

WORKERS' COMPENSATION COLLECTIONS NEWSLETTER

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CIGA POINTS AND AUTHORITIES

THE MEDICAL TREATMENT RENDERED
IN THIS CASE ARE COVERED CLAIMS
UNDER INSURANCE CODE § 1063.1

THE ASSIGNMENT OF COLLECTION
ACCOUNTS TO REPRESENT THE
MEDICAL PROVIDER DOES NOT
DEFEAT LIEN CLAIMANT FROM BEING
A COVERED CLAIM UNDER
INSURANCE CODE § 1063.1.

LIEN CLAIMANT IS A COVERED CLAIM UNDER INSURANCE CODE § 1063.1

The defendant CIGA, acquired the obligations of insolvent insurance carrier. It is CIGA's position that Lien Claimant's medical treatment is not a covered claim under Insurance Code § 1063.1. CIGA is basing their assertion on the fact that _____ engaged in the business of collections, for Lien Claimant _____ in the collection of its medical bills in this industrial case used the word "assignment" in their collections contract. Lien Claimant, _____ is still the real party in interest and has not given up title to the collection of the medical bills, (i.e. no sale or purchase of the collection accounts). CIGA is still making the assertion that they do not have to pay the medical bills even when complete divestment of title has not taken place.

Therefore, the question before the Court is whether the word "assignment" used in Insurance Code § 1063.1, completely defeats the intention of the statute regardless of how it is used in the relation for representation in a collection manner, before the Workers Compensation Appeals Board. It is Lien Claimants contention that defendants narrow interpretation of the word "assignment" would defeat the purpose and intention of the creation of CIGA to pay insolvent insurance companies' obligations. Lien Claimants claim is that CIGA was created to protect the exact claim present before the Court today.

Therefore, it is not disputed that the _____, is the legal and equitable owner of the claimed medical bills and that they have not divested themselves of title and legal right to the accounts. It is also not disputed that _____ represents the interest of _____ in the collection of its medical bills _____ has not purchased the

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within claim. The use of the word "assignment" in their collections contract with _____ is for the purpose of collections and not a transfer of ownership, and does not devoid CIGA of its obligations to pay covered claims from an insolvent insurer. In the case St. Joseph's Hospital v. Workers' Compensation Appeals Bd., 70 Cal. Comp. Cas. (MB) 1612 (Cal. App. 1st Dist. 2005) the Court held as follows:
"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" within the meaning of Insurance Code § 1063.1."

The intent of Insurance Code § 1063.1 was created to protect medical providers in the same relevant facts as in the present case.

AB 1310 as amended in the California Assembly, August 01, 1969 – Insurance Code clearly states that which claims are not eligible for payment by CIGA and assignment of accounts for collection of medical bills in an industrial injury is not among them:

"(5) Claims which are not eligible for payment by the Association include the following:

Obligations arising from the classes of insurance which are not included in this article;

Obligations to refund unearned premiums;

Obligations arising from reinsurance contracts;

Obligations incurred after the insurance policy has expired, been replaced or been cancelled by the association.

Obligations to insurers, insurance pools, underwriting associations, and state and federal governments.

IN THE NEWS AT:

WWW.WORKCOMPLIENS.COM

January 25, 2010: California Insurance Commissioner Steve Poizner today announced that Bellflower-based Staffing Services Inc. has been ordered by the Los Angeles County Superior Court to pay \$20 million in restitution after a plea bargain was reached Jan. 15 in a workers' compensation insurance fraud case.

January 11, 2010: Insurance Commissioner Poizner Announces Morgan Hill Couple Arrested for Not Carrying Workers' Comp Insurance at Local Cafe

January 11, 2010: After the administrative director adopted the Jan. 1, 2010 DMEPOS fee schedule update, Medicare adopted a new fee schedule file which revises two codes, E1405 and E1406. The update includes all changes adopted in the Dec. 2 2009 order and the two code revisions. The order is effective for services on or after Jan. 1, 2010. The order can be found at <http://www.dir.ca.gov/dwc/OMFS9904.htm#3>.

