

## QME/ AME Process, the practitioner's perspective

I. Making the panel request and the need for the parties to have a contemporaneous dispute that can be resolved by a QME before a panel can be issued by the Medical Unit.

A. The necessity of having a “dispute” that can be resolved by a QME

1. Labor Code section 4060
2. Labor Code section 4061
3. Labor Code section 4062
4. Cal. Code of Regs., tit. 8, § 9785

B. Case law

1. *Sandhagen v. WCAB* (2008) 44 Cal. 4<sup>th</sup> 230
2. *Valdez v. Warehouse Demo Services* (2011) 76 Cal. Comp. Cases 970 (En Banc)
3. *Willette v. AU Electric Corporation* (2004) 69 Cal. Comp. Cases 1563 (En Banc)
4. *Messele v. Pitco Foods* (2011) 76 Cal. Comp. Cases -- (En Banc)

II. Ex-parte contact issues

A. Statutes and regulations

1. Labor Code section 4062.3 (f)
2. Cal. Code of Regs., tit. 8, § 35

B. Case Law

1. *State Farm v. W.C.A.B. (Pearson)* (2011) 192 Cal.App.4<sup>th</sup> 51
2. *Alvarez v. W.C.A.B. (SCIF)* (2010) 187 Cal.App.4<sup>th</sup> 575

III. Replacement and additional panel requests

A. Statutes and regulations

1. Cal. Code of Regs., tit. 8, § 31.5
2. Cal. Code of Regs., tit. 8, § 31.7

## **LABOR CODE**

### **SECTION 4060-4068**

4060. (a) This section shall apply to disputes over the compensability of any injury. This section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer.

(b) Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician, except as provided in this section. However, reports of treating physicians shall be admissible.

(c) If a medical evaluation is required to determine compensability at any time after the filing of the claim form, and the employee is represented by an attorney, a medical evaluation to determine compensability shall be obtained only by the procedure provided in Section 4062.2.

(d) If a medical evaluation is required to determine compensability at any time after the claim form is filed, and the employee is not represented by an attorney, the employer shall provide the employee with notice either that the employer requests a comprehensive medical evaluation to determine compensability or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability. Either party may request a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained only by the procedure provided in Section 4062.1.

(e) The notice required by subdivision (d) shall be accompanied by the form prescribed by the administrative director for requesting the assignment of a panel of qualified medical evaluators.

4061. (a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable.

(b) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for continuing medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2.

(c) If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for continuing medical care, and if the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director

with which to request assignment of a panel of three qualified medical evaluators. Either party may request a comprehensive medical evaluation to determine permanent disability or the need for continuing medical care, and the evaluation shall be obtained only by the procedure provided in Section 4062.1.

(d) The qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(e) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 and 4664 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(f) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(g) (1) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the dispute.

(2) If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

(h) No issue relating to the existence or extent of permanent impairment and limitations resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician

or physicians, no evaluation of permanent impairment and limitations resulting from the injury shall be obtained, except in accordance with Section 4062.1 or 4062.2. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board.

4061.5. The treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all medical issues necessary to determine eligibility for compensation. In the event that there is more than one treating physician, a single report shall be prepared by the physician primarily responsible for managing the injured worker's care that incorporates the findings of the various treating physicians.

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer 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. 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. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

(b) 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 expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.

(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

4062.1. (a) If an employee is not represented by an attorney, the employer shall not seek agreement with the employee on an agreed medical evaluator, nor shall an agreed medical evaluator prepare the formal medical evaluation on any issues in dispute.

(b) If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may submit the form prescribed by the administrative director requesting the medical director to assign a panel of three qualified medical evaluators in accordance with Section 139.2. However, the employer may not submit the form unless the employee has not submitted the form within 10 days after the employer has furnished the form to the employee and requested the employee to submit the form. The party submitting the request form shall designate the specialty of the physicians that will be assigned to the panel.

(c) Within 10 days of the issuance of a panel of qualified medical evaluators, the employee shall select a physician from the panel to prepare a medical evaluation, the employee shall schedule the appointment, and the employee shall inform the employer of the selection and the appointment. If the employee does not inform the employer of the selection within 10 days of the assignment of a panel of qualified medical evaluators, then the employer may select the physician from the panel to prepare a medical evaluation. If the employee informs the employer of the selection within 10 days of the assignment of the panel but has not made the appointment, or if the employer selects the physician pursuant to this subdivision, then the employer shall arrange the appointment. Upon receipt of written notice of the appointment arrangements from the employee, or upon giving the employee notice of an appointment arranged by the employer, the employer shall furnish payment of estimated travel expense.

(d) The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, "good cause" shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

(e) If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation.

4062.2. (a) Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation shall be obtained only as provided in this section.

(b) If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may commence the selection process for an agreed medical evaluator by making a written request naming at least one proposed physician to be the evaluator. The parties shall seek agreement with the other party on the physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator, or any additional time not to exceed 20 days agreed to by the parties, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician. The party submitting the request form shall serve a copy of the request form on the other party.

(c) Within 10 days of assignment of the panel by the administrative director, the parties shall confer and attempt to agree upon an agreed medical evaluator selected from the panel. If the parties have not agreed on a medical evaluator from the panel by the 10th day after assignment of the panel, each party may then strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within three working days of gaining the right to do so, the other party may select any physician who remains on the panel to serve as the medical evaluator. The administrative director may prescribe the form, the manner, or both, by which the parties shall conduct the selection process.

(d) The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements.

(e) If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later ceases to be represented, he or she shall not be entitled to an additional evaluation.

4062.3. (a) Any party may provide to the qualified medical evaluator selected from a panel any of the following information:

- (1) Records prepared or maintained by the employee's treating physician or physicians.
- (2) Medical and nonmedical records relevant to determination of the medical issue.

(b) Information that a party proposes to provide to the qualified medical evaluator selected from a panel shall be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to consideration of nonmedical records within 10 days thereafter, the records shall not be provided to the evaluator. Either party may use discovery to establish the accuracy or authenticity of nonmedical records prior to the evaluation.

(c) If an agreed medical evaluator is selected, as part of their agreement on an evaluator, the parties shall agree on what information is to be provided to the agreed medical evaluator.

(d) In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following:

(1) All information received from the parties.

(2) All information reviewed in preparation of the report.

(3) All information relied upon in the formulation of his or her opinion.

(e) All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.

(f) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation.

(g) The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the medical evaluation, additional discovery costs, and attorney's fees for related discovery.

(h) Subdivisions (e) and (f) shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination.

(i) Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator.

(j) If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(k) No disputed medical issue specified in subdivision (a) may be the subject of declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

4062.5. If a qualified medical evaluator selected from a panel fails to complete the formal medical evaluation within the timeframes established by the administrative director pursuant to paragraph (1) of subdivision (j) of Section 139.2, a new evaluation may be obtained upon the request of either party, as provided in Sections 4062.1 or 4062.2. Neither the employee nor the employer shall have any liability for payment for the formal medical evaluation which was not completed within the required timeframes unless the employee or employer, on forms prescribed by the administrative director, each waive the right to a new evaluation and elects to accept the original evaluation even though it was not completed within the required timeframes.

4062.8. The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, with information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing, as appropriate.

4063. If a formal medical evaluation from an agreed medical evaluator or a qualified medical evaluator selected from a three member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or file an application for adjudication of claim.

4064. (a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms.

(b) For injuries occurring on or after January 1, 2003, if an unrepresented employee obtains an attorney after the evaluation pursuant to subdivision (d) of Section 4061 or subdivision (b) of Section 4062 has been completed, the employee shall be entitled to the same reports at employer expense as an employee who has been represented from the time the dispute arose and those reports shall be admissible in any proceeding before the appeals board.

(c) Subject to Section 4906, if an employer files an application for adjudication and the employee is unrepresented at the time the application is filed, the employer shall be liable for any attorney's fees incurred by the employee in connection with the application for adjudication.

(d) The employer shall not be liable for the cost of any comprehensive medical evaluations obtained by the employee other than those authorized pursuant to Sections 4060, 4061, and 4062. However, no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense. In no event shall an employer or employee be liable for an evaluation obtained in violation of subdivision (b) of Section 4060. All comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the appeals board except as provided in subdivisions (d) and (m) of Section 4061 and subdivisions (b) and (e) of Section 4062.

4066. When the employer files an application for adjudication of claim contesting the formal medical evaluation prepared by an agreed medical evaluator under this article, regardless of outcome, the workers' compensation judge or the appeals board shall assess the employee's attorney's fees against the employer, subject to Section 4906.

4067. If the jurisdiction of the appeals board is invoked pursuant to Section 5803 upon the grounds that the effects of the injury have recurred, increased, diminished, or terminated, a formal medical evaluation shall be obtained pursuant to this article.

When an agreed medical evaluator or a qualified medical evaluator selected by an unrepresented employee from a three-member panel has previously made a formal medical evaluation of the same or similar issues, the subsequent or additional formal medical evaluation

shall be conducted by the same agreed medical evaluator or qualified medical evaluator, unless the workers' compensation judge has made a finding that he or she did not rely on the prior evaluator's formal medical evaluation, any party contested the original medical evaluation by filing an application for adjudication, the unrepresented employee hired an attorney and selected a qualified medical evaluator to conduct another evaluation pursuant to subdivision (b) of Section 4064, or the prior evaluator is no longer qualified or readily available to prepare a formal medical evaluation, in which case Sections 4061 or 4062, as the case may be, shall apply as if there had been no prior formal medical evaluation.

4067.5. This article shall become operative for injuries occurring on and after January 1, 1991.

4068. (a) Upon determining that a treating physician's report contains opinions that are the result of conjecture, are not supported by adequate evidence, or that indicate bias, the appeals board shall so notify the administrative director in writing in a manner he or she has specified.

(b) If the administrative director believes that any treating physician's reports show a pattern of unsupported opinions, he or she shall notify in writing the physician's applicable licensing body of his or her findings.

**IN THE SUPREME COURT OF CALIFORNIA**

STATE COMPENSATION INSURANCE )	
FUND, )	
Petitioner, )	S149257
v. )	Ct.App. 3 C048668
WORKERS' COMPENSATION )	(W.C.A.B. No. RDG 115958)
APPEALS BOARD and BRICE )	
SANDHAGEN, )	
Respondents. )	
_____ )	
BRICE SANDHAGEN, )	
Petitioner, )	
v. )	Ct.App. 3 C049286
WORKERS' COMPENSATION )	(W.C.A.B. No. RDG 115958)
APPEALS BOARD and STATE )	
COMPENSATION INSURANCE FUND, )	
Respondents. )	
_____ )	

This case presents two related workers' compensation issues: (1) When deciding whether to approve or deny an injured employee's request for medical treatment, must an employer conduct utilization review pursuant to Labor Code

section 4610?<sup>1</sup> (2) As an alternative to utilization review, may an employer elect to dispute a request for medical treatment under section 4062, which permits an employer to object to “a medical determination . . . concerning any medical issues . . . not subject to Section 4610 . . . .”? (§ 4062, subd. (a).) We conclude the Legislature intended to require employers to conduct utilization review when considering requests for medical treatment, and not to permit employers to use section 4062 to dispute employees’ treatment requests. The language of section 4610 and 4062 mandates this result; this conclusion is especially clear when the language of those statutes is read in light of the statutory scheme and the omnibus reforms enacted by the Legislature in 2003 and 2004. (Sen. Bill No. 228 (2003-2004 Reg. Sess.) (Senate Bill No. 228); Sen. Bill No. 899 (2003-2004 Reg. Sess.) (Senate Bill No. 899).) Accordingly, we reverse the Court of Appeal’s contrary judgment and remand for further proceedings consistent with our decision.

### **I. BACKGROUND**

In October 2003, a car struck Brice Sandhagen while he was working as a foreman on a road construction project.<sup>2</sup> He injured his neck, back, left elbow, and left wrist and has received medical treatment continuously since the accident. Sandhagen’s physician referred him to SpineCare Medical Group, Inc., for a joint consultation by Drs. Goldthwaite and Josey. The physicians recommended a magnetic resonance imaging (MRI) test of Sandhagen’s spine to determine if disc herniations or disc degeneration was causing his pain. The physicians submitted a report to Sandhagen’s employer’s insurer, State Compensation Insurance Fund (State Fund), on May 24, 2004, with a request to authorize the recommended MRI.

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<sup>1</sup> All further unlabeled statutory references are to the Labor Code.

<sup>2</sup> The factual and procedural history is largely taken from the Court of Appeal’s opinion.

State Fund referred the matter to Dr. Krohn for “utilization review.”<sup>3</sup> On June 11, 2004, when State Fund did not communicate its decision within the 14-day statutory deadline (§ 4610, subd. (g)(1)), Sandhagen requested an expedited hearing. Ten days later (before the expedited hearing but 28 days after the MRI authorization request was submitted), Dr. Krohn sent a written denial of the medical treatment request, citing new medical treatment guidelines.

An expedited hearing took place on July 15, 2004, on the sole issue of the need for the recommended MRI. The workers’ compensation judge found that State Fund’s failure to comply with the statutory deadlines precluded it from relying on the utilization review process or Dr. Krohn’s report to deny Sandhagen treatment. Only Dr. Goldthwaite’s report remained admissible. The workers’ compensation judge, finding the MRI authorization request to be consistent with the new treatment guidelines, ordered State Fund to authorize the MRI.

State Fund sought reconsideration by the Workers’ Compensation Appeals Board (WCAB). State Fund argued that the consequences for failing to comply with utilization review guidelines are set forth in section 4610, subdivision (i), which provides for administrative penalties, and in section 4610.1, which allows possible penalties for delay, and that nothing in the statutory scheme allows for the exclusion of a utilization review report. Sandhagen disagreed, contending section 4610, subdivision (g) requires an employer to meet specific deadlines and that State Fund’s failure to comply with the deadlines meant that it could not rely on the utilization review process to justify denial of treatment. In addition, Sandhagen argued that the workers’ compensation judge properly excluded Dr.

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<sup>3</sup> “Utilization review” is the process by which employers “review and approve, modify, delay, or deny” employees’ medical treatment requests. (§ 4610, subd. (a).) The scope and effect of the term will be more fully addressed below.

Krohn's denial letter. He further argued that he had met his evidentiary burden to prove that the requested treatment was medically reasonable and necessary.

The WCAB granted reconsideration. Due to the important legal issues presented and in order to secure uniformity of future decisions, the matter was assigned to the WCAB as a whole for an en banc decision. On November 16, 2004, the WCAB issued its decision, holding that the section 4610 deadlines are mandatory and State Fund's failure to meet the deadlines means that, with respect to the particular medical treatment dispute in question, it was precluded from using the utilization review process or any utilization review report it obtained to deny treatment. However, the WCAB also held that, while precluded from using the utilization review process, State Fund could nonetheless dispute the treating physician's treatment recommendation using the dispute resolution procedure set forth in section 4062.<sup>4</sup> Accordingly, the WCAB vacated the workers' compensation judge's determination that Sandhagen was entitled to the MRI and instead gave State Fund an opportunity to proceed under section 4062.

State Fund filed a petition for writ of review. Sandhagen also sought review, specifically of the portion of the decision that held that State Fund could object to the treatment authorization under section 4062, notwithstanding its failure to comply with the procedures set forth in section 4610. The Court of Appeal granted both petitions.

The Court of Appeal affirmed both of the WCAB's holdings. The Court of Appeal agreed that State Fund's failure to comply with the mandatory deadlines precluded State Fund from using the process to deny Sandhagen's request for

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<sup>4</sup> Section 4062, subdivision (a) permits an employee or employer to object to "a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610 . . . ."

medical treatment. However, as did the WCAB, the Court of Appeal concluded that State Fund could nonetheless object to the medical treatment request under the dispute resolution process set forth in section 4062, reasoning that an employer is not required to use the utilization review process when considering employees' requests for medical treatment. We granted Sandhagen's petition for review.<sup>5</sup>

## II. DISCUSSION

This case requires us to determine the meaning and effect of section 4610, in which the Legislature established the utilization review process, in relation to section 4062, which generally governs disputes between injured employees and their employers regarding "medical issues . . . not subject to Section 4610 . . . ."<sup>6</sup> In determining that the Legislature intended for employers' review of employees' medical treatment requests to be governed solely by section 4610, rather than section 4062, we rely primarily on the clear statutory language. (*Hsu v. Abbara* (1995) 9 Cal.4th 863, 871.) In addition, comparing the current statutory scheme with previous iterations provides further support for our conclusion.

### A. Statutory Scheme Requires Employers to Conduct Utilization Review When Resolving Requests for Medical Treatment

Section 4610 requires that "[e]very employer . . . establish a utilization review process in compliance with this section" (*id.*, subd. (b)), defining

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<sup>5</sup> State Fund did not seek review of the Court of Appeal's holding that its failure to comply with the section 4610 deadlines precluded it from using the utilization review process to deny the medical treatment request and rendered the Dr. Krohn's report inadmissible.

<sup>6</sup> The WCAB's interpretation of these statutes is subject to de novo review. While we typically give great weight to the WCAB's administrative construction of the statutes it is charged to enforce and interpret, we will annul clearly erroneous interpretations. (*Lockheed Martin Corp. v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1237, 1241.)

utilization review as “functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians . . .” (*id.*, subd. (a)). Notwithstanding the breadth of this statutory directive, State Fund claims that section 4610 simply requires employers to “establish” a utilization review process, but does not require employers to actually *use* the process. We find this argument unpersuasive. Having broadly defined utilization review, and requiring every employer to establish such a process at considerable expense and with numerous statutory safeguards (discussed in further detail below), it is unlikely that the Legislature intended to allow employers to circumvent the process whenever an employer felt it expedient. To the contrary, the statutory language indicates the Legislature intended for employers to use the utilization review process when reviewing and resolving *any and all* requests for medical treatment.

Believing that it can “opt out” of the review process, State Fund claims that it can instead utilize the more general section 4062 dispute resolution procedures. Not so. State Fund’s assertion is belied by the language of section 4062 itself. The statute permits employers to object to a treating physician’s medical determinations, but *only* to those determinations regarding “medical issues not covered by Section 4060 or 4061 *and not subject to Section 4610 . . .*” (§ 4062, subd. (a), italics added.) By contrast, section 4062 explicitly permits *employees* to use its provisions to object to an employer’s “decision *made pursuant to Section 4610* to modify, delay, or deny a treatment recommendation . . .” (*Id.*, subd. (a), italics added.) In summary, section 4062 simultaneously *precludes* employers from using its provisions to object to employees’ treatment requests but *permits* employees to use its provisions to object to employers’ decisions regarding

treatment requests. The Legislature's intent regarding employers' use of section 4062 to dispute treatment requests could not be more clear.

Taken together, the language of sections 4610 and 4062 demonstrates that (1) the Legislature intended for *employers* to use the utilization review process in section 4610 to review and resolve any and all requests for treatment, and (2) if dissatisfied with an employer's decision, an *employee* (and only an employee) may use section 4062's provisions to resolve the dispute over the treatment request. An employer may not bypass the utilization review process and instead invoke section 4062's provisions to dispute an employee's treatment request. The correctness of this conclusion is particularly evident when the current statutory provisions are compared to prior schemes for handling employees' treatment requests.

### **B. Prior Schemes Demonstrate the Legislature Intended for Section 4610 to Govern Employers' Review**

In order to better understand what the Legislature intended when it adopted the procedures in section 4610 and 4062, it is helpful to consider the way in which the process for reviewing employees' treatment requests has changed over time.

#### *1. Historical Evolution of the Treatment Request Process*

The workers' compensation scheme makes the employer of an injured worker responsible for all medical treatment reasonably necessary to cure or relieve the worker from the effects of the injury. (§ 4600, subd. (a).) When a worker suffers an industrial injury, the worker reports the injury to his or her employer and then seeks medical care from his or her treating physician. After examining the worker, the treating physician recommends any medical treatment he or she believes is necessary and the employer is given a treatment request to approve or deny. The standards applied in evaluating these treatment requests and the process by which treatment requests are resolved have both been significantly

modified in the recent past. For our purposes, the relevant periods are: (1) the time preceding passage of Senate Bill No. 228, (2) after Senate Bill No. 228 went into effect on January 1, 2004, and (3) after Senate Bill No. 899 went into effect on April 19, 2004.

*a. Before Senate Bill No. 228*

Before the passage of Senate Bill No. 228, there were no uniform medical treatment guidelines in effect. Whether a medical treatment request was “necessary” depended solely upon the opinion of the treating physician measured against the general standard that “necessary” treatment was that which was “reasonably required to cure or relieve the injured worker of the effects of his or her injury.” (Former § 4600, as amended by Stats. 1998, ch. 440, § 2.) Moreover, former section 4062.9 provided a rebuttable presumption that the findings of an injured employee’s treating physician were correct. (Stats. 2002, ch. 6, § 53.)

If 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, a catchall dispute resolution provision. Former section 4062, subdivision (a) provided that, “[i]f either the employee or employer objects to a medical determination made by the treating physician *concerning . . . the extent and scope of medical treatment . . .* or any other medical issues not covered by Section 4060 or 4061,<sup>[7]</sup> the objecting party shall notify the other party in writing of the objection . . . .” (Stats. 2002, ch. 6, § 52, italics added.)

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<sup>7</sup> Sections 4060 and 4061, like section 4062, are dispute resolution provisions. Section 4060 governs disputes over the compensability of an injury, and section 4061 covers disputes over permanent disability.

An employer objecting to a treatment request had to do so within 20 days if the injured employee was represented by counsel, and within 30 days if the employee was unrepresented, although the time limits could be extended for good cause. (Former § 4062, subd. (a), as amended by Stats. 2002, ch. 6, § 52.) In the case of a represented employee, the statute directed the parties to seek agreement on a physician to prepare a comprehensive medical evaluation resolving the disputed issue. (*Ibid.*) If the parties were unable to pick an agreed medical evaluator (AME) within 10 days (or 20 days if the parties agreed to extend the time), the parties could not thereafter select an AME. (*Ibid.*) After the time for reaching an agreement had expired, the objecting party could select a qualified medical evaluator (QME) to conduct a comprehensive medical evaluation. (*Ibid.*) The nonobjecting party could choose to rely on the treating physician's report or could select a QME of its own, to conduct an additional comprehensive evaluation. (*Ibid.*)<sup>8</sup> The employer was liable for the cost of a medical evaluation obtained by the employee pursuant to former section 4062. (§ 4064, subd. (a).)

