

# WORKERS' COMPENSATION LIEN CLAIMANT COLLECTIONS NEWSLETTER

## 10 CENTS ON THE DOLLAR / 'THOMAS FINDING'

BY WORKCOMPLIENS.COM

Initially cases are denied and then the medical legal dance takes place. The case in chief is then resolved in the majority of cases with a "Thomas Finding", which states in the settlement documents in legally sufficient grounds that if the case was to be tried on the merits of the case that the applicant would take nothing, in other words he or she would lose the case..

Now it does not mean that the statement of the "Thomas Finding" is true or that the evidence exists, it is just a statement that if proven true then the applicant would take nothing on the case for compensability.

The defense may state a "Post Termination Defense" but it is shown that the applicant quit instead of being terminated.

*Cal Lab Code § 3600* Conditions essential

(a) (10) Except for psychiatric injuries governed by subdivision (e) of Section 3208.3, where the claim for compensation is filed after notice of termination or layoff, including voluntary layoff, and the claim is for an injury occurring prior to the time of notice of termination or layoff, no compensation shall be paid unless the employee demonstrates by a preponderance of the evidence that one or more of the following conditions apply:

(A) The employer has notice of the injury, as provided under Chapter 2 (commencing with Section 5400), prior to the notice of termination or layoff.

(B) The employee's medical records, existing prior to the notice of termination or layoff, contain evidence of the injury.

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(C) The date of injury, as specified in Section 5411, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.

(D) The date of injury, as specified in Section 5412, is subsequent to the date of the notice of termination or layoff.

*Cal Lab Code § 5412* . Date of injury; Occupational disease or cumulative injury

The date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability there from and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment.

*Cal Lab Code § 5411*

The date of injury, except in cases of occupational disease or cumulative injury, is that date during the employment on which occurred the alleged incident or exposure, for the consequences of which compensation is claimed.

The employer may deny the injury stating that the employee had a "Per-Existing Injury", Lighting up or aggravation of a preexisting condition by an industrial injury new or aggravated injury which results from medical or surgical treatment of industrial injury is compensable, whether doctor was furnished by employer, his insurance carrier, or was selected by employee. *Fitzpatrick v. Fidelity & Casualty Co.* (1936) 7 Cal 2d 230, 60 P2d 276,

### IN THE NEWS AT:

[WWW.WORKCOMPLIENS.COM](http://WWW.WORKCOMPLIENS.COM)

#### June 02, 2010: News:

##### Orange County District Attorney's Office

The Orange County District Attorney's Office (OCDA) has charged seven defendants, including four chiropractors, one attorney, and two office employees in an undercover sting operation targeting insurance overbilling schemes.

#### June 02, 2010: News:

##### Department of Workers' Compensation

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

#### June 02, 2010: News:

##### California Department of Insurance

Unified School District Claims Examiner self-surrendered to San Francisco County Jail

#### May 21, 2010 News:

##### General News:

Man Stabbed Inside State Office Building (WCAB) In L.A.

#### May 20, 2010 News:

##### California Department of Insurance

Commissioner Poizner Announces Arrest of Sacramento Roofing Business Owner for Alleged Workers' Comp Insurance Fraud

#### May 14, 2010 New:

##### Department of Workers' Comp

The Division of Workers' Compensation (DWC) has modified its medical provider network (MPN) and employee information regulations.

#### May 13, 2010: Department of Insurance

California Insurance Commissioner Steve Poizner today announced that 1,010 insurance companies –have agreed to forgo future investments in 50 companies identified as doing business with Iran's nuclear, energy or defense sectors.

