



Medically Speaking



P O BOX 8888 San Francisco, CA 94128

March 1997

Vol.2 No. 1

Post-Traumatic Stress Disorder Guidelines Adopted

The Council has approved treatment guidelines for post-traumatic stress disorder which establish recommended protocols for psychiatrists and psychologists in treating an emerging common occupational problem. The Guidelines were the product of the Psychiatric Advisory Committee and submitted to the full Council after appropriate public hearings and comment. The Office of Administrative Law approved the Guidelines which became effective February 24, 1997.

The Guidelines state that violent encounters and the threat of violence have become commonplace in the work environment and have resulted in more claims filed before the Appeals Board. Under Labor Code section 3208.3 a claimant must show that an alleged psychiatric injury must be the result of actual events of employment and that these events were the "predominant cause (at least 51 percent) of the injury. However, in cases where the claimant has been directly exposed to a significant violent act, the actual events of employment must constitute a "substantial cause" of the injury.

"Given the unfortunate fact that violence has become an element of many jobs in our society along with the complexity of the psychological factors that are involved in individual cases, we believe that these protocols represent an excellent set of parameters for psychiatrists and psychologists in the critical areas of diagnosis, treatment and clinical intervention." said Dr. Robert Larsen, IMC and committee member.

Both the Guidelines and public comment indicate that early intervention is the key in properly addressing and treating post-traumatic stress disorder. Clinical intervention includes discussion of job accommodations and worksite considerations.

Although other states have enacted treatment guidelines generally dealing with psychiatric injury, Dr. Larsen said the IMC protocols may be the first guidelines to address post-traumatic stress disorder alone and in such detail.

The Guidelines are intended as a resource and not to be substituted for the physician's judgment. The Guidelines also state that treatment authorization or payment for treatment should not be denied based solely upon a provider's failure to adhere to the Guidelines.

The Psychiatric Advisory Committee is comprised of Dr. Larsen, Dr. Glen Repko, also an IMC councilmember, Dr. Jerome Tepperman former IMC councilmember, Dr. Bruce Kaldor, Dr. Roy Curry, Dr. Joel Frank and Dr. Claude Munday.

Copies can be obtained by contacting the IMC.

Council finalizes Guidelines for Knee & Low Back

On February 20th, the Council gave approval to amendments to treatment guidelines for knee and low back problems. The treatment guidelines represent the first of several new guidelines expected to be approved by the Council this year to address common industrial injuries.

They will now be submitted for further public review. Final approval is expected in March.

The guidelines are mandated under Labor Code §139 (e)(8). Work continues on guidelines for the neck, shoulder, hand & wrist, and elbow. Approval is expected within the next few months.

I Declare Under Penalty of Perjury.....I Promise

by David A. Kizer, Esq

OK, so you've finished doing the evaluation of the injured worker. You have reviewed the 12 vertical inches of medical records, personally taken the history, performed the physical examination, taken both active and passive range of motion, dictated the report careful to mention that your nurse took the blood pressure, and, you note that if the report is in the mail by Thursday you will beat the 30 day requirement for service of the report as required by IMC rules. Then you can look forward to an ML 102 provided, of course, someone at a review company doesn't question why you took an additional x-ray when there was a perfectly good one already in the file and therefore you shouldn't be billing for it. And now one last thing - the declaration under penalty of perjury.

Labor Code section 4628 was passed by the legislature in 1989 as part of that first reform act effort. Two things about the section to remember: (1) it applies to physicians - not to non-physicians. A marriage and family counselor cannot violate section 4628 because a MFCC is not a physician as defined under Labor Code section 3209.3; (*Stress Care v WCAB 59 CCC 388 (non pub 1994)*); (2) The main thrust of the statute is the anti-ghost writing language (i.e. no one other than the physician signing the report may do the physical examination). Although there is language in the statute that discusses in detail charges and billings for the physician's services the section is not a fee statute. (*Con't on p. 7*)

D. Allan MacKenzie, MD, FAAOS

EMD Viewpoint

With the turn of the new year we here at the IMC are happy to bring continued progress and good news on several fronts.

First, congratulations to both Dr. Gayle Walsh and Dr. Richard Pitts elected as co-chairs for the coming year and to Dr. Robert Amster who was elected secretary.

