**WORKERS' COMPENSATION APPEALS BOARD**

**STATE OF CALIFORNIA**

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| **JOSE DUBON,**<br><br>***Applicant,***<br><br>**vs.**<br><br>**WORLD RESTORATION, INC.; and STATE COMPENSATION INSURANCE FUND,**<br><br>***Defendants.*** | **Case Nos. ADJ4274323 (ANA 0387677)**<br>**ADJ1601669 (ANA 0388466)**<br><br>**OPINION AND DECISION AFTER RECONSIDERATION (EN BANC)** |

We previously granted the petition filed by State Compensation Insurance Fund (SCIF) seeking reconsideration of our February 27, 2014 Opinion and Decision After Reconsideration (En Banc). (See *Dubon v. World Restoration, Inc.* (2014) 79 Cal.Comp.Cases 313 (Appeals Board en banc) (*Dubon I*).)[1] We now issue a new Opinion and Decision After Reconsideration (En Banc)[2] and hold:

1. A utilization review (UR) decision is invalid and not subject to independent medical review (IMR) only if it is untimely.

2. Legal issues regarding the timeliness of a UR decision must be resolved by the Workers' Compensation Appeals Board (WCAB), not IMR.

3. All other disputes regarding a UR decision must be resolved by IMR.

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[1] Since the February 27, 2014 en banc decision, there has been a change in the membership of the Appeals Board. Commissioner Moresi is no longer serving as a member and the Governor has appointed Commissioner Zalewski as a member.

[2] En banc decisions of the Appeals Board are binding precedent on all Appeals Board panels and WCJs. (Cal. Code Regs., tit. 8, § 10341; *Signature Fruit Co. v. Workers' Comp. Appeals Bd.* (*Ochoa*) (2006) 142 Cal.App.4th 790, 796, fn. 2 [71 Cal.Comp.Cases 1044]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) In addition to being adopted as a precedent decision in accordance with Labor Code section 115 and Appeals Board Rule 10341, this en banc decision is also being adopted as a precedent decision in accordance with Government Code section 11425.60(b).

4. If a UR decision is untimely, the determination of medical necessity may be made by the WCAB based on substantial medical evidence consistent with Labor Code section 4604.5.[3]

Therefore, we will rescind our February 27, 2014 en banc decision in *Dubon I* and affirm the decision of the workers' compensation administrative law judge (WCJ), which held that the medical necessity of applicant's requested back surgery must be determined by IMR, notwithstanding any procedural defects in defendant's timely UR decision.

## I. BACKGROUND

In 2003 and 2004, applicant sustained industrial injuries to his spine and other body parts while employed by World Restoration, Inc., SCIF's insured. Applicant's primary treating physician for both injuries has been Mark W. Brown, M.D. His consulting orthopedic surgeon has been Albert Simpkins, Jr., M.D. The agreed medical evaluator (AME) in orthopedics has been Israel Rottermann, M.D.

For two basic reasons, applicant's physicians have been considering spinal surgery for over three years.

First, the consideration of surgery has been predicated in part on applicant's ongoing symptoms and his failure to respond to conservative treatment. At trial, applicant offered in evidence seven reports from Dr. Brown, eight reports from Dr. Simpkins, and a report from AME Rottermann,[4] all of which establish that: (1) applicant has had continuing problems with back pain, bilateral lower extremity pain, numbness and tingling, limited range of motion, and other problems; and (2) repeated attempts at conservative treatment have not been successful in resolving his problems.[5]

Second, the consideration of surgery has been predicated in part on the results of various

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[3] Unless otherwise specified, all further statutory references are to the Labor Code.

[4] Dr. Brown's seven reports in evidence extend from November 10, 2010 through June 27, 2013. Dr. Simpkins's eight reports extend from March 7, 2011 through September 5, 2013. Dr. Rottermann's AME report is dated January 19, 2012.

[5] These conservative measures have included taking opioid medications for pain (i.e., hydrocodone and Norco), taking a variety of other prescription medications (including sleeping pills, a muscle relaxant, and anti-depressants), having lumbar epidural steroid injections on at least two separate occasions, utilizing a lumbar back brace and a cane for support, participating in physical therapy, following a home exercise program, engaging in activity modification, and using an ice machine at home.

objective tests. On February 12, 2009, an MRI study showed that applicant had a large disc protrusion at L5-S1 and a smaller protrusion at L4-L5. An electromyogram and nerve conduction velocity (EMG/NCV) study of April 28, 2011 reflected that he had left L4-5 radiculopathy. A June 8, 2011 lumbar MRI showed that he had a broad-based disc protrusion at L4-5, with mild left foraminal stenosis. X-rays taken by Dr. Rottermann's office January 19, 2012 showed severe narrowing at L5-S1, causing Dr. Rottermann to conclude that applicant needed a discogram. In an April 8, 2013 report, Michael H. Lowenstein, M.D., found that applicant's discogram was positive for discogenic pain at L4-5 and L5-S1.

On May 6, 2013, Dr. Brown referred applicant to Dr. Simpkins for evaluation and treatment in light of the lumbar discogram.

In a July 1, 2013 report, Dr. Simpkins said that applicant was complaining of persistent low back pain with radiation into the lower extremities and that he had been wearing a back brace and taking Norco for pain. Dr. Simpkins also said that, per the April 8, 2013 discogram report of Dr. Lowenstein, applicant had "positive findings for concordant discogenic pain with posterior annular tear at L4-5 and concordant discogenic pain with a degenerative-appearing disc at L5-S1." Based on the discogram findings, Dr. Simpkins requested authorization to perform an anterior and posterior fusion from L4 through S1 with decompression, as well as authorization for various post-surgical services.[6]

On July 19, 2013, Bunch CareSolutions (Bunch), SCIF's UR provider, denied authorization for the surgery and the post-surgical services as not medically necessary. The UR denial letter attached the July 19, 2013 report of a UR physician, Donald A. deGrange, M.D., a board certified orthopedic surgeon.

Dr. deGrange's report said that he reviewed Dr. Simpkins's July 1, 2013 report, the June 8, 2011 lumbosacral MRI, and "18 additional pages of medical records." Dr. deGrange did not specify what these "18 additional pages of medical records" were. Moreover, nothing in his report reflects that he reviewed: (1) any reports from Dr. Brown; (2) any reports from Dr. Simpkins, except the July 1, 2013 report; (3) the AME report of Dr. Rottermann; (4) Dr. Lowenstein's April 8, 2013 discogram report; (5) the lumbar MRI of 2008 or 2009; or (6) the April 28, 2011 EMG/NCV study.

[6] Although Dr. Simpkins's report is dated July 1, 2013, he signed it on July 8, 2013 and it was received by defendant on July 11, 2013. Applicant never challenged the timeliness of defendant's July 19, 2013 UR denial.

Nevertheless, Dr. deGrange's report determined that the spinal surgery and post-surgical services were not medically necessary. In essence, he found: (1) there was no documented imaging of nerve root compression or of moderate or greater stenosis at each of the requested levels;[7] (2) there was no evidence that conservative treatment had failed; and (3) there was no documentation of a condition/diagnosis for which spinal fusion was indicated.

Dr. Simpkins invoked Bunch's internal UR appeal process.[8] On August 2, 2013, a second UR denial issued based on the report of Kevin Mark Deitel, M.D., another board certified orthopedic surgeon. This report was identical to that of Dr. deGrange in all significant respects.

On August 12, 2013, applicant signed an IMR application.

On August 14, 2013, applicant filed a declaration of readiness (DOR) for an expedited hearing asserting that defendant's UR denial was defective because, among other reasons, there was insufficient record review.

The expedited hearing took place on September 9, 2013. The principal issues raised were: (1) need for further medical treatment; and (2) whether IMR is applicant's exclusive remedy per section 4610.5.

