WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

BRICE SANDHAGEN,

Applicant,

vs.

COX & COX CONSTRUCTION, INC.; and STATE COMPENSATION INSURANCE FUND,

Defendant(s).

Case No. RDG 0115958

OPINION AND ORDER DISMISSING PETITION FOR RECONSIDERATION (EN BANC)

Applicant, Brice Sandhagen ("applicant"), seeks reconsideration of the Opinion and Decision After Reconsideration (En Banc) issued by the Appeals Board on November 16, 2004.

In our November 16, 2004 decision, we rescinded the July 21, 2004 Findings and Award and Order issued by a workers' compensation administrative law judge ("WCJ"). The WCJ's July 21, 2004 decision had determined, in essence: (1) that applicant, who sustained an October 22, 2003 neck, back, left elbow, and left wrist injury while employed as a construction foreman by Cox & Cox Construction, the insured of defendant, State Compensation Insurance Fund ("SCIF"), was entitled to the cervical and upper thoracic MRI recommended by his treating physicians; and (2) that, because SCIF had not complied with the mandatory deadlines of Labor Code section 4610(g)(1),[1] it was barred from reliance on the utilization review process and, accordingly, the report of its utilization review physician was inadmissible.

Although our November 16, 2004 decision rescinded the WCJ's July 21, 2004 decision, we agreed with the WCJ that the deadlines of section 4610(g)(1) are mandatory and that, if a defendant fails to meet those mandatory deadlines, then any untimely utilization review report it

[1] All further statutory references are to Labor Code.

obtains is not admissible in evidence.[2] Accordingly, we affirmed the WCJ's exclusion of SCIF's utilization review report from evidence. We further held, in essence: (1) that if a defendant fails to meet the mandatory deadlines of section 4610(g)(1), then not only is any untimely utilization review report it obtains not admissible in evidence, but also that it cannot be forwarded to a qualified medical evaluator ("QME") or an agreed medical evaluator ("AME") if the medical-legal procedures of section 4062(a) are timely pursued; and (2) that if a defendant fails to meet the section 4610(g)(1) deadlines, it may still use the QME/AME procedure established by section 4062(a) to dispute the treating physician's treatment recommendation, provided it meets deadlines established by section 4062(a), unless those deadlines are extended for good cause or by mutual agreement. Because of this second holding, and because the statutory procedures established by section 4610(g)(1) and 4062(a) were relatively new, we rescinded the WCJ's determination that applicant was entitled to the particular medical treatment in dispute, and we remanded the matter to the WCJ to give SCIF a reasonable opportunity to obtain a section 4062(a) evaluation to assess the reasonableness and necessity of the disputed treatment.

In his petition for reconsideration, applicant contends, in substance: (1) that the utilization review procedure established by section 4610 is mandatory, and that a defendant must comply with all of section 4610's provisions in determining whether or not to approve any treatment recommended by the injured employee's treating physician; and (2) that, if a defendant fails to comply with the mandatory provisions of section 4610, then the defendant cannot use the derivative procedure of section 4062(a) to dispute the applicant's entitlement to medical treatment.

Defendant has filed an answer to the petition for reconsideration.

For the reasons that follow, we will dismiss applicant's petition for reconsideration.

A petition for reconsideration is properly made only from a "final" order, decision, or award. (Lab. Code, §§5900(a), 5902, 5903.) A "final" order has been defined as one "which

[2] If there is a dispute regarding the issue of the timeliness of defendant's initiation of utilization review, an untimely utilization review report is admissible on the limited issue of timeliness. (*Willette v. Au Electric Corp*. (2004) 69 Cal.Comp.Cases 1298, 1307 (Appeals Board en banc).)

