WORKERS' COMP MEDICAL ISSUES AND OTHER FIASCOS

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I. INTRODUCTION.

Mixed in among issues of disability, return to work, and compensability in workers' compensation cases, there are often irritating issues involving medical treatment and choice of medical provider. This paper will address some of the practical aspects of dealing with issues of medical treatment and current Industrial Commission approaches to it. Some of the procedures involving these issues are based on case law, statute or rules, and some appear to be based on tradition. Much of the information contained herein was obtained through discussion with Industrial Commission personnel, experience, and discussions with other lawyers about their experiences. I have promised not to use names, particularly of those within the Commission, in order to shield those persons from pressure to conform, in specific cases, to the generalities they were kind enough to give me. The term "employer" will generally be used to denote also carriers and administrators. The unifying theme in this subject, to the extent there is one, is that the specific facts of a given case, and sometimes the person at the Industrial Commission who is called upon to make the decision, will often be critical to the decision that is made.

II. CHOICE OF PHYSICIAN IN GENERAL.

N.C.G.S. § 97-25 provides that workers' compensation defendants must pay for necessary, related medical treatment. In Schofield v. Great Atlantic & Pacific Tea Co., 299 N.C. 582, 264 S.E.2d 56 (1980), the Supreme Court held that an employee has the right to choose the treating physician, even in the absence of an emergency, subject to approval of the Industrial Commission. In Forrest v. Pitt County Bd. Of Education, 100 N.C. App. 119, 394 S.E.2d 659 (1990), the Court of Appeals clarified that approval of the Commission must be sought within a reasonable time. The definition of a "reasonable" time will vary with the facts of the case, but the Commission may have a rule of thumb that 90 days is the limit in most cases. The best procedure is to file a motion with the Commission seeking approval as soon as possible after a doctor is identified.

While the case law and statute may seem to imply that the employee is entitled to choose the treating physician, the Commission has not traditionally taken that position, with respect to accepted cases. Further, the defense community is convinced that current law allows them to pick the doctors, and any attempts in the political sphere to provide explicitly for patient choice have been met with vigorous resistance. It appears that the defense community considers its perceived right to pick doctors as a very important part of the workers' compensation landscape.

The mechanism by which this apparent contradiction has been maintained is the Commission approval process. The cited case law allows the employee to choose the treating physician, **subject to Industrial Commission approval**. Since the Commission will typically approve the doctors chosen by the employer, the rule announced in Schofield is satisfied, but the

result is that the employee does not get to choose the doctor. The foundation of the Commission's position that employers get to choose is the requirement that they pay. The first sentence of § 97-25, that "Medical compensation shall be provided by the employer," is taken to imply that the employer chooses the doctors provided. Further, the second paragraph of the same section provides that the **employee** can request a change of treating physician. The provision that only an employee can request a change may imply that the default is employer choice.

Of course, there are exceptions to this general rule of employer choice. The most important exception is in denied cases. Just as payment by the employer is taken to imply employer choice, absence of payment by the employer is taken to imply that the employer does not get to choose. Also, just as the employee's right to seek a change of physician is taken to imply that the initial choice lies with the employer, the provision in the fourth paragraph of § 97-25 that the employer must pay for "a physician other than provided by the employer," if the employer has not provided one or in an emergency, may imply that the employer has no control in a denied case. There is no specific statutory provision linking payment of wage compensation and employer control (with the possible exception of § 97-25.3(b)(2), about which there will be more later). However, the Commission has historically taken the position that an employer that is not paying compensation has no right to control medical treatment, and the appellate case law has generally backed that up. Therefore, if the employee is out of work, and the employer is refusing to pay wage compensation, the employee will generally be allowed to pick the doctors, even if the employer is offering medical treatment through its preferred physician. A further convention at the Industrial Commission is that once an employee establishes a treatment relationship with a doctor, when the defendants do not have control, either due to denial of the case or denial of treatment, the employee will generally be allowed to continue treatment with the doctors he or she chose. That is, when a case is initially denied, and the injured worker has obtained treatment, the defendants will not be allowed simply to change the doctors.