Secondly, the OMFS and the MLFS Advisory Committees have been meeting regularly and have scored successes in several areas of dispute. The OMFS Committee has nearly completed its work and should be making several recommendations on the fee schedule which I hope to share with you in the next **Medically Speaking**. The MLFS Committee has also 'closed the gap' on several issues but remains at odds over an increase in the conversion factor. Both providers and payors will submit their points of view, and rationale for same, to Mr. Casey Young for further review.

We have also recently completed and submitted to Mr. Young our first official report on the QME Report Survey which is described below. Dr. Anne Searcy and

staff reported in their findings that there were very few errors that could be called egregious and that most reports contained easily correctible mistakes. Copies of the study are available from the IMC.

You may also have read in this issue that the Office of Administrative Law has approved the Post-Traumatic Stress Disorder Guidelines. The Council has every right to be proud of this work which is intended to assist psychiatrists and psychologists deal with an increasingly important area of occupational illness.

Lastly, the remaining treatment guidelines are beginning to near completion. The low back and knee are in public comment and the Council continues to review comments and amend the neck, elbow, hand and wrist and shoulder. The process has been slow at times, but we believe the final product will fully reflect the general practices in the workers' compensation community. A final reminder. The guidelines are not set in stone. The continuous quality improvement process will begin almost as soon as the guidelines are complete.

QME Satisfaction Survey

by Teidi Lee

We recently sent out a second questionnaire to 974 randomly selected active QMEs asking them to rate IMC on the services we provided. We received 501 surveys back (51% response).

We were pleased to see that 78% of the respondents were satisfied with the quality of the newsletter. We will strive to keep you informed and updated on important issues. A little over half of the respondents, 63%, stated that they are in favor of an IMC-Anonymous Workers Compensation Fraud Hotline. In response to this, we have instituted a toll free number for this purpose. Another item in this newsletter will address the new hotline.

Almost 80% of the respondents were satisfied with the quality of service they have been receiving from the IMC. Our goal is to provide you with the means of becoming an effective QME. If you have any suggestions or comments, please do not wait for a survey to pop in the mail. You may write us at any time.

Again, thank you for taking the time to respond to the survey. You may call us at 1-800-794-6900 at any time if you have other questions or concerns.

First Med-Legal Review Completed

by Anne Searcy, MD

The staff at the IMC started an ongoing project last year to review QME and AME reports that are selected both randomly and those sent to us because of a potential problem. The review consists of a three-tiered system. In the first tier, reports are inspected for twenty five items. The second tier is an in-depth look at the more complicated issues raised in medical legal reports, such as apportionment or permanent disability. The exact criteria for the second level of review may vary slightly depending upon the reason for the review. All the "problem" reports and a portion of the random reports are reviewed in Tier II. The third tier consists of a review to ascertain whether the report complies with the IMC evaluation guidelines for pulmonary, cardiac, psychiatric, immunologic or, in recent reports, neuromuscular problems.

Some of you may have heard from us because we have been writing physicians to inform them of the results of the review. The purpose of the letters generally is educational only. We're trying to let physicians know of their mistakes so that they won't keep repeating the same ones. The intent is not punitive

Reports with potentially serious problems have also been referred to the IMC complaint tracking system. The primary reasons for these referrals have been violations in serving the reports in a timely manner or switching locations or physicians from those named on the panels.

RESULTS OF REVIEW

Five hundred and fifty eight (558) reports have been reviewed to date this far by the IMC staff. The most common mistake was omission of the amount of time that the physician spent face to face with the injured worker. This fact was not mentioned in fifty two percent of the reports. We believe this indicates that evaluating physi-

(Con't on back page)

Newsletter Staff

David A. Kizer, Esq., Editor

Writers: Anne Searcy, M. D., Thomas Brannon, Teidi Lee**Layout & Design:** Jeanne Lum

This newsletter is intended as an informational and educational source for QMEs and interested persons and may be reproduced.

Public Meeting Updates

November 21, 1996
Grosvenor Hotel, SSF

The Council meeting was called to order at 10:10 AM by Chair person, Dr. Richard Pitts.

Treating Physicians: The IMC Future Role

Dr. MacKenzie stated many questions about the IMC's role with issues involving treating physicians have arisen over the past year and Mr. Sommer and Casey Young wished to make a proposal to the Council.

