STATE BAR OF GEORGIA 1964 ®

WORKERS' COMPENSATION LAW

Summer/Fall 2009 John D. Christy, editor Section Newsletter

Ex-Parte Communications with Treating Physicians After *Moreland v. Austin*

By Jarome E. Gautreaux
O'Neal, Brown & Clark, P.C.

In personal injury and workers' compensation matters, the injured person's medical treatment is often the focus of the entire case. Even when the liability situation is clear, disputes arise over whether the medical treatment that a person received was related to the incident giving rise to the claim. Thus, treating physicians are routinely called upon to offer opinions on the issue of causation.

Often, opposing attorneys will seek to meet with treating physicians to discuss a patient's medical condition, history and treatment. It is not unusual for these meetings to occur on an ex parte basis. These ex parte meetings have come under increased criticism due to privacy concerns, especially with the enactment of the Health Insurance Portability and Accountability Act (HIPAA). Recently, in *Moreland v. Austin*, 284 Ga. 730 (2008), the Supreme Court of Georgia addressed the issue of of how Georgia law and HIPAA affected the propriety of ex parte discussions with treating physicians.

The *Moreland* Case

The Moreland case was a medical malpractice case. The defense lawyers sought permission from the trial court to permit ex parte meetings with several physicians who had treated the patient/plaintiff in the case.

The Court of Appeals held that the ex parte meetings were permissible because the defense lawyers had served a formal request for production of the medical records in the litigation. The Supreme Court disagreed with this analysis and the conclusion of the Court of Appeals.

The Supreme Court held that under HIPAA, ex parte meetings to discuss a patient's medical information are permissible in two situations – if the patient consents, or the court issues an order allowing such ex parte contact. *Moreland*, at 734. Since neither of those occurred in *Moreland*, ex parte contact was not proper. The request for medical records from the defendants was not sufficient to go further and allow ex parte conversations after the request for medical records was provided.

Issues after Moreland

While the Moreland case resolves some issues, it also leaves several questions unanswered. For example, if one way to comply with HIPAA is to obtain an order allowing ex parte contact, when should such an order be issued? What

In Memory of David Bartlett Higdon Sr.
Nov. 17, 1946 –June 24, 2009

Chambless, Higdon, Richardson, Katz & Griggs, LLP, regretfully announces the passing of David Higdon. Higdon was a wonderful mentor, partner, and friend to all in the firm. Higdon dedicated his career to representing injured workers, teaching Workers' Compensation to future attorneys, and giving a voice to those who could not otherwise afford representation. Higdon touched the clients he represented, attorneys and staff with whom he worked, and the community in which he lived. All those who had the pleasure of knowing David will deeply miss him.

Whither the "WC-205" Process[1]

By Thomas M. Finn

Currently pending in the Court of Appeals is *Selective HR Solutions, Inc., et al. v. Mulligan*, A09D0304, Discretionary Application granted April 7, 2009, the final appellate decision in which is likely to seal the fate of the present advance authorization process–one way or the other. Whatever that ultimate legal outcome, most would agree that some uniform rapid response process must exist to expedite approval of delivery of health care to Georgia's injured workers–approval which is not a statutory prerequisite. This article will discuss briefly the history of the current advance authorization process, the bases of recent legal attacks on the process and will conclude with some recommendations.

First, Some History

Georgia's current medical delivery model, used by the vast majority of Georgia's employers, is the so-called traditional panel of physicians adopted in 1978 as part of that year's comprehensive amendments to the Act.[2] Originally, the panel required only three or more physicians or group of physicians. The current statutory provision and composition requirement of the traditional panel is found in O.C.G.A. § 34-9-201(b)(1).

