

Utilization Review

I. Utilization review: (General Discussion)

A. Utilization review means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, treatment based whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians.

B. Every employer shall establish a utilization review process in compliance with LC section 4610 either directly or through its insurer.

C. The employer, insurer or entity that uses the review shall employ and designate a medical director who is licensed to practice medicine in this state.

D. Each utilization review process shall be governed by written policies and procedures. The written policy and procedures shall be filed with the Administrative Director and disclosed by the employer to the employee, physicians, and the public upon request. These policies and procedures shall insure that decisions on medical treatment are based on medical necessity to cure or relieve and are based upon guidelines or criteria. The guidelines or criteria are to be evaluated annually. They are to be disclosed to the physician and employee if used as a basis to modify, delay or deny treatment. The guidelines that are used for utilization review to approve, modify or deny treatment are to be based on criteria developed by actively practicing physicians, shall be consistent with the schedule for medical treatment adopted by the administrative director pursuant to LC section 53097.27 and until adopted, by the guidelines of ACOEM.

E. The employer can request additional information from the physician in order to determine if treatment should be approved, modified or denied. The employer can only ask for information reasonably necessary to make the determination.

F. A decision to deny or modify treatment can only be made by a physician within the scope of his or her license and not the adjuster. No person other than a licensed physician who is competent to evaluate the specific clinical services, and where the services are within the scope of the physician practice may modify, delay or deny requests for authorization for medical treatment.

G. If utilization review results in a rejection or modification of the treating physician's recommended treatment and the employee disputes the rejection or modification, the dispute will be resolved by the use of LC section 4062.

II. ACOEM (Generally)

- A. The injured worker is entitled to that medical treatment that is reasonable and necessary to cure or relieve from the effects of the industrial injury as defined by guidelines adopted by the administrative director or until that happens the ACOEM Guidelines for treatment after March 22, 2004.
- B. The ACOEM Guidelines beginning March 22, 2004, and when adoption by the administrative director of a medical treatment utilization schedule pursuant to the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment.
- C. The recommended guidelines set forth in the schedule adopted by the administrative director shall reflect practices that are evidence and scientifically based, nationally recognized, and peer-reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with LC section 4600 for all injured workers diagnosed with industrial conditions.
- D. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.
- E. The presumption created is one affecting the burden of proof.
- F. The guidelines are based on treatment that returns the injured employee to become more functional and return to work rather than to relieve the pain.
- G. LC section 4600 provides that medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthodontic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. 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.
 - 1. As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to LC section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine Practice Guidelines.
- H. For all injuries not covered by the American College of Occupational and Environmental Medicine Practice Guidelines or official utilization schedule after

adoption pursuant to LC section 5307.27, authorized treatment shall be in accordance with other evidence based on medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

I. Leon Smith v. Churn Creek Construction; State Fund: (BPD 96 CCC 1012): Held that where ACOEM Guidelines were in effect (but no presumption) at the time of time of the utilization review, the burden shifts to the treating physician to justify the requested treatment.

III. The Utilization Review Regulations

§ 9792.6. Utilization Review Standards—Definitions

As used in this Article:

(a) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, Second Edition.

(b) “Claims Administrator” is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer or a joint powers authority.

(c) “Concurrent review” means utilization review conducted during an inpatient stay.

(d) “Course of treatment” means the course of medical treatment set forth in the treatment plan contained in the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021 or in the “Primary Treating Physician’s Progress Report,” DWC Form PR-2.

(e) “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.

(f) “Expedited review” means utilization review conducted when the injured worker’s condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker’s life or health or could jeopardize the injured worker’s permanent ability to regain maximum function.

(g) “Expert reviewer” means a physician, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician’s practice, who has been consulted by the reviewing physician or utilization review medical director to provide specialized review of medical information.

(h) "Health care provider" means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

(i) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(j) "Prospective review" means utilization review conducted prior to the delivery of the requested medical services.

(k) "Request for authorization" means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth in Form DLSR 5021, section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of section 9785.

(l) "Retrospective review" means utilization review conducted after medical services have been provided and for which services approval has not already been given.

(m) "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization process.

(n) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.

(o) "Written" includes a facsimile as well as communications in paper form.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.7. Utilization Review Standards—Applicability

(a) Effective January 1, 2004, every claims administrator shall establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date

of injury, in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The name and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) A description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process. It shall include a description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria. Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), Second Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com).

(4) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

(b)(1) The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations.

(2) No person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time

limitations imposed in section 9792.9 subdivisions (b)(1), (b)(2) or (c). Any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (f)(1)(A) through (f)(1)(C) of section 9792.9.

(c) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director.

(d) Upon request by the public, the claims administrator shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process.

(1) The claims administrator may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means. If a member of the public requests a hard copy of the utilization review plan, the claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed \$0.25 per page plus actual postage costs.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.8. Utilization Review Standards—Medically-Based Criteria

(a)(1) The criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, Second Edition. The guidelines set forth in the ACOEM Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to Labor Code section 5307.27. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

(2) For all conditions or injuries not covered by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

(3) The criteria or guidelines used shall be disclosed in written form to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, if used as the basis of a decision to modify, delay, or deny services in a specific case under review. The claims administrator may not charge an injured worker, the injured worker's attorney and the injured worker's physician or the provider of goods for a copy of the criteria or guidelines used to modify, delay or deny the treatment request.

(A) The claims administrator is required to disclose the criteria or guidelines used as the basis of a decision to modify, delay, or deny services for the specific procedure or condition requested in a specified case under review.

(B) A written copy of the relevant portion of the criteria or guidelines used shall be enclosed with the written decision to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney pursuant to section 9792.9, subdivision (i).

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.9. Utilization Review Standards—Timeframe, Procedures and Notice Content

(a) The request for authorization must be in written form.

(1) For purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was transmitted. A request for authorization transmitted by facsimile after 5:30 PM Pacific Standard Time shall be deemed to have been received by the claims administrator on the following business day as defined in section 9 of the Civil Code. The copy of the request for authorization received by a facsimile transmission shall bear a notation of the date and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted.

(2) Where the request for authorization is made by mail, and a proof of service by mail exists, the request shall be deemed to have been received by the claims administrator five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service. Where the request for authorization is delivered via certified mail, return receipt mail, the request shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt. In the absence of a proof of service by mail or a dated return receipt, the request shall be deemed to have been received by the claims administrator on the date stamped as received on the document.

(b) The utilization review process shall meet the following timeframe requirements:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for authorization.

(2) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.

(A) If the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the provider, the claims administrator may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

(3) Decisions to approve, modify, delay or deny a physician's request for authorization prior to, or concurrent with, the provision of medical treatment services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve, modify, delay or deny a request shall be communicated to the physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours for concurrent review and within two business days for prospective review. For purposes of this section "normal business day" means a business day as defined in section 9 of the Civil Code.

(c) When review is retrospective, decisions shall be communicated to the physician who provided the medical services and the provider of goods, if any, to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services.

(d) Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The provider must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:

(1) When the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or

(2) The normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(e) The review and decision to deny, delay or modify a request for medical treatment must be conducted by a physician, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice.