Mr. Sommer stated the IMC has certain statutory mandates to advise the Administrative Director on issues relating to treating physicians, including the fee schedules, but never really took up that role. When the Administrative Director put out the last fee schedules, the payer and provider community questioned why the IMC did not have more input. There have been 18 to 24 advisory task force meetings on the fee schedules this year. The Administrative Director gave the Council full scope to review the fee schedules. Mr. Sommer recommends the IMC take the opportunity to have more control and input in answering questions. The IMC needs to decide who should be involved in answering questions when the fee schedules come out, whether this is an IMC priority and part of its strategic goals.

Mr. Young stated he was lobbied heavily to have the IMC take a greater role in this area. He assumed it included final interpretation of the fee schedules as well. DWC really did not have the resources to handle the fee schedule work. IMC needs to decide if this is a priority and, if so, to commit staff. If not, then whoever hosts the fee schedule advisory committees will have the knowledge to provide interpretations.

Mr. Sommer stated in fairness there is a strategic issue and a resource issue. If the IMC wants to do

it, it needs to give the Executive Medical Director direction by voting whether to continue.

Dr. Walsh expressed concern that while the IMC can advise and recommend changes there is no guarantee those recommendations would be adopted. She asked to see specifics over the IMC's role.

Mr. Young said there are some groundrules; the advisory committees must be open to anybody, all issues must be aired and recorded; unresolved issues can be brought to him and he will resolve them but the more the committee can resolve the better.

Mr. Sommer recommended the discussion be divided: 1) whether the IMC thinks it should do this; 2) logistics of doing it.

Dr. MacKenzie stated there is a philosophical question among the details. This is a magnitude change from 5000 QMEs to a potential 120,000 physicians. The care and feeding of just 51% of the treating physicians will be sizable alone.

Mr. Young noted he had sent a draft interagency agreement addressing some of these issues.

Dr. Goldberg **moved**, Mr. Sommer **seconded** that the IMC supports taking an on-going advisory role with appropriate resource allocation for the Official Medical and the Medical/Legal Fee schedules. **Vote: Motion carried.** Dr. Ng expressed concern that the IMC may be taking on increased responsibilities without increased funding for IMC staff. The draft interagency agreement will be circulated to several Council members by the Executive Medical Director.

Dr. MacKenzie reminded the Council that it still has proposed text on the treatment guidelines for the knee and elbow, and after further work, the shoulder and wrist-related guidelines will also be presented. He asked the Council to review the knee and elbow for adoption at the next meeting.

Adjournment.

ACTIONS TAKEN

(1) The Council reviewed some of the changes to Appropriateness lev-

els in the Low Back Treatment guideline recommended by the Treatment Protocols Committee, affirming some and rejecting others, and decided to continue review of the guideline at the next meeting, Dec. 12, 1996. The Dec. 12th meeting will be scheduled all day.

(2) The Council voted that Ms. Marria prepare a revised draft of the Low Back guideline, which incorporates the changes voted by the IMC and identifies more changes with asterisks. In addition, IMC staff will send this out to all Council members to review and that an ad hoc committee be formed to review the proposed changes and the guideline.

(3) The Post Traumatic Stress Disorder treatment guideline was approved and will be sent out for a 15 day public comment period.

(4) The Council affirmed that the IMC supports taking an on-going advisory role with appropriate resource allocation for the Official Medical and Medical/Legal Fee schedules.

December 12, 1996
Marriott, LA

ACTIONS TAKEN

(1) The Council voted to approve the consent agenda, which included approval of the minutes of the October 1996 and November 1996 meetings.

(2) The Council voted to approve renewal of the course provider status of the I.C.A.C., C.C.A., C.S. I.M.S and DWC for the 2/97 conference. The C.A.A.A. course was approved for a 6 unit course.

(3) The Council voted to adopt a new tabular chart depicting appropriateness levels for the treatment guidelines.

(4) The Council voted to amend the treatment guideline on the elbow to show an appropriateness level of 3 in the secondary phase, and of 2 in the initial phase for acupuncture.

(5) The Council voted to adopt the treatment guidelines for the knee, shoulder, and elbow, as amended.

