"How To Get Medical Bills Paid"

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I - "How to Get Medical Bills Paid"

An Overview

The topic assigned could easily be covered thoroughly in a short article and lecture lasting no more than twenty minutes. However, the problem of "getting medical bills paid" exists in the broader context of a benefit system which is increasingly being administered by national insurers and servicing agents utilizing the same managed care practices and methodologies which are being applied in other health care delivery systems. In Georgia's workers' compensation system, those practices and methodologies interfere with a medical benefit delivery system which was statutorily designed to cloak a treating physician with the status of "authorized treating physician" and to empower that physician to provide treatment, to ". . . arrange for any consultation, referral, and extraordinary or other specialized medical services as the nature of the injury shall require, without prior authorization . . . ."[1]

II – The Topic in a Broader Context (Medical Services Must First Be Delivered)

The broader focus and objective of this paper and presentation will be to enable readers to understand where we are now, how we got here and to recognize which emerging claims handling practices and methodologies might actually accomplish cost containment and which interfere with access to and impede the delivery of qualify medical care without demonstrating any measurable cost savings.

III - A Brief History of Medical Care Delivery in Georgia Workers' Compensation

In 1920, when Georgia's first workers' compensation statute was enacted, the legislature required that employers furnish, 'and that employees shall accept', necessary medical treatment as the nature of the accident may require free of charge but only for a period not to exceed 30 days with a maximum cost limitation per claim of $100.00. However, recognizing that disability and the need of treatment might continue past 30 days, an additional provision was included which permitted an employer "at the [sole] option of the employer" to continue to provide such treatment during the whole or any part of the remaining disability:

> ". . . as may be deemed necessary by said attending physician or the industrial commission."

Section 63 of this same original statute provided that:

> ". . . fees of attorneys and physicians and charges of hospital for service under this act shall be reasonable and measured according to the employee's station and shall be subject to the approval of the commission." (emphasis added)

Section 63 of the 1920 Act appears to be a progenitor of both present O.C.G.A. §§ 34-9-203(a) and 34-9-205(a).[2] Thus, it is obvious that from the very inception of workers' compensation in this State, the legislature declined to give employers any right to interfere with, delay or dispute the necessity of medical service, reserving the question of necessity of services to the industrial commission or the "attending physician." Even though the 1920 Act made post 30 day treatment optional to the employer; even when the employer chose to provide the optional treatment, the employer was still forbidden from interfering

in the treatment plan ". . . deemed necessary by said attending physician or the industrial commission."

This policy, as expressed in The Act, was and remains the clear intent of the legislature since 1920 and particularly since 1978 during the five revisions resulting in present O.C.G.A. Title 34-9-200 in which, *inter alia*, the maximum "cap" on medical care costs that an employer was required to pay per claim was periodically increased.[3]

STATUTORY EVOLUTION OF GEORGIA'S MEDICAL TREATMENT PROVISIONS		
YEAR	MAXIMUM ALLOWED EXPENDITURE "CAP"	DURATION OF EMPLOYER'S FINANCIAL OBLIGATION
1920	$100.00 (no exceptions)	30 days + additional unspecified period solely at employer's option but not to extend beyond exhaustion of "cap"
1937	$500.00 (no exceptions)	10 weeks + such additional period of time as would permit the expenditure of the full $500.00 if not exhausted during the initial 10-week period
1949	$500.00 + additional $250.00	10 weeks + additional time as would permit the exhaustion of the initial $500 + $250 during such extended period
1955	$1,125.00 + additional $375.00	10 weeks + such additional time as would permit the exhaustion of the initial $1,125 + the additional $375 during such extended period
1963	$2,000.00 + additional $500.00	10 weeks + such additional time as may be necessary in the judgment of the Board to exhaust the original $2,000 + an additional $500 during the extended period
1968	$5,000.00	**Time limitation eliminated**
1971	$5,000.00 + such additional sums for necessary medical treatment in judgment of Board. Application for additional sums could be made prospectively or retrospectively (ratified after service rendered). No dollar limitation upon additional sums which could be approved by Board.	
1985	"Cap" eliminated; Peer Review and Fee Schedule enacted	

One reading the original 1920 Act might be alarmed by the provision which made treatment after the initial 30 day period optional at the sole discretion of the employer. See, in this regard *Southern Surety Co. v. Byck*, 39 Ga. App. 699, 148 S.E. 294 (1929). In 1937, having recognized the obvious

problem of giving to an employer the option of continuing treatment after the expiration of the statutory period, the legislature not only extended the treatment/recuperative period from 30 days to 10 weeks; but also, abolished employer option and vested solely in the "Department of Industrial Relations" the decision whether additional treatment beyond the 10 week period would be approved. Even more significantly, however, was the legislative enactment of an evolutionary step along the path to total abolition of employer discretion regarding the nature and extent of medical service that injured workers would be allowed to receive from physicians chosen by the employee:[4]

> "In case of a controversy arising between the employer and the employee relative to the continuance of medical, surgical, hospital or other treatment, the Department of Industrial Relations may order such further treatment as may in the discretion of the Department be necessary."

Much can be learned from one of the first cases decided after the major policy and statutory revision of 1937. In *United States Fidelity & Guarantee Co. v. O-Byrne*, 61 Ga. App. 806, 7 S.E. 2d 689 (1940), the Georgia Court of Appeals ordered the employer to pay for medical treatment which had been rendered after the expiration of the 10 week period, but the cost of which was within the $500.00 cap. The Court of Appeals stated:

> ". . . the record supporting the award of the Board that the further treatment was necessary, this Court will not interfere with the award of the Industrial Board, especially in view of the fact that there was no effort on the part of the employer to show that such further treatment was not necessary." (emphasis supplied)

The *O-Byrne* case demonstrates the policy emerging by 1937; that is, that employers must challenge and demonstrate through procedures adopted or furnished by the Board that medical treatment rendered in conformity with the

statute by an authorized physician is not necessary rather than imposing upon the employee the duty of showing that proposed treatment is necessary.

In 1968, then existing Code Annotated 114-501 was struck in its entirety and a far more generous medical treatment statute was substituted. Time limitation for treatment/recuperation which had existed since 1920 was entirely eliminated, although the "cap" on medical expenses that an employer could be required to pay per claim remained in place, albeit increased to $5,000.00 from the previous cap of $2,000.00 in 1963. Moreover, essentially the same language and policy presently appearing in O.C.G.A. Title 34-9-200(a) was enacted.

Prior to 1971, even if an injured employee still required medical treatment after the $5,000.00 "cap" had been exhausted, the State Board lacked the authority to order the employer to pay for additional necessary treatment. However, in 1971, the legislature gave the Board – for the first time – the authority to order an employer to pay for additional medical treatment even after the $5,000.00 cap had been exhausted. After the exhaustion of the $5,000.00 sum statutorily allotted, the 1971 amendment authorized the employee to petition the State Board for an order requiring the employer to pay for additional necessary medical treatment. It is significant in the evolution of present O.C.G.A. Title 34-9-200 that the petition could be made either before the treatment was rendered which would cause the $5,000.00 cap to be exceeded or could even be made after the treatment had been rendered. In this latter situation, the State Board was effectively ratifying the already rendered treatment or approving its necessity retrospectively. Obviously, prospective approval before the elimination

of the "cap" would only take place when approval was sought by the claimant for proposed treatment.

Next, and specifically pertinent to the narrow topic assigned, an important observation must be made regarding the evolution of the related questions of "necessity of services" and "reasonableness of fees." It seems simple that a medical bill; that is, the fee of the physician, might be considered to be excessive even if the treatment was clearly necessary ". . . to effect a cure, give relief, etc." The two subjects – reasonableness and necessity – have been present in Georgia workers' compensation law and essentially intertwined since 1920. The reason is this: Since there was an absolute "cap" on the amount of medical expense that an employer was obligated to pay (until 1971) and a time limitation placed upon that obligation, it was essential that the board – charged with the duty of administering the newly created system – scrutinize not only what medical service was being rendered and why (necessity); but also, to insure that the bills for that treatment would not be excessive in amount and thus prematurely exhaust the limited sum available for medical care (reasonableness).

As the system continued to evolve, the cap was periodically increased and the time limitation was lengthened and provision made for application to the State Board for extension of the time limitation. By as late as 1977, although the time limitation had been eliminated, the $5,000.00 "cap" remained in place. And although application could be made prospectively or even retrospectively (ratified) for additional sums for necessary medical treatment, the appellate courts of this State stated clearly the intent of the legislature regarding the effort

of employers to attempt to control the quantum and/or quality of necessary medical treatment by stating:

> "An open end award leaves the applying of standards and making the determination as to necessity and reasonableness to the party who must pay. This is not in keeping with the legislative intent." (emphasis added)

See *Blair v. U.S. Fidelity & Guaranty Co*., 140 Ga. App. 880, 232, S.E. 2d 156 (1977). See also, *Fieldcrest Mills, Inc. v. Glass*, 143 Ga. App. 222, 238 S.E. 2d 125 (1977); *Bibb Manufacturing Co. v. Darcy*, 122 Ga. App. 420, 177 S.E. 2d 165 (1970).

Apparently, the Board and courts of this State, concerned employers and/or insurers would manipulate medical treatment, invented a method by which employer's payments for medical treatment which payments were not approved by the Board could not be credited or applied against the "cap." Thus, the origin of the concept that unapproved payments by employers for medical treatment were "mere gratuities." See, e.g., *Reliance Insurance Companies v. Richardson*, 137 Ga. App. 678, 224 S.E. 2d 812 (1976).

In 1978, the legislature again substantially revised the Georgia workers' compensation statute. As everyone now knows, the most significant thing that occurred that year was the creation of the "panel of physicians." The wording of that entirely new statute which conferred upon employers the right to designate the limited list of "authorized" treating physicians from which the injured employee was required to choose comes nearly verbatim from recommended or pattern language contained in the Council of State Governments Draft Section 12(b). See Larsen, Workmen's Compensation Law, §61.12(a).

However, what many do not realize is that the Council of State Governments draft can be traced to the following:

> "The union and management of a particular plant may select a physician panel, *which could then be approved by the Agency. The selection or approval by the agency should be made after consultation with medical authorities and the lists should include those physicians who have demonstrated by practice a special interest and competence in occupational health."* (emphasis supplied)[5]

As everyone familiar with the history of Georgia's workers' compensation system knows, the elimination of "freedom of choice" by the adoption of the "panel" concept was considered to be such a "plum" that employers were willing "to trade" the possibility of "lifetime" income benefits for temporary total disability. In retrospect, the reason for the timing of "the push" to enact the "panel of physicians" model of managed care limited provider choice may now be deduced: an ill conceived reaction to the "hard" insurance market which existed from 1975 – 1978.[6]

A brief digression to explain the meaning of an insurance "hard market:" experienced observers will acknowledge the considerable influence of the insurance industry upon the legislative process in this and other states. Those observers will also recognize that workers' compensation "reform" is most likely to occur in the third year of a "hard market." The February 2004 report by Melissa Taylor Bell and Irakli Khadeli, Trends Alert Workers' Comp., prepared and distributed by the Council of State Governments (which should be required reading for everyone involved in the workers' compensation program of <u>any</u> state) explains it this way at page 10 of that 36-page scholarly treatise:

"Ups and Downs of Workers' Comp

> The workers' comp system goes through a regular cycle of rising and falling premiums. The causes behind the insurance cycle are not precisely identified, but three different economic trends are known to contribute to the cycle: the employment/unemployment cycle, the investment cycle and the underwriting cycle.
>
> First, workers' comp claims ebb and flow somewhat with changes in unemployment. When unemployment rises, previously injured workers are more likely to file a claim, especially if they have already been laid off. Additionally, workers receiving workers' comp have an incentive to wait out the unemployment cycle, which increases costs.
>
> Second, premiums tend to rise and fall in tandem with changes in the stock and bond markets. When stocks are doing well and interest rates are high, insurers tend to compete with lower premiums to attract more customers. When stock and bond markets aren't doing as well, insurers tend to increase premiums.
>
> Third, during a soft market when insurance is relatively available and affordable, insurers tend to practice aggressive pricing in order to increase market share. Eventually, they realize that the premiums collected fall short of covering the claims costs. They then start to tighten underwriting by setting strict rules regarding who can purchase policies and increasing premium prices, thereby limiting the supply of insurance on the market. This leads to a hard market, meaning that insurance is less available and affordable."

In the original 1978 revision and remaining in O.C.G.A. Title 34-9-201(b) until the 1994 amendment which became effective 7/1/94 is the following statement:

> "The employer shall not be responsible for the charges for medical treatment furnished <u>or</u> <u>ordered</u> by any physician, including any person licensed to practice a healing art and any remedial treatment and care in the State of Georgia, or other person selected by the employee in disregard of the provisions of this subsection." (emphasis added)

The converse of the quoted language would be: 'The employer <u>shall</u> be responsible for charges for medical services furnished <u>or</u> <u>ordered</u> by a physician

who was obtained in conformity and compliance with one of the statutory methods by which an ordinary physician is transformed into an "Authorized Treating Physician."

Other significant changes that year were the elimination of the "agreement" system; which, while moving a bit ponderously, had still achieved far greater procedural compliance by essentially requiring employee participation in every step of the benefit payment process. Adopted was the supposedly simpler "direct payment" system, codified as Code Section 114-705, which has had the unintended consequence of reducing or even eliminating regular employer/employee communications following a work injury and has seen income benefits commenced and suspended without compliance with the forms filing and service requirement of O.C.G.A. §34-9-221(c).

One not completely familiar with the evolution of the provision of medical care since 1920 might be tempted to argue that the mere adoption of the "panel" concept would have eliminated any need for Board scrutiny over "necessity of services" or even "reasonableness of fees." Actually, the 1978 revision left in place the $5,000.00 cap and the requirement that expenses in excess of the "cap" must still be approved or, at least, "ratified" retrospectively as having been necessary by the State Board once the $5,000.00 had been exhausted. And, because the cap remained in place, it was also necessary to leave intact a provision subjecting "fees of physicians and charges of hospitals" to Board approval. See Code Section 114-714 appearing in the 1978 revision.

In 1985, however, another major revision, the analysis of which, in conjunction with the examination of statutory antecedents as far back at 1920,

leads to the conclusion that because of the complete elimination of any cap on medical expense and the simultaneous creation of both the "fee schedule" and "peer review" in conjunction with the "panel of physicians" concept created only seven years before in 1978 a simple system requiring prompt medical treatment without any need for prior approval of such treatment was intended.

Since the amendments of 1985 provided the solution to any disputes regarding the reasonableness of fees or the necessity of services by having provided the fee schedule and peer review, the only question that one might ask is when would one actually seek peer review for a service, the necessity of which the employer might question? The answer is found in O.C.G.A. Title 34-9-205(b) for anyone that understands the difference between present and past tense:

> "The Board may require recommendations from a panel of appropriate peers of the physician or hospital or other authorized medical supplier in determining whether the fees submitted and necessity for services rendered were reasonable. The recommendations of the panel of appropriate peers shall be evidence of the reasonableness of fees and necessity of service which the Board shall consider in its determinations." (emphasis added)

What determinations? Since, pursuant to O.C.G.A. Title 34-9-200(a), the Board remains the final arbiter and judge of what medical treatment shall be ". . . reasonably required, etc., . . ." the process requires that the employer which chooses to challenge either a bill not covered in the fee schedule or the necessity of service which has already been rendered, it must follow the procedure "set forth" in Board Rule 203. This system so abhors delay in furnishing medical treatment that peer review is only permitted after the service has been rendered.[7]

To avoid the contention that the Board has illegally delegated its duty imposed by O.C.G.A. Title 34-9-200(a) to the "peer review" committee, the "recommendation" is only given the weight of ordinary evidence for the Board to consider in its determinations. So, who must bear the burden of presenting the dispute "concerning the necessity of services"? Quite simply – and obviously – the burden is on the employer that chooses to dispute necessity of the service that has already been rendered by the authorized treating physician and the bill therefor submitted for payment. Only then is peer review appropriate.