(f)(1) The timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may only be extended by the claims administrator under the following circumstances:

(A) The claims administrator is not in receipt of all of the necessary medical information reasonably requested.

(B) The physician reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

(C) The claims administrator needs a specialized consultation and review of medical information by an expert reviewer.

(2) If subdivisions (A), (B) or (C) above apply, the claims administrator shall immediately notify the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the claims administrator cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the expert reviewer consulted. The claims administrator shall also notify the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. This notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with section 10136, subdivision (b)(1).

(3) Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, modify, or deny the request for authorization within five (5) days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivision (b)(3).

(4) Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, modify, or deny the request for authorization within thirty (30) days of receipt of the information for retrospective review.

(g) Every claims administrator shall maintain telephone access from 9:00 AM to 5:30 PM Pacific Standard Time, on normal business days, for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting

authorization for medical services after business hours. For purposes of this section “normal business day” means a business day as defined in section 9 of the Civil Code. In addition, for purposes of this section the requirement that the claims administrator maintain a process to receive communications from providers after business hours shall be satisfied by maintaining a voice mail system or a facsimile number for after business hours requests.

(h) A written decision approving a request for treatment authorization under this section shall specify the specific medical treatment service approved.

(i) A written decision modifying, delaying or denying treatment authorization under this section shall be provided to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney and shall contain the following information:

(1) The date on which the decision is made.

(2) A description of the specific course of proposed medical treatment for which authorization was requested.

(3) A specific description of the medical treatment service approved, if any.

(4) A clear and concise explanation of the reasons for the claims administrator’s decision.

(5) A description of the medical criteria or guidelines used pursuant to section 9792.8, subdivision (a)(3)(B).

(6) The clinical reasons regarding medical necessity.

(7) A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker’s attorney on behalf of the injured worker to the claims administrator in writing within 20 days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state that the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with section 10136, subdivision (b)(1).

(8) Include the following mandatory language:

"If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

“You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but,

unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

(9) Details about the claims administrator's internal utilization review appeals process, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

"If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process."

(j) The written decision modifying, delaying or denying treatment authorization provided to the physician shall also contain the name of the physician reviewer, the specialty of the reviewer, the telephone number of the reviewer, and hours of availability.

(k) Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods either by facsimile or mail.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.10. Utilization Review Standards—Dispute Resolution

(a)(1) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code section 4062.

(2) An objection to a decision disapproving in whole or in part a request for authorization of medical treatment, must be communicated to the claims administrator by the injured worker or the injured worker's attorney in writing within 20 days of receipt of the utilization review decision. The 20-day time limit may be extended for good cause or by mutual agreement of the parties.

(3) Nothing in this paragraph precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the injured worker and if the injured worker is represented by counsel, the injured worker's attorney have been notified of the 20-day time limit to file an objection to the utilization review decision in accordance with Labor Code section 4062.

(4) Additionally, the injured worker or the injured worker’s attorney may file an Application for Adjudication of Claim, and a Request for Expedited Hearing, DWC Form 4, and request an expedited hearing and decision on his or her entitlement to medical treatment if the request for medical treatment is not authorized within the time limitations set forth in section 9792.9, or when there exists a bona fide dispute as to entitlement to medical treatment.

(b) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the injured worker’s physician and provider of goods, if any, has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the injured worker.

(2) Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

§ 9792.11. Utilization Review Standards—Penalties

(a) [Reserved for Labor Code section 4610 penalty rule.]

(b) The Administrative Director, or his or her delegee, may use the audit powers pursuant to Labor Code sections 129 and 129.5 to assess administrative and civil penalties for violations of this Article.

Authority: Sections 133, 4603.5, 4604.5, and 5307.3, Labor Code.

Reference: Sections 129, 129.5, 4062, 4600, 4600.4, and 4610, Labor Code.

IV. The Cases on the utilization review process (Willette, Sandhagen and Shearson):

A. The WCAB in an en banc decision held as follows in Willette v. AU Electrical Corporation and SCIF, 69 CCC 1298 (WCAB en banc)

(1) If an employer’s utilization review physician does not approve an employee’s treating physician’s treatment authorization request in full, then an unrepresented employee (if he or she desires to dispute the utilization review physician’s determination) must timely object, and then a panel qualified medical examiner (“QME”) must be obtained to resolve the disputed treatment issue(s);

(2) Once the panel QME's evaluation has been obtained, neither the treating physician nor the utilization review physician may issue any further reports addressing the post-utilization review treatment dispute;

(3) The panel QME should ordinarily be provided with and consider both the reports of the treating physician and the utilization review physician regarding the disputed issues;

(4) If a post-utilization review medical treatment dispute goes to trial after the panel QME issues his or her report, both the treating physician's and the utilization review physician's reports are admissible in evidence; and

(5) When a WCJ or the Appeals Board issues a decision on a post-utilization review medical treatment dispute, the reports of the panel QME, the treating physician, and the utilization review physician will all be considered, but none of them is necessarily determinative.

1. Where An Employer's Utilization Review Physician Does Not Approve A Treatment Authorization Request In Full, Then An Unrepresented Employee Who Desires To Dispute The Utilization Review Physician's Determination Must Timely Object And Then A Panel QME Must Be Obtained To Report On The Dispute.

A. If an employer's utilization review physician denies, in whole or in part, the medical treatment requested or provided by the employee's treating physician, then an unrepresented employee who disputes the utilization review physician's determination must timely object to that determination and, thereafter, a panel QME is *required* to be obtained to report on the disputed treatment issue(s).¹ This interpretation is consistent with the express language of sections 4610, 4062, 4062.1, and 4062.3. Specifically, section 4610 states, in relevant part:

“If the [treating physician's] request [for authorization of medical treatment] is not approved in full, *disputes shall be resolved in accordance with Section 4062.*” (Lab. Code, §4610(g)(3)(A). and:

“If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, *the dispute shall be resolved pursuant to Section 4062.*” (Lab. Code, §4610(g)(3)(B) (emphasis added).)

B. Section 4062 states, in relevant part: “*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 ... [and] [i]f the employee is not represented by an attorney, the employer shall immediately provide the employee with a*

¹ Disputes regarding spinal surgery must be resolved under section 4062(b). (Lab. Code, §4610(g)(3)(A); see also, §4062(a) & (b).)

form ... to request assignment of a panel of three [QMEs], [and] the evaluation *shall* be obtained as provided in Section 4062.1” (Lab. Code, §4062(a) (emphasis added).)²

Also, section 4062.1 provides, in relevant part:

“Within 10 days of the issuance of a panel of [QMEs], the employee *shall* select a physician from the panel to prepare a medical evaluation, the employee *shall* schedule the appointment, and the employee *shall* inform the employer of the selection and the appointment.” (Lab. Code, §4062.1(c) (emphasis added).)and

“The unrepresented employee *shall* ... participate in the evaluation.” (Lab. Code, §4062.1(d) (emphasis added).)

Further, section 4062.3 provides, in relevant part:

C. “Upon completing a determination of the disputed medical issue, the [QME] ... *shall* serve the formal medical evaluation ... on the employee and the employer.” (Lab. Code, §4062.3(i) (emphasis added).)

