ARMSTRONG & PEAKE PLLC

AUGUST 2021 NEWSLETTER

UTILIZATION REVIEW PROPOSED REGULATIONS *PART II*

You may recall in our last newsletter that we summarized the newly proposed utilization review (UR) regulation from the date of adoption (which has yet to take place) through January 1, 2022. In this newsletter, we cover part two of the newly proposed regulation which, if approved, shall apply to utilization reviews and medical bill audits conducted on or after January 1, 2022. You can find a copy of the proposed changes to the utilization regulation – 803 KAR 25:190 – here.

On page three, section two (2), the proposed UR regulation establishes sections 10 through 18 of the regulation to be applicable on or after January 1, 2022. The proposed regulation requires that a carrier (defined here as an insurance carrier), third party administrator, or self-insured employer, shall implement and maintain a utilization review and medical audit program, and must provide to the Commissioner of the Kentucky Department of Workers' Claims a written plan describing the utilization review and medical audit program. Vendors of such utilization review and medical audit programs must submit to the Commissioner for approval a written plan describing the utilization review and medical bill audit program. If the Commissioner approves the program, a vendor shall receive written notice from the Commissioner. Plans are approved for four years, and the carrier apply for a renewal of approval at least 90 days prior to the expiration of the period of approval.

Like the part of the proposal through January 1, 2022, this part also requires a description of the plan and qualifications of internal and consulting personnel who run the plan which must be identified to the Commissioner.

The new proposal diverges from the existing UR regulation in terms of the scope and detail of the plan of the vendor plan. Vendors would be required to provide annual summaries to the Commissioner the number of utilization reviews, waivers, approvals of treatment, denials of treatment, and appeals to the new medical director. Annual reports of the approved vendor must be filed with the Department of Workers' Claims by August 1 for the proceed fiscal year ending June 30, and this is a new development.

There are quite a few new additions to the description of the plans for the new regulation and obviously someone at the Department of Workers' Claims or stakeholders that have the ear of the Department of Workers' Claims apparently want to see more thought and detail be placed into utilization review vendors' plans for compliance with Kentucky regulations. For example, in section 12 under utilization review and medical audit plan written requirements, found on page 15, subsection (6) mentions that there needs to be "a description of the process to assure that a physician shall be designated by each employee as required under 803 KAR 25:096." The designation of the gatekeeper physician with the form 113 process found in 803 KAR 25:096 to my knowledge has never been tied to utilization review before. Usually, the form 113 is requested by the claims representative by sending a letter to the claimant, usually within the first week of an accepted claim, asking the claimant/injured employee to identify and designate a form 113 physician. Why would a utilization review plan need a description of a process to assure that a physician shall be designated by each employee?

DATABASE:

Another new development found in subsection 9 of section 12, pages 16-17, requires the utilization review to maintain a database to records each instance of utilization review, each instance of medical bill audit, the name of the reviewer, the extent of the review, the conclusions of the reviewer, and the action, if taken, as a result of the review which must be maintained for a period of two years. This seems to be a push of for big data in this new regulation.

HOTLINE:

A toll-free hotline must be provided for the employee and medical provider to contact the utilization review employer. (page 17) One of the constant challenges of the years has been that a utilization review physician, perhaps in another state, perhaps in another time zone, will call the treating physician who cannot be reached at that time. The physicians then play phone tag which often does not result in the physicians actually speaking by phone or communicating, and then the utilization review physician denies treatment. This subsection states that "the reviewer or representative of the reviewer shall be reasonably accessible to an interested party at least five (5) days per week, 40 hours per week during normal business hours." (see page 17) Do current utilization review physicians work full-time, in-house for the utilization review vendor? Unlikely. To this author's mind, this would tend to be in favor of large companies who can afford in-house utilization review physician(s).