IV - CURRENT STATUTORY DESIGN

A. The Role of the Authorized Treating Physician

We have seen that O.C.G.A. §34-9-200(a) places an affirmative duty ("shall") upon employers to furnish to the injured employee:

> ". . . such medical, surgical, and hospital care and other treatment, items, and services which are prescribed by a licensed physician [selected or accepted in accordance with one of the methods for provision of medical services described in O.C.G.A. §34-9-201(b)]. . . which . . . shall be reasonably required and *appear likely* to effect a cure, give relief, or restore the employee to suitable employment." (emphasis supplied)

O.C.G.A. §34-9-201, in all of its incarnations, has conferred upon a physician selected in accordance with the traditional panel (b)(1), a conformed panel (b)(2), or a managed care organization certified by the State Board (b)(3), the authority to direct the medical care of the injured worker. While the Appellate Courts of this State have not used the phrase "presumption of correctness" as have the courts of other states to describe the level of deference accorded an "authorized treating physician"; nevertheless, decisions suggest that the opinions and treatment plan of "the physician selected under this subsection. . . " is entitled to

far greater weight than the opinion of an "examining" physician; and certainly more than a "records reviewer." See, e.g., *Medley v. Hartford Acc & Ind. Co.*, 121 Ga. App. 54, 172 S.E. 2d 461 (1970); *Bibb County Board of Education v. Bembry*, 2007 Ga. App. LEXIS 862 (7/30/07).

B. *The Emergence of the Problem of Pre-Authorization Or "Mother, May I"*

1. The Second Component of Managed Care "Cost Containment" Introduced

It is essential to understand how dramatic the 1978 legislative changes had been in changing the mechanism for payment of benefits, selection of treating physicians, etc. Among other changes that year was the introduction of the "limited provider choice" model for delivering medical care. Ga. Laws 1978, pp. 2220, 2225-2227 (Section 9) created a "system" that was remarkably simple in concept. Employers would be given "the right" to designate the physicians that would treat their work injured employees. Employees were required to choose from a "list" of three or more physicians or groups of physicians.[8] And, because Employers were expected to choose "good" physicians, Employers were not given "the right" to challenge <u>prospectively</u> the reasonableness or necessity of treatment to be rendered by "authorized" physicians. As previously discussed, a mechanism to challenge treatment, but only <u>after</u> it had <u>already</u> been rendered, was introduced in 1985. (Ga. Laws 1985, p. 727 §5).

2. The Evolution of the Problem

From 1978 until approximately 1993, "authorized" medical care was usually delivered promptly and efficiently, requiring little intervention by claimant attorneys; or, by the Board.

(a) The 1997 Amendment to Board Rule 205

Unfortunately, "utilization management" techniques originating in the "managed care" model infiltrated a system neither designed nor equipped to deal with them. So, authorized treating physicians, used to having their "orders" obeyed without protest, found increasingly that they were "expected" to call before ordering anything more "expensive" than routine diagnostic studies. Younger physicians who knew nothing of the legislative intent of the 1978 amendments that created the "panel of physicians" delivery system in Georgia, hospitals, diagnostic facilities, physical therapists, etc., all acquiesced in demands for "pre-authorization" since it was an increasingly common component of HMO medical care plans through which these same doctors were providing medical treatment for non-work-related conditions.

Effective July 1, 1997, the Board adopted its first "solution" to the problem by promulgating the predecessor to present Board Rule 205(b). Strangely, the Board decided to allow Employers 30 days to approve a request for pre-authorization.

By 1996, the delays in delivery of “authorized” medical care had become a crisis and doctors began declining to treat injured workers. On November 12, 1996, the Georgia Supreme Court issued its decision in *Doss v. Food Lion, Inc.*, 267 Ga. 312, 477 S.E. 2d 577. The following excerpt is important:

> "We consider in this case the following certified question from the Eleventh Circuit Court of Appeals: Does Georgia Law recognize an independent cause of action apart from any remedy available under the Georgia Workers' Compensation Act, where an employer and/or insurer has intentionally delayed *authorizing* medical treatment to which an employee is entitled under the Act and where such delay has exacerbated a work-related physical injury [footnote omitted] Because the Act provides penalties for intentional delay in treatment and allows for compensation for exacerbated injuries, and because an independent cause of action is inconsistent with the public policy behind the statutory scheme, we answer the question in the negative." (emphasis added)

Following the *Doss* decision, it was hardly surprising that the Board would attempt to respond to the ever worsening "pre-authorization" crisis by promulgating Amendments to Board Rule 205 effective 7/1/03.

(b) Creation of the "WC-205 Process"

In 2000-2001, year-long exhaustive discussions and negotiations among claimant and defense attorneys, representatives of Employers, the Insurance Industry, the Medical Community and Labor, all appointed to the Governor's Workers' Compensation Advisory Commission, produced the procedural framework for what now appears in Board Rule 205(b).

Since The Act already placed upon Employers the duty of providing medical treatment for the work injury, O.C.G.A. §34-9-200(a); and, placed a concomitant duty upon the State Board to determine how and to what extent that treatment is to be provided, (" . . . which in the judgment of the State Board of Workers' Compensation shall be reasonably required . . . "), it was presumably within the authority conferred by the General Assembly pursuant to O.C.G.A. §§34-9-40, 58, 59 and 60 to promulgate Board Rule 205. And, it was also within the State Board's authority to create a Form WC-205 "process" to provide a

vehicle for expediting "pre-authorization" in order to remove as many impediments as possible to the delivery of medical care. See present O.C.G.A. §34-9-61(a); present Board Rule 61(b)(30).

It was inevitable that a legal challenge would be made to Rule 205(b)(3)(a) which provides:

> "An *authorized* medical provider *may* request advance authorization for treatment or testing by completing Sections 1 and 2 of Board Form WC-205 and faxing or emailing same to the insurer/self-insurer. The insurer/self-insurer shall respond by completing Section 3 of the WC-205 within five (5) business days of receipt of this form. The insurer/self-insurer's response shall be by facsimile transmission or email to the requesting authorized medical provider. If the insurer/self-insurer fail to respond to the WC-205 request within the five business day period, the treatment or testing stands pre-approved." (emphasis supplied)

That first challenge was made in *Caremore, Inc./Wooddale Nursing Home v. Hollis*, 283 Ga. App. 681, 642 S.E. 2d 375 (2007). The merit of the precise challenge was sidestepped because the employer had actually "authorized" a referral for an evaluation before the challenged provision of Board Rule 205(b)(3)(a) was applied.

The "WC-205 process" promulgated by Board Rule 205(b)(c) and (d) must be read *in pari materia* in order to conclude that the complete "WC-205" process and the Board Rule which incorporates that process for expediting "pre-authorization" should be deemed to be a proper exercise of the Board's rulemaking authority.

Each provision of the rule may be "matched" to an existing statutory provision or appellate decision construing The Act and/or Board Rules. Rule 205(b)(1)(a) and (b)(1-3) essentially "track" O.C.G.A. § 34-9-200(a) and invoke

the provisions of O.C.G.A. §§34-9-203 and 205 (". . . shall be paid in accordance with the Act, where the treatment/tests are . . . "): The "basis" for Board Rule 205(b)(1)(b)(4) may be traced directly to O.C.G.A. §34-9-201(b) and to Appellate decisions such as *Woodgrain Millwork/Windsor Wood Windows v. Millender,* 250 Ga. App. 204, 551 S.E. 2d 78 (2001) (specifically citing an earlier "version" of Board Rule 205(b); *Old Dominion Freight Line v. Anthony,* 216 Ga. App. 267, 454 S.E. 2d 574 (1995)*; Hensel Phelps Const. Co. v. Manigault,* 167 Ga. App. 599, 307 S.E. 2d 79 (1983)*; and Roberson v. Hartford Accident & Cas. Co*., 141 Ga. App. 588, 234 S.E. 2d 145 (1977). Subsection (b)(2) of Rule 205 is "lifted" directly from O.C.G.A. §34-9-200(a), 201(b) as the concepts of "authorized" vs. "unauthorized" treatment are explained by the Court of Appeals in *ITT – Continental Baking Co. v. Powell,* supra.

The "WC-205 process" may be used in either a "lost time" or "medical only" claim since its sole purpose is to expedite the delivery of medical care and to provide reasonable assurance to the treating physician that he/she will be paid for the services rendered; therefore, the provision contested in *Caremore v. Hollis*, supra, does not actually illegally shift the burden and/or impose "compensability" as that word is properly defined.

Upon receipt of a faxed WC-205, an adjuster can "authorize" the treatment/testing or can withhold authorization; or, can choose to do nothing. If the employer chooses to ignore a WC-205 form and fails to respond within five (5) business days of receipt of the form, the treatment is approved as a matter of law.

As a practical matter, however, a physician is unlikely to render service for which he/she has sought pre-approval but has not been given affirmative approval. This is because the lack of a response does not provide reasonable assurance that the physician will be paid for the services if rendered. Rule 205(b)(3)(a) provides that:

> "[t]he insurer/self-insurer shall respond by completing Section 3 of the WC-205 within five (5) business days of receipt of this form." (emphasis supplied).

To fault the physician in any manner for not proceeding with the services when the employer does not make any response to a WC-205 ignores the very purpose of Rule 205 – to provide reasonable assurance to physicians that payment will be made for services rendered. If the Board requires anything beyond proof of the failure to respond to a WC-205 form before faulting and penalizing an employer for violation of Rule 205, it is adding an additional bureaucratic layer onto the 205 process analogous to a "good cause" hearing with the burden on the Employee to show "good cause" for imposing punishment for an employer's failure to respond to a WC-205 form. Only by penalizing as harshly as the law allows those employers who simply ignore a WC-205 form can the integrity and effectiveness of the 205 process be maintained.

But, "notice" satisfying procedural due process, has been given to the Employer. An Employer that refuses to approve the treatment/testing proposed by the employer's authorized treating physician must "give a reason." If the Employer denies "advance authorization" on the basis that the treatment isn't related to the work injury, or isn't being rendered by an "authorized" physician,

the burden of proof is properly placed on the Claimant. *Smith vs. Mr. Sweeper Stores, Inc.*, 247 Ga. App. 726, 544 S.E. 2d 758 (2001); Rule 205(c)(1). But, if the Employer refuses to authorize the treatment/testing on the basis that it isn't "reasonably necessary," the burden is placed on the Employer. See O.C.G.A. §34-9-205, Board Rule 203. Then, to complete the procedural process, the Employer must file a WC-3 notice to controvert within 21 days of initial receipt of the WC-205. See Board Rules 61(b)(4); 221(d). But, that's already the law.[9]

If the Employer does choose to withhold authorization on the basis that the treatment isn't reasonably necessary or believes that the bill – after treatment – was excessive, the rule contemplates that the Employer may then avail itself of the "peer review" process that has existed since 1985 and is found in O.C.G.A. § 34-9-205(b) as interpreted/carried out by Board Rule 203.

(c) Payment of Medical Bills – O.C.G.A. §34-9-203

Another product of the Medical Committee of the Barnes Governors' Workers' Compensation Advisory Committee was the creation of a self-activating "graduated" penalty provision for late payment of medical bills. Until 2000, O.C.G.A. §34-9-203 had been a "toothless tiger" since the previous version of the provision not only required Board involvement before any late payment penalty in any amount could be imposed; but the penalty itself, was also essentially discretionary. The twenty (20%) percent penalty was rarely sought and rarely enforced. Effective July 1, 2000, the late payment penalty of O.C.G.A. §34-9-203 was made mandatory and empowered the medical provider to add to the charges submitted the appropriate amount of penalty due for late payment to the new

provision which "spelled out" exactly how the penalty would be calculated and provided a "defense" if bills were not properly submitted and supported.

The 2000 Amendment to O.C.G.A. §34-9-203 was, itself, amended further in 2001, 2003, 2004 and 2006; yet remains the single most valuable tool available to medical care providers to get their bills paid timely.

V - The Infiltration by Managed Care Devices and the New Threat to Prompt Delivery of Authorized Treatment

A. *The Use of Managed Care in Workers' Compensation – An Overview*

While there is no generally accepted definition of "managed care," it can be identified by the components usually present which distinguish *prospective* or *concurrent* management of health services from *retrospective* traditional indemnity insurance.[10]

The evolving theoretical managed care model in the workers' compensation setting involves the combination of prospective, concurrent and even retrospective medical cost containment strategies and techniques with actual medical treatment to:

- Provide only reasonable and necessary medical services at a lower overall total cost to the payer with the payer determining necessity of treatment;
- Presumably increase the quality of care by attempting to standardize the care delivered; and
- Expedite worker re-entry into the workforce.

Managed care principles and methodologies can be implemented to accomplish the over-arching objective of cost containment if an insurer contends unnecessary medical procedures are being performed, medical fees exceed

competitive price levels, or if some necessary medical procedures are not currently being used.

Insurance companies have increasingly instituted various utilization management methods in recent years to reduce medical costs while continuing to achieve remarkable profits. These methods can be segregated into two broad categories:

- Financial arrangements; and
- Behavior modification methods.

The financial arrangements include discounted fee for service agreements, case rates per claim, capitation contracts and dividend programs. The behavior modification methods include the many categories of utilization review and management, case management by nurses employed by payers and second-opinion programs, treatment and disability guidelines, etc.

If medical costs are perceived to be too high or if the insurer has significant bargaining power, discounts are oftentimes implemented. Thus, a health care provider will agree to a discount from "usual and customary" or even fee schedule rates if injured workers are treated by a member of the health care provider's network. The discounts are often 15% to 25% below the charges allowed by the workers' compensation fee schedules for certain states. For states that do not have fee schedules, the discounts are typically less than the *usual and customary* charges.

Case rates refer to a flat fee per claim for medical costs. Typically, the flat fee will vary by type of injury. Thus, the insurance carrier pays the healthcare provider a flat amount to compensate it for all medical costs for any specific

injured worker among a larger group of which that specific worker is a member. The risk that actual costs may exceed the average (or expected) costs is thereby transferred from the insurance carrier to the healthcare provider.

In *a capitated arrangement* the healthcare provider receives a flat fee for which the healthcare provider contracts to provide appropriate medical services for injured workers which it treats during a contract period. Typically claims occurring outside the state are excluded and only a predetermined dollar limit of medical treatment costs are covered on catastrophic claims. Also, the capitation agreement usually applies only to medical services during the first, second or third year subsequent to the injury date. Under this arrangement, a workers' compensation insurer transfers much of the predictable exposure to the Healthcare provider while the insurer retains the less certain (more variable) exposure.

Dividend plans essentially return some of the projected workers compensation savings, accomplished by the managed care program, to the Healthcare provider, which can result in creating a conflict situation for the physician which might be tempted to provide only a bare minimum of medical treatment in order to increase dividends.

B. Utilization Review/Management – The Hallmark of Managed Care

The most common component of managed care in both "group" health plans and workers' compensation is *utilization review/management* by which proposed medical procedures are scrutinized, to determine their appropriateness as measured by an insurer's proprietary treatment/utilization "guidelines" or

such guidelines adopted for use by any particular insurer. The three utilization review techniques most frequently used are concurrent reviews, retrospective reviews and prospective review which includes pre-authorization and pre-certification. *Concurrent reviews* are designed to identify those treatment patterns considered to be inconsistent with the payer's guidelines and then to force an alternative in the health care services being provided for a worker. *Retrospective reviews* are designed to detect guideline violations in treatment already rendered. These treatment "errors" can then be brought to the attention of the provider in an effort to reduce, limit or terminate treatment which the insurer considers to be excessive. *Pre-certifications* are used to advise the provider of exactly what treatment, surgery, etc. is being "authorized" to direct patients away from costly inpatient care to outpatient services when possible.

Case management involves a medical professional (usually a nurse) overseeing the medical/recovery progress of an injured employee in accordance with that payer's guidelines or protocols. Case managers will typically employ treatment and disability guidelines to get the injured employee back to work as quickly as possible.

