Civil No: S232197

SUPREME COURT OF THE STATE OF CALIFORNIA

KIRK KING, et al.,

Plaintiffs, Appellants and Respondents,

vs.

COMPPARNERS, INC., *et al.*

Defendants, Respondents and Petitioners

After a Decision by the Court of Appeal,
Fourth Appellate District, Division Two (No. E063527)

Amicus Curiae Brief Of

CALIFORNIA WORKERS' COMPENSATION INSTITUTE (CWCI) *and* AMERICAN INSURANCE ASSOCIATION (AIA)

In Support Of Petitioner
COMPPARTNERS, INC., *et al.*

[Submitted Concurrently With Amicus Curiae Application]

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CERTIFICATE OF INTERESTED ENTITIES

Supreme Court

State of California

S232197

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Please check the appropriate box:
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G Interested entities or persons are listed below:

Name of Interested Entity or Person	Nature of Interest

December 2nd , 2016

Signature of Attorney/Party Submitting Form

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VERIFICATION & WORD COUNT

I, Michael A. Marks, swear that I have read the within Amicus Curiae brief and know the contents thereof; that the within brief contains 6,656 words, based on the automated word count of the computer word-processing program; that I am informed and believe that the facts and law stated therein are true and on that ground allege that such matters are true; that I make such verification because the officers of California Workers' Compensation Institute and American Insurance Association are absent from the County where my office is located and are unable to verify the petition, and because as their attorney I am more familiar with such facts and law than are the officers.

I declare the truth of the foregoing under penalty of perjury of the laws of the State of California, and that this verification was executed this 2nd day of December, 2016, at Essex, Vermont.

Michael A. Marks (SBN 071817)

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

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Declaration of Service

I, the undersigned, declare under penalty of perjury that I am a citizen of the United States, over the age of 18, and not a party to the within cause of action. My business address is Allweiss & McMurtry, 18321 Ventura Blvd, Suite 500, Tarzana, CA 91356

On December 6, 2016, I both filed with the Court and served a true copy of the *Application of California Workers' Compensation Institute and American Insurance Association for Leave To File Amicus Curiae Brief* AND *Amicus Curiae Brief of California Workers' Compensation Institute and American Insurance Association* via USPS with postage fully prepaid, addressed as follows:

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. I declare, under penalty of perjury, pursuant to the laws of the State of California, that the foregoing is true and correct. Executed on December 6, 2016, at Essex, Vermont.

Michael A. Marks, Esq. (SBN 071817)

ARGUMENT & AUTHORITIES

A. *The Historical Evolution of Utilization Review in Workers' Compensation Demonstrates the Court Of Appeal's Misunderstanding of the Role of UR in the Dispute Resolution System And Thus Its Erroneous Conclusion Below*

As summarized by the California Division of Workers' Compensation in its 2001 publication entitled "Research Brief – Utilization Review in California's Workers' Compensation System: A Preliminary Assessment"[1], although utilization review was ubiquitous within the group health arena by the late 1980's, it was not legislatively introduced into California workers' compensation system until 1993 when legislation authorized the administrative director to "adopt model utilization protocols in order to provide utilization review standards." [2]

That DWC report compared the early workers' compensation UR provisions with the then existing standards applicable for UR in the California Insurance Code governing disability insurers and in the California Health and Safety Code governing Knox-Keene Health Care Service Plans (HMOs), noting several "potentially significant differences".[3],[4] The initial official workers' compensation system foray into UR produced its first set of implementing regulations in 1995,[5] but with limited impact because (1) UR in workers'

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[1] www.dir.ca.gov/dwc/URreport.pdf

[2] Id, at Pg. 4

[3] Id, at Pgs. 3 and 12

[4] Though Respondents' Answer Brief On The Merits acknowledges that Labor Code Section 4610's UR provisions derive from the group health and disability insurance provisions of the Health & Safety Code and Insurance Code, a special statute was enacted to impose liability for negligent Utilization Reviewer under that system (see Civil Code Section 3428), and no such special statute extends such liability to workers compensation UR.

[5] 8 CCR 9792.6 effective July 20, 1995; *see Commission on Health and Safety and Workers' Compensation, 1995-96 Annual Report*, Section III, available at https://www.dir.ca.gov/chswc/95-96_rpt/Section_three.html

compensation was not then mandatory, (2) the first rules related only to the conduct of insurers and self-insured employers who voluntarily chose to use Utilization Review as part of the medical delivery process, and (3) the utilization reviewer's report was not admissible into evidence[6] but served only the limited function of providing a basis for an employer to litigate a treating doctor's treatment recommendation at the WCAB, commencing with the cumbersome comprehensive medical-legal report dispute process of Labor Code Section 4062 (subsequently repealed and replaced in stages as shown below).