As a word of warning, there have been some rumblings that employees might still be required to request approval for treatment in denied cases, even to obtain treatment over which the defendants are not permitted to assert control. An argument can be made that that makes no sense, and the requirement is not clearly established, but it is something over which it may be better to be safe than sorry.

It is important to recognize a practical consideration at this point. When we speak of the employee's being allowed to choose the treating physician, we are referring to choices for which the employer will be required to pay. The employee is always free to choose treatment from any physician. The usual problem is finding a doctor who will treat, if there is no provision for payment. However, if the employee has an alternative source of payment, that problem may be solved. It is common for employers to disregard the opinions of unauthorized physicians, but there is no validity to that position. Authorization only affects payment. Lack of authorization does not cause the doctor's opinion to disappear. If the employee obtains treatment by using an alternative source of insurance, it is important to keep in mind that that source may have a right of reimbursement, or even a lien, against proceeds of the claim. Those matters are outside the scope of this paper.

III. PREAUTHORIZATION.

One of the changes made in the 1994 revisions to the Workers' Compensation Act was the addition of specific provisions concerning preauthorization of treatment. When N.C.G.S. § 97-25.3 applies, insurers can require preauthorization of certain services. The section erects a potential obstacle to payment for certain treatment, even when the treatment is otherwise payable under the Act. However, the section is most notable for what it does **not** require.

First, under § 97-25.3(b), preauthorization may not be required in case of an emergency, when the claim is denied or when the compensability of the specific condition being treated has been denied. This follows the general Commission policy of not allowing the employer control of medical treatment in denied cases. There is a slight difference, in that the bar to preauthorization only occurs when "the insurer has not admitted liability or authorized payment for treatment." In other words, it may be that an employer is not barred from requiring preauthorization when it is providing a doctor, but refusing to pay wage compensation (perhaps on the purported ground that the employee is not disabled), while it would likely not be given a right to control treatment in general.

Second, under § 97-25.3(a), the ability of an insurer to require preauthorization is limited to inpatient admission to a hospital or other treatment center and to surgery. Any attempt by a defendant to invoke § 97-25.3 for any other type of treatment is misplaced.

Third, the only sanction for failure to obtain preauthorization appears to be cutting the amount paid to the physician by 50%, with a specific prohibition against making the employee pay the difference. Thus, the only party that really must worry about § 97-25.3 is the doctor. And even that sanction will only apply when the insurer has notified the medical provider in writing of the preauthorization requirement.

Fourth, there is a "safety valve" provision, in § 97-23.5(c), allowing the Commission to authorize treatment in the absence of required preauthorization, "if the Commission determines that the treatment is or was reasonably required to effect a cure or give relief."

The important things to recognize about N.C.G.S. § 97-25.3 are that it does allow insurers to require a preauthorization procedure under certain circumstances, even for treatment that is for a compensable injury, but that it does not create a general requirement of preauthorization for treatment.

IV. CHANGE OF TREATING PHYSICIAN.

N.C.G.S. § 97-25 provides that an employee may request a change of treatment. This is an area in which the details of a case are usually determinative of the employee's success in obtaining the requested change.

The request is generally made by motion to the Executive Secretary of the Industrial Commission. Over the years, attorneys have complained with some regularity about the delays involved in processing those motions. One available mechanism that can shorten the process in an appropriate case is to attach the motion to the response to a Form 24 Application to Stop Payment, as permitted by § 97-19(e). Since the Form 24's are generally processed fairly quickly, a motion

associated with that process may be hurried along, too. This can be particularly effective when the Form 24 is based on failure to cooperate with medical treatment, and the Commission can "split the baby" by ordering compliance with medical treatment, or ordering suspension of compensation, while simultaneously ordering a change of physician or, more frequently, a rehabilitation specialist.

In general, changes of treating physician are more likely to be granted when the employee is able to show an articulable reason for the change. The most effective motions will show that the doctor chosen by the defendants has done all that she can and that another doctor is offering additional treatment options, especially if those options appear likely to help. A motion made when active treatment is on-going from the original doctor chosen by the employer will likely be rejected as premature. It is also unlikely that a motion will be granted when the employee is unable to give specific information about what the doctor he chooses will do or whether the doctor will accept him as a patient, or when that doctor's prediction is treatment of a kind already done by the first doctor.

