

# WORKERS' COMPENSATION COLLECTIONS NEWSLETTER

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## NOT PERFORMING UTILIZATION REVIEW WHEN TREATMENT IS REQUESTED MEANS TREATMENT IS AUTHORIZED.

By [www.workcompliens.com](http://www.workcompliens.com)  
November 22, 2009

Through SB 228 many changes in the Workers Compensation Procedures were enacted, from fee schedule for outpatient surgery to Utilization Review.

The Courts continually are giving attention to Utilization Review Process and have been persistent in their quest to ensure that employers / insurers perform utilization review to achieve the ultimate goal of more efficient and expedite medical treatment for the injured worker. Accordingly, the implicit legislative purpose in establishing UR was to create an expeditious and inexpensive method to assess treating physician's medical treatment recommendations.

The important point is that when Utilization Review is not done or not done properly when a request for authorization is made then medical necessity is established for the treatment requested and in the case of a request for spinal surgery when Utilization Review is not done properly or not done then the surgery is authorized. Noted that when a request for spinal surgery is made it must be clearly stated that it is a request for spinal surgery as opposed for other treatment where the request made in the treating physician report appears sufficient.

Recently the Appeal Board handed down a En Banc decision (meaning judges must follow it), although the decision deals with spinal surgery it does reinstate and clarify the procedures and consequence for doing utilization review properly. However, before discussing the case here is a list of a few cases and related statutes to show how Utilization Review has developed in its interpretation over the years.

1. *Sandhagen* specifically states that UR applies to "any and all requests for treatment." (*Sandhagen*, 44 Cal.4th at p. 237 [73 Cal.Comp.Cases at p. 985] (emphasis added).)

2. En Banc Decision of *Simmons v. California*, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005); Utilization review reports are *not* admissible for the purpose of

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determining the issue of whether applicant's industrial injury caused.

a. Labor Code section 4610(a)'s express terms, utilization review is directed solely at determining the "medical necessity" of treatment recommendations. Therefore, section 4610 does *not* authorize a utilization review physician to determine whether the employee's industrial injury caused or contributed to a need for treatment.

3. Authorization means assurance that appropriate reimbursement for a specific treatment will be paid. 8 CCR § 9792.6(b) sets forth how a doctor requests treatment, diagnostic tests or other medical services for an injured worker. A request for authorization may initially be made verbally, but it must be confirmed in writing within 72 hours of the doctor's "First Report of Occupational Injury or Illness" (form DLSR 5021), the "Primary Treating Physician Progress Report" (DWC form PR-2), or in a narrative report that contains the same information required in the PR-2 form. If a narrative report is used, the document must be clearly marked at the top as a request for authorization. (8 CCR § 9792.6(o))

4. En Banc Decision in California Insurance Guarantee Association; and Broadspire (Servicing Facility), September 19, 2009 ADJ3675309 (SAL 0081669) ADJ2967795 (SAL 0101259) ADJ3517685 (SAL 0077391)ADJ1962561 (SAL 0077392) held

"Therefore, if a treating physician seeks authorization for spinal surgery through a narrative report, the narrative report must clearly state at the top that authorization for spinal surgery is being requested.<sup>1</sup>

Rule 9792.6(o) is part of the "Utilization Review Standards" adopted by the Administrative Director. It implicitly recognizes that claims adjusters routinely receive numerous medical reports from treating physicians. Therefore, if in a spinal

IN THE NEWS AT: [WWW.WORKCOMPLIENS.COM](http://WWW.WORKCOMPLIENS.COM)

December 09, 2009: INSURANCE COMMISSIONER POIZNER ANNOUNCES ARREST OF PRUNEDALE WOMAN ON WORKERS' COMPENSATION FRAUD, ELDER ABUSE CHARGES

December 09, 2009: INSURANCE COMMISSIONER POIZNER ANNOUNCES ANALYSIS REVEALS RELATIVELY STABLE WORKERS' COMP RATES FOR 2010

December 07, 2009: Adjustments to the DMEPOS section of the Official Medical Fee Schedule to conform to changes in the Medicare payment system are posted on the DWC Web site

December 02, 2009: Commissioner Poizner Calls for Complete Divestment, Subpoenas 10 Insurance Companies that Failed to Respond to Data Call Insurance Commissioner Steve Poizner today announced that insurance companies licensed to do business in California have admitted to holding \$12 billion in investments in companies that do business with the Iranian energy, nuclear, banking and defense industries

November 30, 2009: Division of Workers' Compensations administrative director announces 2010 profile audit review and full compliance audit performance standards

November 19, 2009: En Banc Decision(1) when a treating physician recommends spinal surgery, a defendant must undertake utilization review (UR); (2) if UR approves the requested spinal surgery, or if the defendant fails to timely complete UR, the defendant must authorize the surgery; (3) if UR denies the spinal surgery request, the defendant may object under section 4062(b), but any objection must comply with AD Rule 9788.1 and use the form required by AD Rule 9788.11; (4) the defendant must complete its UR process within 10 days of its receipt of the treating physician's report, which must comply with AD Rule 9792.6(o), and, if UR denies the requested surgery, any section 4062(b) objection must be made within that same 10-day period; and (5) if the defendant fails to meet the 10-day timelines or comply with AD Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery.

November 14, 2009: Govt: Medicare paid \$47 billion in suspect claims

November 09, 2009: Insurers Continue to Ignore Readily-Available Cost Controls, Commissioner Poizner Says Insurance Commissioner Steve Poizner today declined a second consecutive request by the Workers Compensation Insurance Bureau (WCIRB) to increase the Workers' Compensation Claims Cost Benchmark.

surgery case a particular report might trigger the 10-day deadlines for a defendant to both complete UR and make a section 4062(b) objection, then the defendant should be given clear notice that authorization for spinal surgery is being requested.

Although Rule 9792.6(o) is part of the AD's "utilization review" standards, we conclude that its requirement that a narrative report "shall be clearly marked at the top that it [contains] a request for authorization" applies with equal force to section 4062(b)'s 10-day deadline for objecting to requests to authorize spinal surgery."

A summary of the may issue of the case of Jesus Cervantes v. El Aguila Food Products, Inc.; Safeco Insurance Co. of Illinois; Superior National Insurance Co. In Liquidation; En Banc Decision in California Insurance Guarantee Association; and Broadspire (Servicing Facility), September 19, 2009 ADJ3675309 (SAL 0081669) ADJ2967795 (SAL 0101259) ADJ3517685 (SAL 0077391)ADJ1962561 (SAL 0077392) is as follows:

"The Appeals Board held that the procedures and timelines governing objections to a treating physician's recommendation for spinal surgery are contained in Labor Code sections 4610 and 4062 and in Administrative Director (AD) Rules 9788.1, 9788.11, and 9792.6(o) and are as follows:

- (1) when a treating physician recommends spinal surgery, a defendant must undertake utilization review (UR);
- (2) if UR approves the requested spinal surgery, or if the defendant fails to timely complete UR, the defendant must authorize the surgery;
- (3) if UR denies the spinal surgery request, the defendant may object under section 4062(b), but any objection must comply with AD Rule 9788.1 and use the form required by AD Rule 9788.11;
- (4) the defendant must complete its UR process within 10 days of its receipt of the treating

physician's report, which must comply with AD Rule 9792.6(o), and, if UR denies the requested surgery, any section 4062(b) objection must be made within that same 10-day period; and (5) if the defendant fails to meet the 10-day timelines or comply with AD Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery.

The Appeals Board also disapproved of *Brasher v. Nationwide Studio Fund* (2006) 71 Cal.Comp.Cases 1282 (Appeals Board significant panel decision) (*Brasher*) to the extent it holds:

- (1) a defendant may opt out of UR and instead dispute the requested spinal surgery using only the procedure specified in section 4062(b); and
- (2) if a defendant's UR denies spinal surgery, it is the employee that must object under section 4062(a)."