Thus, because section 4610 states that disputes under that section “shall” be resolved in accordance with section 4062, and because section 4062 states that, if *the employee* objects to a decision made pursuant to section 4610 not to fully approve a treatment recommendation, *the employee* “shall” notify the employer of the objection within specified time frames, then it is incumbent on the employee to make a timely objection under 4062 to a utilization review physician’s determination to disapprove, in whole or in part, the treating physician’s prescribed treatment.³ Also, because section 4062(a) provides that a panel QME evaluation “shall” be obtained, because sections 4062.1(c) and 4062.1(d) provide that the employee “shall” select a panel QME, schedule the appointment, inform the employer of the selection, and participate in the evaluation, and because section 4062.3(i) provides that the panel QME “shall” serve a report that determines the disputed medical issue, then a panel QME report must be obtained whenever an unrepresented employee timely disputes a utilization review determination regarding treatment.

² Section 4062(a) provides that, in general, the employee must notify the employer of the objection in writing within 20 days of receipt of the decision to modify, delay, or deny a treatment recommendation; however, these time limits may be extended for good cause or by mutual agreement. (Lab. Code, §4062(a).)

³ We recognize that neither section 4610(g)(3)(A) nor 4610(g)(3)(B) specifically addresses the issue of retrospective utilization review (i.e., section 4610(g)(3)(A) is concerned with both prospective and concurrent utilization review and section 4610(g)(3)(B) is concerned with only concurrent utilization review). Nevertheless, section 4062(a) makes it clear that the employee must object to *any* decision made under section 4610 to modify, delay, or deny a treatment recommendation.

2. Once The Panel QME's Evaluation Has Been Obtained, Neither The Treating Physician Nor The Utilization Review Physician May Issue Any Further Reports Addressing The Post-Utilization Review Treatment Dispute.

A. The panel QME's evaluation is the *only* medical evaluation that may be obtained to resolve any dispute regarding a utilization review physician's determination not to fully approve a treating physician's treatment request; the treating physician and the utilization review physician cannot issue supplemental reports or provide testimony, either at trial or by deposition, in rebuttal to the panel QME's report. This interpretation is consistent with the language of sections 4610 and 4062. Once more, section 4610 states, in relevant part:

“If the [treating physician's] request [for authorization of medical treatment] is not approved in full, *disputes shall be resolved in accordance with Section 4062.*” (Lab. Code, §4610(g)(3)(A) (emphasis added).) and:

“If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, *the dispute shall be resolved pursuant to Section 4062.*” (Lab. Code, §4610(g)(3)(B) (emphasis added).)

Section 4062 states, in relevant part:

“If the employee objects to a decision made pursuant to Section 4610 ... , the employee shall notify the employer of the objection 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.*” (Lab. Code, §4062(a) (emphasis added).)

B. Because the panel QME's evaluation is the *only* medical evaluation that “shall” be obtained to resolve a dispute regarding a utilization review physician's determination not to fully approve a treating physician's treatment request, then, once the panel QME's evaluation has been obtained, the treater and the utilization review physician cannot comment further (i.e., they cannot do any further “evaluation”) on the post-utilization review dispute.

3. The Panel QME Should Ordinarily Be Provided With And Consider Both The Treating Physician's Reports And The Utilization Review Physician's Reports Relating To The Disputed Issues.

A. When a panel QME assesses a post-utilization review dispute regarding a treatment

request, the panel QME should ordinarily be provided with and consider the treating physician's and the utilization review physician's reports regarding the disputed issues, subject to the limitation just discussed.⁴

This interpretation is consistent with section 4062.3, which provides that "[a]ny party may provide to the ... [panel QME] any of the following information: (1) [r]ecords prepared or maintained by the employee's treating physician or physicians [and] (2) [m]edical and nonmedical records relevant to determination of the medical issue." (Lab. Code, §4062.3(a).) In this regard, we conclude that a utilization review report is a "medical record" within the meaning of section 4062.3(a)(2).

This interpretation is also consistent with the statutory scheme. If the panel QME is going to make "a determination of the disputed medical issue" (Lab. Code, §4062.3(i); see also, §4062.3(a)(2)), then clearly the QME must have the reports that created the medical treatment dispute. (See also, Lab. Code, §4062.3 (the panel QME "shall identify ... [a]ll information relied upon in the formulation of his or her opinion."))

Finally, this interpretation is consistent with the principles that "[a] medical report which lacks a relevant factual basis cannot rise to a higher level than its own inadequate premises" (*Zemke v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal.2d 794, 798 [33 Cal.Comp.Cases 358]), that "[m]edical reports and opinions are not substantial evidence if they are ... based ... on inadequate medical histories" (*Heggin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93]), and that "[t]he chief value of an expert's testimony ... rests upon the [m]aterial from which his opinion is fashioned and the [r]easoning by which he progresses from his material to his conclusion; ... it does not lie in his mere expression of conclusion." (*People v. Bassett* (1968) 69 Cal.2d 122, 141, 144; see also, *Owings v. Industrial Acc. Com.* (1948) 31 Cal.2d 689, 692 [13 Cal.Comp.Cases 80] ["the value of an expert's opinion is dependent upon its factual basis"].)

4. At Any Trial On A Post-Utilization Medical Treatment Dispute, Both The Treating Physician's Reports And The Utilization Review Physician's Reports Are Admissible Evidence.

A. If a post-utilization review medical treatment dispute goes to trial after the panel QME issues his or her report, both the treating physician's reports and the utilization review physician's reports are admissible evidence.

Of course, a treating physician's reports are ordinarily admissible in evidence. (Lab. Code, §5703(a).) And, in the context of a post-utilization review medical treatment dispute, the treating physician's reports are an essential element of the record in determining, for example, the actual nature of the treating physician's disputed treatment recommendation and the reasons for it (see generally, e.g., Lab. Code, §§4610(a) & (e), 4062(a)); the timeliness of the defendant's utilization review (see generally, e.g., Lab.

⁴ The panel QME ordinarily should also consider any relevant ACOEM guidelines (or, in the future, treatment guidelines adopted by the Administrative Director of DWC under section 5307.27) and/or any relevant other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based. (Lab. Code, §4604.5(e); see also, §5703(h).)

Code, §4610(g)); and whether the panel QME considered *all* of the treating physician's relevant reports. (Lab. Code, §4062.3(a) & (d).)

We also conclude that the reports of the utilization review physician are admissible. We recognize, of course, that a utilization review physician is not an "attending or examining physician" within the meaning of section 5703(a) and that the reports of non-attending/examining physicians are generally not admissible in workers' compensation proceedings, at least if their admission would be inconsistent with the statutory scheme. (*Sweeney v. Workmen's Comp. Appeals Bd.* (1968) 264 Cal.App.2d 296, 301-305 [33 Cal.Comp.Cases 404].) Further, we are aware that, in the past, it has been held that utilization review physician reports are *not* admissible. (*Czarnecki v. Golden Eagle Insurance Co.* (1998) 63 Cal.Comp.Cases 742 (significant panel decision).)

