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36 Ways of Taking Medical Control (2011)

Authored by Hinden and Breslavsky and published in this presentation with their permission

Medical Provider Networks (MPN's) have been in existence since 1/01/05.

The issues associated with medical control and MPN's have been a controversy from day one to the present.

The panel will engage in an interactive discussion on the following topics:

1. What happens when the Employer/Claims Administrator does not refer the injured worker for care within the MPN promptly after an injury is reported?
2. What are the most commonly violated notice requirements?
3. Can MPN control be lost for failure to authorize treatment with a new PTP in the MPN?
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8. Some philosophical considerations to ponder;
 - a. What is the purpose of MPN's?
 - b. Why do we need MPN's if we have Utilization Review at our disposal?
 - c. Conversely, why do we need Utilization Review if we have MPN's?

LABOR CODE

SECTION 4616-4616.7

4616. (a) (1) On or after January 1, 2005, an insurer or employer may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of nonoccupational injuries. The goal shall be at least 25 percent of physicians primarily engaged in the treatment of nonoccupational injuries. The administrative director shall encourage the integration of occupational and nonoccupational providers. The number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart.

(b) The employer or insurer shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan if he or she determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27 or the American College of Occupational Medicine's Occupational Medicine Practice Guidelines, as appropriate.

(f) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) On or before November 1, 2004, the administrative director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

4616.1. (a) An insurer or employer that offers a medical provider network under this division and that uses economic profiling shall file with the administrative director a description of any policies and procedures related to economic profiling utilized by the insurer or employer. The

filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The insurer or employer shall provide a copy of the filing to an individual physician, provider, medical group, or individual practice association.

(b) The administrative director shall make each insurer's or employer's filing available to the public upon request. The administrative director may not publicly disclose any information submitted pursuant to this section that is determined by the administrative director to be confidential pursuant to state or federal law.

(c) For the purposes of this article, "economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

4616.2. (a) An insurer or employer that arranges for care for injured employees through a medical provider network shall file a written continuity of care policy with the administrative director.

(b) If approved by the administrative director, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The insurer or employer shall file a revision of the continuity of care policy with the administrative director if it makes a material change to the policy.

(c) The insurer or employer shall provide to all employees entering the workers' compensation system notice of its written continuity of care policy and information regarding the process for an employee to request a review under the policy and shall provide, upon request, a copy of the written policy to an employee.

(d) (1) An insurer or employer that offers a medical provider network shall, at the request of an injured employee, provide the completion of treatment as set forth in this section by a terminated provider.

(2) The completion of treatment shall be provided by a terminated provider to an injured employee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in paragraph (3).

(3) The insurer or employer shall provide for the completion of treatment for the following conditions subject to coverage through the workers' compensation system:

(A) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of treatment shall be provided for the duration of the acute condition.

(B) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the insurer or employer in consultation with the injured employee and the terminated provider and consistent with good professional practice. Completion of treatment under this paragraph shall not exceed 12 months from the contract termination date.

(C) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(D) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

(4) (A) The insurer or employer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer or employer is not required to continue the provider's services beyond the contract termination date.

(B) Unless otherwise agreed by the terminated provider and the insurer or employer, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the insurer or employer for currently contracting providers providing similar services who are practicing in the same or a similar geographic area as the terminated provider. The insurer or provider is not required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(5) An insurer or employer shall ensure that the requirements of this section are met.

(6) This section shall not require an insurer or employer to provide for completion of treatment by a provider whose contract with the insurer or employer has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(7) Nothing in this section shall preclude an insurer or employer from providing continuity of care beyond the requirements of this section.

(e) The insurer or employer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer or employer is not required to continue the provider's services beyond the contract termination date.

4616.3. (a) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall arrange an initial medical evaluation and begin treatment as required by Section 4600.

(b) The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from the medical provider network established pursuant to this article, and the method by which the list of participating providers may be accessed by the employee.

(c) If an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network.

(d) (1) Selection by the injured employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

(2) Treatment by a specialist who is not a member of the medical provider network may be permitted on a case-by-case basis if the medical provider network does not contain a physician who can provide the approved treatment and the treatment is approved by the employer or the insurer.

4616.4. (a) (1) The administrative director shall contract with individual physicians, as described in paragraph (2), or an independent medical review organization to perform independent medical reviews pursuant to this section.

(2) Only physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of the Business and Professions Code may be independent medical reviewers.

(3) The administrative director shall ensure that the independent medical reviewers or those within the review organization shall do all of the following:

(A) Be appropriately credentialed and privileged.

(B) Ensure that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensure that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions consistent with the medical utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

(D) Ensure that confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensure the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensure adequate screening for conflicts of interest.

(4) Medical professionals selected by the administrative director or the independent medical review organizations to review medical treatment decisions shall be physicians, as specified in paragraph (2) of subdivision (a), who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions taken or pending by any hospital, government, or regulatory body.

(b) If, after the third physician's opinion, the treatment or diagnostic service remains disputed, the injured employee may request independent medical review regarding the disputed treatment or diagnostic service still in dispute after the third physician's opinion in accordance with Section 4616.3. The standard to be utilized for independent medical review is identical to that contained

in the medical treatment utilization schedule established in Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate.

(c) Applications for independent medical review shall be submitted to the administrative director on a one-page form provided by the administrative director entitled "Independent Medical Review Application." The form shall contain a signed release from the injured employee, or a person authorized pursuant to law to act on behalf of the injured employee, authorizing the release of medical and treatment information. The injured employee may provide any relevant material or documentation with the application. The administrative director or the independent medical review organization shall assign the independent medical reviewer.

(d) Following receipt of the application for independent medical review, the employer or insurer shall provide the independent medical reviewer, assigned pursuant to subdivision (c), with all information that was considered in relation to the disputed treatment or diagnostic service, including both of the following:

(1) A copy of all correspondence from, and received by, any treating physician who provided a treatment or diagnostic service to the injured employee in connection with the injury.

(2) A complete and legible copy of all medical records and other information used by the physicians in making a decision regarding the disputed treatment or diagnostic service.

(e) Upon receipt of information and documents related to the application for independent medical review, the independent medical reviewer shall conduct a physical examination of the injured employee at the employee's discretion. The reviewer may order any diagnostic tests necessary to make his or her determination regarding medical treatment. Utilizing the medical treatment utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate, and taking into account any reports and information provided, the reviewer shall determine whether the disputed health care service was consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines based on the specific medical needs of the injured employee.

(f) The independent medical reviewer shall issue a report to the administrative director, in writing, and in layperson's terms to the maximum extent practicable, containing his or her analysis and determination whether the disputed health care service was consistent with the medical treatment utilization schedule established pursuant to Section 5307.27, or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, as appropriate, within 30 days of the examination of the injured employee, or within less time as prescribed by the administrative director. If the disputed health care service has not been provided and the independent medical reviewer certifies in writing that an imminent and serious threat to the health of the injured employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the injured employee, the report shall be expedited and rendered within three days of the examination by the independent medical reviewer. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the administrative director for up to three days in extraordinary circumstances or for good cause.

(g) The independent medical reviewer's analysis shall cite the injured employee's medical condition, the relevant documents in the record, and the relevant findings associated with the

documents or any other information submitted to the reviewer in order to support the determination.

(h) The administrative director shall immediately adopt the determination of the independent medical reviewer, and shall promptly issue a written decision to the parties.

(i) If the determination of the independent medical reviewer finds that the disputed treatment or diagnostic service is consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, the injured employee may seek the disputed treatment or diagnostic service from a physician of his or her choice from within or outside the medical provider network. Treatment outside the medical provider network shall be provided consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Practice Guidelines. The employer shall be liable for the cost of any approved medical treatment in accordance with Section 5307.1 or 5307.11.

4616.5. For purposes of this article, "employer" means a self-insured employer, joint powers authority, or the state.

4616.6. No additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any controversy arising out of this article.

4616.7. (a) A health care organization certified pursuant to Section 4600.5 shall be deemed approved pursuant to this article if it meets the percentage required for physicians primarily engaged in nonoccupational medicine specified in subdivision (a) of Section 4616 and all the other requirements of this article are met, as determined by the administrative director.

(b) A health care service plan, licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall be deemed approved for purposes of this article if it has a reasonable number of physicians with competency in occupational medicine, as determined by the administrative director.

(c) A group disability insurance policy, as defined in subdivision (b) of Section 106 of the Insurance Code, that covers hospital, surgical, and medical care expenses shall be deemed approved for purposes of this article if it has a reasonable number of physicians with competency in occupational medicine, as determined by the administrative director. For the purposes of this section, a group disability insurance policy shall not include Medicare supplement, vision-only, dental-only, and Champus-supplement insurance. For purposes of this section, a group disability insurance policy shall not include hospital indemnity, accident-only, and specified disease insurance that pays benefits on a fixed benefit, cash-payment-only basis.

(d) Any Taft-Hartley health and welfare fund shall be deemed approved for purposes of this article if it has a reasonable number of physicians with competency in occupational medicine, as determined by the administrative director.

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

§9767.1. Medical Provider Networks -- Definitions

(a) As used in this article:

(1) "Ancillary services" means any provision of medical services or goods as allowed in Labor Code section 4600 by a non-physician.

(2) "Cessation of use" means the discontinued use of an implemented MPN that continues to do business.

(3) "Covered employee" means an employee or former employee whose employer has ongoing workers' compensation obligations and whose employer or employer's insurer has established a Medical Provider Network for the provision of medical treatment to injured employees unless:

(A) the injured employee has properly designated a personal physician pursuant to Labor Code section 4600(d) by notice to the employer prior to the date of injury, or;

(B) the injured employee's employment with the employer is covered by an agreement providing medical treatment for the injured employee and the agreement is validly established under Labor Code section 3201.5, 3201.7 and/or 3201.81.

(4) "Division" means the Division of Workers' Compensation.

(5) "Economic profiling" means any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

(6) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(7) "Employer" means a self-insured employer, the Self-Insurer's Security Fund, a group of self-insured employers pursuant to Labor Code section 3700(b) and as defined by Title 8, California Code of Regulations, section 15201(s), a joint powers authority, or the state.

(8) "Group Disability Insurance Policy" means an entity designated pursuant to Labor Code section 4616.7(c).

(9) "Health Care Organization" means an entity designated pursuant to Labor Code section 4616.7(a).

(10) "Health Care Service Plan" means an entity designated pursuant to Labor Code section 4616.7(b).

(11) "Insurer" means an insurer admitted to transact workers' compensation insurance in the state of California, California Insurance Guarantee Association, or the State Compensation Insurance Fund.

(12) "Medical Provider Network" ("MPN") means any entity or group of providers approved as a Medical Provider Network by the Administrative Director pursuant to Labor Code sections 4616 to 4616.7 and this article.

(13) "Medical Provider Network Plan" means an employer's or insurer's detailed description for a medical provider network contained in an application submitted to the Administrative Director by a MPN applicant.

(14) "MPN Applicant" means an insurer or employer as defined in subdivisions (7) and (11) of this section.

(15) "MPN Contact" means an individual(s) designated by the MPN Applicant in the employee notification who is responsible for answering employees' questions about the Medical Provider Network and is responsible for assisting the employee in arranging for an independent medical review.

(16) "Nonoccupational Medicine" means the diagnosis or treatment of any injury or disease not arising out of and in the course of employment.

(17) "Occupational Medicine" means the diagnosis or treatment of any injury or disease arising out of and in the course of employment.

(18) "Physician primarily engaged in treatment of nonoccupational injuries" means a provider who spends more than 50 percent of his/her practice time providing non-occupational medical services.

(19) "Primary treating physician" means a primary treating physician within the medical provider network and as defined by section 9785(a)(1).

(20) "Provider" means a physician as described in Labor Code section 3209.3 or other provider as described in Labor Code section 3209.5.

(21) "Regional area listing" means either:

(A) a listing of all MPN providers within a 15-mile radius of an employee's worksite and/or residence; or

(B) a listing of all MPN providers in the county where the employee resides and/or works if

1. the employer or insurer cannot produce a provider listing based on a mile radius
2. or by choice of the employer or insurer, or upon request of the employee.

(C) If the listing described in either (A) or (B) does not provide a minimum of three physicians of each specialty, then the listing shall be expanded by adjacent counties or by 5-mile increments until the minimum number of physicians per specialty are met.

(22) "Residence" means the covered employee's primary residence.

(23) "Second Opinion" means an opinion rendered by a medical provider network physician after an in person examination to address an employee's dispute over either the diagnosis or the treatment prescribed by the treating physician.

(24) "Taft-Hartley health and welfare fund" means an entity designated pursuant to Labor Code section 4616.7(d).

(25) "Termination" means the discontinued use of an implemented MPN that ceases to do business.

(26) "Third Opinion" means an opinion rendered by a medical provider network physician after an in person examination to address an employee's dispute over either the diagnosis or the treatment prescribed by either the treating physician or physician rendering the second opinion.

(27) "Treating physician" means any physician within the MPN applicant's medical provider network other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(28) "Workplace" means the geographic location where the covered employee is regularly employed.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 1063.1, 3208, 3209.3, 3209.5, 3700, 3702, 3743, 4616, 4616.1, 4616.3, 4616.5 and 4616.7, Labor Code; and California Insurance Guarantee Association v. Division of Workers' Compensation (April 26, 2005) WCAB No. Misc. #249.

HISTORY

1. New article 3.5 (sections 9767.1-9767.14) and section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New article 3.5 (sections 9767.1-9767.14) and section refiled 2-28-2005 as

an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New article 3.5 (sections 9767.1-9767.14) and section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section and Note, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

5. New subsections (a)(2) and (a)(25), subsection renumbering and amendment of newly designated subsection (a)(14) filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

§9767.5. Access Standards

(a) A MPN must have at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (b) and (c).

(b) A MPN must have a primary treating physician and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace.

(c) A MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

(d) If a MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically rural areas including those in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (b) and/or (c) are unreasonably restrictive, the MPN applicant may propose alternative standards of accessibility for that portion of its service area. The MPN applicant shall do so by including the proposed alternative standards in writing in its plan approval application or in a notice of MPN plan modification. The alternative standards shall provide that all services shall be available and accessible at reasonable times to all covered employees.

(e)(1) The MPN applicant shall have a written policy for arranging or approving non-emergency medical care for: (A) a covered employee authorized by the employer to temporarily work or travel for work outside the MPN geographic service area when the need for medical care arises; (B) a former employee whose employer has ongoing workers' compensation obligations and who permanently resides outside the MPN geographic service area; and (C) an injured employee who decides to temporarily reside outside the MPN geographic service area during recovery.

(2) The written policy shall provide the employees described in subdivision (e)(1) above with the choice of at least three physicians outside the MPN geographic service area who either have been referred by the employee's primary treating physician within the MPN or have been selected by the MPN applicant. In addition to physicians within the MPN, the employee may change physicians among the referred physicians and may obtain a second and third opinion from the referred physicians.

(3) The referred physicians shall be located within the access standards described in paragraphs (c) and (d) of this section.

(4) Nothing in this section precludes a MPN applicant from having a written policy that allows a covered employee outside the MPN geographic service area to choose his or her own provider for non-emergency medical care.

(f) For non-emergency services, the MPN applicant shall ensure that an appointment for initial treatment is available within 3 business days of the MPN applicant's receipt of a request for treatment within the MPN.

(g) For non-emergency specialist services to treat common injuries experienced by the covered employees based on the type of occupation or industry in which the employee is engaged, the MPN applicant shall ensure that an appointment is available within 20 business days of the MPN applicant's receipt of a referral to a specialist within the MPN.

(h) If the primary treating physician refers the covered employee to a type of specialist not included in the MPN, the covered employee may select a specialist from outside the MPN.

(i) The MPN applicant shall have a written policy to allow an injured employee to receive emergency health care services from a medical service or hospital provider who is not a member of the MPN.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 4616 and 4616.3, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

§9767.6. Treatment and Change of Physicians Within MPN

- (a) When the injured covered employee notifies the employer or insured employer of the injury or files a claim for workers' compensation with the employer or insured employer, the employer or insurer shall arrange an initial medical evaluation with a MPN physician in compliance with the access standards set forth in section 9767.5.
- (b) Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall provide for all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 and as set forth in title 8, California Code of Regulations, section 9792.20 et seq.
- (c) The employer or insurer shall provide for the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars (\$10,000).
- (d) The insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.
- (e) At any point in time after the initial medical evaluation with a MPN physician, the covered employee may select a physician of his or her choice from within the MPN. Selection by the covered employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.
- (f) A Petition for Change of Treating Physician, as set forth at section 9786, cannot be utilized to seek a change of physician for a covered employee who is treating with a physician within the MPN.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 4604.5, 4616, 4616.3, 5307.27 and 5401, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).
5. Amendment of subsections (b) and (f) filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
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§9767.9. Transfer of Ongoing Care into the MPN

(a) If the injured covered employee's injury or illness does not meet the conditions set forth in (e)(1) through (e)(4), the injured covered employee may be transferred into the MPN for medical treatment.

(b) Until the injured covered employee is transferred into the MPN, the employee's physician may make referrals to providers within or outside the MPN.

(c) Nothing in this section shall preclude an insurer or employer from agreeing to provide medical care with providers outside of the MPN.

(d) If an injured covered employee is being treated for an occupational injury or illness by a physician or provider prior to coverage of a medical provider network, and the injured covered employee's physician or provider becomes a provider within the MPN that applies to the injured covered employee, then the employer or insurer shall inform the injured covered employee and his or her physician or provider if his/her treatment is being provided by his/her physician or provider under the provisions of the MPN.

(e) The employer or insurer shall authorize the completion of treatment for injured covered employees who are being treated outside of the MPN for an occupational injury or illness that occurred prior to the coverage of the MPN and whose treating physician is not a provider within the MPN, including injured covered employees who pre-designated a physician and do not fall within the Labor Code section 4600(d), for the following conditions:

(1) An acute condition. For purposes of this subdivision, an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of less than 90 days. Completion of treatment shall be provided for the duration of the acute condition.

(2) A serious chronic condition. For purposes of this subdivision, a serious chronic condition is a medical condition due to a disease, illness, catastrophic injury, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over 90 days and requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be authorized for a period of time necessary, up to one year: (A) to complete a course of treatment approved by the employer or insurer; and (B) to arrange for transfer to another provider within the MPN, as determined by the insurer or employer. The one year period for completion of treatment starts from the date of the injured covered employee's receipt of the notification, as required by subdivision (f), of the determination that the employee has a serious chronic condition.

(3) A terminal illness. For purposes of this subdivision, a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(4) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days from the MPN coverage effective date.

(f) If the employer or insurer decides to transfer the covered employee's medical care to the medical provider network, the employer or insurer shall notify the covered employee of the determination regarding the completion of treatment and the decision to transfer medical care into the medical provider network. The notification shall be sent to the covered employee's residence and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible.

(g) If the injured covered employee disputes the medical determination under this section, the injured covered employee shall request a report from the covered employee's primary treating physician that addresses whether the covered employee falls within any of the conditions set forth in subdivisions (e)(1-4). The treating physician shall provide the report to the covered employee within twenty calendar days of the request. If the treating physician fails to issue the report, then the determination made by the employer or insurer referred to in (f) shall apply.

(h) If the employer or insurer or injured covered employee objects to the medical determination by the treating physician, the dispute regarding the medical determination made by the treating physician concerning the transfer of care shall be resolved pursuant to Labor Code section 4062.

(i) If the treating physician agrees with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in subdivisions (e)(1) through (e)(4), the transfer of care shall go forward during the dispute resolution process.

(j) If the treating physician does not agree with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in subdivisions (e)(1) through (e)(4), the transfer of care shall not go forward until the dispute is resolved.

NOTE

Authority cited: Sections 133, 4616(g), and 4062, Labor Code. Reference: Sections 4616 and 4616.2, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

§9767.10. Continuity of Care Policy

(a) At the request of a covered employee, an insurer or employer that offers a medical provider network shall complete the treatment by a terminated provider as set forth in Labor Code sections 4616.2(d) and (e).

(b) An "acute condition," as referred to in Labor Code section 4616.2(d)(3)(A), shall have a duration of less than ninety days.

(c) "An extended period of time," as referred to in Labor Code section 4616.2(d)(3)(B) with regard to a serious and chronic condition, means a duration of at least ninety days.

(d) The MPN applicant's continuity of care policy shall include a dispute resolution procedure that contains the following requirements:

(1) Following the employer's or insurer's determination of the injured covered employee's medical condition, the employer or insurer shall notify the covered employee of the determination regarding the completion of treatment and whether or not the employee will be required to select a new provider from within the MPN. The notification shall be sent to the covered employee's residence and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible.

(2) If the terminated provider agrees to continue treating the injured covered employee in accordance with Labor Code section 4616.2 and if the injured covered employee disputes the medical determination, the injured covered employee shall request a report from the covered employee's primary treating physician that addresses whether the covered employee falls within any of the conditions set forth in Labor Code section 4616.2(d)(3); an acute condition; a serious chronic condition; a terminal illness; or a performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date. The treating physician shall provide the report to the covered employee within twenty calendar days of the request. If the treating physician fails to issue the report, then the determination made by the employer or insurer referred to in (d)(1) shall apply.

