No. S232197

IN THE

Supreme Court

OF THE STATE OF CALIFORNIA

KIRK KING et al.,

Plaintiffs, Appellants, and Respondents,

vs.

COMPPARTNERS, INC. et al.,

Defendants, Respondents, and Petitioners.

After an Opinion by the Court of Appeal
Fourth Appellate District, Division Two
Case No. E063527

Appeal from a Judgment of the
Riverside County Superior Court
Case no. RIC 1409797, Hon. Sharon J. Walters

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF; AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS KIRK KING ET AL.

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Certificate of Interested Entities or Persons

Pursuant to California Rules of Court, rule 8.208, the undersigned, counsel for the California Medical Association, certifies that there are no disclosures to be made.

DATED: January 30, 2017.

By: _____
LONG X. DO

Attorney for the California Medical Association

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APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFFS KIRK KING ET AL.

Pursuant to rule 8.520(f) of the California Rules of Court, the California Medical Association ("CMA") hereby requests leave to file the attached *amicus curiae* brief in support of Plaintiffs Kirk King and Sara King (collectively "King").

There are no persons or entities to be identified under rule 8.520(f)(4) of the California Rules of Court.

I. INTERESTS OF THE AMICUS CURIAE APPLICANT

CMA is a non-profit, incorporated professional physician association of approximately 45,000 members throughout the State of California. CMA's primary purposes are "to promote the science and art of medicine,

the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA's membership includes California physicians engaged in the private practice of medicine in all specialties and settings. Many CMA physicians provide care to injured workers through the workers' compensation system, as treating doctors and consulting specialists. CMA physicians also participate within the system as qualified medical evaluators or utilization reviewers. CMA has formed committees and subcommittees within its governance structure to investigate, research, and address workers' compensation issues.

II. HOW THE PROPOSED AMICUS CURIAE BRIEF CAN HELP

CMA's mission includes advocating for high quality care and fair access to care within California's workers' compensation system. Meeting these goals entails ensuring that physicians are fairly reimbursed as well as preventing bureaucratic interference with their medical judgment and the care they provide to injured workers. CMA was heavily engaged in the Legislature's efforts in 2012 through SB 863 to enact major reforms to the workers' compensation system. CMA supported the bill after the author accepted numerous amendments designed to improve care of injured workers and efficiency and fairness in resolving disputes over coverage, among other things.

The proposed amicus brief brings CMA's experiences and perspectives to bear upon the issue in this case whether a workers' compensation utilization review physician and company that performs medical utilization reviews on behalf of employers owes a duty of care to an injured worker.[1] In particular, CMA wishes to focus the Court's attention on an issue that has not been properly framed and adequately addressed in the parties' briefing – the nature of utilization review and the real-world impact it has on the medical care of injured workers. CMA's proposed amicus brief explains that utilization review is the practice of medicine, illustrates how utilization review decisions can disrupt and harm the care of workplace injuries, and argues that physicians who engage in utilization review must be held as accountable in the same manner as any other physician who practices medicine.

The discussions in CMA's proposed amicus brief can directly assist the Court in its application of the *Biakanja* factors to determine whether any duty of care exists to hold a third party utilization review company liable for injuries to workers caused by a utilization review decision. That is, a full understanding of utilization review taken from CMA's proposed amicus brief can inform the Court of "the extent to which the transaction was intended to affect the plaintiff, the foreseeability of harm to him, the

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[1]Unless specifically addressed in the proposed amicus brief, CMA takes no position on any other issue that is before the Court.

degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, and the policy of preventing future harm." *Biakanja v. Irving* (1958) 49 Cal. 2d 647, 650.

III. CONCLUSION

For the foregoing reasons, CMA respectfully requests that the Court accept and file the attached amicus curiae brief.

DATED: January 30, 2017

Respectfully,

CENTER FOR LEGAL AFFAIRS
CALIFORNIA MEDICAL ASS'N

By: _____
LONG X. DO

Attorneys for the California Medical Association

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AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION

I. INTRODUCTION

The harm suffered by Plaintiff Kirk King ("King") as a result of the abrupt termination of his anti-depressant drug due to Defendants CompPartners, Inc. and its utilization review physician's (collectively, "CompPartners") decision mirrors the plight of so many injured workers in California. King's case has not garnered mass media attention, but mainstream news outlets have reported on similar experiences suffered by survivors of the San Bernardino terrorist attack in 2015. *See, e.g.*, Perez-Pena, Richard, "'Victimizing Me All Over Again': San Bernardino Victims

Fight for Treatment," NY Times (Nov. 30, 2016).[1]

Survivors of the San Bernardino shooting are receiving treatment exclusively through California's workers' compensation system, and many have reported regular and repeated denials of care, termination of prescriptions, and Kafkaesque dealings with their employer's utilization review administrator. As a result, the California Department of Industrial Relations has opened an investigation. *See* Esola, Louise, "Workers comp treatment delays for San Bernardino victims under investigation," Business Insurance (Dec. 7, 2016).[2] Already, significant blame for the problems is being placed on the workers' compensation utilization review system. According to a San Bernardino County official, "[s]ome people think it's the county . . . . We are just here to administer the state program." *Id.* Another official explained, "it is not the county denying the treatment but a reviewing doctor working under the state-mandated utilization review process." *Id.*

By this amicus curiae brief, the California Medical Association ("CMA") urges the Court to facilitate increased responsibility in the workers' compensation system. As explained herein, so doing would not

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[1]Online at https://www.nytimes.com/2016/11/30/us/victimizing-me-all-over-again-san-bernardino-victims-fight-for-treatment.html?_r=0.