On September 23, 2013, the WCJ issued her decision holding that disputes over claimed procedural defects in defendant's UR denial must be resolved through IMR. In her Opinion, the WCJ observed that: (1) Dr. deGrange did not identify the 18 pages of additional medical records he reviewed, in violation of section 4610(g)(4) and AD Rule 9792.9.1(e)(5)(D) (Cal. Code Regs., tit. 8, § 9792.9.1(e)(5)(D)); and (2) there is "a wealth of medical records" that Dr. deGrange did not review, including all reports of Dr. Brown, the reports of Dr. Simpkins other than the July 1, 2013 report, the AME report of Dr. Rottermann, and the discogram report of Dr. Lowenstein. The WCJ said that the failure of Dr. deGrange, and implicitly of Dr. Deitel, to review all of the relevant medical records "was a

[7] Central canal stenosis, lateral recess stenosis, or neural foraminal stenosis.

[8] The Rules of the Administrative Director (AD) provide that a defendant may elect but is not required to create an "internal" process for appealing an initial UR determination; however, if created, "the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis." (Cal. Code Regs., tit. 8, § 9792.9.1(e)(5)(J).)

critical error" because "the determination [of medical necessity] is made in part based upon the severity of pain, duration of pain, radiculopathy as well as a review as to whether conservative care had been undertaken." The WCJ added that a UR physician "is compelled by ACOEM to look at objective testing performed coupled with subjective complaints, history of radiculopathy, and history of conservative care" and that "a complete review of applicant's medical condition and prior treatment … is especially important when utilizing ACOEM Guidelines in determining whether treatment should be authorized."[9]

Nevertheless, despite the defects the WCJ identified, she found: "the issue of need for surgery and medical care set forth in the medical reports of Dr. Simpkins shall be determined by the [IMR] process and therefore, this Court cannot award surgery or treatment recommended by Dr. Simpkins."

Applicant then filed the original Petition for Reconsideration that led to our February 27, 2014 en banc decision. Defendant filed an Answer. On December 16, 2013, we granted reconsideration to further study the facts and law.

On February 27, 2014, we issued our en banc decision in *Dubon I* and held:

> "1. IMR solely resolves disputes over the medical necessity of treatment requests. Issues of timeliness and compliance with statutes and regulations governing UR are legal disputes within the jurisdiction of the WCAB.
>
> "2. A UR decision is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the UR decision. Minor technical or immaterial defects are insufficient to invalidate a defendant's UR determination.
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> "3. If a defendant's UR is found invalid, the issue of medical necessity is not subject to IMR but is to be determined by the WCAB based upon substantial medical evidence, with the employee having the burden of proving the treatment is reasonably required.

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[9] The WCJ is referring to the Occupational Medicine Practice Guidelines of the American College of Occupational and Environmental Medicine (i.e., the ACOEM Guidelines). When first enacted, section 4604.5 provided that the ACOEM Guidelines were presumptively correct. Presently, section 4604.5 provides that the medical treatment utilization schedule (MTUS) adopted by the AD is presumptively correct. The MTUS regarding "Low Back Complaints" incorporates Chapter 12 of the ACOEM Guidelines. (Cal. Code Regs., tit. 8, § 9792.23.5(a).) The MTUS regarding "Chronic Pain Medical Treatment Guidelines" expressly replaces Chapter 6 of the ACOEM Guidelines (Cal. Code Regs., tit. 8, § 9792.24.2(a)), but it incorporates the Official Disability Guidelines (ODG). (Cal. Code Regs., tit. 8, § 9792.24.2(e).)

> "4. If there is a timely and valid UR, the issue of medical necessity shall be resolved through the IMR process if requested by the employee."
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> (*Dubon I*, *supra*, 79 Cal. Comp. Cases at p. 315.)

Based on these holdings, we rescinded the WCJ's September 23, 2013 decision and returned the matter to her for further proceedings and decision on whether the spinal surgery question is reasonably required.[10]

On March 24, 2014, SCIF filed its current Petition for Reconsideration of our prior en banc decision. In its Petition, SCIF contends: (1) the provisions of section 4610.5, the language of uncodified section 1 of Senate Bill (SB) 863, and the legislative history of SB 863 all unambiguously establish that "any dispute" over a UR decision, including disputes over its timeliness and procedural validity, "shall be" resolved through IMR; (2) even assuming the WCAB has authority over UR timeliness and procedural validity issues, the WCAB should not determine medical necessity; instead, if the WCAB determines that a defendant's UR decision is invalid, the WCAB should simply order that the UR decision cannot be considered by IMR when it determines medical necessity; and (3) it is the responsibility of the treating physician, not the defendant, to provide all documentation in support of a treatment request.

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[10] At the September 9, 2013 expedited hearing, the parties stipulated that applicant sustained both a November 15, 2003 injury in ADJ601669 and a May 20, 2004 injury in ADJ4274323. The WCJ's September 23, 2013 decision listed both case numbers, but only "found" a November 15, 2003 injury. On October 18, 2013, the WCJ issued an Amended Findings and Order, which solely added the May 20, 2004 stipulated injury. Our February 27, 2014 decision failed to make an express disposition regarding the WCJ's October 18, 2013 amended decision. However, because the October 18, 2013 amended decision issued *after* applicant filed the petition for reconsideration that was the subject of *Dubon I*, we deem the amended decision to be void. (Cal. Code Regs., tit. 8, § 10858 (allowing a WCJ to amend a clerical error "*before* a petition for reconsideration is filed" [italics added]); § 10859 (WCJ not permitted to issue an amended decision without granting *all* of the relief requested by a petition for reconsideration).) In any event, our oversight was immaterial because the question of injury on May 20, 2004 was not a disputed issue submitted to the WCJ for determination (see § 5815) and the September 23, 2013 decision did not make an actual finding contrary to the parties' stipulation (see § 5702; Cal. Code Regs., tit. 8, § 10497).

On April 3, 2014, applicant filed an Answer.[11]

On May 22, 2014, we granted reconsideration to further study the facts and issues presented.

## II. DISCUSSION

### A. THE LEGISLATIVE HISTORY OF UR AND IMR

The legislative scheme for reviewing employee treatment requests has changed over time. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Sandhagen*) (2008) 44 Cal.4th 230, 237 [73 Cal.Comp.Cases 981].) As discussed more extensively in *Sandhagen*, prior to SB 228, the employee's treating physician would make a treatment recommendation and, if a dispute arose, the parties would either obtain an AME or they would each separately obtain a qualified medical evaluator (QME). (*Sandhagen*, *supra*, 44 Cal.4th at p. 238.) Thereafter, the issue of medical necessity would be determined by the WCAB based on the medical evidence presented.

In 2003, SB 228 was enacted. (Stats. 2003, ch. 639; *Sandhagen*, *supra*, 44 Cal.4th at pp. 239-241.) Among other things, SB 228 added section 4610. It requires that "[e]very employer shall establish a utilization review process in compliance with this section." (§ 4610(b).) Under this process, when a defendant disputes a treating physician's request for authorization of treatment (RFA), a UR physician must determine, based on "medical necessity," whether to approve, modify, or deny the requested treatment. (§ 4610(a), (c), (e), (g)(4).) In addition, section 4610 requires that "[e]ach utilization review process shall be governed by written policies and procedures" and it mandates that certain procedural requirements "shall be met." (§ 4610(c), (g).)