Readers should be aware that the 1978 enactment of the panel health care delivery model took place toward the end of the era during which fee for service/indemnity was the prevailing health plan model in both group health and in the workers' compensation programs of most states. By 1978, some health care policy analysts were already contending that ". . . the inflationary fee-for-service payment system rewards providers for rendering more, not less, health care."[3] As cost sharing devices such as deductibles and co-payments, used increasingly in group health, whether or not effective in controlling the growth of health care costs,[4] were traditionally not allowed in workers' compensation health care, the structural design of Georgia's medical care delivery model in both medical only and lost time claims provided no statutory prospective or concurrent review method by which employers and insurers could challenge medical care before it was furnished by an authorized treating physician (ATP).[5]

The premise of Georgia's panel system was explained in *ITT-Continental Baking Company v. Powell*, 182 Ga. App. 533, 356 S.E.2d 267 (1987):

> "A distinction must be recognized between income benefits and medical expenses. Income benefits are to be paid automatically once the employer is notified of the injury, unless the employer in return informs the employee by means of a notice to controvert that in its view the injury is not compensable– not arising out of and in the course of the employment, etc. O.C.G.A. § 34-9-221.
>
> **Employer-liable medical expenses, on the other hand, initiate with the services of a physician selected from the approved list. . . as required by O.C.G.A. § 34-9-201(c).**" (Emphasis supplied.)

The *Powell* decision continues, adding:

> "Rule 221(d) of the Workers' Compensation Board provides: 'To controvert in whole or in part the right to income benefits or other compensation, use Forms WC1 or WC3.' *Even if an employer is required to notify the board of its refusal to pay medical expenses, it is not a statutory requirement as the statutory scheme regarding time constraints for a 'notice to controvert'– . . . relates solely to income benefits.*" (Emphasis supplied.)

See, also, *NuSkin International v. Baxter*, 211 Ga. App. 32, 438 S.E.2d 130 (1993).

The Emergence of Pre-Authorization in Traditional Panel Claims

For purposes of this article, the writer assumes that readers understand the medical and legal distinction between pre-authorization and pre-certification.

In the late 80s and early 90s, components of the managed care model, already being applied regularly in group health, began infiltrating Georgia workers' compensation claims.

"The managed care model of health care delivery contains several key characteristics which set it apart from traditional (indemnity) insurance. One of the main differences is that the service delivery and financing functions are integrated under managed care. Managed care organizations (MCOs) employ various techniques to control costs and manage health service use prospectively. Among those techniques are restricting enrollee access to certain providers (in-network providers); requiring primary-care physician approval for access to specialty care (gate keeping); coordinating care for persons with certain conditions (disease management or case management); and requiring prior authorization for routine hospital inpatient care (pre-certification). MCOs may offer different types of health plans that vary in the degree to which cost and medical decision-making is controlled."[6]

In 1994, to create a statutory provision to authorize the use of and to regulate workers' compensation MCOs, present O.C.G.A. § 34-9-201(b)(3) was enacted.[7] Unfortunately by 1997, the pre-authorization prospective utilization review device of the managed care model had become such an impediment to delivery of authorized treatment that the predecessor to the present WC-205 process was promulgated by Board Rule. The former rule did not require use of any particular vehicle, format or content for communication of a request for advance authorization as such request could be submitted by a provider, by a claimant or claimant's attorney. While the primary flaw in the earlier advance authorization process was the 30-day period provided for response by the employer or insurer, nevertheless, the process did work, albeit too slowly.

The Creation of the Present WC-205 Process

By executive order dated Jan. 10, 2000, former Gov. Roy Barnes created the Governor's Workers' Compensation Advisory Commission. Appointed to co-chair the Medical Committee of that Commission were Mark Gannon of Atlanta and the author hereof. The governor's charge to the Commission was to address the increasing problems in health care delivery that were reducing the number of providers willing to accept and treat Georgia's injured workers. That Commission set to work in May 2000, debating and agreeing upon several substantive statutory changes which were then incorporated into H.B. 497:

1. Amendment of O.C.G.A. § 34-9-201 to expand the traditional panel to six or more physicians or groups of physicians;
2. Amendment of O.C.G.A. § 34-9-108 to add (b)(4), an entirely new subsection providing a means for the Board to award specific litigation expenses;
3. Complete revision of O.C.G.A. § 34-9-203 to create a self-activating, graduated penalty provision to encourage prompt payment of provider's bills.[8]

The Medical Committee also devoted considerable time to revising and streamlining the existing advance authorization process. Attorneys on the Medical Committee were careful to be sure that the process was not inconsistent with existing statutory and case law. For example, the provisions of Board Rule 205(b)(c)(d) are applied only in a claim that has already been found to be compensable for purposes of authorized treatment and the only purpose for which those rule provisions were created was to assist the authorized treating physician in expediting the delivery of medical care–medical care that the employer is already statutorily required to provide by O.C.G.A. § 34-9-200(a) through a physician selected by the process established by O.C.G.A. § 34-9-201.