(3) If the employer or insurer or injured covered employee objects to the medical determination by the treating physician, the dispute regarding the medical determination made by the treating physician concerning the continuity of care shall be resolved pursuant to Labor Code section 4062.

(4) If the treating physician agrees with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in Labor Code

section 4616.2(d)(3), the employee shall choose a new provider from within the MPN during the dispute resolution process.

(5) If the treating physician does not agree with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in Labor Code section 4616.2(d)(3), the injured covered employee shall continue to treat with the terminated provider until the dispute is resolved.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Section 4616.2, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3- 1-2005 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6- 29-2005 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10- 27-2005 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

§9767.12. Employee Notification

(a) An employer or insurer that offers a Medical Provider Network Plan under this article shall notify every covered employee in writing about the use of the Medical Provider Network prior to the implementation of an approved MPN. An implementation notice shall also be provided to a new employee at the time of hire. An implementation notice is not required if the MPN Applicant or insured employer is changing from one MPN to another MPN within 60 days. The MPN implementation notice shall be provided in English and also in Spanish, to Spanish-speaking employees. The written MPN implementation notice to all covered employees shall, at a minimum, include the following information:

(1) That medical treatment for new work injuries will be provided through the Medical Provider Network as of the effective date of coverage unless the employee properly predesignates a physician or medical group prior to injury;

(2) The effective date of coverage under the new MPN;

(3) That existing work injuries may be transferred into the new MPN. The worker should check with the worker's claims adjuster for more information;

(4) That more information about the MPN can be found on the workers' compensation poster or by asking your employer.

(b) The following language may be used for the written MPN implementation notice provided to covered employees: "Unless you predesignate a physician or medical group, your new work injuries arising on or after <INSERT EFFECTIVE DATE OF NEW MPN> will be treated by providers in a new Medical Provider Network, <INSERT NEW MPN NAME>. If you have an existing injury, you may be required to change to a provider in the new MPN. Check with your claims adjuster. You may obtain more information about the MPN from the workers' compensation poster or from your employer."

(c) The MPN implementation notice may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the employee has regular electronic access to email at work to receive this notice prior to the implementation of the MPN. If the employee cannot receive this notice electronically at work within the required time frame, then the employer shall ensure this information is provided to the employee in writing prior to the implementation of the MPN.

(d) Separate from the MPN implementation notice, a complete written MPN employee notification with the information specified in subdivision (f) of this section about coverage under the MPN shall be provided to covered employees at the time of injury or when an employee with an existing injury begins treatment under the MPN. This MPN notification shall be provided to

employees in English and also in Spanish to Spanish speaking employees. Before MPN coverage is implemented, the complete written MPN employee notification shall also be posted in both English and Spanish in a conspicuous location frequented by employees during the hours of the workday and in close proximity to the workers' compensation posting required under section 9881.

(e) The complete MPN notification may be distributed through electronic means, including email, if the covered employee has regular electronic access to email at work to receive this notice at the time of injury or when the employee is being transferred into the MPN. If the employee cannot receive this notice electronically at work, then the employer shall ensure this information is provided to the employee in writing at the time of injury or when the employee is being transferred into the MPN.

(f) The complete written MPN employee notification shall include the following information:

(1) How to contact the person designated by the employer or insurer to be the MPN Contact for covered employees to answer questions about MPNs and to address MPN problems. The employer or insurer shall provide a toll-free telephone number with access to the MPN Contact if the MPN geographical service area includes more than one area code;

(2) A description of MPN services;

(3) How to review, receive or access the MPN provider directory. An employer or insurer shall ensure covered employees have access to, at minimum, a regional area listing of MPN providers in addition to maintaining and making available its complete provider listing in writing. If an employee requests an electronic listing, it shall be provided electronically on a CD or on a website. If the provider directory is also accessible on a website, the URL address shall be listed with any additional information needed to access the directory online. All provider listings shall be regularly updated, at minimum, on a quarterly basis with the date of the last update provided on the listing given to the employee, to ensure the listing is kept accurate. Each provider listing shall include a phone number and an email address for reporting of provider listing inaccuracies. If a listed provider becomes deceased or is no longer treating workers' compensation patients at the listed address the provider shall be taken off the provider list within 60 days of notice to the MPN network administrator.

(4) How to access initial care and subsequent medical care;

(5) The mileage, time requirements and alternative access standards required under section 9767.5;

(6) How to access treatment if (A) the employee is authorized by the employer to temporarily work or travel for work outside the MPN's geographical service area; (B) a former employee whose employer has ongoing workers' compensation obligations permanently resides outside the MPN geographical service area; and (C) an injured employee decides to temporarily reside outside the MPN geographic service area during recovery;

- (7) How to choose a physician within the MPN;
 - (8) What to do if a covered employee has trouble getting an appointment with a provider within the MPN;
 - (9) How to change a physician within the MPN;
 - (10) How to obtain a referral to a specialist within the MPN or outside the MPN, if needed;
 - (11) How to use the second and third opinion process;
 - (12) How to request and receive an independent medical review;
 - (13) A description of the standards for the transfer of care policy and a notification that a copy of the policy shall be provided to an employee upon request; and
 - (14) A description of the standards for the continuity of care policy and a notification that a copy of the policy shall be provided to an employee upon request.
- (g) At the time of the selection of the physician for a third opinion, the covered employee shall be notified about the Independent Medical Review process. The notification shall be written in English and also in Spanish to Spanish speaking employees.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616, 4616.2 and 4616.3, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).
5. Amendment filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

§9767.16. Notice to Employee Upon Termination, Cessation of Use, or Change of Medical Provider Network

(a) The Medical Provider Network Applicant is responsible for ensuring that each injured covered employee is informed in writing of the MPN policies under which he or she is covered and when the injured employee is no longer covered by the Applicant's MPN. The MPN Applicant shall ensure each injured covered employee is given written notice of the date of termination or cessation of use of its MPN. The written notice shall be provided to injured covered employees prior to the effective date of termination or cessation of use of the Applicant's MPN. The notices required by this section shall be provided in English and also in Spanish to Spanish speaking employees.

(1) The MPN Applicant whose MPN is being terminated or will cease to be used shall ensure that every injured covered employee is provided the following information prior to the termination or cessation of use of its MPN by a MPN Applicant or an insured employer:

(A) The effective date of termination or cessation of use of the Applicant's MPN.

(B) Whether the MPN will still be used for injuries arising before the date MPN coverage ends.

(C) The address, telephone number, email address and an MPN website, (optional), of the MPN Contact who can address MPN questions.

(D) For periods when an employee is not covered by a MPN, an employee may choose a physician 30 days after the date the employee notified the employer of his or her injury.

(E)(2) The following language may be provided in writing to injured covered employees to give the required notice of termination or cessation of use of a MPN: "The <Insert MPN Name> Medical Provider Network (MPN) will no longer be used for injuries arising after <Insert Date of MPN Termination or Cessation of Use>. You will/will not <Select Whichever is Appropriate> continue to use this MPN to obtain care for work injuries occurring before this date. For new injuries that occur when you are not covered by a MPN, you have the right to choose your physician 30 days after you notify your employer of your injury. You may obtain more information at <Insert MPN Contact Phone Number, Address, Email Address, and MPN Website (optional)."

(3) The notice of MPN termination or cessation of use may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the employee has regular electronic access to email at work to receive this notice prior to the end of MPN coverage. If the employee cannot receive this notice electronically at work within the required time frame, then the employer shall ensure this information is provided to the employee in writing prior to the end of MPN coverage.

(4) Any pending Independent Medical Review will end with the employee's coverage under the MPN.

(b) If a MPN Applicant or insured employer is changing MPN coverage to a different MPN, the MPN Applicant that is providing the new MPN coverage shall ensure that every injured covered employee is provided written notice of the following information prior to the effective date of coverage under that Applicant's MPN:

(1) That medical treatment for new work injuries will be provided through the Medical Provider Network as of the effective date of coverage unless the employee properly predesignates a physician or medical group prior to injury;

(2) The effective date of coverage under the new MPN;

(3) That existing work injuries may be covered under the prior MPN or may be transferred into the new MPN. The worker should check with the worker's claims adjuster for more information;

(4) That for periods when the worker is not covered by a MPN, an employee may choose a physician 30 days after the date the employee notified the employer of his or her injury;

(5) The MPN Contact's telephone number, address, email address, and an MPN website (optional), for the worker to obtain more information about using the MPN.

(c) The following language may be provided in writing to injured covered employees to give the required notice of the change of MPN coverage: "Unless you predesignate a physician or medical group prior to injury, your new work injuries arising on or after <INSERT EFFECTIVE DATE OF NEW MPN> will be treated by providers in a new Medical Provider Network, <INSERT NEW MPN NAME>. If you have an existing injury, you may be required to continue care under your prior MPN or you may be required to change to a provider in the new MPN. Check with your claims adjuster. For periods when you are not covered under a MPN, you may choose a physician 30 days after you've notified your employer of your injury. You may obtain more information at <INSERT MPN CONTACT, PHONE NUMBR, ADDRESS, EMAIL ADDRESS, AND AN MPN WEBSITE (optional)."

(d) Notice of termination or cessation of use of a MPN may be combined with the notice of a change to new MPN coverage if the combined notice meets all the MPN regulatory requirements for termination or cessation of use of a MPN and for change of a MPN.

(e) Notices required by this section shall be provided in English and also in Spanish to Spanish speaking employees.

(f) The notice of a change of MPN coverage may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the covered employee has regular electronic access to email at work to receive this notice prior to the beginning of new MPN coverage. If the employee cannot receive this notice electronically at

work within the required time frame, then the employer shall ensure this information is provided to the employee in writing prior to the beginning of new MPN coverage.

(g) If a change in MPN coverage results in modifications to an MPN's plan application or results in the filing of a new MPN application, the MPN modification or new application filing shall be submitted to DWC pursuant to section 9767.8 or 9767.3, whichever is applicable. Distribution to injured covered employees of the notice of a change of MPNs shall occur after DWC's approval of a MPN modification or new MPN.

NOTE

Authority cited: Sections 59, 124, 133, 138.3, 138.4, 4616 and 5307.3, Labor Code. Reference: Sections 3550 and 4616.2, Labor Code.

HISTORY

1. New section filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).
2. Amendment of section heading, section and Note filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

1 **WORKERS' COMPENSATION APPEALS BOARD**
2 **STATE OF CALIFORNIA**

3
4 **ELAYNE VALDEZ,**

5 *Applicant,*

6 **vs.**

7 **WAREHOUSE DEMO SERVICES; ZURICH**
8 **NORTH AMERICA, Adjusted By ESIS,**

9 *Defendants.*

Case No. ADJ7048296

OPINION AND DECISION AFTER
RECONSIDERATION
(EN BANC)

10
11 On July 14, 2011, the Appeals Board granted reconsideration of the en banc decision issued in
12 this matter on April 20, 2011, to further study the factual and legal issues in this case. The following is
13 our Decision After Reconsideration.

14 For the reasons discussed below, we will affirm the April 20, 2011 en banc decision,¹ wherein we
15 held that, where unauthorized treatment is obtained for an industrial injury outside a validly established
16 and properly noticed medical provider network (MPN), the resulting non-MPN treatment reports are
17 inadmissible and may not be relied upon to award benefits.

18 Applicant seeks reconsideration of our prior decision contending that (1) by the plain meaning of
19 Labor Code section 4616.6,² "inadmissibility of non-MPN reports is limited to the independent medical
20 review appeal;" (2) "ruling that 4616.6 is a broad rule of inadmissibility to all proceedings causes
21 mischief, exorbitant costs, and an absurd result;" (3) the Appeals Board's decision "violates longstanding
22 law;" (4) "defendant waived admissibility of the medical reports by failing to raise it at trial;" (5) the

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24
25 ¹ En banc decisions of the Appeals Board (Lab. Code, § 115) are binding precedent on all Appeals Board panels and WCJs.
26 (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)* (2005) 126 Cal.App.4th 298,
27 313, fn. 5 [70 Cal.Comp.Cases 109, 120, fn. 5]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6
[67 Cal.Comp.Cases 236, 239, fn. 6].) 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).

²All further statutory references are to the Labor Code unless otherwise indicated.

1 Appeals Board’s decision “violates due process;” and (6) the Appeals Board’s decision “lacks substantial
2 evidence.” Defendant filed a timely answer to applicant’s petition, disputing each of applicant’s
3 contentions.³

4 In addition, as noted in our July 14, 2011 Opinion and Order Granting Reconsideration, Armando
5 Saldivar (Saldivar), an applicant in another case (ADJ7516842), also filed a petition for reconsideration,
6 or in the alternative, a petition for removal, from the Appeals Board’s en banc decision of April 20, 2011.
7 For the reasons discussed below, we will dismiss Saldivar’s petition.

8 **I. BACKGROUND**

9 To briefly restate the facts, applicant was initially treated for the admitted October 7, 2009
10 industrial injury to her back, right hip and neck through the employer’s MPN by Dr. Nagamoto, from
11 approximately October 9, 2009 to October 31, 2009. For no apparent reason and without regard to
12 following MPN procedures, applicant began treating with Dr. Nario, a non-MPN physician, upon referral
13 from her attorney.

14 At the hearing held on July 22, 2010, on the issues of temporary disability and attorney’s fees, the
15 workers’ compensation administrative law judge (WCJ) deferred any issues involving the MPN, which
16 had been raised by the defendant, as “not relat[ing] to temporary disability.” Relying on the non-MPN
17 reports of Dr. Nario, the WCJ found that applicant was temporarily disabled from November 2, 2009
18 through February 10, 2010. In his Opinion on Decision, the WCJ rejected defendant’s argument that
19 “reports of non-MPN doctors are inadmissible.”

20 Defendant filed a timely petition for reconsideration from the WCJ’s decision, contending, among
21 other things, that applicant’s non-MPN medical reports were inadmissible. Applicant did not file an
22 answer to defendant’s petition. On April 20, 2011, the Appeals Board held en banc that where
23 unauthorized treatment is obtained outside a validly established and properly noticed MPN, reports from
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25 _____
26 ³ Defendant also contends that applicant’s petition for reconsideration was untimely. Where a final order, decision, or award
27 is served by mail in California, a petition for reconsideration therefrom must be filed within twenty-five days. (Lab. Code §
5903; Code Civ. Proc., § 1013; Cal. Code Regs., tit. 8, § 10507(a)(1)). Here, the WCAB’s en banc decision was served by
mail on April, 20, 2011, and applicant timely filed her petition for reconsideration on Monday May 16, 2011, the 25th day
having fallen on Sunday May 15, 2011. (Gov. Code, §§ 6700, 6706, 6707; *cf.*, Code Civ. Proc., §§ 10, 12-12b.)

1 the non-MPN doctors are inadmissible, and therefore may not be relied upon, and that defendant is not
2 liable for the cost of the non-MPN reports. However, as the WCJ had deferred any issues concerning the
3 MPN, we remanded the matter to the trial level for determination of whether defendant’s MPN was
4 validly established and that all proper notices regarding the MPN were provided to the applicant. (See
5 Lab. Code, § 4616 et seq.; Cal. Code Regs., tit. 8, § 9767.1 et seq.; *Knight v. United Parcel Service*
6 (2006) 71 Cal.Comp.Cases 1423 (Appeals Board en banc).)

7 On May 16, 2011, applicant filed a timely petition for reconsideration. On July 14, 2011, we
8 granted reconsideration to further study the factual and legal issues in this case.

9 **II. DISCUSSION**

10 **A. Applicant’s Petition**

11 We first address applicant’s contentions concerning section 4616.6 that the “plain meaning” of
12 that section limits inadmissibility of non-MPN reports “to the independent medical review appeal” and
13 that interpreting section 4616.6 as “a broad rule of inadmissibility to all proceedings causes mischief,
14 exorbitant costs, and an absurd result.”

15 Contrary to applicant’s contentions, we acknowledged that section 4616.6, by its terms,
16 specifically precludes the admissibility of non-MPN medical reports only with respect to disputed
17 treatment and diagnosis issues, i.e., “any controversy arising out of this article.” We, however, did not
18 predominantly rely on that section to find that medical reports obtained outside a validly established and
19 properly noticed MPN on other issues are inadmissible.⁴ More specifically, we found persuasive the
20 right to change treating physicians within the MPN (Lab. Code, § 4616.3(b)), the multi-level appeal
21 process to dispute the opinions of MPN physicians regarding diagnosis and treatment (Lab. Code, §§
22 4616.3(c), 4616.4(b)-(i)), the provisions requiring the primary treating physician [PTP] to “render
23 opinions on all medical issues necessary to determine the employee’s eligibility for compensation” (Lab.
24 Code, § 4061.5; Cal. Code Regs., tit. 8, § 9785(d)), and the provisions for resolving disputes regarding
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26 ⁴ We also note, however, that because section 4616.6 specifically precludes the admissibility of non-MPN medical reports on
27 disputed issues of diagnosis, a report from a non-MPN treating physician finding an applicant to be temporarily disabled, for
example, based on a different diagnosis from the MPN physician, should not be admissible under section 4616.6.

1 temporary and permanent disability under sections 4061 and 4062.

2 With respect to the opportunities to change treating physicians and to dispute opinions concerning
3 diagnosis and treatment, we stated:

4 “... [A]fter the initial medical evaluation arranged by the employer within the
5 MPN pursuant to section 4616.3(a), ‘[t]he employer shall notify the employee of
6 his or her right to be treated by a physician of his or her choice,’ including ‘the
7 method by which the list of participating providers may be accessed by the
8 employee.’ (Lab. Code § 4616.3(b); Cal. Code Regs., tit. 8, § 9767.6(d).) In
9 addition, AD Rule 9767.6(e) (Cal. Code Regs., tit. 8, § 9767.6(e)) provides that
10 ‘[a]t any point in time after the initial evaluation with a MPN physician, the
11 covered employee may select a physician of his or her choice from within the
12 MPN.’

13 “Furthermore, pursuant to section 4616.3(c), where an injured worker ‘disputes
14 either the diagnosis or treatment prescribed by the treating physician,’ he or she
15 ‘may seek the opinion of another physician in the [MPN],’ and of ‘a third
16 physician in the [MPN],’ if the diagnosis or treatment of the second physician is
17 disputed.

18 “In addition, section 4616.4(b) provides that if the treatment or diagnostic service
19 remains disputed after the third physician’s opinion, ‘the injured employee may
20 request independent medical review.’ Pursuant to section 4616.4(i), if ‘the
21 independent medical reviewer finds that the disputed treatment or diagnostic
22 service is consistent with section 5307.27 or the American College of
23 Occupational and Environmental Medicine's Occupational Medicine Practice
24 Guidelines, the injured employee may seek the disputed treatment or diagnostic
25 service from a physician of his or her choice from within or outside the [MPN],
26 and ‘[t]he employer shall be liable for the cost of any approved medical treatment
27 in accordance with section 5307.1 or 5307.11.’ ”⁵

19 We then indicated that the definition of the PTP includes the physician selected “in accordance
20 with the physician selection procedures contained in the [MPN] network pursuant to [section] 4616”
21 (Cal. Code Regs., tit. 8, § 9785(a)(1)), that “[a]n employee shall have no more than one [PTP] at a time”
22 (Cal. Code Regs., tit. 8, § 9785(b)(1)), and that it is the PTP who “shall render opinions on all medical
23 issues necessary to determine the employee’s eligibility for compensation.” (Lab. Code, § 4061.5; Cal.
24 Code Regs., tit. 8, § 9785(d).) In addition, if an employee “disputes a medical determination made by the
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26 ⁵ Section 4616.3(d)(2) also allows treatment by a specialist who is not a member of the MPN “on a case-by-case basis if the
27 [MPN] does not contain a physician who can provide the appropriate treatment and the treatment is approved by the employer
or the insurer.” Thus, reports from these non-MPN physicians would be admissible notwithstanding section 4616.6.

1 [PTP]... the dispute shall be resolved under the applicable procedures set forth in [sections] 4061 and
2 4062,” and “[n]o other [PTP] shall be designated by the employee unless and until the dispute is
3 resolved.” (Cal. Code Regs., tit. 8, § 9785(b)(3).) Thus, we concluded that under these provisions, where
4 an applicant has left a validly established and properly noticed MPN and impermissibly sought treatment
5 outside the MPN, the non-MPN physician cannot be the PTP; the MPN treater remains the PTP.
6 However, while medical treatment and diagnosis issues must be resolved within the MPN, disputes
7 concerning temporary or permanent disability are to be resolved outside the MPN using the medical-legal
8 procedures of sections 4061 and 4062. Therefore, section 4616.6 does not prevent an applicant from
9 disputing the determination of the MPN PTP on the issues of temporary and permanent disability under
10 sections 4061 and 4062.

11 We also found persuasive the case of *Tenet/Centinela Hospital Medical Center v. Workers’*
12 *Comp. Appeals Bd. (Rushing)* (2000) 80 Cal.App.4th 1041 [65 Cal.Comp.Cases 477], which held that
13 because the applicant was discharged from care by her PTP and she disputed his findings, applicant was
14 not entitled to seek medical treatment with a new physician without first complying with the provisions
15 of sections 4061 and 4062, which required submitting the issue of treatment to an agreed medical
16 evaluator (AME) or a qualified medical evaluator (QME).⁶ The Court stated, at 80 Cal.App.4th p. 1048
17 [65 Cal.Comp.Cases at p. 482]:

18 “When there are disputes about the appropriate medical treatment, temporary or
19 permanent disability, vocational rehabilitation, the disability rating, or the need
20 for continuing medical care, Labor Code sections 4061 or 4062 apply. (*Keulen v.*
21 *Workers’ Comp. Appeals Bd.*, supra, 66 Cal.App.4th at p. 1096.) Sections 4061
22 and 4062 of the Labor Code establish the procedures for resolving such
disagreements. *Rushing* was, therefore required to follow the Labor Code
sections 4061 and 4062 procedures to resolve the dispute before she could
legitimately select a new [PTP].”