In 2004, SB 899 was enacted. (Stats. 2004, ch. 34; *Sandhagen*, *supra*, 44 Cal.4th at p. 241.) "While [SB] 899 did not alter the section 4610 utilization review process, it made a number of changes to

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[11] In addition, the California Chamber of Commerce (CalChamber) and the California Self-Insurers Association (CSIA) jointly requested to file an amicus curiae brief. However, WCAB Rule 10848, which provides that the Appeals Board may consider a supplemental pleading requested or approved by it, applies only to supplemental pleadings filed by a "party." (Cal. Code Regs., tit. 8, § 10848.) Thus, Rule 10848 does not apply to amicus briefs. Furthermore, as stated in *Weiner v. Ralphs Co.* (2009) 74 Cal.Comp.Cases 484, 486, fn. 2 (Appeals Board en banc): "We observe it is not unusual for the Appeals Board *to invite* amicus curiae briefs relating to our en banc cases. The Appeals Board has periodically done so for over 30 years." (Italics added.) Here, however, the Appeals Board has not invited amicus briefs and, generally, it does not accept unsolicited amicus briefs. Accordingly, CalChamber and CSIA's proposed amicus brief is not accepted for filing or deemed filed.

the dispute resolution process in section 4062." (*Sandhagen, supra*, 44 Cal.4th at p. 242.) Among other things, SB 899 amended section 4062 to allow an employee to object to a UR decision and obtain a comprehensive medical-legal report from an AME or a QME. (*Sandhagen, supra*, 44 Cal.4th at pp. 242-245.)

In 2012, SB 863 was enacted. (Stats. 2012, ch. 363.) SB 863 did not change the procedural requirements of section 4610 for UR decisions, but it amended the procedures for resolving post-UR disputes over the "medical necessity" of treatment requests. In its statement of purpose, uncodified section 1(e) of SB 863 pronounced:

> "The Legislature finds and declares all the following: … (e) [t]hat having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy."
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> (Stats. 2012, ch. 363, § 1(e); see also § 1(d), (f), (g).)

To effectuate this purpose, the Legislature amended sections 4062 and 4610 so that an injured employee could no longer use the AME/QME process to dispute a UR decision. Instead, sections 4610.5 and 4610.6 were adopted, introducing a new procedure whereby an injured worker who disputes a UR decision may request IMR. Under sections 4610.5 and 4610.6, an IMR physician evaluates the "medical necessity" of the proposed treatment. (§§ 4610.5(c)(2), (c)(3), (k), 4610.6(a), (c), (e).)

As amended by SB 863, however, section 4604 still vests the WCAB with jurisdiction to determine non-medical disputes regarding the timeliness of UR. Specifically, section 4604 provides that: "[c]ontroversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party, *except as otherwise provided by Section 4610.5*." (Italics added.)

In 2013, based on the foregoing statutory provisions and on its general rulemaking authority (§ 5307(a)(1); see also §§ 133, 5309, 5708), the WCAB adopted Rule 10451.2(c)(1), which provides, in relevant part:

> "Where applicable, independent medical review (IMR) applies solely to disputes over the necessity of medical treatment where a defendant has conducted a timely and

> otherwise procedurally proper utilization review (UR). … All other medical treatment disputes are non-IMR[] disputes. Such non-IMR[] disputes shall include, but are not limited to: … (C) a dispute over whether UR was timely undertaken or was otherwise procedurally deficient; however, if the employee prevails in this assertion, the employee … still has the burden of showing entitlement to the recommended treatment …"
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> (Cal. Code Regs., tit. 8, § 10451.2(e).)[12]

**B. A UR DECISION IS INVALID AND NOT SUBJECT TO IMR ONLY IF IT IS UNTIMELY.**

In our February 27, 2014 en banc decision, we held that "[a] UR determination is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the UR determination" and that "[m]inor technical or immaterial defects are insufficient to invalidate a defendant's UR determination." (*Dubon I,* 79 Cal.Comp.Cases at pp. 315, 320.) We now modify our holding to conclude that a UR decision is invalid only if it is untimely.

As recognized by the Supreme Court in *Sandhagen*, "Section 4610 requires that '[e]very employer [*shall*] establish a utilization review process *in compliance with this section*' (*id.*, subd. (b))." (44 Cal.4th at p. 236 (italics added).)[13] To be "in compliance" with section 4610, there are certain procedural requirements that "*shall* be met" (§ 4610(g) (italics added)), including that a UR decision "shall" be made within specified deadlines. (§ 4610(g)(1), (g)(2), (g)(3)(A).)[14] As used in the Labor Code, "shall" is mandatory language. (§ 15; *Smith v. Rae-Venter Law Group* (2003) 29 Cal.4th 345, 357.)

Where a UR decision is not timely rendered "in compliance" with these mandatory deadlines, there is no "dispute" for IMR to "resolve" within the meaning of section 4610(g)(3)(A) and (B) and

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[12] The provision of Rule 10451.2(c)(1)(C) that non-IMR disputes include "a dispute over whether UR was … *procedurally deficient*" (italics added) is inconsistent with our decision herein. Therefore, pending that Rule's amendment, this provision should not be applied. (Cf. *Mendoza v. Huntington Hospital* (2010) 75 Cal.Comp.Cases 634, 640-641 (Appeals Board en banc) [regulations are invalid to the extent they contravene the statutes under which they were adopted].)

[13] The bracketed "shall" is contained in section 4610(b).

[14] See also *Sandhagen*, *supra*, 44 Cal.4th at pp. 240-241 ("Section 4610, subdivision (g) imposes a number of additional requirements that must be met as part of the utilization review process. Among them are: … treatment decisions must be made in a timely fashion, not to exceed five working days from the receipt of information reasonably necessary to make the determination, and in no event more than 14 days from the date of the request for treatment (§ 4610, subd. (g)(1)) …").

section 4610.5(a), (b), and (k). As observed by the Court of Appeal in *Elliott v. Workers' Comp. Appeals Bd.* (2010) 182 Cal.App.4th 355, 363 [75 Cal.Comp.Cases 81]: "A dispute does not legally arise unless the employer prompts the utilization review in a timely fashion."

This is consistent with the Supreme Court's decision in *Sandhagen*, which considered a case in which the defendant's UR decision and physician's report were excluded because of defendant's failure to comply with the deadlines of section 4610(g)(1).[15] The Supreme Court concluded, based on a review of legislative history, that a defendant must conduct UR with respect to an employee's request for treatment (*Sandhagen*, *supra*, 44 Cal.4th at pp. 233-234, 243-244, 244-245; see also see 44 Cal.4th at p. 246 (conc. opn. of Kennard, J))[16] and that this UR must be timely. (*Sandhagen*, *supra*, 44 Cal.4th at pp. 240-241.)[17]

Accordingly, where a defendant's UR decision is untimely, it is invalid and not subject to IMR. Of course, if a treatment request is denied without medical review, there is no UR decision to appeal to IMR.

**C. LEGAL ISSUES REGARDING THE TIMELINESS OF A UR DECISION MUST BE RESOLVED BY THE WCAB, NOT IMR.**

SCIF asserts that the provisions of section 4610.5, the language of uncodified section 1 of SB 863, and the legislative history of SB 863 all unambiguously establish that "any dispute" over a UR decision, including a dispute over its timeliness, "shall be" resolved through IMR. We reject this assertion.

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[15] See *Sandhagen v. Cox & Cox Construction, Inc.* (2004) 69 Cal.Comp.Cases 1452, 1453, 1456 (Appeals Board en banc).

[16] *Sandhagen* emphasized a defendant may simply approve the treatment request without submitting it to a UR physician for "medical review" (*Sandhagen*, *supra*, 44 Cal.4th at pp. 240, 241) and that such an approval constitutes UR (*id*. at p. 244; see also Cal. Code Regs., tit. 8, § 9792.7(b)(3) ("[a] non-physician reviewer may approve requests for authorization of medical services").)

[17] *Sandhagen* also acknowledged the earlier holdings of the Appeals Board (en banc) and of the Court of Appeal that UR deadlines "are mandatory and [a defendant's] failure to meet the deadlines means that, with respect to the particular medical treatment dispute in question, [the defendant is] precluded from using the utilization review process, or any utilization review report it obtained to deny treatment." (*Sandhagen*, *supra*, 44 Cal.4th at p. 235.)

**1. IMR Physicians Only Resolve "Medical Necessity" Disputes**

There is no question that sections 4610 and 4610.5 provide that disputes over UR decisions shall be resolved by IMR. Section 4610(g)(3)(A) states that if a UR decision does not fully approve a treatment request, then "disputes [regarding the UR decision] *shall be resolved pursuant to Section 4610.5, if applicable … .*" (Italics added; see also § 4610(g)(3)(B).)

