminar
330-19th St., # 108
Oakland, CA 94612
(415) 571-8143
- #590 Center For Professional Education
5435 Balboa Blvd, Ste. 214
Encino, CA 91316
(818) 906-9566
- #600 Academy For Chiropractic Education
1310 E. Swain Rd.
Stockton, CA 95210
- #610 American Academy of Physical Medicine & Rehabilitation
One IBM Plaza, Suite 2500
Chicago, IL 60611-3603
(312) 464-9700
- #620 Law Office of Richard L. Montarbo
280 Hemsted Dr., Ste. 110
Redding, CA 96002
(916) 221-6193
- #630 Law Office Of Hanna, Brophy
220 Sansome Street, 6th Floor
San Francisco, CA 94104
(415) 543-9110
- #640 Palmer College Of Chiropractic
90 E. Tasman
San Jose, CA 95134
(408) 944-6000
- #650 California Workers' Compensation Defense Attorneys
Kegel, Tobin & Truce
3580 Wilshire Blvd., Ste 1000
Los Angeles, CA 90010
- #660 State Compensation Insurance Fund
1275 Market Street
San Francisco, CA 94103
(415) 565-1147

Note: CWCI is no longer a provider of QME Continuing Educational credits.

IMC Investigations Unit Targeting Statutory and Regulatory Violations

By Suzanne Marria, Esq.

The IMC Investigations Unit receives and investigates complaints about physicians in the California workers' compensation system. Investigations revealing misconduct by QMEs are referred to the Executive Medical Director or the IMC Discipline Committee. Investigations revealing misconduct by non-QME physicians are referred to the relevant licensing board, prosecutor, Department of Insurance or other state or federal agency with appropriate jurisdiction.

Each complaint received by the IMC is assigned a complaint tracking number and reviewed by the Investigations Unit staff to determine the course of investigation. The type of investigation depends on the nature of the complaint. In some cases, the complainant is interviewed to obtain further information, then a letter is sent to the QME asking for a response to the complaint. In other cases, an in-field investigation is conducted, including witness interviews prior to contacting the QME.

The results of investigations are reviewed by the supervising attorney, Suzanne Marria. The complaining party is advised by letter of the outcome of the investigation. Where the investigation reveals conduct warranting charges to be issued, the matter is then referred to the Executive Medical Director or the IMC Discipline Committee for further action. If charges are issued, the QME is given a hearing. While an investigation is in progress, the information collected is not open to public inspection. Most QMEs respond immediately and cooperatively when contacted by the IMC Investigations Unit staff handling a complaint.

Under Labor Code § 139.2 (m), the IMC must terminate any QME whose license is revoked or terminated by their licensing board. When a QME's license status has changed due to disciplinary action by the physician's licensing board, the IMC Discipline Committee reviews the nature of the license action and recommends action to the full IMC.

The grounds for QME discipline are broad. QMEs may be disciplined for violations of any material statutory or administrative duty as well as a specific types of misconduct.

Types of violations include fraud, credentials fraud, financial conflicts (kickbacks for referrals, tax evasion, unlawful referrals where the physician has a financial interest, altering report results to suit the requester), mistreatment of the injured worker (assaults, battery, sexual assault or harassment), violations of the report writing requirements in Labor Code § 4628, violations of face-to-face time, failure to follow IMC evaluation guidelines, violations of the time limit for serving the completed report, ex parte communications, ethical violations, requiring an injured worker to take unnecessary tests, switching the location of a panel QME evaluation or using a different QME physician in the group from that specified on the panel letter, improper advertising, etc.

Between July 1996 and June 1997, the IMC referred investigations to 6 prosecutors in 6 counties and referred 4 investigations to other agencies with jurisdiction for prosecuting the alleged misconduct.

Investigations Unit staff includes Sr. Special Investigator Thomas Brannon, who has extensive experience in criminal and civil investigations, Associate Medical Director Anne Searcy, M.D., and Workers' Comp. Assistant Evelyn Ramos.

The IMC has taken action against the following QMEs:

Ahmad Javaheri, M.D. (Lic. No. A 0026399) QME status terminated
Lisa Johnson, D.D.S. (Lic. No. 30076) QME status terminated
Steven Scott Herbets, M.D. (Lic. No. G39476) QME status terminated
Roscoe B. Martin, M.D. (Lic. No. A 39017) QME status terminated
Charles Stockton, Ph.D. (Lic. No. PSY 6141) QME status suspended; further action pending
Barry E. Weiner, D.P.M (Lic. No. E-2459) QME status suspended
Byron Ming Chong, M.D. (Lic. No. A 23615) On IMC/QME probation.
Seibert Summer, M.D. (Lic. No. G 16830) On IMC/QME probation
Steven M. Hurd, M.D. (Lic. No. G 41187) Removed orthopedic surgery specialty designation and reclassified as general medical practitioner only; further action pending.

(Treatment....cont'd from p.3)

The Living Document Concept

There are at least three phases involved in preparing treatment or forensic guidelines: development, implementation, and evaluation. If one invokes 'systems theory', the third phase should make provision for a feedback circuit that would stimulate a revision of the guideline to make allowance for mis-assumptions and omissions as well as technical obsolescence and significant new developments.

Along the way to developing its guidelines, the IMC members became convinced of the importance of emphasizing the fact that these guidelines should be 'living documents' and not cast in stone. This became known as the CQI Initiative and represented the fact that each guideline was an opportunity for Continuous Quality Improvement (CQI) and that each guideline would be reviewed as frequently as is necessary and reasonable.

The Council decided that each treatment and forensic guideline would be reviewed at least every 12 to 18 months to keep pace with new developments in the field of medical science. They also declared that each guideline would have a CQI header on the title page of that document to emphasize their collective concern for this concept.