determines any substantive right or liability of those involved in the case." (*Rymer v. Hagler* (1989) 211 Cal.App.3d 1171, 1180; *Safeway Stores, Inc. v. Workers' Comp. Appeals Bd. (Pointer)* (1980) 104 Cal.App.3d 528, 534-535 [45 Cal.Comp.Cases 410, 413]; *Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Kramer)* (1978) 82 Cal.App.3d 39, 45 [43 Cal.Comp.Cases 661, 665].) Interlocutory *procedural or evidentiary* decisions, entered in the midst of the workers' compensation proceedings, are *not* considered to be "final" orders. (*Maranian v. Workers' Comp. Appeals Bd.* (2000) 81 Cal.App.4th 1068, 1075 [65 Cal.Comp.Cases 650, 655] ("interim orders, which do not decide a threshold issue, such as intermediate procedural or evidentiary decisions, are not 'final' "); *Rymer*, *supra*, 211 Cal.App.3d at p. 1180 ("[t]he term ['final'] does not include intermediate procedural orders or discovery orders"); *Kaiser Foundation Hospitals* (*Kramer*), *supra*, 82 Cal.App.3d at p. 45 [43 Cal.Comp.Cases at p. 665] ("[t]he term ['final'] does not include intermediate procedural orders"); see also, *Jablonski v. Workers' Comp. Appeals Bd.* (1987) 52 Cal.Comp.Cases 399 (writ den.); *Beck v. Workers' Comp. Appeals Bd.* (1979) 44 Cal.Comp.Cases 190 (writ den.).)

Accordingly, where – as here – the Appeals Board grants reconsideration, rescinds the decision of the WCJ, and returns the matter to the WCJ for further proceedings and a new decision, the Appeals Board's action is generally *not* deemed a "final" order, even when it makes procedural or evidentiary rulings, because, under such circumstances, no *substantive* right or liability of those involved in the case has been determined. (*Travelers Ins. Co. v. Workers' Comp. Appeals Bd.* (*Taylor*) (1983) 147 Cal.App.3d 1033, 1036, fn. 3 [48 Cal.Comp.Cases 774, 775, fn. 3] ("a petition seeking review of a [WCAB] order which remands a matter to the trial judge for further proceedings is ordinarily premature").)[3] Therefore, we will dismiss applicant's petition for reconsideration.

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[3] See also, e.g., *Transportation Insurance Co. v. Workers' Comp. Appeals Bd*. (*Van De Hey*) (2003) 68 Cal.Comp.Cases 309 (writ den.); *Anbender v. Workers' Comp. Appeals Bd*. (1999) 64 Cal.Comp.Cases 546 (writ den.); *Employers First Ins. Co. v. Workers' Comp. Appeals Bd. (Morales)* (1997) 62 Cal.Comp.Cases 1710 (writ den.); *Goodrich v. Workers' Comp. Appeals Bd*. (1994) 59 Cal.Comp.Cases 763 (writ den.); *Minton v. Workers' Comp. Appeals Bd.* (1975) 40 Cal.Comp.Cases 313 (writ den.).

Although we are dismissing applicant's petition for reconsideration and, therefore, are not formally reaching its merits, we make the following observations regarding his contentions (1) that the utilization review process of section 4610 is mandatory and (2) that, if a defendant does not timely engage in utilization review, it is precluded from using a QME or an AME under section 4062(a).

When the Appeals Board interprets workers' compensation statutes, its fundamental objective is to determine the Legislature's intent so as to effectuate the purpose of the law. (*DuBois v. Workers' Comp. Appeals Bd*. (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286]; *Nickelsberg v. Workers' Comp. Appeals Bd*. (1991) 54 Cal.3d 288, 294 [56 Cal.Comp.Cases 476]; *Moyer v. Workmen's Comp. Appeals Bd*. (1973) 10 Cal.3d 222, 230 [38 Cal.Comp.Cases 652].)