However, the case reaffirms its summary the

"In *Sandhagen*, the Supreme Court interpreted section 4610(b)'s requirement that "[e]very employer shall establish a utilization review process in compliance with this section" to mean that a defendant must conduct UR when considering an employee's request for medical treatment. (*Sandhagen*, 44 Cal.4th at pp. 237, 243, 245 [73 Cal.Comp.Cases at pp. 985, 991, 992].) *Sandhagen* was not a spinal surgery case, but there is nothing in *Sandhagen* which suggests that a defendant may bypass UR in spinal surgery cases. To the contrary, *Sandhagen* specifically states that UR applies to "any and all requests for treatment." (*Sandhagen*, 44 Cal.4th at p. 237 [73 Cal.Comp.Cases at p. 985] (emphasis added).)"

The Court Further Stated

"For the reasons that follow, a defendant must both complete its UR and, if there is a UR denial,

make its section 4062(b) objection within 10 days of its receipt of the treating physician's report recommending spinal surgery.

Section 4062(b) states, "The employer may object to a report of the treating physician recommending that spinal surgery be performed *within 10 days of the receipt of the report.*" (Emphasis added.) Therefore, based on its clear and unambiguous language, the 10-day time limit for a section 4062(b) objection starts running when the defendant receives the treating physician's report recommending spinal surgery.<sup>1</sup>

However, section 4062(a) states that "[e]mployer 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" (emphasis added). Similarly, section 4610(g)(3)(A) states that "[i]f a request to perform spinal surgery is denied [by utilization review], disputes shall be resolved in accordance with subdivision (b) of Section 4062." (Emphasis added.) Therefore, sections 4062(a) and 4610(g)(3)(A) both plainly and unequivocally provide that the spinal surgery second opinion process of section 4062(b) cannot be initiated unless and until the UR process of section 4610 has denied the requested spinal surgery.<sup>1</sup>

AD Rule 9792.6(o) provides:

" 'Request for authorization' means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the 'Doctor's First Report of Occupational Injury or Illness,' Form DLSR 5021, section

14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization."

"Therefore, if a treating physician seeks authorization for spinal surgery through a narrative report, the narrative report must clearly state at the top that authorization for spinal surgery is being requested.<sup>1</sup>"

Therefore, the courts are ensuring that the employer / insurer comply with the Utilization Review regulations and the consequence of not comply is a waiver of their right to contest to medical necessity on the treatment and or surgery that was requested for authorization

end

Does CIGA Have to Pay Medical Providers When They're "Assigned" to a Collection Company?

There has been a great deal of litigation as to when CIGA is responsible for payment of benefits after taking over from an insolvent insurer. Now, with a recent panel decision, a question that has arisen is: When a medical provider assigns its rights and title to a collection account, is CIGA responsible for payment of that "assigned claim"?

#### **Purpose of CIGA in regards to paying benefits from an insolvent insurer**

California Insurance Guarantee Associations' (CIGA) general purpose is to pay the obligations of an insolvent insurer. When an insurance company becomes insolvent, CIGA takes over the claim and pays benefits that the insolvent insurance carrier was obligated to pay, which includes medical liens.

CIGA primarily receives its funding from Member Insurers, distributions from the estates of insolvent Member Insurers, and investment income.

Waite v. California Insurance Guarantee Assn., 71 Cal. Comp. Cas. (MB) 591 (Cal. App. 2d Dist. 2006)

While CIGA's general purpose is to pay the obligations of an insolvent insurer, it is not itself an insurer. (*R. J. Reynolds Co. v. California Ins. Guarantee Assn.*, *supra*, 235 Cal.App.3d at p. 600.) "CIGA is *not* in the 'business' of insurance . . . . CIGA issues no policies, collects no premiums, makes no profits, and assumes no contractual obligations to the insured's." (*Isaacson v. California Ins. Guarantee Assn.*, *supra*, 44 Cal.3d at p. 787.) Rather, it is authorized by statute to pay only covered claims of an insolvent insurer, those determined by the Legislature to be in keeping with the goal of providing protection for the insured public. (*R. J.*

*Reynolds Co. v. California Ins. Guarantee Assn.*, *supra*, at p. 600.)

#### **What is a "covered claim" that makes CIGA liable when it takes over an insolvent insurer?**

An issue to be resolved is whether the payment sought is for a "covered claim".

Insurance Code section 1063.1, subdivision (c)(9) provides: "Covered claims' *does not include (i) any claim to the extent it is covered by any other insurance ... nor (ii) any claim by any person other than the original claimant under the insurance policy in his or her own name ... and does not include any claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.*"

California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 153 Cal. App. 4th 524, 62 Cal. Rptr. 3d 855, 2007 Cal. App. LEXIS 1196, 72 Cal. Comp. Cas. (MB) 910 (Cal. App. 2d Dist. 2007)

"As is relevant here, a "covered claim" means "(1) ... the obligations of an insolvent insurer, including the obligation ... (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; ... (iv) which were incurred prior to the date coverage under the policy terminated ... (vi) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state ..."

Woodliff v. California Ins. Guarantee Assn., 110 Cal. App. 4th 1690, 3 Cal. Rptr. 3d 1, 2003 Cal. App. LEXIS 1207, 2003 Cal. Daily Op. Service 7076 (Cal. App. 2d Dist. 2006)

In regard to the requirement that a "covered claim" be

"within the coverage of the insurance policy of the insolvent insurer," we concluded the latter phrase "to mean within the risks of loss protected against by an insurance policy. Thus the reading of the pertinent portion of subdivision (c)(1) would be: the obligations of an insolvent insurer within the risks of loss protected against by an insurance policy of the insolvent insurer."

Subdivision (c)(1) of Insurance Code section 1063.1 defines the term "covered claim" to include, "in the case of a policy of workers' compensation insurance," "the obligations of an insolvent insurer ... to provide workers' compensation benefits under the workers' compensation law of this state."

Medical services are covered under Insurance Code section 1063.1.

However, recently CIGA has attempted to claim the defense that an assignment of a claim from the original provider is a basis for not paying medical provider liens. According to CIGA an assignment relieves them of their responsibility to pay medical providers claims against insolvent Workers' Compensation Carriers that have been taken over by CIGA.

There are several appellate cases that address the issue of when CIGA is responsible for covered claims. This includes, but is not limited to, another solvent insurance carrier, whether fully liable, partially, liable, or mistakenly pays the claimed benefits. In such instances, CIGA is not responsible for payment or indemnification of those claims.

Furthermore, in the case of California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 153 Cal. App. 4th 524, 62 Cal. Rptr. 3d 855, 2007 Cal. App. LEXIS 1196, 72 Cal. Comp. Cas. (MB) 910 (Cal. App. 2d Dist. 2007)

"The Legislature did not intend CIGA to defray or diminish the responsibility of other carriers. Because other insurance was available, and the insurers were jointly and severally liable to satisfy the employer's

responsibility to the worker, CIGA had no liability for any portion of the award. (*Garcia, supra*, 60 Cal.App.4th at p. 559.) Even if Garcia had elected to proceed against only one of the solvent insurers for all his benefits, that insurer would have been obligated to pay the entire award and could not institute proceedings against CIGA for contribution."

