

## DWC EDUCATIONAL CONFERENCE 2015

**How to get an Expedited Hearing; Walk Through Settlement Documents and What is Required for Approval; IMR including Petitions Appealing AD's Determination re: IMR**

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## DISCLAIMER

This material and the opinions expressed are my own and do not represent the position of the DIR, the DWC, the WCAB or any Judge within the DIR or DWC.

This presentation is not intended to be used as legal advice and each case or circumstance is unique. The outcome is dependent on its own set of facts.



## PART 1: EXPEDITED HEARINGS



### EXPEDITED HEARING ISSUES

1. Medical treatment, except for issues determined under 4610 (UR) and 4510.5 (IMR)
2. Entitlement to or amount of Temporary Total Disability.
3. Whether IW is required to treat within a MPN.

\*\*If an expedited hearing is requested re: MPN no other issue may be heard until the MPN dispute is resolved.\*\*

## EXPEDITED HEARING ISSUES

4. Medical treatment appointment or medical legal examination.
5. Entitlement to compensation from an employer when two or more employers dispute liability among themselves.
6. Any other issues requiring an expedited hearing and determination as prescribed in the rules and regulations of the Administrative Director

Labor Code section 5502 (b) (1) to (6)

## WHAT ELSE DO YOU NEED TO DO TO GET AN EXPEDITED HEARING?

- WCAB Rules 10414 & 10552\* (formerly Court Ad Rules section 10250 and 10252). \*Effective 1-1-15.
- Statement under penalty of perjury that good faith efforts to resolve issue(s) have been made. *WCAB Rule 10414(d)*
- May request if injury admitted to any part or parts of the body. *WCAB Rule 10552 (a)*.
- Attach a copy of the AME, QME or treating physician report relevant to the issue. *WCAB Rule 10393 (c) (1)*

## IS THIS A PROPER CASE FOR EXPEDITED?

- Includes a situation where TTD or medical treatment is at issue to a disputed body part. *WCAB Rule 10552 (b)*
- The judge may re-designate the Expedited Hearing as a MSC, have parties fill out Pre Trial Conference Statement and set case for Trial on the issues presented in consultation with the presiding judge. *WCAB Rule 10552 (c)*

## WHEN MAY A JUDGE RE-DESIGNATE AN EXPEDITED HEARING?

Re-designation may be appropriate if the direct and cross-examination of the applicant will be prolonged, or where there are multiple witnesses who will offer extensive testimony.

The parties are expected to submit all matters at issue at a single trial and produce all necessary documents, witnesses, medicals etc . . .

*See WCAB Rule 10552 (c)(d); 2013 WCAB Policy and Procedure Manual section 1.20*

EU JAE KIM V. B.C.D. TOFU HOUSE; CYPRESS INS Co. (2014) 79  
CAL. COMP. CASES 140 (SIGNIFICANT PANEL DECISION)

WCAB held that without regard to Court Administrator Rule 10252 which allows expedited hearings for only certain specific issues in admitted cases, L.C. section 5502(b)(2) and Ad. Dir. Rule 9767.6(c) allows for an Expedited Hearing on whether IW must treat with Defendant's MPN during the 90 day delay period.



## PART 2: WALK THROUGH PROCEDURES



## WALK THROUGH SETTLEMENTS

- WCAB Rule 10417 (Effective 1-1-15):
- Walk through hours on court days: 8:00 to 11:00 and 1:00 to 4:00

Re: Compromise & Release Agreements and Stipulations with Request for Award

See WCAB Rule 10417 (d)(1)

- Need all supporting documents not previously filed; and
- Proof of Service showing service of the settlement on all other parties to settlement or any defendant not executing settlement who may be liable for compensation; and all lien claimants whose liens have not been resolved.

## CASE OPENING SETTLEMENT DOCUMENT

- Must submit no later than 12:00 p.m. on the court day before action on the walk through is requested and designated as a “walk through” (i.e. on Document Cover Sheet – whether e-filed or OCR form).
- Judge is assigned for walk through and if unavailable, parties may proceed to PJ for possible reassignment to another judge. *WCAB Rule 10417 (e)*
- If have cases at two or more different WCAB offices, may submit walk through document at either office that has venue, but must be an existing cases. *WCAB Rule 10417(g)*

## WALK THROUGH SUBMITTED TO JUDGE

- WCJ assigned for the walk through may either approve it, disapprove it, suspend action or accept it for later review. *WCAB Rule 10417 (f)*
- If walk through would interfere with cases scheduled on calendar, the judge may refer the settlement to the PJ for possible reassignment to another judge.



## WHAT IS NEEDED TO GET APPROVAL OF THE SETTLEMENT?

- Medical report settlement based upon – treating doctor, QME, AME.
- If settlement involves a proper injured worker, also need:
- DEU or private rating of all P&S reports;
- Print out of benefits;



### “WHAT IS NEEDED” CONTINUED:

- Notices regarding settlement;
- Wage statement if TTD or PD paid at less than maximum;
- Letters advising of QME process;
- Proof of service of settlement document and supporting documents on all lien claimants and injured worker.

*See 2013 WCAB Policy and Procedure Manual Section 1.91A*

### COMMON PROBLEM WITH APPROVAL OF PRO PER SETTLEMENT RE: PD

- Apportionment of PD - to be a valid opinion, the physician’s opinion must be based upon substantial evidence and must “disclose a familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion.” *EL Yeager v. WCAB (Gatten) et, seq.*
- Physician must make apportionment determination by finding what approximate percentage of the PD was caused by the direct result of injury and what approximate percentage of PD was caused by other factors, both before and subsequent to the industrial injury, including prior industrial injuries.

### PART 3: INDEPENDENT MEDICAL REVIEW & PETITIONS APPEALING AN IMR DETERMINATION



#### PRE-REQUISITE TO IMR – TIMELY UR

- Labor Code section 4610 (g) (1) and (2).
- Prospective decisions shall be made within 5 working days from date of receipt of treatment request but not greater than 14 days.
- Concurrent (where employee faces imminent/serious threat to health) – timely depending on condition and not greater than 72 hours after receipt of information necessary to make determination.

## DECISIONS VALID FOR 12 MONTHS

- If UR is properly done and there is no appeal to IMR, then the UR determination is effective for 12 months from the date of the decision unless there is a documented change in facts which is material to the basis of the UR.
- What is a documented change in facts material to the UR?

### **TIMOTHY BODAM V. COUNTY OF SAN BERNARDINO/DEPT OF SOCIAL SERVICES (NOVEMBER 20, 2014) 79 CAL. COMP. CASES \_\_\_\_\_ (ADJ8120989)**

In affirming the Workers' Compensation Judge's finding that defendant's Utilization Review (UR) decision was not timely communicated to the requesting physician and the employee as required by Labor Code section 4610(g)(3)(A) and Administrative Director's Rule 9792.9.1(e)(3), the Appeals Board held: (1) A defendant is obligated to comply with all time requirements in conducting a UR, including the timeframes for communicating the UR decision; (2) A UR decision that is timely made but is not timely communicated is untimely; (3) When a UR decision is untimely and, therefore, invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence.

## IMPORTANT UR REGULATION

- Regulation section 9792.9.1 –
- Must make recommendation on RFA form contained in CCR section 9785.5 – available on line at [www.dir.ca.gov/dwc/forms.html](http://www.dir.ca.gov/dwc/forms.html).
- Very specific timelines if treatment request is made by fax or by mail as to when the request is “received” to begin the timeline for the UR determination.

## INDEPENDENT MEDICAL REVIEW “IMR”

- Labor Code section 4610.5 and 4610.5
  - UR decision reviewed ONLY by IMR.
  - Insurance carrier to provide IMR form and addressed envelope to IW with UR denial, delay or modification.
- \*\* Remember UR and IMR process will not apply when injury is denied or disputed until a final determination is made as to the disputed body parts/injury. LC sections 4610.5 (h)(2) and 4610 (g)(8).

## INDEPENDENT MEDICAL REVIEW TIME LIMITS

- Employee may file IMR request 30 days after service of the UR decision on employee.
- If carrier failed to send 1 page form to EE with UR determination, then time limits extended to file IMR request until 1 page form provided.
- Once referred to IMR and it is determined eligible, then there are specific time limits for the Defendant or Applicant to provide documents to IMR reviewer. *See Labor Code section 4610.5(l), 8 CCR 9792.10.5.*
- DWC Newline 2014-110 November 25, 2014 re: procedure to assess administrative penalties for failure to submit IMR medical records.

## PETITION APPEALING DETERMINATION OF AD - IMR

- Aggrieved party may file a petition appealing the AD's determination re: IMR.
- Appeal is filed with WCAB – local office that has venue.
- Have 30 days from date of service of IMR determination.
- Untimely petition may be summarily dismissed.
- Caption “Petition Appealing Administrative Director’s Independent Medical Review Determination”
- Must include case number assigned by AD to IMR determination

## PETITION APPEALING IMR

- Petition must attach copy of IMR determination and proof of service of determination.
- Must show: 1 of 5 grounds
  1. AD acted without or in excess of powers;
  2. Decision procured by fraud;
  3. Reviewer had a material conflict of interest;
  4. Decision was result of bias;
  5. Decision was the result of plainly erroneous finding of fact.