The best indicator of legislative intent is the clear, unambiguous, and plain meaning of the statutory language. (*DuBois*, *supra*, 5 Cal.4th at pp. 387-388; *Gaytan v. Workers' Comp. Appeals Bd*. (2003) 109 Cal.App.4th 200, 214 [68 Cal.Comp.Cases 693]; *Boehm & Associates v. Workers' Comp. Appeals Bd.* (*Lopez*) (1999) 76 Cal.App.4th 513, 516 [64 Cal.Comp.Cases 1350].) Thus, in interpreting statutory provisions, we look first to the express language of the statutes themselves. (*DuBois*, *supra*, 5 Cal.4th at p. 387; *Moyer*, *supra*, 10 Cal.3d at p. 230.) When the statutory language is clear and unambiguous, we will enforce the statute according to its plain terms. (*DuBois*, *supra*, 5 Cal.4th at p. 387; *Atlantic Richfield Co. v. Workers' Comp. Appeals Bd.* (*Arvizu*) (1982) 31 Cal.3d 715, 726 [47 Cal.Comp.Cases 500].)

Where the words of the statute are clear, the Appeals Board may not add to or alter them in order to accomplish a purpose that does not appear on the face of the statute or from its legislative history. (*In re Jennings* (2004) 34 Cal.4th 254, 265; *Robert F. Kennedy Medical Center v. Belshe* (1996) 13 Cal.4th 748, 756; *Gray v. Superior Court* (2002) 95 Cal.App.4th 322, 327; *In re Ryan* (2001) 92 Cal.App.4th 1359, 1379.) Even if a statute is completely silent on a point, the most the Appeals Board can do is construe it in the context of the entire statutory scheme, with the goal of harmonizing it with other sections, retaining its effectiveness, and promoting the legislative

objective. (*Waterman Convalescent Hospital, Inc. v. State Dept. of Health Services* (2002) 101 Cal.App.4th 1433, 1439; *Bravo v. Ismaj* (2002) 99 Cal.App.4th 211, 224.)

Section 4610 does require every employer to establish a utilization review process. (Lab. Code, §4610(b) ("Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.").) Section 4610 also requires any utilization review process to adhere to certain procedures, standards, and deadlines. (Lab. Code, §4610(c)-(g).)

Nevertheless, there is nothing in section 4610 that requires an employer to use the utilization review process in every case. To the contrary, section 4610 is silent on whether an employer must always use the utilization review procedure. Moreover, section 4600(d)(5) provides that, where the employee is being treated by a predesignated physician, the defendant "*may* conduct reasonably necessary utilization review pursuant to Section 4610." (Lab. Code, §4600(d)(5) (emphasis added).) Of course, the word "may" is permissive, and not mandatory. (Lab. Code, §15.) Accordingly, section 4600(d)(5) makes it clear that utilization review is not a mandatory requirement in the context of treatment proposed by a predesignated physician. We see no practical reason why a defendant should not also have discretion to use or not use utilization review in a non-predesignated physician case. (Civ. Code, §3511 ["Where the reason is the same, the rule should be the same"]; cf., *Ghirardo v. Antonioli* (1994) 8 Cal.4th 791, 804; *County of Los Angeles v. Superior Court* (2001) 91 Cal.App.4th 1303, 1311, fn. 8; *Lee v. Interinsurance Exchange* (1996) 50 Cal.App.4th 694, 713; *Padilla v. State Personnel Bd.* (1992) 8 Cal.App.4th 1136, 1145.)

Additionally, it would be inconsistent with legislative intent to require a defendant to follow the utilization review procedure in every case. The overall goal of section 4610 appears to be to create an expeditious and inexpensive process for the resolution of medical treatment issues (see Cal. Const., art. XIV, §4), without need for an actual examination of the injured employee. If a dispute remains after utilization review is timely undertaken, then the QME/AME process

involving a physical or mental examination may be followed. (See Lab. Code, §§4062(a), 4062.1, 4062.2, 4063.3, 4062.5.)

In light of this, there are numerous reasons why a defendant should not be required to undertake utilization review in every case. We offer just a few illustrations.