23 Applying the rationale in *Rushing* to the facts of this case, we concluded:

24 “Similarly, here, and we reiterate that for purposes of this opinion we are
25 proceeding under the assumption of a validly established and properly noticed
26 MPN, the applicant could not select a new PTP outside the MPN. As set forth

27 ⁶ The fact that *Rushing* involved a treatment dispute (which, as set forth above, must be resolved within the MPN), while the issue here was entitlement to temporary disability indemnity, is of no consequence; it is the failure to follow the mandatory procedures set forth in sections 4061 and 4062 that is dispositive.

1 above, she should have either changed treating physicians within the MPN
2 and/or sought the opinion of a second or third MPN physician, etc. Therefore,
3 the non-MPN physician is not authorized to be a PTP, and accordingly, is not
4 authorized to report or render an opinion on ‘medical issues necessary to
5 determine the employee’s eligibility for compensation’ under section 4061.5 and
6 AD Rule 9785(d). (Cal. Code Regs., tit. 8, § 9785(d).) Moreover, for disputes
7 involving temporary and/or permanent disability, neither an employee nor an
8 employer are allowed to unilaterally seek a medical opinion to resolve the
9 dispute, but must proceed under sections 4061 and 4062. [fn. omitted].
10 Accordingly, the non-MPN reports are not admissible to determine an
11 applicant’s eligibility for compensation, e.g., temporary disability indemnity.”

12 Therefore, contrary to the applicant’s contentions, we have not solely, or even primarily, relied on
13 section 4616.6 in reaching our holding. This also belies the applicant’s contention that “[r]uling that
14 [section] 4616.6 is a broad rule of inadmissibility to all proceedings causes mischief, exorbitant costs,
15 and an absurd result.” Much of applicant’s argument with respect to this contention is based on false
16 assumptions, speculation and unsupported allegations. For example, applicant states that “[b]y the
17 WCAB’s ruling, apportionment would not be provable if it is based on any medical record from a
18 healthcare provide[r] outside of the MPN.” Applicant then states that “[m]any of the medical reports and
19 records finding apportionment predate the inception of the MPN system on January 1, 2005.” However,
20 our decision is applicable only where unauthorized industrial injury treatment reports are obtained
21 outside a validly established and properly noticed MPN, and does not preclude admissibility of any other
22 medical reports and records. Furthermore, as stated previously, disputes concerning permanent
23 disability, including apportionment, are to be determined under the procedures set forth in sections 4061
24 and 4062 with medical-legal reports outside the MPN. Therefore, based on her false assumption
25 regarding admissibility of medical evidence on apportionment, applicant has wrongly speculated that
26 “[i]n all such instances, injured workers will move to strike these reports... and the employer will be
27 unable to prove apportionment under [sections] 4663 and 4664 leading to unintended and exorbitant
costs, surely a mischief and absurdity caused by this ruling.”

Applicant next contends that our decision “violates longstanding law.”

Applicant alleges that “[o]verlooked by [our decision] are numerous provisions of the law which
require and mandate review and consideration of treating doctor medical reports and other health care

1 provider data irrespective of whether these health care providers are in [an] MPN.” The provisions cited
2 by applicant include those containing the term “treating physician” (Cal. Code Regs., tit. 8, § 35(a)(1);
3 Lab. Code, §§ 4060(b), 4061(c), 4061(i), 4061.5, 4062(a) and 4062.3(a)), as well as the *American*
4 *Medical Association () Guides to the Evaluation of Permanent Impairment* (AMA Guides).

5 Apparently because the provisions cited do not qualify the term “treating physician” in any way,
6 i.e., do not specifically mention MPN physicians, or distinguish them from non-MPN physicians,
7 applicant claims that they, without exception, compel admissibility of all treating physician reports,
8 regardless of the existence of a validly established and properly noticed MPN. However, because many
9 cases do not involve an MPN, and because MPN physicians are included in the definition of a treating
10 physician or a PTP under AD Rule 9785(a)(1) (Cal. Code Regs., tit. 8, § 9785(a)(1)),⁷ there is no reason
11 for these provisions to specifically refer to MPN or non-MPN physicians, or to differentiate between
12 them.

13 As expressed in our prior opinion, non-MPN treatment reports are inadmissible where
14 unauthorized treatment has been obtained outside a validly established and properly noticed MPN
15 because the non-MPN doctor is not the PTP.⁸ We concluded:

16 “Similarly, here, and we reiterate that for purposes of this opinion we are
17 proceeding under the assumption of a validly established and properly noticed
18 MPN, the applicant could not select a new PTP outside the MPN. As set forth
19 above, she should have either changed treating physicians within the MPN and/or
20 sought the opinion of a second or third MPN physician, etc. Therefore, the non-
21 MPN physician is not authorized to be a PTP, and accordingly, is not authorized to
report or render an opinion on ‘medical issues necessary to determine the
employee’s eligibility for compensation’ under section 4061.5 and AD Rule
9785(d). (Cal. Code Regs., tit. 8, § 9785(d)). . .”

22 ⁷ That provision defines a PTP to include both MPN physicians, i.e., those selected “in accordance with the physician
23 selection procedures contained in the [MPN] network pursuant to [section] 4616,” and non-MPN physicians, i.e., those
24 selected “pursuant to Article 2 commencing with section 4600) of Chapter 2 of Part of Division 4 of the Labor Code, or under
the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code.”

25 ⁸ This determination was based on the fact that “[a]n employee shall have no more than one [PTP] at a time” (Cal. Code Regs.,
26 tit. 8, § 9785(b)(1)); it is the PTP who “shall render opinions on all medical issues necessary to determine the employee’s
eligibility for compensation” (Lab. Code, § 4061.5; Cal. Code Regs., tit. 8, § 9785(d)); and that where an employee disputes a
27 medical determination made by the PTP, “[n]o other [PTP] shall be designated by the employee unless and until the dispute
is resolved” (Cal. Code Regs., tit. 8, § 9785(b)(3)), as well as reliance on *Rushing, supra*, 80 Cal.App.4th 1041 [65
Cal.Comp.Cases 477].

1 Therefore, based on the foregoing, we are not persuaded that use of the term “treating physician,”
2 in and of itself, necessitates finding the reports of non-MPN physicians admissible.

3 Concerning the AMA Guides, which must be used to rate permanent disability under section
4 4660, applicant states that they “do not limit reporting to MPN doctors.” We agree. Aside from the fact
5 that many cases do not involve an MPN, disputes over permanent disability are to be determined under
6 the procedures set forth in sections 4061 and 4062, i.e., outside the MPN.

7 In addition, applicant has cited two recent writ denied cases in which a WCJ relied on the opinion
8 of the applicant’s treating physician over that of the panel qualified medical evaluator (PQME).⁹
9 However, neither case involved an MPN, and there was no issue regarding the admissibility of the
10 reports of the treating doctors. Similarly, we also fail to see any relevance to the issues here in
11 applicant’s comment regarding section 4610, which involves the utilization review (UR) process that
12 must be established by every employer, that “[t]here is no limit in [section] 4610 that the medical doctor
13 must be in any MPN.”

14 Applicant next contends that “defendant waived admissibility of the medical reports by failing to
15 raise it at trial.” This contention, however, is directly contrary to the evidence of record. As set forth in
16 our en banc opinion of April 20, 2011, while the WCJ deferred “the issue of MPN,”¹⁰ he nevertheless
17 rejected defendant’s argument that “reports of non-MPN doctors are inadmissible.”

18 Applicant further contends that the Appeals Board’s decision “violates [both substantive and
19 procedural] due process.” Specifically, with regard to substantive due process, applicant states:

20 “The practical consequences of this violation of substantive due process by the
21 wrongful judicial legislating of the WCAB in the ODAR [Order and Decision
22 after Reconsideration] are to vastly worsen the costs and delays attendant in the
23 workers’ compensation system. Employers will have a nearly impossible time to
24 prove apportionment which employers would rightfully be entitled to. Utilization review doctors and PQME’s would have to be in the MPN or their medical opinions would not be admissible. A costly and delay-prone battle

25 ⁹ *California Institute of Technology v. Workers’ Comp. Appeals Bd. (Bonzo)* (2010) 75 Cal. Comp. Cases 735 and *Payless Shoesource, Inc. v. Workers’ Comp. Appeals Bd. (Twine)* (2010) 75 Cal. Comp. Cases 1225.

26 ¹⁰ Applicant apparently contends that because at hearing it was indicated only that “[d]efendant wishes to raise the issue of [MPN],” she was not on notice that defendant was challenging the admissibility of her non-MPN medical reports. The WCJ, however, was apparently fully aware of the extent of defendant’s concern, stating in his Opinion on Decision: “Defendant argues that reports from non-MPN doctors are inadmissible. This is incorrect.”

1 would occur over MPN accreditation and notice issues in every single case. . . ”

2 Applicant’s conclusion is wrong. Records of treatment may still be subpoenaed, and UR and
3 PQME reports may still be obtained.

4 Regarding the alleged denial of the substantive right to medical treatment under the California
5 Constitution, applicant takes issue with our determination that section 4605¹¹ does not justify the
6 admission of reports from non-MPN doctors where treatment was improperly obtained outside the MPN,
7 and with the inadmissibility of such reports under section 4616.6. Contrary to applicant’s assertion, our
8 decision did nothing to restrict the right of any injured employee to treat with any physician of the
9 employee’s choice and at the employee’s expense under section 4605. Moreover, we explained:

10 “This determination [of inadmissibility] is supported by the reasons previously
11 given for finding such non-MPN medical reports inadmissible: a validly
12 established and properly noticed MPN; the opportunities within the MPN both to
13 change treating physicians and to dispute opinions regarding diagnosis and
14 treatment, including the limitations on admissibility under section 4616.6 for
15 such disputes; the provisions requiring the PTP to ‘render opinions on all
16 medical issues necessary to determine the employee’s eligibility for
17 compensation’ (Lab. Code, § 4061.5; Cal. Code Regs., tit. 8, § 9785(d)); and the
18 provisions for resolving disputes regarding temporary and permanent disability
19 under sections 4061 and 4062.”

20 We remain of the opinion that our determination concerning section 4605 was justified for the
21 reasons stated in the above paragraph.¹² In addition, consistent with the above paragraph, and as
22 discussed previously, section 4616.6 was only part of the basis for finding that medical reports obtained
23 outside a validly established and properly noticed MPN are inadmissible.

24 With respect to procedural due process, applicant first asserts, incorrectly—for the reasons
25 discussed previously—that the issue of the admissibility of the non-MPN medical reports was not raised
26 at trial. Moreover, because the WCJ deferred any issues concerning the MPN, no determination was
27

¹¹ Section 4605 provides: “Nothing contained in this chapter shall limit the right of the employee to provide, at his own expense, a consulting or any attending physicians whom he desires.”

¹² For these same reasons, coupled with the discretionary language of section 5703(a), i.e., “[t]he appeals board *may* receive as evidence... [r]eports of attending or examining physicians” (italics added), our prior decision also concluded “that unauthorized non-MPN medical reports are not admissible under section 5703(a). That is, our discretion should not be used to admit medical reports or testimony in lieu of such reports resulting from an unauthorized departure outside the MPN.”

1 made as to the validity of the MPN, or whether the applicant received the proper notices pursuant to
2 *Knight, supra*, 71 Cal.Comp.Cases 1423. Thus, as to the admissibility of applicant’s non-MPN reports,
3 we remanded this matter for consideration of these issues. Therefore, the applicant and the defendant will
4 have the opportunity to present documentary and testimonial evidence and fully litigate these issues in
5 further proceedings. There has been no denial of procedural due process.

6 Applicant’s last contention is that “[t]he decision of the WCAB lacks substantial evidence.”¹³ In
7 support of this contention, applicant states only the following:

8 “The decision by the WCAB must be supported by substantial evidence. In
9 Garza v. WCAB 3 Cal.3d 312 (1970), the California Supreme Court held
10 evidence based on guess, surmise, and conjecture is not substantial evidence and
11 does not properly support a decision of the WCAB which must be annulled. See
also Lamb v. WCAB 11 Cal.3d 274 (1974) and Place v. WCAB 3 Cal.3d 372
(1970).

12 “There is no substantial evidence to support the ODAR.”

13 Thus, applicant has presented no facts or argument whatsoever to support this conclusion. She
14 has not demonstrated that the Appeals Board’s decision or the evidence relied on was “based on guess,
15 surmise, and conjecture,” or that it fails to conform to the definition of substantial evidence quoted with
16 approval by the California Supreme Court.

17 Finally, we again disagree with the assertion in the concurring and dissenting opinion of
18 Commissioner Caplane that our decision effectively deprives injured workers from receiving
19 compensation by making non-MPN medical reports inadmissible. On the contrary, it is those applicants
20 who have chosen to disregard a validly established and properly noticed MPN, despite the many options
21 to change treating physicians and to challenge diagnosis or treatment determinations within the MPN,
22 who have removed themselves from the benefits provided by the Labor Code.

23 ///

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25
26 ¹³ The term “substantial evidence” has been defined as evidence “which, if true, has probative force on the issues. It is more
27 than a mere scintilla, and means such relevant evidence as *a reasonable mind might accept as adequate to support a conclusion* ... It must be *reasonable in nature, credible, and of solid value...*” (*Braewood Convalescent Hospital v. Workers Comp. Appeals Bd. (Bolton)* (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566, 568] emphasis in original; internal quotes omitted.)

1 **B. Saldivar’s Petition**

2 Saldivar contends that he “has been aggrieved” under section 5900(a) by the Appeals Board’s en
3 banc decision of April 20, 2011.¹⁴

4 Directly aggrieved persons are those whose rights and liabilities are affected by the proceedings,
5 e.g., the parties (the injured employee, the employer or the insurance carrier). Indirectly aggrieved
6 persons include nonparties who have some direct monetary or other real interest in the case, e.g., a lien
7 claimant whose lien is disallowed or reduced or who is prejudiced by a priority granted another lien; an
8 attorney not satisfied with the fee allowed (*Bentley v. Industrial Acc. Com (Martin)* (1946) 75 Cal.2d 547
9 [11 Cal.Comp.Cases 204]); an alleged but unjoined employer when another alleged employer is
10 dismissed (*Arias v. Workers’ Comp. Appeals Bd. (Aviles)* (1983) 146 Cal.App.3d 813 [48
11 Cal.Comp.Cases 659]). (See *California Workers’ Compensation Practice* (Cont.Ed.Bar 4th ed. June
12 2011 update), Reconsideration, § 21.12, p. 1681.)

13 We interpret the language of section 5900(a) to mean that a person must be aggrieved in the case
14 from which reconsideration is sought. Saldivar, who has a pending claim for workers’ compensation
15 benefits in Case No. ADJ7516842, is not a party in the present case, nor does he have a direct monetary
16 or other real interest in this matter. Interpreting section 5900(a) as urged by Saldivar to allow him seek
17 reconsideration here would mean that any party or nonparty in another case, anyone affected by an en
18 banc decision of the Appeals Board, potentially thousands of litigants, could file petitions for
19 reconsideration, and would also permit such petitions where reconsideration had not been sought by any
20 of the case participants. This is an absurd result, and one we believe was not intended by section
21 5900(a). Moreover, should Saldivar subsequently be aggrieved by an adverse decision in his own case
22 based on the en banc decision here, he may ultimately seek relief in the appropriate Court of Appeal.

23 ///

24
25 _____
26 ¹⁴ Section 5900(a) provides: “Any person aggrieved directly or indirectly by any final order, decision, or award made and filed
27 by the appeals board or a workers' compensation judge under any provision contained in this division, may petition the
appeals board for reconsideration in respect to any matters determined or covered by the final order, decision, or award, and
specified in the petition for reconsideration. . . .” (emphasis added.)

1 Accordingly, we will dismiss Saldivar’s petition.¹⁵
2

3 **III. CONCLUSION**

4 For the reasons discussed above, we affirm the Opinion and Decision After Reconsideration (En
5 Banc) issued on April 20, 2011.

6 For the foregoing reasons,

7 **IT IS ORDERED** that the Petition for Reconsideration or, in the alternative, Petition for
8 Removal filed on behalf of Armando Saldivar, the applicant in case Case No. ADJ7516842, is
9 **DISMISSED.**

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26 ¹⁵ An alternate ground for dismissal is Saldivar’s failure to serve the adverse parties in his own case with this petition. (Lab.
27 Code, § 5905; *Fisher v. Workers’ Comp. Appeals Bd.* (2001) 66 Cal.Comp.Cases 517 (writ den.)) Moreover, that Saldivar
has “in the alternative” sought removal under section 5310, does not change his status in this case as a nonparty with no direct
monetary or other real interest, or otherwise enable him or potentially numerous similarly situated petitioners from
challenging Appeals Board en banc decisions via removal.

1 As correctly indicated by the majority, sections 4061 and 4062 require an injured worker to go
2 outside the MPN to determine issues of temporary and permanent disability, if they are in dispute.
3 Under the majority's decision, however, the opinion of the non-MPN treating physician on those issues,
4 regardless of its worth, would not even merit consideration by the WCJ. I would again emphasize that
5 receiving reports into evidence only means that they will be considered. They may not be relied on
6 unless they constitute substantial evidence and are the most persuasive indication of the injured worker's
7 condition.

8 Section 5703(a) states that "[t]he appeals board may receive as evidence... [r]eports of attending
9 or examining physicians," and provides authority to admit the reports of non-MPN treating physicians.
10 In situations which do not rise to the level of neglect or refusal to provide reasonable medical treatment,
11 but where an injured worker has nevertheless appropriately sought care outside an MPN, the reports of
12 the non-MPN treating physician should be admitted into evidence under section 5703(a) for
13 consideration of any issue in dispute.

14 Finally, I wish to emphasize that the MPN provisions are not to be disregarded lightly, and while
15 an injured worker cannot be prohibited from seeking treatment outside even a validly established and
16 properly noticed MPN, in doing so, he or she runs the risk that any non-MPN reports will be
17 inadmissible. On the other hand, if an injured worker has demonstrated a good reason for leaving the
18 MPN, e.g., a misdiagnosis, a lack of effective treatment, and/or an unreasonable or detrimental delay in
19 providing care, he or she should not be penalized for exercising that right. That the instant matter,
20 assuming the existence of a validly established and properly noticed MPN, presents no justifiable
21 grounds for disregarding the MPN statutes, should not be a basis for extending the majority's holding to
22 all injured workers in every case, regardless of the circumstances.

23
24 /s/ Frank M. Brass
FRANK M. BRASS, Commissioner

1 (2005) 127 Cal.App.4th 625, 641 [70 Cal. Comp. Cases 312, 318]; *Marsh v. Workers' Comp. Appeals*
2 *Bd.* (2005) 130 Cal.App.4th 906, 914 [70 Cal. Comp. Cases 787, 792). In this case, by holding that the
3 limitation on the inadmissibility of medical reports generated by unauthorized, non-MPN treating doctors
4 in section 4616.6 applies to all situations, the majority strips sections 4605 and 5703(a) of all
5 effectiveness, and in essence renders these sections meaningless.

6 Section 4605 states: "Nothing contained in this chapter shall limit the right of the employee to
7 provide, at his own expense, a consulting physician or any attending physician whom he desires."

8 Section 5703 sets forth what evidence the appeals board may receive as proof facts in dispute.
9 Subsection (a) specifically names "[R]eports of attending or examining physicians."

10 The majority takes the position that an unauthorized, non-MPN doctor can not be a PTP and that
11 the PTP continues to be the MPN doctor who initially treated the applicant. While this may make
12 theoretical sense, as a practical matter it's untenable to expect that the MPN doctor with whom the
13 applicant has severed ties will issue medical reports regarding an injured workers disability status. This
14 is unreasonable and inconsistent with the provisions of sections 4605 and 5703(a). Holding that medical
15 reports obtained from unauthorized, non-MPN treating doctors are inadmissible, even though the
16 treatment is permitted under section 4605, deprives injured workers of the tools needed to prove
17 entitlement to compensation under Article 3, and ultimately deprives them of benefits.

18 While legislative intent is not always apparent, it strains credulity to assume that in enacting
19 section 4616.6, the legislature intended that by exercising the right to obtain medical treatment at their
20 own expense, injured workers would preclude themselves from receiving benefits for their industrial
21 injuries. Moreover, the majority has removed the discretion of the WCJ to admit the reports of non-MPN
22 treating physicians in all cases and circumstances where there is a validly established and properly
23 noticed MPN, apparently creating for the first time an exception to section 5703(a), which was enacted in
24 1937.