Second-opinion programs while originally intended to be used by physicians and/or their patients to obtain another opinion, regarding the treating physician's treatment plan, are being used by managed care to reduce the incidence of surgical procedures by, in effect, requiring the authorization of such procedures by two physicians, one of which may be a physician chosen by the insurer. These procedures rely on the "sentinel" effect (i.e., the impact that a "peer review" can have on a physician's recommendation). The effectiveness of

these programs has been difficult to ascertain. Many believe that they result in no net reduction in surgical procedures since some patients, who otherwise would not have had surgery, will consent to surgery after the confirmed first opinion. Moreover, these programs carry relatively high administrative costs.[11]

The common components of the managed care utilization management model will be discussed separately, infra.

C. *The Origins of Managed Care*

The structure and system of care that is known today as "managed care" may be traced to a series of alternative healthcare arrangements that appeared in various communities across the country as early as the 19th century. The goal of these arrangements was to help meet the healthcare needs of select groups of people, including rural residents and workers and families in the lumber, mining, and railroad industries. The enrollees paid a set fee to physicians who then delivered care under the terms of their agreement. These prepaid group practices were a model for later entities that came to be known as Health Maintenance Organizations.

Dr. Michael Shadid, who started a rural farmers' cooperative health plan in Elk City, Oklahoma in 1929, met with significant opposition from other physicians; however, with help from the Okalahoma Farmers' Union he succeeded in enrolling several hundred families which paid a predetermined fee for medical care rendered by Dr. Shadid.

Also in 1929, the Los Angeles Department of Water and Power contracted with Drs. Donald Ross and H. Clifford Loos to provide comprehensive services for about 2,000 workers and their families. Within 5 years, this doctor-owned

and controlled group practice prepayment plan at the Ross-Loos Clinic enrolled 12,000 workers plus 25,000 dependents, at a cost of $2.69 per subscriber per month.

In 1933, also in Los Angeles, Dr. Sidney Garfield and several associates were providing medical care on a prepaid basis for 5,000 workers on an aqueduct construction project. The workers' compensation insurance companies paid Garfield a percentage of their premium income to take care of accident cases; the men contributed 5 cents out of their wages for other medical services. Five years later, Garfield did the same for workers at the Grand Coulee Dam for Henry J. Kaiser, whose name because synonymous with prepaid healthcare. During World War II, Kaiser set up two medical programs on the West Coast to provide comprehensive health services to workers in his shipyards and steel mills. When the war ended, Kaiser opened his plans to the public. Ten years after the war, the Kaiser Permanente health plan had a growing network of hospitals and clinics and a half million people enrolled.

Several other prepaid group practice plans developed in the 1930s and 1940s and became precursers to the modern HMO. Group Health Association in Washington, DC, was organized in 1937 as a nonprofit cooperative by employees of the Federal Home Loan Bank. Group Health Cooperative of Puget Sound in Seattle, Washington, was established at the end of the war by members of the Grange, the aero-Mechanics Union, and local supply and food cooperatives. The Health Insurance Plan (HIP) of Greater New York was launched in 1947 with the support of Mayor Fiorello La Guardia to provide care to city employees after a

study found that a major source of their financial distress was indebtedness caused by illness.

In 1954, the San Joaquin County (California) Medical Society formed the San Joaquin Medical Foundation in response to competition from Kaiser. The foundation accepted capitation payments from subscribers, and it paid the affiliated independent physicians and hospitals according to a relative value-based fee schedule. The foundation heard grievances against physicians, developed peer review procedures, and monitored quality of care. This plan is considered the earliest example of an independent practice association (IPA) model prepaid health plan.

Prepaid health care remained a minor phenomenon until the 1970s. In the late 1960s and early 1970s, politicians and interest groups promoted various proposals for reforming the nation's healthcare system. Issues of cost containment, coverage for the uninsured, access to services for the poor and minorities, consumer rights, efficient delivery systems, and more were all on the agenda. In 1971, the Nixon Administration, through PL 93-222, announced a new national health strategy: the development of health maintenance organizations (HMOs). The federal government would establish planning grants and loan guarantees for HMOs, towards a goal of increasing the number of HMOs from 30 in 1970 to 1,700 by 1976, enrolling 40 million people, and 90 percent of the population by 1980. The HMO Act of 1973 authorized $375 million in federal funds to help develop HMOs; preempted state laws that banned prepaid groups; and required companies with at least twenty-five employees to offer a federally qualified HMO if the HMO asked to be offered. In adopting this

policy, the Administration was influenced by Paul Ellwood, MD of Minneapolis, who argued that the structural incentives of traditional fee-for-service medicine had to be reversed in order to achieve positive reform. Dr. Ellwood coined the phrase "health maintenance organization" to refer to prepaid health plans that enrolled members and arranged for their care from a designated provider network.

While the initial growth and enrollment goals have not been met, managed care, as it has come to be called, continued to grow throughout the 1970s, 1980s and 1990s.[12] While the Nixon Administration was the first to enact Federal legislation to create a framework for the expansion of the HMO Medical Care Model, Princeton University Sociology and Public Affairs Professor, Paul Starr, Ph.D., postulated in his 1984 Pulitzer Prize winning book that it was actually the Reagan Administration that first took deliberate steps to "reform" American health care from its longstanding not-for-profit business model into a for-profit model that would be driven by the insurance industry.[13]

D. An Unheeded Warning from 1972

> "We do not quarrel with rules which arbitrarily preclude medical care regardless of the merit of the claim or the restorative value of the medical benefits. Indeed, these arbitrary rules, while they may be intended to achieve the worthy objective of high quality care at a reasonable cost, are almost invariably inappropriate to that end. In essence, these limits can be self-defeating because they may force a disabled worker to be unproductive indefinitely because his medical rehabilitation is incomplete."

E. The Evolution of Managed Care/Utilization Review and Management

From a beginning in which the primary purpose for a payment of a predetermined periodic fee (capitation) to a physician or group of physicians was

the provision of medical care to a defined group of people, practices and measures intended to achieve "cost containment" have been gradually added to the managed care model.

Various studies released between July 2003 and January 2004 reported that for $2 spent on workers' compensation, about 40 cents was spent on medical care, and the rest spent on reimbursement for lost wages.[14] For a typical claim involving more than seven days of lost work, medical expenses totaled approximately $4,753.[15] Physicians accounted for 33 percent of the average workers' compensation medical payment, hospitals for 34 percent, physical and occupational therapists for 11 percent, chiropractors for 4 percent, and other medical providers, including unclassified providers, for 18 percent.[16]

However, data in workers' compensation changes rapidly. As recently as August 13, 2007, statistics reported by Robert P. Hartwig, Ph.D., President, Insurance Information Institute, painted a far better picture of the financial health of the state of national workers' compensation profitability and costs. The report entitled "Mega-Trends Influencing the Workers' Compensation Industry," presented at the 62nd Annual Workers' Compensation Educational Conference in Orlando, Florida, states the following; *inter alia*:

- Once disastrous line [of property and casualty insurance], now makes healthy profit;
- The workers' compensation combined ratios from 1994 – 2006 (p) for private carriers had lopped 25 points off the combined ratio in just 5 years and the 2006 combined ratio of 97 was the most favorable since the same combined ratio was achieved in 1995;

- Pre-tax Operating Gain Ratio in 2006 increased 13.5%, the first time that remarkable pre-tax profit had exceeded 13% since 1998; and after a loss of 7.8% in 2001, with no net loss or gain reported for 2002 and increases of 0.9, 4.4 and 8.4% for the years 2003, 2004 and 2005, respectively;
- P/C net income after taxes had shown increases from 3 billion dollars in 2002 to a stunning 63.6 billion by the end of 2006. And, in only the first quarter of 2007, P/C net profit of 15.8 billion dollars;
- Lost time claim frequency declined 52.1% between 1991 and the end of 2006.

The 13 August 2007 power point presentation also claims that the medical component of workers' compensation had increased from 34% in 1986 to 48% in 1996 and to 59% by the end of 2006. Hartwig projects that the component will increase to 70% by 2016. But, it is Hartwig's bar graph which claims an annual Medical care cost increase of 9.5% per year with an average medical care cost per claim increase from $8,200 to $24,600 from 1993 to 2006 that may be subject to challenge. *The Wall Street Journal* reported on July 31, 2006:

> "Last year, the top seven health insurance insurers earned a combined $10 billion - - nearly triple their profits of five years earlier. *The windfall came as insurers raised their prices faster than underlying health costs."*[17]

Given that Georgia prices of workers' compensation medical services relative to the cost of group health for the period 1997 – 2004 (using the 2003 Georgia Workers' Compensation Medical Fee Schedule prices for comparison) reflected a

one-to-one ratio (98%),[18] it is reasonable to hypothesize that the same premium overcharging was also occurring in Georgia insured workers' compensation claims.

Past successes in curbing the medical cost growth rate have been relatively short-lived. Medical cost containment in the future will be more difficult to realize because "much of the low lying cost containment fruit was harvested in the cost containment activities of the 1990s"

The central concept in health care cost containment efforts of the 1990s has been the managed care model.

The core principle of managed care in workers' compensation is the existence of a special network of health care providers that contract with insurers to treat injured workers covered by the policy. Ostensibly to control health care costs, these managed care organizations perform utilization reviews, institute medical fee schedules and offer case management of claims.

The components with which we are most familiar in Georgia are "limited provider choice" and "provider fee schedules."

F. Early Techniques

1. Limited Provider Choice

As we know, "limited provider choice" entered Georgia's workers' compensation system during the "hard" market of 1975-1978. The format adopted in Georgia, a panel consisting of three (3) (or more) physicians or groups of physicians, to be selected <u>solely</u> by the employer is actually quite different from the method proposed by the 1972 National Workmen's Compensation Commission.[20]

Theoretically, some cost savings would probably have been achieved had Georgia followed the Commission recommendations that Employees select and the agency approve panels composed of physicians ". . . who had demonstrated a special interest and competence in occupational health." Instead, Employers (or, more likely their insurers) may select physicians which are more malleable and considered to be more "cooperative."

A review of the literature suggests that "limited provider choice," alone, can not achieve measurable cost savings. In one major study, performed as part of the Cornell University doctoral dissertation of Silvana Pozzebon, 350,000 workers' compensation claims from Georgia and sixteen other states were analyzed. The author concluded:

> "States with mandated restrictions to initial provider selection or subsequent provider change have average medical benefit expenditures that are twenty-four percent higher than do jurisdictions not using these cost containment approaches."[21]

The author could not account for that surprising result. Among recent studies, WCRI analyzed a total of 2,573 cases in California, Texas, Massachusetts and Pennsylvania. The conclusions were mixed, at best. Of several findings, one in particular stands out: when the employee selected a "prior provider," defined as one who had treated the patient before for an unrelated condition, WCRI found that the cases "may have had higher costs, but the evidence was weak." [However] employee satisfaction with overall care was higher when the worker saw a prior provider, but other outcomes did not appear to be very different between these cases and ones in which the employer chose the provider."[22]

2. Provider Fee Schedules

The primary argument for adoption of provider fee schedules is that because they essentially control prices for medical services, fee schedules should slow down the rate of growth of such prices; thereby consequently reducing overall health expenditures. The evidence suggests that the effect of fee schedules in moderating the rate of increase is often modest because physicians may react to price controls by increasing the quantity (utilization frequency) of the service provided.[23]

In the early to mid '80s, fee schedules began being adopted widely. As noted previously, in 1985, Georgia simultaneously adopted both "peer review" (retrospective) and conferred upon the Board the authority to create a fee schedule.

Over the years, the two most important factors in the process of fee schedule promulgation appear to have been forgotten. O.C.G.A. §34-9-205(b) states:

> "Annually the Board shall publish a list [1] by geographical location of [2] usual, customary and reasonable charges for all medical services provided under subsection (a) of this Code Section."

Recall that O.C.G.A. §34-9-203(a), which originated in the 1920 Act also still provides:

> "The pecuniary liability of the employer for medical, surgical, hospital service, or other treatment required . . . shall be limited to such charges as prevail in the State of Georgia for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person."

How can these two statutory provisions be reconciled?

One thing appears to be clear: the fee schedule which is now created for the State Board by Ingenix, a wholly owned subsidiary of United Healthcare, is

updated annually and contains fees "presumed reasonable" regardless where in the State the physician's office is located. Moreover, the Ingenix fee schedule reportedly is based, in part, upon the Medicare fee schedule.[24]

There are two types of fee schedules used by those states that have adopted fee schedules. What services *should* cost based on special studies. This type of fee schedule is known as a Relative Value Scale (RVS). Those states which use an "RVS" fee schedule ordinarily use the Medicare fee schedule as the starting point. Other states – including Georgia – compile their fee schedules based upon what providers are currently billing for their services. This is referred to as a "UCR" (Usual, Customary and Reasonable) fee schedule.[25] Among "RVS" states of Florida, Maryland, Colorado, Vermont, Kentucky and Utah, Florida's fee schedule reimburses lower than Medicare, Maryland is "even" with Medicare, the reimbursement relative to Medicare (when the fee schedule exceeds Medicare), increases from less than 150% of Medicare (Kansas) to approximately 200% (Oregon). Those nine "RVS" states which reimburse greater than the Medicare fee are Kansas, South Carolina, Maine, Alabama, Nevada, Arkansas, Mississippi, Nebraska and Oregon.

Interestingly, among those states which use a "UCR" methodology, Georgia ranks dead last in reimbursement relative to Medicare at less than 150% and also "comes in" dead last at 98% of group health (GH) medical care prices, causing NCCI to conclude that five states – including Georgia – have workers' compensation fee schedules which "cap" fees below the expected price.[26]

Other data may also be sources for the determination of permissible fees. The statute, however, would preclude use of Medicare's fee schedule since that

fee schedule is the product of a complex national process by which physicians' fees are adjusted for area differences in physician's costs of operating a private practice. Three indices, known as Geographic Practice Cost Indices (GPCI), raise or lower Medicare fees in an area, depending on whether the area's physicians practice costs are above or below the national average. The three GPCIs correspond to the three components of a Medicare fee: physician work, practice expense, and malpractice expense.[27]

Georgia's fee schedule development process may be legally vulnerable for an additional reason, if based in part upon the Medicare Fee Schedule. Ingenix, despite the clear statutory requirement that "a list be published by geographical location. . .", has created one fee schedule of state wide application. CMS has 89 payment localities which include 34 statewide payment localities; however, sixteen states, California, Florida, Georgia, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, Oregon, Pennsylvania, Texas and Washington have multiple payment localities and thus different fee schedules for the multiple payment locations.[28] Georgia has two payment localities. One, which generally includes 14 "metropolitan" Atlanta counties of Butts, Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, and Rockdale all within one "payment locality." And, the other, which includes all of Georgia's other 144 counties in the second "payment locality." The "Metro" Atlanta counties have a locality Geographic Adjustment Factor (GAF) of 1.036 ("1" = national "base" fee amount) and the remaining 144 counties have a GAF of 0.971. The problem and the potential basis for a legal attack on the Ingenix developed fee schedule is that

more than half of the current physician's payment localities have at least one county within them with a large payment difference; that is, there is a payment difference of 5 percent or more between physician's costs and Medicare's geographic adjustment for an area. There are 447 counties nationally with large payment differences – representing 14 percent of all counties in the United States. These counties are located across the United States; but a disproportionate number are located in only five States. Sixty percent of those counties with large payment differences (>5%) are located in California, Minnesota, Ohio, Virginia and Georgia![29] Large payment differences occur because many payment localities combine counties with very different costs (e.g. Butts and DeKalb in Georgia These differences in costs may be attributed to several factors; e.g. population change. But, not only has CMS not revised geographic boundaries of the physician's payment localities since 1997; but, CMS currently lacks a mechanism to periodically update the physician payment localities and takes the position that the only mechanism which may be used is for a State's Medical Association to petition CMS for a change in payment localities. Despite the dramatic differences in payments by Medicare, Georgia's physicians are apparently unaware of their right to present such a petition. Only California has petitioned for a change in payment location since 1997.