[2]Online at http://www.businessinsurance.com/article/20161207/NEWS08/912310844/Workers-comp-treatment-delays-for-San-Bernardino-victims-under-investigation.

require a drastic or novel legal approach. Rather, the Court need only acknowledge that utilization review in the workers' compensation system is the practice of medicine. The Medical Board of California (which regulates the practice of medicine) and the American Medical Association (which promulgates rules of medical ethics) already have taken well-established positions favoring this approach. Utilization review physicians who practice medicine accordingly should be held to the same standards and obligations as any other physician who practices medicine. The court of appeal's decision finding that a duty of care exists in this case should be affirmed.

II. PURPOSE

A. Interest of Amicus Curiae

CMA is a non-profit, incorporated professional physician association of approximately 45,000 members throughout the State of California. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA's membership includes California physicians engaged in the private practice of medicine in all specialties and settings. Many CMA physicians provide care to injured workers through the workers' compensation system, as treating doctors and consulting specialists. CMA physicians also participate within the system

as qualified medical evaluators or utilization reviewers. CMA has formed committees and subcommittees within its governance structure to investigate, research, and address workers' compensation issues.

CMA's mission includes advocating for high quality care and fair access to care within California's workers' compensation system. Meeting these goals entails ensuring that physicians are fairly reimbursed as well as preventing bureaucratic interference with their medical judgment and the care they provide to injured workers. CMA was heavily engaged in the Legislature's efforts in 2012 through SB 863 to enact major reforms to the workers' compensation system. CMA supported the bill after the author accepted numerous amendments designed to improve care of injured workers and efficiency and fairness in resolving disputes over coverage, among other things.

B. Scope of the Amicus Curiae Brief

This amicus curiae brief is directed to the issue in this case whether a workers' compensation utilization review physician who performs medical utilization reviews on behalf of employers owes a duty of care to an injured worker.[3] Although both CompPartners and its individual utilization review physician are named defendants, CMA's amicus brief focuses on the responsibilities of the individual physician reviewer. To the extent the

[3]Unless specifically addressed herein, CMA takes no position on any other issue in this case that is before the Court.

physician reviewer owes a duty of care and may be potentially liable for the decision to cut off Plaintiff King's anti-depressant medication, CompPartners may be equally liable under principles of agency and *respondeat superior*.

CMA wishes to focus the Court's attention on an issue that has not been properly framed and adequately addressed in the parties' briefing – the nature of utilization review itself and the real-world impact it has on the medical care of injured workers. None of the briefs filed by the parties delves into, as a practical matter, what utilization review is and how it can impact the care of injured workers. Defendant CompPartners too narrowly depicts utilization review as an administrative task to determine if certain recommended medical treatments are medically necessary because they fit within the workers' compensation systems' medical treatment utilization schedule ("MTUS"). *See* Appellants Opening Brief at 34-35. CMA's amicus brief explains that utilization review is the practice of medicine, as confirmed in relevant statutes and regulatory and ethical pronouncements of the Medical Board of California and the American Medical Association, respectively. The amicus brief goes further than any of the parties' briefs to additionally illustrate how utilization review decisions can disrupt and harm the care of workplace injuries, and it concludes that physicians who engage in utilization review must be held accountable in the same manner that physicians practicing medicine are held accountable.

III. DISCUSSION

A. Utilization Review in Workers' Compensation Has Evolved to Limit and Displace Physicians' Independent Medical Judgment.

California has long been a leader in health care delivery and management (e.g., the HMO model was started in Oakland). Most Californians are likely familiar with what it is like to receive health care in a managed care system. Whether through an HMO health plan or a health insurer's preferred provider organization ("PPO") plan, individuals pay plan premiums in exchange for access to health care providers and facilities along with an array of health care benefits. Not every treatment, drug, or test is covered under PPO and HMO plans. Health care plans necessarily have limits on coverage, and their ability to contain administrative costs and plan members' use of health care benefits is vital to the financial viability and survivability of the plans.

Utilization review is a fundamental component of managed care systems. It is the process by which a third party payor prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies coverage for medical care based in whole or in part on determinations of medical necessity. *See* Health & Safety Code §1367.01; Insurance Code §10123.135. Utilization review is intended to help payors to contain costs in a fair and predictable manner, and it can be used to

prevent unnecessary care.[4] For such reasons, California's workers' compensation system heavily relies on utilization review.