After the injured worker was examined, the scheduling of which often resulted in further delays, the AME or QME had 30 days in which to prepare an evaluation, addressing all contested medical issues, and serve the evaluation and a summary on the employee, employer, and the Administrative Director of the Division of Workers' Compensation (administrative director).<sup>9</sup> (Former § 139.2, subd. (j)(1), as amended by Stats. 2000, ch. 54, § 1; former § 4062, subd. (c), as amended by Stats. 2002, ch. 6, § 52.) If a dispute remained after the

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<sup>8</sup> Former section 4062 established a different procedure for unrepresented employees.

<sup>9</sup> Under former section 139.2, subdivision (j)(1), the AME or QME could, for good cause, seek an extension of the 30-day deadline. (Stats. 2000, ch. 54, § 1.)

comprehensive medical evaluations were completed, either party could request an administrative hearing. (§ 5500.) If the hearing failed to satisfy the parties, they could seek reconsideration by the WCAB (§ 5900) and, ultimately, review by the Court of Appeal (§ 5950).

There was also an administrative (rather than statutory) utilization review alternative to proceeding under former section 4062. (Cal. Code Regs., tit. 8, former § 9792.6, Register 98, No. 46 (Nov. 13, 1998).) However, use of the process was voluntary and, because the administrative process contained no uniform medical standards, interested employers had to first undertake a complicated effort to design and submit their own medically-based criteria to the administrative director. (*Id.*, subs. (b), (c), (d) & (e).)<sup>10</sup> As a result, the administrative process was little used and most treatment requests were resolved via the procedures in former section 4062.

*b. Senate Bill No. 228*

Senate Bill No. 228, effective January 1, 2004, enacted comprehensive workers' compensation reform. The Legislature, reacting to escalating costs, made a number of critical changes to the statutory scheme. Particularly relevant here are changes to the standards used in evaluating medical treatment requests as well as alterations to the process for resolving the treatment requests.

The Legislature added section 5307.27, directing the administrative director to adopt a medical treatment utilization schedule to establish uniform guidelines for evaluating treatment requests. (Stats. 2003, ch. 639, § 41.) The provision further provides that this schedule shall incorporate "evidence-based, peer-

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<sup>10</sup> This process was also unattractive to employees, as it permitted a treatment decision to be delayed as long as the employer gave notice of the delay in a timely manner. (Cal. Code Regs., tit. 8, former § 9792.6, subd. (c)(1).)

reviewed, nationally recognized standards of care” and address the “appropriateness of all treatment procedures . . . commonly performed in workers’ compensation cases.” (§ 5307.27.) The Legislature also amended section 4062.9, limiting the presumption of correctness that had previously applied to a treating physician’s opinion (Stats. 2003, ch. 639, § 20), and added section 4604.5, which created a rebuttable presumption that the treatment guidelines in the utilization schedule were correct on the issue of extent and scope of medical treatment.<sup>11</sup> (Stats. 2003, ch. 639, § 27.)

In addition to changing the standards for evaluating treatment requests, Senate Bill No. 228 also made a number of important changes to the process of resolving treatment requests. Most significantly, the Legislature enacted a statutory utilization review process in section 4610. (Stats. 2003, ch. 639, § 28.) In addition to requiring every employer to “establish a utilization review process” (§ 4610, subd. (b)), section 4610 also enacted a number of procedural and substantive requirements. Most notably, subdivision (e) of section 4610 allows only a licensed physician, who is competent to evaluate the specific clinical issues involved, to modify, delay, or deny requests for treatment. Accordingly, while medical review is not required if the employer *approves* the treatment request, section 4610 requires that a licensed doctor deny, delay, or modify the request. This represents a significant departure from the process in former section 4062, which permitted an employer or claims adjuster (without review by a physician) to object to a treatment request. (§ 4062, as amended by Stats. 2002, ch. 6, § 52.)

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<sup>11</sup> Former section 4604.5 provided that until the administrative director adopted a utilization schedule, guidelines promulgated by the American College of Occupational and Environmental Medicine be used as interim standards and be presumed to be correct on the issue of extent and scope of medical treatment. (Former § 4604.5, subd. (c), added by Stats. 2003, ch. 639, § 27.)

Section 4610, subdivision (g) imposes a number of additional requirements that must be met as part of the utilization review process. Among them are: (1) treatment decisions must be made in a timely fashion, not to exceed five working days from the receipt of information reasonably necessary to make the determination, and in no event more than 14 days from the date of the request for treatment (§ 4610, subd. (g)(1)); (2) if the request is not approved in full, disputes shall be resolved in accordance with section 4062 (§ 4610, subd. (g)(3)(A)); and (3) if an employer cannot make a decision within the specified timeframes because it (a) is not in receipt of all the information reasonably necessary and requested, (b) requires consultation by an expert reviewer, or (c) has asked that an additional examination be performed on the employee that is reasonable and consistent with good medical practice, the employer must immediately notify the physician and the employee. (*Id.*, subd. (g)(5).) Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the specified time frames. (*Ibid.*)

As the Court of Appeal here recognized, the Legislature intended utilization review to ensure quality, standardized medical care for workers in a prompt and expeditious manner. To that end, the Legislature enacted a comprehensive process that balances the dual interests of speed and accuracy, emphasizing the quick resolution of treatment requests, while allowing employers to seek more time if more information is needed to make a decision. (§ 4610, subd. (g).) If the treatment request is straightforward and uncontroversial, the employer can quickly approve the request — utilization review is completed without any need for additional medical review of the request. If the request is more complicated, the employer can forward the request to its utilization review doctor for review, since the statute requires that the employer seek a medical opinion before modifying, delaying, or denying an employee's request for medical treatment. (*Id.*, subd.

(e.)<sup>12</sup> This ensures that a physician, rather than a claims adjuster with no medical training, makes the decision to deny, delay, or modify treatment.

*c. Senate Bill No. 899*

As we recently noted, Senate Bill No. 899 was passed as an urgency bill in response to “a perceived crisis in skyrocketing workers’ compensation costs.” (*Brodie v. Workers’ Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1329.) Like Senate Bill No. 228, Senate Bill No. 899 was an omnibus reform that made a number of significant changes to the workers’ compensation scheme, including, as particularly relevant here, altering the standards used in evaluating workers’ requests for medical treatment and the process for evaluating them.

With Senate Bill No. 899, the Legislature amended section 4600 to define “medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury” as “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.” (Stats. 2004, ch. 34, § 23.) Senate Bill No. 899 also repealed section 4062.9, which had contained a presumption of correctness for the findings of an injured employee’s treating physician (Stats. 2004, ch. 34, § 22), while making slight modifications to section 4604.5, which contains a presumption of correctness for the treatment guidelines. (Stats. 2004, ch. 34, § 25.)

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<sup>12</sup> Senate Bill No. 228 also repealed former section 4062 (Stats. 2003, ch. 639, § 16.5) and replaced it with a new section 4062 (Stats. 2003, ch. 639, § 17) addressing the same subject matter. The new section 4062 was the same as the previous version, except for the addition of language concerning requests for spinal surgery. (Compare Stats. 2002, ch. 6, § 52 with Stats. 2003, ch. 639, § 17.)

The Legislature amended section 3202.5 to underscore that all parties, including injured workers, must meet the evidentiary burden of proof on all issues by a preponderance of the evidence. (Stats. 2004, ch. 34, § 9.) Accordingly, notwithstanding whatever an employer does (or does not do), an injured employee must still prove that the sought treatment is medically reasonable and necessary. That means demonstrating that the treatment request is consistent with the uniform guidelines (§ 4600, subd. (b)) or, alternatively, rebutting the application of the guidelines with a preponderance of scientific medical evidence. (§ 4604.5.)

While Senate Bill No. 899 did not alter the section 4610 utilization review process, it made a number of changes to the dispute resolution process in section 4062 that are particularly relevant here. First, the prior version of section 4062, subdivision (a) (Stats. 2003, ch. 639, § 17) permitted an employee or employer to object to a treating physician's medical determination regarding "the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, *the extent and scope of medical treatment*, the existence of new and further disability, *or any other medical issues not covered by Section 4060 or 4061 . . . .*" (Italics added.) The Legislature amended section 4062, subdivision (a), eliminating "the extent and scope of medical treatment" from the list of things to which an employer may object. (Stats. 2004, ch 34, § 14.) Subdivision (a) of section 4062 now permits an employer to object only to medical determinations regarding "any medical issues not covered by Section 4060 or 4061 *and not subject to Section 4610 . . . .*" (Italics added.) Second, Senate Bill No. 899 made another change to section 4062, subdivision (a), adding that "[i]f the *employee* objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision." (Stats. 2004, ch 34, § 14, italics added.)

Senate Bill No. 899 also changed the AME/QME process, eliminating the competing comprehensive evaluations that often existed under former section 4062. In the case of represented employees, the bill repealed former section 4062.2 (Stats. 2004, ch. 34, § 17) and replaced it with new section 4062.2 (Stats. 2004, ch. 34, § 18). As with the procedure under former section 4062, new section 4062.2 instructs the parties to attempt to select an AME. If the parties cannot reach an agreement within 10 days (or 20 days if the parties agree to extend the time), either party may request a three-member panel of QME's be assigned. (*Ibid.*) The parties must then confer and attempt to agree on one of the QME's. (*Ibid.*) "If the parties have not agreed on a medical evaluator from the panel by the 10th day after the assignment of the panel, each party may then strike one name from the panel" and "the remaining [QME] shall serve as the medical evaluator." (*Ibid.*)<sup>13</sup> "[N]o other medical evaluation shall be obtained." (§ 4062, subd. (a).)<sup>14</sup>

## 2. *Evolution of the Review Process Demonstrates Legislature's Intent*

Understood against this historical backdrop, it is clear the Legislature intended for employers to resolve treatment requests via the section 4610 process. As discussed above, Senate Bill Nos. 228 and 899 were aimed at controlling skyrocketing costs while simultaneously ensuring workers' access to prompt,

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<sup>13</sup> As with evaluations performed under former section 4062, evaluations performed under section 4062.2 must be prepared and submitted within 30 days unless the evaluator has sought, and received, an extension of time. (§ 139.2, subd. (j)(1)(A), amended by Stats. 2004, ch. 34, § 2.) If the QME fails to complete the evaluation within the timeline, either party can request a new evaluation and the process begins again. (§ 4062.5, amended by Stats. 2004, ch. 34, § 20.)

<sup>14</sup> As under former section 4062 (added by Stats. 2003, ch. 639, § 17), the procedure is different for unrepresented employees.

quality, standardized medical care. To accomplish those goals, the Legislature made a number of significant changes, the most relevant of which was adopting the comprehensive utilization review process in section 4610 along with the concomitant changes to the dispute resolution procedure in 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)). State Fund asserts that there are instances when, or reasons why, it might not be reasonable to subject a treatment request to the utilization review process. We are not persuaded — indeed, the cited examples betray a fundamental misunderstanding of the scope of utilization review and its requirements.

For example, State Fund claims that “if the employer determines, without [utilization review], that the recommended treatment is reasonably required, ‘imposing the [utilization review] process would be both time consuming and expensive.’ ” But when the employer in the hypothetical reviews the request and determines that treatment is reasonably required, the employer has *engaged in utilization review*. (See § 4610, subd. (a).) The hypothetical actually demonstrates that utilization review provides an expeditious manner of resolving treatment requests, being neither time consuming nor expensive, especially when compared to the process previously in place. In light of the comprehensive nature of section 4610 and the goals the Legislature sought to accomplish, we conclude

the Legislature intended for the utilization review process to be employers' only avenue for resolving an employee's request for treatment.

We also conclude that section 4062 is *not* available to employers as an alternative avenue for disputing employees' requests for treatment. The Legislature made clear that an employer may not use section 4062 to object to a medical determination concerning medical issues "subject to section 4610" while expressly permitting *employees* to use section 4062 to resolve disputes over an employer's decision not to approve treatment requests (Stats. 2004, ch. 34, § 14) — i.e., the plain language of section 4062 establishes that only employees may use section 4062 to resolve disputes over requests for treatment. This limitation is made even clearer when the current section 4062 is compared to previous versions. 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. (Stats. 2004, ch. 34, § 14.) "We presume the Legislature intends to change the meaning of a law when it alters the statutory language [citation], as for example when it deletes express provisions of the prior version . . . ." (*Dix v. Superior Court* (1991) 53 Cal.3d 442, 461.) State Fund would have us read "the extent and scope of medical treatment" back into the statute as one of the matters employers may object to under section 4062. We decline to do so.

Accordingly, in light of the clear statutory language and the Legislature's purpose in enacting the utilization review process in section 4610, we conclude the Legislature intended to require employers to conduct utilization review when considering employees' requests for medical treatment. Employers may not use section 4062 as an alternative method for disputing employees' treatment requests.

### III. DISPOSITION

The judgment of the Court of Appeal is reversed and the matter is remanded to that court for further proceedings consistent with this opinion.

MORENO, J.

WE CONCUR: GEORGE, C. J.  
BAXTER, J.  
WERDEGAR, J.  
CHIN, J.  
CORRIGAN, J.

## CONCURRING OPINION BY KENNARD, J.

I agree with the majority's conclusion and much of its analysis. Specifically, I agree that the "utilization review" process set forth in Labor Code<sup>1</sup> section 4610 is mandatory. I also agree that, if an employer fails to meet section 4610's deadlines, it may not object to the employee's requested medical treatment under section 4062. Certain language in the majority's opinion, however, might be misread to suggest that utilization review is a dispute-resolution process that *replaces* the "cumbersome, lengthy, and potentially costly" dispute-resolution process that previously applied under former section 4062. (Maj. opn., *ante*, at p. 8.) As I understand the statutory scheme, utilization review process adds a *new step* that the employer must take *before* section 4062 comes into play, but it *does not replace the section 4062 process*. Section 4062 remains the means for resolving any dispute between the parties regarding medical treatment, as I explain below.

Section 4600 requires employers to provide their employees with medical treatment for their work-related injuries. When disputes arise regarding the conclusions and recommendations of the treating physician, section 4062 sets forth the primary procedural mechanism for resolving those disputes. Among

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<sup>1</sup> All further statutory references are to the Labor Code.

other things, section 4062 governs disputes regarding which specific medical treatments are appropriate. Section 4062 played this role in the statutory scheme before the Legislature mandated utilization review in the year 2003, and it continues to play this role now.<sup>2</sup> Utilization review, by contrast, is not concerned with dispute resolution; rather, it governs the process by which the employer makes its initial decision whether to approve or deny the proposed medical treatment. Section 4610, subdivision (g)(3)(A), makes this point expressly. It states that if the employer, having followed the utilization review process, does anything short of fully approving the employee's request for medical treatment, any resulting dispute is resolved under section 4062, same as ever.

One purpose of utilization review is to prevent disputes about medical treatment from ever arising. Before 2003, the medical treatment the employer was obligated to provide for work-related injuries was only vaguely defined as "treatment . . . that is reasonably required to cure or relieve from the effects of the injury." (Former § 4600, as amended by Stats. 1998, ch. 440, § 2.) This indistinct standard left a lot of room for disagreement. The Legislature's reforms of the workers' compensation law in 2003 and 2004 much more precisely define the employer's medical treatment obligation in terms of detailed treatment guidelines. (See §§ 4600, subd. (b), 4610, subd. (c).) Because proper application of these treatment guidelines requires medical expertise, the decision to modify, delay, or deny a treatment request must be made by a licensed physician. (§ 4610, subd. (e).) Thus, utilization review is best understood as a *threshold* procedure that the employer must follow before any dispute about medical treatment has arisen. It

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<sup>2</sup> Section 4062 remains the means for resolving medical treatment disputes, but in 2004 the Legislature changed the specifics of this dispute-resolution procedure in significant ways.

governs the employer's evaluation of the treating doctor's recommendation. If the employer approves the requested treatment, then there is no dispute and likewise no need to resort to dispute-resolution procedures. A dispute might arise only if the employer modifies, delays, or denies the requested treatment, in which case the employee may invoke section 4062's dispute-resolution mechanism. (§§ 4610, subd. (g)(3)(A), 4062, subd. (a).)

Hence, section 4610's utilization review is not to be conflated with the process of dispute resolution. Section 4062 continues to govern medical treatment disputes, as it did before the reforms. The statutory scheme does not create two separate dispute-resolution tracks for employers and for employees. Instead, it sets forth two successive stages of a single-track process: The employer first proceeds with utilization review under section 4610, and then the employee may dispute the employer's conclusion under section 4062. (§ 4610, subd. (g)(3)(A).) The fact that the "*employee (and only the employee)*" (maj. opn., *ante*, at p. 7) initiates the dispute-resolution process set forth in section 4062 is not intended to exclude employers from that process; rather, it merely reflects the circumstance that utilization review has been interposed as a threshold step. The employer who seeks to object to a proposed medical treatment must follow the utilization review process. If that process results in a modification, delay, or denial of the requested treatment, then naturally the employee is the party that invokes the section 4062 dispute-resolution mechanism, because the employee is the aggrieved party.

To summarize, after the reforms enacted by the Legislature in 2003 and 2004, section 4062 remains the only process for resolving disputes regarding medical treatment (see § 4610, subd. (g)(3)(A)), and its cumbersomeness and

lengthiness merely reflect the Legislature's desire to ensure fairness to the parties.<sup>3</sup> Section 4610's utilization review does not supplant section 4062's dispute-resolution process; rather, it adds a new threshold step to that process. It can only be said to supplant that process in the practical sense—that is, it might prevent some disputes from ever arising, thereby making resort to that process unnecessary.

KENNARD, J.

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<sup>3</sup> The 2004 reform streamlined the section 4062 dispute-resolution process in several ways that are not at issue here. In particular, the 2004 reform created the single-medical-examiner rule, thereby reducing the likelihood of litigation over medical questions. (§ 4062.2, subd. (c).)

1 **WORKERS' COMPENSATION APPEALS BOARD**

2 **STATE OF CALIFORNIA**

3  
4 **ELAYNE VALDEZ,**

5  
6 *Applicant,*

7 **vs.**

8 **WAREHOUSE DEMO SERVICES; ZURICH**  
9 **NORTH AMERICA, Adjusted by ESIS,**

10 *Defendant(s).*

**Case No. ADJ7048296**

**OPINION AND DECISION AFTER  
RECONSIDERATION  
(EN BANC)**

11  
12 The Appeals Board granted defendant's petition for reconsideration of the Findings and  
13 Award issued by a workers' compensation administrative law judge (WCJ) on July 29, 2010, to  
14 allow time to study the record and applicable law.

15 The WCJ relied on medical reports obtained by the applicant from outside the defendant's  
16 medical provider network (MPN) to award her temporary disability indemnity for the period of  
17 November 2, 2009 through February 10, 2010. Defendant contends, however, that non-MPN  
18 medical reports are inadmissible.

19 In order to secure uniformity of decision in the future, the Chairman of the Appeals Board,  
20 upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en  
21 banc decision<sup>1</sup> on the following issue: if an applicant has improperly obtained medical treatment  
22 outside the employer's MPN, are the reports of the non-MPN treating physicians admissible in  
23 evidence? We hold that where unauthorized treatment is obtained outside a validly established and  
24 properly noticed MPN, reports from the non-MPN doctors are inadmissible, and therefore may not

25  
26 <sup>1</sup> En banc decisions of the Appeals Board (Lab. Code, § 115) are binding precedent on all Appeals Board panels and  
27 WCJs. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)* (2005) 126  
Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109, 120, fn. 5] (*Garcia*); *Gee v. Workers' Comp. Appeals Bd.* (2002)  
96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236, 239, fn. 6] (*Gee*)). In addition to being adopted as a  
precedent decision in accordance with Labor Code section 115 and Appeals Board Rule 10341, this en banc decision is  
also being adopted as a precedent decision in accordance with Government Code section 11425.60(b).

1 be relied upon, and that defendant is not liable for the cost of the non-MPN reports.

2 **I. BACKGROUND**

3 Applicant Elayne Valdez filed a claim for industrial injury to her back, right hip, neck, right  
4 ankle, right foot, right lower extremity, lumbar spine and both knees, while employed as a  
5 demonstrator for Warehouse Demo Services on October 7, 2009. Defendant admitted the claim for  
6 applicant’s back, right hip and neck, and she was sent for medical treatment to the employer’s  
7 MPN, where she was seen by Dr. Nagamoto, who treated her from approximately October 9, 2009  
8 to October 31, 2009. Applicant then began treating with Dr. Nario, a non-MPN physician, upon  
9 referral from her attorney.

10 This matter proceeded to trial on July 22, 2010, on the issues of temporary disability “from  
11 October 7, 2009 and continuing,” and attorney’s fees. The Minutes of Hearing also indicate that  
12 “[d]efendant wishes to raise the issue of [MPN],” which the WCJ deferred as “not relat[ing] to  
13 temporary disability.”<sup>2</sup> The WCJ also deferred the issue of self-procured medical treatment.

14 Applicant testified that her attorney sent her to Dr. Nario because the treatment provided by  
15 Dr. Nagamoto was not helping her. She never spoke to the claims examiner or otherwise notified  
16 defendant about this complaint. Applicant also testified that she “is still on temporary disability,”  
17 and that she received payments from the Employment Development Department (EDD) from April  
18 7, 2010 through May 26, 2010.

19 The WCJ found that applicant was temporarily disabled from November 2, 2009 through  
20 February 10, 2010, for which indemnity was awarded “less duplication of payment made by the  
21 [EDD], whose lien therefore is allowed.” The WCJ relied on the non-MPN reports of Dr. Nario for  
22 this finding and award of benefits. While the WCJ deferred “the issue of MPN,” he nevertheless  
23 rejected defendant’s argument that “reports of non-MPN doctors are inadmissible.”

24 Defendant filed a timely petition for reconsideration from the WCJ’s decision, contending  
25 that (1) applicant’s non-MPN medical reports are inadmissible; (2) there is no evidence to support

26 \_\_\_\_\_  
27 <sup>2</sup> Here, as the WCJ deferred any issues concerning the MPN as not relating to temporary disability, this matter will have to be remanded for consideration of these issues. However, for purposes of this en banc opinion, we will proceed on the assumption that the MPN here was validly established and that all proper notices regarding the MPN were provided to the applicant. (See Lab. Code, § 4616 et seq.; Cal. Code Regs., tit. 8, § 9767.1 et seq.; *Knight v. United Parcel Service* (2006) 71 Cal.Comp.Cases 1423 (Appeals Board en banc).)

1 any reimbursement to EDD for benefits paid to the applicant; and (3) if applicant is awarded  
2 temporary disability indemnity, there is no substantial evidence that applicant was temporarily  
3 disabled through February 10, 2010. Applicant did not file an answer to defendant's petition. On  
4 October 25, 2010, the Appeals Board granted reconsideration for further study.