(6) The Council voted to make changes to the 12/5/96 draft of the low back treatment guideline.

Permanent and Stationary: Easier Done than Said

by D. Allan MacKenzie, MD, FAAOS

In this article I propose to explore one of the more descriptive terms in the California Workers' Compensation (WC) Community - *Permanent and Stationary*. My hope is that Primary Treating Physicians (PTPs) who have been integrated into the system (perhaps against their will) might become more comfortable with this much used and often misunderstood term.

Background and History

In the WC Community, it is understood that the term Permanent and Stationary (P & S) refers to: "the point at which the injured worker's medical condition has resolved or where no further improvement is expected". Historically, the term was first used by California WC Physicians and disability evaluators to imply that the injured worker's physical condition had reached the point where he/she was not going to get much better and had pretty well plateaued. The term is legalistic and used to trigger the idea of disability as we move from the arena of impairment evaluation to disability evaluation.

As discussed in the still relevant case Sweeney v I.A.C. (1951) 16 CCC 265 the Court of Appeal wrote that "... a disability is generally regarded as 'permanent' where further change - for better or worse - is not reasonably to be anticipated under usual medical standards. It may be that no further treatment is possible, or that the only treatment suggested is so problematical of success as to warrant the employee's refusal to undergo it. In such an event, it is permanent within the meaning of the Act (Workers Compensation laws). In practical legal results, the healing period is over and a permanent aftermath of disability exists... Ordinarily the term 'permanent' when applied to a personal injury means 'lasting during the future life of the injured party (citation)."

DWC Regulation (8 CCR §9735) states that *Disability* is considered 'permanent' after the employee has reached *maximum improvement* or his condition has been *stationary for a reasonable period of time*. Everyone has a personal understanding of what a *reasonable period* is, but there does not appear to be one absolute inscribed in stone. In a sense, everyone agrees that everyone else's meaning must be the same as theirs.

Thus, the term permanent and stationary has been understood and accepted by the WC Community and cognoscenti, or inside people for quite some time. For many treating physicians however, the term defies simple description and remains elusive.

The Problem

We recently attended a Commission on Health and Safety and Workers' Compensation (CHSWC) Information Seminar on Improved Communication. There, we learned that P & S is the most misunderstood term in the Workers' Compensation community. One of the attendees concurred and told an apocryphal story in which an injured worker asks his lawyer when he can expect his financial settlement since his provider said that he was P & S. The lawyer replies,

"you'll probably get very little". The injured worker expressed surprise and stated "my doctor says I'm P & S - PAINFUL and SUFFERING. That sounds very serious to me!" There are many similar stories - all allegedly true.

I, personally, am quite concerned by the prospect of confusion amongst primary treating physicians who have not been familiarized and educated with the workers comp 'terms of art', especially permanent and stationary status.

The problem with the term, is that it is vague and was meant primarily for IME's, AME's and QMEs. Most QME's, myself included, take preparatory courses prior to the QME exam. At first, the term P & S was mystifying, however, the concept of P & S was discussed extensively in the prep courses and eventually most QMEs become comfortable with the term. Not all do.

This is important, because since 1994, the Treating Physicians Report is presumed correct and may be submitted into evidence in determining permanent disability. Obviously, the injured worker must reach the point of being P & S to trigger this evaluation.

The Solution

Beyond the borders of California, this 'moment in time' is variably described as the "point of maximum rehabilitation." In California workers compensation parlance, the word rehabilitation has a different connotation and refers to rehabilitation to the same or different employment at the adjusted work level capacity.

The AMA term *maximum medical improvement* is something with which a second year medical student could identify and understand without confusion. When studying pathology, the first clarifying aphorism that medical students learn is: always remember to never say always and never! In other words, avoid the 'absolute' terms always and never. Physicians quickly learn that this is also true in clinical medicine. The difficulty with the concept of P & S is that it smacks of being an absolute that would seldom be completely clinically accurate since the injured workers' medical situation will almost certainly continue to evolve to the point of becoming significantly better - or worse.