25 In most cases, the issue of entitlement to temporary and/or permanent disability indemnity is
26 initiated by a medical report from the applicant's treating doctor. When served with that report, a
27 defendant must either pay the benefits in question, or object and follow the procedures set forth in

1 sections 4061 and 4062 to resolve the dispute. However, as a consequence of the majority's holding that
2 reports of non-MPN physicians are not admissible for any purpose, the defendant is no longer obligated
3 to take any action when served with such reports, and the applicant has been deprived of the opportunity
4 to even present a claim for temporary or permanent disability indemnity. Surely this is not the
5 consequence that was intended by the legislature. It should also be emphasized that admitting non-MPN
6 reports into evidence merely means they will be considered and not that they will necessarily be relied on
7 to award compensation. Furthermore, the admissibility of these reports does not abrogate a defendant's
8 right to obtain an opinion and report from a QME, as provided by sections 4061 and 4062, addressing the
9 issue at hand on which the WCJ can rely.

10 In addition, while the majority continues to find "persuasive" the case of *Tenet/Centinela*
11 *Hospital Medical Center v. Workers' Comp. Appeals Bd. (Rushing)* (2000) 80 Cal.App.4th 1041 [65
12 Cal.Comp.Cases 477], I remain of the opinion that it is inapposite to the situation here. As I indicated in
13 my prior dissent, *Rushing* "pre-dates the MPN statutes which were enacted under Senate Bill 899, and
14 does not involve an applicant exercising the right to seek treatment under section 4605."

15 Accordingly, based on the applicant's right to seek treatment under section 4605, the specific
16 restriction on admissibility to issues of diagnosis and treatment by section 4616.6 (the only issues under
17 the scope of the MPN statutes under Article 2.3), and the discretion afforded by section 5703(a) to admit
18 non-MPN medical reports on issues of compensation, I dissent. As indicated in my prior dissent, I would
19 therefore affirm the WCJ's decision insofar as he properly exercised his discretion under section 5703(a)
20 to admit the reports of the applicant's non-MPN treating physician on the issue of temporary disability. I
21 would, however, return this matter to the trial level for the newly assigned WCJ to address the
22 defendant's contention that these reports do not constitute substantial evidence. If so, the parties should
23 then proceed under sections 4062(a) and 4062.2 to select either an agreed medical evaluator (AME) or a
24 qualified medical evaluator (QME).

25 /s/ Ronnie G. Caplane
26 **RONNIE G. CAPLANE, Commissioner**

1 **WORKERS' COMPENSATION APPEALS BOARD**

2 **STATE OF CALIFORNIA**

3
4 **ELAYNE VALDEZ,**

5
6 *Applicant,*

7 **vs.**

8 **WAREHOUSE DEMO SERVICES; ZURICH**
9 **NORTH AMERICA, Adjusted by ESIS,**

10 *Defendant(s).*

Case No. ADJ7048296

**OPINION AND DECISION AFTER
RECONSIDERATION
(EN BANC)**

11
12 The Appeals Board granted defendant's petition for reconsideration of the Findings and
13 Award issued by a workers' compensation administrative law judge (WCJ) on July 29, 2010, to
14 allow time to study the record and applicable law.

15 The WCJ relied on medical reports obtained by the applicant from outside the defendant's
16 medical provider network (MPN) to award her temporary disability indemnity for the period of
17 November 2, 2009 through February 10, 2010. Defendant contends, however, that non-MPN
18 medical reports are inadmissible.

19 In order to secure uniformity of decision in the future, the Chairman of the Appeals Board,
20 upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en
21 banc decision¹ on the following issue: if an applicant has improperly obtained medical treatment
22 outside the employer's MPN, are the reports of the non-MPN treating physicians admissible in
23 evidence? We hold that where unauthorized treatment is obtained outside a validly established and
24 properly noticed MPN, reports from the non-MPN doctors are inadmissible, and therefore may not

25
26 ¹ En banc decisions of the Appeals Board (Lab. Code, § 115) are binding precedent on all Appeals Board panels and
27 WCJs. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)* (2005) 126
Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109, 120, fn. 5] (*Garcia*); *Gee v. Workers' Comp. Appeals Bd.* (2002)
96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236, 239, fn. 6] (*Gee*)). 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).

1 be relied upon, and that defendant is not liable for the cost of the non-MPN reports.

2 **I. BACKGROUND**

3 Applicant Elayne Valdez filed a claim for industrial injury to her back, right hip, neck, right
4 ankle, right foot, right lower extremity, lumbar spine and both knees, while employed as a
5 demonstrator for Warehouse Demo Services on October 7, 2009. Defendant admitted the claim for
6 applicant’s back, right hip and neck, and she was sent for medical treatment to the employer’s
7 MPN, where she was seen by Dr. Nagamoto, who treated her from approximately October 9, 2009
8 to October 31, 2009. Applicant then began treating with Dr. Nario, a non-MPN physician, upon
9 referral from her attorney.

10 This matter proceeded to trial on July 22, 2010, on the issues of temporary disability “from
11 October 7, 2009 and continuing,” and attorney’s fees. The Minutes of Hearing also indicate that
12 “[d]efendant wishes to raise the issue of [MPN],” which the WCJ deferred as “not relat[ing] to
13 temporary disability.”² The WCJ also deferred the issue of self-procured medical treatment.

14 Applicant testified that her attorney sent her to Dr. Nario because the treatment provided by
15 Dr. Nagamoto was not helping her. She never spoke to the claims examiner or otherwise notified
16 defendant about this complaint. Applicant also testified that she “is still on temporary disability,”
17 and that she received payments from the Employment Development Department (EDD) from April
18 7, 2010 through May 26, 2010.

19 The WCJ found that applicant was temporarily disabled from November 2, 2009 through
20 February 10, 2010, for which indemnity was awarded “less duplication of payment made by the
21 [EDD], whose lien therefore is allowed.” The WCJ relied on the non-MPN reports of Dr. Nario for
22 this finding and award of benefits. While the WCJ deferred “the issue of MPN,” he nevertheless
23 rejected defendant’s argument that “reports of non-MPN doctors are inadmissible.”

24 Defendant filed a timely petition for reconsideration from the WCJ’s decision, contending
25 that (1) applicant’s non-MPN medical reports are inadmissible; (2) there is no evidence to support

26 ² Here, as the WCJ deferred any issues concerning the MPN as not relating to temporary disability, this matter will
27 have to be remanded for consideration of these issues. However, for purposes of this en banc opinion, we will
proceed on the assumption that the MPN here was validly established and that all proper notices regarding the MPN
were provided to the applicant. (See Lab. Code, § 4616 et seq.; Cal. Code Regs., tit. 8, § 9767.1 et seq.; *Knight v.*
United Parcel Service (2006) 71 Cal.Comp.Cases 1423 (Appeals Board en banc).)

1 any reimbursement to EDD for benefits paid to the applicant; and (3) if applicant is awarded
2 temporary disability indemnity, there is no substantial evidence that applicant was temporarily
3 disabled through February 10, 2010. Applicant did not file an answer to defendant's petition. On
4 October 25, 2010, the Appeals Board granted reconsideration for further study.

5 **II. DISCUSSION**

6 **A. Where Unauthorized Treatment Is Obtained Outside a Validly Established and Properly** 7 **Noticed MPN, Reports from the Non-MPN Doctors Are Inadmissible and Therefore May Not** 8 **Be Relied Upon**

9 An employer or its insurer is obligated to provide all medical treatment "that is reasonably
10 required to cure or relieve the injured worker from the effects of his or her injury." (Lab. Code, §
11 4600(a).)³ Section 4600(a) further provides: "In the case of his or her neglect or refusal to
12 reasonably do so, the employer is liable for the reasonable expense incurred by or on behalf of the
13 employee in providing treatment."

14 Section 4600(c) provides: "Unless the employer or the employer's insurer has established a
15 medical provider network as provided for in section 4616, after 30 days from the date the injury is
16 reported, the employee may be treated by a physician of his or her own choice at a facility of his or
17 her own choice within a reasonable geographic area." An MPN is established by an employer or
18 insurer subject to the approval of the administrative director (AD). (Lab. Code, § 4616; Cal. Code
19 Regs., tit. 8, § 9767.3.) Among other things, the regulations require that the employer or insurer's
20 application for approval of an MPN include a statement of how the MPN will comply with the
21 "employee notification process" and the "second and third opinion process." (Cal. Code Regs., tit.
22 8, §§ 9762.1 through 9762.3.) The statutory and regulatory scheme also imposes several other
23 obligations upon both the insurer/employer and the injured worker.

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25 In *Knight, supra*, 71 Cal.Comp.Cases 1423, the Appeals Board held that a defendant's
26 failure to provide the required notices to an employee of rights under the MPN which results in a
27 neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable

³ All further statutory references are to the Labor Code.

1 for reasonable medical treatment self-procured by the employee. As stated previously, we assume
2 for purposes of this opinion that defendant had a validly established MPN, and that all proper
3 notices required under the MPN were provided to applicant. Here, after initially treating with an
4 MPN physician, Dr. Nagamoto, for less than one month, applicant sought treatment outside the
5 MPN with Dr. Nario. This was despite the fact that *within* the MPN she would have had several
6 opportunities to challenge any treatment, diagnosis, or lack thereof with which she disagreed and
7 treat with someone other than Dr. Nagamoto.

8 More specifically, after the initial medical evaluation arranged by the employer within the
9 MPN pursuant to section 4616.3(a), “[t]he employer shall notify the employee of his or her right
10 to be treated by a physician of his or her choice,” including “the method by which the list of
11 participating providers may be accessed by the employee.” (Lab. Code § 4616.3(b); Cal. Code
12 Regs., tit. 8, § 9767.6(d).) In addition, AD Rule 9767.6(e) (Cal. Code Regs., tit. 8, § 9767.6(e))
13 provides that “[a]t any point in time after the initial evaluation with a MPN physician, the covered
14 employee may select a physician of his or her choice from within the MPN.”

15 Furthermore, pursuant to section 4616.3(c), where an injured worker “disputes either the
16 diagnosis or treatment prescribed by the treating physician,” he or she “may seek the opinion of
17 another physician in the [MPN],” and of “a third physician in the [MPN],” if the diagnosis or
18 treatment of the second physician is disputed.⁴

19 In addition, section 4616.4(b) provides that if the treatment or diagnostic service remains
20 disputed after the third physician’s opinion, “the injured employee may request independent
21 medical review.” Pursuant to section 4616.4(i), if “the independent medical reviewer finds that the
22 disputed treatment or diagnostic service is consistent with section 5307.27 or the American
23 College of Occupational and Environmental Medicine's Occupational Medicine Practice
24 Guidelines, the injured employee may seek the disputed treatment or diagnostic service from a
25 physician of his or her choice from within or outside the [MPN], and “[t]he employer shall be
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27 ⁴ Section 4616.3(d)(2) also allows treatment by a specialist who is not a member of the MPN “on a case-by-case basis if the [MPN] does not contain a physician who can provide the appropriate treatment and the treatment is approved by the employer or the insurer.”

1 liable for the cost of any approved medical treatment in accordance with section 5307.1 or
2 5307.11.”

3 The foregoing provisions allow an applicant to treat with any physician of his or her
4 choice within the MPN, and also afford a multi-level appeal process where treatment and/or
5 diagnosis are disputed. Consistent with these provisions, section 4616.6 provides: “No additional
6 examinations shall be ordered by the appeals board and no other reports shall be admissible to
7 resolve any controversy arising out of this article.” Thus, section 4616.6 precludes the
8 admissibility of non-MPN medical reports with respect to disputed treatment and diagnosis issues,
9 i.e., “any controversy arising out of this article.” Here, for unknown reasons, the applicant almost
10 immediately chose to go outside the MPN and seek treatment in violation of the MPN statutes and
11 procedures. Subsequently, the WCJ awarded compensation, i.e., temporary disability indemnity,
12 based on the reports of the unauthorized, non-MPN physician. As discussed below, the reports of
13 non-MPN physicians are inadmissible and therefore may not be relied on to award compensation.

14 The definition of the “primary treating physician” [PTP] set forth in AD Rule 9785(a)(1)
15 (Cal. Code Regs., tit. 8, § 9785(a)(1)) includes the physician selected “in accordance with the
16 physician selection procedures contained in the [MPN] network pursuant to [section] 4616.” AD
17 Rule 9785(b)(1) (Cal. Code Regs., tit. 8, § 9785(b)(1)) further provides that “[a]n employee shall
18 have no more than one [PTP] at a time.” In addition, pursuant to AD Rule 9785(b)(3) (Cal. Code
19 Regs., tit. 8, § 9785(b)(3)), if an employee “disputes a medical determination made by the [PTP]...
20 the dispute shall be resolved under the applicable procedures set forth in [sections] 4061 and
21 4062,” and “[n]o other [PTP] shall be designated by the employee unless and until the dispute is

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25 resolved.”⁵ Thus, where an applicant has left a validly established and properly noticed MPN and
26 impermissibly sought treatment outside the MPN, the non-MPN physician cannot be the PTP; the

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⁵ One of the disputes mentioned by AD Rule 9785(b)(3) is “a determination that the employee shall be released from care.” Section 4062(a) sets forth procedures where either the employee or employer “objects to a medical

1 MPN treater remains the PTP.⁶ As stated by section 4061.5 and AD Rule 9785(d) (Cal. Code
2 Regs., tit. 8, § 9785(d)), the PTP “shall render opinions on all medical issues necessary to
3 determine the employee’s eligibility for compensation.”

4 In *Tenet/Centinela Hospital Medical Center v. Workers’ Comp. Appeals Bd. (Rushing)*
5 (2000) 80 Cal.App.4th 1041 [65 Cal.Comp.Cases 477], the applicant disagreed with the opinion of
6 her PTP, Dr. Glousman, who had found her condition to be permanent and stationary, released her
7 to return to work without restriction, and prescribed no further doctor-involved treatment or visits.
8 Rather than select a qualified medical evaluator (QME) under sections 4061 and 4062 to resolve
9 her dispute, applicant retained counsel and began treating with Dr. Stokes, whose report was
10 ultimately relied on to award applicant compensation.

11 The Court in *Rushing* held that because the applicant was discharged from care by Dr.
12 Glousman, her PTP, and she disputed his findings, applicant was not entitled to seek medical
13 treatment with Dr. Stokes without first complying with the provisions of sections 4061 and 4062
14 by submitting the issue of treatment to an agreed medical evaluator (AME) or a QME. The Court
15 stated, at 80 Cal.App.4th p. 1048, [65 Cal.Comp.Cases at p. 482] :

16 “When there are disputes about the appropriate medical treatment,
17 temporary or permanent disability, vocational rehabilitation, the disability
18 rating, or the need for continuing medical care, Labor Code sections 4061 or
19 4062 apply. (*Keulen v. Workers’ Comp. Appeals Bd., supra*, 66 Cal.App.4th
20 at p. 1096.) Sections 4061 and 4062 of the Labor Code establish the
21 procedures for resolving such disagreements. *Rushing* was, therefore
22 required to follow the Labor Code sections 4061 and 4062 procedures to
23 resolve the dispute before she could legitimately select a new [PTP].”

24 Similarly, here, and we reiterate that for purposes of this opinion we are proceeding under
25 the assumption of a validly established and properly noticed MPN, the applicant could not select a
26 new PTP outside the MPN. As set forth above, she should have either changed treating physicians

27 determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610,” which, in addition to temporary disability, would also include medical treatment issues. As stated above, however, the MPN statutes contain specific provisions for addressing disputes over treatment and diagnosis within the MPN, and section 4616.6 provides that “[n]o additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any controversy arising out of this article.” Thus, while medical treatment and diagnosis issues must be resolved within the MPN, as discussed below, disputes concerning temporary or permanent disability are to be resolved under sections 4061 and 4062, i.e., outside the MPN.

⁶ Of course, where an applicant has refused at the outset to treat within a validly established MPN, the fact that there has been no PTP within the MPN, does not render the non-MPN doctor a PTP.

1 within the MPN and/or sought the opinion of a second or third MPN physician, etc. Therefore, the
2 non-MPN physician is not authorized to be a PTP, and accordingly, is not authorized to report or
3 render an opinion on “medical issues necessary to determine the employee’s eligibility for
4 compensation” under section 4061.5 and AD Rule 9785(d). (Cal. Code Regs., tit. 8, § 9785(d).)
5 Moreover, for disputes involving temporary and/or permanent disability, neither an employee nor
6 an employer are allowed to unilaterally seek a medical opinion to resolve the dispute, but must
7 proceed under sections 4061 and 4062.⁷ Accordingly, the non-MPN reports are not admissible to
8 determine an applicant’s eligibility for compensation, e.g., temporary disability indemnity.

9 Furthermore, we conclude that neither section 4605 nor section 5703(a) justifies the
10 admission of reports from non-MPN doctors where treatment was improperly obtained outside the
11 MPN.

12 Section 4605 provides:

13 “Nothing contained in this chapter shall limit the right of the employee to
14 provide, at his own expense, a consulting or any attending physicians
whom he desires.”

15 Section 5703(a) provides:

16 “The appeals board may receive as evidence either at or subsequent to a
17 hearing, and use as proof of any fact in dispute, the following matters, in
addition to sworn testimony presented in open hearing:

18 (a) Reports of attending or examining physicians.”

19 We first note that neither section 4605 nor section 5703(a) uses the term “treating
20 physician.” Moreover, section 4605 recognizes both the practical and legal issues involved in
21 attempting to restrict the right of individuals to seek a doctor of their own choosing, especially at
22 their own expense. Furthermore, section 4605 does not address the issue of admissibility, including
23 that of improperly obtained non-MPN medical reports, but merely allows for consulting and
24 attending physicians at an employee’s own expense. Therefore, we conclude that section 4605 does
25 not justify the admission of unauthorized non-MPN medical reports. This determination is

26 ⁷ For disputes involving temporary disability, section 4062(a) provides that a medical evaluation shall be obtained
27 pursuant to sections 4062.2 for represented employees and under section 4062.1 for unrepresented employees. For
disputes involving permanent disability, section 4061(c) provides that a medical evaluation shall be obtained pursuant
to sections 4062.2 for represented employees, and section 4061(d) provides that a medical evaluation shall be obtained
pursuant to sections 4062.1 for unrepresented employees.

1 supported by the reasons previously given for finding such non-MPN medical reports inadmissible:
2 a validly established and properly noticed MPN; the opportunities within the MPN both to change
3 treating physicians and to dispute opinions regarding diagnosis and treatment, including the
4 limitations on admissibility under section 4616.6 for such disputes; the provisions requiring the
5 PTP to “render opinions on all medical issues necessary to determine the employee’s eligibility for
6 compensation” (Lab. Code, § 4061.5; Cal. Code Regs., tit. 8, § 9785(d)); and the provisions for
7 resolving disputes regarding temporary and permanent disability under sections 4061 and 4062.

8 For these same reasons, coupled with the fact that section 5703(a) is discretionary, i.e.,
9 “[t]he appeals board *may* receive as evidence...” (italics added), we also conclude that
10 unauthorized non-MPN medical reports are not admissible under section 5703(a). That is, our
11 discretion should not be used to admit medical reports or testimony in lieu of such reports resulting
12 from an unauthorized departure outside the MPN.⁸

13 Finally, the concurring and dissenting opinion of Commissioner Caplane asserts that our
14 decision effectively deprives injured workers from receiving compensation in these circumstances.
15 On the contrary, it is those applicants who have chosen to disregard a validly established and
16 properly noticed MPN, despite the many options to change treating physicians and challenge
17 diagnosis or treatment determinations within the MPN, and to dispute temporary or permanent
18 disability opinions under sections 4061 and 4062 outside the MPN, who have removed themselves
19 from the benefits provided by the Labor Code.

20
21 **B. Where Unauthorized Treatment Was Obtained Outside the MPN, a Defendant Is Not
22 Liable for the Cost of the Inadmissible Reports from Non-MPN Physicians**

23 As stated previously, we held, in *Knight, supra*, 71 Cal.Comp.Cases at p. 1435, that the

24 ⁸ We acknowledge that in some prior Appeals Board panel decisions it was determined that medical reports from
25 treatment obtained outside a validly established and properly noticed MPN were admissible. Panel decisions, however,
26 are not binding precedent on other Appeals Board panels (including even the same panel or panel members in a
27 subsequent case) or on WCJs. (Lab. Code, §115; Cal. Code Regs., tit. 8, § 10341; *Garcia, supra*, 126 Cal.App.4th at
p. 313, fn. 5 [70 Cal.Comp.Cases 109, 120, fn. 5]; *Gee, supra*, 96 Cal.App.4th at p. 1425, fn. 6 [67 Cal.Comp.Cases
236, 239, fn. 6].) Nor do panel decisions undergo the expanded discussion and analysis of the Appeals Board as a
whole consistent with preparing an en banc opinion. For the reasons stated previously in finding unauthorized, non-
MPN reports inadmissible, we disavow any panel decision to the contrary.

1 defendant's failure to provide an injured employee with notice of his or her rights under the MPN
2 which resulted in a neglect or refusal to provide reasonable medical treatment, rendered the
3 defendant liable for the reasonable medical treatment self-procured by the employee. In *Knight*,
4 the applicant testified that he never received written notice about the MPN and there was no
5 written notice in evidence. In addition, the applicant was never provided notice of whether an
6 MPN physician had been designated as his PTP, nor was he notified of his rights to be treated by
7 an MPN physician of his choice after his first visit, and to obtain second and third opinions.