## 5 **II. DISCUSSION**

### 6 **A. Where Unauthorized Treatment Is Obtained Outside a Validly Established and Properly** 7 **Noticed MPN, Reports from the Non-MPN Doctors Are Inadmissible and Therefore May Not** 8 **Be Relied Upon**

9 An employer or its insurer is obligated to provide all medical treatment "that is reasonably  
10 required to cure or relieve the injured worker from the effects of his or her injury." (Lab. Code, §  
11 4600(a).)<sup>3</sup> Section 4600(a) further provides: "In the case of his or her neglect or refusal to  
12 reasonably do so, the employer is liable for the reasonable expense incurred by or on behalf of the  
13 employee in providing treatment."

14 Section 4600(c) provides: "Unless the employer or the employer's insurer has established a  
15 medical provider network as provided for in section 4616, after 30 days from the date the injury is  
16 reported, the employee may be treated by a physician of his or her own choice at a facility of his or  
17 her own choice within a reasonable geographic area." An MPN is established by an employer or  
18 insurer subject to the approval of the administrative director (AD). (Lab. Code, § 4616; Cal. Code  
19 Regs., tit. 8, § 9767.3.) Among other things, the regulations require that the employer or insurer's  
20 application for approval of an MPN include a statement of how the MPN will comply with the  
21 "employee notification process" and the "second and third opinion process." (Cal. Code Regs., tit.  
22 8, §§ 9762.1 through 9762.3.) The statutory and regulatory scheme also imposes several other  
23 obligations upon both the insurer/employer and the injured worker.

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25 In *Knight, supra*, 71 Cal.Comp.Cases 1423, the Appeals Board held that a defendant's  
26 failure to provide the required notices to an employee of rights under the MPN which results in a  
27 neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable

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<sup>3</sup> All further statutory references are to the Labor Code.

1 for reasonable medical treatment self-procured by the employee. As stated previously, we assume  
2 for purposes of this opinion that defendant had a validly established MPN, and that all proper  
3 notices required under the MPN were provided to applicant. Here, after initially treating with an  
4 MPN physician, Dr. Nagamoto, for less than one month, applicant sought treatment outside the  
5 MPN with Dr. Nario. This was despite the fact that *within* the MPN she would have had several  
6 opportunities to challenge any treatment, diagnosis, or lack thereof with which she disagreed and  
7 treat with someone other than Dr. Nagamoto.

8 More specifically, after the initial medical evaluation arranged by the employer within the  
9 MPN pursuant to section 4616.3(a), “[t]he employer shall notify the employee of his or her right  
10 to be treated by a physician of his or her choice,” including “the method by which the list of  
11 participating providers may be accessed by the employee.” (Lab. Code § 4616.3(b); Cal. Code  
12 Regs., tit. 8, § 9767.6(d).) In addition, AD Rule 9767.6(e) (Cal. Code Regs., tit. 8, § 9767.6(e))  
13 provides that “[a]t any point in time after the initial evaluation with a MPN physician, the covered  
14 employee may select a physician of his or her choice from within the MPN.”

15 Furthermore, pursuant to section 4616.3(c), where an injured worker “disputes either the  
16 diagnosis or treatment prescribed by the treating physician,” he or she “may seek the opinion of  
17 another physician in the [MPN],” and of “a third physician in the [MPN],” if the diagnosis or  
18 treatment of the second physician is disputed.<sup>4</sup>

19 In addition, section 4616.4(b) provides that if the treatment or diagnostic service remains  
20 disputed after the third physician’s opinion, “the injured employee may request independent  
21 medical review.” Pursuant to section 4616.4(i), if “the independent medical reviewer finds that the  
22 disputed treatment or diagnostic service is consistent with section 5307.27 or the American  
23 College of Occupational and Environmental Medicine's Occupational Medicine Practice  
24 Guidelines, the injured employee may seek the disputed treatment or diagnostic service from a  
25 physician of his or her choice from within or outside the [MPN], and “[t]he employer shall be  
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27 <sup>4</sup> Section 4616.3(d)(2) also allows treatment by a specialist who is not a member of the MPN “on a case-by-case basis if the [MPN] does not contain a physician who can provide the appropriate treatment and the treatment is approved by the employer or the insurer.”

1 liable for the cost of any approved medical treatment in accordance with section 5307.1 or  
2 5307.11.”

3 The foregoing provisions allow an applicant to treat with any physician of his or her  
4 choice within the MPN, and also afford a multi-level appeal process where treatment and/or  
5 diagnosis are disputed. Consistent with these provisions, section 4616.6 provides: “No additional  
6 examinations shall be ordered by the appeals board and no other reports shall be admissible to  
7 resolve any controversy arising out of this article.” Thus, section 4616.6 precludes the  
8 admissibility of non-MPN medical reports with respect to disputed treatment and diagnosis issues,  
9 i.e., “any controversy arising out of this article.” Here, for unknown reasons, the applicant almost  
10 immediately chose to go outside the MPN and seek treatment in violation of the MPN statutes and  
11 procedures. Subsequently, the WCJ awarded compensation, i.e., temporary disability indemnity,  
12 based on the reports of the unauthorized, non-MPN physician. As discussed below, the reports of  
13 non-MPN physicians are inadmissible and therefore may not be relied on to award compensation.

14 The definition of the “primary treating physician” [PTP] set forth in AD Rule 9785(a)(1)  
15 (Cal. Code Regs., tit. 8, § 9785(a)(1)) includes the physician selected “in accordance with the  
16 physician selection procedures contained in the [MPN] network pursuant to [section] 4616.” AD  
17 Rule 9785(b)(1) (Cal. Code Regs., tit. 8, § 9785(b)(1)) further provides that “[a]n employee shall  
18 have no more than one [PTP] at a time.” In addition, pursuant to AD Rule 9785(b)(3) (Cal. Code  
19 Regs., tit. 8, § 9785(b)(3)), if an employee “disputes a medical determination made by the [PTP]...  
20 the dispute shall be resolved under the applicable procedures set forth in [sections] 4061 and  
21 4062,” and “[n]o other [PTP] shall be designated by the employee unless and until the dispute is

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25 resolved.”<sup>5</sup> Thus, where an applicant has left a validly established and properly noticed MPN and  
26 impermissibly sought treatment outside the MPN, the non-MPN physician cannot be the PTP; the

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<sup>5</sup> One of the disputes mentioned by AD Rule 9785(b)(3) is “a determination that the employee shall be released from care.” Section 4062(a) sets forth procedures where either the employee or employer “objects to a medical

1 MPN treater remains the PTP.<sup>6</sup> As stated by section 4061.5 and AD Rule 9785(d) (Cal. Code  
2 Regs., tit. 8, § 9785(d)), the PTP “shall render opinions on all medical issues necessary to  
3 determine the employee’s eligibility for compensation.”

4 In *Tenet/Centinela Hospital Medical Center v. Workers’ Comp. Appeals Bd. (Rushing)*  
5 (2000) 80 Cal.App.4th 1041 [65 Cal.Comp.Cases 477], the applicant disagreed with the opinion of  
6 her PTP, Dr. Glousman, who had found her condition to be permanent and stationary, released her  
7 to return to work without restriction, and prescribed no further doctor-involved treatment or visits.  
8 Rather than select a qualified medical evaluator (QME) under sections 4061 and 4062 to resolve  
9 her dispute, applicant retained counsel and began treating with Dr. Stokes, whose report was  
10 ultimately relied on to award applicant compensation.

11 The Court in *Rushing* held that because the applicant was discharged from care by Dr.  
12 Glousman, her PTP, and she disputed his findings, applicant was not entitled to seek medical  
13 treatment with Dr. Stokes without first complying with the provisions of sections 4061 and 4062  
14 by submitting the issue of treatment to an agreed medical evaluator (AME) or a QME. The Court  
15 stated, at 80 Cal.App.4th p. 1048, [65 Cal.Comp.Cases at p. 482] :

16 “When there are disputes about the appropriate medical treatment,  
17 temporary or permanent disability, vocational rehabilitation, the disability  
18 rating, or the need for continuing medical care, Labor Code sections 4061 or  
19 4062 apply. (*Keulen v. Workers’ Comp. Appeals Bd., supra*, 66 Cal.App.4th  
20 at p. 1096.) Sections 4061 and 4062 of the Labor Code establish the  
21 procedures for resolving such disagreements. *Rushing* was, therefore  
22 required to follow the Labor Code sections 4061 and 4062 procedures to  
23 resolve the dispute before she could legitimately select a new [PTP].”

24 Similarly, here, and we reiterate that for purposes of this opinion we are proceeding under  
25 the assumption of a validly established and properly noticed MPN, the applicant could not select a  
26 new PTP outside the MPN. As set forth above, she should have either changed treating physicians

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27 determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610,” which, in addition to temporary disability, would also include medical treatment issues. As stated above, however, the MPN statutes contain specific provisions for addressing disputes over treatment and diagnosis within the MPN, and section 4616.6 provides that “[n]o additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any controversy arising out of this article.” Thus, while medical treatment and diagnosis issues must be resolved within the MPN, as discussed below, disputes concerning temporary or permanent disability are to be resolved under sections 4061 and 4062, i.e., outside the MPN.

<sup>6</sup> Of course, where an applicant has refused at the outset to treat within a validly established MPN, the fact that there has been no PTP within the MPN, does not render the non-MPN doctor a PTP.

1 within the MPN and/or sought the opinion of a second or third MPN physician, etc. Therefore, the  
2 non-MPN physician is not authorized to be a PTP, and accordingly, is not authorized to report or  
3 render an opinion on “medical issues necessary to determine the employee’s eligibility for  
4 compensation” under section 4061.5 and AD Rule 9785(d). (Cal. Code Regs., tit. 8, § 9785(d).)  
5 Moreover, for disputes involving temporary and/or permanent disability, neither an employee nor  
6 an employer are allowed to unilaterally seek a medical opinion to resolve the dispute, but must  
7 proceed under sections 4061 and 4062.<sup>7</sup> Accordingly, the non-MPN reports are not admissible to  
8 determine an applicant’s eligibility for compensation, e.g., temporary disability indemnity.

9 Furthermore, we conclude that neither section 4605 nor section 5703(a) justifies the  
10 admission of reports from non-MPN doctors where treatment was improperly obtained outside the  
11 MPN.

12 Section 4605 provides:

13 “Nothing contained in this chapter shall limit the right of the employee to  
14 provide, at his own expense, a consulting or any attending physicians  
whom he desires.”

15 Section 5703(a) provides:

16 “The appeals board may receive as evidence either at or subsequent to a  
17 hearing, and use as proof of any fact in dispute, the following matters, in  
addition to sworn testimony presented in open hearing:

18 (a) Reports of attending or examining physicians.”

19 We first note that neither section 4605 nor section 5703(a) uses the term “treating  
20 physician.” Moreover, section 4605 recognizes both the practical and legal issues involved in  
21 attempting to restrict the right of individuals to seek a doctor of their own choosing, especially at  
22 their own expense. Furthermore, section 4605 does not address the issue of admissibility, including  
23 that of improperly obtained non-MPN medical reports, but merely allows for consulting and  
24 attending physicians at an employee’s own expense. Therefore, we conclude that section 4605 does  
25 not justify the admission of unauthorized non-MPN medical reports. This determination is

26 <sup>7</sup> For disputes involving temporary disability, section 4062(a) provides that a medical evaluation shall be obtained  
27 pursuant to sections 4062.2 for represented employees and under section 4062.1 for unrepresented employees. For  
disputes involving permanent disability, section 4061(c) provides that a medical evaluation shall be obtained pursuant  
to sections 4062.2 for represented employees, and section 4061(d) provides that a medical evaluation shall be obtained  
pursuant to sections 4062.1 for unrepresented employees.

1 supported by the reasons previously given for finding such non-MPN medical reports inadmissible:  
2 a validly established and properly noticed MPN; the opportunities within the MPN both to change  
3 treating physicians and to dispute opinions regarding diagnosis and treatment, including the  
4 limitations on admissibility under section 4616.6 for such disputes; the provisions requiring the  
5 PTP to “render opinions on all medical issues necessary to determine the employee’s eligibility for  
6 compensation” (Lab. Code, § 4061.5; Cal. Code Regs., tit. 8, § 9785(d)); and the provisions for  
7 resolving disputes regarding temporary and permanent disability under sections 4061 and 4062.

8 For these same reasons, coupled with the fact that section 5703(a) is discretionary, i.e.,  
9 “[t]he appeals board *may* receive as evidence...” (italics added), we also conclude that  
10 unauthorized non-MPN medical reports are not admissible under section 5703(a). That is, our  
11 discretion should not be used to admit medical reports or testimony in lieu of such reports resulting  
12 from an unauthorized departure outside the MPN.<sup>8</sup>

13 Finally, the concurring and dissenting opinion of Commissioner Caplane asserts that our  
14 decision effectively deprives injured workers from receiving compensation in these circumstances.  
15 On the contrary, it is those applicants who have chosen to disregard a validly established and  
16 properly noticed MPN, despite the many options to change treating physicians and challenge  
17 diagnosis or treatment determinations within the MPN, and to dispute temporary or permanent  
18 disability opinions under sections 4061 and 4062 outside the MPN, who have removed themselves  
19 from the benefits provided by the Labor Code.

20  
21 **B. Where Unauthorized Treatment Was Obtained Outside the MPN, a Defendant Is Not  
22 Liable for the Cost of the Inadmissible Reports from Non-MPN Physicians**

23 As stated previously, we held, in *Knight, supra*, 71 Cal.Comp.Cases at p. 1435, that the

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24 <sup>8</sup> We acknowledge that in some prior Appeals Board panel decisions it was determined that medical reports from  
25 treatment obtained outside a validly established and properly noticed MPN were admissible. Panel decisions, however,  
26 are not binding precedent on other Appeals Board panels (including even the same panel or panel members in a  
27 subsequent case) or on WCJs. (Lab. Code, §115; Cal. Code Regs., tit. 8, § 10341; *Garcia, supra*, 126 Cal.App.4th at  
p. 313, fn. 5 [70 Cal.Comp.Cases 109, 120, fn. 5]; *Gee, supra*, 96 Cal.App.4th at p. 1425, fn. 6 [67 Cal.Comp.Cases  
236, 239, fn. 6].) Nor do panel decisions undergo the expanded discussion and analysis of the Appeals Board as a  
whole consistent with preparing an en banc opinion. For the reasons stated previously in finding unauthorized, non-  
MPN reports inadmissible, we disavow any panel decision to the contrary.

1 defendant's failure to provide an injured employee with notice of his or her rights under the MPN  
2 which resulted in a neglect or refusal to provide reasonable medical treatment, rendered the  
3 defendant liable for the reasonable medical treatment self-procured by the employee. In *Knight*,  
4 the applicant testified that he never received written notice about the MPN and there was no  
5 written notice in evidence. In addition, the applicant was never provided notice of whether an  
6 MPN physician had been designated as his PTP, nor was he notified of his rights to be treated by  
7 an MPN physician of his choice after his first visit, and to obtain second and third opinions.

8 Conversely, where there has been no neglect or refusal to provide reasonable medical  
9 treatment, a defendant is not liable for the medical treatment procured outside the MPN. This is  
10 consistent with section 4605, which provides: "Nothing contained in this chapter shall limit the  
11 right of the employee to provide, *at his own expense*, a consulting or any attending physicians  
12 whom he desires." (emphasis added.) Accordingly, having determined that where treatment was  
13 improperly obtained outside the MPN, any non-MPN medical reports are inadmissible, we can  
14 discern no reason to find a defendant liable for the cost of such reports.

### 15 **III. DISPOSITION**

16 As set forth throughout this opinion, whether the defendant had a validly established MPN  
17 and whether it provided the required MPN notices to the applicant are highly relevant to determine  
18 the propriety of the applicant seeking treatment outside the MPN and the reliance on a non-MPN  
19 physician to award temporary disability benefits. Accordingly, based on the WCJ's deferral of this  
20 issue, his decision must be rescinded, and this matter remanded to the trial level for further  
21 proceedings consistent with this opinion.<sup>9</sup>

22 Finally, we note that should further proceedings determine the existence of a validly  
23 established and properly noticed MPN, then the applicant should comply with the applicable MPN  
24 provisions and resolve any dispute concerning temporary and/or permanent disability under the  
25 procedures set forth in sections 4061 and 4062. On the other hand, should the evidence fail to

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26 <sup>9</sup> As the WCJ who heard this matter has since retired, we will return this matter to the presiding WCJ to assign a new  
27 WCJ. In addition, we note that although the defendant appears to be correct in its assertion there is no evidence to  
support any reimbursement to EDD for benefits paid to the applicant, the issue of reimbursement to EDD is now moot  
in light of our determination that the present record does not support the award of temporary disability benefits and  
our disposition rescinding the WCJ's decision and remanding for further proceedings.

1 determine the existence of a validly established and properly noticed MPN, then the applicant may  
2 continue to treat outside the MPN until the defendant is in compliance with the MPN regulations  
3 (see *Babbit v. Ow Jing dba National Market* (2007) 72 Cal.Comp.Cases 70 (Appeals Board en  
4 banc)) and the WCJ assigned to this matter may award temporary disability benefits on the present  
5 record, or in his or her discretion, may allow defendant to object to the report in question under  
6 section 4062(a) should it be determined under the circumstances of this case that “good cause”  
7 exists to extend the time limits of that section. Of course, any award of temporary disability must  
8 be supported by substantial medical evidence, and if such evidence is lacking, the medical record  
9 should be further developed as expeditiously as possible.

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20 For the foregoing reasons,

21 **IT IS ORDERED**, as the Decision After Reconsideration of the Appeals Board (En Banc),  
22 that the Findings and Award of July 29, 2010, are **RESCINDED** and that this matter is  
23 **RETURNED** to the presiding WCJ for assignment to a new WCJ for further proceedings and  
24 decision consistent with this opinion.

25 **WORKERS' COMPENSATION APPEALS BOARD**

26 /s/ Joseph M. Miller  
27 **JOSEPH M. MILLER, Chairman**

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/s/ James C. Cuneo  
*JAMES C. CUNEO, Commissioner*

/s/ Alfonso J. Moresi  
*ALFONSO J. MORESI, Commissioner*

/s/ Deidra E. Lowe  
*DEIDRA E. LOWE, Commissioner*

*I CONCUR, in part and I DISSENT, in part  
(See attached Concurring and Dissenting Opinion)*

/s/ Frank M. Brass  
*FRANK M. BRASS, Commissioner*

*I CONCUR, in part and I DISSENT, in part  
(See attached Concurring and Dissenting Opinion)*

/s/ Ronnie G. Caplane  
*RONNIE G. CAPLANE, Commissioner*

**DATED AND FILED AT SAN FRANCISCO, CALIFORNIA  
4/20/2011**

**SERVICE MADE BY MAIL ON ABOVE DATE ON THE PERSONS LISTED BELOW AT  
THEIR ADDRESSES AS SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD:  
ELAYNE VALDEZ  
LAW OFFICES OF JEFFREY N. SARDELL  
LAW OFFICES OF JOHN MENDOZA**

*VB/bgr*

**CONCURRING AND DISSENTING OPINION OF  
COMMISSIONER BRASS**

Assuming the existence of a validly established and properly noticed MPN, I concur in the result reached by my fellow Commissioners. I concur, under the facts of this case, that the applicant’s non-MPN medical reports are inadmissible, and that the defendant is not liable for the cost of such reports. I also concur in returning this matter to the trial level to determine the existence of a validly established and properly noticed MPN, as well as the issues of temporary disability and EDD’s lien.

I dissent because there may be situations when an injured worker has good reasons to seek care outside even a validly established and properly noticed MPN, and thus, an appropriate exercise of authority under section 5703(a) would be to admit the reports of the non-MPN treating

1 physician.

2 In the instant case, it does not appear that applicant made a good faith attempt to treat  
3 within defendant's MPN or to avail herself of the opportunities to change treating physicians  
4 and/or request another opinion. Instead, apparently on the advice of her attorney, she left the  
5 MPN after approximately three weeks. Such behavior should not be condoned. Consequently, if  
6 the existence of a validly established and properly noticed MPN is determined, I concur with the  
7 majority in finding the non-MPN reports inadmissible, thereby reversing the award of temporary  
8 disability benefits based on those reports.

9 Nevertheless, I do not believe that this decision should be used to penalize injured workers  
10 when it would be in their best interest to seek care outside a validly established and properly  
11 noticed MPN. There may be a misdiagnosis, a lack of effective treatment, and/or an unreasonable  
12 delay in providing care. An employee seeking care outside a validly established and properly  
13 noticed MPN already has to pay for that treatment (*Knight v. United Parcel Service* (2006) 71  
14 Cal.Comp.Cases 1423 (Appeals Board en banc); § 4605) and for the cost of any non-MPN  
15 reports. Furthermore, under the majority's opinion, injured workers exercising their right under  
16 section 4605 to seek and pay for their own medical treatment outside the MPN are also foreclosed  
17 from receiving any compensation based on the non-MPN reports.

18 Sections 4061 and 4062 require an injured worker to go outside the MPN to determine  
19 issues of temporary and permanent disability, if they are in dispute. According to the majority's  
20 decision, the opinion of the non-MPN treating physician on those issues, regardless of its merits,  
21 would not even be considered. It must be emphasized that receiving reports into evidence only  
22 means that they will be considered. They may not be relied on unless they constitute substantial  
23 evidence and are the most persuasive indication of the injured worker's condition.

24 Section 5703(a) states that "[t]he appeals board may receive as evidence... [r]eports of  
25 attending or examining physicians," and provides authority to admit the reports of non-MPN  
26 treating physicians. In situations which do not rise to the level of neglect or refusal to provide  
27 reasonable medical treatment, but where an injured worker has nevertheless appropriately sought

1 care outside an MPN, the reports of the non-MPN treating physician should be admitted into  
2 evidence under section 5703(a) for consideration of any issue in dispute.

3  
4 /s/ Frank M. Brass  
**FRANK M. BRASS, Commissioner**

5  
6 **DATED AND FILED AT SAN FRANCISCO, CALIFORNIA**

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

10 **ELAYNE VALDEZ**  
11 **LAW OFFICES OF JEFFREY N. SARDELL**  
12 **LAW OFFICES OF JOHN MENDOZA**

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14 **VB/bgr**

15  
16 **CONCURRING AND DISSENTING OPINION OF**  
**COMMISSIONER CAPLANE**

17 I concur with the majority that a defendant is not liable for the cost of medical reports  
18 obtained by an applicant outside of a validly established and properly noticed MPN, and that such  
19 reports are inadmissible under Labor Code section 4616.6 to resolve any dispute related to  
20 treatment and diagnosis. However, I dissent from the holding that these reports are inadmissible as  
21 to issues of compensation, i.e., temporary disability and permanent disability.