California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 128 Cal. App. 4th 307, 26 Cal. Rptr. 3d 845, 2005 Cal. App. LEXIS 540, 70 Cal. Comp. Cas. (MB) 556, 2005 Cal. Daily Op. Service 3060, 2005 D.A.R. 4123 (Cal. App. 2d Dist. 2005)

"Under the unambiguous language of the statutory scheme, an original claimant can be any person (other than the insurer) instituting a liability claim within the coverage of the policy, provided that he or she does so in his or her own name and not through assignment or by right of subrogation"

#### **What does the recent panel decision in *Licea* mean?**

In a recent Panel Decision of Mirna Licea v. Minson Corporation; California Insurance Guarantee Association for Phico Insurance Company, in liquidation ADJ 1857578 (AHM 0089872) decided June 23, 2009, it appears that the WCAB panel interpreted CIGA's liability in respect to an assigned claim. The facts of the case are as follows:

Applicant Mirnia Licea, while employed as a laborer by Minson Corporation sustained injury, arising out of and in the course of employment to her back, right leg, right wrist, right hand and right hip. At the time of the injury, the employer's workers' compensation carrier was Phico Insurance Company. CIGA assumed the obligations of Phico Insurance which it became insolvent. The matter resolved by Compromise and Release for \$70,000.00.

Missurian Orthopedic provided treatment to the applicant for charges in the amount of \$39,354.07.

The Trial Judge's Opinion and Recommendation on Petition for Reconsideration, which was incorporated into the Appeals Boards' Denial of Petition for Reconsideration, held that "[KM Financial] did not establish any basis for reimbursement under the Guarantee Act and accordingly, its lien in the amount of \$39,354.07 was correctly disallowed."

The Trial Judge relied on the case of Baxter Healthcare Corp v. California Insurance Guarantee Assn. (2000) 85 Cal. App. 4th 306, 314, wherein the Court held,

"The Guarantee Act excludes from coverage claims asserted by an assignee. That term is not defined or qualified by the act. It must be read in the context of the entire statute and given the meaning it bears in ordinary usage."

It is unclear from the documents reviewed if KM Financial purchased the account of Missirian Orthopedic Medical Group (Missirian) or if they assigned KM Financial for collections (based on wording below it appears the account was purchased), as set forth in the Trial Judge's recommendation and opinion;

"The Notice of Assignment is undated but indicates that Missirian "hereby assigns all title and thereby transfers, without recourse, to KM Financial Services, Inc. "Assignee" or "Buyer" all rights, title interest in the attached Medical Account Receivable' KM in turn appointed Alliance Medical Billing and Collection Services as representative In Fact for the purpose of securing payment of Medical Bills. KM offered no evidence to refute this

assignment. Thus the asserted claim here is clearly the claim of the assignee."

In the language of Licea supra, the Judge states that the claim in the case was clearly a claim of assignee in that the provider transferred all interest in the claim without recourse, and, therefore, no dispute of an assignment for the purpose of relieving the original claimant has taken place and would be different if the claim had been assigned for collection purposes only with the original claimant retaining title and ownership interest.

Further in Baxter Healthcare Corp v. California Insurance Guarantee Assn. supra

The Guarantee Act, which created CIGA in 1969, requires CIGA to "pay and discharge covered claims and in connection therewith pay for or furnish loss adjustment services and defenses of claimants when required by policy provisions." (§ 1063.2, subd. (a).) The term "covered claims" means, "the obligations of an insolvent insurer, including the obligation for unearned premiums, (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; (iii) which are presented as a claim to the liquidator in this state or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings; (iv) which were incurred prior to the date coverage under the policy terminated and prior to, on, or within 30 days after the date the liquidator was appointed; (v) for which the assets of the insolvent insurer are insufficient to discharge in full; (vi) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state; and (vii) in the case of other classes of insurance if the claimant or insured is a resident

of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state." (§ 1063.1, subd. (c)(1).)

Excluded from the definition of "covered claims" is "any claim by any person other than the original claimant under the insurance policy in his or her own name, . . . and . . . any claim asserted by an assignee . . ." (§ 1063.1, subd. (c)(9)(ii).)

KM Financial in its petition for reconsideration cited two cases, the first of which is Richey v. Ziegler (1938) 89 Cal App. 35, in which the Court found that the award to the employee could be assigned legally to the assignee. However, the court dismissed the relevancy of the case as not addressing the Insurance Code 1063.1 issue of assignment.

The second case cited by KM Financial in its petition for reconsideration was the case of Burrow v. Pike (1987) 190 Cal. App. 3d 384, which held that the California Department of Transportation's lien for workers' compensation benefits was not excluded from the definition of a "covered claim" and found CIGA liable for reimbursement of benefits to the injured worker. However, the Court stated the case had no applicability as the case had to do with the employer failing to file a claim with CIGA regarding the obligations of a third party liability carrier.

It appears in Licea, supra, that the WCAB panel stated that an assigned claim cannot be brought forth against CIGA:

Subdivision (c)(1) of Insurance Code section 1063.1 defines the term "covered claim" to include, "in the case of a policy of

workers' compensation insurance," "the obligations of an insolvent insurer . . . to provide workers' compensation benefits under the workers' compensation law of this state."

### Case research

In the workers' compensation system, medical benefits are considered a covered claim, regardless of whether the provider is bringing forth the claim.

California Ins. Guarantee Assn. v. Workers' Comp. Appeals Bd., 136 Cal. App. 4th 1528, 39 Cal. Rptr. 3d 721, 2006 Cal. App. LEXIS 265, 71 Cal. Comp. Cas. (MB) 139, 2006 Cal. Daily Op. Service 1668, 2006 D.A.R. 2296 (Cal. App. 2d Dist.

"CIGA's authority and liability in discharging 'its statutorily circumscribed duties' are limited to paying the amount of 'covered claims.' [Citations.]" ' ' ' ' (California Insurance Guarantee Assn. v. Workers' Comp. Appeals Bd., supra, 112 Cal.App.4th at p. 363.) With certain exceptions, "covered claims" are "the obligations of an insolvent insurer" ' (Ins. Code, § 1063.1, subd. (c)(1)), including the obligation "to provide workers compensation benefits under the workers' compensation law of this state." (Ins. Code, § 1063.1, subd. (c)(1)(vi).)"

St. Joseph's Hospital v. Workers' Compensation Appeals Bd., 70 Cal. Comp. Cas. (MB) 1612 (Cal. App. 1st Dist. 2005)

"With regard to the lien of St. Joseph's Hospital, the WCAB stated that reasonable charges for treatment that relate to Applicant's injury would constitute a "covered claim"

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within the meaning of Insurance Code § 1063.1."

California Insurance Guarantee Assn. v. Workers' Compensation Appeals Bd., 71 Cal. Comp. Cas. (MB) 808 (Cal. App. 1st Dist.2006)

"In addressing CIGA's contention that the WCJ erred in allowing the lien claim of EDD and in ordering CIGA to pay EDD, the WCAB observed that the parties stipulated at trial to defer all liens. The WCAB stated in relevant respects:

" Furthermore, we note that CIGA must generally pay and discharge the "covered claims" of an insolvent insurer. (Ins. Code § 1063.2.) However, "covered claims" do not include "any obligations to any state" government. (Ins. Code § 1063.1(c)(4).) EDD is a "state" agency for purposes of applying Insurance Code section 1063.1(c)(4) (Gov. Code, §12800, 12803.)"

" In Viveros, supra, and in its companion case, Karaiskos v. Metagenics, Inc. (2002) 69 Cal.Comp.Cases 900 [Appeals Board en banc opinion], the Appeals Board en banc held that EDD's liens for UCD benefits are not obligations to the state and therefore are "covered claims" for which CIGA is responsible. We explained that when the Appeals Board finds CIGA or its insolvent carrier "liable for compensation against which an EDD lien may be allowed, *whether by Findings & Award, Stipulations & Award, or Order Approving Compromise & Release (OACR)*, the EDD lien is, in essence, an 'obligation' to the injured worker and not to the 'state.'" Therefore, we concluded that Insurance Code section 1063.1(c)(4) does not exclude EDD's liens from the definition of "covered claims." (Italics added [by WCAB])."

Black Diamond Asphalt, Inc. v.