It was not until passage of SB228[7] and SB899[8] workers' compensation reforms in 2003 and 2004, that the legislature implemented a formal "medical treatment utilization schedule"[9] with a presumption of correctness on the extent and scope of medical treatment,[10] and made utilization review mandatory.[11] Regulatory implementation of the legislative mandate first occurred by way of emergency regulations effective December 13, 2004, and permanent regulations were first adopted September 22, 2005 (and later periodically updated).

The new mandatory role of UR in the workers' compensation medical treatment dispute resolution process was recognized by the Court in *State Comp. Ins. Fund v. WCAB (Sandhagen)* (2008) 44 Cal.4th 230, 240-243. There, the Court noted that utilization review was enacted in California's workers' compensation as

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[6] See, e.g., *Czarnecki v. WCAB* (1998) 63 CCC 742 (The utilization reviewer's report was held not to be admissible into evidence, because the UR reviewer was not an examining or treating physician as required by Labor Code Section 5703(a) and 8 CCR 10606.).

[7] Sen. Bill No. 228 (2003-2004 Reg. Session), Ch. 639

[8] Sen. Bill No. 899 (2003-2004 Reg. Session), Ch. 34

[9] Labor Code Section 5307.27

[10] Labor Code Section 4604.5

[11] Labor Code Section 4610; *State Comp. Ins. Fund v. WCAB (Sandhagen)* (2008) 44 Cal.4th 230

a substitute for the historically expensive, slow, time consuming, unpredictable and inconsistent traditional "dueling doctors" litigation process of Labor Code Section 4062 (*Sandhagen*, at 243) UR provides a more cost-effective and expeditious method of dispute resolution for contested medical treatment recommendations, newly requiring application of uniform evidence-based peer reviewed nationally recognized standards of appropriateness of care. The new presumptively correct medical treatment utilization schedule replaced the prior failed treating physician's presumption of correctness[12] that had been an explosive cost-driver (*Sandhagen*, at 241) without any demonstrated positive outcome for employees or employers. Specifically, the Court recognized utilization review under SB228/SB899's changes as the sole means of an employer to challenge a treating doctor's recommendation. In that regard, the Court stated that,

> First ... [t]he 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.) .... 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."
>
> Senate Bill No. 899 also changed the AME/QME process, eliminating the competing comprehensive evaluations that often existed under former section 4062. ... The parties must then confer and attempt to agree on one of the QME's. (*Ibid.*) "If the parties have not agreed on a medical evaluator from the panel by the 10th day after assignment of the panel, each party may then strike one name from the panel" and "[t]he remaining [QME] shall serve as the medical evaluator." (*Ibid.*) [13]"[N]o other medical evaluation shall be obtained." (§ 4062, subd. (a).)

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[12] *State Comp. Ins. Fund v. WCAB* (*Sandhagen*) (2008) 44 Cal.4th 230, [text accompanying fn. 11],

Initial implementation of the now mandatory UR system was not without its frustrations. As noted in the 2007 Commission on Health and Safety and Workers' Compensation (hereafter CHSWC) annual report at pg 38,

> Mandatory requirements for utilization review (UR) became effective January 1, 2004. At first, there were many problems that could be attributed to the roll-out of a large new program where nothing on this scale had existed before, so there were infrastructure problems on the employer and insurer side. On the other side of the transaction, doctors who had been accustomed to a presumption that all their opinions were correct suddenly had to adapt to being second-guessed by utilization reviewers and being challenged to substantiate their recommendations with scientific evidence

Even with these changes introducing UR and limiting expert witness jousting at the WCAB, the continued role of litigation as a means of resolving disputes over an employer's UR decisions was severely criticized.

> Issues of appropriateness of particular medical treatments are addressed first by utilization review (UR), with recourse to medical-legal evaluation if the worker disputes the result of a UR. A medical-legal evaluation is performed by an Agreed Medical Evaluator (AME) if the worker is represented and the parties agree, otherwise by a Qualified Medical Evaluator (QME) selected from a panel of three assigned by DWC. Problems exist due to delays in selecting evaluators, obtaining examinations, and producing the evaluation reports. Problems also exist with deficiencies in the content of reports that fail to comply with the legal standards or omit necessary components and thus necessitate supplemental reports. In addition, problems exist with the consistency of reports because the outcome of the evaluation is significantly influenced by the selection of the evaluating physician. All of these problems contribute to increased frictional costs and delays in resolving disputes and delivering benefits to injured workers.[13]

