MEDICAL TREATMENT FOR THE INJURED WORKER

History

Prior to the legislative reform of 5/18/92, employees had complete choice of physician, treatment, and treatment facility. It was often jokingly suggested that an injured worker would go to one provider to get better and then switch to another to remain on compensation. There was no oversight of the treating physicians and no limit on billing. Thus, medical expenses were out of control, and disability costs climbed exponentially.

In 1992, the General Assembly established the Medical Advisory Board (MAB) to provide guidance, treatment standards, and policy formulation for the Workers' Compensation system, and placed it under the jurisdiction of the Workers' Compensation Court.

R.I.G.L. 28-30-22 created the Medical Advisory Board charged with the duty to address medical disputes and charges of improper or unethical conduct by medical care providers. The MAB consists of eleven members from eight (8) different areas of specialization. The MAB is appointed by the Chief Judge of the Workers' Compensation Court and the members serve at his or her pleasure.

Standard for Review of Medical Evidence

One of the MAB's first functions was to designate a standard for review of medical evidence for use by the Court.

In creating the standard, the Board noted the distinction between objective findings and subjective complaints made by the insured worker.

Objective Findings

While demonstrable, reproducible evidence confirmed by objective testing (EMG, X-Ray, MRI, etc.) is perhaps the most reliable form of an objective finding, the clinical examination of the medical provider also provides a solid basis for objective findings. Clinical findings such as swelling or contusion are direct evidence of an injury and must be given credence.

Subjective Findings

Subjective findings such as spasm, restricted movement, and numbness are considered reliable findings when a physician observes them during examination. Limitation of motion is somewhat less reliable than the other subjective findings because the physician must rely upon the complaints of the employee rather than the physician being able to validate by observation during exam. A claim of limited motion can be validated, however, by a physician during exam.

It must also be realized that numerous valid tests combine subjective and objective components. While a complaint of discomfort or numbness is based on the subjective perception of the patient, its correlation to a particular function or nerve distribution makes it a valuable tool in diagnosing an injury and assessing impairment.

In addition, subjective complaints, even in the absence of demonstrable objective testing, can provide an insight into assessing disability. A patient may present with numerous subjective complaints following a trauma indicating the body's work to heal itself.

The standard goes on to note that the validity of subjective complaints may diminish with the passage of time. "It should be noted, however, that injuries presenting claims of disability in excess of thirty (30) days should manifest themselves in some objective findings. Subjective complaints which persist beyond thirty (30) days without supporting objective findings that correlate with the subjective complaints should be disregarded" (W.C.C. Court Order of 8/05/92). Nothing herein should prevent an earlier determination by a physician or interfere with medical protocols developed by the Board.

Finally, it must be remembered that certain testing is available to assess the physical basis for a patient's continued subjective complaints. Complaints of pain not correlated with a specific anatomical position or nerve distribution raise the issue of a non-organic basis for the patient's complaints of pain. Such complaints may be due to a genuine psychological problem resulting in real disability or may be due to malingering or other secondary gain factors. In order to properly evaluate this question, the credibility of the patient is of paramount importance, and the patient's work and social history must be considered.

This standard has been adopted by the Court, and serves as a benchmark for it.

Where the employee's testimony is dismissed by the trial judge as lacking in credibility, the Court is not required to accept an expert's opinion or causal relationship because it is based upon a history found to be unreliable. In such circumstances, the expert's opinion is deemed incompetent Lafazia v Canada Dry Corporation 99 RI 9, 205 A.2d 16 (1964), Mazzarella v ITT Royal Electric Division 120 RI 333, 388 A.2d 4 (1978).

In Jessica A. Seale v. Oakland Grove Health Center W.C.C. 2000-01099 (App. Div. Sept, 2006), the Appellate Division sustained the trial judge's decision that the employee's testimony lacked credibility, and reiterated the line of cases which have consistently held that "[if] the history given to a physician is rejected as lacking in credibility or accuracy, the court is free to reject the medical opinions of the physician as incompetent due to inadequate or tainted foundation."