Yet, the situation in *Czarnecki* is readily distinguishable from that present here. When *Czarnecki* issued, there was no statutorily-established utilization review process. Rather, there was merely statute directing the Administrative Director of DWC to adopt model utilization protocols (see former, Lab. Code, §139(e)(8)) and an Administrative Director's rule establishing a pilot utilization review program. (See former Cal. Code Regs., tit. 8, §9792.6.)⁵ Moreover, neither the statutory provision nor the Administrative Director's rule provided that the utilization review physician's opinion would be admissible for resolving medical treatment disputes. To the contrary, DWC's publication regarding the utilization review rule implicitly recognized the continuing validity of former section 4062 for resolving medical treatment disputes. Thus, in the absence of any statutory utilization review procedure, *Czarnecki* concluded that the rule adopted by the Administrative Director could not be relied upon to circumvent or override the then existing statutory procedure for resolving medical treatment disputes under former section 4062. Therefore, the utilization review reports were deemed inadmissible.

Now, however, there is a statutory scheme in place that specifically provides for utilization review reports to assess the medical necessity of treating physician's treatment recommendations. (Lab. Code, §4610.) And, at any trial regarding a post-utilization review treatment dispute, the utilization review physician's report is relevant to determining: the reasons for the decision regarding medical necessity (Lab. Code, §4610(g)(4), see also, e.g., §4610(e) & (f)(2)); what procedures, information, and criteria the utilization review physician used (Lab. Code, §4610(c), (d), & (f)); whether the utilization review decision was made by a person legally competent to make it (Lab. Code, §4610(e)); whether the utilization review decision was timely made and/or communicated (Lab. Code, §4610(g)); the nature of the disputed medical issue (Lab. Code, §4062(a)); and whether the panel QME considered all of the utilization review reports, i.e., whether the panel QME's report constitutes substantial evidence. (Lab. Code, §4062.3(a)(2).) Thus, the statutory scheme makes it clear that the utilization review report is an essential part of

⁵ When the utilization review provisions of section 4610 went into effect, the Legislature repealed Labor Code section 139 and, also, expressly repealed Administrative Director Rule 9792.6. (See, Stats. 2003, ch. 639, §§8, 49 [SB 228].)

the record in determining a post-utilization review medical treatment dispute.⁶ Moreover, when utilization review reports are offered in evidence, the reports are not rendered inadmissible solely because they do not contain statements under penalty of perjury that there has been no violation of section 139.3 and/or the information is true and correct. (See, Lab. Code, §§5703(a)(2), 4628(j).) Because a utilization review physician is not referring the applicant for treatment, the anti-self-referral provisions of section 139.3 are irrelevant and inapplicable. Moreover, because a utilization review physician's opinion is not a "medical-legal report" within the meaning of section 4628, the declaration provisions of that statute are inapplicable. Further, although medical reports "should" be signed (Cal. Code Regs., tit. 8, §10606(o)), the failure to sign a report does not make it inadmissible. (Cal. Code Regs., tit. 8, §10606.) Thus, the overall statutory scheme contemplates the admission of utilization review reports in evidence in proceedings relating to post-utilization review disputes.

5. When A Decision Is Rendered On A Post-Utilization Review Medical Treatment Dispute, The Reports Of The Panel QME, The Treating Physician, And The Utilization Review Physician Will All Be Considered, But None Of Them Is Necessarily Determinative.

A. When faced with differing medical opinions from the panel QME, the treating physician, and the utilization review physician on the issue of whether prescribed treatment is reasonably required to cure or relieve the effects of the employee's injury, the WCJ or the Appeals Board need not rely on the opinion of a particular physician. It is the WCAB, and not any individual physician, which is the ultimate trier-of-fact on medical issues. (*Klee v. Workers' Comp. Appeals Bd.* (1989) 211 Cal.App.3d 1519, 1522 [54 Cal.Comp.Cases 251]; *Robinson v. Workers' Comp. Appeals Bd.* (1987) 194 Cal.App.3d 784, 792-793 [52 Cal.Comp.Cases 419]; *Johns-Manville Products Corp. v. Workers' Comp. Appeals Bd. (Carey)* (1978) 87 Cal.App.3d 740, 753 [43 Cal.Comp.Cases 1372].) Of course, in determining whether to rely on the panel QME, the treating physician, or the utilization review physician, the WCJ or the Appeals Board will consider the weight to be given to the respective opinions and will consider whether they constitute substantial evidence. (*Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 280-281 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312, 317 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627, 637 [35 Cal.Comp.Cases 16]; see also, Cal. Code Regs., tit. 8, §10606 [compliance with Rule 10606 goes to weight to be given report]; *Insurance Co. of North America v. Workers' Comp. Appeals Bd. (Kemp)* (1981) 122 Cal.App.3d 905, 917 [46 Cal.Comp.Cases 913] [a report that is "woefully inadequate" in its compliance with Rule 10606 should not be relied upon].)

⁶ Because the utilization review reports are admissible under the statutory scheme, we are not persuaded that they are made inadmissible under section 5703. Section 5703, which lists items that the Appeals Board "may receive as evidence ... in addition to sworn testimony," is not strictly exclusive. Items not listed in section 5703 can be admitted, at least if their admission is not inconsistent with a statutory provision.

B. Shearson v. St. Paul Ins. Co. (32 CWCR 318) (October 2004)

1. Applicant suffered an industrial injury and a treatment dispute arose under the utilization review system. Applicant was represented. At trial the opinions of the UR doctor were excluded on the grounds that that physician had not examined or interviewed the injured worker. The WCAB granted reconsideration and directed the trial judge to apply *Willette* for an unrepresented applicant. The board pointed out the parties failed to follow the procedure set forth in *Willette* to resolve disputes over treatment recommend by the PTP. The Board went on to state that in *Willette* the board set forth the procedure to be followed if the employee is not represented by an attorney. The board ruled that if the employee is represented the procedure is basically the same except the process provided in 4062.2 rather than 4062.1 is followed. The board also indicated as outlined in *Willette*, the report of the UR physician is admissible.
2. The appeals board in this case applied the old QME procedure even though for this date of injury (2003) the QME sections were repealed as of 4-19-05 and the new procedure did not go into effect until to 1-1-05.
3. In Godinez v. Buffer Inc. and Specialty Risk: (69 CCC 1311) (Significant Panel Decision). In this case the board concluded that the timeliness of an appeal from any determination or recommendation of the Administrative Director's vocational rehabilitation unit with reference to an injury occurring before January 1, 2004, is controlled by former Labor Code section 4645(d), and that defendant's appeal in this case was filed timely. The date of injury in this case is June 18, 2000. The board stated that the issue in the case was what "timely" means when the statutory definition of "timely" has been repealed. The board indicated that timeliness of an appeal from the decision of the Rehabilitation Bureau in Cabrera v. Intercell Industries (1980) 45 Cal.Comp.Cases 3 [Appeals Board en banc], timeliness was governed by Administrative Director Rule 10014. (See 45 Cal.Comp.Cases at 7). That Rule was codified by Labor Code section 4645(d), first enacted in 1989 (1989 ch. 892, §33) and amended in 1993 (1993 ch. 121 [AB 110], §52). Administrative Director Rule 10014 was repealed in 1996 as superfluous. Before 2003, section 4645(d) provided: "Any determination or recommendation of the administrative director's vocational rehabilitation unit or by the arbitrator shall be binding unless a petition is filed with the appeals board within 20 days after service of the determination or recommendation. Nothing in this section shall affect an employee's rights pursuant to Sections 5405.5, 5410, and 5803."