In turn, section 4610.5 states:

> (a) *This section applies to the following disputes*:
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> > (1) *Any dispute over a utilization review decision* regarding treatment for an injury occurring on or after January 1, 2013.
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> > (2) *Any dispute over a utilization review decision* if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.
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> (b) A dispute described in subdivision (a) *shall be resolved only in accordance with this section*.
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> (e) A utilization review decision *may be reviewed or appealed only by independent medical review pursuant to this section*.
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> ***
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> (k) The [AD] … shall expeditiously review [IMR] requests and … [i]f there appears to be any medical necessity issue, *the dispute shall be resolved pursuant to an independent medical review* [with specified exceptions not relevant here].
>
> (Italics added.)

Additionally, as mentioned above, various provisions of uncodified section 1 of SB 863 expressly declare a legislative intent that IMR is to be the vehicle for reviewing a UR decision. (Stats. 2012, ch. 363, § 1(d), (e), (f), (g).)

However, sections 4610.5 and 4610.6 expressly circumscribe the role of an IMR physician to evaluating the "medical necessity" of the proposed treatment. (§§ 4610.5(c)(2), (c)(3), (k), 4610.6(a), (c), (e).) For example, section 4610.6(a) states that "[IMR] *shall be limited to an examination of the medical necessity* of the disputed medical treatment." (Italics added.) These provisions of sections 4610.5 and 4610.6 are consistent with uncodified section 1(e) of SB 863, which declares a legislative intent "[t]hat

having medical professionals ultimately *determine the necessity of requested treatment* furthers the social policy of this state …" (Stats. 2013, ch. 363, § 1(e) (italics added).)

Furthermore, nothing in SB 863 suggests that IMR physicians will have either the legal expertise or resources to decide whether a UR decision was untimely. To the contrary, SB 863 consistently refers to the IMR physicians as "*medical* professionals" (italics added). (§§ 4610.6(e), (f), 139.5(b)(1), (d)(2)(G), (d)(3)(A), (B), (C), & (E), (d)(4); Stats. 2013, chap. 363, § 1(e); see also § 4610.6(b) [referring to IMR physicians as "*medical* reviewer[s]" (italics added)].) Additionally, although section 4610.5 specifies what documents are provided to the IMR organization (§ 4610.5(f)(3), (l), (m)),[18] section 4610.5 nowhere indicates that IMR physicians are to be provided with documents relating to the timeliness of the defendant's UR decision[19] or with legal authority relating to the timeliness of UR.[20]

Accordingly, legal issues regarding UR timeliness are not issues of medical necessity and cannot be resolved by IMR.

**2. The Timeliness of a UR Decision Is a Legal Dispute Within the Jurisdiction of the WCAB.**

Sections 4610.5 and 4610.6 limit IMR to disputes over "medical necessity." Legal disputes over UR timeliness must be resolved by the WCAB. (§ 4604 ("[c]ontroversies between employer and employee arising under this chapter shall be determined by the appeals board, … *except as otherwise provided by Section 4610.5*" (italics added)); § 5300 (providing that "except as otherwise provided in Division 4," the WCAB has exclusive initial jurisdiction over claims "for the recovery of compensation, or concerning any right or liability arising out of or incidental thereto"); see also Cal. Code Regs., tit. 8, § 10451.2(c)(1)(C).)

**D. ALL OTHER DISPUTES REGARDING A UR DECISION MUST BE RESOLVED BY IMR.**

In addition to timeliness, a UR decision must be "in compliance with" other elements of section 4610. (§ 4610(b); see also, *Sandhagen*, *supra*, 44 Cal.4th at pp. 240, 241; § 4610(c), (d), (e), (g), (h), (i).)

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[18] The defendant must provide the IMR physician with: (1) copies of specified "relevant" medical records and other information used by the defendant or the UR physician in determining whether the employee is entitled to the requested medical treatment; and (2) copies of any newly developed or discovered relevant medical records. (§ 4610.5(l), (m).) Additionally, however, the employee may provide information. (§ 4610.5(f)(3).)

[19] E.g., documents relating to when the treatment request was sent to and received by defendant and when the UR denial was served by defendant.

[20] E.g., copies of relevant provisions of the Labor Code and the AD's Rules.

With the exception of timeliness, all other requirements go to the validity of the medical decision or decision-making process. The sufficiency of the medical records provided, expertise of the reviewing physician and compliance with the MTUS are all questions for the medical professional. If an injured worker disputes a UR decision, section 4610 mandates that it "*shall be resolved in accordance with Section 4610.5,* if applicable … ." (§ 4610(g)(3)(A) (italics added); see also § 4610(g)(3)(B).) Similarly, sections 4610.5 and 4610.6, more thoroughly discussed above, specifically provide that where there is a dispute regarding a UR decision on "medical necessity,"[21] the dispute shall be resolved only by IMR. (§ 4610.5(a)(1) & (2), (b), (e), (k).) With the exception of timeliness, all defects in the UR process can be remedied when appealed to IMR.

The legislature has made it abundantly clear that medical decisions are to be made by medical professionals. To allow a WCJ to invalidate a UR decision based on any factor other than timeliness and substitute his or her own decision on a treatment request violates the intent of SB 863.

The fundamental rule in construing a statute or a statutory scheme is to effectuate the Legislature's intent. (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286].) In determining legislative intent, the provisions of a statute "must [be] consider[ed] in the context of … the statutory scheme of which it is a part" and "the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole." (*DuBois*, *supra*, 5 Cal.4th at p. 388.) When applying these harmonizing principles, we still must "choose the construction that comports most closely with the Legislature's apparent intent, endeavoring to promote rather than defeat the [Legislature's] general purpose … ." (*Smith v. Superior Court* (2006) 39 Cal.4th 77, 83.) Accordingly, in construing the UR/IMR statutory scheme, we cannot consider the procedural requirements of section 4610 in isolation; rather, we must harmonize them with the other provisions of section 4610 and with the provisions of section 4610.5, section 4610.6, and uncodified section 1 of SB 863 which states:

> The Legislature finds and declares all of the following: …
>
> (d) That the current system of resolving disputes over the medical necessity of

[21] See §§ 4610.5(c)(2), (c)(3), (k), 4610.6(a), (c), (e).

> requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine …
>
> (e) That having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state [of] using evidence-based medicine to provide injured workers with the highest quality of medical care and that … establishing independent medical review [is] necessary to implement that policy.
>
> (f) That the performance of independent medical review … will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations … . Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise of specialists … [and]
>
> (g) That the establishment of independent medical review and provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review of such decisions.[22]

Commissioner Sweeney suggests that a UR decision that does not comply with the mandatory requirements of section 4610 is not a decision subject to IMR. (See § 4610.5(c)(3).) We disagree. The legislative intent is clear. IMR is the sole mechanism for reviewing a UR physician's opinion regarding the medical necessity of a proposed treatment. Consistent with this, we hold that where a UR decision is timely, IMR is the sole vehicle for reviewing the UR physician's expert opinion regarding the medical necessity of a proposed treatment, even if the UR process did not fully comply with section 4610's requirements.

This holding does not imply that UR is not important nor that compliance with section 4610 is unnecessary. UR is a crucial part of the medical treatment review process. If done properly, UR is effective, expeditious and inexpensive. (Cal. Const., art. XIV, § 4.)

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[22] See also, e.g., Sen. Com. on Labor and Industrial Relations, 3d reading analysis of SB 863 (2011-2012 Reg. Sess.) as amended August 30, 2012, at p. 2, ¶¶ 1, 3 (SB 863 "Implements an Independent Medical Review (IMR) process" that "Eliminates the Workers' Compensation Appeals Board's (WCAB) authority to adjudicate medical treatment disputes that are directed to the IMR process"); Assem. Floor, 3d reading analysis of SB 863 (2011-2012 Reg. Sess.) as amended August 30, 2012, at p. 1, ¶¶ 2, 5 (SB 863 "establish[es] an Independent Medical Review (IMR) system" that "Eliminates the Workers' Compensation Appeals Board's (WCAB) authority to adjudicate medical treatment disputes that are directed to the IMR process").