#### May 13, 2010: Department of Insurance

Insurance Commissioner Steve Poizner today announced the sentencing of a Prunedale (Monterey County) woman who pled guilty to Work Comp insurance fraud, perjury and financial elder abuse

#### May 07, 2010; News Department of Insurance:

Commissioner Poizner Announces Arrest of Mountain View Man for Alleged Working While Receiving Insurance Payments for Work-Related Injury

#### May 05, 2010 News Department of Insurance

Commissioner Poizner. "I will not allow insurers to inflate their rates based on faulty systems or inaccurate data." (Blue Cross)

Compensation is recoverable for disability which results from the aggravation of a pre-existing disease if the aggravation is reasonably attributable to an industrial accident; but compensation is not recoverable for disability which results, irrespective of such accident, from the normal progress or development of a pre-existing disease.

Granado v. Workmen's Comp. App. Bd. (1968) 69 Cal. 2d 399, 404 [71 Cal. Rptr. 678, 445 P.2d 294]; states as follows:

"There can be no doubt that medical expense is not apportionable. Neither section 4600 nor any of the succeeding sections in the article of the code dealing with medical and hospital treatment state or even suggest that the employer may pay part of the expense. So long as the treatment is reasonably required to cure or relieve from the effects of the industrial injury, the employer is required to provide the treatment, and treatment for nonindustrial conditions may be required of the employer where it becomes essential in curing or relieving from the effects of the industrial injury itself. Medical treatment unrelated to the industrial injury need not be furnished by the employer. If medical expenses reasonably necessary to relieve from the industrial injury were apportionable, a workingman, who is disabled, may not be able to pay his share of the expenses and thus forego treatment. Moreover, the uncertainties attendant to

the determination of the proper apportionment might cause employers to refuse to pay their share until there has been a hearing and a decision on the question of apportionment, and such delay in payment may compel the injured workingman to forego the prompt treatment to which he is entitled."

**SUCCESS OF SELF-PROCURED TREATMENT** is a factor in determining the necessity of that treatment. However, reimbursement for treatment procured by the employee will not be denied automatically solely on the basis of an unsuccessful result.. *FOREMOST DAIRIES, INC. V. I.A.C. (MCDANNALD)* (1965) 237 Cal. App. 2d 560, 577, 47 Cal. Rptr. 173, 30 Cal. Comp. Cases 320 (reimbursement awarded for unsuccessful self-procured treatment where the employee's condition was difficult to diagnose).

"The test of when an employer may be held liable for self-procured medical help cannot be frozen into one interpretation of a single sentence contained in the opinion in *Pacific Indemnity Co. v. Industrial Acc. Com.*, supra, 220 Cal.App.2d 327. To read that sentence into a mechanistic formula that liability can never attach to an employer unless the medical assistance procured by the employee is successful is to say that an employer may wrongfully deny medical treatment to an injured employee, thus shifting to the employee the

burden of bearing his own medical expenses without hope of reimbursement from the employer, unless the self-procured treatment is deemed to be successful. Such a situation would be intolerable and contrary to the purposes of the compensation act."

What happens when a case is denied than the Case in Chief is resolved with a "Thomas Finding"? What normally happens is the Insurance Company offers the medical provider 10 cents on the dollar claiming it was a denied case and it settled with a "Thomas Finding", normally the provider will take such an amount.

However, there are several different ways a case can settle with a "Thomas Finding", that would not effect the providers right to full reimbursement, of which the defense would not offer such information, therefore knowing and understanding a "Thomas Finding" is essential.

Denied to cumulative and admitted as to specific injury, the defense will state that the injury was denied and settled with a "Thomas Finding", but will not tell you that the specific was admitted of which the provider probably treated for.

Denied for specific body part but admitted for other body parts, but defense will just state that the case settled with a "Thomas Finding" even though the treatment the provider rendered was on the admitted body part. It is important to know that for a body part that is connected to a another body that was

industrial injury but cannot be treated without treating the non-industrial injury, the treatment for the non-industrial injury is compensable regardless of the "Thomas Finding,"

The "Thomas Finding", was initially decided with the injured worker in mind to prevent the worker from signing away rehabilitation benefits for a settlement fee and then being without a marketable trade or skill once the settlement, money was gone. The case held that in order for an injured worker to sign away his or her rehabilitation benefits, that the defense had to state in legally sufficient grounds if the case went to court the case would be decided against the injured worker and he or she would have a take nothing order. The problem is that the case said nothing at all about medical providers or lien claimants, and as such a great confusion for medical providers as to its applicability to the payment of their medical bills existed when the case was decided.