January 05, 2010: Division of Workers Compensation administrative director issues clarification of utilization review audit measures due to Cervantes decision

December 30, 2009: Adjustments to the pathology and clinical laboratory section of the Official Medical Fee Schedule to conform to the changes in the Medicare payment system are posted on the DWC Web site

December 15, 2009: \$193,000 In Federal Stimulus Funds Awarded For Training Health Professionals in Community Clinics

December 14, 2009: Mileage rate for medical and medical-legal travel expenses will decrease Jan. 1, 2010

Except for workmen's' compensation claims of \$100 or less, nor first \$100 of the claim, nor any amount in excess of the insolvent insurer's policy limits, nor any portion of a claim in excess of \$500.00

Any other insurance, covered by this article, which is available to the claimant.

GENERAL INTENT OF INSURANCE CODE 1063.1 THROUGH AB 1310 (1969)

"A.B. 1310 sets up the statutory system for the protection of claimants against the effects of property and casualty insurer without the expenditures of public funds A.B. 1310 makes available insolvency funds for all insurers in California which provides workers' compensation, automobile, and other property and casualty insurance with the over-all effect that all members of the public in California can be assured that their claims will be paid despite the fact that a company may become insolvent"

This is further clarified by the California Legislature in August 11, 1969, letter from John V. Briggs Assemblymen Thirty-Fifth District to California Governor Ronald Reagan stated as follows:

"A.B. 1310 will make available insolvency funds for all insurers in California which provides workers' compensation, automobile, and other property and casualty insurance with the over-all effect that all members of the public in California can be assured that their claims will be paid despite the fact that a company may become insolvent"

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) CIGA was established to protect members of the public from the insolvency of insurers by spreading throughout the industry a loss suffered by an

insured as the result of the insolvency of an insurer. (§ 1063.5; Phoenix Ins. Co. v. United States Fire Ins. Co., *supra*, 189 Cal. App. 3d at p. 1525.) CIGA was not intended to protect solvent insurers against risks they insured. Accordingly, CIGA accomplishes its purpose by assessing its member insurers for sums to cover claims brought by members of the public for which insurance is otherwise unavailable, while excluding coverage where payment would inure to the benefit of a solvent insurer. (Phoenix Ins. Co. v. United States Fire Ins. Co., *supra*, 189 Cal. App. 3d at p. 1525.) CIGA was not intended to protect its member insurers against contribution to a loss by shifting the burden of the loss to a member of the public who otherwise has no insurance available to cover the loss. Indeed, such a result would be contrary to the very purpose for which CIGA was established.

Lien Claimant is within the category of protected claims based upon the fact that the claim falls within the general intent of the statute and recent case law interpretation.

HISTORY OF AB 1310 AND THE CREATION OF CIGA

The catalyst for the creation of CIGA was when Key Insurance Company, an automobile insurance carrier went insolvent leaving over 6000 insured having policies with Key Insurance Company without coverage together with loss of their premium paid. The California Department of Insurance took over Key Insurance Company and was given the task of trying collect the debt of the over 6000 policy holders., which caused the introduction of AB 1310 which in turn became Insurance Code § 1063.1.

Although at the time of the introduction of AB 1310 there was a similar bill pending by federal regulators, California Governor Ronald Reagan wanted to ensure that The State of

California had its own protection against insolvent insurance companies and thus supported AB 1310 which created CIGA.

Baxter Healthcare Corp. v. California Ins. Guarantee Assn., 85 Cal. App. 4th 306, 102 Cal. Rptr. 2d 87, 2000 Cal. App. LEXIS 929, 2000 Cal. Daily Op. Service 9763, 2000 D.A.R. 12987 (Cal. App. 2d Dist. 2000)

"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).)"

Therefore, the medical bills and or services performed by Lien Claimant in this case are within the coverage that is the intent of AB 1310 and CIGA's creation to protect medical providers from insolvent insurance companies.

It is defendants contention, that the word "assignment" in the contract of representation between _____ and _____, defeats _____ protection by CIGA in paying claims of insolvent insurance companies.