The Standard of Care?

Late in the saga, the IMC was challenged by the California Applicants Attorney Association, the California Medical Association, and the California Association of Neurosurgeons who felt strongly that, from a legal standpoint, that this guideline should not be considered as the unique medical standard of care.

Ultimately, it was recognized that because of the vigorous rulemaking process through which these guidelines had to pass, that they would 'de facto' become regulatory in nature. To prevent these regulations from becoming restrictive, the IMC then defined its treatment guidelines to be 'advisory' regulations. This means that they are not prescriptive regulations. The introduction to each of the guidelines states that they are not intended as the legal standard of care. Thus, it is the Council's intention that these be educational and descriptive guidelines for the large number (122,000) of treating physicians and providers in the WC community.

Finale?

The process is far from over. Once the guidelines are in place the Continuous Quality Improvement (CQI) will begin immediately. Groups who felt disenfranchised by these protocols will be submitting more supportive evidence as it emerges in their specialty in the hope that the guidelines will be modified further. Also, the tertiary care segment of the guidelines needs to be addressed. We expect another mixture of community spirit and contentiousness on this as well. The Council stands ready for these tasks.

The guidelines, of course will be monitored and reviewed as disputes may occur. We will keep you advised as this saga continues. Although the French speaking Normans prevailed at the Battle of Hastings in 1066, France and England have co-existed peacefully for centuries.

We ultimately hope to be as fortunate with these guidelines.



QME → Q & A

We are still receiving questions regarding the treating physician as a result of our article in the previous Newsletters. We have tried to address some of the follow-up questions here.

Q: Is the injured worker a 'party' that can request a medical from a treating physician?

A: Yes. There must be a disputed issue though. The "definitional" problem has always been that there really isn't a disputed claim until after the treater has offered his or her conclusions on the issue.

Q: Are the 45 day status reports billable as separate reports?

A: No they are part of the E & M coding and are included with the office visit.

Q: How does one overcome the treater's presumption of correctness?

A: Although the *Minniear* decision stated that the presumption can only be overcome by specific references to 8 CCR 10606, there is no current appellate court or appeals board *en banc* decision directly on point. However, under a recent decision, a WCAB panel stated that an inaccurate history can overcome the presumption *Gipson v WCAB 61 CCC 1247 (WD 1996)*. This area will certainly be developed by the courts as time goes by.

Q: Can an insurance carrier object to the specialty selected by the unrepresented worker on a panel case.

A. The answer is generally 'no.' However, the carrier may send notice to the IMC whenever the selected specialty is not within the scope of practice for that particular injury (i.e., a podiatrist is selected for a hand injury). The IMC will notify the worker that the specialty is inappropriate and a replacement(s) will be given.

IMC Publications List

The following publications are available from IMC at no charge.

- *The Treating Physicians' Alert*
- *Your Medical Evaluation (English and Spanish)*

• **Treatment Guidelines**

- Low Back Guidelines (8 CCR § 70)
- Neck Guidelines (8 CCR § 71)
- Occupational Asthma (8 CCR § 72)
- Contact Dermatitis (8 CCR § 73)
- Post Traumatic Stress Disorder (8 CCR § 74)
- Shoulder Guidelines (8 CCR § 75)
- Knee Guidelines (8 CCR § 76)
- Elbow Guidelines (8 CCR § 76.5)
- Hand & Wrist Guidelines (8 CCR § 77)

• **Evaluation Guidelines**

- Psychiatric Disability (8 CCR § 43)
- Pulmonary Disability (8 CCR § 44)
- Cardiac Disability (8 CCR § 45)
- Neuromusculoskeletal Disability (8 CCR § 46)
- Immunologic Disability (8 CCR § 47)



Random Notes

❖ The Council has completed its fee schedule meetings on the revisions of the OMFS and the MLFS as requested and made its recommendations to Administrative Director **Casey Young**. The Council wishes to express its appreciation to everyone who contributed their time and effort toward a proposed resolution of many troublesome areas.

Mr. Young has indicated that he will hold public hearings on the fee schedule revisions shortly.

❖ The Council recently finished public hearings regarding changes to the cardio and pulmonary evaluation guidelines. **Dr. Jonathan Ng**, committee chairman, has worked with committee members to update selected portions of the guidelines.

❖ The *IMC Physicians' Guide* is in the final stages of revision and should be available to the public in the Fall. Updates include recent revisions to the Labor Code and the IMC regulations as well as new material on report writing and information for office staff.

❖ **Mr. Richard Sommer** has been elected as Vice-Chair to the Council. The current Executive Committee is now: **Dr. Richard Pitts**, **Dr. Gayle Walsh** Co-Chairs, **Mr. Sommer** Vice-Chair, **Dr. Robert Amster** Secretary.

❖ The Education Committee has begun its review of the course assessment sheets for all continuing



Hot Line

Senior Investigator Tom Brannon works in concert with various law enforcement agencies in the identification of those involved in potential fraud and of QMEs involved in irregularities and/or violations of Labor Code. When information is developed, those investigations are referred to the appropriate authorities, i.e., District Attorney's Office, Department of Insurance, Dept. of Justice, Licensing Board, FBI, and other U.S. Governmental Agencies.

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education courses approved by the Council. The review is to determine whether the current system of continuing education is as effective as it can be made. Course providers are notified to submit all course assessment materials by attendees to the Council as soon as the course has been administered.

❖ Work is continuing on the survey of QME reports both randomly selected from DEU and those alleged to be problem reports by parties before the WCAB. **Dr. Anne Searcy** who is chairing the reviewing team, welcomes reports from parties for the review which will be included in a report to the Administrative Director at the end of the year.

DEPARTMENT OF INDUSTRIAL RELATIONS INDUSTRIAL MEDICAL COUNCIL

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