This is where legal logic and applicability of a case law comes into play making mandatory to understanding how to apply case law.

The defense attorneys who saw the case starting thinking well if the injured worker would take nothing then it stands to reason that the injury did not occur or did not occur at the place of employments and thus we should not be liable for any medical bills, which is correct in the truest sense of the law. However, the only time it should actually apply to the medical provider is if the injury never occurred and fraud or misrepresentation by the injured work has

transpired with sufficient proof to sustain of such a finding.

*THOMAS V. SPORTS CHALET, INC.* (1977) 42 Cal.Comp.Cases 625, decided in banc (Thomas), "The Board is likewise concerned that if a complete release cannot be executed the parties will be unable to settle those cases where there is a genuine doubt or question as to the validity of the claim which if resolved against the applicant would result in a denial of all benefits. Considering that the State Study Commission continually referred to injured workers and Section 5100.6 refers to settlement of benefits "to which the employee is entitled under rehabilitation," the Board does not find it necessary to interpret Section 5100.6 to prohibit complete settlement in this type of case. To hold otherwise would put the Board in the position of requiring a determination in every case that the employee is or is not entitled to benefits, thereby effectively doing away with settlements in those cases where legitimate and serious issues, which would totally bar recovery if successfully proved by the defense, exist."

Prior to the creation of the MPNs (Medical Provider Network) in 2005, it was a simple process, meaning that the employer had medical control (the right to send the employer to their medical providers) and after 30 days the employee had the right to choose his or her own medical provider at the employers expense. The employers failure to provide reasonable medical

treatment within the initial 30 days allowed the injured workers to seek self-procured medical treatment. With the creation of the MPNs, the employer now has medical control over the life time of the claim, provided all applicable rules and regulations are complied with. However, the subject of this "Booklet" is what happens after the injured workers goes out and obtains his or her medical treatment (self-procured medical treatment) and when does the medical provider get reimbursed for such treatment.

Labor Code § 4600.

Medical treatment provided by employer; Liability for reasonable expense; Medical provider network; Predesignation of personal physician; Expenses incurred in submitting to examination; Qualified interpreter

(a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

(c) Unless the employer or the employer's insurer has established a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.

*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."

## Utilization Review in Denied Case

The employer has 90 days from the date a claim is filed to either admit or deny the injury. Failure by the employer to deny the injury within the 90 days deems the injury admitted, and the procedures for utilization review of admitted claim govern.

*Cal Lab Code § 5402*

(a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.

Within one working day after an employee files a claim form, the employer is responsible for the first \$10,000.00 in medical treatment regardless of whether they deny the injury thereafter.

*Cal Lab Code § 5402 (c)*

Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section

5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).

*Cal Lab Code § 5402 (c)* applies to any date of injury – retroactive application *Heike M. Ruvalcaba, Applicant v. Scott Roberg, DPM, State Compensation Insurance Fund*, Defendants W.C.A.B. No. OXN 0129714--Workers' Compensation Appeals Board (Panel Decision) Opinion Filed March 9, 2007:

“The consequence of SB 899 as presented in the language of Section 47, noting that any amendments or additions under SB 899 are to be applied prospectively regardless of the date of injury, would make subsection (c) of 5402 applicable to any pending case. This conclusion is consistent with the appellate decisions in *Kleemann, supra, Marsh, supra*, and *Rio Linda Union School District v. Workers' Comp. Appeals Bd. (Scheftner)* (2005) 131 Cal.App.4th 517 [70 Cal.Comp.Cases 999], and thus would justify the WCJ's disposition herein...”