1. Utilization Review in Workers' Compensation Increasingly Has Become More Central and Rigid.

Because efficiency and cost are such important goals in California's workers' compensation system, the California Legislature has broadly adopted the use of utilization review and given it a central role in adjudication of coverage decisions. Like in commercial health plans, employers use third parties to conduct utilization review and approve, modify, delay, or deny medical care requested by an injured workers' treating physician prospectively, retrospectively, or concurrently. *See* Labor Code §4610.

In the nascent stage of California's workers' compensation system, which dates back to 1911, it was optional for employers to elect to be covered and, in return, receive immunity from lawsuits in tort for personal injuries sustained by workers while on the job. In 1913, workers' compensation coverage became mandatory and most negligence-based remedies previously available to workers for injuries sustained on the job were eliminated. In return for giving up the ability to sue employers for the monetary value of all damages resulting from a work injury, workers were

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[4] *See generally* Saunier, Benjamin, *The Devil is in the Details: Managed Care and the Unforeseen Costs of Utilization Review as a Cost Containment Mechanism*, 27 Issues L. & Med. 21 (Summer 2011).

guaranteed adequate, albeit limited, benefits of disability payments and provision of medical care. *See* California Const. art. XIV, §4.

The California workers' compensation system is a no fault system in which benefits are automatically provided if certain conditions surrounding the injury are met. Under this system, employers are relieved from liability with very limited exceptions for serious and willful misconduct, fraud, or failure to be insured. *See* Labor Code §§3600-3605.

Labor Code section 4600 dictates the standard by which injured workers are entitled to medical treatment. It establishes a broad definition of medical treatment that must be covered:

> Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, 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.

Labor Code §4600(a). Prior to 2004, this simply was the language in section 4600 governing the standard for coverage of medical care in workers' compensation. In a workers' compensation claim, determining whether a treating physician's recommended treatment was covered involved medical judgments exercised by physicians.

The Legislature in 2004 enacted major reforms to the workers'

compensation laws that drastically impacted utilization review and the standard in section 4600. Until the mid-1990s, treatment disputes between an injured workers' treating physician and a utilization reviewer who denied recommended care were decided based on a preponderance of the evidence standard, and matters that could not be resolved were adjudicated by a workers' compensation judge and the Workers' Compensation Appeals Board ("WCAB"). In 1993, the Legislature added to the Labor Code a presumption that the determination of a treating physician as to the medical necessity of particular treatment is correct. *See* Labor Code §4062.9 (repealed, Stats. 2004, ch 34 §22 (SB 899) (2004)). That presumption was called into question in 2004 when the Legislature concluded it had caused an increase in medical treatment costs for injured workers.

Through SB 228 (Stats. 2004, ch. 639) and SB 899 (Stats. 2004, ch. 34), the Legislature eliminated the presumption of correctness as to the treating physician's determination of medical necessity and implemented a standard of care that was less flexible and supposedly more tethered to evidence-based medicine. The most impactful change to utilization review came with development of the Medical Treatment Utilization Schedule ("MTUS"), a set of medical treatment guidelines designed to serve as a standard by which recommended medical treatment is evaluated. The MTUS became the core of utilization review. Subdivision (b) was added to

Labor Code section 4600 to specify that medical treatment that is "reasonably required to cure or relieve" the injured worker means treatment based upon the MTUS. This new definition of reasonable care was a radical departure from the previous application of section 4600.

Under the reformed definition of section 4600, if a requested medical treatment is covered in the MTUS guidelines, which are presumptively correct as to scope and extent of treatment (*see* Labor Code §4604.5), a non-physician utilization reviewer may approve it. Decisions to modify or deny a request for treatment for reasons of medical necessity can only be made by reviewers who are physicians. *See* Labor Code §4610(e). Although such physicians need not be licensed in California, they must be "competent to evaluate the specific clinical issues involved in the medical treatment services [and] these services [must be] within the scope of the physicians' practice." *Id.*; *see also* 9 C.C.R. §9792.6(s). Only the medical director of a utilization review company needs to be a physician with an unrestricted license to practice medicine in California; the medical director is responsible for all decisions made in the utilization review system and must ensure that the process complies with applicable laws. Labor Code §4610(d); 9 C.C.R. §9792.6(m).

2. Dispute Resolution Over Utilization Review Decisions Has Become More Narrow and Limited.

Immediately following the creation of the MTUS in 2004, disputes over medical treatment between the treating physician and the utilization reviewer had been adjudicated through a medical-legal process, with the opportunity for a hearing before a workers' compensation appeals judge, an appeal to the WCAB, or an appeal to the Superior Court.