However, in County of Orange v. FST Sand & Gravel, Inc., 63 Cal. App. 4th 353, 73 Cal. Rptr. 2d 633, 1998 Cal. App. LEXIS 353, 98 Cal. Daily Op. Service 2983, 98 D.A.R. 4037 (Cal. App. 4th Dist. 1998)

"The acid test of statutory interpretation based on principles of statutory construction is always whether the interpretation yields an absurd result."

American Nat. Ins. Co. v. Low, 84 Cal. App. 4th 914, 101 Cal. Rptr. 2d 288, 2000 Cal. App. LEXIS 859, 2000 Cal. Daily Op. Service 9023, 2000 D.A.R. 11961 (Cal. App. 2d Dist. 2000)

"The meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible. . . . An interpretation that renders related provisions nugatory must be avoided."

_____ is the owner of the account for the medical services rendered. If the Court rules that in using the word assignment with their collection company, they are barred from collecting or asserting a claim against CIGA, such a ruling would defeat the intent of the statute and would not in the end devoid CIGAs' responsibility to pay the covered claim asserted and would just delay the inevitable.

Weighed against the interpretation of one word verses the intent of AB 1310 and the creation of Insurance Code § 1063.1 which is to protect claimants' from insolvency insurance company would defeat the effect and specific purpose of Insurance Code § 1063.1 and CIGA, in collecting money from

insurance companies to pay the obligations of insolvent insurance companies.

PURPOSE AND APPLICABILITY OF THE WORD "ASSIGNMENT" UNDER INSURANCE CODE § 1063.1

Catholic Healthcare West v. California Ins. Guarantee Assn., 178 Cal. App. 4th 15, 100 Cal. Rptr. 3d 125, 2009 Cal. App. LEXIS 1628, 74 Cal. Comp. Cas. (MB) 1231 (Cal. App. 5th Dist. 2009) "CIGA also contends that Catholic Healthcare West is an assignee of an original insured and thus excluded from coverage by the language in section 1063.1, subdivision (c)(9) that states a covered claim "does not include any claim asserted by an assignee . . ." In Baxter, the court concluded that BHC was an assignee because substantially all of the assets of AHSC were transferred to a predecessor corporation pursuant to a document titled "Assignment and Assumption." (Baxter, supra, 85 Cal.App.4th at p. 309.) In this case, the record does not contain an assignment document. Furthermore, we will not interpret the word "assignee" so broadly as to include the surviving corporation of the mergers that occurred in this case. Doing so would defeat, rather than promote, the legislative purpose of the statute."

The issue that the defendants are relying upon is a term of words i.e., assignees as not a covered claim, the interpretation as put forth in the "Baxter Case" **an assignment as defined is the complete divestment which has not happened in the case before the Board.** (emphasis added)

Two legislative bills relating to Insurance Code §1063.1 show the legislative intent when dealing with when a assigned claim is not a covered claim under CIGA Insurance code 1063.1 (c)(9) "Covered claims" does not include (A) any claim to the extent it is covered by any other insurance of a class covered by

this article available to the claimant or insured or (B) any claim by any person other than the original claimant under the insurance policy in his or her own name, his or her assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into prior to insolvency, his or her executor, administrator, guardian, or other personal representative or trustee in bankruptcy, and does not include any claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

The original AB 1310 that created CIGA shows that it was the intent to protect CIGA from being a creditor for assigned finance premium policies through assignment. This can be shown from Insurance Commissioner Richard D. Barger dated July 28, 1969 page two to "The Honorable Members of the Senate Insurance and Financial Institutes Committee" which he states as follows:

"AB-1310 is an attempt to protect the claimants of the insolvent company and to ask that the Association and its member-companies provide funds for the repayment of unearned premiums imposes a tremendous burden upon its members of the association, taking into consideration that they are also paying the claims of the insolvent company. I would respectfully submit that the premium financiers and the policy holders should be treated as general creditors of the insolvent insurer and no more; and ..."

In 1992 Insurance Code Section 1063.1 was amended to make an exception to the excluded covered claims of an assignee further defining the term assignee AB 1581 Added "his or her assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into prior to insolvency" in subd (c)(9).