The solution to this medical conundrum and legal riddle is that the system simply needs a nexus or an 'end point' which will allow the injured worker's case to proceed forward. Please note that P & S status is not the same as stating that the injured worker is capable of returning to work. Many injured workers can and are released by their physician to return to work prior to becoming P & S (e.g. light duty or shorter work days etc.) The fact that the worker is not receiving temporary partial disability payments is not related to the physician's role in determining medical improvement and also is not to be confused with the fact that further

(Con't on next page)

(Cont' from P & S Easier Done....)

treatment or possibly even surgery may be necessary or may be considered in the future.

The IMC's *California Physicians' Guide* states that a worker's medical condition is considered permanent and stationary after it has medically stabilized, although some slight medical improvement might be anticipated in the future, or, when the condition has been stationary for a 'reasonable period of time'. The Guide goes on to state that, whereas the patient's condition has reached a plateau, some future improvement or deterioration may still occur. The judgment that a condition is permanent and stationary is usually made by the treating physician, but often an evaluating physician's opinion is also sought. Further, the term permanent and stationary implies that the worker *did not* return to the previous pre-injury level of function, and that there are residual effects from the injury. If the PTP determines that the patient has no continuing symptoms, no permanent disability, and is able to return to work with no restrictions or dimin-

ished capacity related to this injury, then the patient should be "discharged as cured," with the comment that the patient "has no new permanent disability".

When the treating physician reports that the worker's condition is permanent and stationary, the employer will likely terminate the worker's temporary disability benefits and begin the process to determine whether the worker is entitled to other benefits including permanent disability benefits. If there remains any question or contention as to whether the injured worker is P & S, a Qualified Medical Evaluator may be called upon to address the issue. Further, if there is a dispute over the continued need for treatment the parties may also utilize the QME process. That, however, is an article for another day.

Finally, it is my pleasure to say that we have received overwhelming positive response to **Medically Speaking** and I encourage each of you to let us know your questions or thoughts as to what issues you would like us to address. This is your publication and we will continue to do our best to serve your needs.

Briefs . . .

The Council has voted to recognize the American Board of Pain Medicine as an approved specialty board for the QME process. The ABPM met the Medical Board's review as 'equivalent' of an ABMS board in December.

The last 12 months have been a pivotal transition period for the IMC investigations Unit. It has progressed from a largely in-take based investigations program to a dynamic in field investigation and complaint tracking program.

Coupled with our investigative unit, IMC established in February a 800 complaint tip hotline (800-999-1041). The hotline allows for messages up to 4 minutes. They may be anonymous or not and details of the complaint are encouraged to allow for proper investigative coverage of the complaint.

QME Pioneers Work on Violence in the Workplace

by Thomas E. Brannon, Senior Special Investigator

If Idle hands are the devil's companion then Thomas D. Harpley, Ph.D certainly had nothing to worry about in the after life. His vision and determination coupled with the foresight to expand his practice set the stage for defusing "violence in the workplace", while founding The National Trauma Services.

Dr. Harpley's educational background reflects a sociology degree as an undergraduate, followed by upper graduate education in counseling and guidance and the completion of his Doctorate in Psychology, Clinical Specialty. He is also a Marriage, Family and Child Counselor.

Dr. Harpley's experience includes the following: Psychotherapy (outpatient and Inpatient), involving individual psychotherapy with adults, children and adolescents. Forensic Evaluations and the completion of literally hundreds of forensic psychological evaluations for the City and County of San Diego and the State of California. Dr. Harpley has also taught for six years in both undergraduate and graduate level psychology courses and human relations at a local university in San Diego and the San Diego Community College Adult Education Program.

Dr. Harpley early on recognized that violence in the workplace was on the increase in the American work-

place. Using that foresight, he formed the National Trauma Services and was one of the first to set up a training program for "Defusing Workplace Violence". Since August 1989, he has served as a consultant to the United States Postal Service, after being called in as part of the Trauma Team, following the Escondido postal shooting.

Dr. Harpley's studies for the National Trauma Services indicate that during a one year period, more than 2 million Americans were physically attacked, another 6 million were threatened, and 16 million were harassed, at work. Homicide is the second leading cause of occupational injury death. Seventeen percent of all occupational injury deaths, and forty percent of all females who die due to workplace violence, are the result of homicide.