22 Section 4616.6 states:

23 “No additional examinations shall be ordered by the appeals board and no  
24 other reports shall be admissible to resolve *any controversy arising out of*  
25 *this article.*” (emphasis added.)

26 *This article* is 2.3, “Medical Provider Networks” (MPNs), and is comprised of sections  
27 4616-4616.7. These sections deal *exclusively* with diagnosis and treatment, and thus, section  
4616.6 precludes admissibility of reports obtained outside an MPN *only* on those issues. Here,

1 however, the non-MPN medical reports were not admitted and relied on to resolve a dispute over  
2 diagnosis and treatment, but one of compensation, i.e., temporary disability, about which the MPN  
3 statutes are silent. Statutes governing temporary and permanent disability are contained in  
4 Article 3, sections 4650-4664 and are outside the scope of the MPN statutes under Article 2.3.

5 The majority's opinion also fails to give effect to sections 4605 and 5703(a). These  
6 sections were not repealed when the MPN statutes were enacted. It is a fundamental rule of  
7 statutory construction that the Legislature is presumed to be aware of existing law.

8 Section 4605 states that "[n]othing contained in this chapter shall limit the right of the  
9 employee to provide, at his own expense, a consulting or any attending physicians whom he  
10 desires." Thus, injured workers have the right to seek medical care outside a validly established  
11 and properly noticed MPN if they pay for that care. However, by excluding the reports of non-  
12 MPN doctors from evidence, the majority penalizes an applicant for exercising that right by  
13 effectively precluding him or her from receiving any benefits under the workers' compensation  
14 system.

15 The issue of entitlement to temporary and/or permanent disability indemnity is usually  
16 triggered by a medical report from the applicant's treating doctor. Upon receipt of that report, a  
17 defendant can either pay the benefits in question, or object and follow the procedures set forth in  
18 sections 4061 and 4062 to resolve the dispute. Under the majority's holding that reports of non-  
19 MPN physicians are not admissible for any purpose, a defendant when served with such reports  
20 can simply do nothing. Without an admissible medical report, the applicant has been deprived of  
21 the opportunity to even present a claim for temporary or permanent disability indemnity, and has  
22 essentially been removed from the workers' compensation system. This is an unduly harsh result  
23 for exercising the right to seek treatment under section 4605, and certainly one not intended by the  
24 legislature. Moreover, an injured worker, who has exercised the right to seek treatment with a non-  
25 MPN doctor under section 4605, is already liable for both the cost of treatment and any non-MPN  
26 reports, and admitting such reports into evidence merely means they will be considered and not  
27 that they will necessarily be relied on to award compensation. Under the majority's disposition, an

1 applicant would have to return to the MPN before he or she is eligible to receive compensation,  
2 which may needlessly delay the resolution of a case and the provision of benefits to injured  
3 workers.

4 Section 5703(a) provides that “[t]he appeals board may receive as evidence... [r]eports of  
5 attending or examining physicians.” As acknowledged by the majority, there is discretion under  
6 section 5703(a) which, like section 4605, refers to “attending” physicians, to admit into evidence  
7 the reports of non-MPN physicians on issues of compensation. The majority’s opinion, however,  
8 takes away the discretion of the WCJ under this section to admit the reports of non-MPN treating  
9 physicians on these issues in *all* cases where there is a validly established and properly noticed  
10 MPN.

11 The majority has relied in part on *Tenet/Centinela Hospital Medical Center v. Workers’*  
12 *Comp. Appeals Bd. (Rushing)* (2000) 80 Cal.App.4th 1041 [65 Cal.Comp.Cases 477] for its  
13 disposition here. *Rushing*, however, pre-dates the MPN statutes which were enacted under Senate  
14 Bill 899, and does not involve an applicant exercising the right to seek treatment under  
15 section 4605.

16 While I do not condone the actions of an applicant’s attorney directing a client to treat with  
17 a non-MPN physician when a validly established and properly noticed MPN exists, an applicant  
18 nevertheless has the right to do so under section 4605 and should not be penalized for exercising  
19 that right. Moreover, in light of the specific restriction on admissibility to issues of diagnosis and  
20 treatment by section 4616.6, the discretion provided by section 5703(a) can be utilized to admit  
21 non-MPN reports on issues of compensation.

22 The issue here is only the admissibility of the non-MPN doctor’s reports. Once admitted,  
23 the WCJ must decide if the reports constitute substantial evidence and the weight to assign to  
24 them.

25 Where there is a validly established and properly noticed MPN, Article 2.3 gives MPN  
26 doctors exclusive control over issues of diagnosis and treatment. To extend that control to issues  
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1 of compensation goes beyond the MPN statutory mandate and gives no effect to sections 4605 and  
2 5703(a).

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14 Accordingly, I dissent and would affirm the WCJ's decision insofar as he properly  
15 exercised his discretion under section 5703 to admit the reports of the applicant's non-MPN  
16 treating physician on the issue of temporary disability. I would, however, return this matter to the  
17 trial level for the newly assigned WCJ to address the defendant's contention that these reports do  
18 not constitute substantial evidence. If so, the parties should then proceed under sections 4062(a)  
19 and 4062.2 to select either an agreed medical evaluator (AME) or a qualified medical evaluator  
20 (QME).

21  
22 /s/ Ronnie G. Caplane \_\_\_\_\_

23 **RONNIE G. CAPLANE, Commissioner**

24 **DATED AND FILED AT SAN FRANCISCO, CALIFORNIA**

25 **4/20/2011**

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

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**ELAYNE VALDEZ**  
**LAW OFFICES OF JEFFREY N. SARDELL**  
**LAW OFFICES OF JOHN MENDOZA**

*VB/bgr*

1 **WORKERS' COMPENSATION APPEALS BOARD**

2 **STATE OF CALIFORNIA**

3  
4 **Case No. ADJ7232076**

5 **TSEGAY MESSELE,**

6 *Applicant,*

7 **vs.**

8 **PITCO FOODS, INC.; CALIFORNIA  
INSURANCE COMPANY,**

9 *Defendants.*

**OPINION AND DECISION  
AFTER RECONSIDERATION,  
ORDER GRANTING REMOVAL, AND  
DECISION AFTER REMOVAL  
(EN BANC)**

10  
11  
12 The Appeals Board previously granted applicant's petition for reconsideration of the January 20,  
13 2011 decision of the workers' compensation administrative law judge (WCJ), wherein it was found that  
14 the properly assigned qualified medical evaluator (QME) panel in this case was the panel requested by  
15 defendant, not the panel requested by applicant.<sup>1</sup>

16 On reconsideration, applicant contends that the WCJ erred in applying Code of Civil Procedure  
17 (CCP) section 1013 to extend by five calendar days the 10-day time period provided in Labor Code  
18 section 4062.2(b) for the parties to agree on an agreed medical evaluator (AME), during which time  
19 period the parties may not request a panel QME. Applicant further contends that, if CCP section 1013 is  
20 held to apply, the five-day extension would invalidate defendant's panel QME request as well as  
21 applicant's request.

22 Because of the important legal issues regarding the timeline set forth in Labor Code section  
23 4062.2(b) for selecting an AME and requesting a panel QME, the Chairman of the Appeals Board, upon  
24 a majority vote of its members, assigned this case to the Appeals Board as a whole for an en banc

25  
26 <sup>1</sup> The caption of our Opinion and Order Granting Petition for Reconsideration, as well as the WCJ's Finding of Fact and  
27 applicant's Petition for Reconsideration, show applicant's name as "Messele Tsegay." As his correct name appears to be  
"Tsegay Messele," we have used that name in this opinion and have corrected the record in the Electronic Adjudication  
Management System (EAMS).

1 decision. (Lab. Code, § 115.)<sup>2</sup>

2 For the reasons discussed below, we hold: (1) when the first written AME proposal is “made” by  
3 mail or by any method other than personal service, the period for seeking agreement on an AME under  
4 Labor Code section 4062.2(b) is extended five calendar days if the physical address of the party being  
5 served with the first written proposal is within California;<sup>3</sup> and (2) the time period set forth in Labor  
6 Code section 4062.2(b) for seeking agreement on an AME starts with the day after the date of the first  
7 written proposal and includes the last day.<sup>4</sup>

8 **I. BACKGROUND**

9 On January 29, 2010, applicant sustained an admitted industrial injury to his hand. Amendments  
10 to his application added additional body parts.

11 On April 20, 2010, defendant objected by mail to the primary treating physician’s opinion,  
12 pursuant to Labor Code section 4062, and proposed a physician to serve as AME. On April 26, 2010,  
13 applicant’s attorney proposed via fax several different physicians to serve as AME. On May 1, 2010,  
14 applicant submitted to the Division of Workers’ Compensation (DWC) Medical Unit a QME panel  
15 request (Form 106). (See Cal. Code Regs., tit. 8, § 106.) Applicant requested a pain medicine specialist  
16 panel, indicated that the treating physician was a hand specialist, and indicated that the opposing party’s  
17 specialty preference was a hand specialist.<sup>5</sup> On May 4, 2010, defendant submitted a QME panel request.

18 \_\_\_\_\_  
19 <sup>2</sup> En banc decisions of the Appeals Board are binding precedent on all Appeals Board panels and WCJs. (Cal. Code Regs., tit.  
20 8, § 10341; *City of Long Beach v. Workers’ Comp. Appeals Bd. (Garcia)* (2005) 126 Cal.App.4th 298, 313, fn. 5 [70  
21 Cal.Comp.Cases 109, 120, fn. 5]; *Gee v. Workers’ Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67  
22 Cal.Comp.Cases 236, 239, fn. 6].) In addition to being adopted as a precedential decision in accordance with Labor Code  
23 section 115 and WCAB Rule 10341, this en banc decision is being adopted as a precedential decision in accordance with  
24 Government Code section 11425.60(b).

25 <sup>3</sup> To avoid cumbersome verbiage and to reflect the facts of this case, this opinion generally refers to a “five calendar day  
26 extension.” Our holding regarding an extension of the 10-day time period in cases of non-personal service of the first written  
27 AME proposal nonetheless applies in those circumstances described in WCAB Rule 10507 (Cal. Code Regs., tit. 8, § 10507)  
where the extension is for 10 or 20 calendar days, not five days. Rule 10507 provides a 10 calendar day extension for service  
on a party, lien claimant, attorney, or other agent of record with a physical address outside of California but within the United  
States, and a 20 calendar day extension for those with a physical address outside the United States. (See also Code Civ. Proc.,  
§ 1013(a).)

<sup>4</sup> Ordinarily, the time period for agreeing on an AME under Labor Code section 4062.2(b) is 10 days, and the last day of that  
period will therefore be the 10<sup>th</sup> day; however, the parties may agree to additional time, not to exceed 20 days.

<sup>5</sup> Labor Code section 4062.2 requires the party submitting the request to designate “the specialty of the medical evaluator, the  
specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request,  
and the specialty of the treating physician.”

1 Defendant requested a hand specialist panel and indicated that the treating physician was an orthopedic  
2 specialist. Defendant did not state the opposing party's specialty preference.

3 The DWC Medical Unit received applicant's request on May 5, 2010, and issued a panel  
4 consisting of three physicians in the specialty of pain medicine. The DWC Medical Unit received  
5 defendant's request on May 10, 2010, and issued a panel of three hand specialists. On October 6, 2010,  
6 applicant was evaluated by Brendan Morley, M.D., one of the physicians on applicant's panel. (See  
7 Defendant's Exhibit E.)

8 Trial was held on December 29, 2010. The "only issue" was "which of two QME panels is  
9 proper in this matter." (Minutes of Hearing, 1:40-41.) Additionally, the Minutes of Hearing state,

10 "As sub issues:

11 "Defendant contends that the 'Mail Box Rule' applies to extend the period  
12 for applicant to request a panel to 15 days, rather than the 10 days provided  
13 by regulation. In addition, defendant contends that the specialty of  
14 physician selected by applicant is improper and that the proper specialty is  
15 orthopedics." (*Id.* at 2:3-10.)

16 The WCJ served his Finding of Fact on January 20, 2011. He explained in his Opinion on  
17 Decision that if CCP section 1013(a) applies to extend by five calendar days the 10 days within which to  
18 agree on an AME, the first day on which either party could request a panel was May 6, 2010. Relying  
19 on *Poster v. Southern California Rapid Transit District* (1990) 52 Cal.3d 266 (*Poster*), and  
20 distinguishing *Camper v. Workers' Comp. Appeals Bd.* (1992) 3 Cal.4th 679 [57 Cal.Comp.Cases 644]  
21 (*Camper*) and *Alvarado v. Workers' Comp. Appeals Bd.* (2007) 72 Cal.Comp.Cases 1142 (writ den.)  
22 (*Alvarado*), the WCJ concluded that CCP section 1013(a) does apply. He found that applicant's request  
23 was premature and that defendant's panel was the proper one. He did not make any finding regarding  
24 the appropriate specialty.

25 Applicant filed a petition for reconsideration. Defendant filed an answer.

26 In his Report and Recommendation on Petition for Reconsideration (Report), the WCJ  
27 recommended that we grant removal and find both panel requests premature.

We granted reconsideration on April 13, 2011.

1 **II. DISCUSSION**

2 We note initially that applicant’s petition seeks reconsideration of a Finding of Fact determining  
3 which QME panel was properly assigned. The WCJ’s finding did not determine any substantive rights or  
4 liabilities of the parties and was, therefore, not a “final order, decision, or award” within the meaning of  
5 Labor Code sections 5900 and 5903. (See *Maranian v. Workers’ Comp. Appeals Bd.* (2000) 81  
6 Cal.App.4th 1068 [65 Cal.Comp.Cases 650]; *Safeway Stores, Inc. v. Workers’ Comp. Appeals Bd.*  
7 (*Pointer*) (1980) 104 Cal.App.3d 528 [45 Cal.Comp.Cases 410]; *Kaiser Foundation Hospitals v.*  
8 *Workers’ Comp. Appeals Bd. (Kramer)* (1978) 82 Cal.App.3d 39 [43 Cal.Comp.Cases 661].) Because  
9 the WCJ did not issue a final order, his decision was not properly reviewable by reconsideration.  
10 Applicant’s petition should have requested removal instead of reconsideration, and we erred in granting  
11 reconsideration instead of removal. (See Lab. Code, § 5310; Cal. Code Regs., tit. 8, § 10843.) To  
12 correct this error, we will vacate our April 13, 2011 Opinion and Order Granting Petition for  
13 Reconsideration and, deeming applicant’s petition as one for removal, we will grant removal and issue  
14 our Decision After Removal.

15 Under Labor Code section 4062(a), if an injured employee is represented by an attorney the  
16 parties have 20 days to object to a medical determination by the treating physician concerning any  
17 medical issue not covered by sections 4060 or 4061 and not subject to section 4610. “If the employee is  
18 represented by an attorney, a medical evaluation to determine the disputed medical issue shall be  
19 obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained.” (Lab. Code,  
20 § 4062(a).)<sup>6</sup>

21 Labor Code section 4062.2(b) provides,

22 “If either party requests a medical evaluation pursuant to Section 4060,  
23 4061, or 4062, **either party may commence the selection process for an**  
24 **agreed medical evaluator by making a written request naming at least**  
25 **one proposed physician to be the evaluator. The parties shall seek**  
26 **agreement with the other party on the physician, who need not be a**  
27 **qualified medical evaluator, to prepare a report resolving the disputed**

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26 <sup>6</sup> Labor Code section 4062(a) provides that the period of time within which an objection may be made, when an employee is  
27 not represented by an attorney, is 30 days. The employer is then required to provide the unrepresented employee a form with  
which to request a QME panel, (see Cal. Code Regs., tit. 8, § 105), for resolution of the medical dispute pursuant to Labor  
Code section 4062.1.

1 issue. **If no agreement is reached within 10 days of the first written**  
2 **proposal that names a proposed agreed medical evaluator**, or any  
3 additional time not to exceed 20 days agreed to by the parties, **either party**  
4 **may request the assignment of a three-member panel of qualified**  
5 **medical evaluators to conduct a comprehensive medical evaluation.**  
6 The party submitting the request shall designate the specialty of the  
7 medical evaluator, the specialty of the medical evaluator requested by the  
8 other party if it has been made known to the party submitting the request,  
9 and the specialty of the treating physician. The party submitting the request  
10 form shall serve a copy of the request form on the other party.” (Emphasis  
11 added.)

8 **A. When the First Written AME Proposal is “Made” by Mail or by Any Method Other Than**  
9 **Personal Service, the Period for Seeking Agreement on an AME Under Labor Code Section**  
10 **4062.2(b) is Extended Five Calendar Days if the Physical Address of the Party Being Served with**  
11 **the First Written Proposal is Within California.**

11 **1. Code of Civil Procedure Section 1013(a)**

12 CCP section 1013, subdivision (a) provides,

13 “In case of service by mail, the notice or other paper shall be deposited in a  
14 post office, mailbox, subpost office, substation, or mail chute, or other like  
15 facility regularly maintained by the United States Postal Service, in a  
16 sealed envelope, with postage paid, addressed to the person on whom it is  
17 to be served, at the office address as last given by that person on any  
18 document filed in the cause and served on the party making service by  
19 mail; otherwise at that party's place of residence. Service is complete at the  
20 time of the deposit, but any period of notice **and any right or duty to do**  
21 **any act or make any response within any period or on a date certain**  
22 **after service of the document, which time period or date is prescribed**  
23 **by statute or rule of court, shall be extended five calendar days, upon**  
24 **service by mail**, if the place of address and the place of mailing is within  
25 the State of California, 10 calendar days if either the place of mailing or  
26 the place of address is outside the State of California but within the United  
27 States, and 20 calendar days if either the place of mailing or the place of  
address is outside the United States, but the extension shall not apply to  
extend the time for filing notice of intention to move for new trial, notice  
of intention to move to vacate judgment pursuant to Section 663a, or  
notice of appeal. This extension applies in the absence of a specific  
exception provided for by this section or other statute or rule of court.”  
(Emphasis added.)

Subdivision (c) governs service by Express Mail, subdivision (e) governs facsimile transmission, and  
subdivision (g) governs electronic service, all of which provide an extension of two court days.

1           In *Poster, supra*, 52 Cal.3d 266, a personal injury case cited by defendant and relied on by the  
2 WCJ, the plaintiff had served a settlement offer by mail on the defendant pursuant to CCP section 998  
3 and Civil Code section 3291. CCP section 998 required a response within 30 days after the offer was  
4 made, if the defendant wanted to accept the offer. CCP section 998 did not specifically require service of  
5 the settlement offer by mail, but it stated that “any party may serve an offer in writing”; and the  
6 plaintiff’s settlement offer was in fact served by mail. The defendant accepted the offer on the 32<sup>nd</sup> day  
7 after service by mail of the plaintiff’s offer. Noting that CCP section 1013 has been held inapplicable to  
8 statutes that set forth jurisdictional deadlines, the Supreme Court held that the 30-day response  
9 requirement of CCP section 998 was not jurisdictional, and that CCP section 1013 applied to extend the  
10 period to respond by five days.

11           The Court stated, “Under section 998, the 30-day period runs from the time the offer is ‘made.’  
12 Because an offeror ‘makes’ the offer by serving it in writing, when a section 998 offer is served by mail  
13 it is clear that the statutory period for response runs from the service by mail.” (52 Cal.3d at p. 274, fn.  
14 4.)

15           With regard to CCP section 1013, the Court said,

16                   “By its terms, section 1013 appears clearly to apply to the time period  
17 prescribed by section 998 for accepting statutory offers of compromise.  
18 Section 1013 applies to the service by mail of a ‘notice or other paper’  
19 which would certainly include a section 998 settlement offer. And by  
20 specifically extending for five days ‘any prescribed period...to do any act  
21 or make any response’ to any paper served by mail, section 1013 appears  
22 clearly to apply to the time period for accepting a statutory settlement  
23 offer. In light of the language of section 1013, and the general applicability  
24 of its provisions, there appears to be no sound reason not to apply the  
25 statute in this context.” (52 Cal.3d at p. 274.) (Footnote omitted.)

26           Accordingly, the Court concluded “that when a statutory settlement offer pursuant to section 998 is  
27 served by mail, the provisions of section 1013 apply and extend the 30-day period for acceptance of the  
offer by 5 days.” (52 Cal.3d at p. 275.)

          In *Camper, supra*, 3 Cal.4th 679 [57 Cal.Comp.Cases 644], cited by applicant in the present case,  
the employee filed a petition for writ of review 50 days after the Appeals Board issued its decision in

1 response to the employee’s petition for reconsideration. The Supreme Court held CCP section 1013  
2 inapplicable to the 45-day period within which to file a petition for writ of review from a decision of the  
3 Appeals Board. Labor Code section 5950 provided that “application for writ of review must be made  
4 within 45 days after a petition for reconsideration is denied, or, if a petition is granted or reconsideration  
5 is had on the appeals board’s own motion, within 45 days *after the filing* of the order, decision, or award  
6 following reconsideration.” (Emphasis added.) Because the Court determined that the “operative  
7 trigger” for the time period set forth in Labor Code section 5950 was the “filing” of the denial of  
8 reconsideration or the decision following reconsideration, and not “service” of the order, the Court found  
9 no basis for extending the 45-day period. (3 Cal.4th at p. 684 [57 Cal.Comp.Cases at p. 647].) The  
10 Court explained that “‘cases have consistently held that where a prescribed time period is commenced by  
11 some circumstance, act or occurrence other than service,’” CCP section 1013 will not apply; but, “‘where  
12 a prescribed time period is triggered by the term “service” of a notice, document or request then section  
13 1013 will extend the period.’” (3 Cal.4th at pp. 684-685 [57 Cal.Comp.Cases at p. 647].)

14 The Court specifically considered its previous decision in *Poster* and found it “clearly  
15 distinguishable.” (3 Cal.4th at p. 686 [57 Cal.Comp.Cases at p. 648].)

16 “In *Poster*, we held that the 30-day period for the acceptance of a statutory  
17 settlement offer pursuant to Code of Civil Procedure section 998 is  
18 extended by section 1013 when it is served by mail. Section 998 provides  
19 that the applicable time period runs from the time that the offer is ‘made.’  
20 We reasoned that ‘[b]ecause an offeror “makes” the offer by serving it in  
21 writing, when a section 998 offer is served by mail it is clear that the  
22 statutory period for response runs from the service by mail.’ (*Poster*,  
23 *supra*, 52 Cal.3d at p. 274, fn. 4.) As **the offer cannot be ‘made’ without  
communicating it through service**, the trigger adopted by the Legislature  
for the prescribed time period in section 998 necessarily included service;  
the same cannot be said about the trigger adopted for Labor Code section  
5950. Filing is accomplished independently of service.” (3 Cal.4th at p.  
686 [57 Cal.Comp.Cases at pp. 648-649].) (Emphasis added.)