Rule 205(b)(1)(a) and (b)(1-3) essentially track O.C.G.A. § 34-9-200(a) and invoke the fee schedule 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 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); *Roberson v. Hartford Accident & Cas. Co.*, 141 Ga. App. 588, 234 S.E.2d 145 (1977).

Subsection (b)(2) of Rule 205 is also a correct statement of the law and was lifted directly from O.C.G.A. § 34-9-200(a), 201(b) as the concepts of authorized versus unauthorized treatment are explained by *Powell* and *NuSkin*, supra.

As the Commission and members of the Board recognized that the revised process would be available for use in only compensable lost-time claims and accepted medical-only claims in which authorized treatment was being provided by an ATP, revision of the existing Board Rule was considered to be sufficient when each of the following objectives was met:

1. Create a non-mandatory simple process by which authorized treating physicians could obtain advance authorization if/when those physicians so desired;
2. Create a rapid turn around between request and response by reducing the 1997 30-day response time to five business days;
3. Create a process which, itself, would provide proof of service of the request in order to satisfy due process by requiring that the request be either e-mailed or faxed, creating a paper trail to prove the date and time of submission of the request for advance authorization and the adjuster to whom the request had been e-mailed or faxed;
4. Create a uniform process by permitting use of only one specific form which would contain the exact wording, punctuation and format [since altered to accommodate ICMS]. To prevent obstructive or spurious bases for denial, an exact set of pre-listed check-off reasons for denial–and only those reasons–were included in the section of the form in which the employer's response would be made;
5. Create finality so that physicians wouldn't be left hanging. To that end, the Committee agreed to add a final step to conclude the stage of the

process where all communications and interaction had been between the physician and the party responsible for payment; i.e., Form WC-3 would be filed and served within 21 days of initial receipt of the new form WC-205 if there had been an initial refusal to convey advance authorization.

Attacks on the WC-205 Process

Between 2000 and 2005, use of the revised WC-205 process increased slowly among medical providers as it was not as heavily promoted as it could have been. However, in some geographic pockets of the state, use increased rapidly as claimant attorneys familiar with the process encouraged its use by ATPs to expedite delivery of medical care to the clients of those claimant attorneys.[9]

Unfortunately, by late 2005, legal attacks on the WC-205 process coincided with the expansion of use of managed care utilization review, surgical second opinions, PPOs, pre-certification, case management and treatment and practice guidelines to screen treatment ordered by ATPs in traditional panel claims. The first case to reach the Court of Appeals in which a specific attack was made on Board Rule 205(b)(3)(a) was *Caremore, Inc./Wooddale Nursing Home v. Hollis*, 283 Ga. App. 681, 642 S.E.2d 375 (2007). The attack in *Caremore* was still-born since the employer had actually approved the Dalton ATP referral of Hollis to an Atlanta orthopedic specialist before an order enforcing the rule had been entered.

Since *Caremore v. Hollis*, supra, the cross hairs have been placed squarely on subsections (b)(3)(a) and (b)(3)(b) of Rule 205. The author has analyzed three recent Appellate Division decisions.

In one case, the employer/insurer had apparently made a timely initial denial of surgery, advance authorization for which had been requested by WC-205 submitted by the ATP. The ALJ ordered the surgery and assessed attorney fees against the employer/insurer for failure to file the WC-3 required by Board Rule 205(b)(3)(b). By award dated May 29, 2009, the Appellate Division affirmed the assessment of attorney fees. Neither the administrative law judge nor the Appellate Division addressed the alternate requirement of Rule 205 (b)(3)(b); that is, "(a) authorize the requested treatment or testing in writing. . . ."