Although the fee schedule is only a "guideline," *Chatham County Dept. of Family & Children Services v. Williams*, 221 Ga. App. 366, 471 S.E. 2d 316 (1996), and because the General Assembly provided no guidance or criteria for how the fee schedule was to be compiled other than collecting data geographically of the ". . . usual, customary, and reasonable charges. . ." one might postulate

that provider fees were intended to represent an average of the "usual and customary" fees charged by physicians in various (unspecified) geographical areas of Georgia. Certainly, the General Assembly would not have considered Medicare fees paid in either of Georgia's two "payment localities" to represent a basis for determining "usual and customary" for purposes of compilation of Georgia's Workers' Compensation Medical Fee Schedule.

As of November 2006, 42 states had adopted some form of medical fee schedule for workers' compensation claims. A recent WCRI Report[31] documented an alarming difference from state to state which is attributed to the vagaries of politics. The WCRI report, while basing some of its conclusions upon a misunderstanding of the complete process used by Medicare to adjust fees from state to state and even within states, nevertheless makes some findings which demonstrate that fee schedules are less effective than they could be. For example, WCRI finds that there are substantial differences in fee schedules from state to state which are not rationally related to the interstate variables in the expenses that the medical providers incur to produce the medical services. WCRI also found that most fee schedules create financial incentives to under-use primary care and over-use invasive and specialty care.[32] One finding, in particular by WCRI, should be considered to be a warning to those states which set fee schedules near or below the state's Medicare rates; i.e., such states' fee schedules raise concerns about access to quality care.[33]

Access to quality care is also threatened by a recent push to attempt to apply in workers' compensation contracts entered into between various health care providers and PPO and other health care plans.

3. Provider Bill Repricing

Board Rule 203(a) authorizes an employer to "automatically" conform charges to those in the fee schedule. However, in doing so, Employers may not "reprice" to the fee schedule by changing any CPT-4 code of the provider. Only those CPT-4 codes submitted by the provider may be "automatically" reduced.

This process of reducing charges (by CPT-4 Code) to the correct reimbursement authorized by the fee schedule is part of a process referred to as "Medical Bill Repricing." One authority opines that a medical bill repricing program should achieve annual savings of 20 – 30% of the total amount of medical billings.[34]

"Repricing" to a "network" contract percentage is now commonplace; however, increasingly, claim administrators are applying such contracts to providers in the workers' compensation setting and are contending that if the physician is a member of a network by which medical care is provided in benefit systems other than workers' compensation, there will be an attempt to apply that same contract "to reprice" bills submitted by the provider of medical care in a workers' compensation claim. The obvious financial incentives are such that one "authority" writes:

> "Discounts are prearranged prices for services that are negotiated with medical providers. Discounts can be arranged directly by claim payers *or by other organizations that allow claim payers to use their network for a fee*." (emphasis supplied)[35]

Therein lies an emerging problem. These contracts usually specify that a provider will agree to accept as a fee a stated percentage below "usual and customary." These contracts have been entered into over the past decade,

applied in "group" health, but only now are being applied in workers' compensation.[36] To date, no contract examined by the author hereof has expressly stated that it was intended to apply to the workers' compensation benefit system or to the fee schedule of that system. The danger is that workers' compensation providers against which such PPO contracts are sought to be applied will cease accepting for treatment Georgia's injured workers. Moreover, when the attempt to impose such contracts to workers' compensation billings has occurred, and has been challenged by the employee, in some instances, despite the clear language and intent of the 1990 amendment to O.C.G.A. §34-9-206(a), those seeking to enforce such contracts against a workers' compensation medical services provider claim that the injured worker lacks "standing" to assert the interest of the provider in order to require payment in accordance with the workers' compensation medical fee schedule. Given that Title 43 of the Georgia code includes at least 15 occupations or professions which are commonly involved in providing treatment to Georgia's injured workers, the potential volume of litigation challenging the attempt to apply reduced fee contracts in a benefit system to which providers never contemplated that such contracts would be applied could reach tsunamic proportion.

F. National Dissatisfaction with Manage Care, A Failed Solution and a Resumption of Abuses

1. A Growing Dissatisfaction

The pace of introduction of various components of the Managed Care Model quickened following the 1984 – 1987 "hard market" which produced the next "round" of "reform" around the country, particularly between 1990 and 1992.

In 1987 only 13 percent of privately-insured Americans received health care through a managed care organization; however, by 2002, that percentage had grown to 75%.[37]

The number of Managed Care Plans gradually increased following the enactment of The Managed Care Act of 1973 (P.L. 93-222). This far reaching federal legislation invalidated all existing state and local measures designed to prevent prepaid medical service, giving legal sanction to a new form of medical delivery system called a "Health Maintenance Organization" (HMO), a name coined by the bill's originator, Dr. Paul Ellwood. This Act set minimum standards for coverage and quality that, if met, would grant an HMO federal "qualification." Once qualified, an HMO became eligible to receive low-cost loans from the government to support its growth and development. A key aspect of the Act was to require private businesses that provided traditional insurance to employees to offer at least one closed – and one open – panel HMO as options. This was known as "dual choice," a requirement which was eliminated by amendment in 1988 with an effective date seven (7) years thereafter; i.e., October 24, 1995.[38]

Health care costs increased a reported 10 to 13 percent per year between 1970 and 1990; the total growth in the total value of the nation's output of goods and services (gross national product) averaged only 8.5 percent per year.[39]

This high rate of growth spurred an increase in <u>all</u> health-related expenses from $27 billion in 1960 to $949 billion by 1995.[40]

This economic pressure combined with the Managed Care Act of 1973, the elimination of the "dual choice" requirement by amendment in 1988 to be

effective seven (7) years later produced explosive growth in the managed care industry. In 1980, seven years after the initial Managed Care Act was passed, nine million Americans were enrolled in 250 different HMOs nationwide. But, the single most important statistic: of those 250 HMOs, only 18 percent were for-profit corporations. By 1995, 56 million people were enrolled in more than 500 HMOs, 70 percent of which were for-profit![41]

In that context, it is not difficult to understand why a nationwide backlash began brewing by the mid-1990s. It was contended by many that the "quality of care" objective of the managed care model had "taken a back seat" to a pure profit motive and that the "strict" application of utilization review/management devices together with both limited choice of primary care physicians and the ability of that physician to arrange referrals to specialists, had resulted in a health care delivery system that was "broken."

2. A Failed Solution

By 1995, because of widespread complaints that HMOs were imposing such severe impediments to delivery of health care, state legislatures began intervening. The first state to enact legislation to confer upon HMO plan members a right to sue was Texas. In 1997, State Senator David Sibley (R.Waco) sponsored S.B. 386, which passed and became law effective 9/97.[42]

Interestingly, then Texas Gov. George W. Bush, first threatened to veto the legislation; however, realizing the political implications of vetoing a bill with such wide and bi-partisan support, instead simply allowed the bill as passed to become law – albeit without signing the legislation into law.[43]

Texas S.B. 386 became law and Texas HMO members were given the right to sue health insurance carriers, HMOs and other managed care entities for failure to exercise ordinary care when making treatment decisions. The State of Texas sued Aetna U.S. Healthcare in the District Court of Travis County, Texas, alleging that Aetna had engaged in deceptive trade practices. That suit was settled by the Texas Attorney General and now U.S. Senator, John Cronyn, by an Assurance of Voluntary Compliance which may be found at: www.org.state.tx.us/notice/avc.fin1.pdf. Houston Univ. Law Professor, Seth J. Chander, authored an analysis of that settlement for the U.H. Health Law Policy Institute, entitled "The Texas-Aetna Settlement: A Significant Experiment in Managed Care Reform."[44]

In that settlement, Aetna agreed to waive the ERISA Preemption, agreed to publish its medical necessity guidelines on its website and, agreed that "medical necessity" would be defined as 'that treatment that improves or preserves health, life or function, slows the deterioration of health, life or function or can be used to prevent or diagnose medical problems.' However, with an eye upon impending claims certain to be brought under the recently passed Texas Health Care Liability Act ("THCLA"), Aetna left itself an "out." That "out" became involved in landmark ERISA litigation. Aetna insisted that it should not be barred from contending that if less expensive but equally effective treatment was available, the more expensive treatment would be considered to be 'not medically necessary.' That precise "out" was involved in the case of Juan Davila, who was a participant in an ERISA regulated employee benefit plan administered by Aetna Health, Inc. In administering Davila's plan, Aetna reviewed requests for

coverage of medical treatment and paid medical providers for covered expenses. Davila's doctor prescribed VIOXX for arthritis pain which Aetna refused to cover. Aetna insisted that Davila must first 'try and fail' Naproxyn. Davila complied rather than purchasing the VIOXX and paying for it himself. The Naproxyn caused stomach problems, loss of blood and hospitalization in intensive care. Davila sued in state court. About that same time, three (3) other cases alleging violation of THCLA were also proceeding in Texas state courts. Each of those cases were removed to U.S. District Court which ruled that ERISA preempted the suits. Those four cases were then appealed to the 5th U.S. Circuit of Appeals.[45]

The 5th Circuit reversed finding that the suits could proceed and that ERISA did not preempt.[46] The U.S. Supreme Court granted certiorari and agreed to hear both *Calad* and *Davila*.[47]

The U.S. Supreme Court reversed on June 21, 2004, holding that Section 88.001- 003 of the Texas Healthcare Liability Act were preempted by ERISA §502(a).[48]

The 1997 Texas Legislation was followed by enactment of similar legislation in other states; Georgia and California (1999), Washington, Arizona, Maine and Oklahoma (2000), West Virginia, North Carolina and New Jersey (2001). More restrictive legislation was also enacted in Oregon (2001), Louisiana (1999, Missouri (1997) and New Mexico (1998).[49]

3. Resumption of Abuses

Not surprisingly, with Managed Care Organizations and their utilization review policies under nationwide attack and 'HMO Law Suit' bills being introduced in approximately 30 other states between 1997 and 2004,[50] HMOs

quickly sought to alter their perception and "strict" managed care plans began to be replaced by "loose" plans. These changes were principally directed to appeasing physicians and patients regarding the most obvious and frequent basis for complaints; e.g., limitation on provider choice, restrictions on referrals to a specialists, etc.

Weiss Ratings news releases track the return to profitability of managed care organizations after experiencing a slump in revenue and membership in the mid-1990s and particularly after the nationwide campaign to enact legislation that would give HMO members a right to sue for injuries resulting from overly aggressive use of utilization management devices and restrictions upon access to specialists, a timeline is illustrative:

08/11/98 "Nearly 60% of HMOs Lost Money in 1997"

01/11/00 "Financial Scorecard for 1999: HMO Failures Surge 78%; Insurance Company Failures Rise 5%; Bank Failures increase 167%"

08/06/01 "HMOs Return to Profitability Earning $990 Million"

11/26/01 "HMO Earnings Climb 8 percent to $323 Million in First Quarter 2001"

09/03/02 "HMOs' and Health Insurers' Profits Increase 25% to $4.1 Billion in 2001"

12/18/02 "HMO Profits Climb 81% to $5.5 Billion in 2002"

08/30/04 "HMOs Earn $10.2 Billion in 2003, Nearly Doubling Profits"

05/24/05 "Profitability Continues to Surge for The Nation's HMOs"

01/30/06 "HMOs Earn $7 Billion in First Half of 2005"[51]

4. "Claims Editing"

Admittedly, the Property and Casualty Insurance Industry, as a whole, began experiencing a remarkable financial turnaround beginning in 2002.[52]

But, physicians all across America believed that Managed Care and P & C profitability was being accomplished at the expense of medical providers. In 2002, a number of lawsuits filed on behalf of physicians nationwide against managed care organizations and health insurers were certified as a class action while others continue to be pursued in various state courts. The consolidated litigation is known as *In re Managed Care Litigations* and is being pursued by 20 medical societies against several of the nation's largest managed care companies, including Aetna, Cigna, Anthem, Coventry, Foundation, Humana, PacifiCare, Prudential, United Health Care and Well Point. These suits, alleging RICO violations, were assigned to U.S. District Judge Federico Moreno of the Southern District of Florida in Miami. Similar litigation against the for-profit Blue Cross and Blue Shield Plans of 28 states and Puerto Rico brought on behalf of 850,000 physicians and involving 77 million insureds was also assigned to Judge Moreno and is entitled *Rick Love, M.D. v. Blue Cross and Blue Shield Association.* The RICO action against Aetna, Cigna, Health Net, Prudential, Anthem and Well Point and Humana been resolved by settlement:[53]

HEALTH PLAN SETTLEMENTS OVERVIEW:
SETTLEMENT VALUES AND IMPORTANT DATES

	AETNA	CIGNA	HEALTH NET	PRUDENTIAL	ANTHEM AND WELLPOINT	HUMANA	COMBINED SETTLEMENT TOTALS
PHYSICIAN CASH RECOVERY	$100 Million	>$70 Million	$39 Million	N/A	$135 Million	$40 Million	>$384 Million
PHYSICIANS' FOUNDATION FUNDS	$20 Million	$15 Million	$0	N/A	$5 Million	$0	$40 Million
FUNDING FOR COMPLIANCE AND ENFORCEMENT EFFORTS	$0	$0	$1 Million	$22 Million	$0	$0	$23 Million
CHANGES IN HEALTH PLAN BUSINESS PRACTICES	>$300 Million	>$400 Million	>$80 Million	N/A	>$250 Million	>$75 Million	>$1.1 Billion
TOTAL PHYSICIAN DAMAGES	>$420 Million	>$485 Million	>$120 Million	N/A	>$390 Million	>$115 Million	>$1.53 Billion
ATTORNEYS' FEES*	$50 Million	$55 Million	$20 Million	$5 Million	$58 Million	$18 Million	$131 Million
SETTLEMENT APPROVAL DATES	11/6/03 (Final Approval)	4/22/04 (Final Approval)	9/26/05 (Judge Approved; Appeal Pending)	9/26/05 (Judge Approved; Appeal Pending)	Hearing Scheduled: 12/2/05	Hearing Scheduled: 3/6/06	

*Attorneys' fees reflect approximately 10% of the value of the settlements.

Note: Trial against remaining defendants (PacifiCare, United, and Coventry) is scheduled to begin 9/18/06.

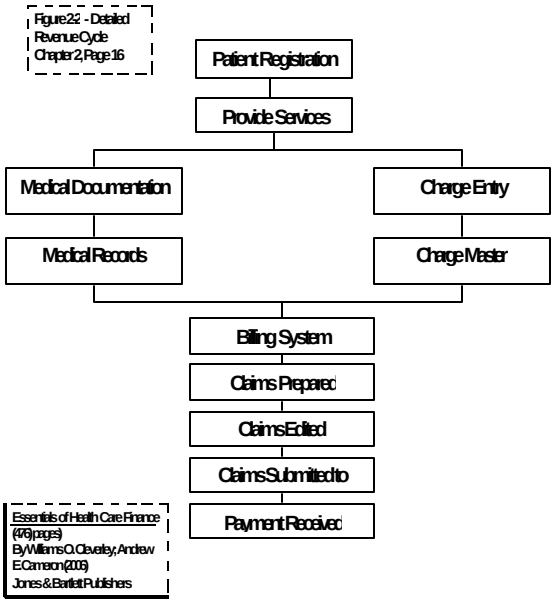
Earlier this year, settlement was reached in the class action against 90% of all Blue Cross and Blue Shield Plans in the country and the Blue Cross and Blue Shield Association. The Notice of proposed settlement specifying its terms was entered on the docket on April 27, 2007.