However, section 4645 was itself repealed in 2003 (2003 ch. 635 [AB 227]), together with the rest of Division 4, Chapter 2, Article 2.6. Section 139.5 was also repealed and replaced by a new section that applies to injuries occurring on or after January 1, 2004. In 2004, former section 139.5 was re-enacted, with modifications, to apply to injuries occurring before January 1, 2004 (2004 ch. 34 [SB 899], §5). But the vocational rehabilitation sections of Article 2.6 were not re-enacted.

The Board noted that the version of section 139.5(c) now operative refers to “former Section 4642” and “subdivision (d) or (e) of former Section 4644.” Thus, even though these sections were repealed in 2003 and not reenacted in 2004, they still have a shadowy existence for injuries prior to January 1, 2004.⁷ Like ghosts “doomed for a certain term to walk the night” (*Hamlet* I, v), these statutes have no material existence but linger until their work is done. Because there is no other operative law, we hold that former section 4645 is a similar “ghost statute” that continues to govern the timeliness of appeals from decisions of the Rehabilitation unit

4. The Board's in an en banc decision in *Marilyn Simi v. Sav-Max Foods, Inc.*, SAC 323226, filed and served on February 1, 2005 held that for injuries occurring prior to January 1, 2005, section 4062, as it existed before its amendment by SB 899, continues to provide the procedure by which Agreed Medical Evaluation (AME) and QME medical-legal reports are obtained in cases involving represented employees. The board cited the *Godinez* (above) for its rationale.

C. The Process - Sandhagen v. Cox & Cox and SCIF: (69 CCC 1452 WCAB en banc)

1. The Utilization Review Time Deadlines Of Section 4610(g)(1) Are Mandatory And, Therefore, A Defendant That Fails To Meet The Mandatory Deadlines Is Precluded From Using The Utilization Review Procedure.

a. The utilization review provisions of section 4610 establish a process by which a defendant may prospectively, retrospectively, or concurrently review the treatment recommendation of a treating physician and then decide whether to approve, modify, delay, or deny authorization for the treatment, based in whole or in part on its medical necessity to cure and relieve the effects of the injury in accordance with section 4600. (Lab. Code, §4610(a)-(f).)

Section 4610, however, sets forth specific time frames that govern the utilization review process. As relevant here, section 4610(g)(1) provides:

⁷ As a former U.S. President stated in a different context, “that depends on what the meaning of is is.”

“(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following *requirements must be met*:

(1) Prospective or concurrent decisions *shall be made* in a timely fashion that is appropriate for the nature of the employee’s condition, *not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician*. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual’s designee, within 30 days of receipt of information that is reasonably necessary to make this determination. ... (Lab. Code, §4610(g)(1) (emphasis added).)

b. It is a principle of statutory construction that the word “shall,” as used in the Labor Code, ordinarily connotes a mandatory duty. (Lab. Code, §15 [“ ‘[s]hall’ is mandatory and ‘may’ is permissive”]; see also, *Smith v. Rae-Venter Law Group* (2003) 29 Cal.4th 345, 357; *Jones v. Tracy School Dist.* (1980) 27 Cal.3d 99, 109; *Morris v. County of Marin* (1977) 18 Cal.3d 901, 907.) The word “must” is also normally mandatory. (*Long Beach Police Officers Assn. v. City of Long Beach* (1988) 46 Cal.3d 736, 743; *In re Angela M.* (2003) 111 Cal.App.4th 1392, 1398, fn. 4; *Larson v. State Personnel Bd.* (1994) 28 Cal.App.4th 265, 276; see also, Cal. Rules of Court, Rule 200.2(4) [“The words ‘must’ and ‘shall’ are mandatory and the word ‘may’ is permissive.”]; Rule 1401(b)(1) [“ ‘Shall’ and ‘must’ are mandatory and ‘may’ is permissive.”].) Similarly, the word “require” means “to direct, order, demand, instruct, command, ... [and] compel.” (*In re Barfoot* (1998) 61 Cal.App.4th 923, 931 [quoting from Black’s Law Dict. (6th ed. 1990), at p. 1304.]

C. Here, we construe the deadlines for commencing utilization review established by section 4610(g)(1) to be mandatory.

Section 4610(g)(1) unequivocally speaks of “*requirements*” that “*must*” be met. (Lab. Code, §4610(g)(1) (emphasis added).) It also commands that prospective or concurrent utilization review decisions “*shall be made*” in a timely fashion, “*not to exceed*” five working days from the receipt of the necessary information, but “*in no event*” more than 14 days from the date of the medical treatment recommendation. (Lab. Code, §4610(g)(1) (emphasis added).) Thus, section 4610(g)(1) frames a defendant’s duty to comply with the statutory deadlines in mandatory terms. The words of section 4610(g)(1) in no way imply a legislative intent that the declared deadlines are merely permissive.

Moreover, the implicit legislative purpose in establishing these deadlines is to ensure that, where a defendant decides to undertake the utilization review process, it must do so expeditiously (see Cal. Const., art. XIV, §4), so that any utilization review decisions regarding what medical treatment is “reasonably required” for the injured worker is not

unduly delayed. In this regard, it has long been recognized: that the workers' compensation statutory scheme "is designed to help an employee obtain promptly the cure or relief he is entitled to under the law" and to "encourag[e] the employer and carrier to provide prompt medical treatment" (*Avalon Bay Foods v. Workers' Comp. Appeals Bd. (Moore)* (1998) 18 Cal.4th 1165, 1173, fn. 3, & 1178 [63 Cal.Comp.Cases 902]; *Adams v. Workers' Comp. Appeals Bd.* (1976) 18 Cal.3d 226, 229 & 230 [41 Cal.Comp.Cases 680]); that a delay in the provision of medical treatment "may impose a great hardship upon an employee, who due to the injury frequently is without funds to properly support himself and his family or is without funds to obtain the necessary care" (*Zeeb v. Workmen's Comp. Appeals Bd.* (1967) 67 Cal.2d 496, 501 [32 Cal.Comp.Cases 441]); and that "[t]he broad purpose of workmen's compensation is to secure an injured worker seasonable cure or relief from industrially caused injuries in order to return him to the work force at the earliest possible time." (*Carver v. Workers' Comp. Appeals Bd.* (1990) 217 Cal.App.3d 1539, 1547 [55 Cal.Comp.Cases 36]; *Davison v. Industrial Acc. Com.* (1966) 241 Cal.App.2d 15, 18 [31 Cal.Comp.Cases 77].) Accordingly, in addition to the express language of section 4610(g)(1), the basic and essential purposes of the workers' compensation statutory scheme support a construction that the time deadlines of section 4610(g)(1) are mandatory.