24 The *Camper* Court added that even if it were persuaded that Labor Code section 5950, when read  
25 in light of the WCAB Rules,<sup>7</sup> incorporated the CCP section 1013 extension, it would still hold the  
26

27 <sup>7</sup> At the time of the *Camper* decision, WCAB Rule 10507 (Cal. Code. Regs., tit. 8, § 10507) provided, “The requirements of  
Code of Civil Procedure Section 1013 shall govern all service by mail.” See this opinion’s discussion below of Rule 10507, as  
amended effective November 17, 2008.

1 extension inapplicable because section 1013's extension for service by mail has been held inapplicable to  
2 jurisdictional deadlines; and "it is now too well established to question that the time limitation set forth in  
3 Labor Code section 5950 is jurisdictional." (3 Cal.4th at p. 686 [57 Cal.Comp.Cases at p. 649].)

4 Similarly, in *Alvarado, supra*, 72 Cal.Comp.Cases 1142,<sup>8</sup> the Appeals Board panel found CCP  
5 section 1013 inapplicable to extend the time for a party to strike a physician's name from a QME panel,  
6 because the operative trigger for the time period was not service. The trigger in *Alvarado* was  
7 assignment of the panel: "the time limits prescribed by Labor Code § 4062.2(c) run from the date of  
8 assignment of the three-member panel, not from service of the panel." (72 Cal.Comp.Cases at p. 1145.)

9 While none of the cases cited by the parties are directly on point, they provide some guidance.  
10 As the Supreme Court said in *Poster*, an offer is "made" when it is served in writing. The Court further  
11 explained in *Camper* that an offer cannot be made "without communicating it through service." Labor  
12 Code section 4062.2(b) provides that the procedure for selecting an AME commences with either party  
13 "making a written request naming at least one proposed physician to be the evaluator." If that written  
14 request is not served on the other party in some manner, the AME selection process cannot commence.  
15 In the strictest, most literal sense, Labor Code section 4062.2(b) does not specifically require "service" of  
16 the first written AME proposal. No triggering event is specified for the 10-day period other than the  
17 "making" of the first written proposal. However, consistent with the Supreme Court's decisions in  
18 *Poster* and *Camper*, we do not consider a request made unless it is communicated in writing to the other  
19 party. Applicant's attempt to read significance into Labor Code section 4062.2(b)'s explicit requirement  
20 to "serve" a copy of the QME panel request on the other party and the absence of such an explicit  
21 requirement for the first written AME proposal is unpersuasive. The party requesting a QME panel  
22 submits that request to the DWC Medical Unit. It, therefore, makes sense to require explicitly that a

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24 <sup>8</sup> "Writ denied" cases are citable authority as to the holding of the Appeals Board panel in its underlying decision. (E.g.,  
25 *Farmers Ins. Group of Companies v. Workers' Comp. Appeals Bd. (Sanchez)* (2002) 104 Cal.App.4th 684, 689, fn. 4 [67  
26 Cal.Comp.Cases 1545]; *Bowen v. Workers' Comp. Appeals Bd.* (1999) 73 Cal.App.4th 15, 21, fn. 10 [64 Cal.Comp.Cases  
27 745].) However, unlike Appeals Board en banc decisions, which are binding on WCJs and Appeals Board panels (Cal. Code  
Regs., tit. 8, § 10341; *Gee v. Workers' Comp. Appeals Bd., supra*, 96 Cal.App.4th at p. 1425, fn. 6), Appeals Board panel  
decisions, even if appellate review is denied, are not binding precedent and have no stare decisis effect. (*MacDonald v.*  
*Western Asbestos Co.* (1982) 47 Cal.Comp.Cases 365, 366 (Appeals Board en banc).)

1 copy of the request be served on the opposing party. The written proposal for an AME, on the other  
2 hand, is communicated directly to the opposing party; there is no need for a redundant service  
3 requirement.

4 Joint selection of an AME cannot occur if the process is not initiated by communication of the  
5 first written proposal. Therefore, when the first written AME proposal is made by mail, the five calendar  
6 day extension applies and guarantees the parties the full 10-day period determined appropriate by the  
7 Legislature for negotiation and selection of an AME.

8 We will now consider additional authority for the five calendar day extension.

9 **2. Labor Code and WCAB Rules**

10 Labor Code section 5708 states that the WCAB is not bound by the common law or statutory  
11 rules of evidence and procedure, but is bound by Division 4 of the Labor Code and the WCAB's own  
12 Rules of Practice and Procedure.

13 Labor Code section 5316 provides, "Any notice, order, or decision required by this division to be  
14 served upon any person either before, during, or after the institution of any proceeding before the appeals  
15 board, may be served in the manner provided by Chapter 5, Title 14 of Part 2 of the Code of Civil  
16 Procedure, unless otherwise directed by the appeals board. In the latter event the document shall be  
17 served in accordance with the order or direction of the appeals board." Chapter 5, Title 14 of Part 2 of  
18 the CCP includes section 1013.

19 WCAB Rule 10507, as effective November 17, 2008, "otherwise" directs, as follows:

20 "(a) If a document is served by mail, fax, e-mail, or any method other than  
21 personal service, the period of time for exercising or performing any right  
or duty to act or respond shall be extended by:

22 "(1) five calendar days from the date of service, if the physical address  
23 of the party, lien claimant, attorney, or other agent of record being served  
is within California;

24 "(2) ten calendar days from the date of service, if the physical address  
25 of the party, lien claimant, attorney, or other agent of record being served  
26 is outside of California but within the United States; and  
27

1           “(3) twenty calendar days from the date of service, if the physical  
2 address of the party, lien claimant, attorney, or other agent of record being  
3 served is outside the United States.

4           “(b) For purposes of this section, ‘physical address’ means the street  
5 address or Post Office Box of the party, lien claimant, attorney, or other  
6 agent of record being served, as reflected in the Official Address Record at  
7 the time of service, even if the method of service actually used was fax, e-  
8 mail, or other agreed-upon method of service.

9           “(c) This rule applies whether service is made by the Workers’  
10 Compensation Appeals Board, a party, a lien claimant, or an attorney or  
11 other agent of record.”

12           Thus, Rule 10507(a)(1) extends for five calendar days the period of time for exercising or  
13 performing any right or duty to act or respond, if a document is served by any method other than  
14 personal service on a party whose physical address is within California. Labor Code section 5316  
15 applies to service “upon any person,” and subdivision (c) of Rule 10507 expressly provides that the rule  
16 applies to documents served, not just by the WCAB, but also by “a party, a lien claimant, or an attorney  
17 or other agent of record.” Written proposals to utilize an AME fall within these provisions, and the  
18 period in which to exercise the right to select an AME is, therefore, extended as provided by Rule  
19 10507.

20           When the WCAB amended Rule 10507, effective November 17, 2008, it made a deliberate  
21 decision to deviate from the provisions of CCP section 1013 pertaining to service by methods other than  
22 mail. Describing the differences between CCP section 1013 and the proposed amended Rule 10507, the  
23 Final Statement of Reasons for Rule 10507 stated at page 30, “The WCAB has concluded, however, that  
24 less confusion will result if the time extensions of five calendar days, ten calendar days, and twenty  
25 calendar days apply to *all* non-personal service, whether made by first-class mail or by some other  
26 authorized method.”<sup>9</sup>

27           Pursuant to Labor Code sections 5708 and 5316, the WCAB's Rules govern service if they differ  
from CCP section 1013. Because current Rule 10507 provides a five calendar day extension for service

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<sup>9</sup> ([http://www.dir.ca.gov/WCAB/WCABProposedRegulations/WCAB\\_RulesofPracticeandProcedure/WCAB\\_FSOR.doc](http://www.dir.ca.gov/WCAB/WCABProposedRegulations/WCAB_RulesofPracticeandProcedure/WCAB_FSOR.doc).)  
(Emphasis in original.)

1 by mail, fax, e-mail, or any method other than personal service, its provisions are no longer identical to  
2 CCP section 1013; and Rule 10507 is, therefore, the controlling authority.

3 In the present case, defendant mailed its first written AME proposal, so the extensions provided  
4 by Rule 10507 and CCP section 1013(a) are the same — five calendar days.<sup>10</sup> The record in EAMS  
5 shows that applicant designated U.S. mail as the preferred method of service. (See Cal. Code Regs., tit.  
6 8, § 10218(a).) Defendant’s written AME proposal was sent by mail on April 20, 2010, and applicant  
7 responded to it six days later. While there may be other cases where the exact date of service of the first  
8 written AME proposal is disputed,<sup>11</sup> there is no doubt or dispute in this case. The WCJ was correct in  
9 calculating that May 6, 2010, the 16<sup>th</sup> day after service of the first written proposal, was the first day on  
10 which a valid request for a QME panel could be made. Applicant’s QME panel request shows a  
11 “Request date” of May 1, 2010, and defendant’s request shows a “Request date” of May 4, 2010.

12 Applicant’s argument that his request was timely is simple. His request was made on the 11<sup>th</sup>  
13 day, and he argued that the five calendar day extension is inapplicable – an argument we reject.  
14 Applicant’s request was premature.

15 Defendant’s argument that its request was timely is not clearly stated: “[W]hen Defendant made  
16 their request for a panel of QMEs waiting the 10 days plus 5 days on May 4, 2010, they waited the  
17 proper time as required as it was received by the DWC-Medical Unit on May 10, 2010.” (Defendant’s  
18 Answer to Applicant’s Petition for Reconsideration, 3:11-14.) Defendant acknowledges that the five  
19 calendar day extension applies, but its conclusion that its request was timely is incorrect. Pursuant to the  
20 rule for computing time, which is discussed below and applied in this opinion, defendant’s request —  
21

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22 <sup>10</sup> See WCAB Rule 10508 (Cal. Code Regs., tit. 8, § 10508), which provides that the act or response may be performed or  
23 exercised upon the next business day, if the last day for exercising or performing any right or duty to act or respond falls on a  
24 weekend or on a holiday for which the WCAB offices are closed. Pursuant to Rule 10508 and pursuant to the rule for  
25 computing time discussed below, if the 15<sup>th</sup> day for agreeing on an AME falls on a weekend or holiday, the next business day  
26 counts as the 15<sup>th</sup> day; and a panel may be requested on the following day, the 16<sup>th</sup> day. For the purpose of determining when a  
27 panel request may be made, it does not matter if the 10<sup>th</sup> day after the first written AME proposal falls on a weekend or  
28 holiday, unless the proposal was personally served, in which case the 10<sup>th</sup> day would be the next business day.

<sup>11</sup> Although Labor Code section 4062.2(b) may not explicitly require “service” of the AME proposal, the wise practitioner will  
avoid any doubt as to when the first written proposal was “made” by including proof of service. (See Cal. Code Regs., tit. 8, §  
10505.)

1 made on the 14<sup>th</sup> day — was premature as well. Defendant is also incorrect if it argues that the date the  
2 DWC Medical Unit received its request is somehow relevant to the request’s timeliness. The action  
3 specified in Labor Code section 4062.2(b), which may not occur until after completion of the required  
4 time period for negotiating an AME, is the “request” for a panel QME, not receipt of the request.

5 We add that while the time periods set forth in section 4062.2(b) are “mandatory” they are not  
6 “jurisdictional” in the “fundamental sense” discussed in *Poster*, i.e., “failure to comply does not render  
7 the proceeding void.” (52 Cal.3d at pp. 274-275.) Hence, to the extent one may argue that Rule 10507,  
8 like CCP section 1013, is inapplicable to statutes that set forth jurisdictional deadlines, Labor Code  
9 section 4062.2(b) presents no such impediment.

10 **B. The Time Period Set Forth in Labor Code Section 4062.2(b) for Seeking Agreement on an AME**  
11 **Starts With the Day After the Date of the First Written Proposal and Includes the Last Day.**

12 CCP section 12, Civil Code section 10, and Government Code section 6800 provide, “The time in  
13 which any act provided by law is to be done is computed by excluding the first day, and including the  
14 last, unless the last day is a holiday, and then it is also excluded.” These statutory provisions state “the  
15 ordinary rule of computation of time, which excludes the first day and includes the last... .” (*Ley v.*  
16 *Dominguez* (1931) 212 Cal. 587, 594.) “Where the law requires or permits an act to be done within a  
17 statutory period of time or number of days, the question becomes one simply of the measurement of time,  
18 and so measuring time the first day is excluded, all of the last day included, and fractions of days are  
19 totally and universally disregarded. The acting party has all of the last day within which to proceed.”  
20 (*Scoville v. Anderson* (1901) 131 Cal. 590, 596.) “The gravest considerations of public order and  
21 security require that the method of computing time be definite and certain. Before a given case will be  
22 deemed to come under an exception to the general rule the intention must be clearly expressed that a  
23 different method of computation was provided for.” (*Ley v. Dominguez, supra*, 212 Cal. at pp. 594-595.)  
24 “Absent a compelling reason for a departure, this rule governs the calculation of *all* statutorily prescribed  
25 time periods. Our Supreme Court has encouraged the use of uniform rules so that the method of  
26 computing time not be a source of doubt or confusion.” (*In re Anthony B.* (2002) 104 Cal.App.4th 677,  
27 682 (italics in original); see also *Latinos Unidos de Napa v. City of Napa* (2011) 196 Cal.App.4th 1154,

1 1161.)

2 In *Johnson v. Kaeser* (1925) 196 Cal. 686, a conditional sales contract provided for monthly  
3 installment payments to be made on the first day of each month or “within ten days thereafter.” The  
4 Court found premature an action brought for default in the payment of an installment on the 11<sup>th</sup> day of  
5 the month, stating,

6 “The installments were due and payable on the first day of each month, or  
7 ‘within ten days thereafter.’ Thus the defendants, by the terms of the  
8 contract, had all of the eleventh day of May, 1923, to pay the installment  
9 for said month. In other words, the ten days began to run after the first day  
10 of the month, or on the second day thereof, the first day of the month being  
11 excluded in the computation of the time. (Civ. Code, sec. 10; Code Civ.  
12 Proc., sec. 12.) ... The action was brought on the eleventh day of May, the  
last day of the ten; hence the defendants, before action brought, were not  
given the full ten days to which they were entitled within which to make  
the May payment. The bringing of the action was, therefore, premature.”  
(196 Cal. at pp. 700-701.)

13 In *Latinos Unidos de Napa v. City of Napa, supra*, 196 Cal.App.4th 1154, the Court applied CCP  
14 section 12 to compute the 30-day time period the city was required by Public Resources Code section  
15 21152 to post a notice of determination. It found that the city had not demonstrated any “clear  
16 expression of intent, or compelling reason, to except the computation” of the 30-day period from the  
17 general rule of CCP section 12. (*Id.* at p. 1161.) Consistent with CCP section 12, the Court did not count  
18 the first day of posting. It found that the 30-day posting requirement was not satisfied because the notice  
19 of determination was not posted for the entire last day, i.e., the 30th day. Rejecting an argument of  
20 “substantial compliance,” the Court emphasized, “Predictability and certainty are the twin guiding virtues  
21 that enable people to comply with legal requirements.” (*Id.* at p. 1167.)

22 Pursuant to this “ordinary” rule for computing time, in those cases where the parties have not  
23 agreed to “additional time not to exceed 20 days” (Lab. Code, § 4062.2(b)), the 10-day time period for  
24 agreeing on an AME excludes the first day, the date of the first written proposal, and includes the last,  
25 i.e., the 10th, day. The parties have the entire 10th day in which to reach agreement on an AME, and a  
26 request for a panel QME filed before the end of the 10th day would be premature.

27 If the first written AME proposal is personally served, and the 10-day time period is therefore not

1 extended, a request for a panel QME may be made only after the 10th day, i.e., on the 11th day or later.  
2 If the first written proposal is served by mail or by any method other than personal service, and the 10-  
3 day time period for agreeing on an AME is consequently extended five calendar days, a request for a  
4 panel QME may be made only after the 15th day, i.e., on the 16th day or later.

5 Turning to the present case, we initially observe that applicant has not demonstrated any clear  
6 expression of intent or compelling reason not to compute the 10-day time period using the ordinary rule.  
7 (See *Latinos Unidos de Napa v. City of Napa*, *supra*, 196 Cal.App.4th at p. 1161; *Ley v. Dominguez*,  
8 *supra*, 212 Cal. at pp. 594-595.) The WCJ applied the rule correctly to determine that May 6, 2010 —  
9 the 16<sup>th</sup> day after the first written AME proposal — was the first day a panel request was permissible.  
10 Applicant’s panel QME request was made on the 11<sup>th</sup> day after defendant’s April 20, 2010 first written  
11 AME proposal — on May 1, 2010. The WCJ found it premature because he concluded that CCP section  
12 1013(a) extends the time for agreeing on an AME by five calendar days. For the same reason, the WCJ  
13 concluded in his Report that defendant’s May 4, 2010 panel QME request was also premature because it  
14 was made on May 4, 2010, the 14<sup>th</sup> day after defendant’s April 20, 2010 AME proposal. The WCJ  
15 correctly stated that either party may file a request for a QME panel, but neither may do so before  
16 expiration of the 10-day period, plus five calendar days because the first written AME proposal was  
17 mailed.

18 CCP section 12, Civil Code section 10, and Government Code section 6800 state the general rule  
19 for computation of time, applicable to all statutorily prescribed time periods, regardless of whether they  
20 govern the time within which to do something or the time within which a particular action may not be  
21 taken. Pursuant to this rule, Labor Code section 4062.2(b) designates 10 days, excluding the date of the  
22 first written proposal, for agreement on an AME after which either party may request a QME panel.  
23 Labor Code section 4062.2(b) envisions use of this time period for negotiation and selection of an AME  
24 — the first and preferred option for obtaining a medical evaluation. This section commands that the  
25 “parties shall seek agreement with the other party on the physician....” This mandated time period  
26 provides each party with a guaranteed time within which to consider the other party’s proposal(s) and to  
27 propose other AMEs, without the risk that the other party may request a QME panel during this period.

1 **III. CONCLUSION**

2 We will vacate our grant of reconsideration of the WCJ's non-final decision regarding the  
3 properly assigned QME panel. We deem applicant's petition for reconsideration a petition for removal,  
4 and we will grant removal. As our Decision After Removal, we will rescind the WCJ's finding that  
5 Panel No. 1148407 was properly assigned, since defendant's panel request, like applicant's, was  
6 premature.<sup>12</sup> By counting the days according to the rule articulated in CCP section 12, Civil Code  
7 section 10, and Government Code section 6800, and by extending by five calendar days the period for  
8 agreeing on an AME, because defendant's April 20, 2010 written proposal was made by mail, we  
9 determine that the earliest date either party could file a valid QME panel request was May 6, 2010.  
10 Therefore, the panels the DWC Medical Unit issued in response to applicant's May 1, 2010 request and  
11 defendant's May 4, 2010 request were not properly assigned.

12 For the foregoing reasons,

13 **IT IS ORDERED**, as the Decision After Reconsideration of the Workers' Compensation  
14 Appeals Board, that our April 13, 2011 Opinion and Order Granting Petition for Reconsideration is  
15 **VACATED**, and that applicant's petition for reconsideration of the January 20, 2011 Finding of Fact is  
16 deemed a petition for removal.

17 **IT IS FURTHER ORDERED** that removal is **GRANTED**.

18 **IT IS FURTHER ORDERED**, as the Decision After Removal of the Workers' Compensation  
19 Appeals Board, that the January 20, 2011 Finding of Fact is **RESCINDED** and the following  
20 **SUBSTITUTED** in lieu thereof:

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26 <sup>12</sup> Defendant notes at page 2, footnote 1, of its answer that applicant has requested another QME panel since filing his petition  
27 for reconsideration. Defendant argues that this request is invalid because "there is currently a valid panel according to Judge  
Shields' Finding of Fact." The validity of any panel requested after the filing of applicant's petition for reconsideration has  
not been considered by the WCJ and is not properly before us on reconsideration/removal.

1 **FINDING OF FACT**

2 Neither Panel No. 1148407 nor Panel No. 1148235 was properly assigned,  
3 because both panels were requested before expiration of the 10-day period set forth in  
4 Labor Code section 4062.2(b) for agreement on selection of an AME, plus five calendar  
5 days pursuant to WCAB Rule 10507 (Cal. Code Regs., tit. 8, § 10507).

6  
7 **WORKERS' COMPENSATION APPEALS BOARD**

8  
9 /s/ Joseph M. Miller  
**JOSEPH M. MILLER, Chairman**

10  
11 /s/ Frank M. Brass  
**FRANK M. BRASS, Commissioner**

12  
13 /s/ Ronnie G. Caplane  
**RONNIE G. CAPLANE, Commissioner**

14  
15 /s/ Alfonso J. Moresi  
**ALFONSO J. MORESI, Commissioner**

16  
17 /s/ Deidra E. Lowe  
**DEIDRA E. LOWE, Commissioner**

18  
19  
20  
21 **DATED AND FILED AT SAN FRANCISCO, CALIFORNIA**

22 9/26/2011

23 **SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR**  
24 **ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.**

25 **JOHN HILL**  
26 **TSEGAY MESSELE**  
**MONIKA HIGHT**

27 **CB/bea/jmp**



1 panel qualified medical evaluator (QME). We held,

2 “(1) when the first written AME proposal is ‘made’ by mail or by any  
3 method other than personal service, the period for seeking agreement on an  
4 AME under Labor Code section 4062.2(b) is extended five calendar days if  
5 the physical address of the party being served with the first written  
6 proposal is within California; and (2) the time period set forth in Labor  
7 Code section 4062.2(b) for seeking agreement on an AME starts with the  
8 day after the date of the first written proposal and includes the last day.”  
9 (*Messele v. Pitco Foods, Inc.* (2011) 76 Cal.Comp.Cases 956, 958  
10 (*Appeals Board en banc*.) (Footnotes omitted.)

11 As we explained in our November 4, 2011 notice of intention,

12 “Our intention in issuing the September 26, 2011 decision was to clarify  
13 the existing law on issues not previously addressed in a binding Appeals  
14 Board decision and to prevent inconsistencies in rulings by WCJs and  
15 Appeals Board panels. It was not our intention to throw into uncertainty  
16 the validity of QME panels previously obtained in ongoing workers’  
17 compensation proceedings or to allow parties, based on our decision, to  
18 challenge the timeliness of a panel request or the validity of panels to  
19 which they had not previously objected solely because, after the fact, they  
20 were displeased with the make-up of the panel or, worse, because the  
21 resulting QME evaluation produced a report unfavorable to their client. It  
22 was also not our intention to allow reopening of any orders, decisions, or  
23 awards based on our decision. (See Lab. Code, §§ 5803, 5804.)” (2011  
24 Cal. Wrk. Comp. LEXIS 172.) (Footnote omitted.)