Superior Court, 114 Cal. App. 4th 109, 7 Cal. Rptr. 3d 466, 2003 Cal. App. LEXIS 1827, 2003 Cal. Daily Op. Service 10641, 2003 D.A.R. 13420 (Cal. App. 3d Dist. 2003)

Section 1063.1, subdivision (g), states a "claimant" includes "any insured making a first party claim or any person instituting a liability claim." <sup>2</sup> Accordingly, the plaintiffs in this action are claimants within the meaning of laws applicable to CIGA since they assert liability claims under third party insurance.

The question must be asked: If it is the obligation of CIGA to pay the claims of the insolvent insurer, is there an obligation of the insolvent insurer to pay the medical bills? If the answer is yes, how could CIGA be relieved from the obligation to pay the medical benefits? If CIGA is not responsible for paying the medical benefits, then what is the purpose of CIGA?

It is understood that Licea supra was decided because the medical provider no longer retained any legal or financial interest in the claim based on the language of the assignment, and in this writers' opinion, this may have been the justification for the decision.

#### **Claim Assigned to Collection Agency**

The question that remains unanswered in Licea supra is what happens when a claim is assigned to a collection company for collection purposes only, where the provider does not assign all right, title, and interest to the claim and is not substituting one claimant for another?

Under the language of the Cal. Ins. Code § 1063.1, an original claimant can be any person (other than the insurer) instituting a liability claim within the coverage of the policy, provided that he or she does so in his or

her own name and not through assignment or by right of subrogation. As interpreted by the case cited below, subrogation and assignment of a claim is the passing of title of a cause of action. Therefore, when a party transfers a claim and or "assigns" a claim to a representative for the qualified and limited purpose to collect on an account in the name of the medical provider without transferring title, it is not excluded under Cal. Ins. Code § 1063.1 as not being a covered claim.

National Union Fire Ins. Co. of Pittsburgh, PA v. Cambridge Integrated Services Group, Inc., 171 Cal. App. 4th 35, 89 Cal. Rptr. 3d 473, 2009 Cal. App. LEXIS 170, 74 Cal. Comp. Cas. (MB) 184 (Cal. App. 1st Dist. 2009

"Whether the transfer be technically called assignment or subrogation or equitable assignment or assignment by operation of law its ultimate effect is the same, to pass the title to a cause of action from one person to another."

In Licea supra it can be seen that the title and rights to the claim was transferred to KM Financial, with the provider retaining no legal right to the claim of liability.

"The Notice of Assignment is undated but indicates that Missirian "hereby assigns all title and thereby transfers, without recourse, to KM Financial Services, Inc. "Assignee" or "Buyer" all rights, title interest in the attached Medical Account Receivable"

Although, one may argue that this is not a subrogated claim, however, because of the plain language of Cal. Ins. Code § 1063.1. It would be hard pressed, if not impossible, to show that the claim was not assigned, as the provider in this case no longer had any rights and/or claim against CIGA. Therefore, the ruling that the claim was not a covered claim seems justified

at face value. In addition, as stated by the Trial Judge, KM Financial did not argue the issue of assignment.

#### **Conclusion**

This writer contends, even in the strictest interpretation of " (§ 1063.1, subd. (c)(9)(ii).)" the law does not limit the providers' legal right to assign a claim to a Collection Company for collection purposes.

Due to the lack real clarity in Licea supra, we contend that the issue of assignment may cause additional litigation and force medical providers to once again rethink if practicing industrial medicine is financially feasible and viable.

Based upon the case law cited and from a practical standpoint, we contend that CIGA must pay when a claim is assigned for collection purposes only, but may have a valid defense under the Insurance Code if the original provider has divested itself of all interest in the claim.

**WORKERS' COMPENSATION  
APPEALS BOARD**

**STATE OF CALIFORNIA**

**JESUS CERVANTES,**

*Applicant,*

vs.

**EL AGUILA FOOD PRODUCTS, INC.;  
SAFECO INSURANCE CO. OF ILLINOIS  
; SUPERIOR NATIONAL INSURANCE  
CO., In Liquidation; CALIFORNIA  
INSURANCE GUARANTEE ASSOCIATIO  
(Servicing Facility),**

*Defendant(s).*

We granted the petition for reconsideration of defendant, Safeco Insurance Company of Illinois (Safeco), to allow time to further study the record and applicable law. Thereafter, to secure uniformity of decision in the future, the Chairman of the Appeals Board, upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en banc decision (Lab. Code, § 115)<sup>1</sup> regarding the proper procedure to be followed when an injured employee's treating physician has recommended spinal surgery. We hold that the procedures and timelines governing objections to a treating physician's recommendation for spinal surgery are contained in Labor Code sections 4610 and 4062<sup>1</sup> and in Administrative Director (AD) Rules 9788.1, 9788.11, and 9792.6(o)<sup>1</sup> and are as follows: (1) when a treating physician recommends spinal surgery, a defendant must undertake utilization review (UR);<sup>1</sup> (2) if UR approves the requested spinal surgery, or if the defendant fails to timely complete UR, the defendant must authorize the surgery; (3) if UR denies the spinal surgery request, the *defendant* may object under section 4062(b), but any objection must comply with AD Rule 9788.1 and use the form required by AD Rule 9788.11; (4) the defendant must complete its UR process within 10 days of its receipt of the treating physician's report, which must comply with AD Rule 9792.6(o), and, if UR denies the requested surgery, any section 4062(b) objection must be made within that same 10-day period; and (5) if the defendant fails to meet the 10-day timelines or comply with AD Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery. We expressly disapprove of *Brasher v. Nationwide Studio Fund* (2006) 71 Cal.Comp.Cases 1282 (Appeals Board significant panel decision) (*Brasher*) to the extent it holds: (1) a defendant may opt out of UR and instead dispute the requested spinal surgery using only the procedure specified in section 4062(b); and (2) if a defendant's UR denies spinal surgery, it is the *employee* that must object under *section 4062(a)*.

**I. BACKGROUND**

Applicant, Jesus Cervantes, sustained several industrial injuries to his low back in 1996, 1997, and 1998, while employed by El Aguila Food Products, Inc. (El Aguila). El Aguila was insured by Safeco for two of these injuries. On September 2, 2003, a stipulated Findings and Award issued which determined, among other things, that applicant is entitled to further medical treatment, administered by Safeco.

Applicant began treating with Catalino Dureza, M.D. who sent four narrative reports to Safeco between September 2008 and January 2009. All four reports described applicant's current problems and diagnosed "lumbar discopathy with disc displacement" and "lumbar radiculopathy." The September 30, 2008 report requested authorization for a lumbar MRI; the November 4, 2008 report said that applicant "may be a surgical candidate" pending the results of the MRI; and the December 13, 2008 report set forth the MRI findings, but said Dr. Dureza would continue to provide applicant with medication for symptomatic relief. In the January 16, 2009 report, Dr. Dureza said: "I do feel somewhat confident that the patient would benefit from surgery ... Therefore, I am requesting L4-L5 and L5-S1 posterior lumbar interbody fusion with pedicle screw fixation and extensive decompression by a Gill Procedure. ... [¶] Authorization should be forthcoming in order to prevent further neurological and musculoskeletal deterioration." However, the January 16, 2009 narrative report did not clearly state at the top that Dr. Dureza was requesting authorization for surgery.

On February 25, 2009, Dr. Dureza sent Safeco a fax captioned "WRITTEN REQUEST FOR SURGERY AUTHORIZATION," which referenced his earlier reports and requested that Safeco authorize an "L4-5 + L5-S1 posterior lumbar interbody fusion with pedicle screw fixation."

On March 4, 2009, Safeco obtained a UR report from Allen Deutsch, M.D., who concluded that the requested surgery "is not recommended as medically necessary" based in part on the ACOEM Guidelines.<sup>1</sup>

An expedited hearing was held before a workers' compensation administrative law judge (WCJ), at which the reports of Dr. Dureza and Dr. Deutsch were admitted in evidence.