As a practical matter, the most effective approach in seeking a change of treatment is to wait until the employer's doctor has given up, then to go to the new doctor for evaluation and treatment recommendations, then to file the motion with the supporting information. Information from the doctor whose treatment is sought can be difficult to obtain, when the employee has no alternative source of payment for medical care. However, a person within the Executive Secretary's office has informed me that she will fairly readily approve a one-time visit to the desired physician, for purposes of obtaining supporting information, at the employer's expense.

V. SPECIAL RULES FOR CHANGE OF REHABILITATION PROFESSIONAL.

Rehabilitation nurses and vocational specialists, including those assigned by employers, are considered to fall within the definition of "rehabilitative procedure" in the third paragraph of N.C.G.S. § 97-25. As such, they are accorded the same dignity as physicians, and employees can be compelled to cooperate with them. Rule X.A. of the Industrial Commission Rules for Utilization of Rehabilitation Professionals in Workers' Compensation Claims provides specifically for removal of rehabilitation professionals but does not state any criteria. From past experience, it appears that the probability of getting an RP removed are enhanced by a showing that the presence of the RP is interfering with treatment and by providing an alternative source of rehabilitation. The Commission is likely to be less impressed by a desire to get rid of rehabilitation than by a plan to replace it with something that might be more effective, coupled with a stated willingness of the employee to work toward being rehabilitated. A ready source of neutral rehabilitation is the Industrial Commission's staff of nurses. Be aware that removal of the employer-assigned RP may not eliminate private rehabilitation forever. The Commission will sometimes order review of the file by a Commission nurse, which may result in a recommendation of assignment of additional private rehabilitation.

Another significant feature of Rehabilitation Rule X is that it requires either a motion or the consent of **both** parties for a change. That is, the employer is not permitted to change rehabilitation personnel unilaterally. This is particularly helpful when an employee has undergone an exhaustive, but fruitless, course of vocational rehabilitation and the employer wants to assign a new vocational person to duplicate the activity, perhaps in a more abusive fashion. Any attempt by an employer to try a new vocational person, after a prior one has given up, can be resisted. If the employer presses

the issue to the Industrial Commission, it is fair to insist that the employer make a showing as to what the new vocational person will add to the process.

VI. COMPULSORY MEDICAL EXAMINATIONS (IME's).

Pursuant to N.C.G.S. § 97-27(a), an employee who is claiming compensation "must submit himself to examination, at reasonable times and places," to physicians chosen and paid for by the employer. Under § 97-27(b), the employee has a right to an examination by a physician of his choice, at the employer's expense. While these examinations are typically referred to as independent medical examinations, or "IME's," the intent is usually to find a favorable physician, not an independent one, so the term does not really fit. The two types of IME's are significantly different, so they will be treated separately here.

The employer-requested IME of § 97-27(a) is limited only by reasonableness. Therefore, there is no theoretical limit on how many there can be or how frequent they can be. The Commission has traditionally allowed great latitude to employers. However, some Commission personnel will be reluctant to require an employee to submit to an IME without at least some explanation as to why it is being requested and why the requested doctor has been chosen. One example given was that an employee from Charlotte would likely not be required to go to Greensboro for an exam by an orthopedist, unless that orthopedist had something unusual to offer. The rationale is that there are plenty of orthopedists in Charlotte, so there is no need to go to Greensboro. On the other hand, if there is a doctor in Greensboro who has special expertise in treatment of a condition, which is not available from orthopedists in general, then the examination will likely be required. Similarly, with respect to frequency, the Commission may not tolerate "doctor shopping." If the employer has already been allowed one IME with an orthopedist, the Commission may require some articulation as to the reason for another one. In sum, the Commission may be requiring a greater showing from employers than it has in the past, so it may be worth resisting requested IME's, if there is a reason to do so.