All of these suits have a similar theme: the use of software and techniques by which these Managed Care Organizations "edited" the bills submitted by physicians in order to pay the physicians substantially less than the bills submitted. Essentially, these HMOs agreed to extensive changes in their coding and reimbursement practices – chiefly to cease bundling and downcoding, to disclose the fee schedules they were using "to set" fee reimbursements, to disclose

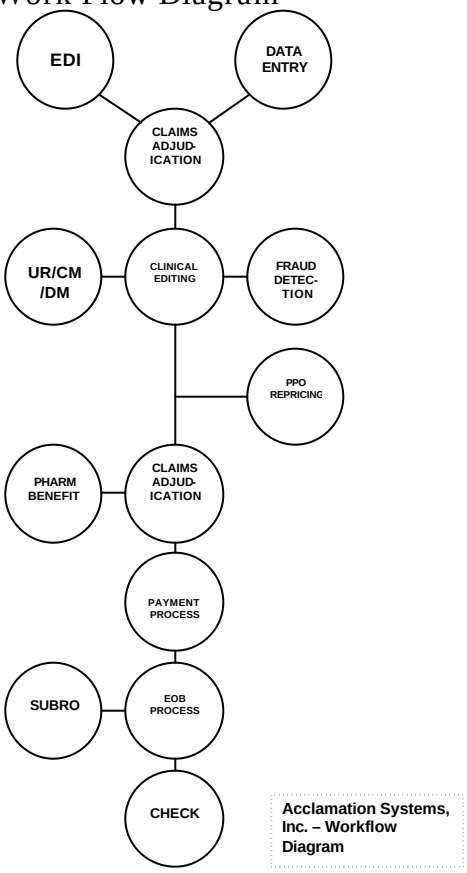
reimbursement coding protocols, to adopt new reimbursement appeal mechanisms, to reimburse physicians for wrongfully denied claims, and to use a clinically sound definition of *medical necessity*.[54]

G. The Tension between "Revenue Cycle" Of Physicians and the Payment Process Of Health Care Insurers/HMOs

"Revenue Cycle"



Health Insurer Payment Work Flow Diagram



Claims billings are submitted to payers which use sophisticated software "to edit" the bills. That software is both proprietary and commercially available.[55]

The Board's Fee Schedule contracted developer/compiler is also deeply involved in claims editing with its proprietary "Claims Editing Knowledge Base" which it touts as being able to detect:

> "More than three million improper coding relationships relating to CPT and HCPES Level II Procedure Codes and ICD-9 diagnosis codes including:
>
> - Unbundling
> - Incidental services
> - Mutually exclusive services
> - New patient visit auditing
> - Diagnosis to procedure appropriateness
> - Surgical assistant appropriateness
> - Maximum frequency per day editing
> - Place of service editing
> - Procedure diagnosis/modifier validations
> - Multiple procedure reductions"

1. So What's the Problem?

One authority, Martin Jensen, COO, Chief Analyst, and the webmaster/host of the website, "Healthcare IT Transition Group," an organization promoting 'harmonization'[56] of HIT (Healthcare Information Technology) software points out graphically the facility of software to be:

> ". . . used to flexibly regulate claim payouts for non-fraudulent claims. Payers use these systems to 'throttle' payments, cutting back as far as the traffic will allow, by selectively enforcing denial-generating edits.
>
> Makers of Denial Engine systems research all of the possible means by which a claim could be denied, amounting to literally millions of edits. It would be hard to imagine that all of the edits would ever be enforced at once, otherwise the payer would incur a provider revolt. But let's say one week's claim payments exceeded some desired maximum; next week they can throttle back by engaging more of the edits. Not only can the throttle control which edits are in force, but also for which types of providers."

2. The War You Never Heard of Before

As Health Care Industry payers become more creative in applying "edits," physicians, hospitals and other providers billing for health care services rendered have had to resort to electronic counter measures and software developers which create software to overcome what physicians describe as ". . . complex, opaque claims systems [designed] to confound their efforts to get paid fairly for their work."[57]

Jensen's assertions that health care payers have the ability to shift among myriad edits appears to be corroborated by Johnathon Bush, the President's cousin who co-founded Athenahealth Co., after a business folded due to insurance problems and payment delays. Bush reported to *The Wall Street Journal* that Athenahealth's software engineer can spot new "denial patterns" and quickly program an alert into the system. The new "denial pattern" is usually the result of a new coding "rule" that an insurer has introduced into its software.[58]

Martin of Healthcare IT Transitions Group adds:

> "Now here comes the notion of an anti-Denial Engine that resides on the provider side of the transaction. This could be very useful to providers. *Theoretically*, as long as the same logic is in effect with the payers (not awfully likely), providers would be able to test, adjust, retest, readjust until a claim was squeaky clean enough to slide through the tightest edit matrix. The caveat, of course, is that throttle. Remembering that there are enough edits available to squeeze health claim payments off to a dribble, you can't let your software consider every edit or you'd submit far too few claims. You'll never know which ones a given payer is enforcing on a given day."[59]

But, in addition to creative "editing" of claims, reports abound of reliance upon other means to avoid payment or to reduce exposure for payments. Other seemingly obvious forms of "denial" continue to be used by healthcare insurers, such as reducing payments based upon claims that providers are "out of network" – even when they aren't.[60]

The problem of "claims editing" is pervasive across all forms of healthcare insurance – including workers' compensation. In direct response to the Managed Care Policies which led to the Managed Care class action litigation, in 2003, North Carolina adopted G.S. 58-3-227 which provides in pertinent part that an insurer is required to disclose its fee schedule, claims bundling "and other claims editing processes," etc. New York goes even further, requiring that "HMOs and insurers must provide the name of the commercially available claims editing software product that the health plan utilizes and other significant edits on their provider websites are in provider newsletters"

VI - Is There an Inverse Relationship Between The Use of Managed Care Medical Cost Containment Devices and Delivery/Quality of Care?

Evidence has been accumulating for many years which suggests that investor-owned HMOs were providing a lesser quality of care than not-for-profit HMOs. However, the first confirmatory study was conducted and reported in the July 14, 1999, edition of the *Journal of the American Medical Association* (*JAMA*).[62]

The *JAMA* Study analyzed 1996 quality-of-care data for 329 HMO plans (248 investor-owned and 81 not-for-profit), representing 56% of the total HMO

enrollment in the U.S. The results were startling. Compared with not-for-profit HMOs, investor-owned plans had lower rates for all 14 quality-of-care indicators. The Study then concluded – without equivocation - that "Investor-owned HMOs deliver lower quality of care than not-for-profit plans" In 2003, a study performed by the University of Washington, Dept. of Family Medicine, opined that the quality of care provided by for-profit HMOs suffered because "[f]or profit HMOs are typically driven by the market with a strong focus on managing costs rather than care."[63] The next year, in 2004, another study was reported in *JAMA* which had analyzed the quality of care rendered by Medicare Advantage HMO plans versus traditional fee for service. The study, supported in part by the Agency for Healthcare Research and Quality (HSO9205), concluded that Medicare Advantage was better at delivery of preventive services; but that traditional fee-for-service did a better job in the overall care experience.[64] In May of this year, 2007, the AMA reported in a statement to the U.S. House Ways and Means Subcommittee on Health that more than half of physicians report that Medicare Advantage HMO and PPO plans were denying coverage for services typically covered by traditional Medicare. Physicians also reported that payments for services were less from Medicare Advantage than payments for exactly the same services rendered under fee-for-service.[65] And, in 2005, a new study found that some for-profit Medicare health plans provided lower quality of care than not-for-profit plans.[66] Even more distressing, a GAO study (GAO-07-945), reported in the September 10, 2007, *New York Times*, revealed that CMS has failed to audit these Medicare HMOs as required by law; allowing them to

retain millions of dollars that should have gone to consumers in the form of reduced premiums.

But, the definitive study referred to as "The First National Report Card on Quality of Health Care in America" was performed jointly by the *New England Journal of Medicine* and the Rand Corporation and released March 16, 2006. The result should dismay all Americans. Thirteen thousand individuals in twelve (12) metropolitan areas throughout the county were interviewed. Six thousand two hundred gave permission for researchers to review their medical records. Notably, the study focused on what percentage of recommended care was actually received by the interviewees whose healthcare was provided by a number of different healthcare delivery systems. Traditional Medicare fee-for-service did the best overall job of providing the medical care recommended. On the other hand, managed care, at 55.2%, scored only slightly better (1.5%) than the percentage of medical care received by those who had no medical coverage at all! (53.7%).

Are Georgians Satisfied With Their Healthcare?

As recently as October 13, 2005, the GAO reported that of 75 licensed Small Group Health Insurance Carriers, BCBS Health Care Plan of Georgia had a 27% market share in Georgia.[67]

The September, 2007, *Consumer Reports* contains ratings for HMO and PPO health plans in the U.S. Georgians are apparently not too pleased with those health care plans which have the largest enrollments: None of the HMOs in Georgia were ever given ratings; however, among PPOs, both Blue Cross Blue Shield of Georgia and United Healthcare were rated. BCBS "came in" ranked

32nd of 46, the "bottom one third," while United Healthcare did even worse – 35th out of 46. Significant numbers of enrollees in both plans expressed a preference to switch to other plans - 26% of enrollees in BCBS and 27% of United Healthcare enrollees.[68]

VII - Until the General Assembly Provides Otherwise, Managed Care Utilization Review/Management Devices are Limited to WC/MCOs

A. Utilization Review/Management (defined)

Utilization Review (UR): A system designed to monitor the use of, or evaluate the medical appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Utilization review may include ambulatory review, case management, certification, concurrent review, discharge planning, prospective review, retrospective review or second opinions.

Utilization Review Organizations (URO): Independent organizations that conduct utilization review for a managed care plan. UROs do not include insurers or health plans that conduct their own internal utilization review.[69]

1. References to Utilization Review/Management Devices in The Act and Board Rules

O.C.G.A. §34-9-208, Board Rules 200, 201, 205 and 208 contain terms, commonly used by Managed Care Organizations, albeit without any definitions, standards or criteria for use and/or evaluation of use/application in a proposed WC/MCO, by the Board or others. To assist readers hereof, the terms, pertinent to this paper and presentation will be defined with "citation" when such terminology or its equivalent is used in The Act and/or Board Rule. Examples [by Power PointPresentation] will also be provided. Additionally, for those terms/managed care devices which are already being used in traditional "Panel"

fee-for-service Georgia workers' compensation claims, an additional discussion of that term will also be provided:

	DEVICE	STATUTORY PROVISION(S)	BOARD RULE(S)
1	Authorization/Pre-Authorization/ Advance Authorization	----------	205(b)(2)
2	Case Management/Medical Management	O.C.G.A. § 34-9-208	200.1(a)(i)(ii)(iii), (2); 208(a)(j)(1), (k)(i), (p), (q)(3)(1)(A), (h)
3	Certification/Pre-Certification	----------	205(b)(2)
4	Complaint(s)/Greivance	----------	208(a)(1)(n); (c)(1)(c)
5	Consultation/Consultation Services	O.C.G.A. § 34-9-201(a)(1); § 34-9-208(d)(4)	201(a)(1)(i)
6	Dispute/Internal Dispute Resolution	O.C.G.A. § 34-9-208(d)(3)	208(a)(1)(n), (c)(1), (d)
7	Duration of Disability	----------	208(g)(2)
8	Effective/Effectiveness/Cost Effectiveness	O.C.G.A. § 34-9-208(d)(3)	208(a)(1), (k)(v)
9	Financial Incentive(s)	O.C.G.A. § 34-9-208(d)(2)	208(d)(2)
10	Geographical Service Area	----------	208(a)(1)(D)(E)
11	Managed Care Plan	O.C.G.A. § 34-9-208(c)(1)	208(a)(1)(B)(6), (a)(1), (k)(ii)(iv), (d)(1)(2)
12	Participating Provider/Participating Healthcare Provider	----------	208(a)(1)(k)(vi), (c)(2)(B), (c)(3), (d)(1)(2)
13	Peer Review	O.C.G.A. § 34-9-205(b), § 208(d)(1,6), (f)(g)(h)	208(c)(1)(C), (g)
14	Quality/Quality Assurance/Quality of [Medical] Service	O.C.G.A. § 34-9-208(d), (1,6), (f), (g), (h)	208(a)(1)(m), (c), (d)(1)
15	Treatment/Necessary Treatment Inappropriate/Excessive Treatment	O.C.G.A. § 34-9-208(d)(3)	208(k)(ii)(v)
16	Treatment Standards/"Uniform Treatment Standards Required by Georgia Law"	O.C.G.A. § 34-9-208(d)	208(a)(1)(c)(H)
17	Utilization/Service Utilization	O.C.G.A. § 34-9-208(d)(2,3), (f), (g), (h)	208(c)(1)(C), (2)(C), (M), (g)

O.C.G.A. §33-20A-3(11) defines a "Managed Care Plan" as:

"(11) "Managed care plan" means a major medical, hospitalization or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; and

(c) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; provided, however, that the term "managed care plan" does not apply to Chapter 9 of Title 34, relating to workers' compensation."[70]

A better definition of "Managed Care Plan" and "Managed Care Organizations":[71]

Managed Care Plan: A health benefit plan that creates a financial incentive to use providers that are in the health plan's network. Some managed care plans limit coverage to care obtained from network providers. Others pay more if the member obtains care from within the network, but will pay something for covered services obtained from non-network providers. Two of the primary components of a managed care system are systems that oversee the amount and type of health services being used ("utilization review") and provider reimbursement methods that discourage unnecessary care.

Managed Care Organization (MCO): A generic term applied to managed care companies such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or Point of Service (POS) plans."

Of the 17 "Managed Care" terms of art found in The Act and/or Board Rules, not one is defined; however, some accurate and applicable definitions may be found in Georgia law and elsewhere from other credible sources. O.C.G.A.

§33-20A-1, entitled "The Patient Protection Act of 1996," might be of benefit where a definition specific to/consistent with Georgia law does not exist or may not be easily inferred.

2.PROSPECTIVE REVIEW

"Utilization review conducted before an admission or a course of treatment. Prospective review includes pre-authorization and pre-certification requirements that may be needed before a patient can be admitted to a hospital or obtain certain health care."

(a) Pre-Authorization/Pre-Certification

O.C.G.A. §33-20A-3(15):

> " 'Precertification' or 'preauthorization' means any written or oral determination made at any time by an insurer or any agent thereof that an enrollee's receipt of health care services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as pre-requisite for payment for such services have been satisfied."[72]

These terms, conjoined by the Georgia General Assembly for definition are very definitely not synonymous. The Glossary of Managed Care terms available at the website of the North Carolina Medical Institute[73] defines the terms more precisely:

"Preauthorization: The health plan's approval that a requested hospital admission, treatment or procedure is a covered service and is medically necessary and appropriate. Managed care organizations often require that a member or insured individual obtain prior authorization from the health plan before a hospital admission or selected health care services, treatment or procedure will be covered. See also prior authorization or prior approval.

Precertification of Pre-Admission Screening: Authorization that must be obtained from the health plan before inpatient care is provided in order for the plan to pay for the hospitalization. Pre-admission screening reviews the appropriateness of the requested care, while precertification may specify the allowable length of stay in addition to what services/procedures will be covered.

Noncertification: A determination by an insurer or its designated utilization review organization to deny, reduce or terminate a requested service, treatment or procedure. The denial must be based on a review and a decision that the requested service, treatment or procedure does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness."

3. CONCURRENT REVIEW

"Utilization Review Conducted During the Course of a Patient's Hospital Stay or Course of Treatment, to Determine Whether The Hospital Stay or Treatment is Still Necessary."[74]

(a) Peer Review/Peer-to-Peer

As noted previously, in 1985, Georgia adopted a "Peer Review" process which was designed to operate retrospectively. While the statutory provision continues to exist, Peer Reviews conducted in accordance with the process specified by O.C.G.A. §34-9-205(b) and Board Rule 203(c)(2,3) rarely, if ever, take place. The void caused by the unintended consequence of a laudable legislative effort to preclude concurrent review and thereby create a basis for medical care delay, has been filled by insurers utilizing a Peer-to-Peer managed care device/process. "Peer-to-Peer", defined as a component of managed care utilization review, may involve several elements. Again, the North Carolina Institute of Medicine provides definitions of those elements:

"**Peer Review**: Mechanism of ensuring quality of care within the medical community. The quality assurance review is conducted by health care professionals (peers) to ensure that care provided and services used are appropriate. It is also used to identify fraud and other abuses of health care payment systems."

Peer-to-Peer reviews, as conducted by managed care organizations, may be "internal"; that is performed by a physician employee of the HMO, another

physician in the network or may be contracted out to a third party which then may either perform the "peer-to-peer" or may assign the "peer review" to a physician with which the third party organization has contracted to provide such reviews.