That cumbersome WCAB litigation process was described in the CHSWC annual report for 2012 as follows:

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[13] CHSWC 2010 annual report, Pg.9 [www.dir.ca.gov/chswc/Reports/2010/CHSWC_AnnualReport2010.pdf].' see also CHSWC 2013 annual report, Pg 8 [www.dir.ca.gov/chswc/Reports/2013/CHSWC_AnnualReport2013.pdf]

> it typically takes nine to 12 months to resolve a dispute over the treatment needed for an injury. The process requires: (1) negotiating over selection of an agreed medical evaluator; (2) obtaining a panel, or list, of state-certified medical evaluators if agreement cannot be reached; (3) negotiating over the selection of the state-certified medical evaluator; (4) making an appointment; (5) awaiting the examination; (6) awaiting the evaluator's report, and then if the parties still disagree; (7) awaiting a hearing with a workers' compensation judge; and (8) awaiting the judge's decision on the recommended treatment. In many cases, the treating physician may also rebut or request clarification from the medical evaluator, and the medical evaluator may be required to follow up with supplemental reports or answer questions in a deposition.[14]

The much maligned WCAB litigation track was replaced when SB863[15] adopted Independent Medical Review] (hereafter IMR). As confirmed in the legislative history[16], the intent behind adoption of IMR with limited appellate review was as follows:

> SB 863 proposes to change the way medical disputes are resolved. Currently, when there is a disagreement about medical treatment issues, each side attempts to obtain medical opinions favorable to its position, and then counsel for each side tries to convince a workers' compensation judge based on this evidence what the proper treatment is. This system of "dueling doctors" with lawyers/judges making medical decisions has resulted in an extremely slow, inefficient process that many argue does not provide quality results. Long delays in obtaining treatment result in poorer outcomes, reduced return to work potential, and excessive costs in the system, none of which are good for injured workers. SB 863 would instead adopt an independent medical review system patterned after the long-standing and widely applauded IMR process used to resolve medical disputes in the health insurance system. Thus, a conflict- free medical expert would be evaluating medical issues and making sound medical decisions, based on a hierarchy of evidence-based medicine standards drawn from the health insurance IMR process, with workers' compensation-specific

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[14] www.dir.ca.gov/chswc/Reports/2012/CHSWC_AnnualReport2012.pdf, Pg. 186

[15] 2011-2012 regular session, Chapter 363

[16] Assembly Committee on Insurance, August 31, 2012 Hearing http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201120120SB863

modifications. The bill contains findings that this system would result in faster and better medical dispute resolution than existing law.

The IMR system is designed to ensure that medical expertise is used to resolve medical disagreements. Thus, the decision from the IMR is final and binding on the parties. Nonetheless, in the exercise of the Legislature's plenary authority to establish a workers' compensation system that includes a review of decisions, there is a process to appeal the IMR result, but this review process does not allow the second-guessing of medical expertise. Rather, the appeal is limited to circumstances where there was fraud, conflict of interest, discrimination based on protected classes, or clear mistakes of facts that do not involve medical expertise.

As the foregoing history demonstrates, the legislature's overhaul of the workers' compensation medical treatment dispute resolution system to put medical decisions into the hands of independent doctors trained in using evidence-based medicine and performing an adjudicatory function, and lessen the involvement of lawyers and judges, has been a multi-step multi-year process. It began with SB228 adopting formal treatment guidelines for physicians, enforced trough adoption of mandatory utilization review in SB899. The final chapter in taking lawyers and judges out of the mix, and replacing them with physicians schooled in evidence-based medicine, was the adoption of IMR, as embodied within SB863. The sequence of reforms reflects the legislature's studied response to a bloated dispute resolution process that was too slow, too expensive, too unpredictable and inconsistent, and produced poor outcomes ... instead turning the medical decision-making to physicians schooled in evidence-based medicine and enforced through UR with independent oversight administered by the Administrative Director of the Division of Workers' Compensation and the IMR process.

It should be apparent from the foregoing that the workers' compensation utilization review process has become integral to the formal adversarial litigation process within the workers' compensation arena. As hown in more detail below, the UR physician is not an examining nor attending physician, but instead is part

of an adversarial administratively regulated dispute resolution process, and the UR doctor is therefore immune as part of the workers" compensation "exclusive remedy" and under the litigation privilege.