DEFAULT FAVOR APPROVING TREATMENT:

In proposed section 13 under claims selection criteria, one noticeable change is that claims subject to utilization review when costs exceed $1,000.00 instead of the current $3,000.00 (see page 18). Utilization reviews, under section 13, are said to commence when the medical payment obligor has notice that the claims selection criteria has been met. This new regulation states that failure by the medical payment obligor to waive and communicate its waiver to the employee and medical provider or to initiate utilization review process within two business days "shall result in the medical payment obligor paying for the

subject medical services pursuant to the appropriate fee schedules." (see page 18) In other words, the employer, insurer, and TPA are in the hot seat now because they failed to initiate the UR process within two days, they appear to be liable for medical services by operation of law. In this author's mind, this takes away discretion by the Administrative Law Judge. The Kentucky Supreme Court ruled in R.J. Corman RR Construction, Co. v. Haddix, 864 S.W.2d 915 (Ky. 1993) that the "thirty-day rule" does not apply to pre-claim expenses. This newly proposed regulation seems contrary to the lack of enforcement of the pre-award/pre-litigation, the R.J. Corman v Haddix decision and the other decisions that flowed from that case. The regulation really seems to put the onus on the employer, insurer, or TPA to perform utilization reviews immediately or waive them / lose on the issue of reasonableness and necessity.

The newly proposed section 15, found on page 21, states that the Department shall develop a form on its website that a medical payment obligor may use to deny treatment. This is not a bad idea because different carriers and their employers have different means issuing utilization review notices of denial. Some uniformity with the form may be helpful to that end.

MEDICAL DIRECTOR PROPOSAL:

One of the seriously drastic changes in this proposed regulation is found in section 16, on page 20, which indicates that the Secretary of the Department of Labor shall appointment a medical director to handle and process appeals of utilization review decision and medical bill audit decisions. This eliminates entirely the utilization review of the current in-house utilization appeal to a subspecialist. For instance, in the current regulation in existence now, if the issue is over whether or not an orthopedic surgery is reasonable and necessary, the first line of utilization review does not have to be performed by an orthopedic surgeon and can simply be denied or approved by a physiatrist, an internist, etc. An appeal by the employee however, must be reviewed an rendered by the same level of specialty as the treating physician such that if an orthopedic is requesting surgery, the appeal should be performed by an orthopedic surgeon. This new proposed change would have the medical director handle all of the appeals in the State of Kentucky.

Interim Commissioner Hon. Robert Walker has indicated that the proposed medical director program is modeled after the system in Tennessee.

$400 FEE FOR APPEAL / FINES FOR LATE PAYMENT:

Even more radical is in section 17(5), found on page 24, which states that the Department of Worker's Claims shall charge a $400.00 fee for each appeal submitted to the medical director, payable within 15 days, **paid by the medical payment obligor – which of course is the employer, insurer, or self-insurer/TPA**. If an employee, such as a Teamster, is denied medical treatment, one would expect that each and every denial would be appealed. Just think of how many utilization review denials there are a year, and multiply that number $400.00. This regulation seems arbitrary and capricious on its face: "Failure to pay the fee shall constitute a failure to complete a necessary step in the administrative review process and be construed as an admission by the employer that the denial was an error, and the medical director should find accordingly. Failure to pay the fee may also result in assessment in a civil penalty pursuant to KRS 342.990(7)(e)." KRS 342.990(7)(e) requires a fine not less than $100.00 and not more than $1,000.00 for each violation.

As we noted in our last newsletter, the current utilization review regulation is four and a half pages long. This proposed regulation is 29 pages long. This author believes it has been designed with land mines for any employer/ insurer / TPA who seriously wishes to challenge a physician's plan for medical treatment. The intent of this proposed regulation seems to be to dissuade employers from challenging the reasonableness and necessity of medical treatment through this bureaucratic quagmire.

This regulation will go before a Kentucky Senate subcommittee hearing in mid September 2021.

CASE SUMMARIES

Armstrong Coal Company, Inc. v. Piper

Case Number: 2020-SC-0226-WC, Supreme Court of Kentucky, March 25, 2021
(not to be published)

By: Matt Brotzge

Issue: Whether the ALJ can alter findings of fact when the ALJ issues a new opinion on remand.

Holding: The Court of Appeals held an ALJ can alter findings of fact on remand if the ALJ is acting within the instructions provided by the Appellate courts. In practical terms, this case shows a party can win their initial appeal and end with a worse result.

Facts: This case highlights the opportunities and dangers of appealing an ALJ's award. In this claim, the ALJ originally awarded a 16% impairment rating and made findings of a pre-exiting and active impairment. The employer appealed and asserted there was no 16% impairment in the record and the only impairment rating which apportioned pre-existing and active impairment was 7% offered by Dr. Michael Best. After appeal and remand, the ALJ awarded a 20% impairment rating without pre-existing and active apportionment. The Court of Appeals upheld the 20% impairment rating.