In another very recent case, the ATP had submitted a WC-205 to the adjuster who had timely denied the treatment on the sole basis that the ATP had not first submitted to that insurer's treatment criteria/protocol in a claim in which medical was not delivered via a workers' compensation MCO. Forty-five days after initial receipt of the WC-205, the employer/insurer finally controverted, raising for the first time that the proposed treatment was not reasonably necessary. The Appellate Division's language is puzzling and alarming in its implication that substantial compliance is sufficient:

". . . the failure to comply *strictly* with Board Rule 205(b)(3)(b) does not *in this case*, estop the employer/insurer from raising defense to controvert the requested treatment or testing." (Emphasis supplied.)

The June 24, 2009, Appellate Division decision in this second case appears to be based upon this legal reasoning, ". . .the Board Rule 205 advance authorization provision cannot be read without reference to other provisions of the Act and to Board Rules."[10] As this decision relies upon *Raines & Milam v. Milam*, 161 Ga. App. 860, 289 S.E.2d 785 (1985) and *Holt Service Co., V. Modlin*, 163 Ga. App. 283, 293 S.E.2d 741 (1982), it is not difficult to understand the source of the Appellate Division's concern. The author and many others believe that *Raines & Milam* and *Modlin* can easily be distinguished factually and legally. Both cases were all issues claims in which the employers disputed the compensability of the claims–even as to provision of authorized medical care!

In *Raines & Milam v. Milam*, the Court of Appeals held that the failure of an employer/insurer to file a notice to controvert a claim within 21 days after knowledge of the alleged injury or death as required by O.C.G.A. § 34-9-221(d) did not prevent a controversion of the compensability of a claim more than 21 days after the employer's notice or knowledge.

In *Holt Service Company v. Modlin*, the issue was the effect of former Board Rule 705(d), which provided: "If Form No. WC3 is not filed on or before the 21st day after knowledge of the injury or death, the accident will be presumed to be compensable, subject to rebuttal." The Court of Appeals in *Modlin* noted that "the claimant in a workers' compensation proceeding has the burden of proof to show that his injury is compensable" and that the "effect of Rule 705(d) is to shift the burden of proof on the main point that claimant would otherwise have to prove." (Emphasis supplied.) The Court of Appeals held in *Modlin* that Rule 705(b) was in excess of the Board's authority because it provided that, upon an employer/insurer's failure to controvert a claim within 21 days of knowledge of the injury or death, the burden was shifted to the employer/insurer to prove an injury was not compensable. Both *Milam* and *Modlin* are concerned with O.C.G.A. § 34-9-221(d) [predecessor § 114-705(d)], which is directed at the issue of the compensability of a claim. The Board Rule at issue in *Modlin* granted claimant a rebuttable presumption of compensability and was, therefore, invalid as substantive rule-making. The substantive right at issue in *Modlin* was the right of an employer/insurer not to be required to prove the noncompensability of an alleged work injury. An injured employee has the burden to prove the underlying compensability of an alleged work injury.

In contrast, Board Rule 205 is not concerned with the underlying compensability of a claim or the compensability of any part of a claim, including medical treatment or testing for which the ATP is seeking advance authorization. Board Rule 205 also is not concerned with

an employer/insurer's substantive right not to be required to prove the noncompensability of a claim. Board Rule 205 is concerned only with an injured employee's right to receive prompt medical care from ATPs. The concept of a compensable injury is quite different than the concept of authorized treatment. *ITT-Continental Baking Company v. Powell*, supra.

Board Rule 205 is applicable when advance authorization is requested, regardless whether a claim is a medical only claim or a lost time claim.[11] A claimant has a right/entitlement to authorized medical care immediately following the work-related injury; unless, of course, the employer/insurer controverts the underlying compensability of the claim pursuant to O.C.G.A. § 34-9-221(d) and requires the injured employee to prove the compensability of an alleged work injury. But once it is accepted (or once it is proven) that a compensable claim exists, the injured employee is entitled to authorized medical treatment.

Cases such as *Milam* and *Modlin* are concerned with compensability in the sense of an employee's right/entitlement to any benefits as dependent upon whether the employee suffered a compensable injury. Board Rule 205, on the other hand, is concerned only with an employee's right to receive promptly the medical care recommended/ordered by ATPs.

