



LAW OFFICES  
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McDERMOTT & CLAWSON, LLP

## LEGAL BRIEFS NEWSLETTER

CASES & COMMENTS ON WORKERS' COMPENSATION

July 2008

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# TREATMENT DISPUTE RULES CLARIFIED BY SUPREME COURT

## EMPLOYER OPTIONS SEVERELY LIMITED

Just before the July 4<sup>th</sup> Holiday, the State Supreme Court decided to release some fireworks of its own. *In Sandhagen v. WCAB*, No. S149257, 7/3/08 (official citation not yet available) the Court ruled that employers are limited to using Utilization Review if they wish to dispute the reasonableness or necessity of recommended medical care. This is a very well written (if not exactly welcome) opinion and we thought it best to focus on the words of the opinion itself to explain what it means.

### In The Words of the Court

“This case presents two related workers’ compensation issues: (1) When deciding whether to approve or deny an injured employee’s request for medical treatment, must an employer conduct utilization review pursuant to Labor Code section 4610? (2) As an alternative to utilization review, may an employer elect to dispute a request for medical treatment under section 4062, which

permits an employer to object to “a medical determination . . . concerning any medical issues. . . not subject to Section 4610 . . . .”? (§ 4062, subd. (a).) **We conclude the Legislature intended to require employers to conduct utilization review when considering requests for medical treatment, and not to permit employers to use section 4062 to dispute employees’ treatment requests.”**

“Taken together, the language of sections 4610 and 4062 demonstrates that (1) the Legislature intended for *employers* to use the utilization review process in section 4610 to review and resolve any and all requests for treatment, and (2) **if dissatisfied with an employer’s decision, an employee (and only an employee) may use section 4062’s provisions to resolve the dispute over the treatment request.** An employer may not bypass the utilization review process and

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instead invoke section 4062's provisions to dispute an employee's treatment request."

"The prior version of section 4062, subdivision (a) (Stats. 2003, ch. 639, § 17) permitted an employee or employer to object to a treating physician's medical determination regarding "the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, *the extent and scope of medical treatment*, the existence of new and further disability, *or any other medical issues not covered by Section 4060 or 4061 . . .*" (Italics added.)"

"The Legislature amended section 4062, subdivision (a), eliminating "the extent and scope of medical treatment" from the list of things to which an employer may object. (Stats. 2004, ch 34, § 14.) Subdivision (a) of section 4062 now permits an employer to object only to medical determinations regarding "any medical issues not covered by Section 4060 or 4061 *and not subject to Section 4610 . . .*" (Italics added.) Second, Senate Bill No. 899 made another change to section 4062, subdivision (a), adding that "[i]f 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." (Stats. 2004, ch 34, § 14, italics added.)"

In light of the comprehensive nature of section 4610 and the goals the Legislature sought to accomplish, we conclude the

Legislature intended for the utilization review process to be employers' only avenue for resolving an employee's request for treatment." (emphasis added)

### Our Comments

By way of review, LC 4060 covers disputes regarding compensability of the injury itself (not disability, and not parts of the body involved). Utilization Review does not apply to disputes which fall under LC 4060. LC 4061 deals with disputes regarding the existence and extent of Permanent Disability. Utilization Review does not apply to these disputes either.

Labor Code 4062 and the AME/QME process is still available to employers when disputing ongoing need for temporary disability, MMI status, temporary work restrictions, QIW status, and the need for Vocational Rehabilitation. Since questions regarding new parts of the body (compensable consequences) do not seem to fall under LC 4600, 4060 or 4062, we believe these questions also may be the subject of an LC 4062 dispute. We believe that once the QME/AME process is appropriately invoked on any of these issues (or any other issue arguably not falling under LC 4600 treatment disputes), the AME or QME is obligated to weigh in on *all issues in dispute* in the case including any that (legally) arise regarding the necessity for and scope of medical treatment.

However, we believe this decision and LC 4610 are going to be construed very strictly in favor of the applicant. Where an adjuster

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fails to timely invoke the UR process, or where the UR process is technically defective, or where the UR decision has not been properly served, and the case thereafter goes to an AME or QME, we suspect that the defective treatment denial may not be curable by an AME who thereafter disagrees with the treating doctor's recommendations. This is because LC 4062.3 mandates that: (i) Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. Expect the argument to be raised that if the UR denial is defective, treatment is not *legally* contested and therefore the AME's comments regarding scope of treatment have no legal effect.

A question was raised in our Education Committee as to whether requests for spinal surgery fall under the mandate of this ruling, requiring such requests to be submitted to UR for review. We note the following footnote in the Court's discussion: "12 Senate Bill No. 228 also repealed former section 4062 (Stats. 2003, ch. 639, § 16.5) and replaced it with a new section 4062 (Stats. 2003, ch. 639, § 17) addressing the same subject matter. The new section 4062 was the same as the previous version, except for the addition of language concerning requests for spinal surgery. (Compare Stats. 2002, ch. 6, § 52 with Stats.