For example, there would be little point in mandating utilization review – particularly over minor treatment issues – if a defendant determines, without utilization review, that the recommended treatment is reasonably required and is consistent with the applicable medical treatment guidelines. (See Lab. Code, §§4600(a) & (b), 4604.5, 5307.27.) To require utilization review under these circumstances would delay treatment to the injured employee and impose undue costs on the defendant.

Additionally, the utilization review process, by its nature, does not involve either an interview with or a physical or mental examination of the injured employee, and it ordinarily does not involve a thorough medical record review. Thus, in cases involving complex medical treatment issues – where either a physical or mental examination, a complete history of the injury, a complete medical history, or a complete medical record review could be called for – a utilization review may result in needless expense to the defendant, as well as needless to delay to the applicant. Instead, it may be more expeditious, economical, or appropriate for the defendant to go directly to the QME/AME process.[4]

To give another example, issues regarding temporary disability cannot be assessed through the utilization review process (see Lab. Code, §4610(a)); they can only be assessed through the QME/AME process. (See Lab. Code, §4062(a).) Yet, when treating physicians propose a treatment, they often also state that a period of temporary disability will be associated with that treatment. If a defendant questions not only the proposed treatment, but also the need for a period of temporary disability – or the length of the period of temporary disability – proposed by the

[4] Of course, there may be instances, particularly in less complex cases, where utilization review would be faster and less costly – for example, where communication between the utilization review physician and the treating physician could clarify the justification for the proposed treatment, without the need for a full-blown QME/AME work-up.

treating physician, then it would be illogical to require defendant to initiate the QME/AME process for the temporary disability issue, but require it to first undertake utilization review for the medical treatment issue.

For these reasons, among others, we will not insert into section 4610 language that the Legislature has not included, i.e., a requirement that utilization review must be used in every case. Pursuant to section 4610, a defendant has discretion to undertake or not undertake utilization review with respect to any particular proposed medical treatment.

We also see no reason why a defendant is precluded from timely initiating the QME/AME process of section 4062(a), if the defendant either decides not to initiate utilization review or does not timely initiate it.

Applicant notes that section 4610 provides that, if the treating physician's treatment request is not approved in full, then "disputes shall be resolved in accordance with Section 4062." (Lab. Code, §4610(g)(3)(A), see also, §4610(g)(3)(B).) Applicant contends this means that utilization review under section 4610 is a condition precedent to the QME/AME process under section 4062(a). Applicant, however, reads too much into this language of section 4610. This language means simply that, *if a defendant timely elects to follow the utilization review process* but does not fully authorize the proposed treatment after utilization review is completed, then any remaining disputes regarding the particular proposed treatment must be resolved using the procedure established by section 4062(a).

Applicant further contends that section 4062(a) is "derivative" of 4610, i.e., a defendant's right to object under 4062(a) is conditional upon its compliance with section 4610.

Section 4062(a) provides, in relevant part:

> "If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection … If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a

> treatment recommendation, the employee shall notify the employer of the objection.…" (Lab. Code, §4062(a).)

The latter of these two quoted sentences of section 4062(a) means that, if the defendant elects to follow the utilization review procedure and, as a result, does not fully authorize the proposed treatment, then the injured employee may object to this full or partial denial of treatment by using the QME/AME procedure. (*Willette v. Au Electric Corp*. (2004) 69 Cal.Comp.Cases 1298 (Appeals Board en banc).)

The issue, therefore, is what does the first quoted sentence mean.