Recognizing that, on average, less than 20 percent of injured workers are represented, that medical providers are not attorneys, the contention that Board Rule 205 is burden shifting/works a forfeiture despite a two-step process that amply provides due process, written notice that provides to respondents more than enough information to make an initial decision within five business days, that gives respondents nearly three weeks to decide whether to adhere to the basis for denial made within five business days and to prepare, file[12] and serve a WC-3 seems entirely misplaced.

The emergence of pre-authorization in traditional panel claims is, at least, partly the result of complaints that the fee-for-service model for the delivery of health care is inflationary and encourages excessive treatment. Board Rule 205(b) has always been an attempt to create symbiosis with pre-authorization while ensuring that medical care provided by ATPs is not delayed or denied by payers without Board regulatory oversight that prevents medical necessity decisions from being motivated predominantly by financial rather than medical interests.

Some Recommendations

Regardless the outcome of *Mulligan*, Georgia's traditional panel health care model is a policy anachronism.

Even if the Court of Appeals affirms the Superior Court's reversal of the Appellate Division, the present advance authorization process remains a metaphorical temporary tire awaiting legislative modernization of the Act. The tension between the medical necessity review techniques used by national insurers and third party administrators to determine prospectively/concurrently medical necessity is irreconcilable with the present WC-205 process. We would be wise to begin reviewing and comparing the solutions to expedite health care delivery other states have adopted recently. We would be wise to consider carefully the explanation given by the Office of the Chair, New York State Workers' Compensation Board regarding the draft treatment guidelines specific to the five work injuries found to occur frequently and to consume the most health care dollars:

"In the absence of medical treatment guidelines, New York practitioners do not have easily accessible up-to-date standards for care. Similarly, claims examiners at the insurance carriers and self-insureds (carriers) do not have agreed upon standards by which to assess the medical necessity of care. One result is the generation of substantial disputes about medical care that is harmful to both employee and employer, as delivery of care is delayed and frictional costs increase.

Carriers (and their administrative third-party payors) use a variety of tools to assess appropriateness of care in an effort to control costs and ensure quality, a process that is called utilization management or review (UR). There is no requirement that carriers employ the same UR standards or processes and this lack of uniformity may cause injured worker-patients with the same conditions to be treated differently. This lack of standardization may lead to variations in the treatment of injured workers that are not explained by the nature of their injuries, so that some workers may receive lower quality of care than others. Lack of standardization also adds to frictional costs by producing needless disputes." [13]

We would also be wise to monitor carefully national health care reform efforts to incorporate the scholarship of (e.g.) National Academies' Institute of Medicine which released on June 30, 2009, its four quartile Initial National Priorities for Comparative Effectiveness Research, at least five of which are injuries/health conditions we see regularly in Georgia workers' compensation claims.[14] By the time sufficient interest and political will coalesce in Georgia, the body of credible research findings will enable Georgia to avoid the mistakes made by states such as California and Texas in adopting one size fits all comprehensive sets of treatment/practice guidelines as part of integrated UR. The research to be developed in accordance with the Patient-Centered Outcomes Research Act of 2009, SB 1213, introduced June 9, 2009, should also be available.[15]

We should avoid using code terms such as health care rationing since use of valid evidence-based medicine will enable us to incorporate statutorily the findings of research organizations such as The Dartmouth Institute for Health

Policy & Clinical Practice; which, with a grant from The Robert Wood Johnson Foundation, has produced widely acclaimed studies such as the landmark analysis of Medicare spending released jointly on Feb. 26, 2009, by *The New England Journal of Medicine* and the *Dartmouth Atlas of Health Care,* confirming that more utilization does not necessarily produce better medical outcomes.[16]

Finally, an integrated medical care delivery system relying upon evidence-based medicine, if constructed carefully, could eliminate some of the shortcomings of the current statutory medical delivery system and incorporate processes which create a uniform and scientifically valid system by which medical necessity is determined. But, until then, the WC-205 process must be enforced exactly as written. ***WC***

(Endnotes)