If the employer denies treatment based on causation, then the employer must initiate the medical legal process. However, the employee may initiate the medical process. *En Banc Decision of Simmons v. California*, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

“Where a utilization review physician finds that a treatment is medically necessary but questions whether the need for that treatment is causally related to the industrial injury, the defendant must either: (a) authorize the treatment; or (b) timely deny authorization based on causation within the deadlines set forth in section 4610(g)(1); timely communicate the denial based on causation to both the treating physician and the applicant within the deadlines set forth in section 4610(g)(3)(A); and timely initiate the AME/QME process within 20 days of the receipt of the utilization of physician's report, if the employee is represented by an attorney, or 30 days, if the employee is unrepresented, in accordance with section 4062(a) and...”

Utilization review reports are admissible for the limited purpose of determining the need for the medical treatment requested and cannot be used to show that the injury was caused by the industrial accident. *En Banc Decision of Simmons v. California*, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005): “A utilization review physician's report is not admissible for the purpose of determining whether the industrial injury caused or contributed to the need for a

particular treatment, i.e., a utilization review physician may address only the issue of whether a particular treatment is medically necessary;...”

If the employer denies the claim based on a medical legal report prior to denying the claim, the employer is not entitled to another medical legal report unless the treating physician puts medical causation with respect to another body part at issue. Then the employer has 20 days to initiate the medical legal process. Pursuant to *8 CCR 30 (d)(3)*, once a claim has been denied in its entirety, only the employee may request a Panel QME. Therefore, the Courts must look to the reports of the self-procured treating physician. *8 CCR 30 (d)(3)* “Whenever an injury or illness claim of an employee has been denied entirely by the claims administrator, or if none by the employer, only the employee may request a panel of Qualified Medical Evaluators, as provided in Labor Code sections 4060(d) and 4062.1 if unrepresented, or as provided in Labor Code sections 4060(c) and 4062.2 if represented.”

*En Banc Decision of Simmons v. California*, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

“If in prescribing treatment for the disputed body part, the treating physician either explicitly or implicitly determines for the first time that the

injury to the disputed body part is industrial, then utilization review is not appropriate. Instead, the defendant must initiate the AME/QME process within the deadlines established by section 4062(a).”

If the case is denied and the employer does not perform a medical legal evaluation and a request for treatment with a determination by provider for causation, then employer has a second chance to do medical legal. *En Banc Decision of Simmons v. California*, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005):

“If in prescribing treatment for the disputed body part, the treating physician either explicitly or implicitly determines for the first time that the injury to the disputed body part is industrial, then utilization review is not appropriate. Instead, the defendant must initiate the AME/QME process within the deadlines established by section 4062(a).”

It is the defendant's duty to object to the treating physician's causation determination and to initiate the AME/QME procedure under section 4062(a). *En Banc Decision of Simmons v. California*, 70 Cal. Comp. Cases 866 (W.C.A.B. 2005): “In essence, the defendant is objecting to the treating physician's explicit or implicit determination that the need for the prescribed treatment was caused, in whole or in part, by the industrial injury. Such an issue of causation is outside the scope of utilization review. Accordingly, it is not the employee's responsibility either to object to the

treatment denial based on causation or to initiate the AME/QME procedure established by section 4062(a). Rather, it is the defendant's duty to object to the treating physician's causation determination and to initiate the AME/QME procedure under section 4062(a)".

In addition to the medical legal procedure and utilization review process a medical legal report may not completely prove the medical treatment was not reasonable even if stated as shown by the case of *Kellogg Co. v. Workers' Compensation Appeals Bd. (Battle)*, (1996) 61 Cal. Comp. Cas. (MB) 519, 521

"The WCJ noted that, here, there were several reasons to reject Dr. Strassberg's opinion. Dr. Strassberg failed to state his opinion in terms of reasonable medical probability and did not set forth the reasoning behind his opinion. Rather, he merely stated that it was his impression" that chiropractic treatment was "not require[d]" and was "contraindicated." Dr. Strassberg did not provide any facts or reasoning to support and explain his "impression." Moreover, the WCJ did not interpret the AME's mere "impressions" to constitute statements of reasonable medical probability."