25 In addition, the DWC Medical Unit had been overburdened with panel requests even before our  
26 September 26, 2011 decision inadvertently increased the likelihood of multiple panel requests being  
27 made in the same case. We did not wish to exacerbate the delay in parties obtaining QMEs to report on  
disputes involving compensability, medical treatment, and disability. Furthermore, we did not wish to  
encourage litigation over which of multiple QME panels is the correct panel, when the Legislature’s  
obvious intent in establishing the statutory procedure was to streamline the evaluation process.

When it became apparent that our September 26, 2011 decision, while resolving some of the  
issues relating to the timing of QME panel requests, had created confusion about the status of many  
ongoing proceedings and potentially contributed to further litigation and delay over previously  
uncontested evaluations, we issued our notice of intention to clarify our prior decision to explain its  
application to ongoing cases.

1 In *Farris v. Industrial Wire Products* (2000) 65 Cal.Comp.Cases 824, 832 (Appeals Board en  
2 banc) (*Farris*), we discussed the need and appropriateness of applying some decisions prospectively:

3 “In workers’ compensation cases, it is not uncommon to provide that  
4 newly stated judicial rules **or newly stated judicial interpretations of**  
5 **statutes** shall be applied prospectively only. Such a declaration of  
6 prospective application is made primarily to prevent a landslide of  
7 reopenings in previously adjudicated workers’ compensation cases,<sup>8</sup> which  
8 would burden the workers’ compensation system and result in unfairness  
9 to those parties who had relied on a different understanding of law or had  
10 accepted a different application of the law; a declaration of prospective  
11 application may also be made to harmonize statutory provisions. (E.g.,  
12 *LeBoeuf v. Worker’s Comp. Appeals Bd.* (1983) 34 Cal.3d 234, 246, fn. 13  
13 [193 Cal. Rptr. 547, 666 P.2d 989, 48 Cal.Comp.Cases 587, 597, fn. 13];  
14 *Summer v. Worker’s Comp. Appeals Bd.* (1983) 33 Cal.3d 965, 972-973  
15 [191 Cal. Rptr. 811, 663 P.2d 534, 48 Cal.Comp.Cases 369, 375]; *Atlantic*  
16 *Richfield Co. v. Worker’s Comp. Appeals Bd.* (*Arvizu*), *supra*, 31 Cal.3d at  
17 pp. 727-728 [47 Cal.Comp.Cases at pp. 509-510]; *Estrada v. Worker’s*  
18 *Comp. Appeals Bd.* (1997) 58 Cal.App.4th 1458, 1472-1473 [69 Cal. Rptr.  
19 2d 176, 62 Cal.Comp.Cases 1384, 1394-1395]; *Messina v. Worker’s*  
20 *Comp. Appeals Bd.* (1980) 105 Cal.App.3d 964, 971-972 [164 Cal. Rptr.  
21 762, 45 Cal.Comp.Cases 505, 510-511]; *cf.*, *Camper v. Worker’s Comp.*  
22 *Appeals Bd.* (1992) 3 Cal.4th 679, 688-690 [12 Cal Rptr. 2d 101, 836 P.2d  
23 888, 57 Cal.Comp.Cases 644, 650-652].) Although decisions regarding  
24 procedural issues are more commonly given prospective effect than are  
25 decisions regarding substantive issues (e.g., *Camper v. Worker’s Comp.*  
26 *Appeals Bd.*, *supra*, 3 Cal.4th at p. 688 [57 Cal.Comp.Cases at pp. 651-  
27 652]), decisions affecting an applicant’s substantive right to receive or a  
defendant’s substantive duty to pay workers’ compensation benefits will  
be applied prospectively under appropriate circumstances. [Emphasis  
added.]

<sup>8</sup> The Board has continuing jurisdiction over its decisions and, within five years of an injured employee’s date of injury, a Board decision can be reopened upon a showing of good cause. (Lab. Code, §§ 5803, 5804.) Ordinarily, a change in the judicial interpretation of a statute will constitute ‘good cause’ to reopen a Board decision which had been based on prior law. (*Atlantic Richfield Co. v. Workers’ Comp. Appeals Bd. (Arvizu)* (1982) 31 Cal.3d 715, 727-728 [182 Cal. Rptr. 778, 644 P.2d 1257, 47 Cal.Comp.Cases 500, 509]; *State Comp. Ins. Fund v. Industrial Acc. Com. (Dean)* (1946) 73 Cal.App.2d 248, 257 [166 P.2d 310, 11 Cal.Comp.Cases 30, 36].)”

23 In *Farris*, we concluded that our decision in that case, on the application of section 5814 penalties  
24 to unreasonably delayed section 4650(d) penalties, should be applied prospectively to avoid “an undue  
25 burden on the administration of justice in the workers’ compensation system” and the “overwhelming  
26 adverse effect on the workers’ compensation system and on the reasonable expectations of the parties  
27 participating in it.” (65 Cal.Comp.Cases at p. 833.)

1           These considerations apply equally to the purely procedural issues addressed in the present case.  
2 Having invited comments from the community on our proposed modification and having received no  
3 comments in response to our notice of intention, we now amend our September 26, 2011 decision to  
4 clarify that it shall apply prospectively from September 26, 2011. Specifically, if prior to our September  
5 26, 2011 decision, a panel was prematurely but otherwise properly requested and there was no objection  
6 on the ground of prematurity, then the resulting panel may not later be challenged on that ground. In  
7 other words, if an objection based on prematurity was not made prior to our September 26, 2011  
8 decision, neither party may challenge the request, the ensuing panel, the remaining QME following the  
9 striking of names, or the resulting report for prematurity. Of course, other grounds for challenge may  
10 exist and are not affected by this modification of our decision. Moreover, our September 26, 2011  
11 decision does not constitute good cause to reopen any order, decision, or award.

12           Thus, for example, if a QME evaluation has already taken place, our September 26, 2011 decision  
13 does not provide grounds for a new one. If the DWC Medical Unit has already issued a panel and no  
14 objection based on the panel request's prematurity was raised prior to our September 26, 2011 decision,  
15 that panel may not be challenged based on our September 26, 2011 decision. If an otherwise proper  
16 panel request was made, and was premature according to our September 26, 2011 decision, but no  
17 objection based on its prematurity was raised prior to September 26, 2011, any panel subsequently issued  
18 in response to that request shall not be invalidated based on that decision.

19           If, on the other hand, a panel request was made prior to our September 26, 2011 decision, which  
20 was premature according to that decision, and the opposing party promptly objected **on that basis** before  
21 the September 26, 2011 decision issued, the objecting party is entitled to the benefit of its correct  
22 interpretation of section 4062.2(b) because the party timely raised the issue in its own case. We express  
23 no opinion at this time as to what constitutes an adequate objection.

24           Undoubtedly there will be cases where application of the principles expressed herein and in our  
25 prior decision will not be clear, and the parties in those cases may seek initial resolution of any disputes  
26 by a WCJ. Nevertheless, regardless of the certain existence of a few difficult cases, we wish to avoid "a  
27 landslide of reopenings" (*Farris, supra*, 65 Cal.Comp.Cases at p. 832; *Atlantic Richfield Co. v. Workers'*

1 *Comp. Appeals Bd. (Arvizu)* 31 Cal.3d 715, 728 [47 Cal.Comp.Cases 500, 509]) or other objections to  
2 panels, to which the parties had previously acquiesced, and to reports that have already issued and may  
3 have formed the basis for settlements.

4 For the foregoing reasons,

5 **IT IS ORDERED**, as the Decision After Reconsideration of the Workers' Compensation Appeals  
6 Board (En Banc), that the September 26, 2011 Opinion and Decision After Reconsideration, Order  
7 Granting Removal, and Decision After Removal (En Banc) is **AFFIRMED, EXCEPT** that it is  
8 **AMENDED** to add the following order:

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1 **WORKERS' COMPENSATION APPEALS BOARD**

2 **STATE OF CALIFORNIA**

3 **Case No. LBO 0340807**

4 **LISA SIMMONS,**

5 *Applicant,*

6 **vs.**

7 **STATE OF CALIFORNIA, DEPT. OF**  
8 **MENTAL HEALTH (METROPOLITAN**  
9 **STATE HOSPITAL), Legally Uninsured; and**  
10 **STATE COMPENSATION INSURANCE**  
11 **FUND (Adjusting Agent),**

12 *Defendant(s).*

13 **OPINION AND DECISION**  
14 **AFTER RECONSIDERATION**  
15 **(EN BANC)**

16 The Appeals Board granted reconsideration of the May 6, 2004 Findings and Award  
17 issued by the workers' compensation administrative law judge (WCJ), to further study the record  
18 and the applicable law. This is our Decision After Reconsideration.

19 Lisa Simmons (applicant) sustained an industrial injury to her right shoulder and bilateral  
20 wrists on August 20, 2002. At the time of her injury, she was employed as a janitor by the State  
21 of California, Department of Mental Health (Metropolitan State Hospital), legally uninsured and  
22 adjusted by State Compensation Insurance Fund (collectively, SCIF).

23 In his May 6, 2004 decision, the WCJ found that right shoulder surgery is necessary to  
24 cure or relieve the effects of applicant's injury. Moreover, the WCJ determined that the  
25 utilization review reports of Patricia D. Pegram, M.D., which SCIF had obtained to determine  
26 the medical necessity of the proposed right shoulder surgery, are not admissible in evidence  
27 because they are not the reports of an examining or treating physician.

28 In its petition for reconsideration, SCIF contends in substance: (1) that the utilization  
review reports of Dr. Pegram should have been received in evidence consistent with the

1 utilization review process established by Labor Code section 4610;<sup>1</sup> (2) that the intent of section  
2 4610 is to provide an expedited and efficient method for defendants to determine the medical  
3 necessity of proposed treatment and to eliminate the agreed medical evaluator (AME) and  
4 qualified medical evaluator (QME) procedures set forth in section 4062; (3) that, under section  
5 4604.5(c), in effect at the time of the April 28, 2004 trial, the American College of Occupational  
6 and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM guidelines)  
7 are presumptively correct on the issue of extent and scope of medical treatment; and (4) that,  
8 because Dr. Pegram's utilization review reports are presumed to be correct under section  
9 4604.5(c), and because applicant did not offer any evidence establishing that a variance from the  
10 ACOEM guidelines is reasonably required to cure or relieve her from the effects of her injury,  
11 applicant is not entitled to right shoulder surgery on an industrial basis.

12 Applicant did not file an answer to defendant's petition. The WCJ, however, prepared a  
13 Report and Recommendation on Petition for Reconsideration (Report) recommending that the  
14 May 6, 2004 decision be affirmed.

15 Because of the important legal issue presented, and to secure uniformity of decision in  
16 the future, the Chairman of the Appeals Board, upon a majority vote of its members, assigned  
17 this case to the Appeals Board as a whole for an en banc decision. (Lab. Code, §115.)<sup>2</sup>

18 Based on our review of the relevant statutory and case law, we hold:

- 19 (1) If a defendant undertakes utilization review to determine whether a  
20 proposed treatment is medically necessary, and if the utilization  
21 review physician finds that the treatment is medically necessary but  
22 raises questions as to whether the treatment is industrially-related, the  
23 utilization review report is admissible in evidence for the limited  
24 purposes of establishing: (a) utilization review was undertaken and

25 <sup>1</sup> All further statutory references are to Labor Code.

26 <sup>2</sup> The Appeals Board's en banc decisions are binding precedent on all Appeals Board panels and  
27 WCJs. (Cal. Code Regs., tit. 8, §10341; *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)*  
28 (2005) 126 Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109]; *Gee v. Workers' Comp. Appeals Board*  
(2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236]; see also Govt. Code, §11425.60(b).)

1 the date(s) of the utilization review physician’s report(s); (b) the  
2 utilization review physician found the proposed treatment to be  
3 medically necessary; and (c) the utilization review process has  
4 resulted in a dispute as to whether the industrial injury caused or  
5 contributed to the need for the treatment;

6 (2) A utilization review physician’s report is *not* admissible for the  
7 purpose of determining whether the industrial injury caused or  
8 contributed to the need for a particular treatment, i.e., a utilization  
9 review physician may address only the issue of whether a particular  
10 treatment is *medically necessary*;

11 (3) Where a utilization review physician finds that a treatment is  
12 medically necessary but questions whether the need for that treatment  
13 is causally related to the industrial injury, the defendant must either:  
14 (a) authorize the treatment; or (b) timely deny authorization based on  
15 causation within the deadlines set forth in section 4610(g)(1); timely  
16 communicate the denial based on causation to both the treating  
17 physician and the applicant within the deadlines set forth in section  
18 4610(g)(3)(A); and timely initiate the AME/QME process within 20  
19 days of the receipt of the utilization of physician’s report, if the  
20 employee is represented by an attorney, or 30 days, if the employee is  
21 unrepresented, in accordance with section 4062(a);<sup>3</sup> and

22 (4) Although the ACOEM guidelines are “presumptively correct on *the*  
23 *issue of extent and scope of medical treatment*” (Lab. Code,  
24 §4604.5(c) (emphasis added)), they are *not* presumptively correct on  
25 the issue of whether a need for medical treatment is causally related  
26 to the industrial injury.

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27 <sup>3</sup> In reaching this holding, we are *not* addressing any issues relating to proposed spinal surgery under  
28 sections 4610(g)(3)(A) & (B) and 4062(b).

1           Moreover, while this case involves the issue of whether treatment for an admitted  
2 industrially injured body part is causally related to the industrial injury, similar reasoning and  
3 principles will apply in the context of cases where injury to one body part is admitted but injury  
4 to another body part is denied. In such cases, a utilization review physician's reports will *not* be  
5 admissible on the issue of whether the disputed body part is industrial. If in prescribing  
6 treatment for the disputed body part, the treating physician either explicitly or implicitly  
7 determines for the first time that the injury to the disputed body part is industrial, then utilization  
8 review is *not* appropriate. Instead, the defendant must initiate the AME/QME process within the  
9 deadlines established by section 4062(a).<sup>4</sup>

10           Here, the WCJ's May 6, 2004 decision finding that right shoulder surgery is necessary to  
11 cure or relieve from the effects of applicant's injury does not fully comply with the principles  
12 above. Accordingly, we will rescind the decision. Instead, we will admit Dr. Pegram's  
13 utilization review reports for the limited purposes of establishing: (1) that utilization review was  
14 undertaken and the dates of Dr. Pegram's utilization review reports; (2) that Dr. Pegram  
15 considered the proposed right shoulder surgery to be medically necessary; and (3) that, as a  
16 result of Dr. Pegram's utilization review, a dispute arose over whether applicant's injury caused  
17 or contributed to her need for right shoulder surgery.

18           When SCIF received Dr. Pegram's utilization review reports questioning whether  
19 applicant's need for right shoulder surgery was causally related to her industrial injury, SCIF did  
20 *not* initiate the AME/QME process under section 4062(a). Until now, no binding Appeals Board  
21 or Court of Appeal decision has interpreted the procedure to be followed when a utilization  
22 review physician finds a treatment to be reasonably necessary but questions whether the  
23 treatment is industrially-related. Therefore, in this case, we will remand the matter to the WCJ  
24 to allow SCIF a reasonable time to initiate the AME/QME procedure. After completion of the  
25 AME/QME procedure, the WCJ should again determine the issue of applicant's entitlement to  
26 right shoulder surgery.

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27 <sup>4</sup> If no body part is accepted as industrial, the parties must follow the procedures set forth in section  
28 4060.

1 **I. BACKGROUND**

2 Applicant sustained an injury to her right shoulder and both wrists on August 20, 2002.

3 She was initially diagnosed with adhesive capsulitis of the right shoulder. She was  
4 placed on temporary total disability until October 15, 2002, when she returned to modified duty.  
5 She again became temporarily totally disabled on October 29, 2002.

6 On December 4, 2002, applicant had a right shoulder MRI. It showed no evidence of a  
7 rotator cuff tear, but it showed evidence of down-sloping of the acromion with mild to moderate  
8 impingement on the supraspinatus tendon.

9 On December 11, 2002, applicant had right shoulder surgery, apparently authorized by  
10 SCIF. She never returned to work after that surgery.

11 Following the December 2002 right shoulder surgery, applicant complained of constant  
12 right shoulder pain, as well as limited motion of and popping sounds in that shoulder.  
13 Eventually, her treating physicians decided that the right shoulder surgery had failed.

14 On May 27, 2003, applicant had another right shoulder MRI. The new MRI showed  
15 post-operative changes in the soft tissues and acromioclavicular joint, an abnormal signal in the  
16 anterior aspect of the supraspinatus tendon, and a small amount of fluid in the subdeltoid bursa.  
17 The radiologist read the MRI as “suspicious for a small full thickness rotator cuff tear.”

18 On or about October 16, 2003, applicant started treating with Hillel Sperling, M.D. After  
19 reviewing the May 27, 2003 right shoulder MRI, Dr. Sperling ordered a repeat MRI scan  
20 because the May 2003 scan “was almost five months ago” and “[i]t was not clear whether there  
21 was a rotator cuff tear.”

22 On December 4, 2003, applicant had another right shoulder MRI. Although the  
23 radiologist’s report on this third MRI is not in the WCAB’s file, Dr. Sperling stated in his  
24 December 18, 2003 report that he had reviewed this MRI. Dr. Sperling’s December 18, 2003  
25 reading of the MRI states: “There is a perforation, which is complete. There is a tear of the  
26 rotator cuff tendon. There are postoperative changes seen in the acromion.” Dr. Sperling’s  
27 December 18, 2003 report diagnosed applicant to have a rotator cuff tear. He recommended  
28 open rotator cuff repair surgery. He stated that the indications for surgery were: (1) persistent

1 pain in the right shoulder, despite the prior right shoulder surgery; (2) a frozen right shoulder;  
2 and (3) MRI evidence of a rotator cuff tear.

3 SCIF referred the issue of right shoulder surgery for utilization review. On January 5,  
4 2004, the utilization review physician, Dr. Pegram, issued a report stating:

5 “Based on the results of R [right] shoulder MRI sx [surgery] is  
6 indicated. However, AOE/COE [injury arising out of and in the  
7 course of the employment] issue re: R shoulder has not been resolved.  
8 // [applicant] has been TTD [temporarily totally disabled] since  
9 injury? Definitely TTD since 1st R shoulder sx 12/11/02. 1st MRI  
prior to 1st sx revealed no tears. R shoulder MRI 12/4/03 reveals  
rotator cuff tear.”

10 On January 16, 2004, SCIF sent a letter to Dr. Sperling (with copies to applicant and her  
11 attorney) stating it was delaying a decision on the request for right shoulder surgery. The letter  
12 appended Dr. Pegram’s January 5, 2004 report. It also asked the following question:

13 “MRI of right shoulder reveals no tear on 12/11/02. MRI of right  
14 shoulder dated 12/4/03 reveals rotator cuff tear. Claimant has been off  
15 work since 12/10/02, how is the tear industrially related?”

16 On January 22, 2004, Dr. Sperling issued a responsive report opining why the rotator cuff  
17 tear is industrially related. He stated:

18 “Despite a normal right shoulder MRI on 12/4/02, the patient had an  
19 impingement syndrome that is a clinical diagnosis, which occurred as  
20 a result of the industrial accident. With normal daily activities the  
21 impingement disrupted the vascularity of the right shoulder therefore  
22 causing a rotator cuff tear, which is evident in the right shoulder MRI  
of 12/4/03.”

23 Dr. Sperling then again requested authorization for rotator cuff repair surgery.

24 Thereafter, SCIF wrote to Dr. Pegram, once more inquiring about the right shoulder  
25 surgery issue. SCIF’s note to Dr. Pegram stated:

26 “Sx [surgery] appears to be M/N [medically necessary] but you had  
27 issues for M.D. to address as per your 1/5/04 review/response to clt  
28 [claimant].”

1 On February 2, 2004, Dr. Pegram issued a responsive note stating that her  
2 recommendation was to “delay.” She further said:

3 “[SCIF should obtain a] 2nd opinion regarding MN [medical  
4 necessity] for sx [surgery] under the auspices of workers comp &  
5 explanation of RCT [rotator cuff tear]. Dr. Sperling’s explanation of  
6 appearance of RCT is highly questionable.”

7 On February 6, 2004, SCIF sent a letter to Dr. Sperling (with copies to applicant and her  
8 attorney) denying authorization for the right shoulder surgery, based on the utilization review  
9 reports of Dr. Pegram.

10 On April 28, 2004, the issue of applicant’s entitlement to right shoulder surgery came on  
11 for an expedited hearing. On the basis of applicant’s objection, the WCJ excluded Dr. Pegram’s  
12 two utilization reports from evidence because they were not the reports of an examining or  
13 treating physician.

14 On May 6, 2004, the WCJ issued the decision at issue, allowing right shoulder surgery  
15 based on Dr. Sperling’s reports. The WCJ’s opinion stated that the ACOEM guidelines did not  
16 become presumptively correct under section 4604.5(c) until 90 days after their publication, i.e.,  
17 they did not become presumptively correct until March 22, 2004. The WCJ stated, therefore,  
18 that the “presumption is not applicable to services requested in January [2004].”

19 SCIF then timely sought reconsideration.

## 20 **II. DISCUSSION**

21 The WCJ is correct that, ordinarily, only the reports of attending or examining physicians  
22 are admissible in evidence in workers’ compensation proceedings. (Lab. Code, §5703(a);  
23 *Sweeney v. Workmen’s Comp. Appeals Bd.* (1968) 264 Cal.App.2d 296, 301-305 [33  
24 Cal.Comp.Cases 404].) Nevertheless, the statutory scheme created by section 4610 makes it  
25 clear that utilization review reports are an essential part of the WCAB’s record in any post-  
26 utilization review proceedings regarding medical treatment disputes. Accordingly, the Appeals  
27 Board has concluded that this scheme creates a *limited* exception to the section 5703(a). That is,  
28 even though utilization review physicians are not “attending or examining” physicians within the

1 meaning of section 5703(a), utilization review reports generated under section 4610 are  
2 admissible in WCAB proceedings, *if their admission would be consistent with the statutory*  
3 *scheme. (Willette v. Au Electric Corp. (2004) 69 Cal.Comp.Cases 1298, 1306-1307 & fn. 9*  
4 *(Appeals Board en banc).)* Utilization review reports that are not consistent with section 4610's  
5 statutory scheme, however, are *not* admissible in evidence. (*Sandhagen v. Cox & Cox*  
6 *Construction, Inc. (2004) 69 Cal.Comp.Cases 1452, 1458-1459 (Appeals Board en banc)*  
7 *[utilization review reports obtained in violation of the mandatory time deadlines of section*  
8 *4610(g)(1) are not admissible in evidence].)*

9 We hold that Dr. Pegram's reports are admissible for the limited purposes of showing: (1)  
10 utilization review was undertaken by SCIF and the dates of Dr. Pegram's reports; (2) Dr. Pegram  
11 considered the proposed right shoulder surgery to be medically necessary;<sup>5</sup> and (3) as a result of  
12 Dr. Pegram's utilization review, there is now a dispute as to whether applicant's injury caused or  
13 contributed to this need for surgery.