Medical Treatment Protocols

R.I.G.L. 28-33-6

As noted earlier, prior to the creation of the Medical Advisory Board, medical expenses had reached critical mass. The legislature had adopted several different fee schedules in an effort to limit the amount a healthcare provider could charge per treatment. The efforts were a series of abysmal failures. Each fee schedule attempted to impose a maximum

limit on the amount a healthcare provider could charge for a particular treatment or modality. However, it did nothing to address whether the treatment was necessary or the frequency of the treatment was excessive.

With the creation of the Board, a new approach was adopted; the focus of the Board was to craft treatment guidelines for the most common compensable injuries. The protocols for the treatment of compensable injuries are available from the Workers' Compensation Court and online at:

http://www.Courts.RI.Gov/Courts/WorkersCompensationCourt/MedicalAdvisoryBoard/Pages/Protocols.aspx

The Protocols are regularly reviewed and modified to be sure that the treatment guidelines remain current. The treatment guides have some built-in flexibility for particular case situations, providing room for aggressive treatment when necessary. An important aspect to note is that protocols address the timing and use of expensive diagnostics, depending on the injury. If a healthcare provider demonstrates a pattern of unnecessary, inappropriate or excessive treatment, he or she will be subject to discipline by the Medical Advisory Board.

Discipline of Healthcare Providers

The MAB is also charged with the discipline and disqualification of any healthcare provider who is found to consistently violate the medical protocols, to provide unnecessary or inappropriate treatment, or to file an untimely or untruthful affidavit. If a medical care provider is found to be subject to discipline, such provider will not be permitted to recover any costs or fees for treatment of compensable injuries.

Disciplinary proceedings are initially heard by the Medical Advisory Board. Any appeal of the Board's determination is heard by the Workers' Compensation Court which reviews the record to ensure that there was sufficient evidence to support the Board's findings and that the correct law was applied Workers' Compensation Court R.P. 2.31.

Palliative Care Defined

R.I.G.L. 28-33-10

The MAB was also given the task of defining palliative care and developing protocols for the provision of palliative care. Such care will be viewed as medical maintenance or medical services designed to relieve symptoms but not intended to cure or rehabilitate the employee. Palliative care is limited to a maximum of 12 visits or 60 days. Additional palliative care must be approved by the employer.

Palliative care can be considered the treatment provided after a judgment of M.M.I.. The Medical Advisory Board stated: "In some patients, response to treatment will be less than total and a point of M.M.I. will be reached. At this point, active diagnostic and therapeutic measures have failed to totally relieve the worker's condition, a presumption is made that active measures are unlikely to totally relieve the worker's problem."

Palliative care will include: 1) Infrequent re-examination of the injured worker to prevent further deterioration of his condition, if necessary; 2) Follow-up of patients requiring specific medications, for example, continuing control of post-traumatic convulsive seizures, etc.

Palliative care will not include extensive diagnostic tests, comprehensive treatment programs, or frequent services of any type. It is understood that palliative care will be unnecessary in most patients who complete a course of active treatment. If, however, follow-up care is required, the treating physician will need to submit a plan to the insurer for approval that describes the nature and frequency of examinations required and the estimated duration that such follow-up care will be necessary.

Implementation of Medical Fee Schedule R.I.G.L. 28-33-7

The reasonable cost for healthcare provider's services is determined by the Workers' Compensation Fee Schedule. In the past, the legislature attempted to limit medical expenses in compensation cases by artificially reducing the amount a provider could charge for a treatment or modality. This tactic achieved two results: (1) many highly respected providers refused to handle workers' compensation cases because the demands were so high and the recompense so low and (2) some providers would bill according to the fee schedule, but would treat excessively. The system ultimately collapsed under its own weight.

The current fee schedule is a prevailing rate schedule which compensates providers based upon the current charges in the community. The schedule is published by the Director of Department of Labor and Training utilizing the Physician's Current Procedure Terminology (CPT) coding system as published by the American Medical Association. The control of the expense of the system is exercised through the protocols to ensure that treatment is reasonable and necessary.