8 Conversely, where there has been no neglect or refusal to provide reasonable medical
9 treatment, a defendant is not liable for the medical treatment procured outside the MPN. This is
10 consistent with section 4605, which provides: "Nothing contained in this chapter shall limit the
11 right of the employee to provide, *at his own expense*, a consulting or any attending physicians
12 whom he desires." (emphasis added.) Accordingly, having determined that where treatment was
13 improperly obtained outside the MPN, any non-MPN medical reports are inadmissible, we can
14 discern no reason to find a defendant liable for the cost of such reports.

15 **III. DISPOSITION**

16 As set forth throughout this opinion, whether the defendant had a validly established MPN
17 and whether it provided the required MPN notices to the applicant are highly relevant to determine
18 the propriety of the applicant seeking treatment outside the MPN and the reliance on a non-MPN
19 physician to award temporary disability benefits. Accordingly, based on the WCJ's deferral of this
20 issue, his decision must be rescinded, and this matter remanded to the trial level for further
21 proceedings consistent with this opinion.⁹

22 Finally, we note that should further proceedings determine the existence of a validly
23 established and properly noticed MPN, then the applicant should comply with the applicable MPN
24 provisions and resolve any dispute concerning temporary and/or permanent disability under the
25 procedures set forth in sections 4061 and 4062. On the other hand, should the evidence fail to

26 ⁹ As the WCJ who heard this matter has since retired, we will return this matter to the presiding WCJ to assign a new
27 WCJ. In addition, we note that although the defendant appears to be correct in its assertion there is no evidence to
support any reimbursement to EDD for benefits paid to the applicant, the issue of reimbursement to EDD is now moot
in light of our determination that the present record does not support the award of temporary disability benefits and
our disposition rescinding the WCJ's decision and remanding for further proceedings.

1 determine the existence of a validly established and properly noticed MPN, then the applicant may
2 continue to treat outside the MPN until the defendant is in compliance with the MPN regulations
3 (see *Babbit v. Ow Jing dba National Market* (2007) 72 Cal.Comp.Cases 70 (Appeals Board en
4 banc)) and the WCJ assigned to this matter may award temporary disability benefits on the present
5 record, or in his or her discretion, may allow defendant to object to the report in question under
6 section 4062(a) should it be determined under the circumstances of this case that “good cause”
7 exists to extend the time limits of that section. Of course, any award of temporary disability must
8 be supported by substantial medical evidence, and if such evidence is lacking, the medical record
9 should be further developed as expeditiously as possible.

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20 For the foregoing reasons,

21 **IT IS ORDERED**, as the Decision After Reconsideration of the Appeals Board (En Banc),
22 that the Findings and Award of July 29, 2010, are **RESCINDED** and that this matter is
23 **RETURNED** to the presiding WCJ for assignment to a new WCJ for further proceedings and
24 decision consistent with this opinion.

25 ***WORKERS’ COMPENSATION APPEALS BOARD***

26 /s/ Joseph M. Miller
27 ***JOSEPH M. MILLER, Chairman***

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/s/ James C. Cuneo
JAMES C. CUNEO, Commissioner

/s/ Alfonso J. Moresi
ALFONSO J. MORESI, Commissioner

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

*I CONCUR, in part and I DISSENT, in part
(See attached Concurring and Dissenting Opinion)*

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

*I CONCUR, in part and I DISSENT, in part
(See attached Concurring and Dissenting Opinion)*

/s/ Ronnie G. Caplane
RONNIE G. CAPLANE, Commissioner

**DATED AND FILED AT SAN FRANCISCO, CALIFORNIA
4/20/2011**

**SERVICE MADE BY MAIL ON ABOVE DATE ON THE PERSONS LISTED BELOW AT
THEIR ADDRESSES AS SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD:
ELAYNE VALDEZ
LAW OFFICES OF JEFFREY N. SARDELL
LAW OFFICES OF JOHN MENDOZA**

VB/bgr

**CONCURRING AND DISSENTING OPINION OF
COMMISSIONER BRASS**

Assuming the existence of a validly established and properly noticed MPN, I concur in the result reached by my fellow Commissioners. I concur, under the facts of this case, that the applicant’s non-MPN medical reports are inadmissible, and that the defendant is not liable for the cost of such reports. I also concur in returning this matter to the trial level to determine the existence of a validly established and properly noticed MPN, as well as the issues of temporary disability and EDD’s lien.

I dissent because there may be situations when an injured worker has good reasons to seek care outside even a validly established and properly noticed MPN, and thus, an appropriate exercise of authority under section 5703(a) would be to admit the reports of the non-MPN treating

1 physician.

2 In the instant case, it does not appear that applicant made a good faith attempt to treat
3 within defendant's MPN or to avail herself of the opportunities to change treating physicians
4 and/or request another opinion. Instead, apparently on the advice of her attorney, she left the
5 MPN after approximately three weeks. Such behavior should not be condoned. Consequently, if
6 the existence of a validly established and properly noticed MPN is determined, I concur with the
7 majority in finding the non-MPN reports inadmissible, thereby reversing the award of temporary
8 disability benefits based on those reports.

9 Nevertheless, I do not believe that this decision should be used to penalize injured workers
10 when it would be in their best interest to seek care outside a validly established and properly
11 noticed MPN. There may be a misdiagnosis, a lack of effective treatment, and/or an unreasonable
12 delay in providing care. An employee seeking care outside a validly established and properly
13 noticed MPN already has to pay for that treatment (*Knight v. United Parcel Service* (2006) 71
14 Cal.Comp.Cases 1423 (Appeals Board en banc); § 4605) and for the cost of any non-MPN
15 reports. Furthermore, under the majority's opinion, injured workers exercising their right under
16 section 4605 to seek and pay for their own medical treatment outside the MPN are also foreclosed
17 from receiving any compensation based on the non-MPN reports.

18 Sections 4061 and 4062 require an injured worker to go outside the MPN to determine
19 issues of temporary and permanent disability, if they are in dispute. According to the majority's
20 decision, the opinion of the non-MPN treating physician on those issues, regardless of its merits,
21 would not even be considered. It must be emphasized that receiving reports into evidence only
22 means that they will be considered. They may not be relied on unless they constitute substantial
23 evidence and are the most persuasive indication of the injured worker's condition.

24 Section 5703(a) states that "[t]he appeals board may receive as evidence... [r]eports of
25 attending or examining physicians," and provides authority to admit the reports of non-MPN
26 treating physicians. In situations which do not rise to the level of neglect or refusal to provide
27 reasonable medical treatment, but where an injured worker has nevertheless appropriately sought

1 care outside an MPN, the reports of the non-MPN treating physician should be admitted into
2 evidence under section 5703(a) for consideration of any issue in dispute.

3
4 /s/ Frank M. Brass
FRANK M. BRASS, Commissioner

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6 **DATED AND FILED AT SAN FRANCISCO, CALIFORNIA**

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8 **SERVICE MADE BY MAIL ON ABOVE DATE ON THE PERSONS LISTED BELOW AT**
9 **THEIR ADDRESSES AS SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD:**

10 **ELAYNE VALDEZ**
11 **LAW OFFICES OF JEFFREY N. SARDELL**
12 **LAW OFFICES OF JOHN MENDOZA**

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14 **VB/bgr**

15
16 **CONCURRING AND DISSENTING OPINION OF**
COMMISSIONER CAPLANE

17 I concur with the majority that a defendant is not liable for the cost of medical reports
18 obtained by an applicant outside of a validly established and properly noticed MPN, and that such
19 reports are inadmissible under Labor Code section 4616.6 to resolve any dispute related to
20 treatment and diagnosis. However, I dissent from the holding that these reports are inadmissible as
21 to issues of compensation, i.e., temporary disability and permanent disability.

22 Section 4616.6 states:

23 “No additional examinations shall be ordered by the appeals board and no
24 other reports shall be admissible to resolve *any controversy arising out of*
25 *this article.*” (emphasis added.)

26 *This article* is 2.3, “Medical Provider Networks” (MPNs), and is comprised of sections
27 4616-4616.7. These sections deal *exclusively* with diagnosis and treatment, and thus, section
4616.6 precludes admissibility of reports obtained outside an MPN *only* on those issues. Here,

1 however, the non-MPN medical reports were not admitted and relied on to resolve a dispute over
2 diagnosis and treatment, but one of compensation, i.e., temporary disability, about which the MPN
3 statutes are silent. Statutes governing temporary and permanent disability are contained in
4 Article 3, sections 4650-4664 and are outside the scope of the MPN statutes under Article 2.3.

5 The majority's opinion also fails to give effect to sections 4605 and 5703(a). These
6 sections were not repealed when the MPN statutes were enacted. It is a fundamental rule of
7 statutory construction that the Legislature is presumed to be aware of existing law.

8 Section 4605 states that "[n]othing contained in this chapter shall limit the right of the
9 employee to provide, at his own expense, a consulting or any attending physicians whom he
10 desires." Thus, injured workers have the right to seek medical care outside a validly established
11 and properly noticed MPN if they pay for that care. However, by excluding the reports of non-
12 MPN doctors from evidence, the majority penalizes an applicant for exercising that right by
13 effectively precluding him or her from receiving any benefits under the workers' compensation
14 system.

15 The issue of entitlement to temporary and/or permanent disability indemnity is usually
16 triggered by a medical report from the applicant's treating doctor. Upon receipt of that report, a
17 defendant can either pay the benefits in question, or object and follow the procedures set forth in
18 sections 4061 and 4062 to resolve the dispute. Under the majority's holding that reports of non-
19 MPN physicians are not admissible for any purpose, a defendant when served with such reports
20 can simply do nothing. Without an admissible medical report, the applicant has been deprived of
21 the opportunity to even present a claim for temporary or permanent disability indemnity, and has
22 essentially been removed from the workers' compensation system. This is an unduly harsh result
23 for exercising the right to seek treatment under section 4605, and certainly one not intended by the
24 legislature. Moreover, an injured worker, who has exercised the right to seek treatment with a non-
25 MPN doctor under section 4605, is already liable for both the cost of treatment and any non-MPN
26 reports, and admitting such reports into evidence merely means they will be considered and not
27 that they will necessarily be relied on to award compensation. Under the majority's disposition, an

1 applicant would have to return to the MPN before he or she is eligible to receive compensation,
2 which may needlessly delay the resolution of a case and the provision of benefits to injured
3 workers.

4 Section 5703(a) provides that “[t]he appeals board may receive as evidence... [r]eports of
5 attending or examining physicians.” As acknowledged by the majority, there is discretion under
6 section 5703(a) which, like section 4605, refers to “attending” physicians, to admit into evidence
7 the reports of non-MPN physicians on issues of compensation. The majority’s opinion, however,
8 takes away the discretion of the WCJ under this section to admit the reports of non-MPN treating
9 physicians on these issues in *all* cases where there is a validly established and properly noticed
10 MPN.

11 The majority has relied in part on *Tenet/Centinela Hospital Medical Center v. Workers’*
12 *Comp. Appeals Bd. (Rushing)* (2000) 80 Cal.App.4th 1041 [65 Cal.Comp.Cases 477] for its
13 disposition here. *Rushing*, however, pre-dates the MPN statutes which were enacted under Senate
14 Bill 899, and does not involve an applicant exercising the right to seek treatment under
15 section 4605.

16 While I do not condone the actions of an applicant’s attorney directing a client to treat with
17 a non-MPN physician when a validly established and properly noticed MPN exists, an applicant
18 nevertheless has the right to do so under section 4605 and should not be penalized for exercising
19 that right. Moreover, in light of the specific restriction on admissibility to issues of diagnosis and
20 treatment by section 4616.6, the discretion provided by section 5703(a) can be utilized to admit
21 non-MPN reports on issues of compensation.

22 The issue here is only the admissibility of the non-MPN doctor’s reports. Once admitted,
23 the WCJ must decide if the reports constitute substantial evidence and the weight to assign to
24 them.

25 Where there is a validly established and properly noticed MPN, Article 2.3 gives MPN
26 doctors exclusive control over issues of diagnosis and treatment. To extend that control to issues
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1 of compensation goes beyond the MPN statutory mandate and gives no effect to sections 4605 and
2 5703(a).

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14 Accordingly, I dissent and would affirm the WCJ's decision insofar as he properly
15 exercised his discretion under section 5703 to admit the reports of the applicant's non-MPN
16 treating physician on the issue of temporary disability. I would, however, return this matter to the
17 trial level for the newly assigned WCJ to address the defendant's contention that these reports do
18 not constitute substantial evidence. If so, the parties should then proceed under sections 4062(a)
19 and 4062.2 to select either an agreed medical evaluator (AME) or a qualified medical evaluator
20 (QME).

21
22 /s/ Ronnie G. Caplane _____

23 **RONNIE G. CAPLANE, Commissioner**

24 **DATED AND FILED AT SAN FRANCISCO, CALIFORNIA**

25 **4/20/2011**

26 **SERVICE MADE BY MAIL ON ABOVE DATE ON THE PERSONS LISTED BELOW AT**
27 **THEIR ADDRESSES AS SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD:**

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ELAYNE VALDEZ
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Return to the : Knight v. United Parcel Service

Knight v. United Parcel Service (71 CCC 1423 (2006)) - 10/12/2006

Note: Employer or insurer's failure to provide required notice to an employee of rights under the MPN that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee.

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

Case Nos. AHM 127807 AHM 129147

BRUCE KNIGHT,

Applicant,

vs.

UNITED PARCEL SERVICE; and LIBERTY MUTUAL INSURANCE COMPANY,

Defendants.

OPINION AND DECISION AFTER RECONSIDERATION (EN BANC)

INTRODUCTION

We granted defendant's petition for reconsideration of the December 9, 2005 Findings and Award of the workers' compensation administrative law judge (WCJ) to further study issues raised by this case regarding a medical provider network (MPN) established by an employer or insurer to provide medical treatment pursuant to Labor Code sections 4616 through 4616.7. [fn1] Because of the importance of the legal issues presented, and in order to secure uniformity of decision in the future, the Chairman of the Appeals Board, upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en banc decision. (Lab. Code, § 115.) [fn2]

We hold that an employer or insurer's failure to provide required notice to an employee of rights under the MPN that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee. In this case, defendant is liable for medical treatment self-procured by applicant because it neglected or refused to provide reasonable medical treatment by failing to provide required notice to applicant of his rights under the MPN. (See Section III at pp. 14-16, *infra*.)

FACTS

In 1973, applicant was first employed as a delivery person/driver with United Parcel Service (UPS), insured by Liberty Mutual Insurance Company (Liberty). On February 22, 2005, he was delivering a parcel in inclement weather when he slipped on a wet driveway and fell on his right side, injuring his right wrist, arm and shoulder. Industrial injury was acknowledged and he was referred by UPS to a U.S. HealthWorks clinic for examination and treatment. X-rays were taken and medication was dispensed. He was released to light duty for two days and was then returned to full duty. However, his elbow and shoulder symptoms worsened and he returned to U.S. HealthWorks. U.S. HealthWorks referred him to Anthony Zoppi, M.D. for a consultation. [fn3]

In his April 26, 2005 report to Liberty, Dr. Zoppi provided a summary of his "examination, findings, diagnosis and treatment recommendations" following his "initial orthopedic evaluation" conducted that date "at the request of the treating physician" as authorized by Liberty. During his examination, Dr. Zoppi noted tenderness and restricted range of motion in the wrist, tenderness in the right elbow, and tenderness and "pain with impingement maneuver both Neer and Hawkins" in the right shoulder. He provided a diagnosis

of "Right shoulder pain/strain" and "Right wrist scaphoid nonunion, old nonindustrial injury" and described his "consultation with the patient in which the diagnosis was explained in laymen's terms." He noted a need to "see the patient back following the completion of x-rays" of the shoulder to evaluate the potential for "underlying acromioclavicular joint degenerative joint disease" but concluded that applicant "can continue with his usual and customary work activities without the need for work restrictions." He wrote that "Treatment recommendations were discussed and/or communicated with the patient's treating physician."

It appears that copies of Dr. Zoppi's report were sent to "Treating Physician" and "U.S.HealthWorks Medical Group." However, there is no evidence that the report was ever sent to applicant. Nor is there any evidence that either U.S. HealthWorks or Dr. Zoppi was part of an MPN, or that applicant was being provided medical treatment through an MPN. There is no evidence that applicant was notified that an MPN physician had been designated as his primary treating physician. There is no evidence applicant was notified of his right to choose his primary treating physician within the MPN after the first visit. Nor is there evidence of any notice to him of his right to obtain second and third opinions regarding any MPN diagnosis or treatment plan.

Prior to attending his appointment with Dr. Zoppi, applicant had contacted an attorney regarding his claim. In an April 22, 2005 letter, the attorney advised Liberty that applicant was designating the Intercommunity Medical Group (Robert Hunt, M.D.) as his primary treating physician. It appears that at some point Dr. Hunt contacted Liberty to confirm insurance coverage, but was told he would not be paid for any services he provided because he was not in Liberty's MPN. [fn4]

On May 11, 2005, Dr. Hunt contacted applicant's attorney and advised that he would not treat applicant unless Liberty changed its position and authorized coverage. This is the first evidence of any indication to applicant or his attorney that there was an MPN. That same date, the attorney contacted Liberty by telephone and requested a list of MPN providers.

On May 13, 2005, Liberty telephoned the attorney's office and offered to "go over [the MPN list] on the phone" or to send it by e-mail because it was "about 1,980 pages."

On May 16, 2005, Liberty was informed that the attorney did not have an e-mail address and his staff again asked that the list be sent by regular mail. Liberty responded that the list of MPN providers needed to be requested from the "California Division of Compensation."

On May 19, 2005, the attorney's staff sent a written request for the MPN list to the address provided by Liberty. A woman named Kathy "from California Division of Compensation" telephoned the attorney's staff on May 24, 2005, and told them to contact Liberty for the list of MPN providers. She also provided a telephone number for Liberty.

On May 25, 2005, the attorney's staff left a telephone message requesting a list of MPN providers at the telephone number provided by Kathy. Another message requesting a list of the MPN providers was left by the attorney on May 31, 2005.

On June 1, 2005, the attorney received a return telephone message that Liberty's adjuster was out on medical leave. The attorney that same date sent another written request for the list of MPN providers and left a voice message with another person at Liberty requesting the list. On June 6, 2005, applicant's attorney's staff again directed verbal and written request by facsimile to Chuck Allen at Liberty as follows:

"Please be advised we have requested a copy of the Medical Provider Network List (MPN) from the following, claims adjuster Mr. Frank Quesada on 5/11/05, who advised us we needed to request list from California Division of Compensation. Request was made on 5/19/05, Kathy advised our office to request it from Ann Taintor. Request once again was made on 6/1/05, per Ms. Taintor we now have to obtain it from you. *Due to this delay our client is without medical care.*

"Request is hereby made we be provided with copy of Medical Provider Network List (MPN) as soon as possible." (Emphasis added.)

Not having received a list of MPN providers, the attorney on June 9, 2005, faxed a letter to Mr. Quesada at Liberty advising that "Pursuant to Labor Code, sections 4600 and 4603.3 (sic) and Section 9783 Of the Rules and Regulations" applicant was selecting his treating physician to be Norwalk Orthopedic Surgery (Jacob Rabinovich, M.D.). [fn5] Enclosed with that letter was a copy of the attorney's letter to applicant confirming that an appointment was scheduled with Dr. Rabinovich for June 16, 2005.

On June 14, 2005, Dana Preivity, a senior claims case manager with Liberty, sent a letter to applicant as follows:

"Recent changes in California workers' compensation law, specifically SB 899, now allow insurers and self-

insured employers to direct injured employees to a medical provider network (MPN) for medical treatment. In response to these changes, your employer has implemented the Liberty Mutual UPS Medical Provider Network (MPN) effective, January 1, 2005, for any workers' compensation claims.

"This letter is acknowledgement that you have a workers' compensation injury or illness claim at implementation time of the Liberty Mutual UPS MPN. Our records indicate that your current treating provider, Dr. Robert Hunt is not part of the MPN.

"In order to confirm you continue to receive appropriate medical care please take a few moments to verify the information that best applies to your current treating physician by checking the appropriate box below and returning your response within 10 days...

"_ My current physician is part of the Liberty Mutual UPS MPN. You may continue to treat with this provider. If you need further treatment from another specialist, you and your physician must select a specialist from within the MPN. Contact your employer or the Claims Case Manager if you need assistance in locating an MPN specialist.

"_ My current physician is not part of the Liberty Mutual UPS MPN. You may qualify to continue treatment with your current provider under the Liberty Mutual UPS MPN Transfer of Treatment (TOC) Plan if your condition is acute, serious or chronic, if treatment is for remission, is to prevent deterioration, is a terminal illness or for a scheduled surgery or procedure that will occur within 180 days.

"_ My current physician is not part of the Liberty Mutual UPS MPN network. I do not have any of the conditions above; therefore, I will secure services from another MPN physician. If I need assistance in locating another physician, I will call my employer or Claims Case Manager.

"You must receive confirmation from the MPN to continue using a non-MPN provider. The MPN will contact your non-MPN physician to confirm his/her willingness to continue providing you with treatment under the MPN and the MPN will notify you as to your physician's decision. In the event the physician is not able to continue providing you with medical treatment and services the MPN will advise you to seek treatment from an MPN physician immediately." (Emphasis in original.)

The letter concluded with a request that any questions be directed to the employer or the Claims Case Manager. A copy of the letter was sent to applicant's attorney.