UR is a first step in resolving medical treatment disputes. As noted in *Sandhagen, supra*, UR actually begins with the claims examiner, who may authorize a treatment request without resorting to a formal medical review process. (44 Cal.4th at pp. 240, 241, 244.) If the claims examiner does not authorize the treatment, the RFA, along with relevant medical records, are submitted to the UR provider. The UR doctor can make a decision based on what has been provided, request additional medical records, discuss the treatment recommendation with the treating physician, and extend the allotted time, if necessary.

"To that end, the Legislature enacted a comprehensive process that balances the dual interests of speed and accuracy, emphasizing the quick resolution of treatment requests, while allowing employers to seek more time if more information is needed to make a decision … ." (*Sandhagen*, *supra*, 44 Cal.4th at p. 241; see also *id*. at p. 246 ("One purpose of utilization review is to prevent disputes about medical treatment from ever arising." (conc. opn. of Kennard, J.).)

Although the failure to comply with the requirements of 4610 will not invalidate a UR decision, it can result in: (1) the assessment of significant monetary penalties by the Administrative Director (§ 4610(i); Cal. Code Regs., tit. 8, §§ 9792.11, 9792.12 [AD regulations on UR administrative penalties]; *Smith v. Workers' Comp. Appeals Bd.* (*Amar*) (2009) 46 Cal.4th 272, 280, fn. 6 ("an employer or insurer that fails to comply with the mandates of the utilization review process risks the imposition of penalties under section 4610, subdivision (i)"); and/or (2) increased compensation to the injured worker under section 5814 for an unreasonable delay in completing UR. (§ 4610.1.)

All requirements of section 4610 should be complied with, however, failure to do so will not invalidate a UR decision. A defective UR can be corrected by either exercising an internal UR appeal process, if available,[23] or through IMR where both parties may submit records, and for which an appeal process has been established.

Timeliness, however, cannot be fixed. Whether a UR decision is timely is a legal determination and must be decided by a WCJ. An untimely UR decision is the same as no UR. (*Elliott*, *supra*, 182

[23] See fn. 8, *supra*.

Cal.App.4th at p. 363; see also § 4610.5(a).) Without a UR decision, there is nothing to appeal to IMR. Thus, the question of medical necessity of an RFA can be resolved by the WCJ. This does not mean that the treatment is automatically awarded. As will be discussed in Part II-E, *Sandhagen* makes it clear that there must be substantial evidence supporting the medical necessity of a treatment request for a WCJ to order it.

Commissioner Sweeney suggests that where the WCJ finds a material defect in the UR process, he or she may decide the issue of medical necessity provided there is substantial medical evidence. If not, then the WCJ can deny the treatment request or order the treating physician to resubmit the RFA with proper documentation and the defendant to re-do UR. As stated above, allowing a WCJ to make a medical treatment decision is contrary to the very purpose of SB 863. As for reinitiating the RFA and UR process, this is a very sensible suggestion, but is without any statutory authority. Given that a UR decision must be appealed to IMR within a limited timeframe, restarting the UR process after a denial of a treatment request could result in an injured worker losing his or her opportunity to appeal the UR decision. This could have serious consequences as section 4610(g)(6) provides that a UR decision to deny, modify or delay a treatment recommendation remains in effect for 12 months from the date of the decision.

**E. IF A UR DECISION IS UNTIMELY, THE DETERMINATION OF MEDICAL NECESSITY MAY BE MADE BY THE WCAB BASED ON SUBSTANTIAL MEDICAL EVIDENCE CONSISTENT WITH SECTION 4604.5.**

Where there is no timely UR decision subject to IMR, the issue of medical necessity must be determined by the WCAB. (§§ 4604, 5300.) However, as explained by *Sandhagen*:

> "The Legislature amended section 3202.5 to underscore that all parties, including injured workers, must meet the evidentiary burden of proof on all issues by a preponderance of the evidence. (Stats. 2004, ch. 34, § 9.) Accordingly, *notwithstanding whatever an employer does (**or does not do**)*, an injured employee must still prove that the sought treatment is medically reasonable and necessary. That means demonstrating that the treatment request is consistent with the uniform guidelines (§ 4600, subd. (b)) or, alternatively, rebutting the application of the guidelines with a preponderance of scientific medical evidence (§ 4604.5)."
>
> (*Sandhagen*, *supra*, 44 Cal.4th at p. 242 [italics, underlining, and bolding added].)

Thus, where a defendant's UR decision is untimely, the injured employee is nevertheless entitled only to "reasonably required" medical treatment (§ 4600(a)) and it is the employee's burden to establish his or her entitlement to any particular treatment (§§ 3202.5, 5705), including showing either that the treatment falls within the presumptively correct MTUS or that this presumption has been rebutted. (§ 4604.5; see also § 5307.27.) Moreover, to carry this burden, the employee must present substantial medical evidence. (*Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566]; *Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169-170 [36 Cal.Comp.Cases 93].)

## IV. THE MOOTNESS ISSUE

In her concurring opinion, Commissioner Lowe suggests that *Dubon I* may be moot based on documents in the Electronic Adjudication Management System (EAMS). However, the information contained in EAMS is not part of the record before us, nor are the issues raised in applicant's IMR appeal currently pending before us. If the parties neglected to inform the Appeals Board of a material change of facts, then the Appeals Board may consider imposing sanctions. (§ 5813; Cal. Code Regs., tit. 8, § 10561.)[24]

Even assuming that the present proceedings may be moot or partially moot, it is well-established that " '[i]f a pending case poses an issue of broad public interest that is likely to recur, the court may exercise an inherent discretion to resolve that issue even though an event occurring during its pendency would normally render the matter moot.' " (*Edelstein v. City and County of San Francisco* (2002) 29 Cal.4th 164, 172 [quoting from *In re William M.* (1970) 3 Cal.3d 16, 23].) This public interest exception to the mootness doctrine is frequently applied. (*Abbott Ford, Inc. v. Superior Court* (1987) 43 Cal.3d

[24] An attorney is an officer of the court who has a duty to provide it with relevant information. (E.g., *Williams v. Superior Court* (2007) 147 Cal.App.4th 36, 56-57; *Mendez v. Superior Court* (2008) 162 Cal.App.4th 827, 834; *Datig v. Dove Books, Inc*. (1999) 73 Cal.App.4th 964, 980; see also Bus. & Prof. Code, § 6068(d); Rules of Prof. Conduct, rule 5–200(A), (B).) Moreover, "[a]n appeal that may have been meritorious when commenced can become frivolous by the occurrence of subsequent events." (*Guardianship of Melissa W.* (2002) 96 Cal.App.4th 1293, 1301; see also, e.g., *Wax v. Infante* (1983) 145 Cal.App.3d 1029, 1031.) Accordingly, all practitioners are reminded of their continuing duty to timely advise the WCAB (i.e., both the Appeals Board and the WCJs) of any material change in circumstances that could substantially affect cases pending before it. A failure to do so could result in the imposition of sanctions.

858, 868 (“ ‘There is ample precedent for appellate resolution of important issues of substantial and continuing public interest which otherwise may have been rendered moot and of no further immediate concern to the initiating parties.’ ” [quoting from *DeRonde v. Regents of Univ. of Cal.* (1981) 28 Cal.3d 875, 880]; 9 Witkin, Cal. Procedure (5th ed. 2008) Appeal, § 759 (“A long line of cases, involving myriad factual situations, recognizes [the public interest] exception to the mootness doctrine.”).) Therefore, the potential mootness issue raised by Commissioner Lowe does not preclude us from issuing our current en banc decision.