At trial, applicant argued that he is entitled to surgery because: (1) Dr. Dureza's January 16, 2009 report clearly requested authorization for surgery and, therefore, Safeco's March 4, 2009 UR denial was untimely under section 4610(g); and (2) Safeco did not object to Dr. Dureza's January 16, 2009 report within 10 days of receipt and, therefore, it could not avail itself of the spinal surgery second opinion dispute resolution procedure of section 4062(b).

Defendant argued that applicant is not entitled to surgery because: (1) AD Rule 9792.6(o) requires that any narrative report requesting authorization for proposed treatment "shall be clearly marked at the top that it is a request for authorization"; (2) Dr. Dureza's February 25, 2009 fax was the first written communication that was clearly marked at the top that he was requesting authorization for spinal surgery and, therefore, Safeco's March 4, 2009 UR denial was timely; and (3) once Safeco issued its timely UR denial, it was applicant's burden to initiate the spinal surgery second opinion process by timely objecting to the UR denial, but he did not do so.

On May 13, 2009, the WCJ issued a Findings and Order determining that applicant is entitled to lumbar spinal fusion surgery, concluding that "Dr. Dureza's recommendation for lumbar spinal fusion surgery appears reasonable and appropriate"

and that Dr. Deutsch's UR report is "not persuasive." Accordingly, the WCJ said the legal issues were "moot."

Safeco filed a timely petition for reconsideration that essentially raises the same legal arguments it presented at trial, but also asserts that Dr. Dureza's opinion is not substantial evidence.

Applicant filed an answer that essentially raises the same legal arguments he made at trial, but also contends that Dr. Dureza's reports support the finding of entitlement to spinal surgery.

We granted reconsideration to further study the factual and legal issues presented.

**II. DISCUSSION**

In this opinion, we interpret certain provisions of section 4610 and section 4062, and we consider the interrelationship of these provisions together with the application of relevant AD Rules, in the context of a treating physician's request for authorization of spinal surgery.

**A. Principles of Construction**

The fundamental rule of statutory construction is to effectuate the Legislature's intent. (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286, 289] (*DuBois*)). "When interpreting any statute, it is well-settled that we begin with its words because they generally provide the most reliable indicator of legislative intent." (*Smith v. Workers' Comp. Appeals Bd.* (2009) 46 Cal.4th 272, 277 [74 Cal. Comp. Cases 575, 578] (*Smith*) [internal quotation marks omitted].) "We are required to give effect to statutes according to the usual, ordinary import of the language employed ... ." (*DuBois*, 5 Cal.4th at p. 388 [58 Cal.Comp.Cases at p. 289].) "If the language is clear and unambiguous, there is ordinarily no need for judicial construction [and, therefore,] we presume the Legislature meant what it said and the plain meaning governs." (*Smith*, 46 Cal.4th at p. 277 [74 Cal. Comp. Cases at p. 578] [internal quotation marks omitted]; see also *DuBois*, 5 Cal.4th at pp. 387-388 [58 Cal.Comp.Cases at p. 289].) Nevertheless: "At the same time, we do not consider ... statutory language in isolation. Instead, we examine the entire substance of the statute in order to determine the scope and purpose of the provision, construing its words in context and harmonizing its various parts. Moreover, we read every statute with reference to the entire scheme of law of which it is part so that the whole may be harmonized and retain effectiveness." (*San Leandro Teachers Ass'n v. Governing Bd. of San Leandro Unified School Dist.* (2009) 46 Cal.4th 822, 831 [internal quotation marks and citations omitted]; see also *Chevron U.S.A., Inc. v. Workers' Comp. Appeals Bd. (Steele)* (1999) 19 Cal.4th 1182, 1194 [64 Cal.Comp.Cases 1, 22] (*Steele*) ("The words of the statute must be construed in context ... and statutes or statutory sections relating to the same subject must be harmonized, both internally and with each other, to the extent possible."))

Generally, the rules of statutory interpretation also govern the interpretation of regulations (*Cal. Drive-In Restaurant Ass'n v. Clark* (1943) 22 Cal.2d 287, 292.) Therefore, our duty is to effectuate a regulation's intent and, if the words of a regulation are clear and unambiguous, the plain language of the regulation applies. (*Dept. of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2003) 109 Cal.App.4th 1687, 1695-1696; see also *Diablo Valley College Faculty Senate v. Contra Costa Community College Dist.* (2007) 148 Cal.App.4th 1023, 1037; *Weaver v. Chavez* (2005) 133 Cal.App.4th 1350, 1355.)

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**B. When a Treating Physician Recommends Spinal Surgery, a Defendant Must Undertake Utilization Review**

Based on sections 4062(a) and 4610 and the Supreme Court's decision in *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Sandhagen)* (2008) 44 Cal.4th 230 [73 Cal.Comp.Cases 981] (*Sandhagen*), we conclude that a defendant must conduct UR whenever an injured employee's treating physician recommends spinal surgery.

The plain language of section 4062(a) establishes that spinal surgery cases are subject to UR because it provides that "[e]mployer 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." (Emphasis added.) Section 4610 itself also indicates that spinal surgery cases are subject to UR because it provides that if UR denies a request for spinal surgery then the dispute shall be resolved under section 4062(b). (Lab. Code, § 4610(g)(3)(A) & (g)(3)(B).)<sup>1</sup>

In *Sandhagen*, the Supreme Court interpreted section 4610(b)'s requirement that "[e]very employer shall establish a utilization review process in compliance with this section" to mean that a defendant must conduct UR when considering an employee's request for medical treatment. (*Sandhagen*, 44 Cal.4th at pp. 237, 243, 245 [73 Cal.Comp.Cases at pp. 985, 991, 992].) *Sandhagen* was not a spinal surgery case, but there is nothing in *Sandhagen* which suggests that a defendant may bypass UR in spinal surgery cases. To the contrary, *Sandhagen* specifically states that UR applies to "any and all requests for treatment." (*Sandhagen*, 44 Cal.4th at p. 237 [73 Cal.Comp.Cases at p. 985] (emphasis added).)

Therefore, contrary to *Brasher*, we conclude that when a treating physician requests

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authorization to perform spinal surgery, a defendant must assess that request through UR.<sup>1</sup>

**C. If Utilization Review Approves the Requested Surgery, or if the Defendant Fails to Timely Complete Utilization Review, the Defendant Must Authorize the Surgery**

We also conclude that if UR approves the spinal surgery request, or if the defendant fails to timely complete UR, the defendant must authorize the surgery.

Section 4610 establishes that the purpose of UR is to assess treatment recommendations by physicians and to approve, modify, delay, or deny those recommendations. Furthermore, section 4610(g) establishes certain time "requirements [for UR that] must be met."

Accordingly, the implicit legislative purpose in establishing UR was to create an expeditious and inexpensive method to assess treating physician's medical treatment recommendations. (See Cal. Const., art. XIV, § 4 ("the administration of [workers' compensation] legislation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance [sic] of any character").) As *Sandhagen* states:

"Before the passage of Senate Bill No. 228, [¶] ... [i]f an employer wanted to obtain a report from a doctor other than the treating physician regarding the necessity of certain medical treatment, essentially the only option for the employer was to initiate the rather cumbersome, lengthy, and potentially costly process under former section 4062. ... [¶] ... In place of the often lengthy and cumbersome process employers used to dispute treatment requests prior to the passage of Senate Bill No. 228, the Legislature created a utilization review process that combines what are typically quick resolutions (§ 4610, subd. (g)(1)) with accuracy—employers can have their utilization review doctors review treatment requests, employers can seek additional time to obtain additional information or examinations (*id.*, subd. (g)(5)), and medical review is required before the utilization review doctor can modify, delay, or deny a treatment request (*id.*, subd. (e)). ... [¶] ... [U]tilization review provides an expeditious manner of resolving treatment requests, being neither time consuming nor expensive, especially when compared to the process previously in place." (*Sandhagen*, 44 Cal.4th at pp. 238, 243-244 [73 Cal.Comp.Cases at pp. 986, 991-992].)