When performing such a peer-to-peer, the following elements may be involved:

Clinical Peer: "A health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review." Plans must use clinical peers in the second-level grievance hearings to determine if requested services should be approved.[75]

Clinical Review Criteria: The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. May include clinical protocols or practice guidelines used by an insurer to determine the services or treatments that are appropriate and medically necessary for a person with a specific health condition, disease or illness.[76]

Clinical Guidelines: The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. Clinical guidelines are usually developed by practicing health care providers, and are an attempt to identify the best way to prevent, detect or treat a particular medical condition. Managed care organizations and other health care institutions use clinical guidelines as a way to ensure that practitioners are providing appropriate care, and to standardize care across providers. Clinical guidelines may also be called clinical protocols, practice guidelines, or medical protocols.[77]

Another element of the typical managed care peer-to-peer review is a right of appeal which, in the managed care setting, may be defined as:

> "A request by a member to their health plan to review a non-certification decision; that is, a decision to deny or limit care recommended by the member's physician or provider."[78]

O.C.G.A. §34-9-208(d)(3) mandates that a WC/MCO "provide adequate methods of . . . dispute resolution." Board Rule 208(a)(1)(N) requires internal dispute resolutions. Neither the statute nor the rule provide any definitive

criteria to create or for the Board to assess whether the method(s) of internal dispute resolution are "adequate." The right of an external, independent review contained within O.C.G.A. §33-20A-32 appears to be unnecessary as the Board's Procedure Manual provides:

> "Any issues related to the certified MCOs administration, medical treatment, or additional changes of authorized treating physician are appropriate for the dispute resolution process. The certified MCO must complete the dispute resolution process within 30 days of written notice of the dispute. *After 30 days, the disputing party may request Board intervention if the issue has not been resolved.*[79] (emphasis supplied)

(b) Case Management

As noted in the chart appearing on page 53 hereof, numerous references to "case management" as a required component of a WC/MCO are found in both The Act, Board Rule 208 and the Board's Procedure Manual. Medical case management is central to the managed care model adopted by Board Rule. The commonly accepted definition of "case management" and "case manager" within the managed care context is:

"**Case Management:** A coordinated set of activities to manage the health care services provided to patients with serious, complicated or prolonged health conditions.

Case Manager: A person (often a nurse or social worker) who coordinates all of a person's care. Case managers are often employed by insurance companies or health plans to help coordinate and manage care provided to members with complex or costly medical conditions. In these instances, case managers also help ensure patients receive appropriate care in the least costly setting."[80]

In the instance of "case management," however, the focus on the role of the case management in a Georgia WC/MCO is well described:

"7. Case Management The medical case manager in a certified MCO acts as a patient advocate for the injured employee while coordinating appropriate medical care and return to work with the employer of injury. The primary

purposes of this medical care coordination are to ensure high quality care, reduce recovery time, and minimize the effects of the injury. The medical case manager updates medical treatment information with all involved parties, facilitating the appropriate return to work of injured employees. The medical case manager assesses cases from the first notice of injury when the injured employee calls the certified MCO's toll free number. After initial contact with the authorized treating physician selected by the injured employee, the medical case manager ensures an understanding among all parties on a treatment plan and time frame appropriate to the diagnosis. There is ongoing assessment of the injured employee's recovery. Treatment and anticipated recovery period are modified as indicated. Case management in a certified MCO is primarily accomplished telephonically with limited use of on-site case management services. MCOs must identify when on-site case management is likely to be utilized. In catastrophic injury cases a registered catastrophic rehabilitation supplier must be assigned."[81]

Case Management is distinguished from either "Voluntary Rehabilitation" – Board Rule 200.1(h) – or "catastrophic" case management/vocational rehabilitation - Board Rule 200.1(a)(1)(ii),(2) and Board Rule 208(h).

(c) "Second Opinions"

The term "second opinion" does not appear anywhere in Chapter 9 of Title 34, the Board Rules or the Board's Procedure Manual. The only possible allusion to the "second opinion" process *could be* the ambiguous phrase found in O.C.G.A. §34-9-208(d)(4), "provide a program . . . to promote consultative and other services. . . ." However, in the context in which that phrase appears, it is unlikely that the drafters intended the phrase to refer to that special form of "consultation" known as a "second opinion." As presently used/usurped[82] by the managed care industry, a "second opinion" is now:

"**Second Opinion:** The term used when an insured person obtains a clinical evaluation by another provider in addition to the one who originally recommended a proposed service. Second opinions are used to assess the medical necessity and appropriateness of the proposed service. Sometimes insurers or HMOs require the insured individual to seek a second opinion before covering certain services. At other times the insurer or health plan may be willing to pay for the second opinion at the request of the insured individual."[83]

But, in traditional "panel" cases, the term must retain its original statutory role as a form of consultation procured by the authorized treating physician. O.C.G.A. §34-9-201(b)(1) as originally crafted in 1978 – and a "right" which continues to this day – the authorized treating physician was empowered to ". . . arrange for any consultation. . . ."

By definition – and by CPT Code and the Georgia Fee Schedule – a "second opinion" serves as a "confirmatory consultation." In that regard, a "second opinion" is contrasted with an "IME" which will ordinarily be used in litigation or specifically to provide a basis for an employer/insurer to deny a medical service. See, concurring opinion by Blackburn, *Lancaster v. USAA Casualty Ins. Co.*, 232 Ga. App. 805, 502 S.E. 2d 752 (1998). "Second opinion" serves an entirely different purpose than "IMEs". See, e.g. *Phillips v. Certain Underwriters at Lloyd's London, Gallagher Bassett Services, Inc.*, (M.D, Fla., 2005) 2005 U.S. Dist. LEXIS 24429.

In the past quarter century, there have been eight decisions by the Georgia Court of Appeals in which the Term of Art, "Second Opinion" appears in some context; i.e., *Georgia Power Co. v. Pinson*, 167 Ga. App. 90, 305 S.E. 2d 887 (1983); *Pritchard Services v. Lett*, 183 Ga. App. 298, 358 S.E. 2d 842 (1987); *Am. International Adjusting Co. v. Davis*, 202 Ga. App. 276, 414 S.E. 2d 292 (1991); *Mt. Vernon Mills v. Gunn*, 197 Ga. App. 109, 397 S.E. 2d 603 (1990), *Atlanta Hilton & Towers v. Gaither*, 210 Ga. App. 343, 436 S.E. 2d 71 (1993); *West Marietta Hardware v. Chandler*, 227 Ga. App. 436, 489 S.E. 2d 584 (1997); *Fulton County Board of Education v. Taylor*, 262 Ga. App. 512, 586 S.E. 2d 51 (2003); and *Marta v. Reid*, 282 Ga. App. 877, 640 S.E. 2d 300 (2006). Of those

eight cases, the facts and discussion in *West Marietta Hardware v. Chandler*, supra, describes the correct use of a "second opinion" arranged by an authorized treating physician for the purpose of obtaining a consultative opinion regarding a diagnosis and treatment plan. And, that case is also of value since it refers to an "IME" obtained by the employer following the rendering of the "second opinion." In *Pritchard Services v. Lett*, supra, the Court of Appeals apparently made the same mistake that the litigants had made – referring to the opinion rendered by a second panel physician to whom the claimant had been referred by the employer, after the claimant expressed dissatisfaction with the first panel physician. Thus, the opinion by the second panel physician represented nothing more than the election of the employee's "one free change in physician." *Marta v. Reid*, supra, a WC/MCO case, simply represents the author's point – that "second opinions" are now a process used more for utilization review/management than for the purpose intended, "confirming consultation."

By statute and administrative rule some states have inserted strict controls over the use of "second opinions" in a workers' compensation case setting. For example, Minn. Stat §376.135 (2006) provides:

> "Subd. 1A. Nonemergency surgery; second surgical opinion.
>
> The employer is required to furnish surgical treatment pursuant to subdivision 1 when the surgery is reasonably required to cure and relieve the effects of the personal injury or occupational disease. An employee may not be compelled to undergo surgery. If an employee desires a second opinion on the necessity of the surgery, the employer shall pay the costs of obtaining the second opinion. Except in cases of emergency surgery, the employer or insurer may require the employee to obtain a second opinion on the necessity of the surgery, at the expense of the employer, before the employee undergoes surgery. Failure to obtain a second surgical opinion shall not be reason for nonpayment of the charges for the surgery.

> The employer is required to pay the reasonable value of the surgery unless the commissioner or compensation judge determines that the surgery is not reasonably required."

But, the fact remains that a supposed requirement for a "second opinion" is now being communicated by insurers to treating physicians as a device to obstruct/delay the very medical treatment ordered by authorized treating physicians. Apparently, those relying upon this artifice realize that many physicians are familiar with the inclusion of a requirement for "second opinions" in group health managed care and PPO plans; and – just as happened with the "pre-authorization" problem – physicians are unlikely to realize that a requirement for a "second opinion" (as contrasted with an "IME") would be permissible only if the medical care was being delivered through a WC/MCO; and, even then, only in accordance with a "second opinion" process which was clearly defined in the WC/MCO plan submitted to the Board for initial certification.

Reference to the Georgia Fee Schedule since 1985 would be helpful. As far back as 1989, the fee schedule contained a specific section entitled, "Independent Medical Examination." However, that fee schedule listed separately the fee to be paid for "confirmatory consultations" in accordance with AMA CPT #s 90650-654. This separation/delineation between "IME" and Confirmatory Consultation continued in the fee schedules of 1991[84] and 1992, although the 1992 fee schedule reflects the change in AMA CPT Code for "Confirmatory Consultation" to 99271-275 which remained the CPT#s to be used until 2006.[85]

The "fee schedules" from 1993 – 1998, continued this same pattern. However, the fee schedule effective April 1, 2000, "spelled out" the difference between a "second opinion" and an "IME:"

> "SECTION IV: GENERAL REIMBURSEMENT GUIDELINES
>
> Independent Medical Exam (IME)
>
> Employers/insurers have the right to request the injured employee to submit to an independent medical examination (IME), by a duly qualified physician or surgeon designated and paid by the employer/insurer. The employer/insurer must notify the employee in writing at least ten days in advance of the time and place of the examination. Advance payment of travel expenses must accompany the notice. Travel beyond the employee's home city shall include the actual cost of meals (up to $30 per day) and lodging. When travel is by private vehicle the rate of mileage shall be .25 cents per mile. The employee shall have the right to have present at such examination any duly qualified physician or surgeon, provided and paid for by the employee.
>
> The employee, after an accepted compensable injury and within 60 days of receipt of any income benefits, shall have the right to one independent medical examination (IME) at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and paid for by the employer/insurer. The employer or insurer shall be notified in writing in advance. Such examination shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the cost of such diagnostic procedures in excess of $250 are paid for by a party other than the employer or insurer.
>
> Payment for independent medical examinations will be based on time spent in the review of medical records, test reports, a physical examination and a written report regarding the medical condition of the injured employee. Time will be the essential factor in determining reimbursement for an IME. The following hourly rate will establish the maximum allowable reimbursement for this service.[86]
>
> SECTION V: PAYMENT GROUND RULES BY CATEGORY
>
> SUBSECTION A: EVALUATION & MANAGEMENT (E/M) SERVICES[87]

Consultation

Defined by CPT as type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source. Consultations are reimbursable only to physicians with the appropriate specialty for the services provided. A consulting physician shall only initiate diagnostic and/or therapeutic services with approval from the authorized treating physician. Following a consultation, if the consulting physician assumes responsibility for management of all or any part of the injured employee's condition(s) in accordance with O.C.G.A. §34-9-200, the injured employee becomes an "established patient" (rather than follow-up consultation) under the care of the consulting physician.

When a second opinion is requested or required regarding the necessity or appropriateness of a recommended medical treatment or surgical procedure by the injured employee or employer/insurer/ specific confirmatory (second opinion) codes are used to designate confirmatory medical opinions."[88] (emphasis supplied)

The fee schedule effective September 1, 2001, with annual "updates" survived until Ingenix compiled the fee schedule effective 4/1/05. Despite these "updates" of the 2001 fee schedule for the years between 2001 and 2005, the same distinction between "second opinions" as a subset of "confirmatory consultations," and "IMEs" was continued. However, that 2001 fee schedule further recognizes the difference between "second opinions" and "IMEs" as, for the first time a new sentence was added to the explanation of the purpose and use of an "IME." The new provision regarding "IME" reads in pertinent part:

"SECTION IV: GENERAL REIMBURSEMENT REQUIREMENTS

Independent Medical Exam (IME)

Employers/insurers have the right to request the injured employee to submit to an independent medical examination (IME), performed by a duly qualified physician or surgeon designated and paid by the employer/insurer. The employer/insurer must notify

the employee in writing at least ten (10) days in advance of the time and place of the examination. Advance payment of travel expenses must accompany the notice. Travel beyond the employee's home city shall include the actual cost of meals (up to $30 per day) and lodging. When travel is by private vehicle the rate of mileage shall be .28 cents per mile. The employee shall have the right to have present at such examination any duly qualified physician or surgeon, provided and paid for by the employee.

The employee, after an accepted compensable injury and within 120 days of receipt of any income benefits, shall have the right to one IME performed at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and paid for by the employer/insurer. The employer or insurer shall be notified in writing in advance. Such examination shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the cost of such diagnostic procedures in excess of $250 are paid for by a party other than the employer or insurer.

Payment for independent medical examinations will be based on time spent in the review of medical records, test reports, a physical examination and a written report regarding the medical condition of the injured employee. Time will be the essential factor in determining reimbursement amount for an IME. The provider shall complete Board Form WC-20 (a) Medical Report or the HCFA-1500 form. *Do not use a CPT code when reporting an independent medical exam (IME)".*[89] (emphasis supplied)

And, the provisions regarding the use of "second opinions" as a subject of "consultations":

"SECTION V: EVALUATION & MANAGEMENT (E/M) SERVICES

SUBSECTION A: PAYMENT GROUND RULES FOR E/M CATEGORY

Consultations

Defined by CPT as type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source. Consultations are reimbursable only to physicians with the appropriate specialty for the services provided. A consulting

> physician shall only initiate diagnostic and/or therapeutic services with approval from the authorized treating physician. Following a consultation, if the consulting physician assumes responsibility for management of all or any part of the injured employee's condition(s) in accordance with O.C.G.A. §34-9-200, the injured employee becomes an "established patient" (rather than follow-up consultation) under the care of the consulting physician.
>
> When a second opinion is requested or required regarding the necessity or appropriateness of a recommended medical treatment or surgical procedure by the injured employee or employer/insurer, specific confirmatory (second opinion) codes are used to designate confirmatory medical opinions."[90]

Since Ingenix took over the responsibility for compilation of the fee schedule, the distinction between "IME" and "second opinion confirmatory consultations" has continued through the current fee schedule effective 4/1/07.

Medicare, too, recognizes the traditional purpose served by "second opinions" and for that reason, will pay for a "second" and even a third surgical opinion when requested by the patient or the patient's physician. However, where a "second opinion" is required by a third party payer as a condition precedent to surgical certification, Medicare pays nothing.[91]

The AMA, too, not only recognizes the difference between the roles – and duties – of physicians in connection with consultations, second opinions and the physician – patient relationship in the context of work-related and independent medical examinations, those distinctions and the separate professional and ethical duties imposed upon physicians has been "codified" in the AMA's Principles of Medical Ethics.[92]

These Principles of Medical Ethics are considered to be as "binding" as are the Georgia Rules of Professional Conduct for attorneys. Numerous Appellate Court decisions in Georgia and other jurisdictions have held that the Principles of

Medical Ethics establish – for legal purposes – the standard of care; see, e.g., *In re Baska,* 281 Ga. 676, 641 S.E. 2d 533 (2007); *Ketchup v. Howard,* 247 Ga. App. 54, 543 S.E. 2d 371 (2000); *Downing v. Shumpert*, 235 Ga. App. 500, 510 S.E. 2d 81 (1998).