In 2012, the Legislature, believing that the medical-legal process was too costly and time-consuming, passed SB 863 (Stats. 2012, ch. 363) to establish the independent medical review (IMR) process. In so doing, the Legislature made IMR the sole appeals remedy for injured workers who receive utilization review decisions that modify, delay, or deny the medical treatment ordered by their treating physicians. IMR decisions may be appealed to the WCAB; however, the IMR decision as to medical necessity is presumed correct and the WCAB cannot make a finding of medical necessity contrary to the final determination. Labor Code §4610.6.

While IMR is generally faster and less costly than the medical-legal process it replaced, it achieves these efficiencies by employing a medical review process similar to utilization review. Prior to the adoption of IMR in SB 863, disputes between a treating physician and utilization reviewer as to medical necessity of a course of treatment were resolved with either side choosing a qualified medical evaluator who prepared a report and

presenting evidence at a trial before a workers' compensation judge, who issued a decision based on the entirety of the case. Decisions were issued by the WCAB and the parties had the right to appeal the WCAB ruling to the appropriate court of appeal.

Since the implementation of SB 863, IMR is used to adjudicate disputes that arise when a utilization reviewer denies, modifies, or delays the treatment recommendation of an injured workers' treating physician. Labor Code §4610. IMR decisions generally must be issued within thirty days (fewer if the request meets the requirements for an expedited decision) from the time the Administrative Director of the Division of Workers' Compensation sends a completed request and supporting documentation to the reviewer. IMR medical reviewers base their decisions on the medical records and documents submitted by the parties and must issue a written decision including references to the specific scientific and medical evidence applied and the clinical reasons for regarding the determination of medical necessity. Once the IMR decision is issued, it is binding and can be appealed to the WCAB; however, the WCAB may not make a finding of medical necessity contrary to the IMR determination. *See generally* 8 C.C.R. §§9792.10.1 through 9792.10.9.

According to a 2014 study conducted by the California Workers' Compensation Institute, IMR reviewers uphold the initial utilization review

decision in nearly eighty percent of cases.[5] Thus, while the IMR process may be efficient, it places even greater power in the hands of utilization reviewers to determine the course of an injured worker's care.

3. Physicians Continue to Experience Interference with Patient Care by Utilization Review.

CMA has compiled reliable evidence of the persistent problems physicians face with utilization review in the workers' compensation system. In December 2014, CMA conducted an anonymous electronic survey of California physicians, including both our members as well as members of county medical associations, in which it posed a series of close-ended questions regarding physician experience with the workers' compensation system following SB 863. Of the 231 physician practices that responded – representing 35 different specialties – two-thirds reported difficulties obtaining authorization for patient care through utilization review and more than half reported inappropriate denials of medically necessary tests, services, and procedures as the most significant problem with the utilization review process.[6]

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[5]*See* Rena David, Brenda Ramirez, and Alex Swedlow, "Medical Dispute Resolution: Utilization Review and Independent Medical Review In the California Workers' Compensation System," California Workers' Compensation Institute (Jan. 2014), *online at* http://www.cwci.org/research.html.

[6]The survey methodology and its results are publicly available on CMA's website, at http://www.cmanet.org/files/assets/news/2015/02/cma-workers-compensation-survey-final.pdf.

In addition to problems with utilization review, of the nearly half of the respondents who reported using the IMR dispute resolution process, two thirds indicated a belief that it was unsuccessful in ensuring approval of medically necessary care, citing slow response times and inappropriate denials of treatment as the most problematic aspects.

In the aftermath of SB 863, which was arguably the biggest transformation of the workers' compensation system since its inception in 1911, CMA's member physicians overwhelmingly found that the absence of meaningful oversight of utilization review decisions led to an increase in inappropriate utilization review decisions, leading to delays and denials of medically necessary tests, procedures, and services. Physicians indicated a sense that reviewing physicians either do not read the records or do not get them and that many patients have been strained as a result of denials that clearly indicate that reviewers are not carefully reviewing the medical documentation supporting management/treatment.

B. Utilization Review is the Practice of Medicine.

As determined by the Medical Practice Act, the Medical Board of California, and cannons of medical ethics, physicians who engage in utilization review are engaging in the practice medicine. This characteristic of utilization review remains constant notwithstanding the other significant

transformations utilization review has undergone as a part of workers' compensation reform.

The practice of medicine is defined in the Medical Practice Act broadly to include "practicing[] any system or mode of treating the sick or afflicted in this state" and encompasses anyone "who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person." Bus. & Prof. Code §2052. "Diagnosis" – one of the acts constituting the practice of medicine – is defined in the Medical Practice Act to include "any undertaking by any method . . . or procedure whatsoever . . . to ascertain or establish whether a person is suffering from any physical or mental disorder." Bus. & Prof. Code §2038.