B. Utilization Review Physicians Have Consistently Been Held NOT to be Treating Physicians.

Contrary to the conclusion below, it has long held that an employer's utilization review physician's report was inadmissible into evidence, because the UR reviewer is not an examining or treating physician as required by Labor Code Section 5703(a) and 8 CCR 10606 [see, e.g., *Czarnecki v. WCAB* (1998) 63 CCC 742 (Significant Panel Decision)]. Soon after the reforms of SB228 and SB899 went into effect, the Appeals Board was called upon to again address the role of a UR reviewer's report. In its *en banc* opinion in *Willette v. Au Electric Corporation* (2004) 69 CCC 1298; 2004 Cal. Wrk. Comp. LEXIS 308, the Appeals Board affirmed the continuing validity of rationale behind the earlier *Czarnecki* decision based on pre-SB228/SB899 law.[17] In discussing the continuing limited role of the UR reviewer's report in post-SB228/SB899 treatment disputes, it noted that report's essential litigation role as "part of the record in determining a post-utilization review medical treatment dispute".[18]

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[17] *Willette v. Au Electric Corporation* (2004) 69 CCC 1298 , 1307 ["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.) 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."

[18] "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

Two subsequent decisions again reinforced the different status of a treating physician from a UR reviewer [*Simmons v. State of California* (2005)70 CCC 866 (Appeals Board *en banc* opinion), and *McCool v. Monterey Bay Medicar* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 578 (Appeals Board Noteworthy Panel Decision)] . In *Simmons* the Appeals Board discussed limited permissible admissibility of a utilization review physician's report, and reinforced the view that a utilization review physician is not a treating physician.[19] In *McCool*, which involved a UR denial without regard to a medication weaning program, the decision specifies that the remedy for the erroneous UR decision is that "decisions which violate section 4610(c) may be referred to the Administrative Director to review defendant's written policies and procedures and potentially assess penalties for abuse of the UR process."

Most recently, the Court of Appeal has twice addressed the new litigation continuum from treating doctor recommendation to mandatory utilization review under 4610 and then the independent medical review process enacted by SB863 and the resulting Administrative Director's decision . The Court in *Stevens v. WCAB* (2015) 241 Cal. App. 4th 1074, 1088-1092, recognized that with enactment

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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).) [*Willette, supra,* at pg 1307].

[19] " ordinarily, only the reports of attending or examining physicians are admissible in evidence in workers' compensation proceedings. (Lab Code, § 5703(a) **[**17]** ; *Sweeney v. Workmen's Comp. Appeals Bd.* (1968) 264 Cal.App.2d 296, 301–305 [70 Cal. Rptr. 462] [33 Cal.Comp.Cases 404].) Nevertheless, the statutory scheme created by section 4610 makes it clear that *utilization review reports are an essential part of the WCAB's record in any post-utilization review proceedings regarding medical treatment disputes.* Accordingly, the Appeals Board has concluded that this scheme creates a *limited* exception to the section 5703(a). That is, even though utilization review physicians are not "attending or examining" **[*873]** physicians within the meaning of section 5703(a), utilization review reports generated under section 4610 are admissible in WCAB proceedings, *if their admission would be consistent with the statutory scheme" [Simmons, supra, at 872-873]*

of SB863 [Stats. 2012 ch. 363] new Labor Code Section 4610.5(e) and 4610.6 expressly forbid the WCAB from deciding a disputed medical issue arising from an employer's timely utilization review determination, instead putting that determination solely within the jurisdiction of the Administrative Director. And in *State Comp. Ins. Fund v. WCAB (Margaris)* (2016) 248 Cal. App. 4th 349 the Court described the medical treatment dispute resolution continuum, noting it begins "if an injured worker seeks medical treatment that deviates from the director's treatment schedule, he or she must establish by a preponderance of the evidence that the proposed treatment is "reasonably required to cure or relieve the injured worker from the effects of his or her injury" (Id at 359-360). The process progresses to an employer's utilization review which functions as part of "the way employers review and resolve an injured worker's request for medical treatment." (*Id* at 360). In enacting Independent Medical Review, SB 863 reformed the litigation process following an employer's adverse utilization review determination. The IMR determination of medical appropriateness becomes the decision of the Administrative Director of the DWC, and even if overturned by the WCAB on limited statutory grounds, the remedy is remand to the Administrative Director for a new review, as the WCAB is prohibited from making a determination on the merits of the treatment request. (*Margaris*, at 361-362).[20]