An important facet of § 97-27 is that it has nothing to do with medical treatment. That section regulates only examinations by certain chosen doctors. It does not authorize employers to shift treatment to doctors of their choice. However, the required examinations might yield information that will support a separate motion to the Industrial Commission for a change of treating physician.

Under § 97-27(b), the employee is entitled to examination by a physician of her choice, but with very significant restrictions. First, unlike the employer, the employee is limited to a single examination. Second, she is entitled to it only when there is a question as to the disability rating and the employee has been required to submit to physical examination under subsection (a). The second half of the latter prerequisite is seldom a factor, since the employer has generally chosen the initial physician, so that the employee in an accepted case has been required to submit to examination by an employer-chosen doctor.

There are twists, however, even with these restrictions. First, as mentioned above, the statutory provisions regarding medical treatment mostly have to do with whether the employer must pay for it. An employee with another source of payment for medical expenses can go to as many

doctors as she chooses. Again, the employer may not have to pay for some of those examinations, but that does not affect the validity of the opinions. There are times when it is more sensible to get examinations and opinions, without allowing the process to bog down in Commission decisions as to who must pay for them. Second, while the right to the examination is limited to circumstances involving questions of permanent partial disability, that does not restrict the subjects that the physician can address in her report. Thus, particularly when there is no other source of payment, the examination available under § 97-27(b) can be used to obtain information to support a motion for change of physician.

VII. EXTENSIONS OF AUTHORIZED TREATMENT.

Sometimes, employers will resist continued payment for testing or treatment recommended by physicians who are otherwise authorized to examine or treat. It is rare, but not unheard of, for employers to try to block treatment that has been prescribed directly by authorized doctors. More frequently, the resistance is to referral to another doctor or prescription of tests by an IME doctor. In all of these situations, the Commission will generally order payment for the requested testing or treatment.

Industrial Commission Rule 407(4) provides specifically that employers shall pay providers to whom the employee has been referred by the authorized treating physician. When an IME has been requested, and the IME doctor says that additional testing is necessary to complete his evaluation, the Commission will usually order payment for that testing, unless there is some reason, such as similar recent tests, not to order it. However, as in so many other areas around these medical issues, much will depend on the facts of the case and even the person making the decision. For example, I have had a client who moved to Florida and obtained a referral from his authorized treating Greensboro neurosurgeon to a specifically named neurosurgeon in Florida. When the employer refused to authorize treatment, we moved formally for a change of treating physician. The employer objected, proposing instead an industrial medicine doctor of their choice, without documentation of planned treatment or any other information, other than the doctor's name, specialty and that the employer wanted to use him. The Commission rejected our motion and ordered referral to the doctor chosen by the employer, who was not even of the same specialty as the one recommended by the North Carolina treating physician. Of course, that doctor saw my client once and released him, instead of rendering the treatment envisioned by the treating physician. The Commission decision in that case was clearly contrary to Rule 407(4), and it was rendered on no evidence other than the employer's stated preference.

VIII. TREATMENT AFTER GAPS IN TIME OR SETTLEMENT.

First in Little v. Penn Ventilator Co., 317 N.C. 206, 345 S.E.2d 204 (1986) and then in Hyler v. GTE Prods. Co., 33 N.C. 258, 425 S.E.2d 698 (1993), the North Carolina Supreme Court held that medical treatment was, in essence, on a separate track from wage compensation and not affected by time limitations that might apply to wage compensation. Therefore, in the absence of a clincher agreement, an employer could remain liable for medical expenses indefinitely, without any concerns about filing within some period of time to get it. In response to employer concerns over that, the General Assembly enacted, again as part of the 1994 "reforms," N.C.G.S. § 97-25.1, which regulates "future" medical expense. § 97-25.1 provides that medical compensation ends two years

after the last payment of medical or wage compensation, unless the employee files an application (the Form 18M) for additional medical coverage or the Commission grants it on its own initiative. The standard for granting the additional treatment is "a substantial risk of the necessity of future medical compensation," and the filing or Commission order must happen within the same two-year window after the last payment.