As stated above, when we construe a statute, our first duty is to look to the actual words employed by the Legislature. (*DuBois*, *supra*, 5 Cal.4th at p. 387; *Moyer*, *supra*, 10 Cal.3d at p. 230.) Moreover, it is a basic principle of construction that meaning must be given to every word or phrase of a statute, if possible, so as not to render any word or phrase mere surplusage. (*Hassan v. Mercy American River Hosp*. (2003) 31 Cal.4th 709, 716; *Moyer v. Workmen's Comp. Appeals Bd*., *supra*, 10 Cal.3d at p. 230 [38 Cal.Comp.Cases 652]; *Dept. of Corrections v. Workers' Comp. Appeals Bd*. (*Stentz*) (2003) 109 Cal.App.4th 1720, 1725-1726 [68 Cal.Comp.Cases 853]; *McGee Street Productions v. Workers' Comp. Appeals Bd*. (*Peterson*) (2003) 108 Cal.App.4th 717, 723 [68 Cal.Comp.Cases 708].) Thus, where the Legislature uses a different word or phrase in one part of a statute than it does in another part of the statute, it is presumed the Legislature intended those words or phrases to have different meanings. (*American Airlines, Inc. v. County of San Mateo* (1996) 12 Cal.4th 1110, 1137-1138; *People v. Shabazz* (2004) 125 Cal.App.4th 130, 149; *People v. Stewart* (2004) 119 Cal.App.4th 163, 171; *Kray Cabling Co. v. County of Contra Costa* (1995) 39 Cal.App.4th 1588, 1593; *Campbell v. Zolin* (1995) 33 Cal.App.4th 489, 497.)

Here, the actual words employed by the Legislature in the first sentence of section 4062(a) do *not* state that a defendant *must* engage in a timely utilization review procedure before it can resort to that section's QME/AME dispute resolution process.

Moreover, the first sentence of section 4062(a) states that a defendant can resort to that section's QME/AME dispute resolution process for "any medical issues *not covered by Section*

4060 or 4061[5] *and not subject to Section 4610*." (Emphasis added.) Because the Legislature used the different phrases "not covered by" and "not subject to" in the first sentence of section 4062(a), these two phrases must have different meanings. That is, if "not subject to" had the same meaning as "not covered by," then the Legislature simply would have stated that the dispute resolution process of section 4062(a) applies to "any medical issues not covered by Section 4060, 4061, *or 4610*."

In this context, therefore, we interpret the phrase "not subject to" to mean not dependent on or not contingent on. (See Funk & Wagnalls Standard College Dictionary (1974), at p. 1333.) And, of course, a medical treatment dispute is not dependent on or contingent on section 4610 if the utilization review process was never used, or if it was not timely used and, therefore, was invalid.[6] Thus, contrary to applicant's assertion, the use of (or the timely use of) utilization review is not a condition precedent to a defendant's use of a QME/AME under section 4062(a).

Any other interpretation of section 4062(a) would lead to absurd results, in violation of basic principles of statutory construction. (*City of Cotati v. Cashman* (2002) 29 Cal.4th 69, 77; *People v. Mendoza* (2000) 23 Cal.4th 896, 908.) As discussed above, the Legislature has not required a defendant to follow the utilization review process in every case. Yet, if a defendant elected to exercise its right not to undertake utilization review, but then were entirely precluded from using the QME/AME process to resolve the medical treatment dispute, the defendant would be worse off than it would have been had section 4610 never been enacted.

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[5] Section 4060 applies to disputes over the compensability of any injury. (Lab. Code, §4060(a).) Section 4061 applies to disputes over permanent disability. (Lab. Code, §4061, especially (c) & (d).)

[6] Of course, there are other medical treatment disputes "not subject to Section 4610" that fall within section 4062(a), e.g., instances where it is the *injured employee* who is objecting to the treating physician's opinion regarding the employee's entitlement to medical treatment.

For the foregoing reasons,

IT IS ORDERED that the petition for reconsideration filed by applicant on December 8, 2004, be, and it is hereby, **DISMISSED**.

WORKERS' COMPENSATION APPEALS BOARD (EN BANC)

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WILLIAM K. O'BRIEN, Commissioner

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JAMES C. CUNEO, Commissioner

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