(d) Treatment Guidelines

The term, "treatment guidelines," does not appear in O.C.G.A. §34-9-208, Board Rule 208, the board's Procedure Manual or any other known Board publication. The term, "treatment standards," which appears in O.C.G.A. §34-9-208(d)(1) and the more descriptive and specific term, ". . . quality services that meet all uniform treatment standards. . ." *might suggest* to a proponent of treatment guidelines that such use of "guidelines," at least in WC/MCOs, are presently permissible. But, the next phrase which qualifies and limits such "uniform treatment standards" [to only those] "required by Georgia Law",[93] would confirm that "treatment guidelines" may not be used at the present time in this state. Thus, it could be argued that "uniform treatment standards required by Georgia law" may actually refer to general medical "standards of care."

Given the aggressive push by national insurers for state-by-state legislative adoption of "treatment guidelines" (and/or "disability guidelines); the "sessions" planned to cover Medical Treatment Guidelines,[94] it is wise to understand and be prepared for an attempt to convince Georgia elected and appointed officials to adopt treatment and/or disability guidelines or to condone that use of such guidelines which is already occurring. It would also be appropriate to anticipate that Guidelines, initially "sold" as "recommendations" to encourage treatment standardization, quality of care uniformity, etc. will quickly be transformed into

mandatory parameters as occurred in Minnesota only eight years after the adoption of "Workers' Compensation Treatment Parameter Rules."[95]

The term, "treatment guidelines," in the workers' compensation setting, appears to be an inclusive term which may encompass a number of separate or associated "clinical practice guidelines" for the purpose of managing the complete cycle of medical care delivered to an injured worker from initial office visit to release from care.

Starting with a simpler term, "clinical practice guidelines," the definition is generally agreed to be:

> "Systematically developed statements that aim to help physicians and patients reach the best health care decisions."[96]

In the industrial medicine setting, a compendium of such clinical practice guidelines combine to shift the focus to medical treatment leading to functional improvement rather than a medical "cure."[97]

The difference between medical cure and *functional improvement* is an important distinction and forms the basis in concept for the set of treatment guidelines created and published by the American College of Occupational and Environmental Medicine (ACOEM), Occupational Medicine Practice Guidelines, 2nd Ed. As an adjunct to that publication, ACOEM has added "Utilization Management Knowledgebase," a tool to evaluate, track, and report the medical necessity and/or appropriateness of health care services. Those two works, in conjunction, make recommendations for initial and ongoing treatment modalities, the therapeutic success of which is judged by improved functional capacity, reduced medical needs and subjective improvement.[98]

"Treatment guidelines" or "clinical practice guidelines" are said to be based upon both "evidence" and opinion; however, "good" guidelines have the attributes of validity, reliability, reproducibility, clinical applicability, flexibility, clarity, development through a multi-disciplinary process, scheduled reviews, and documentation.[99]

The quality of guidelines varies considerably. In an evaluation of 279 guidelines published from 1985 through June 1997, the evaluators – which included Dr. Terrence Shaneyfelt, a recognized authority on clinical guidelines – concluded that:

> "Guidelines published in peer-reviewed medical literature during the past decade do not adhere well to established methodological standards. While all areas of guidelines developed need improvement, greatest improvement is needed in the identification, evaluation, and synthesis of the scientific evidence."[100]

The most common criticism of guidelines and guideline development is conflict of interest among the developers or that the guideline development was influenced too much by the very industry to which the guideline would be applied. The British Medical Journal reported in January 2007 that "many clinical guidelines for doctors in the United States are influenced by the pharmaceutical industry and special interest groups" citing NEJM, 2007, 356: 331-3. This same BMJ article stated that the process of evaluation of guidelines by the U.S. NIH Concensus Development Program[101] and the Agency for Healthcare Research and Quality ("AHRQ")[102] has conducted the most systematic review of guidelines.

In a presentation made to the December 7, 2004, "Evidence-Based Decision Making for Health Policy Leaders Workshop," noted authority on guidelines reliability, Dr. Paul G. Shekelle, noted the following:

- Guidelines become outdated in 5.8 years;
- In a 2000 assessment of 17 guidelines developed by AHRQ between 1990 and 1996, 40% needed a major update and 35% needed a minor update.[103]

Treatment/Clinical Practice Guidelines number in the thousands and have been developed by governmental agencies, academics, medical specialty organizations, insurers, and various other groups. Some guidelines have also been developed and are mandated for claims management uses.

The pressure upon policy makers to adopt treatment guidelines is enormous – particularly when a workers' compensation "reform" movement demands immediate action. Such was the case in California between 1997 and 2002 as medical care costs reportedly grew by 111%. To address this problem, the California Legislature passed a series of initiatives aimed at reducing costs by eliminating inappropriate medical care utilization. Accordingly, SB 228, which passed in 2003, called for adoption of medical treatment guidelines to define the appropriate utilization of medical care. The American College of Occupational and Environmental Medicine (ACOEM) guidelines were chosen to be used on an interim basis until a complete set of guidelines specific to California could be completed.[104] The interim adoption of that set of guidelines and the problems which ensued produced a 131 page study evaluating Medical Treatment Guideline Sets funded by The Rand Corporation. A panel of noted guideline experts used the Institute of Medicine (IOM) definition of *guideline*; that is, "systematically

developed statements to assist practitioners and patient decisions about appropriate health care for specific clinical circumstances."[105] Searching the National Library of Medicines MEDLINE and the National Guidelines Clearinghouse, 72 relevant guidelines were identified and evaluated. Sets of guidelines rather than multiple individual guidelines were selected for evaluation. The objective was to identify a single guideline set that would address many concerns and costly work-related injuries in a rigorous, evidence-based fashion. Five guideline "sets" met the screening criteria:

1. AAOS – Clinical Guidelines by the American Academy of Orthopedic Surgeons.
2. ACOEM – American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines.
3. Intracorp – Optimal Treatment Guidelines, part of Intracorp Clinical Guidelines Tool®
4. McKesson – McKesson/InterQual Care Management Criteria and Clinical Evidence Summaries.
5. ODG – Official Disability Guidelines: Treatment in Workers' Comp, by Work-Loss Data Institute.[106]

The RAND team used the AGREE Collaboration (2001) six domains of that system to evaluate unbiased guidelines, using the guidelines themselves as well as detailed descriptions and corroborating evidence provided by guideline developers to evaluate the guidelines as to:

Table 5.1[107]
AGREE Instrument Domains and Questions

Scope and purpose:

- The overall objective is specifically described.
- The clinical questions covered by the guidelines are specifically described.
- The patients to whom the guideline is meant to apply are specifically described.

Stakeholder involvement:

- The guideline development group includes individuals from all the relevant professional groups.
- The patients' views and preferences have been sought.
- The target users of the guidelines are clearly defined.
- The guideline has been piloted among target users.

Rigor of development:

- Systematic methods were used to search for evidence.
- The criteria for selecting the evidence are clearly described.
- The methods used for formulating the recommendations are clearly described.
- The health benefits, side effects, and risks have been considered in formulating the recommendations.
- There is an explicit link between the recommendations and the supporting evidence.
- The guideline has been externally reviewed by experts prior to its publication.
- A procedure for updating the guideline is provided.

Clarity and presentation:

- The recommendations are specific and unambiguous.
- The different options for management of conditions are clearly presented.
- Key recommendations are easily identifiable.
- The guideline is supported with tools for application.

Applicability:

- The potential organizational barriers to applying the recommendations have been discussed.
- The potential cost implications of applying the recommendations have been considered.
- Key review criteria are included for monitoring and review purposes.

Editorial independence:

- The guideline is editorially independent from the funding body.
- Conflicts of interest of guideline development members have been recorded.

Applying the AGREE Instrument Domains and Questions, the RAND panelists assessment of the Comprehensiveness and Validity of the guidelines for Clinical Evaluation:[108]

	AAOS	ACOEM	Intracorp	McKesson	ODG
Appropriateness					
Surgery	2 of 4 topics	3 of 4 topics	1 of 4 topics	3 of 4 topics	2 of 4 topics
Physical therapy and chiropractic	0 of 6 topics	1 of 6 topics	0 of 6 topics	2 of 6 topics	2 of 6 topics
Residual Content					
	Not compre-hensive	Validity uncertain	Validity uncertain	Validity uncertain	Validity uncertain
Entire Content					
Rating	Valid, compre-hensiveness uncertain	Valid, compre-hensiveness uncertain	Not valid	Validity uncertain	Validity uncertain
Median rank	4	1	3	2	2

Several states that have adopted treatment guidelines have seen bizarre, nightmarish results from rigid application. For example, in California, which adopted the ACOEM Guidelines on an interim basis and deemed them "presumed to be correct," such a bizarre result occurred in *Travelers Property Casualty Company of American v. Workers' Compensation Appeals Board*, (Matthew Shuman), 7 WCAB Rptr 10, 248. An Administrative Law Judge applied Labor Code §4610 which provides that the ACOEM Guidelines apply only to the 90-day initial acute stage post-injury, but in applying that strict 90-day provision, made an "Alice in Wonderland" decision that found that even though the claimant's symptoms, wove such that he required further treatment, that treatment could not include the surgery (which he underwent during the acute stage), since the guidelines required that he could not have the back surgery until after conservative methods had been attempted and had failed.

4. RETROSPECTIVE REVIEW (DEFINED)[109]

Retrospective Review: Utilization review of services and supplies that have already been provided to a patient to determine whether they were medically necessary or appropriate.

Retrospective Review – an Anachronism?

As noted previously, Georgia introduced "Peer Review" in 1985; however, as explained, the "official" process was to be applied retrospectively; and, attempts to apply it prospectively or concurrently were, unsuccessful. But, clearly, those designing the retrospective "Peer Review" process failed to realize that a process, which could only be applied *ex post facto*, would inevitably result in exactly what has happened – abandonment of the statutory process and substitution of the present *de facto prospective* and *concurrent* processes.

VIII – What's Next? A Glimpse Over The Horizon

A. The Sorry State of Medical Care in America

1. The Uninsured in America

In a report issued in August of this year,[110] the U.S. Census Bureau reported that there are more than 43 million Americans without any form of health coverage. At page 24, Table 8, of that document, a three year average (2004-2006) is provided. The "trend" and numbers of uninsured is "up." Georgia, for example, is estimated to have 1,594,000 uninsured, representing 17.6% of the total population. The National Center for Health Statistics report of June 25, 2007, reports there were 43.6 million Americans of all ages, 14.8% of the nation's population, without any health coverage. More troubling, among working-age Americans (those ages 18-64), 19.8% had no health insurance, up from 18.9% in 2005.[111]

The number of uninsured Americans represents a new high.[112]

While the State of Texas has the largest number of uninsured at 23.8%,[113] the predictable explanation would be that it is primarily non-native, undocumented workers which represent the majority of the uninsured; however, the evidence is otherwise. Eighty percent (80%) of the uninsured are native or naturalized citizens.[114]

On Tuesday, September 11, 2007, the "online" edition of *USA Today* reported that health insurance premiums paid by workers and their employers rose on average 6.1% already this year, far exceeding both wages, which increased only 2.6%, and the rate of inflation of 3.7%.

2. The Looming Health Care Crisis

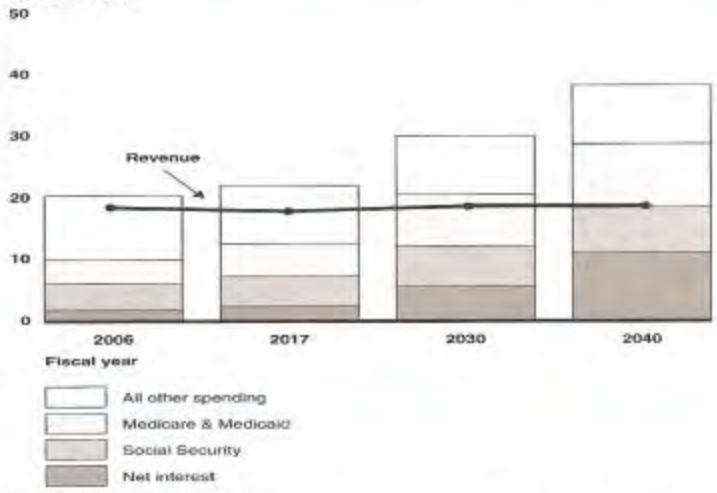
With premium increases doubling or even tripling the growth of wages and doubling the CPI rate of inflation, health care "critical mass" is approaching. And Americans are paying attention. The Kaiser Family Foundation conducted a tracking poll in June 2007. That poll reported that the two issues most pressing in the minds of voters nationwide were, Iraq first and healthcare second. Down the list of issues were immigration, the economy, gas prices/energy and "terrorism"/national security.[115] The issue is growing in political volatility.

U. S. Comptroller General David M. Walker has been traveling around the country holding "town hall" meetings. The essential premise of those meetings:

> "Unless we fix our health care system – in both public and private sectors – rising health care costs will have severe, adverse consequences for the federal budget as well as the U. S. Economy in the future."[116]

The following chart, found at page 5 of the document produced by the Comptroller General's Health Care Forum establishes the need for prompt action:

Figure 1: Revenues and Composition of Spending as a Share of GDP, Fiscal Years 2006-2040



Source: GAO's January 2007 analysis.

Note: This simulation assumes that discretionary spending grows with GDP after 2007 and all expiring tax provisions are extended through 2017. Thereafter revenue returns to historical average of 18.3 percent of GDP plus deferred revenue.

In a refreshingly candid article published in the August 8, 2007, edition of *JAMA*,[117] two scholars, Frank Wharam, Dept. of Ambulatory Care and Prevention, Harvard Medical School, and Norman Daniels, Harvard School of Public Health, observe:

> "Assessment of new health policies is rarely systematic and typically is undertaken by a haphazard collection of the curious, concerned, or adequately funded. The objectivity of these investigators may be difficult to assess. Studies are usually retrospective and often include populations convenient from a sampling perspective rather than relevant to broader policy making."

And, perhaps another observation made by the authors should be kept in mind as we strive to solve medical care delivery/payment problems in our own personal

health care and in the health care which, by law, the injured worker of this state are *supposed* to be receiving promptly:

> "Legislation creating policies does not necessarily include 'impact assessments,' commissioned studies do not use standardized measures, and outcomes examined may be of questionable relevance. *Policy change therefore may be based on expert opinion, funding circumstances, or political sentiment rather than evidence of benefits or harm. The lack of systematic and ongoing evaluations of new health policies had led to the discovery of unintended consequences years later."*[118]

[1] See, O.C.G.A. §34-9-201(b)(1); *ITT – Continental Baking Company v. Powell*, 182 Ga. App. 533, 356 S.E. 2d 267 (1987).

[2] There appears to be a conflict between the fee schedule and the 1920 provision which continues to be present O.C.G.A. §34-9-203(a) which limits "the pecuniary liability of the employer [for medical treatment] . . . to such charges as prevail in the State of Georgia *for similar treatment of injured persons of a like standard of living when said treatment is paid for by the injured person.*"

[3] From $100.00 in 1920, the "cap" was increased to $500.00 in 1937; to $1,125.00 in 1955, to $2,000.00 in 1963 and finally to $5,000.00 in 1968. In 1985, the "cap" was completely eliminated the same year that the "fee schedule" and "peer review" were introduced in the Georgia statute. See chart of evolution of medical cost "cap" and applicable time limitation at p. 4.

[4] The 1937 amendment is significant for another reason: the phrase present in section 26 of the 1920 Act, ". . . and the employee shall accept. . ." was deleted which resulted in employees being permitted to choose "any willing provider," a "right" which remained until 1978.

[5] The report of the National Commission on State Workmen's Compensation Laws, July 1972, Chapter 4, at p. 79.

[6] Mega-Trends Influencing the Workers Compensation Insurance Industry, 62nd Annual Workers Compensation Educational Conference, Orlando, FL, 13 August 2007, presenter: Robert P. Hartwig, Ph.D., CPCU, Pres. Insurance Information Institute.

[7] Unfortunately, Board "peer review" performed <u>after</u> an expensive service was rendered potentially leaving a physician "holding the bag," (see, e.g., *Cowart v. ARA Transportation, Inc.* 178 Ga. App. 766, 344 S.E. 2d 734 (1986), has resulted in "peer reviews," a form of <u>concurrent</u> utilization review, filling the vacuum to deny medical treatment preemptively and with <u>no</u> Board scrutiny. Clearly, amendment to O.C.G.A. §34-9-205(b) is needed. (see infra.)