We here at IMC salute Dr. Harpley who has the foresight, experience, and fortitude to assist mankind in the resolution of the problems affecting all of our daily lives. Continuing our practice of recognizing those with unique backgrounds while serving the worker's compensation community with distinction it is our pleasure to recognize Dr. Harpley. His background, dedication, service and integrity merit his recognition as our QME candidate in this newsletter.

INDUSTRIAL MEDICAL COUNCIL

The following providers are currently approved to provide CME credit for QMEs. QMEs must complete 12 credit hours during their 24 month term of appointment. *The IMC does not endorse individual courses. All QMEs should consult colleagues and contact the providers directly for more information.*

- | | | |
|---|---|---|
| <p>#100 - California Orthopaedic Assoc (COA) - Diane M. Przepiorski
5380 Elvas Ave., #221
Sacramento, CA 95819
(916) 454-9884</p> | <p>#230 Division of Workers' Compensation - Bob C. Wong, Manager
45 Fremont St., Ste. 3160
San Francisco, CA 94105
(451) 975-0700</p> | <p>#380 Academy of Forensic & Ind Chiropractic Consultants
Gary Miller
1115 Geary Blvd.
San Francisco, CA 94109
(415) 563-1888</p> |
| <p>#110 - California Chiropractic Assoc (CCA) - Craig S. Little, DC
7801 Folsom Blvd., #375
Sacramento, CA 95826
(916) 387-0177</p> | <p>#240 Newton Medical Group
Shawn M. King
1700 California St., #300
San Francisco, CA 94109
(415) 775-0122</p> | <p>#390** Learning Edge, Inc.
11260 Wilbur Ave., #102
Northridge, CA 91326
(818) 363-3088</p> |
| <p>#120** David W. O'Brien
Attorney at Law
P.O. Box 3509
Covina, CA 91722
(909) 585-7101</p> | <p>#250 Westwood Seminars
Mark L. Freifeld, President
17200 Ventura Blvd., #117
Encino, CA 91316
(818) 501-0104</p> | <p>#400 Physician Case Management (PCM) - Bob Chase
1020 29th St., #360
Sacramento, CA 95816
(916) 733-8264</p> |
| <p>#130 Medical Management Institute (MMI) - Richard T. Unitan
4050 Katella Ave., #208
Los Alamitos, CA 90720
(310) 795-5678</p> | <p>#270 Int'l Chiropractors Assoc of CA (ICAC) - Eric Banta, Exec. Dir.
9700 Business Park Dr., #406
Sacramento, CA 95827
(916) 362-8816</p> | <p>#410 Michael M. Bronshvag, M.D., Inc./Neuro-Musculo-Skeletal System - Jeanney Lerner
7595 Redwood Blvd., #108
Novato, CA 94945
(415) 464-0373</p> |
| <p>#140** California Society of Industrial Med & Surg. (CSIMS)
Nettie Duyanovich
100 Q Street, #201
Sacramento, CA 95814
(916) 446-4199</p> | <p>#280 Comp-Pro Seminars, Inc.
Scotty Brody
171 Pier Ave., #325
Santa Monica, CA 90405
(310) 822-7471</p> | <p>#420 U C Ctr for Occptl & Envmtl Health - Linda Ellwood
1301 South 46th St., Bldg. 102
Richmond, CA 94804
(510) 231-5645</p> |
| <p>#160 California Applicant's Atty Assoc. (CAAA) - Julie Chavez
801 12th Street
Sacramento, CA 95814
(916) 444-5155</p> | <p>#290 UCSD Orthomed
Kerri Kazala
4150 Regents Park Row
La Jolla, CA 92037
(619) 625-0084</p> | <p>#430 University of California-SF
Warren M. Gold, MD
505 Parnassus Ave., Box 0130
San Francisco, CA 94143
(415) 476-2092</p> |
| <p>#180** California Compensation Seminars - Sheldon C. St. Clair
P.O. Box 280552
Northridge, CA 91328
(818) 349-7853</p> | <p>#310 Comp Rite - Linda Frappia
540 Golden Circle, #210
Santa Ana, CA 92705
(714) 547-5460</p> | <p>#440** CompSense - Beverly Dixon
P.O. Box 178811
San Diego, CA 92177
(619) 899-2382</p> |
| <p>#190 Enviromed Health Services, Inc. - Ilene R. Danse, MD
18 Professional Center Park Way
San Rafael, CA 94903
(415) 472-2783</p> | <p>#330 American Academy of Disability Evaluating Physicians
Sandra L. Yost
150 North Wacker Dr., #920
Chicago, Illinois 60606
(800) 456-6095</p> | <p>#450 Calif Society of PM & R
David Bradshaw, MD
19830 Lake Chabot, C
Castro Valley, CA 94546
(510) 537-7873</p> |
| <p>#210 Los Angeles College of Chiropractic - Rita M. Pierce
16200 East Amber Way Valley Dr
Whittier, CA 90609
(310) 947-8755</p> | <p>#340 Western Occpt'l Health Conference - Carol Parlette, MPH
74 New Montgomery, #230
San Francisco, CA 94105
(415) 764-4803</p> | <p>#460 DIR/Commission. of Health & Safety & Workers' Comp. (CHSWC) - Christine Baker
30 Van Ness Ave., Rm. 2122
San Francisco, CA 94102
(415) 557-1304</p> |
| <p>#220 Lerner Education
Fred N. Lerner, DC, PhD
9911 West Pico Blvd., #1240
Los Angeles, CA 90035
(800) 838-8584</p> | <p>** Audio/A-V/or software course available</p> | |