See WCAB Rule 10957.1.

## STEPS FOR IMR APPEAL

- Serve Petition on:
  - Adverse party; provider and/or attorney representative;
  - Injured employee and attorney if represented;
  - DWC – IMR Review Unit;
  - Not placed on calendar unless DOR filed and must serve IMR Unit with DOR.
- Adjudicated at trial level by WCJ using procedures applicable for ordinary benefits unless Expedited Hearing requested.

**CHRISTOPHER TORRES V. CONTRA COSTA SCHOOLS, ET AL.  
(2014) 79 CAL. COMP. CASES 1181 (ADJ3011154; ADJ3631113)**

Where the injured worker filed an unverified petition appealing an Independent Medical Review (IMR) determination, the Appeals Board held that the petition is subject to dismissal because Labor Code section 4610.6(h) provides that such a determination “may be reviewed only by a *verified* appeal.” Further, Rule 10450(e) requires that any petition filed with the Workers’ Compensation Appeals Board “shall be verified under penalty of perjury in the manner required for verified pleadings in courts of record,” and it provides that a non-verified petition may be summarily dismissed or denied. While lack of verification does not automatically require dismissal of an unverified petition, an appeal may be dismissed for lack of verification if the appealing party does not within a reasonable time cure the defect after receiving notice of the defect.



**DWC Annual Conference 2015**  
**Top 10 Litigation Tips from the Bench**  
**Judge Ralph Zamudio**

The role played by the injured worker's primary treating physician in this post-reform era is paramount. The primary treating physician opinion lays the foundation for speedy resolution of an injured worker's right to compensation or triggers the statutory dispute resolution process of contested medical issues under the medical-legal and/or medical treatment statutory dispute resolution scheme. The failure to understand and comply with the statutes and regulations can adversely impact a party's case as noted below.

Relevant Medical-Legal Statutes

Where Injury AOE/COE is denied:

**§ 4060. Liability for medical-legal evaluation performed by other than treating physician; Procedure; Notice**

**“(a)** This section shall apply to disputes over the compensability of any injury. This section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer.

**(b)** Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician, except as provided in this section. However, reports of treating physicians shall be admissible.

**(c)** If a medical evaluation is required to determine compensability at any time after the filing of the claim form, and the employee is represented by an attorney, a medical evaluation to determine compensability shall be obtained only by the procedure provided in Section 4062.2.”

Where PD or FM is in dispute:

**§ 4061. Notice of permanent disability indemnity; Comprehensive medical “evaluation; Calculation of permanent disability rating; Apportionment; Reconsideration; Admissibility of evaluations in violation**

“This section shall not apply to the employee's dispute of a utilization review decision under Section 4610, nor to the employee's dispute of the medical provider network treating physician's diagnosis or treatment recommendations under Sections 4616.3 and 4616.4.

...

(b) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2.

...

(i) No issue relating to a dispute over the existence or extent of permanent impairment and limitations resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician and by either an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations resulting from the injury shall be obtained, except in accordance with Section 4062.1 or 4062.2. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board." [Emphasis added.]

Accepted cases, other medical-legal disputes:

**§ 4062. Objection to medical determination by treating physician; Notice; Medical evaluation**

“(a) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained. [Emphasis added.]

(b) If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a request for authorization of a medical treatment

recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5.

(c) If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the employer's medical provider network established pursuant to Section 4616, the objection shall be resolved only in accordance with the independent medical review process established in Sections 4616.3 and 4616.4."

**§ 4605. Employee's right to provide own physicians**

"Nothing contained in this chapter shall limit the right of the employee to provide, at his or her own expense, a consulting physician or any attending physicians whom he or she desires. Any report prepared by consulting or attending physicians pursuant to this section shall not be the sole basis of an award of compensation. A qualified medical evaluator or authorized treating physician shall address any report procured pursuant to this section and shall indicate whether he or she agrees or disagrees with the findings or opinions stated in the report, and shall identify the bases for this opinion." [Emphasis added.]

**§ 4064. Costs and attorney fees**

"(a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms, except medical treatment recommendations, which are subject to utilization review as provided by Section 4610, and objections to utilization review determinations, which are subject to independent medical review as provided by Section 4610.5.

...

(d) The employer shall not be liable for the cost of any comprehensive medical evaluations obtained by the employee other than those authorized pursuant to Sections 4060, 4061, and 4062. However, no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense. In no event shall an employer or employee be liable for an evaluation obtained in violation of subdivision (b) of Section 4060. All comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the appeals board except as provided in Section 4060, 4061, 4062, 4062.1, or 4062.2."

Query: Can a party “buy” their own report under Labor Code section 4064(d)? “No” said the board in *Ward v. City of Desert Hot Springs* (2013) 71 Cal. Comp. Cases 1313 (Significant Panel Decision):

WCAB held that, for claimed industrial injuries occurring on or after 1/1/2005, in which worker is represented by attorney, disputes regarding compensability of alleged industrial injury must be resolved, pursuant to Labor Code § 4060(c), by procedure provided in Labor Code § 4062.2, that evaluation regarding compensability may not be obtained pursuant to Labor Code § 4064(d), and that, if report is so obtained, it is not admissible, when WCAB found that, prior to its amendment by SB 899, former Labor Code § 4060(c) allowed any party to obtain additional medical reports at their own expense, that this provision was deleted by SB 899 and replaced with current procedure requiring, in cases involving represented employee, that medical evaluation to determine compensability be obtained only by procedure provided in Labor Code § 4062.2, that Labor Code § 4064(d) was not amended by SB 899, that irreconcilable conflict existed between Labor Code § 4064(d) on one hand, and Labor Code §§ 4060 and 4062.2 on other hand, and that latter statutes prevail because more recently amended and enacted.

#### **§ 4061.5. Opinions by treating physicians**

“The treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all medical issues necessary to determine eligibility for compensation. In the event that there is more than one treating physician, a single report shall be prepared by the physician primarily responsible for managing the injured worker's care that incorporates the findings of the various treating physicians.” [Emphasis added.]

#### **§ 9785. Reporting Duties of the Primary Treating Physician**

(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 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, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616. For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. [Emphasis added.]

(2) A "secondary physician" is any physician 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. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

...

(4) "Medical determination" means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) "Continuing medical treatment" is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the

injury.

(7) "Future medical treatment" is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) "Permanent and stationary status" is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.

(b)(1) An employee shall have no more than one primary treating physician at a time.

(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§ 4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or

(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4600, 4061, 4062, 4600.5, 4616.3, or 4616.4. If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061, 4062, and 4610.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report. [Emphasis added.]

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. . . .

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).  
...

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

- (4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;
- (5) The employee is released from care;
- (6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury;
- (7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code section 3207.
- (8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

...

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the "Request for Authorization," DWC Form RFA, contained in section 9785.5. A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment.

(h) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. . . .

...

(j) Any controversies concerning this section shall be resolved pursuant to Labor

Code Sections 4603 or 4604, whichever appropriate.

(k) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

#### Case Law and Board Panel Decisions

**Dugmore v. State of California/Department of Transportation**  
2014 Cal. Wrk. Comp. P.D. LEXIS 227 (Noteworthy Panel Decision)

**Medical Provider Networks – Liability for Outside Treatment – Utilization Review – WCAB affirmed WCJ's finding that applicant with 7/10/2012 admitted industrial injuries to his upper back and bilateral upper extremities was not allowed to receive medical treatment outside defendant's MPN at defendant's expense because there was insufficient evidence to establish that defendant unreasonably denied medical treatment, when secondary treating physician within defendant's MPN requested authorization from defendant to conduct multiple diagnostic studies involving applicant's upper and lower extremities, but secondary treating physician's request/reports were not reviewed or incorporated by applicant's primary treating physician as required under Labor Code § 4061.5, and WCAB found that, although defendant's utilization review non-certification of two of studies requested by secondary treating physician was untimely, defect in timeliness of non-certification did not establish unreasonable denial of medical treatment such that applicant was entitled to treat outside MPN, and that since applicant failed to provide any evidence from primary treating physician that non-certified diagnostic studies were medically necessary, there was insufficient evidence that defendant unreasonably denied non-certified diagnostic studies, especially given that non-certified studies were for applicant's lower extremities, which were not claimed body parts.**

The WCJ explained his reasoning, in pertinent part, as follows:

“In determining medical necessity, consideration must be given to the primary treating physician's determinations as to treatment recommendations. In this regard, an applicant may have no more than one (primary) treating physician (Title 8 CCR Sec. 9785(b)(1). Applicant may engage secondary treating physicians that are to report to the primary treating physician. Here, it does not appear that the secondary treating physician Dr. Farran directed his report to the primary treating physician Dr. Marcuccilli. The primary treating physician is responsible for obtaining the secondary treating physician reports and within 20 days

therefrom incorporate or reference the findings of the secondary treating physician(s) in a report from the primary treating physician (L.C. Sec. 4061.5 and CCR Sec. 9785(e)(3)(4)). As such, defendant was correct in its letter to Dr. Farran of 05/29/2013 (Applicant Exhibit - 3), in stating that Dr. Farran is not recognized as the primary treating physician as Dr. Marcuccilli was and is. Therefore, since applicant failed to provide any evidence from the primary treating physician Dr. Marcuccilli that the non-certified diagnostic studies were medically necessary there was insufficient evidence offered by applicant that defendant unreasonably denied the non-certified diagnostic studies herein especially in light of the fact the non-certified diagnostic studies were for the applicant's right and left lower extremities. As such, this assertion by applicant is without merit as well."