B. If A Defendant Undertakes An Untimely Utilization Review Procedure, Any Utilization Review Report It Obtains Is Not Admissible In Evidence With Respect To The Particular Medical Treatment Dispute In Question, And Any Utilization Review Report It Obtains Cannot Be Forwarded To An AME Or QME If Section 4062(a) Procedures Are Timely Pursued.

a. Having concluded that the deadlines of section 4610(g)(1) are mandatory, we now consider what consequences flow from a defendant's failure to comply with them. We hold that if a defendant fails to comply with the mandatory deadlines of section 4610(g)(1), then any utilization review report obtained by a defendant that has not complied with the deadlines is inadmissible with respect to the particular medical treatment issue in question.⁸

b. Given that section 4610(g)(1) imposes a mandatory duty on a defendant to comply with its deadlines, it would be incongruous to permit a defendant that fails to comply with the deadlines to nevertheless obtain a utilization review report and to then enter it into evidence. The intent of section 4610(g)(1)'s deadlines is to ensure that a defendant makes its utilization review determination quickly. The natural consequence of a defendant's noncompliance with the mandatory deadlines is that it is precluded from instituting the utilization review procedure. If it attempts to use that procedure, any utilization review report it obtains in the attempt is inadmissible. Indeed, medical reports not timely obtained in accordance with statutory requirements are generally inadmissible in workers' compensation proceedings. (*Strawn v. Golden Eagle Insurance Co.* (2000) 28 Cal. Workers' Comp. Rptr. 105 (Appeals Board panel) [under former section 4061, the

⁸ Of course, if a defendant does comply with the statutory deadlines, then any utilization review report is ordinarily admissible. (*Willette v. Au Electric Corporation* (2004) 69 Cal.Comp.Cases ___, 2004 Cal. Wrk. Comp. LEXIS 308 (Appeals Board en banc).)

report of a QME obtained by the defendant was excluded where the defendant did not timely object to the opinion of the treating physician]; *County of Santa Barbara v. Workers' Comp. Appeals Bd. (Finch)* (1999) 64 Cal.Comp.Cases 907 (writ den.) [similar]; *San Diego Gas & Electric v. Workers' Comp. Appeals Bd. (Morgan)* (1997) 62 Cal.Comp.Cases 384 (writ den.) [if a party failed to timely object to the treating physician's opinion under former section 4062, it could not obtain a QME report under that section].)

c. Moreover, because the natural consequence of a defendant's noncompliance with the mandatory deadlines of section 4610(g)(1) is that it is precluded from employing the utilization review procedure, then any report generated by an untimely utilization review process cannot be used for any purpose. Thus, if a defendant has not complied with the deadlines of section 4610(g)(1), but it timely pursues the AME/QME procedure under section 4062(a) (see Section C, *infra*), then any utilization review report the defendant obtains may *not* be forwarded to the AME or QME. To conclude otherwise would mean that, if an AME or a QME considers or relies upon an untimely utilization review report, and then the AME or the QME's report is admitted in evidence, the untimely utilization review report effectively would be admitted through the back door when the front door is closed. Attempts at "back door" admissions of inadmissible evidence have long been denounced in California. (E.g., *Alling v. Universal Manufacturing Corp.* (1992) 5 Cal.App.4th 1412, 1438; *People v. Casas* (1986) 181 Cal.App.3d 889, 896; *People v. Rioz* (1984) 161 Cal.App.3d 905, 918-919; *City of Monterey v. Hansen* (1963) 214 Cal.App.2d 794, 797.) Further, although a utilization review report is generally a "medical record" within the meaning of section 4062.3(a)(2) (*Willette v. Au Electric Corporation, supra*, 69 Cal.Comp.Cases ___, 2004 Cal. Wrk. Comp. LEXIS 308 (Appeals Board en banc)), section 4062.3(a)(2) expressly limits the "medical records" that a party may submit to a panel QME solely to those that are "*relevant* to [the] determination of the medical issue." (Lab. Code, §4062.3(a)(2) (emphasis added).) Of course, any decision by a WCJ or the Appeals Board "must be based [only] on *admitted* evidence in the record[,] ... including *admitted* medical records." (*Hamilton v. Lockheed Corp.* (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Board en banc) (emphasis added).) Accordingly, an untimely obtained and, therefore, *inadmissible* utilization review report does not constitute a medical record that is "*relevant*" to the determination of the disputed medical issue. Similarly, although section 4062.3(c) allows the parties to agree on what information is to be provided to an AME, we hold that the parties may not agree to provide an AME with an inadmissible and, therefore, irrelevant utilization review report that cannot be relied upon by either a WCJ or the Appeals Board. SCIF suggests that the only consequences of a failure to comply with the mandatory timeframes of section 4610(g)(1) are: (1) the defendant may be assessed administrative penalties by the Administrative Director of the Division of Workers' Compensation ("DWC") (see, Lab. Code, §4610(i)); and/or (2) the defendant may be liable for section 5814 penalties if its delay in the completion of the utilization process is unreasonable. (Lab. Code, §4610.1.) We find no merit in this suggestion.

d. First, it is true that section 4610(i) allows the Administrative Director to assess administrative penalties if a defendant fails to meet any of the timeframes of section

4610. Yet, as pointed out by the WCJ's Report, section 4610(i) states, "The administrative penalties shall not be deemed an exclusive remedy for the administrative director." If the imposition of administrative penalties is not even the sole remedy available to the Administrative Director, who does not even have jurisdiction over workers' compensation proceedings (see, Lab. Code, §§111(a), 5300, 5301), then the availability of administrative penalties certainly does not limit the remedies of the WCAB. (See, Lab. Code, §133 [the WCAB "shall have power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it"].)

e. Second, the possibility that the WCAB may impose section 5814 penalties against a defendant if it unreasonably delays completion of the utilization review process (see, Lab. Code, §4610.1) does not mean that the WCAB cannot also exclude from evidence a utilization review report that the defendant obtained without complying with the mandatory deadlines of section 4610(g)(1). Section 5814 is not the exclusive remedy against a defendant, even when its actions have been unreasonable. (See, e.g., *Rhiner v. Workers' Comp. Appeals Bd.* (1993) 4 Cal.4th 1213, 1227 [58 Cal.Comp.Cases 172]). In this case, the May 14, 2004 joint report Drs. Goldthwaite and Josey that recommended a cervical and upper thoracic spine MRI, as well as a request for authorization of the MRI, were received by SCIF on May 24, 2004. The utilization review report of Dr. Krohn, however, did not issue until June 21, 2004, which was both well over five days after SCIF's receipt of the May 14, 2004 report (SCIF did not request any further "necessary information") and well over 14 days after Drs. Goldthwaite and Josey's treatment recommendation. Therefore, the WCJ properly excluded Dr. Krohn's June 21, 2004 utilization review report from evidence.