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[20] "The IMR determination is deemed as a matter of law to constitute the final determination of the director and is binding on all parties. (§ 4610.6, subd. (g).) Although a worker may appeal the IMR determination and receive a hearing before an administrative law judge (§ 5310; Cal. Code Regs., tit. 8, § 10957.1, subd. (k)), the grounds for appeal are limited by statute: The only specified bases for relief are that the director acted without authority, the determination was procured by fraud, the physician reviewer had a material conflict of interest, the determination was the result of bias, or the determination was based on a plainly erroneous fact that is not a matter subject to expert opinion. (§ 4610.6, subd. (h).) A party adversely affected by the decision of the administrative law judge may seek review of that decision by a panel of the appeals board. (§ 5900; Cal. Code Regs., tit. 8, § 10957.1, subd. (*l*).) Significantly, however, if the appeals board reverses the IMR determination, "it cannot now, as it could before,

These cases underscore the adversary role of Utilization Review in the workers' compensation system, and that the UR physician is not and should not be considered a treating doctor in that system. A workers' compensation UR doctor is more in the vein of an expert witness reporting to the employer on the application of principles of evidence-based medicine,[21] not a treating doctor or patient advocate. The twofold consequences for harm resulting from a UR doctor's failure to follow the MTUS medication weaning protocols are within the exclusive confines of the workers' compensation system via (1) the Administrative Director's utilization review enforcement authority, and (2) that any resulting injury is deemed part of the employer's workers' compensation liability as a "compensable consequence" of the original industrial injury (see below) .

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reweigh the evidence and make a contrary factual determination as to the medical necessity of the requested treatment. [Citations.] Instead, it may only remand the case for a new IMR. (§ 4610.6, subd. (i).)" (*Stevens, supra*, 241 Cal.App.4th at p. 1091; see also Cal. Code Regs., tit. 8, § 10957.1, subd. (m).)"

[21] See, *De Los Reyes v. Hanley* (2012) 77 CCC 515 (unpublished) [tort action against doctor selected by employer to prepare a report for use in a workers' compensation case was precluded by litigation privilege]; *Harris v. King* (60 Cal. App. 4th 1185 [Negligence claim against doctor for contents of a report submitted to the workers' compensation insurer was barred because, as a matter of law, the doctor owed no duty to plaintiff]; *Zarate v. Leitner* (2003) 68 CCC 1475 [No tort liability arising from inaccurate statements contained in the doctor's report which was prepared and submitted in connection with plaintiff's pending workers' compensation case.]; *Felton v. Shaeffer* (1991) 229 Cal.App.3d 229 [279 Cal. Rptr. 713], [physician who performed a pre-employment physical and made an erroneous conclusion about the plaintiff's fitness which caused him to be rejected by the employer, had no duty of care to plaintiff as physician's sole function was to provide information to the prospective employer, and no doctor/patient relationship was created]; *Keene v. Wiggins* (1977) 69 Cal.App.3d 308 [138 Cal. Rptr. 3, 42 CCC 1128], [Court held that there was no doctor/patient relationship giving rise to a duty of care owed to the plaintiff in connection with the medical report prepared by a doctor examining worker on referral by his worker's compensation carrier, despite that plaintiff relied on it to his detriment.]

C. *The Decision Below is Erroneous Insofar As It is Predicated On the Finding that The Seizures Are Not Compensable Under the Workers' Compensation System*

In its decision below, the Court of Appeal specifically discusses that the "conditions of compensation" under Labor Code 3600 have not been met, thus removing the claim from the "exclusive remedy" provisions of Labor Code Section 3602, because

> The seizure injury did not occur in the course of Kirk's job because there are no allegations Kirk was working at the time of the seizures. The seizure injury was not proximately caused by Kirk's job because the cause of the seizures is alleged to be Sharma's failure to provide appropriate information or a weaning regime--nothing about Kirk's job is alleged to be the cause of the seizures. As a result, based upon the Kings' [*14] complaint, the conditions of compensation have not been met.

That analysis is wholly contradicted by the plethora of cases finding liability under the workers' compensation laws extends far beyond whether the individual was working at the time of the consequential injury such as the seizures herein. For example,

- The employer is liable under workers' compensation for the consequences of subsequent negligently provided medical treatment ... when clearly not working [Herlick, California Workers' Compensation Handbook, (2006) §4.11.
- The employer is liable under workers' compensation if an industrial injury contributes to a subsequent non-industrial accident, thus considered a "compensable consequence" of the industrial injury and thus the employer's liability ... despite the fact that claimant was not working at the time [Beaty v. Workers' Comp. Appeals Bd 80 Cal. App. 3d 397].
- The employer is liable under workers' compensation if the employee is injured in a car accident on the way to the doctor after visiting his father ...though he is not working at the time ... as public policy dictates the risk of such injury