Therefore, the assignee is defined as premium financiers it is clear that medical treatment by a medical provider is a covered claim and fits into the intent and purpose of the creation of CIGA as clearly stated in AB 1310.

American Nat. Ins. Co. v. Low, supra

"The meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible. . . . An interpretation that renders related provisions nugatory must be avoided."

The Court further stated

"The meaning attributed to subdivision (c)(4) by respondent and amicus curiae--no insurer claims are covered--is unambiguous only if we disregard the last phrase which could be read to refer back to subdivision (c)(1). We believe that the two provisions must be harmonized where the insurer is also a policyholder. Looking at the terms used in the entire legislation rather than focusing on one phrase in isolation, we believe the statute: (1) creates a general category of covered claims--claims made under an insurance policy; (2) creates an exclusion to the category--claims made by insurers in their role as insurers; and (3) creates an exception to the exception--claims held by insurers who are also policyholders.

To defeat the purpose and the intent of the creation of CIGA, because of the narrow interpretation of the word "assignment" as to include claims assigned to a collection company to collect a medical bill for the medical provider who has not divested themselves of their claim would "yield an absurd result".

ISSUES

WAS THE MEDICAL TREATMENT REASONABLE AND NECESSARY

DID EMPLOYER OFFER OR SHOW PROOF OF OFFER TO THE APPLICANT REASONABLE MEDICAL TREATMENT WITHIN MPN

THE APPLICANT WAS POST SURGICAL AND THEREFORE 24 CAP DOES NOT APPLY

LIEN IS CLAIMANT ENTITLED TO USUAL AND CUSTOMARY FEES FOR SELF-PROCURED MEDICAL TREATMENT

STATEMENT OF FACTS

The applicant sustained an industrial injury while employed by _____ as a preparer to her neck, right shoulder, right arm, middle back, knees and legs from repetitive duties while performing her job responsibilities. The injury was reported to her employer, the applicant subsequently had authorized surgery to her shoulders and wrist on March 20, 2006. Initially applicant was considered permanent and stationary on May 16, 2006, but because showed increase pain the surgery was performed and authorized.

Lien Claimants _____, (hereinafter referred to as Lien Claimant), provided medical treatment to the applicant for an industrial injury July 18, 2007 through December 27, 2007 in the billed amount of \$4,595.00 no payments made.

**I
WAS THE MEDICAL TREATMENT REASONABLE AND NECESSARY**

_____ M.D. in his reported dated June 19, 2006 entitled "comprehensive Primary Treating Physician's Permanent and Stationary Orthopedic Report", page 5 found that 100% causation for the industrial injury. The AME report of Dr. _____ M.D. report dated October 14, 2006 page 22, stated:

Causation:

“Based on the history given to m by the patient today and my review of the available medical records, it was medically probably that the patient sustained a cumulative trauma injury to her neck, right shoulder and right hand/wrist during the course of her employment with Semi-Kinetics”

In addition the AME recommended future medical treatment.

The case resolved by way of Order Approving Compromise & Release for \$58,500.00, with admitted body parts to the arm, neck, back, knees, shoulders, arm and wrist. The defendants sent Lien Claimant a letter stating that the claim was denied as non-industrial (letter dated December 07, 2007), however as shown above all medical evidence shows the injury was industrially related and causation established. Therefore, the treatment was reasonable and necessary and in accordance with the ACOEM guidelines.

DID EMPLOYER OFFER OR SHOW PROOF OF OFFER TO THE APPLICANT REASONABLE MEDICAL TREATMENT WITHIN MPN

The defendants served no documents showing that applicant signed an agreement as to notice of MPN offers. However, it is also the burned upon the defendant to show that reasonable medical treatment was offered within the MPN, as the facts do not show that applicant was offered a list of medical providers after the company failed to provide reasonable medical treatment and follow-up visits as such applicant is entitled to treat outside the MPN at employers expense.

Bruce Knight, United Parcel Service; and Liberty Mutual Insurance Company October 10, 2006 71 Cal. Comp. Cases 1423.