There are several important points about this. First, the time limitation, if viewed from the other side of the coin, provides that as long as there is not a two-year gap in treatment paid for by the employer, no time limit ever starts to run against the employee. Therefore, if an injured worker settles a claim on a Form Agreement providing for payment of a disability rating and continues to take medication for the compensable injury or receive some other treatment, assuming the employer continues to pay for it as it should, the entitlement to medical treatment is indefinite. Second, while § 97-25.1 requires that the Form 18M be filed with the Commission within the two-year window (if one ever opens), no decision need be made by the Commission until treatment is needed. Third, while employers try to persuade the Commission otherwise, there is no requirement that the doctor providing the opinion that there is "a substantial risk of the necessity of future treatment" predict the exact nature of that treatment, only that there is a "substantial risk" that there will be some. And of course, the section has no application in cases that are on-going as to wage compensation.

When issues of the "relatedness" of treatment arise, there is an important presumption available to injured workers. In Parsons v. The Pantry, Inc, 126 N.C. App. 540, 485 S.E.2d 867 (1997), the Court of Appeals held that when issues of the relationship of specific medical treatment to a compensable injury arise, the burden is on the employer to prove the lack of a relationship. In so holding, the Court noted that the employee had already been required to prove the relationship between her compensable accident and her headaches once, and it was inappropriate to require her to prove it again. While this will not provide a quick administrative remedy to a carrier's interruption of medical treatment, it will make it easier to prove entitlement to the treatment at hearing and easier to persuade the Commission in motions. However, as in all other issues, it is dangerous to rely on presumptions, and one should always try to put forth affirmative evidence of the causal connection between the original injury and desired treatment.

Once again, the Commission's decision on a motion or hearing regarding refusal to pay will depend heavily on the facts of a given case. Commission personnel have advised that close questions as to return to a physician after a delay will generally be resolved in favor of allowing the return, at least for one visit that might clarify the relationship of the treatment to the original injury. The probability of obtaining a favorable result is increased when the doctor sought is the previous treating physician.

IX. MANAGED CARE.

Another of the changes made to the Act in 1994 was addition of N.C.G.S. § 97-25.2, which specifically authorizes the use of managed care organizations to fulfill the employer's obligation to provide medical treatment. In the managed care setting, the employee is allowed to choose the treating physician from among those in the managed care organization and can change to another physician within the group, without approval, one time. Thereafter, the employee must obtain

approval from the employer or the Industrial Commission. The employee is required to exhaust internal dispute resolution procedures before going to the Commission.

Thus, § 97-25.2 contains the only explicit provision in the Act that allows employers to choose treating physicians. However, it has been, so far, fairly insignificant, because it appears that the managed care approach is not being utilized very much. This could be because there are some strict requirements, as stated in the Industrial Commission Rules for Managed Care Organizations, which incorporates further regulatory activity by the Insurance Commission. Presumably, the regulatory requirements of managed care organizations are sufficiently onerous as to deter their use. It is also possible that employers think that giving employees a choice of doctors, even out of a limited pool, would represent a step backward in their ability to control treatment. Commission personnel have confirmed that there does not appear to be much managed care in workers' compensation cases.

It is important to recognize what managed care is not. It does not allow employers and insurance carriers unilaterally to set up lists of approved medical providers or to use "internal review" to override or delay treatment based on the decisions of treating doctors. Those sorts of "procedures" are not authorized by § 97-25.2 or anything else in the Act.

X. SUSPENSION OF COMPENSATION FOR FAILURE TO COOPERATE.

Injured workers are expected to cooperate with treatment that is provided under the Workers' Compensation Act. Failure to do so can result in suspension of compensation, as provided by the third paragraph of N.C.G.S. § 97-25. Employers are not required to continue paying compensation to employees who make a choice not to get better, which makes particular sense when compliance with treatment would allow an injured worker to return to work, so that the employer would be able to stop paying. However, there are important limitations on this sanction.