1 Perhaps the heterograph, "wither" might be a more appropriate choice of words.
2 Ga. Laws 1978, p. 2220. § 9.
3 Health Affairs, The Policy Journal of the Health Sphere, Iglehart, "Low-Cost, High Quality Care in America" 7/28/09. (visited 6 August 2009); "Health Insurance: A Primer," Fernandez, Congressional Research Service #R632237 Feb. 3, 2005.
4 Restraining the Health Care Consumer, The History of Deductible and Co-Payments in the U.S. Health Insurance, Social Science History 2006 30(4):501-528. Duke University Press.
5 Note that "peer review" enacted in 1985 is available only retrospectively. See O.C.G.A. §34-9-205(b). The "fee schedule" was also adopted that year.
6 Managed Health Care: A primer, CRS Report for Congress #97-913 EPW, Sept. 30, 1997, at Congressional Research Service, The Library of Congress.
7 Present O.C.G.A.§ 34-9-208/Board Rule 208.
8 See 2001 Annual Survey of Georgia Law, Workers' Compensation, Bagley, et al, 53 Mercer Law Review 521-526.
9 To this day, there is very little guidance to medical providers and their staffs on the Board's website. For example, there are publications specifically directed to medical providers. Best Practices: Guidelines for Medical Providers does not mention the WC-205 process. And, while the July 1, 2009, Procedure Manual does contain two brief paragraphs at p. 7-7 stating that ". . . an authorized medical provider may request advance authorization . . . by utilizing Board Form WC-205. . ." The "fee schedule" actually states at p.7, "In the event that an authorized treating physician requests preauthorization or precertification. . .the procedures provided in Board Rule 205 shall be followed. If mandatory, one would expect the Board website to provide step-by-step directions – something as simple as 10 minute "YouTube" clip – for medical providers and their staffs. The author notes the recent creation of the "MFWCP" Medical Provider Training Program, Section 11-1-4 of the July 1, 2009, Procedure Manual; however, it is unlikely that many providers will have the time to undergo that training program–assuming they ever learn of its existence in the first place.
10 The Appellate Division's Award in *Selection HR Solutions, Inc. v. Mulligan*, contains this exact sentence–and legal reasoning. However, in *Mulligan*, there was neither timely initial deny nor timely WC-3. And, to make matters worse, in reliance upon the employer/insurer's admitted receipt of the WC-205, admitted failure to deny the requested surgery by timely initial denial and timely WC-3, the surgery was performed, the surgeon left hanging. There is no question that the WC-205 process, itself, is in jeopardy. See, www.mag.org/generalcounsel/legal-news.
11 *Smith v. Mr. Sweeper Stores, Inc.*, 247 Ga. App. 726, 544 S.E.2d 758 (2001).
12 It was intended by the Commission that all communication would be between providers and payers until a decision was made to controvert. Only then would the Board [possibly] become involved.
13 "Proposed Medical Treatment Guidelines," New York State Workers' Compensation Board, Office of the Chair, Sub. #046-270 1/22/09. http;//www.ins.state.ny.us/press/2007/p07012032cov.pdf.
14 www.iom.edu
15 www.chsr.org/060909%20pcor%20Section-bySection.pdf
16 www.dartmouthatlas.org

Thomas M. Finn has represented injured workers and Social Security disability applicants for over three decades. He has served as presiding officer of the Workers' Compensation Sections of both the State Bar of Georgia and Georgia Trial Lawyers Association. A frequent lecturer, he has authored and presented papers at 25 seminars and legal symposiums in Georgia and surrounding states. His service as co-chair of the Medical Committee of Gov. Barnes' Workers' Compensation Advisory Commission in 2000-01, resulted in expanding the panel of physicians, rewriting O.C.G.A. § 34-9-203, enacting a provision to authorize award of litigation expenses and the revision of the advance authorization process. His subsequent service on the Data Committee of the Workers' Compensation Review Commission produced the first ever in-depth analysis of Georgia's Workers' Compensation, cited as authoritative in Davis .v Carter Mechanical, Inc. 272 Ga. App. 773. As lead or Amicus attorney, he has been involved in numerous reported appellate decisions affecting workers' compensation law and practice, such as Padgett v. Waffle House, Inc., 269 Ga. 825; Maloney v. Gordon County Farms, 265 Ga. 825. Finn presently serves as a member of the Board of Directors of the Georgia Legal Foundation, Inc., a 501(c)(3) non-profit which reviews significant workers' compensation cases for amicus curiae assistance.