In the original opinion, the ALJ noted the opinions of three different physicians. Dr. Burkett, a treating physician, noted claimant experienced an 80% exacerbation of a pre-existing injury. Dr. Burkett also assigned a 10-13% impairment rating for the prior injury.

Dr. James Butler performed an IME for the plaintiff and found a 20% impairment without any pre-existing and active impairment. Dr. Michael Best performed an IME for the employer and assigned 20% impairment with 13% of it being pre-existing and active. The Court of Appeals highlighted Dr. Best's confusing assertion he needed more medical evidence to determine whether a pre-existing and active condition existed but assigned a 13% pre-existing impairment anyway.

In the ALJ's opinion, the Judge found plaintiff to have a 20% impairment rating with 80% of that being work-related. In other words, the Judge found a 16% impairment.

The employer appealed the ALJ's decision, alleging it was made in error. The employer asserted a 16% impairment rating could not be offered because no such rating was in the record. The Workers' Compensation Board vacated the award in part and remanded for additional findings on an impairment rating listed in the record. The Board's decision was appealed to the Court of Appeals who affirmed the Workers' Compensation Board. The Court of Appeals noted, "the ALJ is not permitted to arrive at a separate and distinct impairment rating from those assigned by the physicians of record." On remand, the ALJ was instructed not to rely upon Dr. Burkett's ambiguous impairment language.

Thereafter, the ALJ relied on Dr. Butler's opinion and cited Dr. Butler's and Dr. Best's opinion that plaintiff had a 20% whole person impairment. The ALJ found the employer did not meet its burden in proving a pre-existing and active condition under Finley v. DBM Technologies., 217 S.W.3d 261, 265 (Ky. App. 2007).

The ALJ found the medical record documented plaintiff's condition to be symptomatic prior to the alleged work injury, but the ALJ also found the employer failed to meet its burden in showing the condition to be impairment ratable prior to the alleged work injury. In short, the ALJ did not find Dr. Best's opinion credible.

The employer appealed again. In the second appeal, the employer asserts the ALJ's opinion was again made in error. Specifically, the ALJ found pre-existing and active impairment in the first decision but did not make such a finding on remand. The employer appealed and the Board affirmed.

The employer then appealed to the Court of Appeals and contended the Board misconstrued the law and "committed reversible error by concluding its prior opinion vacating only part of the ALJ's opinion rendered the entire opinion a legal nullity." The employer contended the Board must have meant something when vacating in part.

The Court of Appeals disagreed with the employer's argument that the Board's opinion vacating in part and remanding meant the ALJ was vacating only the 16% impairment rating such that every other finding of fact and conclusion of law must remain the same.

Typically, as the employer argued, an ALJ cannot properly changed "factual findings that have been fully and fairly adjudicated by an ALJ" in the absence of "newly discovered evidence, fraud, or mistake." However, the Court of Appeals held the ALJ acted within her authority due to the instructions provided by the Workers' Compensation Board. Remember, the Board instructed the ALJ to determine a new PPD award. To do so, the ALJ had to reconsider pre-existing and active impairment ratings. To accurately follow the remand instructions, the Court of Appeals held the ALJ needed to completely reconsider all of the facts creating the impairment rating and award. Thus, the ALJ was correct in re-adjudicating whether pre-existing and active impairment existed.

VinWin Tech Windows and Doors Inc. v. Ivey,

Claim number 2019-SC-0370-WC, Supreme Court of Kentucky, March 25, 2021
(to be published)

By: Steve Armstrong

Issue: Did plaintiff's pre-employment lower back disc herniation and two surgeries require an impairment rating to be carved out of this permanent partial disability rating which his employer would be responsible?

Holding: Yes. The Kentucky Supreme Court held that a carve-out is required under the Fifth Edition *AMA Guides to Permanent Impairment* (formally titled *Guides to Evaluation of Permanent Impairment, Fifth Edition*) This case that is marked "to be published," but has not yet been published.

The Kentucky Supreme Court mentions that legislature directed that impairment be determined by the "latest edition" of the American Medical Association Guides to the Evaluation of Permanent Impairment, however, Kentucky still uses the Fifth Edition AMA Guides, not the Sixth Edition.