**Antonetta Williams v. Claire's Stores, Inc.**

2012 Cal. Wrk. Comp. P.D. LEXIS 497 (Noteworthy Panel Decision)

**Medical Treatment – Attendant Care – Treating Physicians – WCAB rescinded WCJ's finding that applicant with 1/4/2010 industrial injuries to her head, back, neck, shoulders, leg and foot was entitled to attendant care services and reimbursement for attendant care provided by her husband, when WCAB found that WCJ's decision was based solely on reporting of applicant's secondary treating physician, who lacked authority and did not properly request authorization from defendant to provide ongoing attendant care as medical treatment, that defendant did not have an obligation to perform utilization review, that applicant's efforts to retroactively designate secondary treating physician as primary treating physician were ineffective given statutory and regulatory schemes contemplating that request to change treating physicians is effective beginning with date of request, that secondary treating physician's opinion did not constitute substantial evidence, and that it was improper for WCJ to rely solely on secondary treating physician's opinion to award attendant care.**

In reaching its decision, the board panel explained as follows:

"Turning to defendant's contentions, we agree that there can be only one primary treating physician at a time and the primary treating physician is the one who renders opinions on all medical issues necessary to determine eligibility for compensation. (See generally, Lab. Code, § 4061.5; Cal. Code Regs., tit. 8, § 9785(a)(1) and (2), (b)(1), (d), (e)(3) and (4).) If there are secondary treating physicians, it is the primary treating physician who makes the final determination whether to incorporate their findings as part of his or her medical reporting. (*Id.*)

Here, it appears that Dr. Chan was applicant's primary treating physician

throughout the course of her treatment during the relevant time period. As discussed above, Dr. Chan repeatedly identifies himself as the primary treating physician in his reports and he refers to Dr. Hassid as the secondary treater. In his reports, Dr. Hassid never refers to himself as the primary treating physician and the March 20, 2011 discharge report of "Rehab Without Walls" identifies Dr. Chan as the "Attending Physician" and Dr. Hassid as the "Other Treating Physician." Based upon this evidence we conclude that Dr. Hassid was a secondary physician. (Cal. Code Regs., tit. 8, § 9785(a)(2).)

The effort of applicant's attorney at trial to retroactively designate Dr. Hassid as the primary treating physician is unavailing. Although an employee's request to change treating physicians may be made "at any time" (Lab. Code, § 4601(a); Cal. Code Regs., tit. 8, § 9781(b)) and "need not be in writing" (Cal. Code Regs., tit. 8, § 9781(b)(1), the statutory and regulatory schemes implicitly contemplates that a request to change treating physicians is effective *beginning* with the date of the request. Applying any other interpretation could effectively preclude the employer from complying with its several and various statutory and regulatory duties. Thus, on this record, it must be concluded that Dr. Chan was applicant's primary treating physician during the relevant time period.

Because Dr. Hassid was a secondary treating physician, it was improper for the WCJ to rely solely upon that physician's May 3, 2011 report to find that applicant is entitled to attendant care. This is because the "treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician," is the physician who "shall ... render opinions on all medical issues necessary to determine eligibility for compensation." (Lab. Code, § 4061.5; see also Cal. Code Regs., tit. 8, § 9785(d).) If there is more than one physician is providing treatment, "a single report shall be prepared by the physician primarily responsible for managing the injured worker's care that incorporates the findings of the various treating physicians." (Lab. Code, § 4061.5; see also Cal. Code Regs., tit. 8, § 9785(e)(4).)

Here, Dr. Chan was "the physician primarily responsible for managing the injured worker's care" within the meaning of Labor Code section 4061.5, and there is no evidence that he ever incorporated the May 3, 2011 report of Dr. Hassid into his reporting. But even if it could be found that Dr. Chan was not required to incorporate the findings of Dr. Hassid, it was error for the WCJ to rely upon Dr. Hassid's May 3, 2011 report because there is no evidence it was ever served on defendant, it is not marked at the top that it includes a request for authorization of medical treatment, and it is not substantial medical evidence."

**Yolanda Barcenas v. In Home Support Services**

2012 Cal. Wrk. Comp. P.D. LEXIS 330 (Noteworthy Panel Decision)

**Medical-Legal Procedure-Medical Reports of Treating Physicians – WCAB rescinded WCJ's finding that applicant/home caretaker with industrial injuries to her neck and back during period 1/1/2002 to 7/1/2009 sustained injury to her psyche and 50 percent permanent disability, and found that applicant was not entitled to compensation for psychiatric permanent disability, when WCJ's finding of injury to psyche and psychiatric permanent disability were based on report of treating psychiatrist which was not properly admitted into evidence because it was never reviewed or incorporated by applicant's primary treating physician, an orthopedist, as required under Labor Code § 4061.5, and psychiatrist was neither an agreed medical examiner nor a qualified medical evaluator reporting on applicant's condition pursuant to Labor Code § 4062.2.**

In reaching its decision, the board panel explained as follows:

“Section 4061.5 provides: "The treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all medical issues necessary to determine eligibility for compensation. In the event that there is more than one treating physician, a single report shall be prepared by the physician primarily responsible for managing the injured worker's care that incorporates the findings of the various treating physicians."

In this case, Dr. Perelman was the primary treating physician. He neither designated Dr. Curtis to render opinions nor reviewed and incorporated the reports of Dr. Curtis. Dr. Curtis was neither an agreed medical evaluator nor a qualified medical evaluator. Therefore, the reports of Dr. Curtis are not admissible into evidence. Since those reports are the only evidence of psychiatric injury and are inadmissible, there is no evidence that applicant sustained an industrial injury to her psyche or that she sustained psychiatric permanent disability. For this reason, we strike the finding that applicant sustained injury to her psyche and amend the permanent disability award to delete compensation for psychiatric permanent disability.”

**Arthur Wilson v. Capistrano Unified School District**  
2011 Cal. Wrk. Comp. P.D. LEXIS 195 (Noteworthy Panel Decision)

**Medical Treatment – Utilization Review – WCAB held that WCJ erred in admitting and relying upon opinion of evaluating dentist in finding that applicant/custodian with injury to his teeth as a compensable consequence of 5/28/2002 admitted right knee injury was entitled to further medical treatment in form of dental care, when dentist's reports were not admissible as reports of a treating physician, as dentist was not applicant's primary treating physician**

**nor was he designated to write a treating physician report as required by 8 Cal. Code Reg. § 9785(c), and dental reports were not obtained in compliance with procedures in former Labor Code § 4062 (applicable to pre-1/1/2005 injuries), which required that there be a report by a primary treating physician or designated secondary physician and an attempt to agree to an AME.**

Applicant sustained an admitted industrial injury to his right knee on May 28, 2002. Applicant contended that as a consequence of his right knee injury, he fell at his home at two or three in the morning of March 20, 2010, injuring his teeth. Applicant's primary treating physician was orthopedist Bang H. Hoang, M.D., who has been treating the applicant's right knee injury. On referral by applicant's attorney, the applicant was evaluated by Dr. Esagoff on April 15, 2010, who issued a report on the very same day entitled "Comprehensive Initial Dental Evaluation Report & Pre-Authorization Request." In the report, Dr. Esagoff stated that the applicant was referred to him by applicant's attorney. In his report, Dr. Esagoff did not explicitly identify himself as a treating physician. However, in his April 15, 2010 report, he requested authorization for treatment to be performed by his office. Dr. Esagoff's request for authorization was submitted to the utilization review (UR) process established by defendant pursuant to Labor Code section 4610. The UR report of April 23, 2010 opined that, "Although [Dr. Esagoff's] treatment is determined to be medically necessary at this time, the relatedness of this condition to the industrial injury has not been determined." Dr. Hoang was not informed of the applicant's dental condition until some time in July of 2010, when the applicant's counsel sent him a brief letter informing him that the applicant "fell in his home on March 20, 2010 while using crutches causing a dental injury." Applicant's attorney concluded his letter to Dr. Hoang requesting as follows: "As this matter is set for trial on Aug. 19, 2010 and the treating physician is required to evaluate and make appropriate medical recommendation of evaluating physicians. [sic] Can you please prepare a brief report and adopt Dr. Esagoffs dental plan as appropriate dental care following his fall on March 20, 2010." Dr. Hoang reexamined the applicant and issued a report dated July 30, 2010, stating in part, ". . . The consultation note from Dr. Jacob Esagoff, the dentist who evaluated Mr. Wilson on April 15, 2010, is reviewed in its entirety. I would agree with the proposed treatment plan for the repair of his dental injury. All questions and concerns were answered and addressed to the patient['s] satisfaction." At trial, the defendant objected to the admissibility of Dr. Esagoff's reports. Two days prior to the trial, Dr. Hoang sent defendant a letter dated 10/25/2010 stating, "I have reviewed Mr. Arthur Wilson's file and your comments regarding my adoption of Dr. Esagoff's plan. Since my practice does not include dental diagnosis and treatment, I can only agree with treatment for Mr. Wilson's dental injury to improve his nutritional status for wound healing. I did not intend to comment on the specific dental treatment plan for Mr. Wilson."