The Court Further stated:

"The WCJ also was unclear about whether Dr. Strassberg was aware that chiropractic treatment may be reasonable even if it did not cure Applicant's condition, but merely relieves the

## Appearances

Prior to November 17, 2008, Appeals Board Rule 10563 provided, in its first paragraph, that a representative of a lien claimant with settlement authority must be present or available by telephone for mandatory settlement conferences. In the second paragraph, Rule 10563 provided, with reference to trials, "If a lien claimant whose lien has not been resolved or withdrawn is not present at the time of trial, the lien claimant shall have a person available with settlement authority in the same manner as set forth above." (Former Cal. Code Regs., tit. 8, § 10563, repealed November 17, 2008.) Also under the Appeals Board Rules as they existed prior to November 17, 2008, Rule 10770(c) provided, "The lien claimant shall provide the name, mailing address, and daytime telephone number of a person who will be available at the time of all conferences and trials, and will have authority to resolve the lien on behalf of the lien claimant." (Former Cal. Code Regs., tit. 8, § 10770(c).) Rule [\*6] 10562(e) authorized the WCJ to dismiss a lien claim after issuing a 10-day notice of intention to dismiss, if a lien claimant served with notice of a trial fails to appear.

Several regulatory changes became effective on November 17, 2008. Among these changes, Rule 10563, which allowed appearance at trial by telephone, was repealed. The language of Rule 10770(c) now appears, unchanged, in subdivision 10770(e). In addition, Court

Administrator Rule 10240 became operative. This Rule requires that all parties and lien claimants "shall appear at all hearings," with certain enumerated exceptions. (Cal. Code Regs., tit. 8, § 10240(a).) For example, telephone availability is authorized for a lien claimant with a lien of less than \$ 25, 000.00, at mandatory settlement conferences or lien conferences, unless ordered to appear. Subdivision (a)(4) states, "All lien claimants shall appear at trial at which their lien(s) is an issue to be decided." No exceptions are provided. Rule 10562(e) was not changed in the November 17, 2008 amendments.

### [May 28, 2010: Daily Work Comp Issues:](#)

#### → *Cal Evid Code § 623 Stoppel*

Whenever a party has, by his own statement or conduct, intentionally and deliberately led another to believe a particular thing true and to act upon such belief, he is not, in any litigation arising out of such statement or conduct, permitted to contradict it.

### [May 27, 2010: Daily Work Comp Issues:](#)

#### → *Managed Care Contracts*

See Flowchart on the "Bridge" of contracts in managed care contracts.

### [May 26, 2010: Daily Work Comp Issues:](#)

#### → *Lab. Code, §4604.5(c)*

Although the ACOEM guidelines are "presumptively correct on the issue of extent

and scope of medical treatment" (Lab. Code, §4604.5(c) (emphasis added)), they are not presumptively correct on the issue of whether a need for medical treatment is causally related to the industrial injury.

### [May 25, 2010: Daily Work Comp Issues:](#)

#### → *Medical Legal (republished)*

"Moreover, the WCJ did not interpret the AME's mere "impressions" to constitute statements of reasonable medical probability." "The WCJ also was unclear about whether Dr. Strassberg was aware that chiropractic treatment may be reasonable even if it did not cure Applicant's condition, but merely relieves the condition."

### [May 24, 2010: Daily Work Comp Issues:](#)

#### → *Questions About Fee Schedule*

If you have questions regarding the Official Medical Fee Schedule (OMFS) email at [DWCFeeSchedule@dir.ca.gov](mailto:DWCFeeSchedule@dir.ca.gov).

### [May 23, 2010: Daily Work Comp Issues:](#)

#### → *Anesthesia Services*

((basic value + modifying units (if any) + time value) × conversion factor × .95) = maximum reasonable fee.