(Con't on p. 7)

INDUSTRIAL MEDICAL COUNCIL

(I Declare under Penalty. . .)

You are still bound by official medical-legal fee schedule in all matters related to billings for med-legal reports (*Ameri-Medical Corp. v WCAB 24 CWCR 41 1996*).

Always remember to list the names of any person who performs diagnostic testing with respect to your medical-legal reports. Failure to do this may result in the report being ruled inadmissible, your bill not being paid and you potentially being held in contempt by the Appeals Board (*Wilson v WCAB 58 CCC 784 (WD 1993)*). If the employer/carrier does not object to the omission in a timely manner then the objection may be waived but it's advisable to avoid hoping for this result by just listing the names (*LA Times v WCAB 22 CWCR 4 (non-pub 1994)*).

Also, you must list any physician not employed by the physician (independent contractors) who performed non-treatment related services (i.e. med-legal) and how much they were paid (§4628(i)).

As long as §4628 is complied with, the fact that your medical group is doing the billing (but you are the physician signing the report) is OK. Many physicians groups have Fictitious Business Names on file under Bus & Prof Code 2415 (Business & Prof Code section 2285). Labor Code section 4628 addresses who is doing the exam and signing the report - *not* who is doing the billing. (See *Nat. Union Fire Ins. Co. v WCAB 60 CCC 235 (WD 1995)* and *Chavez v Fremont Comp 22 CWCR 119 (1994)*).

A declaration that includes all required information may look something like this:

On (date), I ___ personally examined (injured worker) at my office located at _____. (The worker's) blood pressure; weight, measurements etc. were taken by (nurse's name). I reviewed all medical records as detailed in this report and personally took the history from the injured worker. I spent one hour of actual face-face time with the injured worker during the examination phase. I composed and drafted the conclusions of this report. I have not violated the provisions of Labor Code section 139.3 and the contents of the report and the bill(s) are true and correct to the best of my

knowledge. This statement is made under penalty of perjury as ascribed below.

After Sept. 30, 1992, the following paragraph is always required.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and, except as noted herein, that I believe it to be true.

Dated this ___ day of 1997, in the county of _____. Original Signature.

There you have it. Three declarations under penalty of perjury, date and location of the exam, date and location of signing the report, face to face time and mention of others assisting in the exam process.

Note that failure to comply with Section 4628 by minor omission will not necessarily end your career or kill the report. WCAB rule 10634 provides that failure to comply with Section 4628 shall not make the report inadmissible or non-payable where 'good cause' has been shown

for non-compliance, and after notice to the physician, compliance takes place immediately or when the judge requests. Usually, these instances involve forgetting to sign the declaration or someone simply forgot to staple it to the report.

One last item. Keep all billings organized. Labor Code section 5703 states that no *bill* will be received into evidence by the Appeals Board unless the *billings* are accompanied by a statement under - what else? - penalty of perjury that the billing is true and correct. In most cases the report and the bill are attached together so this isn't a problem, but sometimes services may occur later. Thus, a straggling bill without the required declaration will probably not get paid later on a lien basis.