“The Board held that an employer or insurer's failure to provide required notice to an employee of rights under the MPN (medical provider network) that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee.”

The defendants have failed to serve any medical reports showing the injury was non-industrial. Any medical report and documents used to reduce or disallow Lien Claimants medical bills must be excluded as defendant has failed to serve such documentation. In addition the denial of medical treatment based an MPN defense does not preclude the defendants from the requirement of performing a utilization review which was not done in this case although authorization was requested as required in the physicians' first report.

State Comp. Ins. Fund v. Workers' Comp. Appeals Bd., S149257, SUPREME COURT OF

CALIFORNIA, 2008 Cal. LEXIS 7905, July 3, 2008, Filed

“The insurer referred the matter for utilization review but did not communicate its decision within the 14-day statutory deadline set forth in § 4610, subd. (g)(1). A workers' compensation judge found that the insurer's failure to comply with the statutory deadlines precluded it from relying on the utilization review process or on its doctor's report to deny the requested treatment”

THE APPLICANT WAS POST SURGICAL AND THEREFORE 24 CAP DOES NOT APPLY

The defendants state that they paid according to the fee

schedule and that under Labor Code Section 4604.5 the treatment was limited by 24-visit cap on physical therapy and chiropractic treatment. In 2008 AB 1073 amended Labor Code Section 4604.5 to exempt post-surgical patients from 24-visit caps on physical therapy and chiropractic care if the physical medicine and rehabilitation services comply with post-surgical treatment guidelines established by the administrative director. The postsurgical treatment guidelines are authorized by Labor Code Section 5307.27 and Assembly Bill 1073, which provides that the 24-visit cap on physical medicine services shall not apply to visits for postsurgical physical medicine and rehabilitation services. Although the services in this case were prior to the adoption of Labor Code Section 5307.27 which was part of a clean up legislation that limited 24-visit cap on physical therapy and chiropractic treatment in 2004. Lien Claimant asserts that the reason and policy behind the change for post surgical shows that the limit on 24 visits was unreasonable and that it should apply in principle and in law to the 2005 dates of service in this case as the applicant had surgery and the treatment was post surgical and should be exempt from the 24 visit cap.

LIEN IS CLAIMANT ENTITLED TO USUAL AND CUSTOMARY FEES FOR SELF-PROCURED MEDICAL TREATMENT

The defendants denied the treatment when treatment was requested and denied payment stating that the treatment was self-procured medical treatment. Lien Claimant is entitled to its usual and customary charges in self-procured

treatment that is later found to be an industrial injury as set forth the case of; CNA Ins. Cos. v. Workers' Compensation Appeals Bd. (Valdez), 62 Cal. Comp. Cas. (MB) 1145 (Cal. App. 1st Dist. 1997)

“Additionally, the WCJ again concluded that when an employer or carrier disputes a claim of industrial injury and refuses for that reason to pay the charges of the treating physician, the OMFS is not applicable if the injury is later found to be compensable and the physician is entitled to payment of

Continued from page 4

REPORT ON DURABLE MEDICAL EQUIPMENT

The employer is liable under Labor Code section 4600 for medical treatment, including medical supplies and apparatuses, reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Administrative Director Rule 9790.1(n) defines "medical services" to mean "goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code." (Cal. Code Regs., tit. 8, § 9790.1(n).)

Liens of Direct Medical Providers

Statutory basis

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

IF THE PRESCRIBING PHYSICIAN REQUEST AUTHORIZATION FOR DME AND UR NOT PERFORMED OR PREFORMED IMPROPERLY MEDICAL NEED FOR THAT DME IS ESTABLISHED

Monique Galaviz, Applicant v. Marriott International, PSI, Defendant, 2008 Cal. Wrk. Comp. P.D. LEXIS 514, Opinion Filed June 2, 2008

"Since Defendant did not initiated UR as to the purchase of the H-Wave unit and did not object to Dr. Cohen's recommendation for purchase of the H-Wave Unit under *Labor*

Code section 4062 or utilize *Labor Code* section 4062.2; given Dr. Cohen's recommendations and reasons why the use of the H-Wave Unit was reasonably required medical treatment as referenced in his reports dated November 23, 2005, December 23, 2005 and January 20, 2006; with due consideration given to the ACOEM Guidelines and recommendations as to this type of treatment for acute injuries; and the evidence produced by Lien Claimant providing scientific medical evidence supporting the use of H-Wave Units, which the court believed rebutted the ACOEM Guidelines, it is the court's recommendation that Defendant's Petition for Reconsideration be denied and the W.C.A.B. uphold and affirm the Findings and Order of this court dated April 2, 2008."