[May 22, 2010: Daily Work Comp Issues:](#)→ **Filing an Application**

When Cal. Lab. Code § 5405(a), is tolled by the voluntary furnishing of benefits, the five-year rule of § 5410 is in turn triggered. In this situation, that is, after the voluntary payment of benefits, § 5410 extends the period within which an original proceeding may be instituted from one to five years

[May 21, 2010 Daily Work Comp Issues:](#)→ **Chiropractic Care**

The first issue that must be addressed, then, is whether the treatment at issue is justified under the ACOEM Guidelines. If the treatment falls within the Guidelines, then no rebuttal is necessary. Only if the Guidelines recommend against the treatment does the burden fall to applicant to show that a variance is necessary.

[May 20, 2010 Daily Work Comp Issues:](#)→ **Review Companies / PPO Discounts**

(*Bill Review Company*) They are not an insurance carrier, health care service plan, non profit hospital service plan, nor a governmental unit or any other entity which has an obligation to provide medical benefits to a beneficiary. Diversified can be a "payor" only in so far as their own employees (i.e. beneficiaries) are concerned.

[May 19, 2010: Daily Work Comp Issues:](#)→ **Treating Outside MPN**

"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)

[May 18, 2010: Daily Work Comp Issue](#)→ **Admissibility QME Report**

Only the injured worker may request a panel QME exam), QME Regulation § 30(d)(3), effective 2/17/09.

[May 17, 2010: Daily Work Comp Issues:](#)→ **Denied Cases**

The award of usual and customary fees in denied cases later determined compensable is one of the checks and balances that the Workers' Compensation System has kept in place

[May 13, 2010: Daily Work Comp Issue:](#)→ **AME Report Admissibility**

"The WCJ also was unclear about whether Dr. Strassberg was aware that chiropractic treatment may be reasonable even if it did not cure Applicant's condition, but merely relieves the condition."

[May 12, 2010: Daily Work Comp Issue](#)→ **Medical Determination**

"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."

[May 11, 2010 Daily Work Comp Issues:](#)→ **Reimbursement for Medical Benefits Paid.**

American Psychometric Consultants Inc. is considered to be the leading case regarding the platform for the Insurance Carrier seeking reimbursement for medical benefits paid.

[May 10, 2010; Daily Work Comp Issues:](#)→ **Extent and Scope of Medical Treatment**

Former section 4062 allowed employers to object to medical determinations concerning "the extent and scope of medical treatment . . ." (Stats. 2003, ch. 639, § 17.) In Senate Bill No. 899, the Legislature deleted that phrase. "

[May 08, 2010 Daily Work Comp Issues:](#)→ **Treatment vs Causation**

Employers may not use section 4062 (Medical Legal) as an alternative method for disputing employees; treatment requests

[May 06, 2010: Daily WC Issue:](#)→ **Transferring Into MPN**

"Consequently, I have chosen to be guided by the common sense of the Supreme Court, which has repeatedly held that a lawfully established physician-patient relationship should be preserved unless there

is a change of condition or the treatment provided is defective or incomplete. "

[May 05, 2010: Daily Work Comp Issue:](#)→ **Causation**

"A utilization review physician's report is not admissible for the purpose of determining whether the industrial injury caused or contributed to the need for a particular treatment, i.e., a utilization review physician may address only the issue of whether a particular treatment is medically necessary;..."

[May 04, 2010: Daily Work Comp Issue:](#)→ **CIGA / Covered Claim**

"Since Torrance Memorial Medical Center Still Owns its own debt or lien, this Court will find that the lien has not been assigned

[May 03, 2010: Daily Work Comp Issues](#)→ **Cal Lab Code § 5402 (c)**

Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).

[May 02, 2010: Daily Work Comp Issues:](#)→ **Post Termination**

The employer has notice of the injury, prior to the notice of termination or layoff, employee's medical records, existing prior to the notice of termination or layoff, the date of injury, as specified in Section 5411, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff

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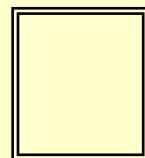
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