14 Admitting Dr. Pegram's reports for these purposes is consistent with the utilization  
15 review scheme established by section 4610. This is because SCIF had the right to undertake  
16 utilization review with respect to Dr. Sperling's request for right shoulder surgery (Lab. Code,  
17 §4610) and because, prior to undertaking utilization review, SCIF did not know that a causation  
18 issue would arise.

19 However, we further hold that Dr. Pegram's utilization review reports are *not* admissible  
20 for the purpose of determining the issue of whether applicant's industrial injury caused or  
21 contributed to her need for right shoulder surgery. To admit Dr. Pegram's reports for this  
22 purpose would be inconsistent with the utilization review scheme established by section 4610.

23 In this regard, section 4610(a) states:

24 \_\_\_\_\_  
25 <sup>5</sup> As discussed above, Dr. Pegram's January 5, 2004 report concedes that, "[b]ased on the results of  
26 [applicant's] R [right] shoulder MRI sx [surgery] is indicated." Although Dr. Pegram's January 5, 2004  
27 report goes on to raise an "AOE/COE issue" (i.e., an industrial causation issue) regarding the right  
28 shoulder surgery, Dr. Pegram does not question the *medical necessity* of the surgery. Indeed, based on  
Dr. Pegram's January 5, 2004 report, SCIF admitted in a subsequent note to Dr. Pegram that "Sx  
[surgery] appears to be M/N [medically necessary]."

1 “For purposes of this section, ‘utilization review’ means utilization  
2 review or utilization management functions that prospectively,  
3 retrospectively, or concurrently review and approve, modify, delay,  
4 or deny, based in whole or in part *on medical necessity to cure and*  
5 *relieve*, treatment recommendations by physicians, as defined in  
6 Section 3209.3, prior to, retrospectively, or concurrent with the  
7 provision of medical treatment services pursuant to Section 4600.”  
8 (Emphasis added.)

9 Thus, by section 4610(a)’s express terms, utilization review is directed solely at determining the  
10 “medical necessity” of treatment recommendations. Therefore, section 4610 does *not* authorize  
11 a utilization review physician to determine whether the employee’s industrial injury caused or  
12 contributed to a need for treatment.

13 This interpretation of the utilization review statutory scheme is consistent with section  
14 4610(f)(2), which provides that utilization review criteria shall be consistent with the medical  
15 treatment utilization review schedule adopted pursuant to section 5307.27. Section 5307.27, in  
16 turn, states that this medical treatment utilization schedule “shall address, at a minimum, *the*  
17 *frequency, duration, intensity, and appropriateness* of all treatment procedures and modalities  
18 commonly performed in workers’ compensation cases.” (Emphasis added.) Accordingly, section  
19 4610(f)(2) and section 5307.27, when read together, demonstrate that utilization review does not  
20 encompass an assessment of whether a need for treatment is causally related to the industrial  
21 injury.

22 This interpretation of the utilization review statutory scheme is also consistent with  
23 Administrative Director Rule 9792.6(n), which states in relevant part: “Utilization review does  
24 not include determinations of the work-relatedness of injury or disease ... .” (Cal. Code Regs.,  
25 tit. 8, §9792.6(n).)

26 Finally, this interpretation is consistent with the nature of the utilization review process.  
27 A utilization review physician does not physically examine the applicant, does not obtain a full  
28 history of the injury or a full medical history, and might not review all pertinent medical records.  
Yet, each of these steps is relevant, if not essential, to determining whether the need for a  
particular treatment is causally related to the industrial injury.

1           Accordingly, utilization review reports are *not* admissible for the purpose of determining  
2 whether the employee’s industrial injury caused or contributed to a need for treatment.

3           We next address the procedures to be followed when a utilization review physician  
4 concludes that a treatment for an undisputed body part is medically necessary but questions the  
5 causal relationship between the need for treatment and the industrial injury.

6           Under these circumstances, a defendant has only two options. Either it must approve the  
7 treatment or it must deny the treatment. (Lab. Code, §4610 (a).)<sup>6</sup>

8           If a defendant decides to deny authorization for concurrent or prospective treatment  
9 based on a question arising in utilization review regarding the treatment’s causal connection to  
10 the injury, then the defendant must reach this decision to deny within the time deadlines  
11 established by section 4610. This means that a decision to deny treatment based on a question of  
12 causation raised by a utilization physician “shall be made in a timely fashion that is appropriate  
13 for the nature of the employee’s condition, not to exceed five working days from the receipt of  
14 the information reasonably necessary to make the determination, but in no event more than 14  
15 days from the date of the medical treatment recommendations by the physician.” (Lab. Code,  
16 §4610(g)(1); but see also, §4610(g)(2) & (g)(5).)

17           Once the decision has been made to deny prospective or concurrent treatment based on a  
18 utilization physician’s causation question, this decision must be communicated to the treating  
19 physician by phone or fax within 24 hours. (Lab. Code, §4610(g)(3)(A).) Also, such decisions  
20 must be communicated in writing to both the treating physician and the applicant within 24  
21 hours for concurrent review and within two business days for prospective review. (Lab. Code,  
22 §4610(g)(3)(A).)

23           Finally, and most pertinent to our decision here, where a decision to deny treatment has  
24 been made based on an issue raised by the utilization review physician regarding the causal  
25 relationship of the treatment to the industrial injury, then “disputes shall be resolved in

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26 <sup>6</sup>           Where an issue exists as to causal connection between the injury and the treatment, a defendant  
27 may elect to authorize the treatment. For example, a defendant may decide that the avoidance of medical-  
28 legal and litigation costs, or even potential penalties or sanctions, might be more appropriate than  
disputing the treatment.

1 accordance with Section 4062.” (Lab. Code, §4610(g)(3)(A).)

2 Section 4062(a) provides, in relevant part:

3 “If either the employee or employer objects to a medical  
4 determination made by the treating physician concerning any medical  
5 issues not covered by Section 4060 or 4061 and not subject to Section  
6 4610, the objecting party shall notify the other party in writing of the  
7 objection within 20 days of receipt of the report if the employee is  
8 represented by an attorney or within 30 days of receipt of the report if  
9 the employee is not represented by an attorney. ... If the employee  
10 objects to a decision made pursuant to Section 4610 to modify, delay,  
11 or deny a treatment recommendation, the employee shall notify the  
12 employer of the objection in writing within 20 days of receipt of that  
13 decision. These time limits may be extended for good cause or by  
14 mutual agreement. ...”

15 As discussed above, utilization review can be undertaken to determine the medical  
16 necessity of a treatment, but it cannot be undertaken to determine whether an employee’s injury  
17 has caused or contributed to the need for that treatment. Therefore, when a defendant’s decision  
18 to deny treatment has been made based on an issue of industrial causation raised by a utilization  
19 review physician, the decision is *not* “made pursuant to Section 4610” within the meaning of  
20 section 4062(a). In such circumstances, the decision to deny is really an objection “to a medical  
21 determination made by the treating physician concerning [a] medical issue[] not covered by  
22 Section 4060 or 4061 *and not subject to Section 4610.*” (Lab. Code, §4062(a) (emphasis added).)  
23 In essence, the defendant is objecting to the treating physician’s explicit or implicit  
24 determination that the need for the prescribed treatment was caused, in whole or in part, by the  
25 industrial injury. Such an issue of causation is outside the scope of utilization review.  
26 Accordingly, it is not the employee’s responsibility either to object to the treatment denial based  
27 on causation or to initiate the AME/QME procedure established by section 4062(a). Rather, it is  
28 the defendant’s duty to object to the treating physician’s causation determination and to initiate  
the AME/QME procedure under section 4062(a).

Ordinarily, when a defendant objects to a treating physician’s medical determination on  
an issue not subject to section 4610, the defendant has 20 days from the receipt of the treating  
physician’s report to object, if the employee is represented by an attorney, or 30 days from

1 receipt, if the employee is not represented. (Lab. Code, §4062(a).) Nevertheless, section 4062(a)  
2 expressly provides that “[t]hese time limits may be extended for good cause . . . .” And, where a  
3 utilization review physician’s report raises for the first time a question of whether the industrial  
4 injury caused or contributed to a need for treatment prescribed by a treating physician, we  
5 conclude there is “good cause” to extend the time limits for a defendant to object to the treating  
6 physician’s report by 20 days (in represented cases) or 30 days (in unrepresented cases) from the  
7 defendant’s receipt of the utilization physician’s report. (Lab. Code, §4062(a).)<sup>7</sup>

8 For the guidance of the workers’ compensation community, we reiterate that a defendant  
9 is *not* required to undertake utilization review in every case. (*Sandhagen v. Cox & Cox*  
10 *Construction, Inc.* (2005) 70 Cal.Comp.Cases 208 (Appeals Board en banc).) Accordingly, if a  
11 defendant believes at the time a treating physician prescribes treatment that there is or may be an  
12 issue of whether the proposed treatment for an admitted body part is causally related to the  
13 industrial injury, the defendant may elect to bypass utilization review and, instead, timely initiate  
14 the AME/QME procedures of section 4062(a). If the defendant does elect to undertake  
15 utilization review, however, it must complete that utilization review within the deadlines  
16 mandated by section 4610. (*Sandhagen v. Cox & Cox Construction, Inc., supra*, 69  
17 Cal.Comp.Cases 1452.)

18 The foregoing discussion applies when a utilization review physician determines that a  
19 proposed treatment for an admitted body part is medically necessary, but questions whether the  
20 industrial injury caused or contributed to the need for the treatment.

21 A different procedure applies where there has been an admission to or a determination of  
22 industrial injury to at least one body part, but where the treatment prescribed relates to a different  
23 and *disputed* body part that the treating physician has explicitly or implicitly found to be  
24 industrial. For the reasons discussed above, utilization review cannot be conducted for the  
25 purpose of determining whether there was an industrial injury to the disputed body part. Instead,

26 <sup>7</sup> This is also consistent with the provisions of section 4610(g)(5) which, although not directly  
27 applicable in this situation, recognizes that the denial of a treatment request often cannot be made within  
28 normal timeframes “because the [defendant] is not in receipt of all of the information reasonably  
necessary” to make a decision.

1 in the context of an admitted injury, if a treating physician prescribes treatment for a *disputed*  
2 body part, then the defendant must timely initiate the AME/QME procedure in accordance with  
3 section 4062(a), if it has not already done so or if the time deadlines of section 4062(a) have not  
4 already elapsed.<sup>8</sup> In any event, a utilization review physician’s report is *not* admissible on the  
5 issue of whether the disputed body part is industrial.

6 Here, SCIF did not initiate the AME/QME procedure of section 4062(a) after it received  
7 Dr. Pegram’s reports questioning whether the surgery proposed by Dr. Sperling was causally  
8 related to applicant’s admitted injury. But because this is a case of first impression, we direct the  
9 WCJ on remand to give SCIF a reasonable opportunity to initiate the AME/QME procedures.  
10 (See *Willette v. Au Electric Corp.*, *supra*, 69 Cal.Comp.Cases at p. 1309 (Appeals Board en  
11 banc).)<sup>9</sup>

12 As to the ACOEM issue in this case, SCIF is correct: (1) that it is liable only for medical  
13 treatment reasonably required to cure or relieve the effects of the injury (Lab. Code, §4600); (2)  
14 that, under the law presently in effect, “reasonably required” medical treatment generally “means  
15 treatment that is based upon ... the updated [ACOEM guidelines]” (Lab. Code, §4600(b)); and  
16 (3) that the ACOEM guidelines are “presumptively correct on the issue of extent and scope of  
17 medical treatment, regardless of date of injury.” (Lab. Code, §4604.5(c).) SCIF, however, is  
18 completely mistaken in asserting that a utilization review physician’s opinions are presumed to  
19 be correct under section 4604.5(c) and in asserting that the utilization review process was  
20 intended to “eliminate” the QME/AME procedures established by section 4062(a). (See *Willette*  
21 *v. Au Electric Corp.*, *supra*, 69 Cal.Comp.Cases 1298 (Appeals Board en banc).)

22 Here, however, there are no bona fide ACOEM issues.

23 <sup>8</sup> If the treating physician had previously determined that there was an industrial injury to the  
24 disputed body part, then section 4062(a) would have been triggered at that time. If, subsequently, the  
25 treating physician first prescribes treatment for the disputed body part, then defendant does not get a  
“second bite of the apple” on the causation issue, i.e., section 4062(a) is not re-triggered on the industrial  
injury issue.

26 <sup>9</sup> Because applicant is represented, and because her injury occurred before January 1, 2005, the  
27 AME or QME report should be obtained in accordance with the procedure set forth in former section  
28 4062, as it existed before its amendment by Senate Bill 899 (SB 899). (*Simi v. Sav-Max Foods, Inc.*  
(2005) 70 Cal.Comp.Cases 217 (Appeals Board en banc).)

1 Dr. Pegram agrees that rotator cuff surgery is medically necessary in light of the results  
2 of applicant's December 4, 2003 right shoulder MRI. Moreover, the December 4, 2003 MRI  
3 indicates that applicant has a significant tear, and the ACOEM guidelines specifically state that  
4 "[r]otator cuff repair is indicated for significant tears that impair activities by causing weakness of  
5 arm elevation or rotation, particularly acutely in younger workers." (ACOEM Guidelines, Chapter 9,  
6 p. 210.)

7 Dr. Pegram does question whether applicant's need for rotator cuff surgery is causally  
8 related to her August 20, 2002 injury. Yet, the ACOEM guidelines only are "presumptively  
9 correct on *the issue of extent and scope of medical treatment ...* ." (Lab. Code, §4604.5(c)  
10 (emphasis added).) Thus, although ACOEM contains a chapter on causation (ACOEM  
11 Guidelines, Chapter 4), this chapter is *not* presumptively correct on the issue of whether a need for  
12 medical treatment is causally related to the industrial injury.

13 Accordingly, on remand, the ACOEM guidelines will have no presumptive effect on the  
14 determination of whether an applicant's August 20, 2002 injury caused or contributed to her  
15 need for rotator cuff surgery.

16 For the foregoing reasons,

17 **IT IS ORDERED**, as the Decision After Reconsideration of the Appeals Board (En  
18 Banc), that the Findings and Award issued by the workers' compensation administrative law  
19 judge on May 6, 2004 is **RESCINDED**.

20 **IT IS FURTHER ORDERED** that the January 5, 2004 and February 2, 2004 reports of  
21 Patricia D. Pegram, M.D., are **ADMITTED IN EVIDENCE** for the limited purposes of  
22 showing: (1) that utilization review was undertaken by defendant; (2) that Dr. Pegram found  
23 that right shoulder surgery was reasonably necessary; (3) that, as a result of Dr. Pegram's  
24 utilization review report(s), there is now a dispute as to whether applicant's need for right  
25 shoulder surgery was caused or contributed to by her August 20, 2002 injury; and (4) the date(s)  
26 on which Dr. Pegram questioned whether the industrial injury caused or contributed to the need  
27 for surgery.

28 ///

1     ///

2             **IT IS FURTHER ORDERED** that that this matter is **REMANDED** to the workers’  
3 compensation administrative law judge for further proceedings and a new decision, consistent  
4 with this opinion.

5   ***WORKERS’ COMPENSATION APPEALS BOARD (EN BANC)***

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  ***MERLE C. RABINE, Chairman***

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  ***WILLIAM K. O’BRIEN, Commissioner***

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  ***JAMES C. CUNEO, Commissioner***

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  ***JANICE J. MURRAY, Commissioner***

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  ***FRANK M. BRASS, Commissioner***

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20    **I DISSENT.**  
21    **(See attached Dissenting Opinion.)**

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23    \_\_\_\_\_  
  ***RONNIE G. CAPLANE, Commissioner***

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25     ***DATED AND FILED AT SAN FRANCISCO, CALIFORNIA***

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27     ***SERVICE BY MAIL ON SAID DATE TO ALL PARTIES***  
28     ***AS SHOWN ON THE OFFICIAL ADDRESS RECORD***

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**DISSENTING OPINION OF  
COMMISSIONER CAPLANE**

I dissent.

Labor Code section 4610(a) spells out the purpose of utilization review very specifically and very narrowly as “review and approve, modify, delay, or deny, based in whole or in part on *medical necessity* to cure and relieve, *treatment recommendations by physicians...*” (Emphasis added.) The utilization review doctor is provided with only those medical records necessary to evaluate the treatment recommendation and does not examine the injured worker. (Lab. Code, §4610(d).) The majority opinion expands this statutory mandate to allow a utilization review doctor also to offer an opinion on the more substantive issue of causation. If causation is raised in the report, the time within which a defendant can avail itself of the QME procedure under Labor Code section 4062 begins running anew, allowing medical examinations that might otherwise be time barred. The majority goes on to hold that the utilization review report is admissible to show that a dispute exists.

In interpreting statutes, we are bound to apply the clear and unambiguous command of the statutes; when the plain language of the statute is not ambiguous and is unequivocal, we must follow it. (*DuBois v. Workers’ Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286]; *Atlantic Richfield Co. v. Workers’ Comp. Appeals Bd. (Arvizu)* (1982) 31 Cal.3d 715, 726 [47 Cal.Comp.Cases 500]; *Cal. Ins. Guar. Ass’n v. Workers’ Compensation Appeals Bd. (Karaiskos)* (2004) 117 Cal.App.4th 350, 355 [69 Cal.Comp.Cases 183].)

Labor Code section 4610(a) is clear and unambiguous. It expressly limits utilization review to the “medical necessity” of treatment recommendations. By allowing the utilization review doctor to offer an opinion on causation and then to allow that report in evidence, albeit for the sole purpose of showing that a dispute exists, the Appeals Board has gone beyond the judicial and entered the legislative realm.

Furthermore, by giving the employer what amounts to a second opportunity to avail itself of the QME option, the Appeals Board has lengthened a process that was intended to expedite medical treatment.

1 Clearly, none of this was intended by the express terms of Labor Code section 4610.

2 In our en banc decisions in *Sandhagen I* and *Sandhagen II*, we held that utilization  
3 review and a QME are not mutually exclusive. Both can be pursued simultaneously. (*Sandhagen*  
4 *v. Cox & Cox Construction, Inc.* (2005) 70 Cal.Comp.Cases 208; *Sandhagen v. Cox & Cox*  
5 *Construction, Inc.* (2004) 69 Cal.Comp.Cases 1452.) In the present case the defendant could and  
6 probably should have done just that. Although defendant claims that the utilization review  
7 report was its first indication that the condition leading to Ms Simmons' need for surgery might  
8 not be job related, there was ample evidence to alert the defendant to the causation issue.

9 Ms. Simmons' first surgery was in December 2002 after which, she never returned to  
10 work and the activities that had caused her injury in the first place. Five-and-a-half months after  
11 her surgery, she had an MRI, which was negative. Seven months and another MRI later, the  
12 rotor cuff tear appears and a second surgery is recommended. There were no surprises here. All  
13 of the medical reports setting out this information, had been provided to defendant. It seems that  
14 the above should have been sufficient to suggest that causation should be explored.

15 While defendants should not have to pay for medical treatment unrelated to an industrial  
16 injury, it is not within our purview to rewrite the law in order to protect them from their own  
17 mistakes.

18 For these reasons, I dissent. I would admit Dr. Pegram's reports for the limited purpose  
19 of establishing that the proposed surgery is medically necessary and I would award the requested  
20 surgery based on Dr. Sperling's opinions and Dr. Pegram's reports.

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***RONNIE G. CAPLANE, Commissioner***

***DATED AND FILED AT SAN FRANCISCO, CALIFORNIA***

***6/17/05***

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AS SHOWN ON THE OFFICIAL ADDRESS RECORD***

**TITLE 8. INDUSTRIAL RELATIONS  
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS  
CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL  
EVALUATOR**

Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure

**§35. Exchange of Information and Ex Parte Communications**

(a) The claims administrator, or if none the employer, shall provide, and the injured worker may provide, the following information to the evaluator, whether an AME, Agreed panel QME or QME:

(1) All records prepared or maintained by the employee's treating physician or physicians;

(2) Other medical records, including any previous treatment records or information, which are relevant to determination of the medical issue(s) in dispute;

(3) A letter outlining the issues that the evaluator is requested to address in the evaluation, which shall be served on the opposing party no less than 20 days in advance of the evaluation;

(4) Whenever the treating physician's recommended medical treatment is disputed, a copy of the treating physician's report recommending the medical treatment with all supporting documents, a copy of claims administrator's, or if none the employer's, decision to approve, delay, deny or modify the disputed treatment with the documents supporting the decision, and all other relevant communications about the disputed treatment exchanged during the utilization review process required by Labor Code section 4610;

(5) Non-medical records, including films and videotapes, which are relevant to determination of medical issue(s) in dispute, after compliance with subdivision 35(c) of Title 8 of the California Code of Regulations.

(b)(1) All communications by the parties with the evaluator shall be in writing and sent simultaneously to the opposing party when sent to the medical evaluator, except as otherwise provided in subdivisions (c), (k) and (l) of this section.

(2) Represented parties who have selected an Agreed Medical Evaluator or an Agreed Panel QME shall, as part of their agreement, agree on what information is to be provided to the AME or the Agreed Panel QME, respectively.

(c) At least twenty (20) days before the information is to be provided to the evaluator, the party providing such medical and non-medical reports and information shall serve it on the opposing party. Mental health records that are subject to the protections of Health and Safety Code section 123115(b) shall not be served directly on the injured employee, but may be provided to a designated health care provider as provided in section 123115(b)(2), and the injured employee shall be notified in writing of this option for each such record to be provided to the evaluator. In

both unrepresented and represented cases the claims administrator shall attach a log to the front of the records and information being sent to the opposing party that identifies each record or other information to be sent to the evaluator and lists each item in the order it is attached to or appears on the log. In a represented case, the injured worker's attorney shall do the same for any records or other information to be sent to the evaluator directly from the attorney's office, if any. The claims administrator, or if none the employer, shall include a cover letter or other document when providing such information to the employee which shall clearly and conspicuously include the following language: "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days."

(d) If the opposing party objects within 10 days to any non-medical records or information proposed to be sent to an evaluator, those records and that information shall not be provided to the evaluator unless so ordered by a Workers' Compensation Administrative Law Judge.