R.I.G.L. 28-33-7 allows for reimbursement to healthcare providers according to a medical fee schedule established by the Director of Labor and Training. The new fee schedule provides for the reimbursement of healthcare providers at the ninetieth (90) percentile of the usual and customary fees charged for each service by healthcare providers in the State of Rhode Island. If payment is made in accordance with the fee schedule, the burden is on the physician seeking any payment in excess of the schedule to establish that the rate is unreasonable in light of the peculiar nature of the services performed or other factors requiring greater than normal expenditures of time. In the absence of such proof, the fee schedule is presumed to be binding.

Austin v. The Providence Journal, W.C.C. Nos. 2005-03305; 2005-03304; 2005-03301; 2005-03286; 2005-03285; 2005-03284; 2005-03283 (App. Div. 03/20/08). A treating physician filed consolidated petitions to review alleging that the employer had failed to pay medical expenses in accordance with the Act. The trial court determined that the employer had paid the medical charges in accordance with the law and rejected the

petitions. The Appellate Division sustained the trial decision and held that the employer had the right to rely upon the contents of the medical reports in determining the appropriate level of reimbursement in accordance with the AMA's CPT guidelines. If the treating physician encountered extraordinary circumstances which required additional time or resources but did not include them the report, he or she could not expect to be paid at a higher level of reimbursement for the services.

Employee's Choice of Physician & Physician Reporting Schedule

R.I.G.L. 28-33-8

This section has a significant effect on the employee's choice of a treating physician as well as on the physician's duty to report on treatment and progress. Under the terms of this section, the employee retains the right to initially choose a healthcare provider and may be referred by the initial provider for consultation, assessment or specific treatment without prior approval. If the employee seeks to switch from the initial physician and the employer has established a preferred provider network (PPN), the employee may only switch to a healthcare provider within the network. If the employee prefers a physician outside of the PPN, he or she may submit a request to the insurer for approval.

A separate preferred provider network must be submitted for each self-insured employer or insurer, and each submittal is subject to approval by the MAB. The MAB looks at the following in determining whether or not to approve a PPN:

a) The demographics of the employees;
b) The types and frequency of the injuries sustained;
c) The number and specialty of physicians in the network to be sure that employees would have a realistic choice within each specialty.

R.I.G.L. 28-33-8 also discusses what constitutes an initial choice of a treating physician. The statute specifically exempts initial treatment at an emergency room or by a physician under contract with the employer from consideration as a first choice of treating physician by the employee.

This section of the law also establishes a strict reporting schedule for treating physicians, and mandates the information which the treating physician must supply in order to obtain payment for services rendered. The Workers' Compensation Act requires the treating physician to submit a notice of compensable injury on a form, approved by the administrator of the MAB, as well as a notice of release within three (3) days of the employee's discharge to return to work or recovery from the injury. The healthcare provider is entitled to charge a twenty dollar ($20) fee for completion of these forms.

The treating physician is also required to submit an affidavit at 6 weeks from the date of injury and, thereafter, every 12 weeks until the employee has reached the point of maximum medical improvement. The affidavit must set forth:

a) The nature of the injury
b) The nature of the treatment being given
c) Anticipated future treatment
d) The employee's work ability

e) Any financial interest which the treating physician may have in any facility providing ancillary services (e.g. laboratory, radiology, pharmacy or physical therapy).

The treating physician may charge twenty dollars ($20) for the completion of this affidavit. In addition to the fees which may be charged by the treating health care provider, the Workers' Compensation Act also imposes sanctions for failure to submit the necessary reports. The failure to submit the 6 week affidavit within 1 week of the time it is due can more significantly result in a 10% discount on the bill submitted with the affidavit. The Act maintains the prior penalty against the physician who fails to notify the employer or insurer of the employee's choice of treating physician within 15 days of the date on which treatment was commenced.