For the foregoing reasons,

**IT IS ORDERED** as the Decision After Reconsideration of the Workers’ Compensation Appeals Board (En Banc) that the Opinion And Decision After Reconsideration (En Banc) issued on February 27, 2014 is **RESCINDED**, the Petition for Reconsideration filed by applicant on October 15, 2013, is **DENIED**, and the September 20, 2013 Findings and Order of the workers’ compensation administrative

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law judge, as amended on October 18, 2013, is **AFFIRMED**.

**WORKERS' COMPENSATION APPEALS BOARD (EN BANC)**

**/s/ Ronnie G.Caplane**
***RONNIE G. CAPLANE, Chairwoman***

**/s/ Frank M. Brass**
***FRANK M. BRASS, Commissioner***

**/s/ Katherine A. Zalewski**
***KATHERINE A. ZALEWSKI, Commissioner***

**/s/ Deidra E. Lowe**
***DEIDRA E. LOWE, Commissioner***
**(See also attached Concurring Opinion)**

***I CONCUR AND DISSENT*** **(See attached Concurring and Dissenting Opinion)**

**/s/ Marguerite Sweeney**
***MARGUERITE SWEENEY, Commissioner***

**DATED AND FILED AT SAN FRANCISCO, California**

**10/06/2014**

**SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.**

**JOSE DUBON**
**MAURICE ABARR**
**STATE COMPENSATION INSURANCE FUND**

**/abs**

## CONCURRING OPINION OF COMMISSIONER LOWE

I fully concur with the majority's holdings regarding the merits of this case. However, I do not think it is necessary to reach the merits. Instead, as the Appeals Board's decision after reconsideration, I would dismiss both SCIF's current Petition for Reconsideration and applicant's initial Petition for Reconsideration and vacate *Dubon I* as moot.

Even if a case presents a true controversy at its inception, it is well-established that a case should be dismissed if subsequent events render the initial controversy moot. As stated by the Supreme Court in *Paul v. Milk Depots, Inc.* (1964) 62 Cal.2d 129: "It is settled that the duty of this court, as of every other judicial tribunal, is to decide actual controversies by a judgment which can be carried into effect, and not to give opinions upon moot questions or abstract propositions, or to declare principles or rules of law which cannot affect the matter in issue in the case before it. It necessarily follows that when, pending an appeal from the judgment of a lower court … an event occurs which renders it impossible for this court … to grant … any effectual relief whatever, the court will not proceed to a formal judgment, but will dismiss the appeal." (62 Cal.2d at p. 132 (internal quotation marks and citations omitted); *Wilson v. Los Angeles County Civil Service Com.* (1952) 112 Cal.App.2d 450, 453 ("although a case may originally present an existing controversy, if before decision it has, through act of the parties or other cause, occurring after the commencement of the action, lost that essential character, it becomes a moot case or question which will not be considered by the court"); 3 Witkin, Cal. Proc. (5th ed. 2008) Actions §§ 32, 35.)

I would take judicial notice (see Evid. Code, § 452(d)) of the following documents in the Electronic Adjudication Management System (EAMS) file in this case: (1) the "Petition Appealing the Administrative Director's Independent Medical Review Determination" (IMR appeal) filed by applicant on April 21, 2014, including the exhibits appended to the IMR appeal; (2) the "Answer to Petition Appealing the Administrative Director's Independent Medical Review Determination" (IMR answer) filed by defendant on May 28, 2014; and (3) the post-IMR appeal documents uploaded by Maximus Federal Services, Inc. (Maximus), the IMR organization, into EAMS.[25]

[25] See Cal. Code Regs., tit. 8, § 10957.1(i).

These documents establish that:

(1) in October and November 2013, there was a significant worsening of applicant's back condition and back surgery was re-requested;

(2) on November 26, 2013, SCIF, through Bunch, authorized the L4-S1 fusion and decompression surgery and also authorized the majority of post-surgical services requested in conjunction with the surgery, but did not authorize some of the post-surgical services;[26]

(3) on December 20, 2013, SCIF sent a letter to Maximus asking it to "[p]lease cancel/withdraw the eligibility for IMR" for the L4-S1 fusion and decompression surgery and for those post-surgical services that SCIF had authorized;

(4) on January 28, 2014, applicant's attorney sent a letter to Maximus stating that applicant "hereby withdraws" his IMR application with respect to the L4-S1 fusion with decompression surgery and to those post-surgical services SCIF had authorized;

(5) both SCIF and applicant requested that Maximus continue the IMR process only with respect to the unauthorized post-surgical services; and

(6) despite the requests from both SCIF and applicant for IMR to consider only the unauthorized post-surgical services, Maximus nevertheless issued a final IMR determination letter on April 10, 2014 stating that "the request for Anterior/Posterior L4-S1 Fusion with Decompression is not medically necessary and appropriate" and that "[s]ince the primary procedure is not medically necessary, none of the associated services are medically necessary."

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[26] It appears that, in addition to certifying the anterior posterior fusion at L4-S1 with decompression, Bunch also certified: "facility inpatient 3-5 days, consult with Dr. Vanderlinden, vascular surgeon, co-surgeon to perform exposure of the spine, diagnostic test lab blood, medical clearance with internist, post op use of LSO [lumbosacral orthotic] brace, DME [durable medical equipment] purchase elevated toilet seat, DME purchase front wheeled walker, [and] DME bone growth stimulator."

It appears, however, that Bunch did *not* authorize "[t]hermo cool unit post op, DME grabber, combocare 4 stim unit, EMG/NCV BLE [bilateral lower extremity]" (all entirely denied by Bunch) and "DVT [deep vein thrombosis] Max Unit" (modified by Bunch).

For two reasons, these facts demonstrate that this case is moot.

First, when applicant filed his original Petition for Reconsideration on October 15, 2013, the essential issue was whether, in light of alleged procedural deficiencies in SCIF's utilization review, the WCAB should order SCIF to authorize surgery for applicant's back. (Applicant's Petition for Reconsideration, at 1:19-1:21; 2:2-2:5; 3:18-3:25; 4:2-4:11; 8:24-8:28.) However, as established by the discussion above, applicant's April 21, 2014 IMR appeal and defendant's May 28, 2014 IMR answer both agree that SCIF authorized the requested back surgery on November 26, 2013. Therefore, by the time of our February 27, 2014 decision in *Dubon I*, the essential issue to be decided by the Appeals Board was already moot.

Second, even assuming that the issue of applicant's entitlement to surgery was not moot when we issued our February 27, 2014 decision in *Dubon I*, it has since become moot because the issue went to IMR (which is where it properly belongs) and applicant has now filed a petition with the WCAB appealing the IMR determination.

Accordingly, although I unequivocally concur in the majority's holdings, I maintain that it was not necessary to reach the merits here.[27]

**/s/ Deidra E. Lowe**
***DEIDRA E. LOWE, Commissioner***

**DATED AND FILED AT SAN FRANCISCO, California**

**10/06/2014**

**SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.**

**JOSE DUBON**
**MAURICE ABARR**
**STATE COMPENSATION INSURANCE FUND**

**/abs**

[27] I agree with the majority, however, that the various failures of applicant's and defendant's respective counsel to notify the Appeals Board of the changed circumstances may warrant the imposition of sanctions.

## CONCURRING AND DISSENTING OPINION OF COMMISSIONER SWEENEY

I concur with the majority that an untimely medical treatment determination is not subject to independent medical review, and that under that circumstance, section 4604 authorizes the WCAB to decide the necessity of the requested medical treatment.

Otherwise, I respectfully dissent. I would affirm *Dubon I.*[28]

Section 4610.5 is adjunctive to section 4610 and should be read in harmony with it. As defined by section 4610.5(c)(3), a utilization review decision is a medical treatment determination that complies with section 4610, and section 4610.5 only applies to a dispute over a utilization review decision.[29] Under 4604, the WCAB has jurisdiction to decide whether a treatment determination complies with sections 4610 and 4610.5. If the treatment determination does not comply with sections 4610 and 4610.5, then the treatment dispute may be resolved by the WCAB.