The board granted defendant's petition for reconsideration contesting the award of dental treatment, and remanded the matter to the trial level so that a proper report from treating physician designated by Dr. Hoang be obtained noting the reports of Dr. Esagoff be stricken from the record, and any dispute regarding the dental part of body injured be addressed under Labor Code § 4062. The board panel explained its reasoning, in pertinent part, as follows:

"In this case, the defendant does not appear to contend, and the WCJ did not find, that Dr. Esagoff's reports were admissible as the reports of a treating physician. It is uncontested that Dr. Hoang is the applicant's primary treating physician. Additionally, Dr. Hoang did not designate Dr. Esagoff to write a treating physician report as required by Rule 9785(c). Dr. Hoang had no knowledge that the applicant was evaluated by Dr. Esagoff until he was directed to incorporate Dr. Esagoff's report by the applicant's attorney.

We do not reasonably expect Dr. Hoang to know the intricacies of Administrative Rule 9785, and thus his "agree[ment] with the proposed treatment plan," made under pressure from applicant's attorney, and later retracted in an October 25, 2010 letter, is insufficient to retroactively render Dr. Esagoff's report one "made by the treating physician," pursuant to [section 4062](#). In any case, we note that Dr. Hoang did not incorporate or comment upon the industrial causation of the need for any proposed medical treatment.

Because the date of injury in this case was before January 1, 2005, [section 4062](#) as it existed before changes made during the 2004 Legislative Session governs the medical-legal procedure to be utilized when there is a dispute regarding the need for medical treatment for a disputed body part, in an otherwise accepted injury. [Citations omitted.]"

**Shan Won Ym v. Abee Restaurant, dba Karuta Restaurant**

2008 Cal. Wrk. Comp. P.D. LEXIS 881 (Noteworthy Panel Decision)

**Liens – Medical Treatment – Reporting Requirements – WCAB disallowed lien for medical treatment of applicant chef's two industrial injuries, holding that lien claimant did not comply with reporting requirements of Labor Code § 4061.5 and 8 Cal. Code Reg. § 9785(e)(3), (4) and did not establish medical necessity of treatment provided by lien claimant, when WCAB found that applicant sustained injury AOE/COE on 9/10/2005 and in period ending 12/19/2006 to neck, both shoulders, right knee, and left ankle, that lien claimant provided treatment as secondary treating physician on referral from applicant's primary treating physician, that primary treating physician did not mention referral or review, incorporate, or adopt secondary**

treating physician's reports, and that there were no reports from lien claimant in evidence.

**Abel Arteaga v. Marshalls Industries**

2012 Cal. Wrk. Comp. P.D. LEXIS 264 (Noteworthy Panel Decision)

**Liens – Medical – Reasonableness and Necessity of Medical Treatment – WCAB affirmed WCJ's order disallowing lien in amount of \$ 49,186.57 for psychological treatment provided by secondary physicians to applicant/forklift driver with 6/22/94 back injury and 7/1/98 hernia, when WCAB found that need for psychological treatment was not reasonably necessary to cure or relieve applicant from effect of his injuries based on lack of compliance with treating physician reporting requirements in 8 Cal. Code Reg. § 9785, lack of incorporation by primary treating physician of secondary physicians' findings pursuant to 8 Cal. Code Reg. § 9785(e)(4) and Labor Code § 4061.5, and t lack of explanation as to need and continuing need for psychological treatment.**

**Maria Gonzalez v. American Apparel, Inc.**

2014 Cal. Wrk. Comp. P.D. LEXIS 120 (Noteworthy Panel Decision)

**Medical-Legal Procedure – Reports of Treating Physicians – WCAB rescinded WCJ's order excluding four medical reports offered by applicant/picker who alleged that she sustained industrial injury to her head, neck, back, shoulders, both lower extremities, psyche and in form of sleep disturbance from 9/3/2008 through 5/11/2012, and held that there was no basis for exclusion of medical reports pursuant to Labor Code § 4061.5, when applicant was referred by primary treating physician for treatment and consultation to four other physicians, and WCAB found that under Labor Code § 4060, applicable to disputed claims such as applicant's, reports of treating physicians are admissible even if there is no liability for cost of medical-legal evaluation performed by treating physicians, and that, although preferred method is for primary treating physician to review and incorporate reports of secondary treating physician, there is nothing in Labor Code § 4061.5 **indicating** that reports of secondary treating physicians are inadmissible.**

After quoting Labor Code sections 4060 and 4061.5, the panel briefly explained it's reasoning as follows:

“Although the preferred method is for the primary treating physician to review and incorporate the reports of the secondary treating physicians, there is nothing in Labor Code section 4061.5 which indicates that the reports of the secondary treating physicians are inadmissible. Accordingly, we do not find any basis for the WCJ's decision to exclude exhibits 8 through 11 Labor Code section 4061.5.

Our position is supported by *Georgia Pacific v. Workers' Comp. Appeals Bd. (Samuelson)* (2006) 71 Cal.Comp.Cases 467 (writ den.) by (reports of physicians who consulted with treating physician need not comply with Labor Code section 4061.5 when claim is denied). Therefore, we shall grant reconsideration, rescind the Findings of Fact and Order (Take Nothing), admit the exhibits 8 through 11 into evidence, and return this matter to the trial level for further decision by the WCJ." [By WCJ Zamudio: *Please note the Samuelson case cited by the board panel is a headnote-only writ-denied with no summary of the case setting forth the reasoning employed in reaching the decision made.*]

**Kirk Christensen v. Illinois Tool Works/Zurich American Ins. Co.**  
2014 Cal. Wrk. Comp. P.D. LEXIS 490 [42 Cal. Wrk. Comp. Rptr. 249]  
(Noteworthy Panel Decision)

Granting removal on its own motion, the board rescinded a WCJ order vacating submission to develop medical record, and instead found the applicant sustained industrial injury to the left knee and awarded left knee surgery the board panel deemed to have been recommended by PTP, inferring from the record the applicant's left knee had been injured as alleged, and that defendant had not timely objected to a RFA. The reports of the treating physician required defendant initiate the procedure specified in Labor Code section 4062(a), which provides that if the employer objects to a medical determination made by a treating physician concerning any medical issues not covered by Labor Code sections 4060 or 4061 and not subject to 4610, the objecting party must notify the other party in writing of the objection.

Mr. Christensen suffered an admitted specific injury on 1/29/2009 when he fell. Although defendant accepted the injury it apparently disputed the nature and extent of injury. The applicant filed an application 11/19/2009, alleging that he sustained injury "[w]hile offloading a 300 lbs item off truck fell down injuring right knee left knee and back as a compensable consequence of lifting [sic]." He received treatment for his injury with Dr. Greenfield, his primary treating physician. In his January 26, 2012 report, Dr. Greenfield stated that, in addition to right knee pain, applicant was also experiencing pain in his left knee. A "weight bearing x-ray" of his left knee reviewed at that time was within normal limits."

The PTP was deposed on 9/9/2013. He testified he had no diagnosis for the left knee, and in order to more adequately diagnose the left knee he required an MRI, and acknowledged he had essentially not treated the left knee.

In his next report dated 11/12/2013 the PTP noted the applicant's left knee was very sensitive, and requested that an MRI be performed.

The MRI was performed on 12/6/2013 showing a "torn lateral meniscus, torn medial meniscus, tri-compartmental (o)steoarthritis, small effusion and popliteal cyst." The PTP examined the applicant and reported on 12/20/2013 the left knee remained painful causing the applicant to limp. In light of the MRI, and physical examination, he sent the claims administrator a RFA for left knee surgery on 12/20/2013. There was no objection to the PTP's findings, and UR certified the left knee surgery as medically necessary.

The PTP issued a subsequent report dated 1/19/2014 stating, "Right knee injury – torn ACL 01/29/09. Increased stress on left knee with walking, squatting and climbing. Became more and more painful left knee. No evidence pre-existing pathology in left knee." This report was not served on the defendant until the expedited hearing held on 2/19/2014 at which time the defendant objected to the PTP's 1/19/2014 report regarding treatment for the left knee. The treatment dispute was submitted for decision at the expedited hearing. Rather than awarding applicant the left knee surgery, the Expedited Hearing WCJ vacated submission and ordered development of the record.

The applicant sought removal, contending: (1) defendant did not timely object to the reports of Dr. Greenfield dated November 12, 2013, December 12, 2013, and December 20, 2013; (2) the remedy for defendant's failure to timely object to these three reports is that defendant should be ordered to authorize the left knee surgery proposed by Dr. Greenfield in these reports; and (3) defendant's referral of the request for surgery to its Utilization Review, concurrent with its denial of liability for the surgical procedure is inconsistent.