The June 14, 2005 letter from Dana Preivity is the first evidence of any written notice from Liberty to applicant or his attorney that refers to the existence of an MPN. However, the letter did not explain where and how applicant was to obtain medical treatment. The letter does not state whether treatment was initiated in the MPN by the employer's referral of applicant to U.S. HealthWorks or by its referral of applicant to Dr. Zoppi. It does not identify any MPN physician that had been designated as the primary treating physician. It does not notify applicant of his right to change the primary treating physician and choose a new primary treating physician within the MPN. It does not notify him of his right to obtain second and third medical opinions within the MPN or of his right to obtain review by an independent evaluator. It does not transmit a list of MPN physicians notwithstanding the numerous requests for the list by applicant's attorney.

On a July 7, 2005, applicant's attorney wrote Frank Quesada at Liberty:

"Please be advised that we are referring our client for medical treatment pursuant to Labor Code section 4600. Our client reported the injury but referral for medical treatment by the employer has been refused and/or neglected.

"Be advised we shall seek penalties for each instance of refusal to authorize or any unreasonable delay in authorizing all medical treatment as indicated by our doctors(s)."

Applicant was seen again by Dr. Rabinovich on July 28, 2005. Following an MRI and EMG and nerve conduction studies, Dr. Rabinovich in his report of July 28, 2005 diagnosed, "1) Tendinitis/impingement syndrome, right shoulder per MRI scan. 2) Bilateral carpal tunnel syndrome, per neurodiagnostic tests. 3) Bilateral ulnar nerve entrapment at the cubital fossae, clinically on the left and per neurodiagnostic tests on the right." Surgery was recommended.

On August 31, 2005, Dana Preivity on behalf of Liberty sent a letter to applicant, with a copy to his attorney, as follows:

"This letter concerns the Liberty Mutual UPS Medical Provider Network (MPN). It is our understanding that Robert W. Hunt, MD (Intercommunity Medical Group) and Jacob Rabinovich (Norwalk Orthopedic Surgery) are not participating in the Liberty Mutual MPN.

"As you were aware the MPN was in place and decided to change to a NON UPS MPN physician, we are considering any and all treatment with these doctors self-procured. Therefore, you will be responsible for all medical treatment and service charges.

"It is also important to note that if you elect to continue treating with either of these doctors, you will be responsible for all medical treatment and service charges.

"Please direct any questions regarding this letter to your attorney. Thank you."

Also on August 31, 2005, Dana Previty on behalf of Liberty sent the following letter to both Dr. Hunt and Dr. Rabinovich:

"This letter concerns the Liberty Mutual UPS Medical Provider Network (MPN). It is our understanding that you are not participating in the Liberty Mutual UPS MPN.

"As Mr. Knight was aware the MPN was in place and elected to treat with you anyway, we are considering any and all treatment with you self-procured. Therefore, Mr. Knight will be responsible for all medical treatment and service charges.

"Also be advised that if Mr. Knight elects to continue treatment with you, he will be responsible for all medical treatment and service charges."

The physicians were requested to contact Liberty with any questions.

Also on August 31, 2005, Liberty wrote applicant's attorney:

"This letter concerns the Liberty Mutual UPS Medical Provider Network (MPN).

"I received your letter requesting a copy of the UPS MPN list. The file is very large, therefore I would like to email it to you. I spoke with Irene in your office today and she advised you would be out of the office until September 14, 2005. She was unable to give me your email address. Therefore I have enclosed a copy of all UPS MPN ortho's (sic) as of July 11, 2005.

"Please contact me with you email address so that I may supply you with a copy of the UPS MPN list, should you desire a copy."

Any list of providers enclosed with that letter or otherwise sent by Liberty to applicant or his attorney is not in evidence.

In none of the correspondence described above did Liberty explain where or how applicant was to obtain medical treatment. He was never notified that treatment had or had not been initiated in the MPN. He was never notified that an MPN physician had or had not been designated as primary treating physician. He was never notified of his right to change any designated primary treating physician and his right to select a new primary treating physician of his choice within the MPN. He was never notified of his right to obtain second and third medical opinions within the MPN or of his right to obtain review by an independent evaluator. Instead, Liberty wrote only that the medical treatment he sought was unauthorized, without tendering any information about how he was to obtain treatment for the admitted injury.

On October 7, 2005, applicant filed a Declaration of Readiness to Proceed to Expedited Hearing on the issues of his entitlement to reasonable medical treatment and temporary disability indemnity. Defendant admitted specific injury to applicant's right shoulder, right elbow, right wrist and right upper extremity, and admitted a need for medical treatment. However, defendant denied liability for all treatment self-procured by applicant outside the MPN.

At the hearing on November 29, 2005, the above described materials were received into evidence along with applicant's testimony that he never received "any notice of his requirement to belong to an M.P.N. prior to his injury or after his injury." [fn6] On December 9, 2005, the WCJ issued his decision, finding that defendant had waived its right to require medical treatment through the MPN, and that it was estopped to deny coverage of medical treatment self-procured by applicant. [fn7] Applicant was awarded "surgery as recommended by Dr. Rabinovich."

Defendant petitioned for reconsideration of the WCJ's findings and award, contending that "all appropriate notices were sent to the applicant with regard to the Medical Provider Network" and requested that he be directed "to obtain treatment with a doctor on the Medical Provider Network list."

We find on this record that defendant is liable for medical treatment self-procured by applicant because it

neglected or refused to provide reasonable medical treatment by failing to provide required notice to applicant of his rights under the MPN.

DISCUSSION

I. An Authorized MPN May Be Used To Satisfy The Obligation Of An Employer Or Insurer To Provide Reasonable Medical Treatment.

An employer or its insurer is obligated to provide all medical treatment "that is reasonably required to cure or relieve the injured worker from the effects of his or her injury." (Lab. Code, § 4600(a).) "In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment." (Lab. Code, § 4600(a).) An employer will not be relieved of the duty to furnish medical care absent good cause, and section 4600 has been liberally interpreted in favor of the employee's right to obtain reimbursement. (California Union Ins. Co. v. Industrial Acc. Com. (Mitchell) (1960) 183 Cal.App.2d 644 [25 Cal.Comp.Cases 172]; Simien v. Industrial Acc. Com. (1956) 138 Cal.App.2d 397 [21 Cal.Comp.Cases 10].)

Before January 1, 1976, an employee could not choose a physician to treat an industrial injury if the employer made an unequivocal tender of medical treatment reasonably calculated to cure or relieve from the effects of the injury. However, if the employer had notice of the injury, it was obligated under section 4600 to promptly notify the employee about how and where to obtain medical treatment. The employer could not be passive; instead it had an affirmative duty to be active in offering treatment to the injured worker and in instructing the employee as to which physician to see. (United States Casualty Co. v. Industrial Acc. Com. (Moynahan) (1954) 122 Cal.App.2d 427 [19 Cal.Comp.Cases 8]; Draney v. Industrial Acc. Com. (1949) 95 Cal.App.2d 64 [14 Cal.Comp.Cases 256] (Draney).) The failure to provide that required notice of information was recognized to be neglect or refusal to provide reasonable medical treatment even if the employee did not ask for medical attention before self-procuring care. (Leadbetter v. Industrial Acc. Com. (1918) 179 Cal. 468 [5 I.A.C. 233]; Bethlehem Steel Co. v. Industrial Acc. Com. (Seaquist) (1945) 70 Cal.App.2d 382 [10 Cal.Comp.Cases 171].) If the employer made an equivocal and inadequate offer of medical treatment, the employee could select his or her own physician and obtain reimbursement for the reasonable cost of reasonable self-procured medical treatment pursuant to section 4600. (Voss v. Workers' Comp. Appeals Bd. (1974) 10 Cal.3d 583, 588 [39 Cal.Comp.Cases 56] (Voss); Zeeb v. Workers' Comp. Appeals Bd. (1967) 67 Cal.2d 496, 501-503 [32 Cal.Comp.Cases 441] (Zeeb); McCoy v. Industrial Acc. Com. (1966) 64 Cal.2d 82, 86 [31 Cal.Comp.Cases 93] (McCoy).)

Effective January 1, 1976, section 4600 was amended to provide that "after 30 days from the date the injury is reported, the employee may be treated by a physician of his own choice or at a facility of his own choice within a reasonable geographic area." (Lab. Code, § 4600(c).) In addition, an employee was allowed under certain circumstances to select his or her personal physician to provide treatment during the 30 day period following injury. (Lab. Code, § 4600(d).) An employee also had an essentially unlimited ability to change treating physicians. (Ralphs Grocery Company v. Workers' Comp. Appeals Bd. (Lara) (1995) 38 Cal.App.4th 820 [60 Cal.Comp.Cases 840] (Lara).) Thus, the employee had the choice to select any treating physician, limited only by the employer's right to show good cause in a petition to the Administrative Director (AD) of the Division of Workers' Compensation that an order should issue directing the employee to select a new treating physician from a list of five selected by the employer. (Lab. Code, § 4603; Cal. Code Regs., tit. 8, § 9786.)

With the enactment of Senate Bill 899, section 4600(c) was again amended. It now provides: "Unless the employer or the employer's insurer has established a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area." This amendment added another method by which an employer or insurer could meet its obligation to provide reasonable medical treatment by referring the employee to an MPN. (Lab. Code, § § 4600(c) and 4616-4616.7; see also Cal. Code Regs., tit. 8, § § 9767.1-9767.15.)

An MPN is established by an employer or insurer subject to the approval of the AD. (Lab. Code, § 4616; Cal. Code Regs., tit. 8, § 9767.3.) Among other things, the regulations require that the employer or insurer's application for approval of an MPN include a statement of how the MPN will comply with the "employee notification process" and the "second and third opinion process." (Cal. Code Regs., tit. 8, § § 9762.1 through 9762.3.) The statute and regulations also impose several other obligations upon both the insurer/employer and the injured worker.

In this case, we specifically address the provisions of section 4616.3 and California Code of Regulations, title 8, section 9767.12(a). Section 4616.3 provides in full:

"(a) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall arrange an initial medical evaluation and begin

treatment as required by Section 4600.

"(b) *The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from the medical provider network established pursuant to this article, and the method by which the list of participating providers may be accessed by the employee.*"

"(c) *If an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network.*"

(Emphasis added.)

California Code of Regulations, title 8, section 9767.12(a) provides in full:

"An employer or insurer that offers a Medical Provider Network Plan under this article shall notify each covered employee in writing about the use of the Medical Provider Network 30 days prior to the implementation of an approved MPN, at the time of hire, or when an existing employee transfers into the MPN, whichever is appropriate to ensure that the employee has received the initial notification. The notification shall also be sent to a covered employee at the time of injury. The notification(s) shall be written in English and Spanish. The initial written notification shall include the following information:

(1) *How to contact the person designated by the employer or insurer to be the MPN contact for covered employees. The employer or insurer shall provide a toll free telephone number of the MPN geographical service area includes more than one area code;*

(2) *A description of MPN services;*

(3) *How to review, receive or access the MPN provider directory. Nothing precludes an employer or insurer from initially providing covered employees with a regional area listing of MPN providers in addition to maintaining and making available its complete provider listing in writing. If the provider directory is also accessible on a website, the URL address shall be listed;*

(4) *How to access initial care and subsequent care, and what the access standards are under section 9767.5;*

(5) *How to access treatment if (A) the employee is authorized by the employer to temporarily work or travel for work outside the MPN's geographical service area; (B) a former employee whose employer has ongoing workers' compensation obligations permanently resides outside the MPN geographical service area; and (C) an injured employee decides to temporarily reside outside the MPN geographical service area during recovery;*

(6) *How to choose a physician within the MPN;*

(7) *What to do if a covered employee has trouble getting an appointment with a provider within the MPN;*

(8) *How to change a physician within the MPN;*

(9) *How to obtain a referral to a specialist within the MPN or outside the MPN, if needed;*

(10) *How to use the second and third opinion process;*

(11) *How to request and receive an independent medical review;*

(12) *A description of the standards for transfer of ongoing care into the MPN and a notification that a copy of the policy shall be provided to an employee upon request; and*

(13) *A description of the continuity of care policy and a notification that a copy of the policy shall be provided to an employee upon request."*

(Emphasis added.)

Therefore, as relevant here, the employer is required to give the injured employee notice of information about use of the MPN, notice of the right to be treated by an MPN physician of choice after the first visit, notice of the method of accessing the list of MPN providers, and notice of the employee's right to use the second and third opinion process if he or she disputes either the diagnosis or the treatment prescribed by the MPN treating physician. [fn8]

II. Failure To Provide Required Notice To An Employee Of Rights Under The MPN That Results In A Neglect Or Refusal To Provide Reasonable Medical Treatment Renders The Employer Or Insurer Liable For Reasonable Medical Treatment Self-Procured By The Employee.

Employers have long been obligated to provide notice of workers' compensation information to their employees as part of the obligation to provide reasonable medical treatment under section 4600. The duty to provide notice of workers' compensation information begins before the report of an injury. An employer is required to provide new employees with written notice of information about the workers' compensation process and about where and how to obtain medical treatment at the time of hire or before the end of the first pay period. (Lab. Code, § 3551; Cal. Code Regs., tit. 8, § 9880.) The employer is also obligated to post conspicuous notice in the workplace of information about the workers' compensation process and where and how to obtain medical treatment. (Lab. Code, § 3550; Cal. Code Regs., tit. 8, §§ 9881 and 9881.1.) The failure to properly post such notice "shall automatically permit the employee to be treated by his or her personal physician with respect to an injury occurring during that failure." (Lab. Code, § 3550 (e).)

Additional notice obligations are triggered at the time of an industrial injury. Within one working day of receiving notice of injury, the employer must provide the employee with a claim form, information about benefits available to the employee and the workers' compensation process. (Lab. Code, §§ 5401 through 5402; Cal. Code Regs., tit. 8, §§ 9810 through 9812; see also Lab. Code, §§ 138.3 and 138.4.) The failure to properly provide such notice may toll the statute of limitations. (*Reynolds v. Workers' Comp. Appeals Bd.* (1974) 12 Cal.3d 726 [39 Cal.Comp.Cases 768]; *Buena Ventura Gardens v. Workers' Comp. Appeals Bd.* (Novak) (1975) 49 Cal.App.3d 410 [40 Cal.Comp.Cases 434].)

In the context of the provision of medical treatment, failure to provide other required notices may be a neglect or refusal to provide medical treatment that renders the employer or insurer liable for self-procured medical treatment. For example, failure to provide an injured worker with adequate notice that a designated alternative physician is the primary treating physician pursuant to section 4601 has been held to be such a neglect or refusal because the employee is not properly informed of where and how to obtain medical treatment. (*Pinkerton, Inc. v. Workers' Comp. Appeals Bd.* (Samuel) (2001) 89 Cal.App.4th 1019 [66 Cal.Comp.Cases 695]; *U.S. Flowers v. Workers' Comp. Appeals Bd.* (Carranza) (1997) 62 Cal.Comp.Cases 244 (writ denied).)

Neglect or refusal to provide medical treatment in other situations has been held to render the employer or insurer liable for the reasonable cost of reasonable medical treatment self-procured by the employee. (*Voss, supra*; *Zeeb, supra*; *McCoy, supra*; *Draney, supra*; *County of L. A. v. Industrial Acc. Com.* (Allen) (1936) 13 Cal.App.2d 69 [1 Cal.Comp.Cases 127]; see also *Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (Bolton) (1983) 34 Cal.3d 159 [48 Cal.Comp.Cases 566].)

We hold that an employer or insurer's failure to provide required notice to an employee of rights under the MPN that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee.

III. Defendant's Failure To Provide Applicant With Notice Of His Rights Under The MPN In This Case Resulted In A Neglect Or Refusal To Provide Reasonable Medical Treatment.

Defendant contends in its petition that applicant was required to use the MPN because he was provided "appropriate notice" of information. However, as discussed above, a significant part of an employer's obligation to provide reasonable medical treatment includes the responsibility to notify the injured worker about where and how to obtain that medical treatment.

The employee's right to change physicians within an MPN, and the right to be notified how to change physicians, is analogous to the right of an employee who is not being treated within an MPN to change physicians. (Lab. Code, § 4601; *Lara, supra*.) Moreover, the right of an employee to change physicians within an MPN - perhaps to a physician the employee trusts, or relates better to, or has better communication with, or in whom he or she has more confidence - is a crucial element of an employee's treatment rights under an MPN. The Supreme Court has stated that under section 4600, "a doctor-patient relationship which will inspire confidence in the patient is an ingredient aiding in the success of the treatment..." (*Zeeb, supra*, 67 Cal.2d 496, 502; *Voss, supra*, 10 Cal.3d 589.)

In regard to notice, the burden of proof rests on the party holding the affirmative of the issue. (Lab. Code, § 5705.) In the event of a dispute about whether the injured worker was provided notice of rights under an MPN, the employer carries the burden of proof. In this case, defendant not only failed to carry its burden of proving that it provided notice to applicant of his rights under the MPN, the evidence established that its failure to provide such notice was a neglect or refusal to provide reasonable medical treatment rendering it liable for applicant's self-procured treatment.

Applicant testified that he *never* received written notice about the MPN from defendant and there is no such written notice in evidence. This is contrary to the requirement that an employee be notified "in writing about the use" of the MPN prior to its implementation and at the time of injury. (Cal. Code Regs., tit. 8, § 9767.12(a).) Moreover, applicant was never notified if treatment had or had not been initiated in the MPN. He was never notified that an MPN physician had or had not been designated as primary treating physician. He was never provided notice of his right to be treated by an MPN physician of his choice after the first visit as required by section 4616.3(b). He was never notified of his right under section 4613(c) to dispute an MPN diagnosis and to obtain second and third opinions. The only evidence of notice regarding the "method" for accessing the list of MPN physicians as required by section 4613(b) are the uncertain and confusing references in the June 14, 2005 letter. Despite the June 6, 2005 letter from applicant's attorney notifying Liberty that applicant was without medical care, Liberty provided no guidance on how he was supposed to obtain medical treatment.

Information about how to access medical treatment, how to choose and change physicians, how to obtain independent medical review, and, thus, how to generally and specifically "use" the MPN, are all crucial to the provision of reasonable medical treatment. In this case, defendant failed to tender reasonable medical care through the MPN and failed to provide required notice to applicant of his rights under the MPN. Instead, defendant informed applicant, Dr. Hunt and Dr. Rabinovich that any medical treatment provided by those physicians would be deemed self-procured and applicant would be financially responsible for their charges.

In sum, the record in this case compels the conclusion that defendant neglected and refused to provide reasonable medical treatment by failing to provide applicant with required notice of his rights under the MPN. Because reasonable medical treatment was neglected or refused, applicant is entitled to self-procure reasonable treatment and defendant is liable under section 4600(a) for that treatment.

For the foregoing reasons,

IT IS ORDERED as the decision after reconsideration of the Appeals Board (en banc) that the December 9, 2005 Findings and Award is AFFIRMED.
WORKERS' COMPENSATION APPEALS BOARD (EN BANC)

/s/ Joseph M. Miller _____
JOSEPH M. MILLER, Chairman

/s/ Merle C. Rabine _____
MERLE C. RABINE, Commissioner

/s/ William K. O'Brien _____
WILLIAM K. O'BRIEN, Commissioner

/s/ James C. Cuneo _____
JAMES C. CUNEO, Commissioner

/s/ Janice J. Murray _____
JANICE JAMISON MURRAY, Commissioner

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

/s/ Ronnie G. Caplane _____
RONNIE G. CAPLANE, Commissioner

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA
10/10/2006

=====FOOTNOTES=====

1. All further statutory references are to the Labor Code. Attached to the petition for reconsideration are copies of documents that have already been received into evidence, or that have already been made part of the legal file. Such documents are not to be attached as exhibits to petitions for reconsideration, and they have been recycled. (Cal. Code Regs., tit.8, § 10842.)
2. The Appeals Board's en banc decisions are binding precedent on all Appeals Board panels and workers' compensation administrative law judges. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)* (2005) 126 Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236]; see also Govt. Code, § 11425.60(b).)
3. This opinion does not address the reasonableness of medical treatment provided during the first 30 days after the date of injury.
4. Portions of the chronology of contacts between applicant's attorney, the physicians and Liberty are taken from Applicant's Exhibit 7, which was received into evidence without objection. The exhibit purports to be the notes of applicant's attorney's staff regarding their effort to obtain a list of MPN physicians from defendant. Quotations are taken from that exhibit unless otherwise stated.
5. There was no section 4603.3 at that time.
6. Defendant offered no evidence of any notices to applicant other than as described above. Although Applicant testified that he did not receive the June 14, 2005 letter from defendant because of a change of address, it appears a copy was sent to applicant's attorney. In all events, the letter does not include information required by section 4613.3 and California Code of Regulations, title 8, section 9767.12(a).
7. Although both the WCJ's December 9, 2005 decision and defendant's petition for reconsideration reference Case No. AHM 129147, that case involves a denied claim of cumulative trauma injury to various body parts. It was agreed at trial that the only issues before the court were those presented in this Case No. AHM 127807 regarding the claim of specific injury. The parties stipulated that Case No. AHM 129147 "has no impact upon the issues presented." Accordingly, Case No. AHM 129147 is not addressed as part of this decision. Because we find that defendant neglected or refused to provide reasonable medical treatment, we do not reach the questions of waiver or estoppel.
8. Also see section 4616.4(b) regarding the second and third opinion process.