VisionQuest v. WCAB (Mejia) 68 CCC 363, writ denied

"held that lien claimant did not make prima facie case of necessity for medical device when ... applicant's treating physician issued prescription for interferential stimulator and noted this device 'is indicated' but provided no explanation for prescription or further information about what kind of unit was indicated, how often it was to be used, what treatment result was anticipated, or why it was likely to benefit applicant."

End ##

CASE LAW SELF-PROCURED MEDICAL TREATMENT AND MPNs (Medical Provider Networks)

Bruce Knight, United Parcel Service; and Liberty Mutual Insurance Company October 10, 2006 71 Cal. Comp. Cases 1423

"The Board held that an employer or insurer's failure to provide required notice to an employee of rights under the MPN (medical provider network) that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee."

Jennifer Balkowitsch, Applicant v. Home Depot, PSI, adjusted by Sedgwick Claims Management Services, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 567, Opinion Filed August 11, 2008

"We agree with applicant's contentions that the record demonstrates that defendant neglected or refused to provide reasonable medical treatment through its MPN. Applicant testified without contradiction that five of the MPN physicians she contacted from the list sent to her by defendant refused to accept her as a patient, and defendant offered no evidence to show that there were a sufficient number of other physicians willing to accept applicant as a patient who were made available to her within the applicable MPN access standards.

The court further stated:

"However, a failure to comply with applicable statutes and regulations that results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for medical treatment self-procured by the injured worker. (*Knight v. United Parcel Service*

(2006) 71 Cal.Comp.Cases 1423 (Appeals Board en banc) (*Knight*).)"

Joaquin Valencia, Applicant v. Taylor Fresh Foods, Zurich North America, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 596, Opinion Filed August 6, 2008

Applicant then commenced treatment with Dr. Davis. The only objection made by defendant when applicant commenced treatment with Dr. Davis was that he was not a member of defendant's Medical Provider Network (MPN hereinafter). Defendant did not raise the issue of applicant's prior discharge from treatment by Salinas Urgent Care until the Mandatory Settlement Conference. When the matter proceeded to trial, defendant did not introduce any notice letters regarding the MPN process. Applicant testified in un rebutted, uncontradicted fashion that he did not receive any notices about MPN physicians or about transfer of care or continuity of care. Applicant received no information about how to object to any opinion by the company doctor or MPN physician.

Carlos S. Gonzales, Applicant v. Gilberto Portillo Painting, State Compensation Insurance Fund, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 463, Opinion Filed July 2, 2008 WCAB held that applicant with 6/25/2005 left hip, back, upper and lower extremity, neck, left eye, and psyche injuries and injuries in the form of headaches and sleep disorder, was entitled to treat outside defendant's medical provider network (MPN) and that WCJ properly relied on treating physician's report to award benefits, when defendant did not comply with Labor Code § 3550 as it failed to provide applicant with adequate notice of MPN physicians, and did not request an expedited hearing to compel

applicant to treat within MPN; WCAB found that, since defendant did not object to treating physician's report at trial, defendant waived issue of admissibility.

Courtney Penebaker, Applicant v. CIGNA Healthcare, CIGNA Property & Casualty Company/ACE USA, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 475, Opinion Filed June 20, 2008

"The was no evidence presented to show that the single medical facility was able to treat patients with MRSA or prone to skin infections; nor any indication of what facilities would be available to respond to any MRSA flare-up in response to either surgical procedure being recommended for Applicant, nor that any physician at the facility has the skill necessary to treat Applicant's special medical conditions.