### I. A TREATMENT DETERMINATION THAT IS NOT A "UTILIZATION REVIEW DECISION" AS DEFINED BY SECTIONS 4610 AND 4610.5 IS NOT SUBJECT TO INDEPENDENT MEDICAL REVIEW.

Section 4610.5 requires that a dispute over a utilization review decision may only be reviewed by independent medical review. Section 4610.5(c)(3) defines a utilization review decision as follows:

> "'Utilization review decision' means a decision *pursuant to Section 4610* to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402." (Italics added.)

Section 4610 requires every employer to "establish a utilization review process *in compliance with* this section." (§ 4610(b), italics added; see *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.*

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[28] *Dubon v. World Restoration, Inc.* (2014) 79 Cal.Comp.Cases 313 (Appeals Board en banc)

[29] For clarity, a "utilization review decision" means a determination that meets the statutory definition in section 4610.5(c)(3) of a utilization review decision. Hereafter, "treatment determination" means a determination following a medical treatment request that does not meet the 4610.5(c)(3) definition of a utilization review decision.

(*Sandhagen*) (2008) 44 Cal.4th 230, 236 [73 Cal.Comp.Cases 981] (*Sandhagen*).)[30] It is clear from the language of section 4610 that there are multiple requirements in addition to mandatory timeframes.

The utilization review process was enacted as part of omnibus legislation intended to define an employer's obligation for medical treatment through treatment guidelines. Because medical expertise was needed to properly apply the treatment guidelines, the Legislature determined that decisions to modify, delay, or deny a treatment requests were required to be made by licensed physicians. (§ 4610(e).) Section 4610(g) enumerates the "requirements" that "shall be met" when "determining whether to approve, modify, delay, or deny requests by physicians." These requirements are not solely concerned with timeliness of utilization review ((g)(1),(2),(3), and (8)), but also detail communication requirements ((g)(4) and (5)), and other procedural requirements ((g)(6) and (7). Subdivision (g)(5) also specifies that an employer shall "approve, modify, or deny the request for authorization … upon receipt of all information reasonably necessary and requested by the employer."

In *Sandhagen*, the Supreme Court found that employers were required to address medical treatment requests under the process in section 4610 and emphasized that section 4610 imposes procedural and substantive requirements. (*Sandhagen, supra,* 44 Cal.4th at pp. 240-241, 245.) As explained by the Court: "Most notably, subdivision (e) of section 4610 allows only a licensed physician, who is competent to evaluate the specific clinical issues involved, to modify, delay, or deny requests for treatment." (*Sandhagen, supra*, at pp. 240-241; see *Smith v. Workers' Comp. Appeals Bd.* (*Amar*) (2009) 46 Cal.4th 272, 279 [74 Cal.Comp.Cases 575] [holding that "under the statutory scheme, only an employer's utilization review physician applying approved criteria can modify, delay, or deny treatment requests—an employer may not, on its own, object to a treatment request"]; see also *Elliott v. Workers' Comp. Appeals Bd.* (2010) 182 Cal.App.4th 355, 362 [75 Cal.Comp.Cases 81].) Moreover, the Court reiterated that: "Section 4610, subdivision (g) imposes a number of additional requirements that *must be met* as part of the utilization review process." (*Sandhagen, supra*, 44 Cal.4th at pp. 240-241, italics

[30] Utilization review was described as a necessary first step, "a *threshold* procedure" that an employer was required to follow in addressing a treating physician's request for authorization to perform medical treatment. (*Sandhagen, supra,* 44 Cal.4th at p. 246 (conc. opn. of Kennard, J, italics in original).)

added.) In fact, every court that has interpreted section 4610 has described the utilization review process as having multiple requirements, and no court has construed the timeliness requirement to be more important than any other requirement. (*Smith, supra,* 46 Cal.4th at p. 279; *Sandhagen, supra,* 44 Cal.4th at pp. 240-241; *Adventist Health v. Workers' Comp. Appeals Bd.* (*Fletcher*) (2012) 211 Cal.App.4th 376, 384 [77 Cal.Comp.Cases 935]; *Elliott, supra,* 182 Cal.App.4th at p. 362.)

"If the language of the statute is clear and unambiguous, there is no need for construction." (*Edgar v. Workers' Comp. Appeals Bd.* (1998) 65 Cal.App.4th 1, 8 [63 Cal.Comp.Cases 703] (*Edgar*); see *DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387-388 [58 Cal.Comp.Cases 286]; *Williams v. Workers' Comp. Appeals Bd.* (1999) 74 Cal.App.4th 1260, 1265 [64 Cal.Comp.Cases 995].) By defining a utilization review decision as "a decision pursuant to Section 4610" the Legislature clearly and unambiguously mandated that the substantive and procedural requirements of the section 4610 utilization review process must be followed in order to proceed to independent medical review. Because a utilization review decision is "a decision pursuant to Section 4610," a treatment determination produced by a process that does not comply with section 4610 is not a utilization review decision and cannot be reviewed as if it were a utilization review decision.

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According to the Legislative Counsel's Summary Digest of SB 863:

> "Existing law requires every employer to establish a medical treatment utilization review process, *in compliance with specified requirements*, either directly or through its insurer or an entity with which the employer or insurer contracts for these services.
>
> This bill would require the administrative director to contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews in accordance with specified criteria." (Legis. Counsel's Dig., Sen. Bill No. 863, 2012 Stats. Ch. 363, section 11, italics added.)[31]

When enacting legislation, the Legislature is presumed to be aware of judicial interpretations of previously enacted statutes. (*Nickelsberg v. Workers' Comp. Appeals Bd.* (1991) 54 Cal.3d 288, 298 [56 Cal.Comp.Cases 476].) SB 863 did not make changes to the utilization review process governed by section 4610; section 4610.5 is adjunctive to section 4610 and should be read in harmony with it. More importantly, as set forth above, a utilization review decision that may be appealed to independent medical review is defined in section 4610.5(c)(3) as a decision that issues "*pursuant*" to section 4610. (Italics added.) Thus, by defining a utilization review decision "as pursuant to section 4610," it is presumed that the Legislature was aware of the Supreme Court's conclusion that section 4610 created a mandatory utilization review process with compulsory procedural and substantive requirements. (See *Sandhagen, supra,* 44 Cal.4th at pp. 240-241.)

Section 4610.5(a) and (b) require a "dispute over a utilization review decision" to "be resolved in accordance with" section 4610.5, which provides for independent medical review. Section 4610.5(c)(3) defines "utilization review decision" as "a decision pursuant to Section 4610." Section 4610 sets forth

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[31] As stated by the Supreme Court in *Jones v. Lodge at Torrey Pines Partnership* (2008) 42 Cal.4th 1158, 1169-1170:

> "The Legislative Counsel's summaries 'are prepared to assist the Legislature in its consideration of pending legislation.' (*California Assn. of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 17 [270 Cal. Rptr. 796, 793 P.2d 2].) Although the Legislative Counsel's summaries are not binding (*State ex rel. Harris v. PricewaterhouseCoopers, LLP* (2006) 39 Cal.4th 1220, 1233, fn. 9 [48 Cal. Rptr. 3d 144, 141 P.3d 256]), they are entitled to great weight. (*California Assn. of Psychology Providers v. Rank, supra*, at p. 17.) 'It is reasonable to presume that the Legislature amended those sections with the intent and meaning expressed in the Legislative Counsel's digest.' (*People v. Superior Court* (*Douglass*) (1979) 24 Cal.3d 428, 434 [155 Cal. Rptr. 704, 595 P.2d 139].)"

the procedural and substantive requirements for the utilization review process. A treatment determination that does not comply with section 4610 is not a "decision pursuant to Section 4610," and thus by definition is not a "utilization review decision." A utilization review decision is a necessary prerequisite for independent medical review, and by the terms of sections 4610 and 4610.5, only a dispute after a utilization review decision, i.e., a treatment determination that complies with section 4610, is resolved through independent medical review. Therefore, a dispute over a treatment determination without compliance with section 4610 is not a dispute over a utilization review decision pursuant to section 4610.5(a), and such a dispute is not subject to section 4610.5 independent medical review.