A physician who engages in utilization review evaluates the medical necessity of a particular treatment, drug, or medical procedure. *See* Health & Safety Code §1367.01; Insurance Code §10123.135; Labor Code §4600(a) and (b). Determining "medical necessity" necessarily involves assessing the patient's medical conditions and determining whether and to what extent they suffer from such conditions. Utilization review accordingly meets the Medical Practice Act's definition of the practice of medicine.[7]

[7]Nowhere in the definitions of the practice of medicine or medical diagnosis is there a requirement that a physician examine or have direct

The Medical Board of California ("Medical Board") is the state agency charged with enforcing the Medical Practice Act. For decades, the Medical Board has staked the position that utilization review constitutes the practice of medicine. Its first pronouncement came in 1998, when the Medical Board issued a formal resolution on the matter:

> RESOLVED, That the Medical Board of California finds and declares the following:
>
> a) The making of a decision regarding the medical necessity or appropriateness, for an individual patient, of any treatment or other medical service, constitutes the practice of medicine.
>
> b) As provided in the practice acts of the licensed health professions, a current valid California license to practice is required of any individual who practices medicine, or who practices any portion of the authorized scope of practice of another licensed health profession.
>
> c) Any person who, on his or her own or on the direction of another, including an employer, agent or contractor, makes a decision of medical necessity or appropriateness, without at that time

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contact with a patient. The lack of direct interaction between a utilization review physician and the injured worker is not dispositive in determining whether that physician has rendered professional medical service to the worker.

possessing a license which authorizes the making of such a decision, shall be guilty of violating California law.

See Webb, Kerrie, "Reminder: Utilization Review is the Practice of Medicine," Medical Board of California Newsletter at 11 (Spring 2016) ("Webb").[8] This position was reaffirmed in 2013 and 2015. *Id.* Of note, in 2013, after testimony by CMA and the California Society of Physical Medicine and Rehabilitation, the Medical Board agreed that physicians conducting workers' compensation utilization review were engaged in the practice of medicine and subject to investigation and discipline by the Medical Board. *See* Medical Board of California, Enforcement Comm. Minutes at 4 (Apr. 25, 2013).[9]

When a complaint to the Medical Board alleges that a utilization review physician's opinion resulted in the wrongful delay, modification, or denial of treatment, the Medical Board's Central Complaint Unit treats the case as a quality of care issue. *See Webb* at 11. The patient's records are then obtained from the treating physician, along with any correspondence relating to the utilization review and its findings. *Id.* The utilization review physician is provided a summary of the complaint and is asked for copies of relevant records and to provide a statement of explanation. *Id.* A

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[8]Available online at http://www.mbc.ca.gov/Publications/Newsletters/newsletter_2016_04.pdf.

[9]Available online at http://www.mbc.ca.gov/About_Us/Meetings/2013/Minutes/minutes_20130425_enf.pdf.

Medical Board medical consultant may review the case to determine whether deviations occurred in the standard of care when reaching the utilization review decision. *Id.* If so, the matter can be referred for prosecution by the Health Quality Investigations Unit in the California Attorney General's office.

The American Medical Association ("AMA") has also taken positions surrounding utilization review that are consistent with the Medical Board's interpretation of the Medical Practice Act. The AMA's Code of Medical Ethics, rule 10.1.1 is directed at physicians who engage in utilization review and provides:

> Physicians' core professional obligations include acting in and advocating for patients' best interests. When they take on roles that require them to use their medical knowledge on behalf of third parties, physicians must uphold these core obligations. When physicians accept the role of medical director and must make benefit coverage determinations on behalf of health plans or other third parties or determinations about individuals' fitness to engage in an activity or need for medical care, they should:
>
> (a) Use their professional expertise to help craft plan guidelines to ensure that all enrollees receive fair, equal consideration.
>
> (b) Review plan policies and guidelines to ensure that decision-making mechanisms: (i) are objective, flexible, and consistent; (ii)

rest on appropriate criteria for allocating medical resources in accordance with ethics guidance.

(c) Apply plan policies and guidelines evenhandedly to all patients.

(d) Encourage third-party payers to provide needed medical services to all plan enrollees and to promote access to services by the community at large.

(e) Put patient interests over personal interests (financial or other) created by the nonclinical role.

See AMA Code of Medical Ethics 10.1.1.[10]

Introduction of the MTUS as a central component of "medical necessity" in workers' compensation does not undercut the conclusion that utilization review is the practice of medicine. Defendant CompPartners suggests that utilization review is an administrative, perhaps ministerial task because the reviewer "is tasked solely with reviewing the medical necessity of the treating physician's 'treatment recommendations'" and "must base their decisions on the MTUS." Petitioners' Opening Brief at 34. However, utilization review decisions are not always based on the MTUS. A recommended medical treatment may not be denied on the sole basis that a condition or injury is not addressed by the MTUS. *See* 8 C.C.R. §9792.21(d). There are two situations whereby a recommended

[10]Available online at https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-10.pdf

treatment may be approved even though it is based on recommendations found outside of the MTUS:

> (1) First, if a medical condition or injury is not addressed by the MTUS, medical care shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the Medical Evidence Search Sequence set forth in section 9792.21.1.
>
> (2) Second, if the MTUS' presumption of correctness is successfully challenged. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Id.