Despite the Defendant insisting that Applicant treat within their MPN starting in January 2007, no questions were asked of the AME, by letter or at the deposition on October 23, 2007, about the appropriateness of treatment at the MPN facility.

Defendant has not met their burden of showing that they have offered appropriate medical treatment within their MPN.

The Defendants' Petition also contends that the wrong specialty was assigned to the panel QME. The applicant's attorney requested a specialty in chiropractic medicine and Defendants contend that a medical doctor should be the panel QME. The Defendants cite ACOEM Guidelines in support of their argument."

Jose Garrido, Applicant v. San Francisco Marriott, PSI, administered by Marriott Claims Services, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 332, Opinion Filed April 30, 2008

Medical-Legal Procedure--Panel Qualified Medical Evaluations--Medical Provider Networks--WCAB denied defendant's request for removal from WCJ's Order allowing applicant with 3/16/2007 injuries to left shoulder, neck, back and left leg to undergo a panel qualified medical evaluation with a

chiropractor outside defendant's medical provider network (MPN) after objecting to findings of treating physician within MPN, and held that applicant was not required to exhaust all remedies set forth in MPN statutes (Labor Code § 4616 et seq.) before requesting a panel qualified medical evaluation pursuant to Labor Code § 4062.2, and that applicant was entitled to choose a chiropractor as a qualified medical evaluator, rather than a medical doctor.

The current version of Labor Code Section 4062.2 does not state anything with respect to disputes between the parties regarding the medical specialty to be assigned by the administrative director. It is clear that the party submitting the request shall designate the specialty of the medical evaluator and the specialty of the medical evaluator requested by the other party, if it has been made known to the party submitting the request

In this case, the evidence showed that the applicant's attorney requested a specialty in chiropractic medicine. Defendants sent written objections after the panel QME in chiropractic medicine was sent by the administrative director contending that a medical doctor in orthopedic medicine should be the panel QME.

After considering the arguments, I decided that in light of the absence of any language in Labor Code Section 4062.2, I have no statutory authority to allow me to change the medical specialty designation of the panel QME from the request made by applicant and his attorney. Therefore, the panel QME is Dr. Greensides, a chiropractor. If Dr. Greensides feels that there are issues outside his expertise, he does have the right to select consultants in those specialties to examine the applicant and issue reports that he could review and incorporate into his own reports.

Walter Roque, Applicant v. Louise's Trattoria, Liberty Mutual Insurance Company, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 349, Opinion Filed April 21, 2008

Here, we conclude that defendant failed to meet its burden of proving, pursuant to section 3202.5, that it provided applicant with the required notices to transfer his medical treatment into its MPN. Defendant's sent its initial MPN notice to applicant in March 2005. However, that notice was only in English and not in Spanish. It appears that defendant did not correct this notice deficiency until December 2006, more than a year and half later, when it sent applicant a MPN transfer notice in Spanish. Furthermore, in January 2007, defendant sent applicant a notice that it was transferring his medical treatment to

Dr. Rahimi. However, that notice was not sent to applicant in Spanish, only in English, and defendant did not prove that it sent a copy to applicant's treating physician, Dr. Konstat, as required pursuant to Administrative Director's Rule 9767.9, subd. (f). (Cal. Code Regs. tit. 8, § 9767.9, subd. (f).)

Mitzi L. Thomas, Applicant v. Bakers Burgers, Inc., State Compensation Insurance Fund, Defendants, 2008 Cal. Wrk. Comp. P.D. LEXIS 351, Opinion Filed April 21, 2008 Medical Provider Networks-Medical Treatment-WCAB held that applicant with 1/7/2006 right knee injury was entitled to seek medical treatment outside defendant's medical provider network (MPN) and that defendant was liable for self-procured medical expenses, when defendant did not provide timely authorization or provision of an MRI of applicant's right knee, and provided inadequate medical treatment within MPN.

END ###

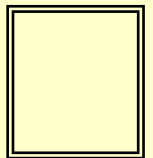
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Web Page
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Company Name
Street Address
City, ST ZIP Code



Customer Name
Street Address
City, ST ZIP Code