C. When A Defendant Does Not Meet The Section 4610(g)(1) Deadlines, It May Use The OME/AME Procedure Established By Section 4062(a) To Dispute The Treating Physician's Treatment Recommendation; However, The Defendant (Not The Applicant) Is Then The "Objecting Party" And The Defendant Must Meet The Section 4062(a) Deadlines, Unless Those Deadlines Are Extended For Good Cause Or By Mutual Agreement.

a. When a defendant fails to comply with the deadlines established by section 4610(g)(1), however, it may still be able to use the procedure established by section 4062(a) to dispute the treating physician's treatment recommendation.
Section 4062(a) 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. ... 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 If the employee is not represented by an attorney, ... the evaluation shall be obtained as provided in Section 4062.1” (Lab. Code, §4062(a).)

b. Thus, section 4062(a) applies to any objection to a treating physician’s medical determination not subject to section 4610, which would include a defendant’s objection where it has failed to meet the mandatory time deadlines of section 4610(g)(1.). Accordingly, in situations where a defendant does not timely initiate or complete the utilization review process, or where a defendant chooses not to participate in the utilization review process, the defendant is essentially in the same position it would have been prior to the Legislature’s enactment of utilization review, i.e., it is within the AME/QME procedure.

c. Section 4062(a), however, requires that *the objecting party* “shall” notify the other party in writing of the objection within 20 days of receipt of the physician’s report if the injured employee is represented, or within 30 days if he or she is not represented, and then utilize the appropriate procedure for obtaining a QME or AME. Thus, the section 4062(a) procedure cannot be used if the party’s objection to the treating physician’s opinion is untimely. (*Cf.*, *Strawn v. Golden Eagle Insurance Co.*, *supra*, 28 Cal. Workers’ Comp. Rptr. 105; *County of Santa Barbara v. Workers’ Comp. Appeals Bd. (Finch)*, *supra*, 64 Cal.Comp.Cases 907; *San Diego Gas & Electric v. Workers’ Comp. Appeals Bd. (Morgan)*, *supra*, 62 Cal.Comp.Cases 384 (writ den.).)

d. Here, SCIF received the May 14, 2004 report of Drs. Goldthwaite and Josey no later than May 24, 2004, but it did not notify applicant (who is represented) of any objection to their medical determination within 20 days thereafter. Therefore, under the procedures announced here, SCIF would be precluded from obtaining a QME report in rebuttal to Drs. Goldthwaite and Josey’s determination.

Nevertheless, we recognize that the statutory procedures established by section 4610(g)(1) and 4062(a) are relatively new and that no binding Appeals Board or Court of Appeal decision has previously interpreted the interplay between them. Therefore, we will rescind the WCJ’s July 21, 2004 decision and remand the matter to the WCJ to give SCIF a reasonable opportunity to obtain a section 4062(a) evaluation.

e. Within 20 days of the date of this decision, SCIF may initiate the QME/AME process. (Lab. Code, §4062(a).) If SCIF elects to initiate this process, however, then neither it nor applicant *shall submit the untimely-obtained utilization review report to any QME or AME.*

f. Once the QME/AME process is completed (or if SCIF fails to initiate this process within 20 days of the date of this decision), applicant or SCIF may bring the matter on calendar before the WCJ by filing either a declaration of readiness to proceed (Cal. Code Regs., tit. 8, §10410) or a declaration of readiness to proceed to an expedited hearing. (Cal. Code Regs., tit. 8, §10415.)

g. Because we are rescinding the WCJ's decision and are remanding the matter to him so that SCIF may obtain a section 4062(a) report, if it so elects, we will not now address any ACOEM issues. Any QME or AME, if obtained, should address the ACOEM issues in the first instance, and then the WCJ may re-address the ACOEM issues at any new trial.

IV. The cases and procedure applying ACOEM:

A. Labor code Sections:

1. 4600. (a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. 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.

(b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

2. 4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer-reviewed. The guidelines shall be designed to assist providers

by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

(c) Three months after the publication date of the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule, pursuant to Section 5307.27, the recommended guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment, regardless of date of injury. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury, in accordance with Section 4600. The presumption created is one affecting the burden of proof.

(e) For all injuries not covered by the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

B. Lamin v. City of Los Angeles, 89 CCC 1002 (Board Panel Decision)

1. Under the present law reasonably required medical treatment means treatment based upon the ACOEM Guidelines and they are presumed correct on the issue of extent and scope of treatment. The presumption of correctness is rebuttable and may be controverted by a preponderance of evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury. It is a presumption effecting burden of proof. (Lamin v. City of LA, VNO 0337532).

2. If the ACOEM Guidelines cover the type of injury the applicant must show that the ACOEM Guidelines call for the treatment or prove by a preponderance of the evidence the treatment is reasonably required notwithstanding ACOEM Guidelines.

3. A medical opinion with a statement that has a mere conclusion that disagrees with the ACOEM Guidelines will not be sufficient to rebut the presumption of correctness, rather the medical opinion must provide specific facts and specific reasons establishing the treatment other than set forth in the ACOEM Guidelines is reasonably required. The chief value of an expert's testimony rests upon the material from which the opinion is

fashioned and the reasoning by which the expert progresses from his material to his conclusion. (People v. Bassett 69 Cal 2d 122) It does not lie in the mere expression of conclusion and the opinion of an expert is no better than the reasons upon which it is based. (Hegglin v. WCAB 36 CCC 93). Not all expert medical opinions are substantial evidence. Medical reports and opinions are not substantial evidence if they are known to be erroneous, or if they are based on facts no longer germane, or an inadequate medical history and examinations or incorrect legal theories. Medical opinion also fails if it is based on surmise, speculation, conjecture, or guess. (Owings v IAC 13 CCC 80). The value of an expert's opinion is dependent upon its factual basis.

4. If the ACOEM Guidelines do not cover the type of injury, applicant may go forward with evidence-based medical treatment guidelines generally recognized by the national medical community that are scientifically based. (LC 4604.5) Defendant may present contrary evidence.

The appeals Board in the Lamin case indicated the following, "Nevertheless, we observe (without deciding the issue) that other evidence in lieu of, in addition to evidence-based medical treatment guidelines might also be admissible."

C. The ACOEM Guidelines - do they apply only to acute treatment (first 90 days) and not chronic treatment? In the chapter on back injuries, the Guidelines say they only apply to acute treatment (first 90 days). It appears that is the only chapter that so indicates. Some attorneys and physicians believe ACOEM only applies to the acute stage (first 90 days) and not the chronic stage of treatment. Other physicians and attorneys take the position that the guidelines apply to both acute and chronic treatment stages. These physicians say that the guidelines are based on a concept of return to function and maintaining function and after the first 90 days any treatment to be allowed under the guidelines must show it is being done to meet these goals. In addition, the physicians take the position that chapter six of the guidelines covers treatment for chronic conditions. This chapter would apply after the first 90 days. If treatment does not increase or maintain function it is not allowed under the guides. If treatment is undertaken and after a reasonable period does not increase function it should be stopped. These physicians also indicate that many of the guidelines would apply no matter when the treatment occurs by nature of the treatment. For example, certain treatment is prohibited and when you do surgery or certain tests would be the same under the guides no matter when the requested treatment occurs. The board in one case below has ruled that the guides do not apply to chronic treatment in a back case and in another hinted that the function test described above is applicable. This issue will need to be decided by an en banc at some point or the court of appeal.

1. Hamilton v. SCIF (32 CWCR 249 Board Panel Decision): The WCJ in his report on reconsideration indicated that the ACOEM guidelines expressly apply to the treatment of acute injuries. Based on the fact the disputed treatment occurred over 90 days post injury the judge indicated that the injury was no longer in the acute stage. Labor Code Section 4604.5 requires scientific medical evidence to rebut the presumption that ACOEM Guidelines are correct on the issue of the extent and scope of medical treatment. Here the Judge ruled the guidelines are inapplicable according to the terms of the Guidelines themselves. The scientific evidence is required only when seeking to

rebut an ACOEM standard. The Judge found that since there was nothing to rebut, the issue did not exist. The panel upheld the WCJ adopting his reasoning.