Return to the : Knight v. United Parcel Service

Print Case

**Return to the : SCIF vs. WCAB (Silva)****SCIF vs. WCAB (Silva) (71 Cal.App.3d 133, 42 CCC 493) - 06/27/77****Note: Change in right to medical control procedural, not substantive.**

[Civ. No. 40411. Court of Appeals of California, First Appellate District, Division One. June 27, 1977.]

STATE COMPENSATION INSURANCE FUND, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and EDWARD J. SILVA, Respondents

(Opinion by Sims, Acting P. J., with Elkington, J., and Lazarus, J., concurring.)

COUNSEL

James J. Vonk, George S. Bjornsen, Arthur Hershenson and Frank Evans for Petitioner.

Airola & Ringgold, Lowell A. Airola and Kathryn E. Ringgold for Respondents.

OPINION

SIMS, Acting P. J.

A writ of review was issued in this case, on the petition of the insurer, for the purpose of inquiring into and determining the lawfulness of an opinion and order after reconsideration of the Workers' Compensation Appeals Board, sitting en banc, three commissioners dissenting. The opinion affirmed and adopted as its decision after reconsideration, an order filed April 16, 1976, granting an employee-applicant, injured prior to January 1, 1976, the right to designate a physician under the provisions of section 4600 of the Labor Code, which [71 Cal.App.3d 135] became effective as of that date. fn. 1 The petitioner contends that the amendments to the statute affected substantive rights and cannot be retroactively applied to a prior injury, and that the construction given the amendments by the appeals board should not be allowed because it may disrupt existing compatible physician-client relationships. We reject these contentions; the amendments affect no substantive rights. The opinion and order of the appeals board must be affirmed.

The applicant, an employee of the Oakland Unified School District, was injured on January 22, 1975, in the course of his duties as a schoolteacher. In addition to receiving treatment for his physical injuries, the applicant consulted a psychiatrist for attendant emotional problems. Several months after the incident, when first notified of the psychiatric [71 Cal.App.3d 136] treatment, petitioner arranged for the applicant to be examined by another psychiatrist. Upon his recommendation that the applicant's treatment be changed, petitioner arranged for the employee to be treated by a psychiatrist it had chosen, and on July 3, 1975, petitioner informed the applicant that it would not pay for any further treatments by the psychiatrist he had been consulting. After receiving some treatment from the psychiatrist selected by petitioner, the applicant on January 5, 1976, petitioned the board to be allowed to continue treatment with his own physician. Before a hearing was held on that petition, the applicant on February 19, 1976, gave notice of his choice of physician. The insurer refused to recognize his right to do so, and on March 4, 1976, he filed his petition to confirm his right to designate his own physician pursuant to section 4600 and an administrative rule, rule 9783, adopted by the administrative director January 22, 1976. The order under review resulted.

It is established that "[s]ince the industrial injury is the basis for any compensation award, the law in force at the time of injury is to be taken as the measure of the injured person's right of recovery." (Aetna Cas. & Surety Co. v. Ind. Acc. Com. (Charlesworth) (1947) 30 Cal.2d 388, 392 [182 P.2d 159]. See also State of California v. Ind. Acc. Com. (Erickson) (1957) 48 Cal.2d 355, 361 [310 P.2d 1]; and Harrison v. Workmen's Comp. Appeals Bd. (1974) 44 Cal.App.3d 197, 202 [118 Cal.Rptr. 508].)

In Charlesworth, supra, the court reviewed a change in the law which modified a prior restriction on the award of both temporary and permanent disability payments. It added: "The 1945 amendment of section 4661 increased the amount of compensation above what was payable at the date of the injury, and to that extent it enlarged the employee's existing rights and the employer's corresponding obligations. The amendment is therefore clearly substantive in character, and the commission, by applying it in the present proceedings, gave it a retrospective operation." (30 Cal.2d at p. 392.) The decision continues: "The

authorities support the conclusion that a statute changing the measure or method of computing compensation for disability or death is given retrospective effect when applied to disability or death resulting from an injury sustained before the effective date of the statute. [Citations.] ... [¶] It is an established canon of interpretation that statutes are not to be given a retrospective operation unless it is clearly made to appear that such was the legislative intent. [Citations.]" (Id., at pp. 392-393. [71 Cal.App.3d 137] See also Mannheim v. Superior Court (1970) 3 Cal.3d 678, 686 [91 Cal.Rptr. 585, 478 P.2d 17]; DiGenova v. State Board of Education (1962) 57 Cal.2d 167, 172-173 [18 Cal.Rptr. 369, 367 P.2d 865]; State of California v. Ind. Acc. Com., supra, 48 Cal.2d 355, 361; Harrison v. Workmen's Comp. Appeals Bd., supra, 44 Cal.App.3d 197, 204; and Coast Bank v. Holmes (1971) 19 Cal.App.3d 581, 594 [97 Cal.Rptr. 30].)

Acknowledgedly the medical, surgical, chiropractic and hospital treatment to be provided by the employer or his insured are benefits under the act. In Union Iron Wks. v. Industrial Acc. Com. (1922) 190 Cal. 33 [210 P. 410], the court noted, after referring to disability payments paid in lieu of wages, "And to secure the speedy return of the workman to productive employment it is provided that medical and surgical services shall be furnished by the employer. This liability for medical and surgical services is not, therefore, a burden placed upon the employer as a penalty for any failure of duty on his part, but is merely a part of the whole compensation due the employee as the result of his injury. It therefore follows that the medical and surgical services contemplated and called for by the statute in question should be such as will tend to secure the return of the workman to productive employment." (190 Cal. at pp. 39-40. See also Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (1977) 19 Cal.3d 329, 332-333 [137 Cal.Rptr. 878, 562 P.2d 1037]; Zeeb v. Workmen's Comp. App. Bd. (1967) 67 Cal.2d 496, 500-501 [62 Cal.Rptr. 753, 432 P.2d 361]; and McCoy v. Industrial Acc. Com. (1966) 64 Cal.2d 82, 87 [48 Cal.Rptr. 858, 410 P.2d 362].) In McCoy the court referred to "the mandate of section 4600 according him [the employer] the right to control the employee's medical care"(64 Cal.2d at p. 89, italics added.) In Zeeb, the court explained the rationale for the control vested in the employer prior to January 1, 1976, as follows: "Obviously, it will ordinarily be in the interests of both the employer and the employee to secure adequate medical treatment so that the employee may recover from his injury and return to work as soon as possible. Permitting the employer to control the medical treatment permits the employer, who has the burden to provide the medical treatment, to minimize the danger of unnecessary and extravagant treatment, and in the light of the employer's interest in speedy recovery, the employer's control should rarely result in a denial of necessary treatment. Thus the two purposes underlying section 4600 of the Labor Code, effective treatment and minimization of expense, will ordinarily be served where the employer is permitted control of the medical treatment."(67 Cal.2d at p. 501.) [71 Cal.App.3d 138]

From the foregoing the insurer, and the dissenting minority of the appeals board, conclude, as stated by the latter: "It is abundantly clear that the Supreme Court has interpreted the right of medical control under Labor Code section 4600 prior to the 1975 amendment to be a substantive one." We disagree. In McCoy the court carefully distinguished between the medical benefits due from the employer to the employee and the manner in which they were to be furnished, as follows: "It is important to note at the outset that we are not here concerned with the scope of the employer's responsibility to furnish medical attention to an employee who suffers an industrial injury. The employer, whether providing the treatment himself or reimbursing the employee for self-procured care, is required by section 4600 to pay only the cost of such care as is reasonably required to cure or relieve. The aspect of the statute with which we deal is the extent of the employer's privilege to control the course of the injured employee's medical care."(64 Cal.2d at p. 86, italics added.) It also referred to the employer's "opportunity to render medical assistance." (Id., at p. 87, italics added.)

The rationale of Zeeb, which is quoted above, does not bear analysis. If there is unnecessary and extravagant treatment the employer or his insurer should not bear the cost of such treatment. As stated in McCoy and recognized in Zeeb, "And we emphasize also that, whether the treatment is administered by a doctor chosen by the employee or one selected by the employer, the latter is liable for no more than the reasonable cost of such treatment as is reasonably required to cure or relieve from the effects of the injury." (64 Cal.2d at p. 89, 67 Cal.2d at p. 502. See also Bell v. Samaritan Medical Clinic, Inc. (1976) 60 Cal.App.3d 486, 489-492 [hg. den.] [131 Cal.Rptr. 582].)

The Legislature has neither increased nor decreased the cost of the medical benefits due from the employer to the employee. It has rejected the rationale of Zeeb, and changed the procedure under which the benefits will be furnished. As a matter of policy it has recognized that the employee may secure a speedier and more efficient recovery under the care of a physician of his own selection in whom he has trust and confidence. We can no more assume that such a physician will furnish "unnecessary and extravagant treatment" than we can infer that a physician selected by the insurer will fail to furnish adequate treatment in an effort to cut down the insurer's costs.

In Charlesworth the contention was made that the change in benefits related solely to matters of procedure or remedy which were not subject [71 Cal.App.3d 139] to any proscription of retroactive application (30 Cal.2d at p. 393). The court pointed out the reason for the exception as follows: "[P]rocedural statutes may

become operative only when and if the procedure or remedy is invoked, and if the trial postdates the enactment, the statute operates in the future regardless of the time of occurrence of the events giving rise to the cause of action. [Citation.] In such cases the statutory changes are said to apply not because they constitute an exception to the general rule of statutory construction, but because they are not in fact retroactive. There is then no problem as to whether the Legislature intended the changes to operate retroactively." (Id., p. 394. See also *Safeway Stores, Inc. v. County of Alameda* (1975) 51 Cal.App.3d 783, 786-788 [124 Cal.Rptr. 503]; *Van Nuis v. Los Angeles Soap Co.* (1973) 36 Cal.App.3d 222, 228, fn. 2 [111 Cal.Rptr. 398]; *Jenkins v. Workmen's Comp. Appeals Bd.* (1973) 31 Cal.App.3d 259, 263-264 [107 Cal.Rptr. 130]; *Coast Bank v. Holmes*, supra, 19 Cal.App.3d 581, 593-595; and *McBarron v. Kimball* (1962) 210 Cal.App.2d 218, 220 [26 Cal.Rptr. 379].) The court rejected that analysis, stating: "As we have heretofore concluded, the amendment of section 4662 is substantive in its effect, and its operation would be retroactive, since it imposes a new or additional liability and substantially affects existing rights and obligations." (Id., at p. 395.)

In this case the change effected by the Legislature does not on its face impose a new or additional liability. Although it affects the privilege of the employer and his insurer to control the employee's medical care it does not do so retroactively. Care through December 31, 1975, was presumably furnished under the prior statute. The order can only affect the treatment of the employee by the selected physician after February 19, 1976, when notice was given as required by the new statute. There is no retroactive effect in applying the statute to medical treatment due from the employer after December 31, 1976. Moreover, it is clearly the legislative policy that one treated in 1976 and thereafter for an injury that occurred after January 1, 1976, should have the privilege of being treated by a physician of his choice after 30 days from the date the injury was reported. There is no reason why the same policy should be withheld and not apply to those who were injured previously. The statute is effective after 30 days from the date the injury was reported.

We reject the concept that such an application of the statute will destroy existing compatible physician-client relationships. There is no reason to infer that such consequences would necessarily ensue, or that if they do it will necessarily result in unnecessary or extravagant treatment [71 Cal.App.3d 140] which will increase the liability of the employer and his insurer. We would, therefore, also conclude that the Legislature impliedly intended that the statute should apply to all and any medical treatment the employer was obligated to furnish after January 1, 1976. (See *Mannheim v. Superior Court*, supra, 3 Cal.3d 678, 686-687; *Safeway Stores, Inc. v. County of Alameda*, supra, 51 Cal.App.3d 782, 788; *Harrison v. Workmen's Comp.*, supra, 44 Cal.App.3d 197, 204-206; *Van Nuis v. Los Angeles Soap Co.*, supra, 36 Cal.App.3d 222, 228-229; and *Coast Bank v. Holmes*, supra, 19 Cal.App.3d 581, 595.)

The opinion and order of the appeals board are affirmed.

Elkington, J., and Lazarus, J., concurred.

FOOTNOTES

-FN 1. By Statutes 1975, chapter 1259, section 1, the first paragraph of section 4600 was amended by the addition of the emphasized language: "Medical, surgical, chiropractic, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, which is reasonably required to cure or relieve from the effects of the injury shall be provided by the employer. In the case of his neglect or refusal seasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. After 30 days from the date the injury is reported, the employee may be treated by a physician of his own choice or at a facility of his own choice within a reasonable geographic area."

By section 2 of the same statute the provisions of former section 4601 were repealed, and by section 3 the provisions set forth below were enacted as a new section 4601. New provisions are emphasized; deleted relevant portions of the repealed section are included in brackets; the remaining provisions are found in both the old and new sections. "If the employee so requests, the employer shall tender him one change of physicians. Upon request of the employee for a change of physicians, [12 days shall be] the maximum amount of time permitted by law for the employer or insurance carrier [to nominate at least five additional practicing physicians or if requested by the employee, four physicians and one chiropractor competent to treat the particular case from among whom the employer may choose] to provide the employee an alternative physician or, if requested by the employee, a chiropractor, shall be five working days from the date of the request. The employee is [also] entitled, in any serious case, upon request, to the services of a consulting physician or chiropractor of his choice at the expense of the employer. [All of such] Such treatment shall be at the expense of the employer." (Other repealed provisions dealt with the failure to nominate and the manner in which those nominated should be approved by the medical director.)

Section 4 repealed former section 4603 which provided that the provisions relating to change of physicians were inapplicable where the employer maintained an approved hospital and hospital staff for his

employees. Section 5 added a new section 4603 reading, "If the employer desires a change of physicians or chiropractor, he may petition the administrative director who, upon a showing of good cause by the employer, may order the employer to provide a panel of five physicians, or if requested by the employee, four physicians and one chiropractor competent to treat the particular case, from which the employee must select one."

Sections 6 and 7 added section 4603.2 and 4603.5 to provide administrative details for the new provisions.

Return to the : SCIF vs. WCAB (Silva)

[Print Case](#)

36 Ways of Taking Medical Control – 2011

Prepared by The Law Offices of Hinden & Breslavsky

Some Common Factual Situations

Scenario 1: MEDICAL CARE NOT OFFERED OR PROVIDED BY THE EMPLOYER AFTER THE REPORT OF INJURY

Argument: a. Labor Code Section 4600 requires the employer to provide medical care needed to cure or relieve from the effects of an injury.
 b. Labor Code Section 4600 requires more than a passive willingness on the part of the employer to respond to a demand or request for medical aid. This section requires some degree of active effort to bring to the injured employee the necessary relief, (Braewood Convalescent Hospital v. WCAB (1983) 48 CCC 566).
 c. Regulation 9767.6 requires the employer/insurer to provide treatment within their MPN until the claim is rejected.

Conclusion: **TAKE MEDICAL CONTROL**. The employer had the right to control and the obligation to provide medical care. That right was lost as a result of the employer's failure to act. (Braewood).

NOTE: This conclusion applies whether or not an MPN has been established. Neglect or refusal to provide medical care creates employer liability for all reasonable medical expenses (Labor Code 4600(a)).

Author's Question: If the employer submits their MPN doctors' treatment recommendation to UR, which issues a denial, does that denial constitute a refusal to provide medical care per L.C. 4600?

Scenario 2: MPN ESTABLISHED AND MEDICAL CARE WAS OFFERED BY THE EMPLOYER BUT NOT PROVIDED WITHIN THE 3 WORKING DAY REQUIRED TIME

Argument: Regulation 9767.5(f). The employer shall schedule the injured worker to be seen within three working days. Labor Code 4600. In the case of neglect or refusal on the part of the employer to provide medical care, the employer is liable for the reasonable expense incurred by or on behalf of the injured worker in providing treatment.

Conclusion: **TAKE MEDICAL CONTROL**

Scenario 3: EMPLOYER/INSURANCE HAS NOT ESTABLISHED A MEDICAL PROVIDER NETWORK (MPN), MEDICAL CARE WAS PROVIDED BY THE EMPLOYER AND THE APPLICANT IS STILL UNDER THE EMPLOYER'S MEDICAL CARE

- Situation A. Within the first 30 days:
- a. Assert medical control by requesting change of physicians under Labor Code Section 4601. The employer has 5 working days to offer an alternate physician. **If employer does not timely respond, you have medical control!!**
 - b. Nominate a physician as the Primary Treating Physician.
- Situation B. More than 30 days since the injury:
- a. Assert medical control under Labor Code Sections 4600 and 4601 (5-day rule does not apply).
 - b. Nominate a physician as the Primary Treating Physician.

Scenario 4: EMPLOYER/INSURANCE HAS ESTABLISHED A MEDICAL PROVIDER NETWORK (MPN) L.C. 4616. MEDICAL CARE WAS PROVIDED BY THE EMPLOYER AND THE APPLICANT IS STILL UNDER THE EMPLOYER'S MEDICAL CARE (3 WORKING DAY RULE)

1. Employer is obligated to schedule a medical appointment within 3 working days of notice of industrial injury. Injured worker (IW) must attend appointment with the MPN physician (must see this physician at least one time). Regulation 9767.5(f).

Argument: If employer fails to advise the injured worker that he/she has the right to be treated by a physician of hi/her choice within the MPN, or fails to provide the injured worker with the list of participating providers, argue waiver and estoppel and take medical control. Reg. 9767.6(d).

Conclusion: If employer fails to follow the mandates of L.C. 4616.3(b) or Reg. 9767.5, TAKE MEDICAL CONTROL.

Scenario 5: MPN ESTABLISHED, IW DISPUTES FINDING OF MPN DOCTOR, IW REQUESTS 2ND/3RD OPINION WITHIN THE MPN

If employer follows the mandates of L.C. 4616.3 and the injured worker has obtained a 2nd and 3rd opinion within the network and a dispute over treatment or

diagnostic service still exists, the injured worker is entitled to an Independent Medical Review (IMR) L.C. 4616.4(b). IMRs are appointed by the Administrative Director

NOTE: Only the injured worker can request an IMR L.C. 4616.4(b).

NOTE: Both MPN, IMR and Treating Physicians must comply to ACOEM Guidelines or the MTUS when applicable.

NOTE:

1. The IMR is appointed by the AD.
2. The IMR must be either an M.D. or D.O.
3. The IMR cannot be in the employer's MPN.
4. The IMR conducts a physical examination at the employee's discretion.
5. The IMR may order diagnostic tests and submits a report. L.C. 4616.4(e).

NOTE: If the IMR finds the disputed treatment to be proper, the injured employee may seek the disputed treatment either within or outside the MPN. L.C. 4616.4(i).

NOTE: This author has not seen the IMR procedure used to date (This may change with Valdez).

Conclusion: If employer fails to follow the mandates of Reg. 9767.7 and L.C. 4616.4, **TAKE MEDICAL CONTROL**

Scenario 6: **NON MPN-MEDICAL CARE WAS PROVIDED BY THE EMPLOYER AND THE APPLICANT HAS BEEN RELEASED WITHOUT A RECOMMENDATION OF FURTHER MEDICAL CARE AND SERVED WITH THE MEDICAL REPORT BEFORE CHANGING THE PTP. REG. 9785(B)(3): TENET/CENTINELA HOSPITAL MEDICAL CENTER V. WCAC (RUSHING) 2000 (65 CCC477)**

Conclusion: Dispute the findings of the treating doctor and offer to go to an AME/PQME.

1. If no agreement on an Agreed Medical Examiner is received within the 10-20 day time frame, request a panel of Qualified Medical Evaluators from the AD pursuant to L.C. 4062.2. **DO NOT TAKE MEDICAL CONTROL**

NOTE: Without service of the report, **TAKE MEDICAL CONTROL**. (See Scenario 7)

Scenario 7: A NON MPN PHYSICIAN RELEASES THE INJURED WORKER WITHOUT A RECOMMENDATION OF FURTHER MEIDCAL CARE. IF THE REPORT WAS NOT SERVED ON THE INJURED WORKER OR APPLICANT'S ATTORNEY BEFORE CHANGING THE PTP

Conclusion: **TAKE MEDICAL CONTROL.** Defense is required to serve the report on the injured worker or applicant's attorney before a new PTP is chosen. If they fail to do so, they lose medical control, Pinkerton, Inc. v. WCAB (Samuel) 2001 (66 CCC695).

Scenario 8: NON MPN MEIDCAL CARE WAS PROVIDED BY THE EMPLOYER AND THE APPLICANT HAS BEEN RELEASED WITH A RECOMMENDATION OF FUTURE MEDICAL CARE

Conclusion: **TAKE MEDICAL CONTROL** (Reg. 9785(b)(2)(A) or (B))

NOTE: Regulation 9785 was amended June 2004 to allow a change of PTP. Whether the future medical care is ongoing/active or needed in the future.

Scenario 9: MPN MEDICAL CARE WAS PROVIDED UNTIL THE EMPLOYER DENIED THE CLAIM WHICH RESULTED IN THE TERMINATION OF TREATMENT. REG. 9767.6

Upon termination of treatment, the injured worker was P&S (MMI) with a recommendation of no further medical care and report was served on injured worker or his/her attorney.