The board granted removal on its own motion so as to rescind the WCJ's Findings and Order Vacating Submission; Opinion on Decision and Notice of Hearing (Findings and Order), and issued its own decision to explicitly find that applicant sustained injury arising out of and in the course of employment to the left knee, and to order that defendant authorize the left knee surgery. In doing so, the board first cited its own en banc decision in *Simmons v. State of California/Department of Mental Health* (2004) 70 Cal. Comp. Cases 866 (Appeals Board en banc) where it addressed the interplay between utilization review and whether the medical treatment at issue is related to the industrial injury. Quoting from *Simmons*, the board observed it was held in that case:

"Moreover, while this case involves the issue of whether treatment for an admitted industrially injured body part is causally related to the industrial injury, similar reasoning and principles will apply in

the context of cases where injury to one body part is admitted but injury to another body part is denied. In such cases, a utilization review physician's reports will *not* be admissible on the issue of whether the disputed body part is industrial. If in prescribing treatment for the disputed body part, the treating physician either explicitly or implicitly determines for the first time that the injury to the disputed body part is industrial, then utilization review is *not* appropriate. Instead, the defendant must initiate the AME/QME process within the deadlines established by section 4062(a). (Emphasis in original.) (*Simmons v. State of California/Department of Mental Health* (2004) 70 Cal. Comp. Cases 866, 869-870 (Appeals Board en banc).)"

The board stated, “. . ., the question here is whether any of the three reports from Dr. Greenfield submitted between November 12, 2013 - December 20, 2013 explicitly or impliedly determined that the injury to the left knee is related to the accepted injury of January 29, 2009. In addressing this issue, we are mindful that these reports are to be viewed in the context of the entire record. (*LeVesque v. Workers' Comp. Appeals Bd.*, 1 Cal.3d at pp. 638-639, fn. 22.) After our review of the entire record, we agree with defendant that none of the reports of Dr. Greenfield expressly stated that the left knee injury is industrial. We do find, however, that the December 20, 2013 report and RFA from Dr. Greenfield implicitly determined that the left knee was injured as a result of the January 29, 2009 injury. Therefore, defendant is ordered to authorize the left knee surgery which Dr. Greenfield requested in his report and RFA of December 20, 2013."

The board further explained "in the November 12, 2013 report addressing the left knee, the only date of injury listed is January 29, 2009. Although the PTP diagnosed a torn medial meniscus in the left knee, however, he did not provide any recommendation for therapy or treatment for the left knee. Dr. Greenfield did, however, recommend/request an MRI of the left knee. The MRI is a diagnostic tool, which can be differentiated from a request for medical treatment for the left knee. Therefore, it does not appear that the November 12, 2013 report expressly or impliedly determined that the left knee was related to the January 29, 2009 injury."

It further noted, "In the December 20, 2013 report, Dr. Greenfield reviewed the results of the MRI of the left knee, which documented several positive findings. In the section of the report entitled "Treatment Plan," Dr. Greenfield stated, "Recommends/requests arthroscopically (L) knee with partial medial & lateral meniscectomy & chondroplasty." On the same date, the RFA requested that defendant provide authorization for the left knee surgery. In both the report and the RFA issued by Dr. Greenfield on December 20, 2013, the date of injury

referenced is January 29, 2009.”

“Although Dr. Greenfield did not expressly state that the left knee is industrial, the report and RFA from December 20, 2013 imply that the left knee was injured as a result of the January 29, 2009 injury. First, the only date of injury listed on the reports and the RFA is the January 29, 2009 injury. Additionally, the claims administrator for the January 29, 2009 date of injury was requested to authorize the surgery for the left knee on December 20, 2013. This serves to put defendant on notice of the implication that the left knee condition and the need for surgery are related to the January 29, 2009 injury.”

“Moreover, although Dr. Greenfield indicated in his September 9, 2013 deposition that he had no diagnosis of the left knee condition, that was *before* he had the benefit of the December 6, 2013 MRI, which he indicated in his deposition would be helpful to diagnose the left knee condition. In the context of the 2009 application which included the left knee, and Dr. Greenfield's deposition testimony regarding the diagnostic purpose of an MRI to the left knee, we find that the December 20, 2013 report and RFA from Dr. Greenfield constitute an implicit determination by Dr. Greenfield that the left knee condition is industrial.”

“Pursuant to *Simmons, supra*, Dr. Greenfield's December 20, 2013 report and RFA required defendant to initiate the AME/QME process within the deadlines established by Labor Code section 4062(a), which states in relevant part:

If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. . . . If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement. . . . (Lab. Code section 4062(a).)

“There is no indication that defendant timely objected to the December 20, 2013

RFA and report. Defendant does not contest the medical necessity of the left knee surgery, likely because it concedes that its own Utilization Review report of December 20, 2013 determined that the left knee surgery was medically necessary. Because the time frames for defendant to initiate the AME/QME process under Labor Code section 4062(a), have expired, defendant can no longer contest whether the left knee was injured on January 29, 2009. Therefore, we shall rescind the WCJ's March 11, 2014 decision, and issue our own decision to find that the left knee was injured arising out of and in the course of employment on January 29, 2009, and to order defendant to authorize the left knee surgery requested by Dr. Greenfield."

The board's analysis in Christensen is consistent with the principal set forth in the *JC Penny* case that if either an employer or employee fails to raise a dispute about a medical determination within the ambit of Labor Code section 4062, within the time prescribed under § 4062(a) that party may not attack that determination thereafter. *J.C. Penny Co. v. Workers' Comp. Appeals Bd. (Edwards)* (2009) (175 Cal.App.4<sup>th</sup> 818 [74 Cal. Comp. Cases 826]).

**Mitzi L. Thomas v. Bakers Burgers, Inc.**

2008 Cal. Wrk. Comp. P.D. LEXIS 351 (Noteworthy Panel Decision)

**Medical Provider Networks-Medical Treatment-WCAB held that applicant with 1/7/2006 right knee injury was entitled to seek medical treatment outside defendant's medical provider network (MPN) and that defendant was liable for self-procured medical expenses, when defendant did not provide timely authorization or provision of an MRI of applicant's right knee, and provided inadequate medical treatment within MPN.**

# DWC 20<sup>th</sup> Annual Conference

## Top Tips for Trial



By Colleen S. Casey  
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## Top Tips for Trial



1. Medical – Legal Issues
2. No Objection = Waiver
3. Filing the DOR
4. Propose a Rating String @ MSC
5. Prep Exhibits per 10629
6. Have You Met Your Burden of Proof?
7. Checklists

3

## 1. Medical – Legal Issues

### Requesting a QME Panel

8 CCR 31.1(b): “If party requests Panel QME specialty other than PTP’ s specialty, they must submit documentation to support the reason for requesting a different specialty.”

See *Richmond v. Santa Rosa Tile Co.*, (NPD) 2014 Cal Wrk Comp PD LEXIS --



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# 1. Medical – Legal Issues



Use of **electronic signature**  
by physicians and VR experts:

**Torres v. Auto Zone**, 2013 Cal Wrk Comp PD 230

“Dr. Moelleken, in his report of January 14, 2013 (**Exhibit #4**) indicates his personal use of an electronic signature, there is no signature stamp or auto pen used. This procedure is used by the undersigned and is not deemed as contrary to Workers' Compensation Laws. (*See US Fire Ins Co v. WCAB, (Love)* (2007) 72 CCC 865.)

An **electronic signature** does not render treating doctor reports inadmissible.”

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# 2. No Objection = Waiver

What happens if the PTP declares that an IW continues to be TTD **after** P&S/MMI date (or maybe **after** the IW wins 1<sup>st</sup> place in a recent Iron Man competition in Hawaii,) BUT the defense fails to object to that PTP's determination?

**Has D waived credit for overpayment of TTD?**

**Yes**, because LC 4062 requires D object to PTP report **or waive** the determination.

**J.C. Penney v. WCAB, (Edwards)**, (2009)

74 Cal. Comp. Cases 826



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## 2. No Objection = Waiver

7/23/2003 – IW, a painter, fell off a ladder, injured his knee and was paid TD

2/9/2005 – Knee surgery

**(8/9/2005 – 6 months post knee surgery)**

5/24/2006 – PTP states that IW “= TTD through **6/2006.**” **(No objection by D.)**

2/5/2007 – IW = P&S per AME (and “**probably became so 6 months after knee surgery**” i.e. **8/9/2005.**)

**3/14/2007** – TD payments end.



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## 2. No Objection = Waiver

**J.C. Penney v. WCAB, (Edwards), (2009)**

74 Cal. Comp. Cases 826



1. Since D failed to object to PTP's report of 5/24/2006 stating IW = TTD until **6/2006**, may D take credit for 18 months of overpaid TD from **8/9/05 - 3/14/2007**? No.

2. Since D had been deemed to have waived that objection, may D take credit for 9 months of overpaid TD from **6/2006 to 3/14/2007**? Probably.<sup>8</sup>

## 2. No Objection = Waiver



**LC 4062(a):** “If either the e’ ee or e’ er objects to a medical determination made by PTP concerning any medical issue, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report . . .”

The PTP’s determination of TD is considered a medical determination per 8 CCR 9785(a)(4).