For all conditions or injuries not addressed by the MTUS, the claims administrator is required to authorize treatment if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed medical treatment guidelines that are nationally recognized by the medical community. For conditions or injuries that are addressed by neither the MTUS nor the specified guidelines or for cases when a recommended treatment is at variance with another treatment guideline, the statute and regulations lay out strength of evidence rating methodology to evaluate the

recommendation. *See* Labor Code §4610.5(c)(2); 8 C.C.R. §9792.25.1. These statutes contemplate professional medical judgment to be exercised by utilization review physicians in determining medical necessity in cases that are not addressed by the MTUS.

Moreover, even the act of assessing medical necessity within the boundaries of the MTUS involves medical judgment and decisionmaking. This was illustrated in *Palmer v. Superior Court* (2002) 103 Cal. App. 4th 953. The defendant there argued that utilization review is an administrative activity which does not arise out of professional negligence. Dismissing the argument, the *Palmer* court reasoned that determinations of coverage "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 969. Furthermore, "medical necessity decisions take place in the context of professional duties of care." *Id.* "[T]he [workers' compensation] statutes require that utilization review be conducted by medical professionals, and they must carry out these functions by exercising medical judgment and applying clinical standards." *Id.* at 972; *see also Murphy v. Board of Medical Examiners of State of Arizona* (1997) 190 Ariz. 441, 447 (in denying coverage through utilization review, reviewer "substituted his medical judgment for [the treating physicians] . . . . There is no other way to characterize [the utilization review physician's] decision: it was a 'medical decision'").

C. Utilization Review Physicians Owe the Same Duties as Any Other Physician Practicing Medicine.

Utilization review physicians should be held accountable in the same manner that all other physicians practicing medicine are held accountable. That is not to say, however, that all physicians must be treated the same in terms of their ethical obligations, the existence of a doctor-patient relationship, and the duties of care they assume. Physicians' duties and obligations are dependent on the circumstances in which they render professional services. In any event, absolving utilization review physicians of all responsibility for the foreseeable consequences of their medical decisions, while compensating them for such work, facilitates a workers' compensation system that can systematically deny and delay care to the detriment of real people.

1. Utilization Review Decisions Can and Do Cause Harm to Injured Workers.

a. San Bernardino Shooting Survivors

Survivors of the San Bernardino terrorist attack in 2015 (whose injuries are covered under the workers' compensation system) have experienced extensive delays in access to care and draconian denials or terminations of their care. Below are a few stories that have been widely reported.

Multiple bullets hit Amanda Gaspard, fracturing her thighbone, destroying muscle tissue, and ripping cartilage from her knee. Her treating

physician requested a bone graft, but the treatment was denied by a utilization review physician. Gaspard reported that the utilization reviewer contacted her doctor to request "peer-reviewed journal articles about the safety and efficacy of bone grafts," but her doctor was out of the office. Not receiving a response, the claims administrator on her case rejected the request for a bone graft. *See* Plevin, Rebecca, "San Bernardino survivors still face workers' comp delays, denials," SCPR (Jan. 26, 2017).[11] Gaspard also reported, "I have gone to weekly psychological appointments since January, and the county has made only two payments, and that was only after I called them," she said. Perez-Pena, "'Victimizing Me All Over Again,'" *supra*. She also went to weekly physical therapy sessions, but workers' compensation refused to cover that, and her doctors' requests for therapeutic exercise sessions with a trainer have been denied. *See id.*

Another survivor of the San Bernardino attacks, Sally Cardinale was on anti-depressants, anti-anxiety, and blood pressure medicine "to help level [her] out and help let [her] sleep without nightmares and things like that." Ross, Brian et al., "San Bernardino Terror Victims Claim Medical Care Frustrations, 1 Year After Attack," ABC News (Dec. 2, 2016).[12] However, utilization review resulted in abrupt denial of her medication.

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[11]Online at http://www.scpr.org/news/2017/01/26/68459/san-bernardino-survivors-still-face-workers-comp-d/.

[12]Online at http://abcnews.go.com/US/san-bernardino-terror-victims-claim-medical-care-frustrations/story?id=43924590.

She reported that, "[n]one of those three medicines are supposed to be cut off without any weaning or anything like that, and they just cut them off." *Id.*

As a result of gunshot wounds and numerous surgeries and infections that followed, Valerie Kallis-Weber has a paralyzed left hand, bone and bullet fragments in her pelvis, psychological trauma, and tissue damage, including a fist-size gouge in her thigh where a bullet tore away the muscle. She still needs more operations, she relies on a home health aide, and her doctors want her to get physical and occupational therapy. However, utilization review decisions have reduced her health aide home visits (and she has been told they will end soon), withdrawn her antidepressant medication, and cut off her occupational therapy. Her physical therapy stopped, restarted, and stopped again. *See* Perez-Pena, "'Victimizing Me All Over Again,'" *supra.*

b. San Jose Firefighters

Sixty-eight firefighters in San Jose have filed complaints since 2014 regarding Athens Administrators, the city's third-party claims administrator for workers' compensation claims. The complaints allege that San Jose's human resources department overturned 95 percent of denials issued as a result of Athens Administrators' utilization review. One denial involved Marty Hoenisch, a retired San Jose fire captain, who suffered a fractured spine, broken pelvis, and broken leg during a warehouse fire in 1999. In