2003, ch. 639, § 17.)" The language added begins in 4062(a) which states: "Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b) and, after denial of the physician's recommendation, in accordance with section 4610." Thus, it appears that UR is the first waypoint in a potential dispute about the need for spinal surgery.

### **Our Recommendations**

It is now critically important that, whenever there is a question about the extent and scope of recommended treatment, the UR process be timely and appropriately invoked regarding treatment questions before the case ends up before an AME or QME. The operative rules including timeframes, service and content requirement are specified in Rule 9792.9.

We recommend these rules be strictly adhered to, and that your defense counsel be provided with all UR determinations as soon as they are available. Extremely important is LC 9792.9(b)(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.

(b)(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 by a reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written request for authorization to

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make the proper determination. In no event shall the by the health care provider.”

Also watch Rule 9792.9 (b)(4): “ Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.”

### **COURT OF APPEAL TO HEAR BENSON DECISION**

We have commented previously on the importance of the WCAB *en banc* determination in Diane Benson v. Permanente Medical Group (2007) 72 CCC 1620. Appeal was made by the applicant to the Court of Appeal and the Court has decided to consider the case. We suspect it will be a while before a decision is issued, possibly after scheduling oral argument. Additional briefs have been filed by interested organizations on both sides.

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In the meantime, cases with similar apportionment issues continue to confront judges at trial level. As a matter of law, trial judges are bound by the WCAB decision which mandates that, where multiple injuries are distinct causes of disability, separate awards must issue for each injury, thereby reducing the monetary recovery of the applicant. However, in our experience, many judges may try to delay or defer making a determination on cases with similar issues until the Court of Appeal issues a decision. Stay tuned.

### **MILEAGE RATE GOING UP**

If you have purchased gas lately, this bulletin should not come as a surprise. On June 23<sup>rd</sup>, the Internal Revenue Service announced an increase in the standard mileage rates for the final six months of 2008. Taxpayers may use the optional standard rates to calculate the deductible costs of operating an automobile for business, charitable, medical or moving purposes.

The rate will increase to 58.5 cents a mile for all business miles driven from July 1, 2008, through Dec. 31, 2008. This is an increase of eight (8) cents from the 50.5 cent rate in effect for the first six months of 2008, as set forth in Rev. Proc. 2007-70.

In recognition of recent gasoline price increases, the IRS made this special adjustment for the final months of 2008. The IRS normally updates the mileage rates once a year in the fall for the next calendar year.

Why is this important in Workers' Compensation? Because the rate employers

are required to reimburse injured workers for mileage incurred for medical treatment is tied via a roundabout set of statutes and agreements to the IRS rate. So, for any mileage incurred on or after 7/1/2008, you will be required to reimburse at 58.5 cents per mile. Be on the lookout sometime this Fall for another pronouncement for yet another increase for 2009 mileage.

### **EAMS IS AROUND THE CORNER**

The new Electronic Adjudication Management System (EAMS) is in the testing phase now and purportedly will go live August 25<sup>th</sup>. At first, the only significant change will be use of new forms, ironically requiring the use of more paper as the Board goes paperless. There will also be electronic forms available which can be completed on line as the system begins to swing into effect. In addition there will be delays in getting things accomplished at the WCAB as training of staff and judges pulls personnel away from normal work duties over the next few weeks.

Based on everything we have been told, the full effect of the conversion will grow over approximately the next 12 to 18 months. If everything stays on schedule as planned, the WCAB by that time will be operating in a paperless environment, computers will be used at trial, and documents will be either placed in evidence electronically or paper documents will be scanned by the WCAB and then destroyed.

All this will mandate changes to the AD rules of practice and procedure, and those proposed changes are being debated now. You may

review them at

[http://www.dir.ca.gov/dwc/DWCPropRegs/EAMS\\_regulations/EAMS\\_regulations.htm](http://www.dir.ca.gov/dwc/DWCPropRegs/EAMS_regulations/EAMS_regulations.htm).

### **Need Assistance with Training?**

McDermott & Clawson, LLP is happy to assist with the training needs of your organization. Our education committee has extensive experience in providing seminars and discussions on Workers' Compensation topics of concern to adjusters and employers. We have worked with numerous carriers, third party administrators, and brokers to provide educational assistance, and would be happy to discuss your needs. Call or email [Howard Stevens](mailto:Howard.Stevens@mcclawson.com) at (714) 288- 1700 or feel free to speak with any of our attorneys for further information.

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