Good afternoon, Chairman Gingrich, Minority Chairman Gergely, and staff. I am Daniel Bricmont, Chair Elect of the Pennsylvania Bar Association, Workers' Compensation Section. I am accompanied by Michael Routch, Vice Chair of the Section. We represent approximately 650 attorneys of the Commonwealth's Workers' Compensation bar. I primarily represent claimants and Mr. Routch primarily represents employers and insurance carriers in Workers' Compensation matters. On behalf of the Workers' Compensation Section of the PBA, we oppose the imposition of evidence-based medical treatment guidelines into the Pennsylvania Workers' Compensation Act.

The proposed legislation will fundamentally transform the delivery of medical treatment to Pennsylvania's injured workers. Instead of leaving treatment decisions to doctors and injured workers, the legislation will have the effect of delegating medical decisions to a panel far removed from the circumstances of each particular case.

The Workers' Compensation Section understands that it is in the best interest of everyone to reduce Workers' Compensation costs in the Commonwealth. We note that Workers' Compensation rates in Pennsylvania have been decreasing annually each year since 2012. In fact, the lost cost filings, which are the baseline premium variable that is used to calculate insurance premiums for employers, have decreased since 2012 as follows: 2012 – decreased 5.66%; 2013 – decreased 4.01%; 2014 – decreased 5.15%; and 2015 – decreased 0.90%, as reported by the Pennsylvania Compensation Ratings Bureau.

The Section believes that concerns regarding controlling costs and frequency of surgery have already been effectively addressed in the Workers' Compensation Act via the fee schedules and utilization review process. Additionally, the Legislature reduced the prescribing of addictive medications in Act 184 of 2014.

The “one-size fits all” prospect of the evidence-based treatment guidelines is wrong for claimants and employers in Pennsylvania.

Beyond adding new regulations, HB1800 delegates legislative authority to an unelected body of academics or other medical review group to develop rules governing patient care. These regulations will determine medical care for your constituents. Inevitably an insurer or patient in your district will call on you when confronted with a new pronouncement that either disallows some medication, assistive device or new therapy method. Would this Committee be powerless to address those legitimate concerns? Imagine the ire of a voter whose physician recommends a biologic, or new advanced medication, but the guidelines says “no” and your response must be,

1http://www.dcrb/shared/p_contents.htm, see filings.
"No legislator or judge can review it because we gave that authority to a medical/academic agency to decide."

Currently, claimants and employers can obtain review of treatment recommendations, and have a neutral judge rule on specific and individual patient treatment options. To limit that evaluation to a specific recipe from the guidebook is unwarranted and limits the authority of the Legislature, which has the first responsibility to govern.

Beyond concerns over who gets to decide the guideline for patient care, there are a number of questions raised by the complex nature inherent in medical decisions.

Doctors are legally obligated to treat a specific patient and condition, based on the individual health profile and the current standards of the profession which reflect years of medical knowledge and experience. The specific patient is a critical component because tort law traditionally requires that the practitioner treat the patient as one finds him or her. In the legal community, this is sometimes called the egg shell skull doctrine and it allows an injured patient/plaintiff to recover for all the damages he or she sustains even if he or she had an underlying condition prior to the injury which made the injury worse or treatment more expensive. Thus it is not a defense to liability to assert that "most people would have been recovered pursuant to the standard treatment protocols".

Doctors should not face restrictions on care adopted from cost savings guidelines while still bearing responsibility for a patient’s health and well-being. While employers in workers’ compensation have tort law immunity, the medical providers who treat these patients do not. The current system has the flexibility to let physicians make the treatment recommendations for the specific patient, while still permitting utilization review on a case by case basis. Additional regulations that limit a physician’s options to the mean or average patient will have unintended consequences that cannot be foreseen. There is also concern that the guidelines may have a chilling effect on treatment recommendations as a physician approaches the end of "approved" care but has not yet obtained the predicted result. Does the patient get referred to a different specialty in the hope that a different guideline will apply or is the patient simply stuck? These are legitimate concerns in the current system as well but the current system satisfies equal protection and due process concerns by affording notice, an opportunity to be heard and a neutral judge to resolve disputes on evidence of a specific patient’s circumstances.

Experience teaches that patient specific factors such as age, diabetes, coronary artery disease, obesity, cigarettes smoking and alcohol use, will likely affect the rate of recovery for certain ailments and delay recovery or trigger different treatment options. Do we really want to ration health care by adopting generalized regulations based on the expected results rather than the actual results? Respectfully, no. Pennsylvanians should not be pawns in the medical cost savings war and this Legislature should not adopt a medical recipe book to limit medical care.

An additional concern with this proposed amendment is its reliance on the diagnosis of the patient’s injury” to determine how much treatment should be permitted. This places significant emphasis on the physician making the correct diagnosis. As attorneys, we have observed, for example, shoulder injuries being diagnosed and treated as a sprain at first only to later be characterized as an impingement syndrome, slap tear, rotator cuff tear and sometimes even a cervical disc injury. If a physician starts with wrong diagnosis, we fear the wrong guideline will limit care to the patient for the true injury.
Ultimately, clinical observations, patient symptoms and imaging studies come together to create the correct diagnosis. One size fits all guidelines should not limit care for the partially informed diagnosis. Even where the diagnosis is self-evident (the broken bone or carpal tunnel syndrome), treatment could encompass a wide range of what is medically acceptable in the case of a 30 year old professional versus a 60 year old male laborer. The responsible physician is in the best position to rely on the evidence of the specific patient to make that determination and is thereafter subject to current utilization review oversight where an employer or insurer believes that care is excessive.

The current system accords the insurer the ability to challenge causation of a specific injury and diagnosis for each specific claim. Physicians have legitimate differences of opinion as to the diagnosis and cause of a condition after all. If treatment options after the amendment turn on the magic diagnosis, how will it be challenged by either side? The stakes will certainly be higher because the ability to get care will now depend on it.

Employers and their insurance carriers will be surrendering control over treatment protocols to standards decided by the political process which may turn out to be more favorable to employees, their unions or their lawyers. We direct the Committee's attention to a Wisconsin case where an employer/insurance carrier was denied the right to cross-examine a medical liability determination made by a state appointed Workers' Compensation physician. This is currently unheard of in Pennsylvania where both sides are entitled to cross-examine the opinions of physicians in workers' compensation cases. Once the standard treatment protocol is established by legislation, there can likely be no challenge by an employer or its insurance carrier.

Medical treatment under this bill will be prescribed by those special interests in power, which is always subject to future change. That is bad for employers. It will delay effective treatment and return to work in many cases.

The Workers' Compensation Section of the Pennsylvania Bar Association is divided roughly evenly between attorneys representing claimants and employers and their insurance carriers. The Section does not usually become involved in the legislative process unless the proposal affects the integrity of the Workers' Compensation system.

Involvement, such as the testimony here today, occurs only when there is unanimity by the entire governing Council of the Section. This is such an occasion.

The governing Council of the Workers Compensation Section of the Pennsylvania Bar Association respectfully opposes H.B. 1800 and any similar legislation imposing evidenced-based medical treatment guidelines on injured workers and their employers.

Thank you.