2009, he retired and was awarded lifetime medical benefits. When the claim was transferred to Athens Administrators, Hoenisch's doctor submitted a request for an MRI, an epidural, and physical therapy. Athens denied the request claiming it was not medically necessary, but the city reversed. "But the [utilization review] company said the Department of Industrial Relations sets the treatment guidelines for injured workers and Athens is just following the state's playbook." Wagner, Liz et al., "Dozens of Injured San Jose Firefighters Denied Workers' Compensation Treatment," NBC Bay Area News (Aug. 13, 2016).[13]

c. Lorrie Mays

Lorrie Mays was a nurse working for the Fresno County Health Department when she slipped on a flight of stairs, experiencing chronic pain in her legs and lower back. She was put on anti-depressants due to chronic pain and depression, but the drugs did not help. Her treating doctor then requested a treatment called transcranial magnetic stimulation, a procedure used to treat depression in patients resistant to medication. The first round of treatment appeared successful, so her physician requested additional rounds. A workers' compensation utilization review denied the requested treatment on the basis that:

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[13]Online at http://www.nbcbayarea.com/news/local/Dozens-of-San-Jose-Firefighters-Denied-Workers-Comp-390041022.html.

> The new criteria for proceeding with this treatment includes failure of multiple medications and failure of a trial of electroconvulsive therapy. The records do not clearly establish that the paint has recently failed a trial of electroconvulsive therapy. Further, the [MTUS] guidelines advise that a standard course of treatment includes 30 treatments. The patient has far exceeded this treatment.

Mays appealed the denial, asking for an IMR. In 2016, the doctor reviewing her appeal upheld the denial and in the same week, Lorrie Mays committed suicide. *See* Wagner, Liz, "Injured Workers Face Stacked Deck During Workers' Comp Appeals Process, Critics Say," NBC Bay Area News (Aug. 24, 2016).[14]

The IMR company that denied Mays' appeal was Maximus Federal Holdings ("Maximus"), which is paid on a per-claim basis. In a sample of 500,000 IMR cases, Maximus physician reviewers upheld 90 percent of denials. *Id.* According to a news report, the names of Maximus physician reviewers are confidential and there is no requirement that they be licensed in California. *Id.* "IMR doctors never actually examine the patient, either. Instead, they're provided a slice of that worker's medical history and make a determination using a standard set of guidelines." *Id.*

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[14]Online at http://www.nbcbayarea.com/news/local/Injured-Workers-Face-Stacked-Deck-During-Workers-Comp-Appeals-Process-Critics-Say--391202731.html.

2. Utilization Review Physicians Should be Held Accountable.

Plaintiff King is correct that, under ordinary principles of tort, all physicians can potentially be held liable to individuals (even those who are not their patients) who may be harmed by their medical judgments and decisions. The case law is replete with examples. *See* King's Answer Brief on the Merits at 17-20. There is no basis to categorically deny application of these cases to physicians who practice medicine in the form of utilization review.

Wickline v. California (1986) 192 Cal. App. 3d 1630, is a helpful case addressing liability for utilization review decisions causing harm to patients. None of the parties addresses it. As summarized by the court, the case concerned "the legal responsibility that a third party payor . . . has for harm caused to a patient when a cost containment program is applied in a manner which is alleged to have affected the implementation of the treating physician's medical judgment." *Id.* at 1632-33.

The facts in *Wickline* are straightforward. *See id.* at 1634-35. The case involved a Medi-Cal beneficiary who needed to be hospitalized for surgery. Medi-Cal had preapproved her hospitalization up to ten days. Due to complications from the original surgery, the patient required additional surgery and an extension of hospitalization days. Her treating physician recommended eight additional days. However, Medi-Cal's claims review

process approved only a 4-day extension, so the patient was accordingly discharged earlier than her treating physician had recommended. She suffered severe injury leading to the amputation of her leg. All three of her treating physicians were aware that there was a process whereby the Medi-Cal decision could be appealed, but none of them appealed.

Wickline held that the third-party payor (in this case, it was Medi-Cal, which also served as its own claims administrator) was not liable. *Id.* Medi-Cal was absolved because the injured patient could not prove causation, i.e., that Medi-Cal did anything to proximately cause her injuries; rather, her own treating physicians were intervening causes of her injury. The court reasoned that the decision to discharge the patient earlier than her treating physician recommended was made by the attending physicians at the hospital, who had the power to appeal Medi-Cal's decision. The court noted that Medi-Cal was not a party to that medical decision and could not be held liable if that decision was negligently made. *Id.* at 1645-46. In refusing to find liability, the court placed responsibility for the hospital discharge on the attending physicians and implicitly criticized them for not appealing the Medi-Cal denial decision if they disagreed with it:

> [T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's

care. **He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.**

Id. at 1645 (emphasis added).