[8] Now six (6) as a result of compromise made by the Members of the Governor's Workers' Compensation Advisory Commission. See § 1.15. p. 85, <u>Georgia Workers' Compensation Law</u>, 2nd Ed., Kissiah, Lexis/Nexis.

[9] Note that the heading for O.C.G.A. § 34-9-200 contains the words: "<u>Compensation</u> for Medical care. . . ." since, historically, that code section required the employer to reimburse the claimant's medical care expenses. Gradually, over the years, Employers simply paid the Employee's medical bills submitted directly to the provider – a legal anachronism that led to the 1989 decision in <u>Murray County Board of Education v. Wilbanks</u>, 190 Ga. App. 611, 379 S.E. 2d 559 and the hasty "corrective" legislative amendments to O.C.G.A. § 34-9-200(a) the very next year after <u>Wilbanks</u> was decided. Infra.

[10] Health Insurance: A primer, CRS Report for Congress 17 January 2006 at p. 16-17.

[11] The Integration of Managed Care in Workers' Compensation, B. Brown and M. Schmitz, 1997 Casualty Actuarial Society. www.casact.org/pubs/dpp/doo97.97dppool.pdf

[12] A Brief History of Managed Care, 1998, Tufts Managed Care Institute, New England Medical Center/Tufts University School of Medicine. www.thci.org/downloads/BriefHist.pdf

[13] Transforming American Medicine: A Twenty-Year Retrospective on the Social Transformation of American Medicine. Starr, Paul, Stuart Professor of Communications and Public Affairs, Princeton University. (Basic Books, 1982).

[14] James M.P. Solheim, Workers' Compensation Guide: Managing Workers' Compensation Claims and Costs HR-esource, Gale Group. http://www.hr-esource.com/hresources/sampleChapters/wcgsampleChapter.html (13 October 2003).

[15] Workers' compensation Health Initiative, University of Massachusetts Medical School, "Workers' Compensation medical are: Controlling Costs." <http://www.umassmed.edu/workerscomp/pdfs/fact_sheets/costs.pdf> (January 13, 2004).

[16] Stacy M. Eccleston, Xiaoping Zhao and Michael Watson, *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996-2000* (Cambridge, Massachusetts: Workers Compensation Research Institute, July 2003).

[17] Wall Street Journal, Vanessa Fuhrmans, July 31, 2006.

[18] "Effectiveness of Workers' Compensation Medical Fee Schedules" Lipton, Barry NCCI 2007 Annual Issues Symposium at p. 10 – 13 of 184.

[20] The report of the National Commission on State Workmen's Compensation Laws, July 1972, Chapter 4, at p. 79.

[21] Do Traditional Health Care Cost Containment Practices Really Work? Pozzebon, Silvana, Ph.D., Article based on doctoral dissertation: 1994 Workers' Compensation Year Book, Burton, at P. l-106-110.

[22] The Impact of Provider Choice on Workers' Compensation Costs and Outcomes" Workers' Compensation Research Institute, Victor, et al, November, 2005.

[23] Pozzebon [citing] Journal of Health Politics, Policy and Law, Labelle, et al. Fall, 1989.

[24] One of the stated bases for rejection of the Ingenix created fee schedule for PIP benefits in New Jersey. "In Re Matter of a Public Hearing Regarding Proposed New Rule, Medical Fee Schedules: Automobiles." 24 April 2001, Karen Garfing, Hearing Officer, New Jersey Dept. of Banking and Insurance.

[25] Effectiveness of Workers' Compensation Medical Fee Schedules, NCCI Annual Issues Symposium, May 11, 2007, at p. 4, 8, 9, 12, 13, 23, 24 of 184

[26] Id.

[27] "Medicare: Physician Fees: Geographic Adjustment Indices Are Valid in Design, But Data and Methods Need Refinement." GAO-05-119, March 11, 2005.

[28] "Medicare: Geographic Areas Used to Adjust Payments for Variation in Practice Costs Should be Revised." GAO07-466, June, 2007.

[29] Id.

Id.

[31] Id.

[32] "Benchmark for Designing Workers' Compensation medical Fee Schedule." Workers' Compensation Research Institute. November, 2006. WC-06-14.

[33] Id.

[34] "Achieving Workers' Compensation Savings Through Medical Bill Repricing." McGavin, M., 2002 Managerial Technologies Corp. www.rmis.com

[35] Id.

[36] Id.

[37] "ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans." Congressional Research Service. The Library of Congress, June 27, 2002.

[38] "Managed Health Care: Federal and State Regulation." October 8, 1997. Congressional Research Service CRS-11.

[39] National Health Expenditures Aggregate and Per Capita Amounts, Percent Distributions, and Average Amount Percent Growth by Source of Funds: Selected Years 1960 – 1994." Office of the Actuary, Health Care Financing Administration [Now CMS]. Public Document at www.hefa.dhhs.gov.

[40] "Managed Care 101" American Medical Student Association, at p.4, May 10, 1007. www.amsa.org/programs/qpit/mancare.ctm.

[41] Id.

[42] Capitol Research Master Bill History Report (1997). Capitol Research Service of Texas. www.capitol/research-texas.com/reports/civil-practice/hmo.1997.html

[43] "ERISA May Shield HMO Liability: Texas Law Under Fire." Grinfield, M. Psychiatric Times, February 1998, Vol. XV, Issue 2. And see also, "Managed Care Liability; An Analysis of Texas and Missouri Legislation" Menlo Park: Kaiser Family Foundation, 1997.

[44] University of Houston Law Center, Health Law Policy Institute, 100 Law Center, Houston, Texas 77204 – 6060. wwwlaw.uh.edu/healthlaw.com.

[45] *Roark v. Humana, Calad v. Cigna Healthcare, Thorn v. Cigna Healthcare and Davila v. Aetna U.S. Healthcare.*

[46] 307 F 3d 298 (9/17/02)

[47] *Cigna Healthcare of Texas, Inc., v. Calad*, 124 S. Ct. 463 (2003); *Aetna Health, Inc. v Davila*, 124 S. Ct. 462 (2003).

[48] *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004).

[49] "Managed Care Insurer Liability," National Conference of State Legislatures, April, 2006.

[50] Id.

[51] Weiss Ratings: HMO & Health Insurance News Releases. www.weissratings.com/news/ins/HMO/

[52] Megatrends Influencing the Workers' Compensation Insurance Industry, Hartwig, Insurance Information Institute, 62nd Annual Workers' Compensation Education Conferences, Orlando, Fla., August 13, 2007.

[53] HMO Settlements Website. www.hmosettlements.com

[54] Id.

[55] See, e.g., by Acclamation Systems, Inc. which had recently formed a strategic partnership with Bloodhound Technologies by which Bloodhound's ASP claims editing and analytics services will be imbedded in LuminX LX ™ suite of products. www.prnewswire.com

[56] U.S. Dept. of Health and Human Services, through the Offices of National Health Information Technology Coordinator has awarded a contract to American National Standards Institute (ANSI) to lead the "harmonization" efforts in Healthcare IT which, through the Healthcare Information Technology Standards Panel is "to achieve a widely accepted and useful set of standards . . . to enable and support widespread interoperability among healthcare software applications." www.ansi.org/standards.

[57] "Billing Battle: Fights over Health Claims Spawn a New Arms Race; Insurers and Doctors are Spending Billions; Firms Help Both Sides." Wall Street Journal, Fuhrmans, V. Feb. 14, 2007.

[58] Id.

[59] Healthcare IT Transitions Group. http://hittransition.com/

[60] "System Itself is Diseased" Dallas Morning News. Krugman, Paul. February 26, 2007.

[62] "Quality of Care in Investor-Owned vs. Not-for-Profit HMOs" *JAMA* Vol. 282, No. 2, July 14, 1999.

[63] "The Corporate Transformation of Medicine and Its Impact on Costs and Access to Care." Geyman, John, The Journal of the American Board of Family Practice 16:443-454 (2003).

[64] "Comparison of performance of Traditional Medicare vs. Medicare Managed Care," London and others. Journal of the American Medical Association, April 14, 2004. 291(14) pp. 1744-1752.

[65] "AMA Reports Problems with Medicare Advantage ."
www.kyma.org/news/2007.news/AMA. Medicare-Advantage

[66] "Quality of Care in For-Profit and Not-For-Profit Health Plans Enrolling Medicare Beneficiaries." Schneider, Eric C., and others, American Journal of Medicine 118, pp. 1392-1400.

[67] "Private Health Insurance: Number and Market Share of Carriers in the Small Group: Health Insurance Market in 2004." GAO-06-155R

[68] "Rating the Health Plans: 37,000 Readers Pick the Best HMOs and PPOs." Consumer Reports, Sept. 2007, pp. 21-23.

[69] North Carolina Institute of Medicine, Chapel Hill, NC "Understanding Managed Care" Glossary. www.nciors.org/hmoconguide/GLOSS31E.htm/

[70] Note that 11(c) appears to have been intended to preclude any argument that the Workers' Compensation Fee Schedule could be circumvented by use of "network provider" reduced fee

contracts. However, see O.C.G.A. §34-20A-10 which states "nothing in this Article shall apply to Chapter 9 of Title 35, relating to workers' compensation."

[71] "Understanding Managed Care": Glossary, North Carolina Institute of Medicine, Chapel Hill, NC. www.nciom.org/hmoconguide/GLOSS31Entml

[72] Compare Board Rule 205(b)(1)(a), (b), 2.

[73] "Understanding Managed Care": Glossary, North Carolina Institute of Medicine, Chapel Hill, NC. www.nciom.org/hmoconguide/GLOSS31Entml

[74] Id.

[75] Id.

[76] Id.

[77] Id.

[78] Id.

[79] Georgia State Board of Workers' Compensation, Procedure Manual. July, 2006 at p. 7 -21.

[80] "Understanding Managed Care": Glossary, North Carolina Institute of Medicine, Chapel Hill, NC. www.nciom.org/hmoconguide/GLOSS31Entml

[81] Procedure Manual, July 2006 at 7 -21. Georgia State Board of Workers' Compensation.

[82] One scholarly article notes, "in the early 1970s insurance companies started using SMOs [second medical opinions] as a utilization review technique . . . to reduce costs associated with overuse and inappropriate surgery. With this fundamental change, getting a second opinion was no longer a choice. Rather, patients facing elective or high-cost surgery were required to get one to verify that the procedure was clinically appropriate." "Who Gets Second Opinions," Wagner Health Affairs, Sept/Oct 1999.

[83] "Understanding Managed Care": Glossary, North Carolina Institute of Medicine, Chapel Hill, NC. www.nciom.org/hmoconguide/GLOSS31Entml

[84] "Schedule of Fees for Physicians and Surgeons and Pharmaceutical for Services Rendered under the Georgia Workers' Compensation Law," Effective March 1, 1991, at pp. 2, 10 -11.

[85] "Schedule of Fees for Physicians and Surgeons and Pharmaceuticals for Services Rendered Under the Georgia Workers' Compensation Law," Effective March 1, 1992, at pp. 2, 19-21.

[86] State of Georgia, "The Workers' Compensation Medical Fee Schedule for Services Provided Under the Georgia Workers' Compensation Law." Effective April 1, 2000, at pp.11.

[87] Note that "consultations" are also found in an entirely different section of the fee schedule, entitled, "Evaluation & Management (E/M) Services whereas "IME" has always been "placed" in the section entitled "General Reimbursement Guidelines."
[88] Id at p. 21. It should be obvious that there is no statutory framework supporting/authorizing the use of "second opinions" by either employers or employees except (possibly) within the context of a WC/MCO.

[89] Id. at p. 13-14.

[90] Id. at p. 24.

[91] "Medicare Basics, A Guide for Families and Friends of People with Medicare." Pp. 8 – 9; www.aoa.gov/prof/aoaprog/caregiver/carefam/Medicare_Basics.pdf

[92] See E-8.04, "Consultation"; E-8.041, "Second Opinions" and E-10.03, "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations." American Medical Association, www.ama-assn.org, Principles of Medical Ethics.
[93] Board Rule 208(a)(1)(c). See also Board Rule 208(a)(1)(H).

[94] Compus Juris Sawcundum, January 2006, Southern Association of Workers' Compensation Administrators, President's Message. Oliver, Kathy.

[95] Such administrative rules, §§ 5221.6010-5221.8900 were promulgated under Chapter 176, Minnesota Statutes to apply to all treatment provided after January 4, 1995. The minutes of the Dec. 10, 2003, Minnesota Workers' Compensation Advisory Council note that proposal was made to make the parameters for more than mere guidelines. In the minutes of the February 18 2004, a pro-legislative "package" to include the following:

> "**Utilization** Add to the statutory definition of "reasonably required treatment" as defined by any applicable treatment parameter. The treatment exceeding a parameter is presumed to be not reasonably required. The presumption is rebuttable by a preponderance of medical evidence. This section will sunset in three years.
> Require judges and payers to apply the parameters. Payers must cite the parameters to deny claims of treatment to injured workers. Fact finders must make decisions based on those parameters. If the parameter was not used, the fact finder must explain why. This section would sunset three years post enactment."

[96] "Guidance for Guidelines," Steinbrook, R. New England Journal of Medicine 356:4, January 25, 2007; "Are Guidelines following Guidelines," The Methodological Quality of Clinical Practice Guidelines in the Peer-Reviewed Medical Literature." Shaneyfelt, T. and others. JAMA May 26, 1999, Vol. 281, No. 20.

[97] "Clinical Care Update. UM: A means to Improve Quality" Sherman, B. Occupational Medicine, Vol. 13, No. 6, August 8, 2006.

[98] Id.

[99] Clinical Practice Guidelines: Directions for a new Program. Field, Loku Eds. National Academy Press, 1980.

[100] Are Guidelines following Guidelines? The Methodological Quality of Clinical Practice Guidelines in the Peer-Reviewed Medical Literature. Shaneyfelt and others. JAMA, May 26, 1999, Vol. 281, No. 20.

[101] www.concensus.nih.gov

[102] www.ahrq.gov

[103] Clinical Practice Guidelines and Quality Indicator, a Presentation at 2004 Evidence-Based Decision Making for Health Policy Leaders Workshop, Dec. 7, 2004, Shekelle, Paul. MD

[104] Evaluating Medical Treatment Guideline Sets for Injured Workers in California. Nuchols and others. Rand Institute for Civil Justice and Rand Health at p. xiii.

[105] Field and Lohr, 1990.

[106] Evaluating Medical Treatment Guideline Sets for Injured Workers in California. Nuchols and others. Rand Institute for Civil Justice and Rand Health at p. xviii.

[107] Id. at p. 30.

[108] Id. at Summary xxv.

[109] Excerpted from Glossary, "Understanding Managed Care," North Carolina Institute of Medicine, Chapel Hill, NC 27515. www.nciom.org

[110] "Income, Poverty, and Health Insurance Coverage in the United States," DeNovas, Walt and others. U.S. Census Bureau, Current Population Reports p. 60-233, August 2007.

[111] "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2005," National Center for Health Statistics, June 25, 2007.

[112] "Number of Americans Without Health Insurance Hits New High," Pugh, Tony, McClatchy Newspapers, Tuesday, August 28, 2007. www.mcclatchyd/c.com/homepage/story/19319.html

[113] National Center for Health Statistics, report of June 25, 2007.

[114] "Health Insurance Coverage: Facts on Health Insurance Coverage." National Coalition on Health Care. www.nchc.org/facts/coverage.shtml.; see also, "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance." October, 2006, The Henry J. Kaiser Family Foundation. www.kff.org.

[115] Kaiser Healthcare Tracking Poll, Election 2008. The Kaiser Family Foundation. Issue 2, June 2007.

[116] "Health Care 20 Years From Now, Taking Steps Today to Meet Tomorrow's Challenges" Highlights of a Forum Covered by The Comptroller General of the United States. Sept. 2007 GAO-07-1155SP.

[117] "Toward Evidence-Based Policy Making and Standardized Assessment of Health Policy Reform," Wharam, Daniels. JAMA. Volume 298, no. 6.

[118] Id. at p. 677.