Given the purpose of section 4610, we conclude that if UR approves the recommended spinal surgery, the defendant must authorize it.

This conclusion comports with the statutory language. The purpose of the spinal surgery second opinion procedure is to obtain a report "resolving the disputed surgical recommendation." (Lab. Code, § 4062(b) (emphasis added).) Therefore, if UR approves spinal surgery, there is no "dispute" to "resolv[e]." Similarly, section 4062(a) states that "[e]mployer objections ... shall be subject to [section 4062(b)] ... after denial of the physician's recommendation, in accordance with Section

4610." (Emphasis added). Thus, if there is no UR "denial" under section 4610, then there is no spinal surgery issue that could be "subject to" section 4062(b). Also, section 4610(g)(3)(A) states that "[i]f a request to perform spinal surgery is denied," then "disputes shall be resolved in accordance with [section 4062(b)]." (Emphasis added.) Once again, if there is no UR "deni[al]" there is no "dispute" to "resolve[.]"

Furthermore, given both the purpose and timelines of section 4610, we conclude that if a defendant fails to timely complete UR it must authorize the spinal surgery.

This conclusion is supported by the recent decision of the Court of Appeal in *J.C. Penney Co. v. Workers' Comp. Appeals Bd. (Edwards)* (2009) 175 Cal.App.4th 818 [74 Cal.Comp.Cases 826] (*Edwards*). In *Edwards*, the Court addressed a treating physician's determination regarding temporary disability. This determination did not pertain to medical treatment, so UR did not apply. Therefore, objections to the determination were governed by section 4062(a), including its specific deadlines for objections not subject to section 4610.<sup>1</sup> J.C. Penney did not timely object under section 4062(a), but instead argued that the treating physician's determination did not constitute substantial evidence. In rejecting this argument, the Court said:

"A determination by a treating physician that an injured worker continues to be temporarily totally disabled is a medical determination subject to the objection requirement of Labor Code section 4062. ... The question is: What is the effect of failing to object within the 'time limits' of that statute?"

"The requirement for an objection under section 4062 is stated in mandatory language: 'the objecting party shall notify the other party in writing.' The ordinary meaning of a mandatory time limit is that once the prescribed time has passed the action subject to the time limit may no longer be taken. When J.C. Penney failed to object to a medical determination of temporary total disability by Edwards's treating physician within the time limit provided in section 4062, it lost the right to object to that determination in the future.

"The evident purpose of the time limits in section 4062 is to induce both employer and employee to declare promptly medical determination disputes and expeditiously resolve them through the prescribed mechanisms. This purpose cannot be attained if a party such as J.C. Penney can fail to object in a timely manner and nonetheless thereafter tender a claim that contradicts a medical determination subject to the objection requirement of the statute. If either employer or employee fails to raise a dispute about a medical determination within the ambit of section 4062 within the prescribed time, they may not attack that determination thereafter.

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"We find the core reasoning of the WCAB correct. '[I]t is contrary to the spirit of [section] 4062 to permit a retrospective determination of a permanent and stationary date' when to do so would be to allow a belated objection to a medical determination by the treating physician."

(*Edwards*, 175 Cal.App.4th at pp. 825-827 [74 Cal.Comp.Cases at pp. 831-832].)

Even more so than section 4062(a), section 4610(g) emphatically makes clear that its UR deadlines are mandatory. Section 4610(g) declares: "In determining whether to approve, modify, delay, or deny requests by physicians ... all of the following requirements must be met: (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician." (Emphasis added). All of these italicized words indicate a mandatory and time-limited process. (Lab. Code, § 15 ("[s]hall' is mandatory and 'may' is permissive"); *Long Beach Police Officers Assn. v. City of Long Beach* (1988) 46 Cal.3d 736, 743 ("the ordinary meaning of 'shall' or 'must' is of mandatory effect"); *In re Barfoot* (1998) 61 Cal.App.4th 923, 931 (the word "require" means "to direct, order, demand, instruct, command, ... [and] compel").)

Accordingly, if a defendant fails to complete UR in a timely manner, it must authorize the recommended spinal surgery.<sup>1</sup>

**D. A Defendant May Object under Section 4062(b) to a Spinal Surgery Request, but any Objection Must Comply with Administrative Director**

**Rule 9788.1 and Use the Form Required by Administrative Director Rule 9788.11**

For the reasons that follow, we conclude that in the sole context of a recommendation for spinal surgery, it is only the defendant, and not the injured employee, that may object under section 4062.

The opening sentence of section 4062(b) expressly states: “*The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report.*” (Emphasis added.) Accordingly, the plain language of section 4062(b) clearly and unequivocally provides that it is the *defendant* that may initiate that statute’s spinal surgery second opinion procedure. This is confirmed by the unambiguous language of section 4062(a), which provides in relevant part: “*Employer objections to the treating physician’s recommendation for spinal surgery shall be subject to subdivision (b) . . . .*” (Emphasis added.) Thus, the language of both sections 4062(b) and 4062(a) refers only to an “employer” objection to a treating physician’s spinal surgery recommendation; neither section makes any reference to an objection by an injured employee.

As will be discussed later, a defendant’s objection under section 4062(b) to a treating physician’s spinal surgery request may be made only after that request has been denied by UR. (See Section II-E, *infra*.) It may seem redundant to provide for a defendant to object again after its own UR has just denied the spinal surgery request, but in the context of spinal surgery this is exactly what sections 4062(b) and 4062(a) specify. The legislative framework for spinal surgery cases is simply different than it is for non-spinal surgery cases because, at every step, section 4062(b) places the onus on the defendant. For example, in addition to providing for only “employer” objections to a treating physician’s spinal surgery recommendation, section 4062(b) requires that “[i]f the second opinion report does not recommend surgery, *the employer shall file a declaration of readiness to proceed.*” (Emphasis added.) Because a declaration of readiness is the document that triggers a hearing before the WCAB (Cal. Code Regs., tit. 8, § 10250), section 4062(b) gives the defendant the primary responsibility for initiating the adjudicatory process, even if the second opinion report *agrees* with the defendant’s UR denial. This, of course, is consistent with section 4062(b)’s provision making the defendant responsible for initiating the second opinion process, even though its own UR has denied the spinal surgery. We recognize that section 4062(a) states: “If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision.” Yet, the fact that section 4062(a) refers generally to “employee” objections to UR determinations does not by itself establish a legislative intent to allow “employee” objections to UR determinations *relating to spinal surgery*.

“It is well settled . . . that a general provision is controlled by one that is special, the latter being treated as an exception to the former. A specific provision relating to a particular subject will govern in respect to that subject, as against a general provision, although the latter, standing alone, would be broad enough to include the subject to which the more particular provision relates.” (*Miller v. Superior Court* (1999) 21 Cal.4th 883, 895 (internal quotation marks omitted); see also Code Civ. Proc., § 1859; Civ. Code, § 3534.) Here, we conclude that the “employee” objection language of section 4062(a) states the general rule for when UR modifies, delays, or denies a treatment recommendation *other than spinal surgery*, but that the “employer” objection language of sections 4062(b) and 4062(a) states the specific rule for spinal surgery cases.

In this regard, the Legislature established a fast track for spinal surgery cases. Specifically, section 4062(b) provides, in pertinent part:

“The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expeditious basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician’s report.”

Therefore, under section 4062(b), a second opinion physician must be

agreed to or selected, the examination must be scheduled and completed, and the second opinion report must issue – all within 45 days after the defendant has received the treating physician’s report recommending spinal surgery.

Yet, the general procedure of section 4062(a) for “employee” objections to UR determinations is utterly inconsistent with this specific and expeditious 45-day procedure of section 4062(b) for spinal surgery cases.