While it absolved Medi-Cal of liability, the *Wickline* court noted that "defects in the design or implementation of cost containment mechanisms" that result in the denial of medically necessary services could sustain liability for the utilization reviewer. The court also astutely remarked upon the dangers of utilization review, especially prospective utilization review, which can lead to denials of medically necessary care. The court noted that utilization review's "purpose is to promote the well recognized public interest in controlling health care costs by reducing unnecessary services while still intending to assure that appropriate medical and hospital services are provided to the patient in need." *Id.* at 1634. "However, such a cost-containment strategy creates new and added pressures on the quality assurance portion of the utilization review mechanism." *Id.* "An erroneous decision in a prospective review process . . . in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death." *Id.* In its concluding remarks, the *Wickline* court warned, "[w]hile we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, **it**

is essential that cost limitation programs not be permitted to corrupt medical judgment." *Id.* at 1647 (emphasis added).

Defendants are not in the same position as Medi-Cal in *Wickline* and should not be absolved of liability. Unlike Medi-Cal, CompPartners and its utilization review physicians are alleged to have directly caused harm to Plaintiff King, by failing to properly warn or advise about the dangers of immediate cessation of Klonopin. As for Defendant Sharma, as *Wickline* teaches, the exercise of medical judgment and professional discretion afforded to physicians carry independent obligations and duties, even within a utilization review context. After all, under the workers' compensation system, utilization review physicians have discretion to exercise independent medical judgment, and such actions can and do cause harm to injured workers.

None of the policy arguments proffered by CompPartners justifies a categorical denial of liability for utilization review physicians. First, CompPartners argues that "[i]mposing a duty for utilization reviewers to provide direct medical advice . . . would convert them into secondary treating physicians. . . . [and] increase the risk of confusion and error." Petitioners' Opening Brief at 45. CompPartners also argues that "forcing the utilization reviewer into a direct treatment role could undermine the role of the actual treating physician." *Id.* Such arguments are premised on a false assumption that finding a duty of care will force utilization reviewers

to affirmatively provide medical care. *See* Petitioner's Reply Brief on the Merits at 19-20. There is no support for this claim. Negligence is not absolute or to be measured in all cases in accordance with some precise standard, but always relates to some circumstance of time, place and person. *Fouch v. Werner* (1929) 99 Cal. App. 557, 564. Accordingly, while the law imposes some duty upon a utilization review physician, the contours and scope of such duty will be depend on the unique circumstances of the case. Depending on the circumstances, courts could recognize a duty to warn or some other minimal duty of care to an injured worker that does not necessarily require the sort of affirmative action CompPartners warns about. Because King's case was dismissed on demurrer, these fact-specific issues were not allowed to be developed. The Court need not, and probably cannot, make such determinations on the current state of the record.

CompPartners also argues that "making utilization reviewers liable in tort would subject them to the potentially varying standards of care depending on the locality and the evidence in each case." Of course, physicians who practice medicine, like all utilization review physicians, are subject to varying standards of care depending on locality and other circumstances. That is precisely the point of a professional standard of care. The "law has never held a physician or surgeon liable for every untoward result which may occur in medical practice . . . . but it demands

only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession **in the same locality** and that he exercise ordinary care in applying such learning and skill to the treatment of his patient." *Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.

IV. CONCLUSION

The posture of this case before the Court calls only for a determination whether a utilization review physician owes some duty or other obligation to injured workers, not the extent or the scope of such a duty or obligation. Well established case law, as well as pronouncements of the Medical Board of California and the American Medical Association's canons of medical ethics, firmly support the court of appeal's holding that utilization review physicians do owe a duty to injured workers. In this respect, the court of appeal should be affirmed.

DATED: January 30, 2017.

Respectfully,

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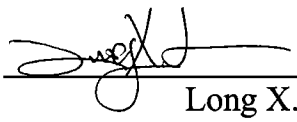
CERTIFICATION OF WORD COUNT

(Cal. R. of Ct., rule 8.520(c))

The text of this brief consists of 6,806 words as counted by the Microsoft Word word-processing computer application used to generate the brief.

DATED: January 30, 2017



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PROOF OF SERVICE

King v. CompPartners, Inc., no. S232197

I, Kerry Sakimoto, hereby declare:

I am employed in Sacramento, California. I am over the age of eighteen years and am not a party to the above-entitled action. My business address is 1201 J Street, Suite 200, Sacramento, California 95814.

On January 30, 2017, I caused the document(s) to be served as indicated below:

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF; *AMICUS CURIAE* BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS

U.S. Mail: By mailing a true copy thereof via first-class postage through the United States Postal Service, as set forth in the attached Service List.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on January 30, 2017, at Sacramento, California.

Kerry Sakimoto

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