Thus, in filing liens, you need the following: cover letter, DWC Form 6 (green), a copy of the report with the declaration, a copy of the bill with the declaration, proof of service and, depending on DOI, DWC claim form or declaration under penalty of perjury of efforts to obtain the claim form (see WCAB Rule 10770 and Physician's Guide, Chapter 8).

(Con't from p. 6 - Providers List)

#470 Livingstone-Lopez Consulting
Dana Livingstone-Lopez
132 N. El Camino Real, #265
Encinitas, CA 92024
(619) 994-6769

#480 Osteopathic Physicians & Surgeons of CA (OPSC)
Matt Weyuker
455 Captiol Mall, Ste. 230
Sacramento, CA 95814
(916) 447-2004

#490 Glenn A. Ocker, DPM
1148 San Bernardino Rd., Ste. C-1
Upland, CA 91786
(909) 985-1831

#500 Adam Duhan, MD
1498 Solano Ave.
Albany, CA 94706
(510) 524-1680

#510 Ronald A. Bortman, MD
400 Twenty Ninth St., Ste. 512
Oakland, CA 94603
(510) 231-8923

#520 Insurance Educational Association (IEA) - Martha Cockrell
1201 Dove St., Ste. 570
Newport Beach, CA 92660
(800) 655-4432

#530 CA Workers' Comp. Institute (CWCI) - Rea B. Crane, RN
120 Montgomery Street
San Francisco, CA 94104
(415) 981-2107

#540 Industrial Claims Assoc. (ICA)
Francie R. Lehmer, Esq.
180 Montgomery St., Ste. 880
San Francisco, CA 94104
(415) 986-2011

#550 Parkside Acupuncture
Jeffery Lee, LAc
2526 32nd Ave.
San Francisco, CA 94116
(415) 665-7682

#560 St. Francis Memorial Hospital
Gary Chan, MD
900 Hyde Street
San Francisco, CA 94109
(415) 353-6000

(Con't from Med-Legal Review)

Q: Can a final treating visit resulting in a P & S report just be scheduled and billed as a med-legal?

A: No. A treater is *required* to complete a final P & S report. You can't just bill as a med-legal even if you've put a lot of thought and effort into the report. Under the regulations, the report must meet the definition of a med-legal before being billed as such. (ADR § 9785.5 (f)). The definitional problem is that there must be a "disputed claim" involved and in the majority of accepted claims there is none. However, something in dispute often can turn out to be something that the parties originally thought was no problem but is about to become one. If the treater's report settles these issues to the parties satisfaction the report might be paid as ML by the defense. After all, if the case settles on the treater's report, the carrier automatically avoids the additional expenses (both legal and med-legal) involved in the QME process.

Physicians are not aware of this requirement.

In Tier I, the next most frequent mistakes was omission of the entire mandatory declaration "I declare under the penalty of perjury...", the county where the declaration was made, or a statement about not violating Labor Code 139.3. Each of these errors occurred in approximately 17% of the reports.

Non-random reports were more likely to have specific patterns of mistakes than the random reports.

These "problem" reports were much more likely to not include a diagnosis, permanent and stationary status, objective/subjective factors or work restrictions. They were also more likely to have not been submitted in a timely manner.

Approximately ten percent of the random reports had no mistakes. A letter was sent to these physicians to inform them that their report passed the audit.

The most common (27% of the reports) mistake in the Tier II review was failure to make work re-

strictions applicable to the open job market. The next most common mistake was to not include a thorough physical examination as required by the IMC Guidelines or by Packard Thurber. An example of this problem is not including grip strength in upper extremity injuries.

The "problem" reports had a much higher rate of error in Tier II. Forty one percent had mistakes in subjective factors, 33% in objective factors, and 33% in work restrictions.

Relatively few reports have been eligible for review in Tier III. In general, the reports have complied with the IMC evaluation guidelines, but the numbers are too small for adequate reporting at this time.

We plan to continue informing physicians of the results of our review through letters to individual physicians and through means such as this article. We expect the errors of omission to decrease over the next year. We'll also look at some of the topics in more depth in the future in this publication.

**DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL MEDICAL COUNCIL**

PO BOX 8888
SAN FRANCISCO, CA 94128-8888