First, no sanction will be imposed when the Industrial Commission finds that the refusal is justified, which usually comes down to analysis of whether the refusal is reasonable. In making a decision, the Commission will take into account the risks of the treatment in question, which has historically resulted in a reluctance to force surgery. In Watkins v. City of Asheville, 99 N.C. App. 302, 392 S.E.2d 754 (1990), the Court of Appeals affirmed the Commission's suspension of compensation for refusal to undergo back surgery, but only because the surgery in question was considered relatively routine by that time in surgical history, and the testifying doctors had opined that the chances of significant improvement, when balanced against the extremely low probability of a negative result, compelled a decision that any reasonable person would accept the surgery. That case was rare, as it is unusual for doctors to be quite so unequivocal in predicting results. In any event, the Watkins case represents the outer edge of the kind of case in which the Commission is likely to pressure injured workers into treatment. Most cases in which employers seek suspension involve refusal to show up for appointments.

Second, the sanction is suspension of compensation during the refusal to accept treatment, not a permanent termination. The sanction is intended to be coercive—to pressure

employees into getting treatment they should be getting. Therefore, the suspension ceases as soon as the worker complies.

Third, unlike the suspension permitted in N.C.G.S. § 97-32 for refusing suitable employment, suspension for refusal of medical treatment requires a two-step process. N.C.G.S. § 97-25 allows suspension for refusal of treatment "when ordered by the Industrial Commission." That has been interpreted as requiring that the employer first obtain an order compelling certain treatment, then show that the employee failed to comply with the order. This procedure allows an employee to test whether the Commission will find the treatment in question to be reasonably required, without risking suspension of compensation. Fortunately, the Commission takes seriously the issuance of the first order, and an employee can resist the order successfully in an appropriate case.

Sanctions for refusal of "treatment" can be messy in the area of vocational rehabilitation. As stated above, voc is considered a species of medical treatment, which is the rationale under which injured workers are forced to participate in that process. The principle underlying the sanction is somewhat warped with voc, as the sanction is based on the assumption that it is unreasonable for an employee to resist medical treatment that can make him healthier, while vocational "rehabilitation" imposed by employers is very often designed to hurt injured workers, so that it makes perfect sense for workers to resist it. Furthermore, the Industrial Commission has, ironically, been more likely to order compliance with vocational "treatment" than actual medical treatment, often ignoring the fact that voc might be pointless and requiring little justification for the "treatment" beyond a rehabilitation professional's demand for it. The waters have been further muddied by Johnson v. Southern Tire Sales & Serv., 358 N.C. 701, 599 S.E.2d 508 (2004), in which (in this author's respectful opinion) the North Carolina Supreme Court characterized a failure to cooperate with vocational rehabilitation as a constructive refusal of suitable employment, so that compensation could be suspended without a prior order of compliance.

XI. PRACTICAL CONSIDERATIONS.

There are some generally applicable practical considerations in matters involving medical care in workers' compensation cases.

First, sources in the Executive Secretary's office of the Commission indicate that they encourage conference calls, mediated by the Commission, to resolve motions or otherwise deal with these issues. They say that experience has shown that a significant number of conflicts can be resolved through discussion.

Second, it is sometimes not productive to stand on principle. If the attorney representing the employee allows himself to become bogged down in the legalities of medical issues, the claim as a whole can suffer, or a lot of stress can be created over an issue that is simply not worth all the trouble.

Finally, there are times when an attorney or employee should consider allowing the employer to "get away with" something that might be successfully resisted. Particularly when the employee would benefit from settlement of her case, it may be necessary, as a practical matter, to allow the employer to obtain an IME from an undesirable doctor that could be avoided, as the employer may never settle without it. That is, there are times when it makes sense to allow a client to be seen by a **P**rofessional **I**ndependent **M**edical **P**ractitioner chosen by the employer, when there is a high probability that the PIMP in question will be unable to damage the client's claim for lifetime compensation, instead of fighting over the examination for a year. If the carrier will never settle a claim without the examination, and the case ought to be settled, then the client's interests may not be served by successfully avoiding the examination. Depending on the case, such examinations can even backfire on the employer, enhancing settlement value. As with so many areas in workers' compensation, we can help our clients with medical issues by keeping our minds open and being aware of the circumstances around us.