In such cases, the treating physician forfeits the right to be paid for any services rendered, and may not pursue a claim against the employer, insurer, **or the injured employee**. Note, if an injured employee is treating with an out-of-state medical service provider, the R.I. Workers' Compensation Court considers that medical service provider to be bound by the provisions of the R.I. Workers' Compensation Act.

Medical Opinion - Loss of Use/Maximum Medical Improvement

R.I.G.L. 28-33-8(e)(3) establishes the responsibility of the employer or insurer for charges for opinions on loss of use and maximum medical improvement by employee physicians.

Reimbursement of Employees for Medical/Rehabilitation Travel

Employee transportation costs will be paid when an impartial medical examination has been ordered by the Court, a medical examination has been requested by the employer or the travel is incurred as part of a rehabilitation plan approved by the Director of the Department of Labor and Training pursuant to R.I.G.L. 28-33-41. See Joseph Caldeira v. Majestic Motors, W.C.C. 2000-00150, Appellate Division.

IMPARTIAL MEDICAL EXAMINERS

R.I.G.L. 28-33-35

This section expands the panel of impartial medical examiners to include a comprehensive healthcare review team. The review team is a multidisciplinary group of healthcare providers which may be appointed by the Court in cases involving complex medical and rehabilitation issues.

The section also imposes a burden on any party who wishes to contest the findings of the impartial examiner by requiring it to file a notice of contest within ten (10) days. In addition, the party must pay the fees incurred in obtaining the testimony of the impartial examiner with the provision that, if the employee prevails, any fees paid may be reimbursed as costs. If no notice of contest is filed within ten (10) days, the findings contained in the report of the impartial examiner become final and binding.

The impartial examiner must provide a report of the evaluation within fourteen (14) days, and the report must address the employee's degree of disability, the propriety of the treatment being rendered, anticipated future treatment and the expected date of M.M.I.. This report is submitted to the Administrator of the MAB who, in turn, forwards the report to the employee, employer and insurer.

In conjunction with the periodic medical review, the Workers' Compensation Court is also available to conduct an anniversary review in all cases where the employee is collecting disability benefits fifty-two (52) weeks after the compensable injury. The employer must file a petition for an anniversary review to be scheduled by the Court, and, if the petition is not filed, it is considered to be waived by the employer.

REHABILITATION

Recently, there has been a greater focus on rehabilitation to assist an employee to regain lost earnings capacity. R.I.G.L. 28-33-41 was promulgated to assist the rehabilitation of injured employees. It defines rehabilitation as "the prompt provision of appropriate services to assist an employee... to his or her optimum physical, mental, vocational and economic usefulness." The objective of the plan must be to assist the injured worker to regain the earning capacity at the time of the injury.

Where the employee has undergone physical rehabilitation, the provider must establish the employee's degree of functional impairment. The employee must then be referred to the Court for an earnings capacity adjustment.

Although this provision will ultimately result in a reduction of the employee's weekly benefits, it should also facilitate the employee's approval for rehabilitation. Previously, employers were reluctant to voluntarily agree to a rehabilitation program because there was no reliable means of ensuring that the employee would return to work upon completion of the program. Since this section now provides for a benefit reduction at the end thereof, voluntary approval of the program should be given more freely by employers.

Pursuant to R.I.G.L. 28-33-41, the employer shall bear the expense of rehabilitative services agreed to or ordered pursuant to this section.

In the case of John Panciotti v. R. Martin & Sons , W.C.C. 2004-02437 (January, 2006), an employee's petition to review seeking reimbursement of educational expenses was denied by the trial court on the grounds that the employee had failed to obtain approval of

the rehabilitation plan before incurring expenses. The Appellate Division discussed the evolution of the statute, and sustained the decision of the trial judge on the grounds that the provisions of R.I.G.L. 28-33-41 require either approval of a rehabilitation plan between the parties or a court order approving a proposed rehabilitation plan as a precondition to obtaining payment for rehabilitation services.