**No timely objection = waiver of the issue**

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## 2. No Objection = Waiver

### **8 CCR 30(b)(1): Objection Requirements:**

- Be in writing
- Identify “PTP”
- Identify PTP’ s report that is subject of objection
- Describe medical determination that requires a medical evaluation, such as “I object to the PTP’ s determination that the IW continues to be TTD.”



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## 2. No Objection = Waiver

May 27, 2006

Dear opposing counsel,

I am in receipt of the 5/24/2006 report of primary treating physician, Dr. Kimbel.

I object to his conclusion that Mr. Edwards continues to be TTD through June 2006.

I offer the following as AMEs to resolve this dispute:



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## 3. Filing the DOR

**Page 2 of DOR which requires:**

**“Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following **specific, genuine, good faith efforts to resolve** the dispute(s) listed below:”**



**“Board intervention needed” without more may result in sanctions.**

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## 4. Propose Rating String @ MSC



**What is your proposed PD rating?**

PRE-SB863:

13.01.00.99 – 3 [6] – 4 – 322F – 4 – 4%

POST-SB863

13.01.00.99 – 3 [1.4] – 4 – 322F – 4 – 4%

**Rating string for 40 year old pantry worker - stand alone for head pain.**

LC Section 5502(d)(3):

“If the claim is not resolved at the MSC, the parties shall file a pretrial conference statement noting the specific issues in dispute, **each party’s proposed PD rating**, and listing the exhibits, and disclosing witnesses...”

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## 5. Prep Exhibits per 10629

**Comply with 8 CCR § 10629**

**Which exhibits will you offer into evidence to meet your burden of proof? Where in the exhibits can this be found; exhibit number or letter, page number and line?**

***Bresler v. WCAB, (Miller)*** (2012) 77 CCC 547; “On the day of trial, Dr. Bresler filed an “exhibit package” in EAMS, which allegedly contained all medical reports. The WCJ declined to admit the exhibit package into evidence, because exhibits must be separately e-filed and not lumped together as a single filing.”



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## 6. Have You Met Your Burden of Proof?



**Do you have substantial evidence to prove each issue?**

AME is considered to be the “opinion of each party's physician.”  
See *Green v. WCAB*, (2005) 70 CCC 294 and *Berry v. WCAB*,  
(1969) 34 CCC 507.

*AME's are not bullet proof. Make sure their reports are.*

## 6. Have You Met Your Burden of Proof?

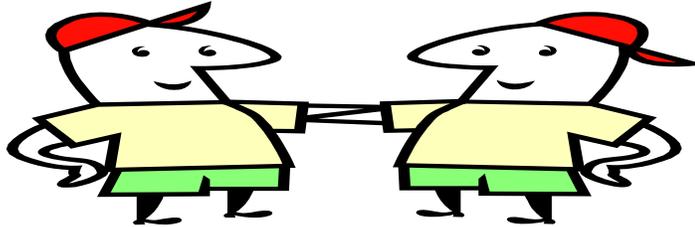


**Can't unilaterally rescind AME agreement.**

LC 4062.2 (f): "A QME panel shall not be requested... on any issue that has been agreed to be submitted to or has been submitted to an AME unless the agreement has been canceled by mutual consent."

See *Castorena v. Mark One Corporation*, (NPD) 2014 Cal Wrk Comp PD LEXIS --

## 7. Checklists

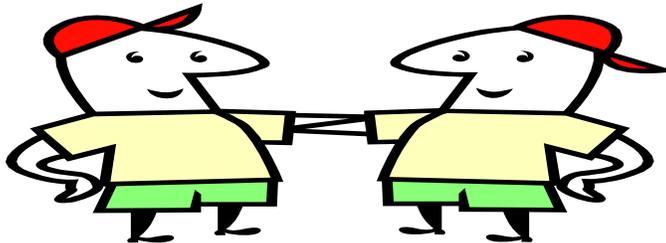


### Issues to consider before submitting a settlement doc:

- Are medical reports in file? Bring extra copies of P&S report, and the one that supports the settlement
- Is PD indicated and accurate
- If no QME, include proof that IW got notice of QME option
- Extent of FMT? Is surgery recommended?

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## 7. Checklists



### Issues to consider before submitting a settlement doc:

- If C&R – Is amount sufficient for FMT?
- If Stip – has FMT box (yes or no) been checked?
- Has IW RTW? w/ or w/o restrictions?
- Document – properly signed? (See *Marchese v. Home Depot*, (2009) 37 CWCR 282.)

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## 7. Checklists

### Gold Standard for Substantial Evidence:

*Place v. WCAB*, (1970) 35 CCC 525



### Opinion can't be based on:

- Surmise, speculation, conjecture or guess
- Incorrect legal theory
- Inadequate medical history or exam
- Must set forth the reasons, the “how and why” for the conclusions
- Must be based on **reasonable medical probability**

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## 7. Checklists

### For psych AOE/COE:

*Rolda v. Pitney Bowes* (2001) 66 CCC 241

1. Did psych injury involve “actual events of employment” (**legal issue** – IW’ s b/p)
2. Is there > 50% industrial causation (**medical issue** – IW’ s b/p)
3. Were there personnel action(s)? If so, were they lawful, nondiscriminatory & in good faith? (**legal issue** – D’ s b/p)
4. Were personnel action(s) the substantial cause (35-40%) of the psych injury (**medical issue** – D’ s b/p)



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## 7. Checklists

### Checklist for *Guzman* rebuttal trial:

*Milpitas Unified v. WCAB (Guzman III)*, (2010)  
75 CCC 837



1. What is the **strict** AMA Guides rating?
2. Is strict rating accurate?
3. If not, why not? (**Example:** IW = 0% WPI, but physician has stated IW is unable to return to his usual and customary job because of the injury **OR other adequate explanation.**)
4. Does the physician's report = substantial evidence? (See slide #24.)

**NOTE:** **Make sure to explain which rebuttal theory is being used**  
(*Guzman*, LC 4662 or maybe even *LeBoeuf*).  
**Evidentiary proof requirements are different based on the theory used.**

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## 7. Checklists

Ideally, in most cases, per *Guzman*, **the physician should:**



- Begin with a **strict** AMA Guides rating found in the **chapter** addressing the body part injured.
- Note which specific **facts** require an alternate rating. (**Example:** complicated objective factors, failed back surgery, disfiguring facial scar.)
- Set forth "**how** the physician arrived at an alternate rating," (Physician must "show their work.")
- Provide an **analysis** as to "**why** departure rating from the WPI is necessary" (why it's more **accurate**), which may include "standard texts or recent research data."
- State the conclusion based on **reasonable medical probability**.

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## 7. Checklists

### Apportionment Checklist:

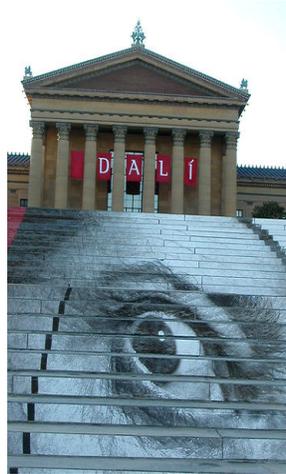
*Escobedo v. Marshalls*, (2005) 70 CCC 604

**Step 1:** Dr. must make an apportionment determination

**Step 2:** Dr. must base his conclusion on “reasonable medical probability.”

**Step 3:** Dr. must explain basis for how and why he reached his conclusion.

**Step 4:** Dr. must avoid the danger zones (age, risk factors, **fairness**)



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## 7. Checklists

### VR expert's report checklist:

WCAB Reg § 10606.5:



- Declaration under penalty of perjury
- Curriculum Vitae – list of qualifications
- VR report should include: date of eval; history of injury; e'ee's vocational history; IW's complaints; list of info reviewed by VR expert; IW's medical history; findings by VR expert; Rationale for conclusion.

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# SETTLEMENTS

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HOW TO INCREASE THE CHANCES FOR  
APPROVAL AND IMPRESS AT THE SAME  
TIME

By Joel Harter

## INTRODUCTION

WHEN YOU SUBMIT A SETTLEMENT FOR APPROVAL YOU SHOULD HAVE A REASONABLE EXPECTATION THAT THE SETTLEMENT WILL BE APPROVED. AT THE END OF THE DAY, MOST SETTLEMENTS ARE CONSIDERED ADEQUATE AND ARE APPROVED, BUT MANY ARE NOT APPROVED AT THE OUTSET OR APPROVAL IS DELAYED, FOR REASONS THAT COULD HAVE, AND SHOULD HAVE, BEEN AVOIDED. MOST OF THESE REASONS ARE A RESULT OF HAPHAZARD PREPARATION OF SETTLEMENT DOCUMENTS OR FAILURE TO KNOW AND UNDERSTAND THE TERMS OF THE SETTLEMENTS THEMSELVES.

## FILING PROBLEMS - OCR

### FAXED COPIES ARE UNACCEPTABLE.

FAXED COPIES ARE SHRUNKEN, MAKING IT IMPOSSIBLE FOR THE SCANNER TO READ THE FIELDS AND CAPTURE INFORMATION. THAT MEANS THAT DWC STAFF WILL HAVE TO MANUALLY INPUT THE INFORMATION NOT CAPTURED BY THE SCANNER, WHICH MORE THAN TRIPLES THE LENGTH OF TIME IT TAKES TO PROCESS THE SETTLEMENT DOCUMENT AND ASSIGN IT TO A JUDGE.