Facts: Plaintiff Ivey alleged a June 2015 low back injury while lifting a box for his employer. Ivey had a long medical history before coming to work for ViWin Tech, including a myelogram CT scan with a disc herniation at L4-5 (objective evidence by any measure) and a surgical discectomy Dr. Theodore Davies in Paducah from 2004. In 2012, Dr. Davies again performed a second discectomy, and thus this plaintiff had two low back surgeries before he came to work for ViWin Tech.

After his June 2015 alleged injury, he began treating with Dr. Rex Arendall who performed three surgeries on plaintiff Ivey's spine between December 2015 and June 2017. At least one of these surgeries involved the same vertebra.

Dr. Arendall assessed at 28% whole person impairment rating but did not state an impairment in his correspondence as a result of the two prior surgeries. That he stated he believed that Mr. Ivey's pre-existing back injury was dormant and asymptomatic after the 2012 surgery. This is important because under the 2007 case of Finley v. DBM Technologies, 217 S.W.3d 261 (KY. APP. 2007) in order to carve out a pre-existing active impairment, the administrative law judge must find and there must be evidence that the pre-existing active condition was "both symptomatic and impairment-ratable immediately before a work injury," (Finley at 256.) The Finley case has been a serious problem for Kentucky employers since it was issued by the Kentucky Court of Appeals in 2007. Frankly, this author thinks Finley has put Kentucky workers' compensation on the wrong track for a long time.

Other physicians assessed AMA ratings as well, specifically, Dr. Ellen Ballard and Dr. Thomas O'Brien for the employer. Dr. Ballard cited the Fifth Edition AMA Guides and gave her opinion that following the

2004 surgery, the plaintiff would have had at least a 10% impairment rating and would have had this impairment rating following the 2012 surgery. She referred to Table 15.3, page 394 indicating a DRE category III impairment rating with the range of 10 to 13% whole person impairment would have existed before this work injury. She noted that her belief that plaintiff was asymptomatic for some time prior to the 2015 work injury at ViWin Tech. Dr. O'Brien gave similar testimony. The administrative law judge noted that plaintiff had two prior low back surgeries, but found that plaintiff's condition was asymptomatic prior to his June 2015 work injury, and thus assessed the full 28% rating from Dr. Arendall to the plaintiff relying on Finley v. DBM, Id.

On appeal, the Kentucky Supreme Court noted that the employer has the burden of proving a pre-existing injury. (See Comair, Inc v. Helton, 270 S.W.3d 909, 914 (KY. APP. 2008). The Supreme Court discussed at length the Fifth Edition AMA Guides and that table 15.3 requires a person to be rated as DRE category III, which mandates a 10 to 13% impairment rating if the person has a history of a herniated disc at that level and "individuals who had surgery for radiculopathy but are now asymptomatic." (See Fifth Edition AMA Guides at page 384). The Supreme Court thus held that based on the plain reading of the statutes and the guides, that the administrative law judge erred in concluding that the carve-out for pre-existing impairment was unwarranted. The Supreme Court further stated that the ALJ's reliance on Finley was misplaced. In Finley, plaintiff's condition was congenital scoliosis that really required no treatment.

The Supreme Court noted that here, plaintiff Ivey had undergone two prior surgeries at the same vertebrae L4-5, and that that his work injury in 2015 for this employer included the same vertebra. Kentucky Supreme Court distinguished this case from Wetherby v. Amazon.com, 580 S.W.3d 521 (KY. 2019) because in Wetherby, a different part of the spine was injured, among other reasons. One further highlight, in their footnote, the Supreme Court mentioned that Dr. Ballard described that in a discectomy, there are changes to the disc because a laminotomy cuts into the lamina, and a foraminotomy cuts some of the bone away from the foramen. These anatomical changes are permanent changes to the human organism consistent with the definition of "injury" found in KRS 342.0011(1).

Key Takeaway

Perform discovery and look for a prior surgery on the spine or any other body part that took place before the work injury that is the subject of your, and break out the Fifth Edition AMA Guides and read it regarding what type of impairment ratings are required under the Fifth Edition AMA Guides after a surgery. This case, at least to some extent, helps move Kentucky away from the employer unfriendly case of Finley v. DBM Technologies, 217 S.W.3d 261 (KY. APP. 2007), and this will certainly be helpful to employers if published.