Conclusion: CANNOT TAKE MEDICAL CONTROL per Regulation 9785(b)(3). Dispute the findings and do the AME/QME dance.

Scenario 10: UPON TERMINATION OF MPN TREATMENT, THE INJURED WORKER WAS P&S (MMI) WITH A RECOMMENDATION OF NO FURTHER MEDICAL CARE, BUT REPORT WAS NOT SERVED ON INJURED WORKER OR HIS/HER ATTORNEY

Conclusion: Per Valdez, IW must seek 2nd/34d opinion within the MPN. Reg. 9767.7. **CANNOT TAKE MEDICAL CONTROL.**

Exception: Defendant did not advise the IW he/she could change treaters within the MPN. TAKE MEDICAL CONTROL.

Scenario 11: UPON TERMINATION OF TREATMENT, THE MEDICAL STATUS OF THE INJURED WORKER IS UNKNOWN OR NOT ADDRESSED, DOCTOR STOPS TREATING WITHOUT EXPLANATION

Conclusion: **TAKE MEDICAL CONTROL OUTSIDE THE MPN.** Aruge Article 14, Section 4, California Constitution and Braewood Convalescent Hospital.

Scenario 12: UPON DENIAL OF THE CLAIM, THE DEFENDANT WITHDREW AUTHORIZATION TO TREAT

Conclusion: **TAKE MEDICAL CONTROL OUTSIDE THE MPN,** Braewood Convalescent Hospital.

Scenario 13: MPN MEDICAL CARE PROVIDED, THE IW EXHAUSTED HIS/HER CHANGE OF PHYSICIANS WITHIN THE MPN, IW REQUESTS AN IMR. IMR FINDS THAT THE DISPUTED TREATMENT OR DIAGNOSTIC TESTING IS PROPER

Conclusion: **TAKE MEDICAL CONTROL.** Injured worker has free choice to treat from within or outside the MPN, L.C. 4616.4(i)

Hint: Prior to going to an IMR, get a second opinion per L.C. 4601. (if a serious injury)

Scenario 14: MPN CARE PROVIDED. IW REQUESTS AN IMR. IMR FINDS THAT THE DISPUTED TREATMENT OR DIAGNOSTIC TEATING IS NOT NEEDED (NOT ACOEM COMPLIANT)

NOTE: Case law will have to establish whether the AME or panel QME can recommend the disputed medical treatment or only address the nature and extend of permanent disability.

Scenario 15: IW REQUESTS MORE THAN 3 TREATING PHYSICIANS WITHIN THE MPN

Conclusion: No restriction as to how many changes per L.C. 4616.3 (Not disputing, just changing treaters)

Scenario 16: MPN CARE WAS PROVIDED BUT RECOMMENDED TREATMENT, DIAGNOSTIC TESTING OR CONSULT WITH SPECIALIST NOT AVAILABLE WITHIN THE MPN

Conclusion: Injured worker could seek the treatment, testing or consult outside the MPN (L.C. 4616.3(d)(2)).

Scenario 17: EMPLOYER HAS ESTABLISHED AN MPN BUT PARTICIPATING PHYSICIANS ARE NOT GEOGRAPHICALLY CONVENIENT FOR THE INJURED WORKER

Argument: Reg. 9767.5(b): An MPN must have a PTP and a hospital for emergency health services 30 minutes or 15 miles of each covered employee residence or workplace.

Reg. 9767.5(c): Specialists within 60 minutes or 30 miles (Exception: rural areas) Reg. 9767.5(d).

Reg. 9767.5(g): Non-emergency specialist shall be available within 20 business days of the referral.

Conclusion: **TAKE MEDICAL CONTROL OUTSIDE THE MPN.**

Scenario 18: EMPLOYER HAS ESTABLISHED AN MPN BUT MEDICAL TREATMENT NOT PROVIDED IN A TIMELY MANNER, i.e. PHYSICAL THERAPY APPOINTMENTS ARE NOT AVAILABLE WITHOUT DELAYS

Conclusion: Change treating physicians within the MPN. If delays in treatment continue, **TAKE MEDICAL CONTROL.**

Scenario 19: EMPLOYER HAS ESTABLISHED MPN, THE MPN PTP REFERS IW TO A TYPE OF SPECIALIST NOT CONTAINED IN THE MPN

Conclusion: The IW may select a specialist outside the MPN. Reg. 9767.5(h)

Scenario 20: THE INJURED WORKER IS TREATING WITH HIS FREE CHOICE DOCTOR (EITHER PRE OR POST AWARD). THE EMPLOYER HAS NOT ESTABLISHED AN MPN AND NOTIFIED THE INJURED WORKER AND HIS PHYSICIAN TO DISCONTINUE TREATMENT AND TO CHOOSE A PHYSICIAN WITHIN THE MPN

Argument: Determine if the injury falls within one of the four exceptions of Regulation 9767.9(e). If the PTP agrees, object to the transfer in writing. The PTP also needs to notify the employer that he/she will continue to treat. PTP needs to support his/her determination.

IF DATE OF INJURY IS WITHIN FIRST 90 DAYS, THE INJURY IS ACUTE, BOTH ATTORNEY AND PTP NEED TO OBJECT.

NOTE: One of the exceptions is for “an acute condition” that requires prompt medical attention. Allows thirty (30) additional days of treatment.

Conclusion: **MAINTAIN MEDICAL CONTROL.**

Scenario 21: IF DATE OF INJURY IS BEYOND 90 DAYS (INCLUDES POST AWARDS)

Argument: Both attorney and PTP need to object.

NOTE: One of the exceptions is a “serious chronic condition”. A condition that persists more than 90 days without full cure. This could be due to a disease, illness, catastrophic injury or the medical problem or disorder and requires ongoing treatment. Allows completion of treatment for up to one year. Reg. 9767.9(e)(2).

Conclusion: **MAINTAIN MEDICAL CONTROL.**

Scenario 22: EMPLOYER HAS FAILED TO ADVISE THE WORKER THAT HE/SHE HAS THE RIGHT TO PREDESIGNATE A TREATING PHYSICIAN. L.C. 4600 & L.C. 3500

Conclusion: **TAKE MEDICAL CONTROL.**

NOTE: Employers are supposed to advise employees of their right to pre-designate annually.

NOTE: Right to pre-designate does not apply to all employees. L.C. 4600(d)(1)(A) or (B) and 4600(d)(2)(A), (B), (C).

Scenario 23: **EMPLOYER HAS FAILED TO POST THE REQUIRED NOTICES REQUIRED IN L.C. 3550**

Argument: L.C. 3550(b) “*failure to keep any notice required by this section conspicuously posted shall constitute a misdemeanor and shall be prima facie evidence of noninsurance.*”

Conclusion: **TAKE MEDICAL CONTROL.**

NOTE: Must be posted in a conspicuous place frequented by the employees.

NOTE: Many of our clients/patients work on job sites. They drive cars or trucks, paint houses, or trim trees; They are farm workers or roofers, etc. These workers rarely go to an office and are not exposed to the postings required under L.C. 3350 or 3351

Hint: Subpoena the personnel file. L.C. 3551. Notices are rarely present. If they are not in the personnel file, defense will have a hard time trying to prove that the employer complied with L.C. 3551.

Scenario 24: **EMPLOYER HAS FAILED TO PROVIDE A NEW EMPLOYEE IN WRITING WITH THE INFORMATION REQUIRED TO BE POSTED PER L.C. 3550 AND L.C. 3351**

Argument: This is a violation of L.C. 3551. Notice must include:
1. How to obtain medical care for a work injury;
2. The role and function of the PTP;
3. The form an employee may use to designate a personal physician or D.C.
4. As of 10-2010 the MPN information.

Conclusion: **TAKE MEDICAL CONTROL.**

NOTE: The notices must be in a language understood by the employee.

Scenario 25: MPN MEDICAL CARE PROVIDED TIMELY. THE EMPLOYER FAILED TO ADVISE THE INJURED WORKER THAT HE/SHE HAS THE RIGHT TO BE TREATED BY A PHYSICIAN OF HIS/HER CHOICE WITHIN THE MPN AFTER THE FIRST VISIT WITH THE MPN PHYSICIAN SELECTED BY THE EMPLOYER

Argument: Violates L.C. 4616.3(b) and Reg. 9767.6(d).

Conclusion: **TAKE MEDICAL CONTROL.**

Scenario 26: THE EMPLOYER FAILED TO ADVISE THE INJURED WORKER IN WRITING THAT HE/SHE CAN OBTAIN FREE INFORMATION FROM AN I&A OFFICER OR THAT THE INJURED WORKER HAS THE RIGHT TO BE REPRESENTED BY AN ATTORNEY

Argument: Violates L.C. 5401(b)(9)(B) & (C).

Conclusion: **TAKE MEDICAL CONTROL.**

Scenario 27: MPN MEDICAL CARE PROVIDED TIMELY, THE MEDICAL CARE AND/OR REPORTING IS NOT ACOEM COMPLIANT

Argument: 1. Violates L.C. 4616€ All medical treatment shall be provided in accordance with the ACOEM Guidelines or MTUS. See L.C. 5307.27.

NOTE: Some would argue that Valdez would require the IW to change doctors within the MPN.

2. If the doctor violates the requirement of ACOEM and/or MTUS and the insurance company does not require compliance, they waive their right to assert medical control. Argue Waiver and Estoppel; Failure to Enforce; Show a lack of due diligence on the part of the insurance company.

Conclusion: Need to notify the MPN doctor and insurance company in writing, demanding compliance with the MTUS or ACOEM. If no response, **TAKE MEDICAL CONTROL.**

Scenario 28: MPN CARE PROVIDED TIMELY, THE MPN PHYSICIAN FAILS TO IDENTIFY AND/OR ADDRESS ALL OF APPLICANT'S PHYSICAL COMPLAINTS IN VIOLATION OF THE MANDATES OF THE AMA GUIDES AND ACOEM

Argument: Request compliance.

Conclusion: If MPN physician fails to comply, **TAKE MEDICAL CONTROL** (see Scenario 27).

Scenario 29: MPN CARE PROVIDED TIMELY, THE MPN PHYSICIAN REFUSES TO SEND THE APPLICANT TO SECONDARY TREATERS IN OTHER SPECIALITIES AFTER IDENTIFYING COMPENSABLE CONSEQUENCE ISSUES

Conclusion: **TAKE MEDICAL CONTROL**.

AUTHOR'S OPINION: The common thread that runs through all these scenarios is the importance of medical care and control. In order to insure that the injured worker receives quality medical care, the applicant's attorneys must take a pro-active position. We must be the watchdogs, looking over the shoulder of the employers/insurance companies to make sure they satisfy the time lines mandated by the statutes. We must raise our voices in order to be heard, by utilizing quality physicians, scrutinizing the medical reports for accuracy, deposing the defense doctors, understanding ACOEM, the MTUS, and the AMA Guides and filing objections when appropriate regarding UR denials, transfer of medical care into the MPN and failure to provide timely and/or quality care.

- A. Need to notify the MPN doctor and insurance company in writing, advising them that the doctor is not ACOEM complaint by refusing to refer to a secondary treater after identifying a boy part outside his/her field of specialty. Additionally, if the referral is not made or denied, we will transfer care outside the MPN for further treatment.
- B. Dispute the findings of the MPN doctor. Take medical control and do the AME/PQME dance. Argue: Waiver and Estoppel. Defendant cannot violate certain Labor Code sections and/or Regulations, then try to hide behind others to defeat the IW's right to medical care.

NOTE: If you take medical control and the PTP is ACOEM compliant and complies with the recently adopted changes in the Medical Treatment Utilization Schedule, you get the presumption as to the issues of the extent and scope of medical care and treatment. Additionally, ACOEM mandates that the PT address all body parts and gives the PTP authority to obtain a functional capacity assessment and refer out to other specialists. L.C. 4604.5 and Reg. 9792.25.

AUTHOR'S OPINION: Why wouldn't you want to take medical control?

Scenario 30: FAILURE TO GIVE WRITTEN NOTICE TO NEW EMPLOYEES AT HIRE OR BY THE END OF THE FIRST PAY PERIOD. REG. 9880©(14) REGARDING VALIDLY ESTABLISHED MPN

Argument: Violates Knight and Valdez.

Conclusion: **TAKE MEDICAL CONTROL.**

Scenario 31: FAILURE TO POST THE MPN INFORMATION UNDER REG. 9881

Conclusion: **TAKE MEDICAL CONTROL.** Failure to advise the new employee of his right to pre-designate his/her personal physician. Violation of Regulation 9767.12 and 9881(c)(7). Employee notification notice must include "how to obtain a referral to a specialist within the MPN or outside the MPN if needed. Reg. 9881(c)(13).

Scenario 32: WITHIN ONE WORKING DAY AFTER FILING A CLAIM FORM. PER L.C. 5401.1, THE EMPLOYER/INSURER DOES NOT PROVIDE ALL TREATMENT PER ACOEM. REG. 9767.6(b)

Conclusion: **TAKE MEDICAL CONTROL.**

Scenario 33: THE EMPLOYER/INSURANCE DOES NOT PROVIDED FOR THE TREATMENT WITH MPN PROVIDERS FOR THE ALLEGED INJURY AND DOES NTO CONTINUE TO PROVIDE THE TREATMENT THROUGH THE DATE LIABILITY FOR THE CLAIM IS REJECTED

Conclusion: **TAKE MEDICAL CONTROL.** Reg. 9767.6(c).

Scenario 34: EMPLOYER'S MPN IS NOT VALIDLY ESTABLISHED AND/OR NOTICED

Application for certification must be submitted to the AD. Applicant must meet the requirement of Labor Code 4616 et seq. See Reg. 9767.1 – 9767.16.

An MPN must have at least 3 physicians of each specialty, expected to treat common injuries experienced by injured workers, based upon the type of occupation or industry, in which the employee is engaged and within the access standards set forth in (b) and (c). Reg. 9767.5.

Argument: Burden of proof is on defendant to establish that their MPN is validly established.

Conclusion: **TAKE MEDICAL CONTROL.**

Scenario 35: UNREPRESENTED INJURED EMPLOYEE (IW) IS TREATING WITH HIS/HER PRE-DESIGNATED TREATING PHYSICIAN OUTSIDE THE MPN

IW retains counsel. Attorney may not take medical control and treat outside the MPN. Thirty (30) day rule under L.C. 4600 does not apply. If attorney identified additional body parts or compensable consequence claims, the referrals must be made by pre-designated PTP. (Scudder panel decision 2011)

The pre-designated PTP could designate another physician to write the comprehensible medical legal report (CMLE).

Conclusion: Medical control stays with the pre-designated physician. If you pull control away and the employer/insurance have a validly established MPNY, you lose medical control to the MPN.

Scenario 36: VALIDLY ESTABLISHED AND PROPERLY NOTICE MPN, IW IS TREATING WITH MPN PTP, PTP RECOMMENDS TREATMENT WHICH WAS SUBMITTED TO AND DENIED BY UR

Argument: Treatment recommended by the employer's doctor but denied by the employer's UR provider constitutes a refusal to provide care per L.C. 4600(a).

Conclusion: **TAKE MEDICAL CONTROL.**

MPN MEDICAL TREATMENT

Intake: 'Reasonable Treatment' Issues

1. Did you report injury or symptoms to any body parts (*including emotional symptoms, sleep difficulties, or internal organ symptoms*) to the company doctor, which the company doctor did not treat or address?

2. Were there any reasons you were unhappy with the treatment provided to you by the company doctor?

3. Were you ever denied treatment of any kind by the company doctor, at any time?

4. Did the company doctor ever provide any diagnostic testing, such as an MRI, ultrasound, electromagnetic nerve testing, x-rays, etc...?

5. Did the company doctor ever deny a request for any diagnostic testing, such as an MRI, ultrasound, electromagnetic nerve testing, x-rays, etc...?

6. Did the company doctor provide you with any physical therapy, including chiropractic treatment, electric impulse therapy, aquatic therapy, acupuncture, etc...?

7. Did the company doctor ever deny any requests for physical therapy, including chiropractic treatment, electric impulse therapy, aquatic therapy, acupuncture, etc...?

MPN MEDICAL TREATMENT

8. Did the company doctor provide any epidurals or steroid injections?

9. Did the company doctor ever deny any requests for epidurals or steroid injections?

10. Did the company doctor ever provide you with any referrals to a specialist or surgery consultation for any injuries?

11. Did the company doctor ever deny any request for a referral to a specialist or surgery consultation for any injuries?

12. Did the company doctor send you back to work with work restrictions that you felt you were not physically capable of at that time?

13. Did the company doctor send you back to work at full duty when you felt you were not physically capable at that time?

14. How far was the company doctor from your home? From your job? Please estimate or list addresses.

MPN MEDICAL TREATMENT

15. Did the company doctor provide you with medical reports including injuries, symptoms, diagnosis, and treatment plans, for each time you had an appointment, within on months time of that appointment?

16. Did you ever request to switch company doctors? If so, was that request complied with by the employer / insurance?

17. Did the employer / insurance ever switch your treating doctor without notifying you, or getting your permission?

18. Were you forced to treat with doctors who are also employed by your employer, whether actually on site or as by a doctor who is a member of an affiliated medical group? (For hospital / health care workers only, ex. Kaiser Permanente employees)

19. Do you feel there was a conflict of interest regarding your medical treatment between yourself, your employer, or the treating physician at any time?

MPN MEDICAL TREATMENT

To: _____

Fax: _____

Company: _____

Date: _____

From: _____

Pages: _____ (including cover sheet)

Re: MPN Rule Violation for: _____

**The patient mentioned above is treating outside of the Medical Provider Network.
Please check the box(s) below which allows us to treat the patient.**

- Employer/Insurer has not rejected applicant's claim per CCR §9767.6(c).
- The applicant was in an MPN, and requested a 4601(a) change of physician, and the insurance company failed to provide an alternative physician within 5 working days of the request.
- The employer failed to provide applicant within 1 working day of notice of knowledge of work related injury, with a Claim Form per LC §5401(a).
- An initial evaluation with the MPN was not arranged within 3 working days by the employer after notice of the injury or the filing of a claim form per CCR §9767.6(a).
- The employer, within 1 day after the filing of a Claim Form, failed to authorize the provision of all medical treatment in accordance with CCR §9767.6(b).
- At the time of hire, or at the time of the creation of the MPN, or upon the applicant transferring into the MPN, the employer fails to give the employee a notification that contained the following information required to be given in accordance with CCR §9767.12.
- The employer failed to give the employee the required LC §5401 notice in writing, within 1 working day of the employer receiving notice of knowledge or the injury in accordance with CCR §9767.12.
- At the time of the injury, the employer failed to inform the applicant, in writing, in accordance with LC §5401(b)(9)(A), that he/she has a right to disagree with decisions affecting his/her claim.
- At the time of the injury, the employer failed to inform the applicant, in writing, in accordance with LC §5401(b)(9)(B), that he/she can obtain free information from an information and assistance officer of the state Division of Workers' Compensation, or can hear recorded information and a list of local offices by calling a given telephone number.
- At the time of the injury, the employer failed to inform the applicant, in writing, that he/she can consult an attorney, that most attorneys offer one free consultation, that if you decide to hire an attorney, the attorney's fee will be taken out of some of the applicant's benefits, and that to get a list of workers' compensation attorneys, to contact the State Bar of California's legal specialization program at a given phone number in accordance with LC §5401(b)(9)(C).

MPN MEDICAL TREATMENT

- At the time of the referral for initial care, the employer failed to notify the applicant of their right to be treated by a physician of his/her choice within the MPN in accordance with CCR §9767(d),
- The employer failed to post a LC §3550 Notice in a conspicuous location frequented by employees where it could be seen throughout the entire workday in accordance with LC §3550(a).
- The LC §3550 Notice posted by the employer failed to state the name of the current workers' compensation insurance carrier of the employer pursuant to LC §3550(a).
- The LC §3550 Notice posted failed to tell the employee the kinds of events, injuries, and illnesses covered by workers' compensation in accordance with LC §3550(d)(2).
- The LC §3550 Notice posted failed to tell the employee of the rights of the employee to select and/or change his/her treating physician pursuant to the provisions of LC §3550(d)(4).
- The LC § Notice posted failed to tell the employee of the rights to receive temporary disability indemnity, permanent disability indemnity, vocational rehabilitation services, and death benefits in accordance with LC §3550(d)(5).
- The LC §3550 Notice posted failed to tell the employee to whom injuries should be reported in accordance with LC §3550(d)(6).
- The LC §3550 Notice posted failed to tell the employee of the time limits in which to report a claim.
- The LC §3550 Notice posted failed to tell the employee of his/her rights to protection from discrimination per LC §132(a) in accordance with LC §3550(d)(9)
- The employer failed to give the employee upon being hired, or by the time of the first pay check, a written notice containing all of the LC §3550 posted information in accordance with LC 3551.
- The employer failed to give the employee, upon being hired or by the time of the first paycheck, an additional written notice in English or Spanish, explaining how to obtain appropriate medical care for a work-related injury.
- The employer failed to give the employee, upon being hired or by the time of the first paycheck, an additional written notice in English or Spanish, explaining the role and function of the primary treating physician.
- At the time of hire, the employee informs the employer that he/she has a pre-designated treating physician, and that the employee chooses not to participate in the employer's MPN.

Attorney signature: _____

Date: _____