## FILING PROBLEMS - OCR

EVEN WHEN SUBMITTED AS A “CORRESPONDENCE – OTHER” ATTACHMENT TO AN E-FILE SETTLEMENT, THE PRINT IS OFTEN TOO SMALL, DARK OR GRAINY TO READ. SOMETIMES PARTS OF A PAGE ARE MISSING.



## FILING PROBLEMS - OCR

DO NOT SUBMIT DOCUMENTS THAT HAVE STAPLES IN THEM. EVEN IF THE STAPLES ARE REMOVED THE DOCUMENTS MAY GET HUNG UP WHEN BEING SCANNED. 8 Cal Code Regs 10205.12(a)(12).



## FILING PROBLEMS - OCR

DO NOT SUBMIT FOLDED UP, ABUSED OR WRINKLED SETTLEMENT DOCUMENTS. (8 Cal Code Regs 10205(a)(12)) THESE WILL GET HUNG UP WHEN SCANNING THE DOCUMENT.



## FILING PROBLEMS - OCR

### OTHER PROBLEMS:

- LACK OF COVER SHEETS.
- LACK OF SEPARATOR SHEETS.
- WRONG DOCUMENT TITLES USED.
- WRONG DOCUMENT AUTHORS IDENTIFIED.



## FILING PROBLEMS - OCR

THE PROBLEMS DESCRIBED ABOVE RESULT IN DELAYS IN PROCESSING THE SETTLEMENT DOCUMENT, OR IF BAD ENOUGH, WILL RESULT IN A REJECTION OF THE DOCUMENTS FOR FILING.



## SETTLEMENTS IN GENERAL

SETTLEMENT DOCUMENTS SHOULD BE FULLY COMPLETED. FAILURE TO FILL OUT PERIODS OF TD OR PD PAID, OR AMOUNT OF MEDICAL TREATMENT PAID WILL RESULT IN AN ASSUMPTION THAT NO SUCH BENEFITS WERE PAID.

IF THIS IS INCONSISTENT WITH THE MEDICAL REPORTS SUBMITTED, THE SETTLEMENT WILL NOT BE APPROVED WITHOUT VALID EXPLANATION.

## SETTLEMENTS IN GENERAL

IDENTIFY AND SUBMIT THE REPORT(S) OR RECORDS THAT ARE RELEVANT TO THE ISSUES BEING SETTLED.

NOTE: "RELEVANT" REPORTS OR RECORDS ARE NOT NECESSARILY THE SAME AS REPORTS OR RECORDS "RELIED UPON" FOR THE SETTLEMENT. A DOCUMENT MAY BE RELEVANT AND NOT SUPPORTIVE OF THE SETTLEMENT AS SUBMITTED.

## SETTLEMENTS IN GENERAL

IF TD OR PD WAS NOT PAID AT MAXIMUM RATES, PROVIDE DOCUMENTATION OF THE BASIS FOR THE RATES SET FORTH IN THE SETTLEMENT DOCUMENT.



## SETTLEMENTS IN GENERAL

IF CREDIT IS BEING TAKEN FOR AN ALLEGED OVERPAYMENT OF BENEFITS (MOST LIKELY TD), PROVIDE AN EXPLANATION. SOME JUDGES WILL NOT ALLOW A TD OVERPAYMENT CREDIT AGAINST PD, ABSENT A SHOWING OF DOUBLE PAYMENTS OR SOME KIND OF IW CULPABILITY, AS THE TAKING OF SUCH A CREDIT DEFEATS THE PURPOSE OF THE RECEIPT OF PD.

## SETTLEMENTS IN GENERAL

### DO NOT HIDE THE BALL.

IF A SETTLEMENT IS FOR LESS THAN FULL VALUE OF THE MEDICAL REPORTS, INCLUDE AN EXPLANATION. IF THERE WAS A DEU RATING, LET THE JUDGE KNOW. IF A JUDGE HAD DETERMINED THE APPORTIONMENT DESCRIBED BY THE QME WAS NOT LEGALLY VALID, LET THE JUDGE KNOW. IF A REPORT CONTRADICTS THE REPORT BEING RELIED UPON FOR THE SETTLEMENT, LET THE JUDGE KNOW. NOTHING MAKES A LITIGANT LOOK WORSE THAN FOR A JUDGE TO FIND OUT SOMETHING NOT REVEALED BY THE PARTIES.

## LIENS AND SETTLEMENTS

8 CAL CODE REGS section 10886: WHEN A C&R OR STIPS HAS BEEN FILED, A COPY SHALL BE SERVED ON ANY LIEN CLAIMANTS. THAT INCLUDES A SETTLEMENT DOCUMENT BEING SUBMITTED FOR A WALK-THROUGH (8 CAL CODE REGS section 10417(D)(1)).

## LIENS AND SETTLEMENTS

BEFORE ISSUANCE OF AN ORDER APPROVING COMPROMISE AND RELEASE THAT RESOLVES A CASE OR AN AWARD THAT RESOLVES A CASE BASED UPON THE STIPULATIONS OF THE PARTIES, IF THERE REMAINS ANY LIENS THAT HAVE NOT BEEN RESOLVED OR WITHDRAWN, **THE PARTIES** SHALL MAKE A GOOD FAITH ATTEMPT TO CONTACT THE LIEN CLAIMANTS AND RESOLVE THEIR LIENS. A GOOD FAITH ATTEMPT REQUIRES AT LEAST ONE CONTACT OF EACH LIEN CLAIMANT BY TELEPHONE OR LETTER.

## LIENS AND SETTLEMENTS

AN AGREEMENT TO “PAY, ADJUST OR LITIGATE” A LIEN, OR ITS EQUIVALENT, OR AN AWARD LEAVING A LIEN TO BE ADJUSTED IS NOT A RESOLUTION OF A LIEN. (8 CAL CODE REGS section 10888).



## STIPULATIONS WITH REQUEST FOR AWARD

DO NOT ADD LANGUAGE PURPORTING TO DESCRIBE THE SCOPE AND EXTENT OF FUTURE MEDICAL TREATMENT.

WE ALL KNOW FULL WELL THAT ANY REQUESTS FOR AUTHORIZATION OF TREATMENT WILL BE PUT THROUGH UR.



## COMPROMISE AND RELEASE

SETTLING PARTS OF BODY “AS SET FORTH IN THE MEDICAL RECORDS” IS NOT APPROPRIATE.

THE BODY PARTS SHALL BE SPECIFICALLY STATED.

BUT BEWARE THAT ADDING BODY PARTS WITHOUT ANY MEDICAL ADDRESSING THEM IS A GOOD WAY TO GUARANTEE AN ORDER SUSPENDING ACTION.



## PRO PER SETTLEMENTS

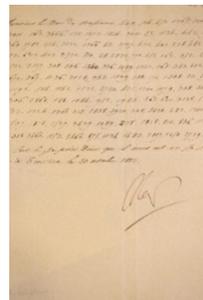
ALL RELEVANT MEDICAL REPORTS OF TREATING PHYSICIANS AND QME'S SHOULD BE SUBMITTED.

INCLUDES TREATMENT REPORTS THAT WERE RELIED UPON TO BEGIN OR TERMINATE TD, OR WHICH WERE OBJECTED TO, RESULTING IN REFERRAL TO A QME.

THIS WOULD ALSO INCLUDE REPORTS OF DIAGNOSTIC TESTS CONDUCTED.

## PRO PER SETTLEMENTS

THERE SHOULD ALWAYS BE A BRIEF EXPLANATION OF THE BASIS FOR SETTLEMENT



## PRO PER SETTLEMENTS

RATINGS OF ALL PERMANENT AND STATIONARY REPORTS SHOULD BE INCLUDED. IF A DEU RATING EXISTS, YOU MAY INDICATE SUCH AND THE WCJ CAN LOOK IT UP.

A DEU RATING SHOULD ALWAYS BE OBTAINED IN CASES INVOLVING MULTIPLE BODY PARTS.

IF SELF-RATED, PROVIDE THE RATING STRING.

## PRO PER SETTLEMENTS

IF SETTLEMENT IS BASED ON THE TREATING PHYSICIAN'S P&S REPORT, I WANT TO SEE A WAIVER OF THE QME PROCESS SIGNED BY THE IW.



## PRO PER SETTLEMENTS

IF SETTLEMENT IS REACHED WITHOUT A P&S OR QME REPORT:

THE INJURED WORKER SHOULD BE PRESENT IF THE SETTLEMENT IS PRESENTED AT A WALK-THROUGH OR HEARING.

OTHERWISE, A DETAILED EXPLANATION OF THE BASIS FOR SETTLEMENT AND WHICH JUSTIFIES THE SETTLEMENT AMOUNT SHOULD BE INCLUDED.

## PRO PER SETTLEMENTS

DOCUMENT THE BASIS AND CALCULATION OF AVERAGE WEEKLY EARNINGS IF LESS THAN MAXIMUM.

ANY LETTERS OR NOTICES SENT TO THE IW SHOULD BE SUBMITTED.