Preliminarily, section 4062(b) requires an employer’s spinal surgery objection to be made within 10 days of the receipt of *the treating physician’s report*. Section 4062(a), however, provides that an employee’s objection may be made within 20 days of the employee’s receipt of *the defendant’s UR decision*. Even with our holding that a defendant must complete UR in a spinal surgery case within 10 days of its receipt of the treating physician’s report (see Section II-E, *infra*), section 4062(a) would add an extra 20 days to the dispute resolution process at the very outset.

Moreover, once an employee’s UR objection has been made, section 4062(a) steers that objection into section 4062.2 for a represented employee and into section 4062.1 for a non-represented employee.<sup>1</sup> Under section 4062.2, either the parties timely agree to utilize an agreed medical evaluator (AME) or, failing that, the AD issues a three-member qualified medical evaluator (QME) panel from which the parties may agree to select one as an AME or they may each strike one QME, leaving one. Under section 4062.1, only a three-member QME panel process is allowed. But, as illustrated below (see fn. 12, *infra*), the procedures under sections 4062.2 and 4062.1 each involve multiple steps that, collectively, allow the AME and/or QME process to extend indefinitely, well beyond the 45-day deadline of section 4062(b).<sup>1</sup>

Furthermore, there is another significant difference between the special “employer” spinal surgery second opinion process of section 4062(b) and the general “employee” process of section 4062(a). Regardless of whether the second opinion physician is agreed to by represented parties or is randomly selected by the AD, section 4062(b) requires the second opinion physician to be a “licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon.” (See also Cal. Code Regs., tit. 8, § 9788.2.) As just discussed, however, section 4062(a) directs a represented employee into section 4062.2 and an unrepresented employee into section 4062.1; yet, neither of those sections requires any AME or panel QME to be an orthopedic surgeon or a neurosurgeon. To the contrary, both sections allow the party who is requesting a QME panel to designate *any* “specialty” for the physicians on the panel (Lab. Code, §§ 4062.2(b), 4062.1(b)) and section 4062.2 does not even require any AME to have been certified as a QME (Lab. Code, § 4062.2(b); see also § 139.2(b)-(e), (h)(3) [standards for QMEs assigned by the AD]).<sup>1</sup>

In sum, section 4062(b) and section 4062(a) refer only to “employer” and not “employee” objections in spinal surgery cases; section 4062(b) establishes a unique 45-day fast-track procedure for resolving spinal surgery disputes; and the generic “employee” objection procedure of sections 4062(a), 4062.2, and 4062.1 takes substantially longer than 45 days and does not require that an orthopedic surgeon or a neurosurgeon be used. Accordingly, we conclude that the Legislature’s specific intent as expressed by section 4062(b)’s spinal surgery provisions controls over the Legislature’s more general intent as expressed in section 4062(a)’s non-spinal surgery provisions. Thus, it is only the defendant which may initiate the section 4062(b) spinal surgery second opinion process.

In reading section 4062(b) to mean that it is the defendant, and not the injured employee, that may initiate the spinal surgery second opinion procedure, we are aware *Sandhagen* repeatedly said that defendants cannot use section 4062 to dispute treatment requests; instead, section 4062 is available only to employees who are dissatisfied with a defendant’s UR decision. (*Sandhagen*, 44 Cal.4th at pp. 234, 237, 244-245 [73 Cal.Comp.Cases at pp. 982, 985, 985-986, 992].) *Sandhagen*, however, was not a spinal surgery case and it did not directly involve the provisions of section 4062(b). “It is axiomatic that language in a judicial opinion is to be understood in accordance with the facts and issues before the court. An opinion is not authority for propositions not considered.” (*Steele, supra*, 19 Cal.4th at p. 1195 [64 Cal.Comp.Cases at p. 28].) Therefore, *Sandhagen*’s statements that only an injured employee (and not a defendant) may use section 4062 in a non-spinal surgery case have no bearing on the question of whether it is the defendant (and not the employee) that may initiate the spinal surgery second opinion procedure of section 4062(b).

We recognize *Brasher* held that when a defendant’s UR denies spinal surgery it is *the injured employee* who must object within 10 days of the denial. (*Brasher, supra*, 71 Cal.Comp.Cases at p. 1287.) However, *Brasher* acknowledged it arrived at this conclusion using a “convoluted” method that had the employee begin on the section 4062(a) track and then switch over to the section 4062(b) track. (*Id.*) Yet, nothing in the statutory language of section 4062 provides for any such track-switching procedure. Moreover, importing an “employee” objection into section 4062(b) would mean the employee has 10 days to object to the spinal surgery recommendation of the employee’s *own physician*, even though there is a possibility that defendant’s UR process might *approve* the requested surgery. (Lab.

Code, § 4610(a).) Accordingly, based on our analysis above, we now expressly reject the *Brasher* holding that, if a defendant's UR denies spinal surgery, the applicant must timely object under section 4062(a), after which the applicant is switched over to the section 4062(b) track.<sup>1</sup>

We observe that, if a defendant objects under section 4062(b), it must comply with AD Rules 9788.1 and 9788.11. Rule 9788.1 is expressly framed in mandatory terms and it provides, in relevant part:

“(a) An objection to the treating physician’s recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in Section 9788.11. The employer shall include with the objection a copy of the treating physician’s report containing the recommendation to which the employer objects. The objection shall include the employer’s reasons, specific to the employee, for the objection to the recommended procedure. The form must be executed by a principal or employee of the employer, insurance carrier, or administrator.” (Cal. Code Regs., tit. 8, § 9788.1 (emphasis added).)

Rule 9788.1 also sets forth certain requirements for: (1) a declaration under penalty of perjury regarding when the defendant received the treating physician’s spinal surgery recommendation; (2) a declaration under penalty of perjury regarding when the defendant served its objection; and (3) service of the objection. Rule 9788.11 adopts the form that, under Rule 9788.1, “shall” be used for a defendant’s spinal surgery objection.<sup>1</sup>

**E. The Defendant Must Complete its Utilization Review Process within 10 days of its Receipt of the Treating Physician’s Report, Which Must Comply with Administrative Director Rule 9792.6(o), and, if Utilization Review Denies the Requested Surgery, any Section 4062(b) Objection Must Be Made within the Same 10-day Period**

For the reasons that follow, a defendant must both complete its UR and, if there is a UR denial, make its section 4062(b) objection within 10 days of its receipt of the treating physician’s report recommending spinal surgery. Section 4062(b) states, “The employer may object to a report of the treating physician recommending that spinal surgery be performed *within 10 days of the receipt of the report.*” (Emphasis added.) Therefore, based on its clear and unambiguous language, the 10-day time limit for a section 4062(b) objection starts running when the defendant receives the treating physician’s report recommending spinal surgery.<sup>1</sup>

However, section 4062(a) states that “[e]mployer 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” (emphasis added). Similarly, section 4610(g)(3)(A) states that “[i]f a request to perform spinal surgery is denied [by utilization review], disputes shall be resolved in accordance with subdivision (b) of Section 4062.” (Emphasis added.) Therefore, sections 4062(a) and 4610(g)(3)(A) both plainly and unequivocally provide that the spinal surgery second opinion process of section 4062(b) cannot be initiated unless and until the UR process of section 4610 has denied the requested spinal surgery.<sup>1</sup>

We cannot consider these various statutory provisions in isolation. Instead, we must harmonize them in the context of the overall statutory scheme for spinal surgery cases. This is accomplished by interpreting sections 4062(a) and 4610(g)(3)(A) to mean that, in spinal surgery cases only, UR must be completed within 10 days of the defendant’s receipt of the treating physician’s report, so that if UR denies authorization for the requested surgery the defendant can still make its section 4062(b) objection within the 10-day timeline of that statute.

This interpretation is fully consistent with section 4610(g)(1).