D. Smith vs. Churn Creek Construction Company and State Compensation Insurance Fund (June 2004) 69 Cal Comp Cases 1012 (Board Panel Decision) A judge ordered treatment in accordance with the recommendations of the PTP and the WCAB reversed. The PTP physician recommended epidural injections because the PTP did not know what else to do. The Utilization Review doctor determined that pursuant to the ACOEM Guidelines such treatment was not appropriate unless applicant had been determined to be a surgical candidate and that two doctors had already indicated he was not such a candidate and thus the treatment should be denied. At the time of the recommendation the ACOEM Guidelines were in effect (1-1-04), but not yet presumed correct (3-22-04). The WCAB concluded the ACOEM Guidelines were in effect, but were not presumed correct, at the time of the of the utilization review physician's opinion. The board concluded that even though the presumption did not apply, because the guidelines were in effect the burden of proof shifted to the treating physician to justify the request for treatment. The Board went on to find that the treating physician's opinion was inadequate because the doctor never provided reasons for the basis of his opinion and failed to respond to the opinion of the utilization review doctor. Because the employer had correctly applied the utilization review process and applicant had not provided adequate rebuttal evidence defendant was not liable to provide the care.

E. The ACOEM Guidelines provide that the guides shall reflect practices that are evidence, and scientifically based, nationally recognized, and peer-reviewed. Each form of treatment in the guides is assigned letter rating based on the quality of evidence that supports the guideline. Ratings are given from A to D. A and B ratings are supported by high quality studies. C is based on adequate studies. D indicates panel information and not based on research based evidence. The question presented is does the evidence as to type and quality needed to rebut the presumption depend on what evidence the guides have to support the particular guide. Does **rebutting the presumption depend on the quality of the** scientific evidence that supports the guideline. For example is less evidence needed to rebut a guideline given an "A" explanation versus a guideline given a "D" explanation?

F. Other ACOEM issues:

1. What treatment does ACOEM and utilization review apply toward. Based on the Smith case above it appears utilization review and ACOEM may apply to treatment on or after 1-1-04 with the presumption on ACOEM only applying to treatment after March 22, 2004. Can ACOEM and utilization review apply to treatment after those dates in which the treatment is based on a findings and award that issued before 1-1-04?
2. The next question - is medical evidence necessary to apply the guides or can the WCJ apply the guides without medical evidence? This would occur if the

utilization review report was inadmissible for being late or utilization review was not done at all and no QME. Can the defendants without any medical evidence argue the WCJ should take judicial notice of the guides and apply the guides and the presumption? Does the WCJ need a medical report that is substantial medical evidence that has applied the guides to the medical treatment in question before the WCJ applies the guides and the presumption? We have no answer to this question at this time. Would the answer be different if it was a procedure the guides prohibit? For example the guides provide for no manipulation under general anesthesia. Therefore could the guides be applied if this was the requested treatment without a medical report?

3. Internal medical conditions are not covered in the guides. How will this type of treatment be handled? Should the treatment be based other generally recognized guidelines?

V. "Cure and Relieve" and maintain function (Grom v. Shasta Wood Products and SCIF (Board Significant Panel Decision))

A. Defendant argued in this case that the WCJ applied an incorrect standard to the determination of whether testosterone treatment was reasonably required to treat applicant's injury. Defendant contended that any recommended treatment must both cure and relieve applicant from the effects of the industrial injury. Defendant cited Labor Code section 4604.5(c), which provides that the ACOEM treatment guidelines are presumptively correct on the issue of medical treatment, but may be rebutted by a preponderance of the evidence "establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury. "

B. The WCAB found that the phrases "cure or relieve" and "cure and relieve" have been used interchangeably for decades. The California Supreme Court interpreted "cure and relieve" to require the furnishing of medical treatment which is intended solely to relieve an injured worker from the effects of an industrial injury. (*US. Fidelity & Guaranty Co. v. Dept. of Indus. Relations (Hardy)* (1929) 207 Cal. 144, 150 [16 IAC 69].)

C. In the case of Smyers and Hoffman v. WCAB 157 Cal.App.3d 36 [49 Cal.Comp.Cases 454, 458 n.3], the court defined the scope of compensable medical treatment in a case where the court allowed as medical treatment under section 4600 a prescription for housekeeping services unrelated to nursing services, stating as follows:

1. "This rule is also harmonious with the general description of the section 4600 right offered by the major treatise authors. According to Hanna, compensable medical treatment includes' *all measures directed* toward the cure or *relief* of the effects of the industrial injury. . . .' (2 Hanna, *Cal. Law of Employee Injuries & Work. Compo* (2d ed. 1983) § 16.01 [1], p. 16-3, emphasis added; see also *id.*, § 16.05 [1][c], p. 16-40.1.) Herlick agrees. Employers are bound to furnish adequate medical care, and '[t]reatment is not adequate if. . . it does not include. . . *all measures indicated to cure or relieve.*' (1 Herlick, *Cal. Workers' Compensation Law Practice* (3d ed. 1984) § 4.8, p. 83, emphasis

added.) Here the housekeeping services were indicated by the physicians as a measure directed toward relief of the industrial condition. Both authors also state that palliative measures are compensable. (2 Hanna, Cal. Law of Employee Injuries & Workmen's Compensation, supra, § 16.01 [1], p. 16-3; 1 Herlick, supra, § 4.14, p. 86.) To palliate is '[to] mitigate; to reduce the severity of; to relieve slightly.' (Stedman's Medical Dict. (4th unabr. law. ed. 1976) p. 1018.) The physicians' reports in this case (see fn. 2, ante) clearly reveal that the housekeeping services were prescribed as a *palliative* measure." (Emphasis in original.)

D. Medical treatment which is intended only to relieve, but not cure, the effects of an industrial injury is appropriate under section 4600. (See *Dept. of Corrections v. Workers' Compo Appeals Bd. (Rowan)* (1997) 62 Cal.Comp.Cases 353 [writ denied]; *Kellogg Co. v. Workers' Compo Appeals Bd. (Battle)* (1996) 61 Cal.Comp.Cases 519 [writ denied].)

E. This is true in cases of chronic conditions where a cure is not possible, but where relief of symptoms is essential for continued functioning, as well as in cases involving the loss of limbs or other body parts where there is a need for relief of symptoms.

F. The WCAB concluded, the phrase "cure or relieve" is identical to the phrase "cure and relieve," such that their use is interchangeable. The WCAB discerned no intent to alter that interpretation by the different formulations used in the different sections of the Labor Code.

VI. Limitation of physical therapy and chiropractic:

A. LC section 4604.5(d)(1) Notwithstanding the medical treatment utilization schedule or the guidelines set forth in the American College of Occupational and Environmental Medicine Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

B. Adjuster can authorize additional treatment without waiving the section. This has been put in the law to allow defendants to waive if for example applicant needs surgery and cannot have it without PT after and all has been used. Defendants can authorize without waiving.