WHERE BENEFITS HAVE BEEN PROVIDED, A CURRENT COMPUTER PRINTOUT OF ALL BENEFITS PAID SHOULD BE INCLUDED.

## WALK-THROUGHS ARE NOT PRO FORMA!

EVERYTHING COVERED ABOVE APPLIES TO WALK-THROUGHS.

WALK-THROUGHS ARE NOT PRO FORMA PROCEEDINGS WHERE SETTLEMENTS ARE APPROVED WITH LITTLE OR NO SCRUTINY.



## WALK-THROUGHS ARE NOT PRO FORMA!

DO NOT SEND SOMEONE FOR A WALK-THROUGH WITHOUT THE FILE AND WHO KNOWS NOTHING ABOUT THE CASE!!



## WALK-THROUGHS ARE NOT PRO FORMA!

A JUDGE HAS HAD NO OPPORTUNITY TO REVIEW THE FILE PRIOR TO A WALK-THROUGH AND WILL LIKELY ASK SEVERAL QUESTIONS AT THE WALK-THROUGH. THIS IS ESPECIALLY THE CASE IF THE SETTLEMENT DOCUMENTS ARE NOT FILLED OUT CORRECTLY AND COMPLETELY AND/OR THE DOCUMENTATION SUBMITTED DOES NOT ADDRESS POSSIBLE AREAS OF CONCERN.

## WALK-THROUGHS ARE NOT PRO FORMA!

APPEARANCE BY SOMEONE WHO HAS NOT PREPARED FOR THE WALK-THROUGH TAKES AWAY TIME THAT A JUDGE CAN SPEND ON THOSE CASES SET FOR HEARING!



## IN CLOSING

FUNNY STORY (SORTA)

## Getting the Medical-Legal Process Started

- Labor Code section 4061
  - If either party objects to the treating physician's determination of PD or future medical care, go to evaluation per Labor Code section 4062.1 (unrepresented applicants) or Labor Code section 4062.2 (represented applicants).
- Labor Code section 4062
  - If either party objects within 20 days (represented) and 30 days (unrepresented) of receipt to the treating physician's determination of medical issues not covered by 4060, 4061 or 4610, go to evaluation per Labor Code section 4062.1 (unrepresented applicants) or Labor Code section 4062.2 (represented applicants).
    - Time limits in this section can be extended for "good cause."

## Getting the Medical-Legal Process Started

- Labor Code section 4062.1 (Unrepresented Applicants)
  - (a): No AMEs
  - (b): Employer must wait 10 days after sending the panel request form to applicant and asking applicant to complete it before it can complete the form. Party sending in the form shall designate the specialty.
  - (c): Employee can choose the PQME from the list, and Employer must wait 10 days after assignment of the panel to the parties before employer can choose the PQME.
  - (e): If applicant becomes represented later, PQME remains in place.

## Getting the Medical-Legal Process Started

- Labor Code section 4062.2
  - (b): The party submitting the panel request designates the specialty of the medical evaluator. The party that submits the request “shall” provide information, including the specialty of the medical evaluator requested by the other party and the specialty of the treating physician. Copies are to be served on the other party.
    - Timing Issues: *Messele v. Pitco Foods* cases and 8 CCR 10507
  - (c): Within 10 days of the assignment of the panel, each party shall strike one name from the panel. The third and remaining doctor will be the sole medical evaluator for the case. If one party fails to timely exercise the right to strike a name, the other party may select any physician who remains on the panel to serve as the evaluator.
  - (d): A represented employee is responsible for setting up an appointment for the evaluation. But if the applicant fails to do so within 10 days after the selection of the panel physician, the defense is to make the arrangements.
  - (f): A PQME cannot be obtained on any issue to which an AME agreement applies. The parties can agree to an AME at any time, except for issues under Labor Code section 4610.5. AME agreements can only be canceled by written mutual consent.

## General Considerations of the Medical-legal Exam

- The role of the medical-legal evaluator
  - Usually one per specialty
    - Replacement Requests - 8 CCR 31.5
    - Additional Evaluations - 8 CCR 31.7
  - Labor Code section 4062.3(k)
    - *Navarro v. City of Montebello (en banc)* 79 Cal.Comp.Cases 619

## Setting Up the Exam

- 8 CCR § 31.3(e): A PQME exam must take place within 60 days from the date of the appointment request, or up to 90 days if requesting party agrees, or beyond 90 days if both parties agree.
- 8 CCR § 34(b): The initial evaluation must be at the address on the panel selection form. Subsequent evaluations may take place at any office that is registered with the medical director and is within a reasonable geographic distance from the injured worker's residence.

## Re-scheduling the Exam

- 8 CCR §34(d): AME, Agreed PQME, and PQME appointments cannot be canceled with less than 6 business days' notice, except for good cause, and the WCAB determines good cause.
- 8 CCR §34(e): A canceled Agreed PQME or PQME must be rescheduled within 30 calendar days of the date the evaluation was canceled, and within 60 calendar days of the date of the initial request, unless the parties waive in writing the 60 day limit.
- 8 CCR §34(f): A canceled AME must be rescheduled within 60 calendar days of the date the evaluation was canceled, and can be extended an additional 30 calendar days by the parties in writing.

## Receipt and Review of Records

- 8 CCR §34(g): Failure to receive relevant medical records prior to the evaluation does not establish good cause to cancel the evaluation, except for psyche evaluators who state in the report that the records are necessary for a full and fair evaluation.
- Labor Code §4628(a)(2): The physician who signs the medical-legal report shall review and summarize medical records, except that, per subsection (c), if someone else does it the physician shall review the excerpts and make additional inquiries as are necessary and appropriate to identify and determine the relevant medical issues.
  - But see 8 CCR §41(c)(2)

## Conducting the Exam

- 8 CCR §41(a)(1): The exam is done at a “Clean, Professional Physician’s Office” with a functioning business office phone for that location.
- 8 CCR 41(f): The exam starts within 1 hour of the scheduled appointment time, unless both parties agree
- Minimum “Face-to-Face” (8 CCR §49(b)) time:
  - Neuromusculoskeletal Exam: 20 minutes (8 CCR §49.2)
  - Psychiatric Exam: 1 hour (8 CCR §49.8)
  - All others: 30 minutes (8 ccr §§49.4, 49.6, 49.9)
- Disclosure Requirements: 8 CCR §40
  - (a) Injured worker is allowed and the evaluator is required to answer all questions about the evaluation procedure
  - (b) Injured worker is allowed to discontinue the exam for good cause.
- CCP §2032.510(a) allows the injured worker’s attorney or designated representative to “attend and observe” the evaluation and allows an audio or stenographic recording of the examination to be made.

## Writing the Report

- Content of Report:
  - 8 CCR §10606(b) (1) – (15) Checklist
  - 8 CCR §10606(c): All reports shall comply with LC §4628 and failure of a physician to comply with this rule will affect weight of report but not its admissibility.
  - LC §4628(a) – (d), (j) requirements
  - LC §4628(e): Failure to comply with LC §4628 shall make the report inadmissible and eliminate any liability for payment; LC §4628(f) can subject evaluator to a civil fine up to \$1000 for a “knowing failure” to comply with LC §4628, in addition to possibilities of affecting the physician’s QME license (LC §4628 (g)) and contempt (LC §4628(h)).

## Writing the report

- More information is needed:
  - 8 CCR §41(c)(4): A QME shall only render an opinion on issues which the evaluator has adequate qualifications, education, and training.
  - 8 CCR 35.5(d): An evaluator shall advise the parties in writing of any disputed medical issues outside of the evaluator’s scope of practice and area of clinical competency so that the parties may initiate the process of obtaining an additional evaluation in another specialty.

## Communicating to the Parties

- Any ex parte communication with a PQME is a violation of Labor Code §4062.3(e) and such action may be a sanctionable offense (Alvarez v. WCAB (2010) 75 CCC 817).
  - Unless the ex parte communication is “insignificant and inconsequential?”
- AMEs are covered by LC §4062.3(f): Communications shall be in writing, but oral communications with the AME or staff is not ex parte communication for administrative matters, unless WCAB says otherwise.
- IMEs are covered by 8 CCR §10718: “All correspondence concerning the examination and reports of a physician appointed pursuant to LC §5701 ... shall be made through the [WCAB] and no party shall communicate with that physician with respect to the merits of the case unless ordered to do so by the WCAB.”

## Timelines for Reports

- 8 CCR §38(a): An initial or follow-up comprehensive medical-legal evaluation report must be prepared and submitted no later than 30 days after a PQME, Agreed PQME, or AME has commenced.
  - Unless a 15 or 30 day extension is sought pursuant to 8 CCR §38(c) – (g)
- 8 CCR §38(i): Any supplemental reports must be completed within 60 days of the date of the request.
  - A 30 day extension can be agreed to by the parties.

## Depositions

- 8 CCR §35.5(f): An evaluator shall be available within 120 days of the notice of deposition, and, if the injured worker is unrepresented, the deposition shall take place at the location of the examination or at a location selected by the deposing party within 20 miles of the examination location.

## Pay or Else

- Labor Code section 4063: Subject to Labor Code section 4650(b)(2), where an AME or PQME has opined that compensation is due, the employer is required to pay or file a DOR.