Section 4610(g)(1) requires UR to be completed “no ... more than 14 days from the date of the medical treatment recommendation by the physician.” (Emphasis added) Ordinarily, a UR timeline of 10 days from receipt of the spinal surgery report is “no more than” 14 days from the date of the recommendation (i.e., the date the report issues).

Moreover, section 4610(g)(1) requires that UR decisions “shall be made in a timely fashion that is appropriate for the nature of the employee’s condition.” (Emphasis added.) In spinal surgery cases, a UR decision that is “timely” made within 10 days of the receipt of the treating physician’s report is “appropriate for the nature of the employee’s condition.” This is because, as discussed above, the Legislature put all spinal surgery cases on a fast track. Section 4062(b) allows only 10 days from the defendant’s receipt of the treating physician’s report to object to a spinal surgery recommendation and then allows only 45 days from the defendant’s receipt of that report for the entire spinal surgery second opinion process to be completed.

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We are cognizant that section 4610(g)(5) allows the deadlines of section 4610(g)(1) to be exceeded in some circumstances.<sup>1</sup> Nevertheless, for the reasons above, we construe the statutory scheme to mean that, in spinal surgery cases only, the UR determination *always* must be made within 10 days of receipt of the treating physician’s report, so that the defendant may still timely object under section 4062(b) if there is a UR denial.<sup>1</sup>

Although we hold that a defendant must both complete its UR and make any section 4062(b) objection within 10 days of receipt of the treating physician’s report recommending spinal surgery, we further hold that these 10-day timelines are triggered only by a treating physician’s report that complies with AD Rule 9792.6(o). AD Rule 9792.6(o) provides:

“ ‘Request for authorization’ means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the ‘Doctor’s First Report of Occupational Injury or Illness,’ Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.”

Therefore, if a treating physician seeks authorization for spinal surgery through a narrative report, the narrative report must clearly state at the top that authorization for spinal surgery is being requested.<sup>1</sup>

Rule 9792.6(o) is part of the “Utilization Review Standards” adopted by the Administrative Director. It implicitly recognizes that claims adjusters routinely receive numerous medical reports from treating physicians. Therefore, if in a spinal surgery case a particular report might trigger the 10-day deadlines for a defendant to both complete UR and make a section 4062(b) objection, then the defendant should be given clear notice that authorization for spinal surgery is being requested.

Although Rule 9792.6(o) is part of the AD’s “utilization review” standards, we conclude that its requirement that a narrative report “shall be clearly marked at the top that it [contains] a request for authorization” applies with equal force to section 4062(b)’s 10-day deadline for objecting to requests to authorize spinal surgery.

Accordingly, a narrative report that requests authorization for spinal surgery will not trigger the 10-day UR and section 4062(b) unless it is “clearly marked at the top” that it requests authorization for spinal surgery.

**F. If the Defendant Fails to Meet the 10-Day Timelines or to Comply with Administrative Director Rules 9788.1 and 9788.11, the Defendant Loses its Right to a Second Opinion Report and It Must Authorize the Spinal Surgery**

As discussed above, the Court of Appeal held in *Edwards* that if a defendant fails to timely object under section 4062(a) to a treating physician’s determination that does not pertain to medical treatment, the defendant loses the right to later object to that determination. (*Edwards*, 175 Cal.App.4th at pp. 825-827 [74 Cal.Comp.Cases at pp. 831-832].) There is no reason why that principle should not also apply where, after a UR denial, a defendant fails to timely object under section 4062(b) to a treating physician’s spinal surgery recommendation. That is, if a defendant fails to meet the 10-day objection timelines of section 4062(b), there no longer is any “dispute” to “resolv[e]” within the meaning of that statute.

This conclusion accords with the provision of section 4062(b) which requires that “[i]f the second opinion report recommends surgery, the employer shall authorize the surgery.” (Emphasis added.) If section 4062(b) requires authorization where the second opinion “resolv[es]” the “dispute[]” by recommending surgery, then section 4062(b) implicitly requires authorization where there is no “dispute[]” to “resolv[e]” because the defendant did not timely initiate the second opinion procedure.

Moreover, a defendant must authorize the spinal surgery if it fails to comply with AD Rule 9788.1 and use the form prescribed by AD Rule 9788.11. A failure to comply with those Rules is the functional equivalent of no timely objection. Rule 9788.1 expressly requires a defendant to include: (1) a copy of the treating physician’s report; (2) an employee-specific reason for its objection; and (3) distinct and particularized

declarations under penalty of perjury regarding when the treating physician's report was received and when the defendant served its objection. If a defendant breaches either of the first two mandates, then the basis of its objection cannot be determined. This is tantamount to not having made an objection. If a defendant does not declare under penalty of perjury when it received the physician's report and when it made its objection, then the AD cannot determine whether the objection was timely. Furthermore, requiring use of the form adopted by Rule 9788.11 gives clear notice to the AD – and to the employee or the employee's attorney – that an objection to the treating physician's spinal surgery recommendation is being made.

### III. CONCLUSION

In this case, it was not until February 25, 2009 that Dr. Dureza first sent Safeco a report that was clearly marked at the top that it was a "WRITTEN REQUEST FOR SURGERY AUTHORIZATION." Dr. Deutsch's UR report denying the requested spinal surgery issued on March 4, 2009, which was well within the 10-day UR deadline set forth above.

However, although Safeco's UR denial issued within 10 days of its receipt of the first report requesting spinal surgery that complied with AD Rule 9792.6(o), defendant did not initiate the spinal surgery second opinion process within that 10-day period as required by section 4062(b). Instead, Safeco took the position that it was applicant's obligation to timely object under section 4062(b).

Nevertheless, we recognize that defendant's position was then fully consistent with the Appeals Board's significant panel decision in *Brasher*. (*Brasher*, 71 Cal.Comp.Cases at p. 1287.) Moreover, at that time, there was no binding opinion – either a published appellate opinion or an en banc decision of the Appeals Board – that expressly or implicitly disapproved of this aspect of *Brasher*. Accordingly, we will rescind the May 13, 2009 Findings and Order determining that applicant is entitled to lumbar spinal fusion surgery and we will give Safeco 10 days from the date of its receipt of this opinion within which to object to Dr. Dureza's spinal surgery recommendation (cf. Lab. Code, § 4062(b)) and commence the spinal surgery second opinion process. Safeco's objection shall comply with AD Rule 9788.1 and shall be on the form prescribed by AD Rule 9788.11.

Because of our disposition, we will not address defendant's substantial evidence contention.

For the foregoing reasons,

**IT IS ORDERED**, as the Decision After Reconsideration of the Workers' Compensation Appeals Board (En Banc), that the Findings and Order issued by the workers' compensation administrative law judge on May 13, 2009 is **RESCINDED** and that this matter is **REMANDED**

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to the workers' compensation administrative law judge for further proceedings and a new decision, consistent with this opinion.

### **WORKERS' COMPENSATION APPEALS BOARD**

/s/ Joseph M. Miller

M. MILLER, Chairman

JOSEPH

/s/ James C. Cuneo

CUNEO, Commissioner

JAMES C.

/s/ Frank M. Brass

M. BRASS, Commissioner

FRANK

/s/ Ronnie G. Caplane

G. CAPLANE, Commissioner

RONNIE

/s/ Alfonso J. Moresi

ALFONSO J. MORESI, Commissioner

/s/ Deidra E. Lowe

LOWE, Commissioner

DEIDRA E.

/s/ Gregory G. Aghazarian

G. AGHAZARIAN, Commissioner

GREGORY

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

11/19/2009

SERVICE MADE BY MAIL ON ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES AS SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD:

Jesus Cervantes  
Rucka, O'Boyle, Lombardo & McKenna  
Bradford & Barthel

NPS/jr

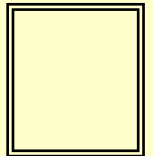
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