**II. WHEN A DISPUTE IS NOT SUBJECT TO SECTION 4610.5, IT IS RESOLVED BY THE WCAB PURSUANT TO SECTION 4604.**

Prior to the adoption of SB 863, the two-step process worked as follows: an employer used the section 4610 utilization review process to address a medical treatment request, and thereafter, an employee could seek review of a utilization review determination using the process in section 4062 to obtain a medical opinion from an agreed medical examiner or a panel qualified medical examiner. SB 863 replaced the second step of the two-step process, the section 4062 process, with a new second step, the section 4610.5 independent medical review process. Now an employee must proceed to independent medical review when disputing a utilization review decision. However, as explained above, a treatment determination that does not comply with section 4610 is not a utilization review decision as defined by section 4610.5(c)(3) and does not fall under section 4610.5. Consequently, a potentially invalid utilization treatment determination creates two related issues: (1) What process should be used to determine whether a utilization review decision exists? (2) If there is no utilization review decision, what process should be used to determine whether the medical treatment should be authorized?

As amended by SB 863, section 4604 provides that: "[c]ontroversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either

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party, except as otherwise provided by Section 4610.5."[32] Under 4604, the WCAB has jurisdiction both to hear controversies over whether particular treatment determinations are utilization review decisions and controversies over treatment determinations that are not subject to independent medical review under section 4610.5. Consideration of whether a treatment determination meets the procedural and substantive requirements of section 4610 involves proper application of the law to questions of fact, and is not an issue of medical necessity. In determining whether a utilization review decision exists, the WCAB does not exercise medical judgment. Instead, the issue is whether a determination complied with section 4610, and that issue must be decided by the WCAB pursuant to section 4604. This means that a dispute must fall squarely within section 4610.5 or it is to be determined by the WCAB.

The majority holds that only a medical treatment dispute arising out of an untimely treatment determination may be heard by the WCAB. They also suggest that a denial of treatment by a claims examiner does not proceed to independent medical review and may be heard by the WCAB. (Majority Opinion, p. 10, lines 12-13; see § 4610(e)[33].) Section 4610.5 requires a utilization review decision before the independent medical review process can be triggered. The majority extends independent medical review to treatment determinations that do not meet the statutory definition of a "utilization review decision" contrary to the clear statutory language. Consequently, under the majority decision, a treatment determination that is based on an evaluation by a nurse or other medical professional other than

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[32] The grounds for appealing an IMR determination to the WCAB are distinctly different from the grounds for appeal pursuant to section 4604. Section 4610.6(h) limits an IMR appeal to five grounds, as follows: (1) The administrative director acted without or in excess of the administrative director's powers. (2) The determination of the administrative director was procured by fraud. (3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5. (4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability. (5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion." Moreover, the only remedy that can be provided is resubmission of the dispute to IMR. (Lab. Code, § 4610.6(i).)

[33] Section 4610(e) states that:

> "No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve."

a licensed physician is still treated as a "utilization review decision" even though it does not meet the definition in section 4610.5(c)(3). In fact, even a treatment determination that is based on the medical records of the wrong employee, the wrong body part or no medical records at all, and even one that does not comply with section 4610 in any way except by being timely, is still treated as a "utilization review decision" by the majority.[34] In short, the majority allows any treatment determination to proceed to the second step of the process so long as it is not untimely, which effectively makes the section 4610 utilization review process optional.

In lieu of judicial review, the majority relies on the Administrative Director's authority under section 4610(i) to impose administrative penalties for violations of the utilization review process and the WCAB's authority under section 4610.1 to impose section 5814 penalties when the utilization review process results in an unreasonable delay in the provision of medical treatment.[35] As important as those sections are, they do not address a request for medical treatment in an individual case. The penalties authorized by section 4610.1 are tied to the responsibility of the Administrative Director to oversee the entire utilization review process and do not provide any individual remedy. Similarly, the penalties allowed by section 5814 only apply after the utilization review process fails and causes unreasonable delay in the provision of necessary medical treatment.

Turning to the second question, if the WCAB finds that a utilization treatment determination is not in compliance with section 4610, and is therefore not subject to section 4610.5, the WCAB may consider the issue of the necessity of the medical treatment requested based on the medical evidence. But, the WCAB may only find that the treatment is necessary if there is substantial medical evidence sufficient to support a decision. (*Sierra Pacific Industries v. Workers' Comp. Appeals Bd.* (*Chatham*) (2006) 140 Cal.App.4th 1498 [71 Cal.Comp.Cases 714]; *San Bernardino Community Hospital v.*

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[34] Moreover, a patently non-compliant treatment determination may trigger the 12 month bar against renewing a treatment request in section 4610(g)(6).

[35] Section 4610.1 states in pertinent part that:

> "A determination by the appeals board or a final determination of the administrative director pursuant to independent medical review that medical treatment is appropriate shall not be conclusive evidence that medical treatment was unreasonably delayed or denied for purposes of penalties under Section 5814."

*Workers' Comp. Appeals Bd.* (*McKernan*) (1999) 74 Cal.App.4th 928 [64 Cal.Comp.Cases 986].) A WCJ is not a medical professional and makes a determination on a medical issue based on evidence from medical professionals. (See *E.L. Yeager Construction v. Workers' Comp. Appeals Bd.* (*Gatten*) (2006) 145 Cal.App.4th 922 [71 Cal.Comp.Cases 1687].) This is entirely consistent with the Legislature's expressed intent that "medical professionals" should "ultimately determine the necessity of requested treatment" as well as with sections 4604 and 4610.5. (Stats. 2013, ch. 363, § 1(e).) In other words, medical decisions are made by medical professionals and medical decisions are made based on medical evidence whether through utilization review, independent medical review, or judicial review.

If the WCAB finds that a treatment determination is not in compliance with section 4610, and is therefore not subject to section 4610.5, but there is not sufficient substantial medical evidence to support a determination of medical necessity, the WCAB may not order the treatment. Where the record is inadequate to make a reasoned determination, the WCAB must develop the medical record. (§§ 5701, 5906; *Tyler v. Workers' Comp. Appeals Bd*. (1997) 56 Cal.App.4th 389, 392, 394 [62 Cal.Comp.Cases 924].) Under those circumstances, the WCAB may order the treating physician to submit a new request for authorization and/or order the defendant to commence the utilization review process anew.[36]

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[36] This procedure was recently followed in an Appeals Board panel decision. (*Smith v. Plant Construction* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 391 (Appeals Board panel decision) [Appeals Board ordered the treating physician to submit an amended RFA and then have defendant recommence utilization review because treating physician's RFA for left shoulder surgery included no substantiating documentation and because utilization review physician's denial reviewed MRI study of the lumbar spine, not left shoulder].)

## CONCLUSION

The Legislature created a two-step process for determining the necessity of a medical treatment request by an employee's treating physician. Section 4610 established a utilization review process with mandatory requirements. Section 4610.5 established a process of independent medical review of a utilization review decisions. Treatment determinations that do not comply with section 4610 are not utilization review decisions and are not subject to independent medical review. Controversies as to those determinations must be resolved by the WCAB pursuant to section 4604.

Therefore, I respectfully dissent.

***/s/* Marguerite Sweeney**
***MARGUERITE SWEENEY, Commissioner***

**DATED AND FILED AT SAN FRANCISCO, California**

**10/06/2014**

**SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.**

**JOSE DUBON**
**MAURICE ABARR**
**STATE COMPENSATION INSURANCE FUND**

**/abs**