(e) In no event shall any party forward to the evaluator: (1) any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code section 4062.5; (2) any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical-legal process in Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a Workers' Compensation Administrative Law Judge; or (3) any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible by a Workers' Compensation Administrative Law Judge, or which otherwise has been deemed inadmissible to the evaluator as a matter of law.

(f) Either party may use discovery to establish the accuracy or authenticity of non-medical records or information prior to the evaluation.

(g) Copies of all records being sent to the evaluator shall be sent to all parties except as otherwise provided in section (d) and (e). Failure to do so shall constitute ex parte communication within the meaning of subdivision (k) below by the party transmitting the information to the evaluator.

(h) In the event that the unrepresented employee schedules an appointment within 20 days of receipt of the panel, the employer or if none, the claims administrator shall not be required to comply with the 20 day time frame for sending medical information in subsection (c) provided, however, that the unrepresented employee is served all non-medical information in subdivision (c) 20 days prior to the information being served on the QME so the employee has an opportunity to object to any non-medical information.

(i) In the event that a party fails to provide to the evaluator any relevant medical record which the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health care provider, to obtain such record(s). If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report to comply with the statutory time frames under section 38 of Title 8 of the California Code of

Regulations. The evaluator shall note in the report that the records were not received within the required time period. Upon request by a party, or the Appeals Board, the evaluator shall complete a supplemental evaluation when the relevant medical records are received. For a supplemental report the evaluator need not conduct an additional physical examination of the employee if the evaluator believes a review of the additional records is sufficient.

(j) The evaluator and the employee's treating physician(s) may consult as necessary to produce a complete and accurate report. The evaluator shall note within the report new or additional information received from the treating physician.

(k) The Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator. Oral or written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication.

(l) In claims involving a date of injury prior to 1/1/2005 where the injured worker is represented by an attorney and the parties have decided to each select a separate Qualified Medical Evaluator, the provisions of this section shall not apply to the communications between a party and the QME selected by that party.

#### NOTE

Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

#### HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).
2. New subsection (c) and subsection relettering, amendment of newly designated subsections (d) and (e) and new subsection (f) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).
3. New subsection (b)(3) and amendment of subsection (e) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
4. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

**CERTIFIED FOR PARTIAL PUBLICATION\***

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

STATE FARM INSURANCE, AMERICAN  
CASUALTY COMPANY OF READING,  
PA,

Petitioner,

v.

WORKERS' COMPENSATION APPEALS  
BOARD and CARL JAMES PEARSON,

Respondents.

B221431

(W.C.A.B. Nos. ADJ1145938 and  
ADJ312755)

PROCEEDING to review a decision of the Workers' Compensation Appeals Board. Annulled and remanded with directions.

Albert and Mackenzie, Amy Creager for Petitioner.

No appearance for Respondent Workers' Compensation Appeals Board.

Law Offices of William S. Lindheim and William S. Lindheim; Law Offices of Steven Klugman and Steven Klugman for Respondent Carl James Pearson.

Andrea S. Ordin, County Counsel, Leah D. Davis, Assistant County Counsel, Derrick M. Au, Principal Deputy County Counsel, as Amicus Curiae on behalf of Petitioner.

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\* Pursuant to California Rules of Court, rules 8.1100 and 8.1110, this opinion is certified for publication with the exception of part IV(B)(1).

## I. INTRODUCTION

State Farm Insurance Company (State Farm) petitions for writ of review pursuant to Labor Code section 5950<sup>1</sup> of the Workers' Compensation Appeals Board's opinion and order denying reconsideration of a joint supplemental findings and award. In that award, the Workers' Compensation Appeals Board (WCAB) found that lien claimant Carl Pearson, husband of applicant Francisca Apparicio, provided Apparicio with attendant care services 24 hours every day from July 24, 2003, and that Pearson was entitled to compensation for those services at \$30 per hour. The total reimbursement to Pearson was \$1,520,640. We conclude that Apparicio and Pearson's ex parte communications to a medical examiner violated the prohibition against ex parte communications in workers' compensation regulations. That violation requires disqualification of the medical examiner and the striking of the medical examiner's reports and testimony. We also conclude that the award of compensation to Pearson for caregiver services was unreasonable, was not authorized by section 4600, subdivision (a), and was not supported by substantial evidence. We annul the opinion and order denying reconsideration and order the matter remanded with directions to disqualify the medical examiner, to strike reports and opinions of the medical examiner, to select a new medical examiner, and to conduct proceedings to redetermine and recalculate compensation to be awarded lien claimant Pearson.

## II. FACTUAL AND PROCEDURAL HISTORY

Francisca Apparicio, employed as a legal assistant by State Farm, sustained injury to her psyche, lumbar spine, and right upper extremity, and developed fibromyalgia. Apparicio made a claim for an injury to her back and bilateral extremities occurring on August 20, 1999. Apparicio made a second claim for a continuous trauma injury from 1993 to January 4, 1995, for her right arm, shoulder, back, fibromyalgia, and for a psychiatric sequela. On August 17, 2006, a stipulated award was entered for industrial injury to psyche, lumbar spine, right upper extremity and fibromyalgia, causing 100

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<sup>1</sup> Unless otherwise specified, statutes in this opinion will refer to the Labor Code.

percent permanent disability and a need for future medical treatment. Jurisdiction was reserved over Pearson's lien claim for his attendant care of and transportation services for Apparicio.

On December 6, 2006, the worker's compensation administrative law judge (WCJ) disallowed the lien claim on the ground that Pearson failed to provide substantial medical evidence of the kind and amount of services Apparicio reasonably required. Pearson's petition for reconsideration was granted, however, and on October 12, 2007, the WCAB ordered the WCJ to develop the record regarding the services and the level of attendant care required by Apparicio.

Following the WCAB's decision, the parties could not agree on a medical expert to address issues identified by the WCAB. On December 19, 2007, the WCJ ordered the parties to have Dr. Donna Barras, M.D. conduct an evaluation and to provide an expert opinion on Apparicio's past and present life care needs, including the nature of home care services and the hours per day they were required.

Without giving notice to State Farm, counsel for Apparicio and Pearson contacted Dr. Barras and provided her with several medical reports. Dr. Barras reviewed those reports and other information, conducted a three-hour evaluation of Apparicio, and prepared an April 18, 2008, report describing Apparicio's condition and her medical, medication, nursing, equipment, and housing needs and their expected costs. Dr. Barras's report valued licensed vocational nursing (LVN) services provided by Pearson at \$35 per hour. State Farm deposed Dr. Barras on August 7, 2008.

State Farm moved to strike Dr. Barras's report based on its allegations that Apparicio's counsel set up the evaluation without notice to State Farm, provided Dr. Barras only with unilaterally selected records, and did not explain to her the nature of the services which the WCJ appointed her to provide.

On January 27, 2009, trial occurred on the need for attendant care and transportation services, liability for self-procured medical expenses (including caregiver services and transportation services), Pearson's lien claim for caregiver and

transportation services rendered to Apparicio, the nature of life care Apparicio required, and State Farm's motion to strike Dr. Barras's report.

The WCJ addressed State Farm's motion to strike in a February 17, 2009, order which vacated the submission and directed further augmentation of the record. The WCJ found that Dr. Barras was not made aware of the purposes for which she was appointed, which included a retroactive analysis of the extent to which lien claimant Pearson's services were reasonable and necessary, and found that Pearson unilaterally submitted documents to Dr. Barras for consideration. The WCJ also found an ambiguity in Dr. Barras's report that required clarification. The WCJ did not find that these issues tainted Dr. Barras's opinion or required it to be stricken, and instead determined that a supplemental opinion from Dr. Barras could rectify these problems. The WCJ therefore vacated the January 27, 2009, order submitting the matter for decision, ordered the parties to jointly submit to Dr. Barras all documents previously submitted into evidence at all hearings and all other medical reports and records in their possession, and ordered that Dr. Barras receive all prior findings and awards, minutes of hearings, and summaries of evidence. The WCJ ordered Dr. Barras to prepare a supplemental report addressing the nature of services reasonably required, determining whether they were more appropriately Certified Nurse's Assistant services or LVN services, and estimating the reasonable number of hours per day Pearson would have been required to provide services in the past.

Dr. Barras served a supplemental report dated May 29, 2009, and the matter was re-submitted for decision. On August 26, 2009, the WCJ's joint supplemental findings and award, and opinion on supplemental decision, found: (1) because of her injuries, Apparicio required a life care plan as described by Dr. Barras's April 18, 2008, plan; (2) lien claimant Pearson had provided attendant care services to Apparicio 24 hours per day from July 24, 2003; (3) the value of Pearson's services, in the capacity of an LVN, was \$30 per hour, for which Pearson was entitled to reimbursement at \$720 per day from July 24, 2003, until implementation of the life care plan by professionals at the employer's expense.

State Farm petitioned for reconsideration and moved to vacate the findings and award. State Farm argued, *inter alia*, that Dr. Barras's reports and opinion should be stricken because *ex parte* communication with Apparicio and Pearson tainted her reports, that Dr. Barras's reports did not constitute substantial medical evidence because she failed to review complete medical records, and that in her deposition testimony Dr. Barras admitted she lacked knowledge of California workers' compensation procedures.

State Farm also argued that the WCJ's finding regarding reimbursement of Pearson for caregiver services was excessive and unreasonable. Specifically, State Farm argued that Pearson's claim for caregiver services was not reasonably necessary to relieve or cure the effects of Apparicio's injury; that Pearson unreasonably asserted entitlement to reimbursement for services provided 24 hours per day, seven days per week; and that \$30 per hour for caregiver services was excessive and unreasonable, because Pearson provided only 2.75 hours of medical services each day and the balance of services involved cooking, cleaning, paying bills, and non-medical errands, which were not reimbursable as medical care at \$30 per hour. State Farm also argued that Pearson failed to meet his burden of proof under sections 5705 and 3202.5.<sup>2</sup>

On November 23, 2009, the WCAB filed its opinion and order denying reconsideration of the WCJ's August 26, 2009, joint supplemental findings and award. The WCAB found that by education, licensure, and experience Dr. Barras was qualified to provide expert opinion regarding the level of attendant care Apparicio required and the value of services Pearson provided, and found that Dr. Barras's reporting was substantial

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<sup>2</sup> Section 5705 states, in relevant part: "The burden of proof rests upon the party or lien claimant holding the affirmative of the issue." Section 3202.5 states: "All parties and lien claimants shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence in order that all parties are considered equal before the law. 'Preponderance of the evidence' means that evidence that, when weighed with that opposed to it, has more convincing force and the greater probability of truth. When weighing the evidence, the test is not the relative number of witnesses, but the relative convincing force of the evidence."

evidence. The WCAB found that the WCJ's decision regarding the hourly rate Pearson was to be paid for services he provided was reasonably based on credible evidence.

The WCAB rejected State Farm's contention that the "taint" of Dr. Barras's reporting because of Pearson and Apparicio's unilateral contacts required that Dr. Barras's reporting be disregarded. The WCAB found that State Farm had a full opportunity to provide Dr. Barras with all relevant information, and deposed Dr. Barras about her qualifications, the information she considered in preparing her April 18, 2008, report, and its content and method of preparation. The WCAB found no substantive evidence that initial contact by Apparicio caused Dr. Barras's reporting to be biased or insubstantial or required that it be disregarded.

The WCAB addressed State Farm's contention that Dr. Barras was not qualified to provide expert opinion on the level of attendant care Apparicio required and the services Pearson provided. The WCAB quoted Dr. Barras's deposition testimony, found that her extensive work experience acquainted her with the needs of persons with disabilities, and determined that her education, licensure as a medical doctor, and personal and professional experiences qualified her to serve as an expert witness.

The WCAB found that the record did not support the assertion that Dr. Barras did not review a complete medical history, and concluded that Dr. Barras was fully informed of Apparicio's diagnosis when she prepared her reports.

With regard to State Farm's contention that the extent and level of care found by the WCJ was excessive, the WCAB concluded that the WCJ's determination was based on Dr. Barras's credible and substantive reporting, whose accuracy State Farm did not dispute. Based on Dr. Barras's testimony, the WCAB concluded that Apparicio's condition and medications required that she be monitored and assisted 24 hours per day, seven days per week, and found that the evidence supported the WCJ's conclusion that the hourly compensation due lien claimant Pearson was near the \$35 hourly rate that State Farm would otherwise have had to pay an LVN to provide 24-hour care. The WCAB stated that services provided by the applicant's spouse did not relieve a defendant from the obligation to pay for those services, and the care Pearson provided by

monitoring and managing Apparicio's health care needs qualified as medical care under section 4600. Therefore the WCAB concluded that Pearson was entitled to be reasonably compensated at the rate such services would command if provided by another. Based on Dr. Barras's testimony that an LVN would be compensated at \$35 an hour, and because State Farm offered no evidence to challenge that \$35 hourly rate, the WCJ's adjustment of the rate to \$30 per hour was in State Farm's favor and was within the range of the only credible evidence in the record concerning the rate for LVN services provided by Pearson. The WCAB therefore affirmed the WCJ's decision that the appropriate rate to compensate Pearson's services was \$30 per hour, and denied State Farm's petition for reconsideration.

State Farm petitions in this court for a writ of review, seeking reversal of the WCAB's November 23, 2009, order denying reconsideration.

### III. ISSUES

State Farm claims that:

1. The reports of Dr. Barras should be stricken and she should be disqualified as a medical examiner; and
2. The WCAB awarded caregiver fees which were excessive and unreasonable.

### IV. DISCUSSION

#### A. *Standard of Review*

With regard to a petition for a writ of review, section 5952 states: "The review by the court shall not be extended further than to determine, based upon the entire record which shall be certified by the appeals board, whether:

- "(a) The appeals board acted without or in excess of its powers.
- "(b) The order, decision, or award was procured by fraud.
- "(c) The order, decision, or award was unreasonable.
- "(d) The order, decision, or award was not supported by substantial evidence.
- "(e) If findings of fact are made, such findings of fact support the order, decision, or award under review.

“Nothing in this section shall permit the court to hold a trial de novo, to take evidence, or to exercise its independent judgment on the evidence.”

“A decision by the WCAB that is based on factual findings which are supported by substantial evidence is affirmed by the reviewing court. Substantial evidence generally means evidence that is credible, reasonable, and of solid value, which a reasonable mind might accept as probative on the issues and adequate to support a conclusion. A factual finding, order, decision or award is not based on substantial evidence if unreasonable, illogical, arbitrary, improbable, or inequitable considering the entire record and statutory scheme. The reviewing court also may not isolate facts which support or disapprove of the WCAB’s conclusions and ignore facts which rebut or explain the supporting evidence, but must examine the entire record. Similarly, the reviewing court may not reweigh evidence or decide disputed facts. [¶] Interpretation of governing statutes or application of the law to undisputed fact is decided de novo by the reviewing court, even though the WCAB’s interpretation is entitled to great weight unless clearly erroneous.” (*Zenith Ins. Co. v. Workers’ Comp. Appeals Bd.* (2008) 159 Cal.App.4th 483, 490, fns. omitted.)

*B. Applicants’ Ex Parte Communications With the Medical Examiner Violated the Prohibition Against Such Communications in Workers’ Compensation Regulations, Which Requires Striking the Medical Examiner’s Reports and Opinions and Disqualification of the Medical Examiner*

State Farm claims that Dr. Barras’s reports should be stricken and she should be disqualified as a medical examiner because Dr. Barras communicated ex parte with Apparicio and Pearson. We agree.

*1. There Was No Waiver of State Farm’s Due Process Objection*

Pearson claims that by failing to object at the time of trial, State Farm waived its request to exclude reports and deposition testimony of Dr. Barras. Issues not raised at the trial level may not be raised for the first time in a petition for writ of review. (*Griffith v. Workers’ Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1265.) State Farm did object to Apparicio and Pearson’s ex parte communications with Dr. Barras by moving to strike

Dr. Barras's report when trial occurred before the WCJ on January 27, 2009. It is unclear whether State Farm raised this objection to Dr. Barras's supplemental report served on May 29, 2009, or when the WCJ conducted further proceedings on August 5, 2009; there is no reporter's transcript of those proceedings and no record of objections made by State Farm. State Farm again objected in its petition for reconsideration of September 11, 2009, which contended that Dr. Barras's reports should be stricken and she should be disqualified as a medical examiner because, inter alia, Dr. Barras communicated ex parte with Apparicio and Pearson. It is of some significance that the WCAB did not treat the issue as having been waived, but instead addressed State Farm's objection to ex parte communications on its merits. Under the unusual circumstances of this case, we deem State Farm to have made a continuing objection, and we find that no waiver occurred.

*2. Prohibited Ex Parte Communication Between Dr. Barras and Claimants  
Apparicio and Pearson Requires Disqualification of Dr. Barras*

Dr. Barras appears to have been appointed as a medical examiner pursuant to section 5701, which states in relevant part: "The appeals board may . . . from time to time direct any employee claiming compensation<sup>[3]</sup> to be examined by a regular physician. The testimony so taken and the results of any inspection or examination shall be reported to the appeals board for its consideration."

State Farm alleged that Apparicio and Pearson scheduled an appointment with Dr. Barras without notifying State Farm, and did not provide State Farm with notice of the time, date, or location of the evaluation. State Farm further alleged that on the day of the evaluation, Apparicio and Pearson provided Dr. Barras with medical records for review which were partial and incomplete and did not include all medical records that State Farm would have provided Dr. Barras if State Farm had been notified of the date, time, and place of the evaluation. These communications with Dr. Barras were with respect to the merits, and were made in connection with Dr. Barras's April 18, 2008, report. The WCJ,

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<sup>3</sup> " 'Compensation' means compensation under this division and includes every benefit or payment conferred by this division upon an injured employee[.]" (§ 3207.)

moreover, relied on that report as a basis for the August 26, 2009, joint supplemental findings and award and opinion on supplemental decision. Apparicio and Pearson do not dispute that these ex parte communications with Dr. Barras occurred; they argue that no prejudice occurred and no bias was created.

Ex parte communications with respect to the merits with a medical examiner appointed pursuant to section 5701 are prohibited. “All correspondence concerning the examination and reports of a physician appointed pursuant to Labor Code Section 5701 . . . shall be made through the Workers’ Compensation Appeals Board, and no party, attorney or representative shall communicate with that physician with respect to the merits of the case unless ordered to do so by the Workers’ Compensation Appeals Board.” (Cal. Code Regs., tit. 8, § 10718.<sup>4</sup>) The prohibition against ex parte communication attempts to prevent decisions based on information not known to one or both parties. An action by “an administrative board exercising adjudicatory functions when based upon information of which the parties were not apprised and which they had no opportunity to controvert amounts to a denial of a hearing.” (*English v. City of Long Beach* (1950) 35 Cal.2d 155, 158.) As a general principle, “ ‘Fundamental fairness in decisionmaking demands both that factual inputs and arguments to the decisionmaker on law and policy be made openly and be subject to argument by all parties.’ ” (*Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2006) 40 Cal.4th 1, 9.)

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<sup>4</sup> California Code of Regulations, title 8, section 10718 was in effect when the ex parte communications took place. A nearly identical prohibition of ex parte communication with the medical examiner became effective on November 17, 2008, and thus was in effect when State Farm moved to strike Dr. Barras’s April 18, 2008, report. Section 10213, subdivision (c) states: “All correspondence concerning the examination and reports of a physician appointed pursuant to Labor Code section 5701 . . . shall be made through the workers’ compensation administrative law judge, and no party, attorney or representative shall communicate with that physician with respect to the merits of the case unless ordered to do so.” (Cal. Code Regs., tit. 8, § 10213, subd. (c).)

Other statutory provisions and regulations similarly prohibit ex parte communication with a medical examiner. Section 4062.3, subdivisions (e) and (f) prohibit ex parte communications with an agreed medical evaluator or a qualified medical evaluator,<sup>5</sup> as does the corresponding regulation.<sup>6</sup>

There are no exceptions for “administrative” or procedural communications or for other classes of ex parte communication which are not on the merits. (See *Alvarez v. Workers’ Comp. Appeals Bd.* (2010) 187 Cal.App.4th 575, 586-588.) The prohibition against ex parte communications is a strict rule, and no showing of prejudice is required to invoke the appropriate remedy. (*Id.* at p. 589.) The applicant and lien claimant violated these requirements in a substantive manner. Dr. Barras should have been disqualified, the reports and opinions of Dr. Barras should have been stricken, and a new medical examiner should have been selected.

The opinion and order denying reconsideration must be annulled and the matter remanded with directions to appoint a new medical examiner. After receiving that medical examiner’s report, the WCAB is to redetermine the expenses for medically necessary treatment for which State Farm is liable, and to recalculate the rate of that reimbursement.

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<sup>5</sup> Section 4062.3, subdivisions (e) and (f) state: “(e) All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.

“(f) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation.”

<sup>6</sup> “Evaluators selected from a [Qualified Medical Evaluator] panel provided by the Administrative Director shall not engage in ex parte communication in violation of Labor Code section 4062.3.” (Cal. Code Regs., tit. 8, § 41(b).)

*C. The Award of Compensation to Pearson for Caregiver Services Was Unreasonable, Was Not Authorized by Section 4600, Subdivision (a), and Was Not Supported by Substantial Evidence*

State Farm claims that the WCAB erroneously awarded fees for caregiver services because reimbursement for services Pearson allegedly provided 24 hours per day, seven days per week was unreasonable, and because a \$30 hourly rate of reimbursement was excessive.

*1. The Award of Compensation to Pearson for Caregiver Services 24 Hours Per Day, Seven Days Per Week Was Unreasonable and Was Not Supported by Substantial Evidence; Section 4600, Subdivision (a) Did Not Authorize Compensation by the Employer for Numerous Services Pearson Provided*

The WCAB affirmed the WCJ's finding that the nature of Apparicio's condition and the medications she received required that she be monitored and assisted 24 hours per day, seven days per week.

A first problem concerns the evidence supporting the finding that Pearson monitored and assisted Apparicio 24 hours per day, seven days per week. Apparicio provided evidence of caregiver services provided by Pearson in a list which set forth the daily average times that he provided services. These times do not total 24 hours per day, except for the final item, "assist [Apparicio] at night," which was listed as "24 hrs." An award of compensation based on Pearson's alleged caregiver services 24 hours per day, seven days per week is therefore unreasonable under section 5952, subdivision (c), and based on this record substantial evidence did not support this award under section 5952, subdivision (d).

A second problem with the evidence of caregiver services Pearson allegedly provided is that many of those services do not constitute treatment which the employer is required to provide the injured worker. The employer is required to provide an injured worker with care reasonably required to cure or relieve the worker from the effects of the injury. Section 4600, subdivision (a) states: "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.”

Care provided by a family member to monitor and manage the industrially injured worker’s health care needs may qualify in some cases as medical care under section 4600. (*Hodgman v. Workers’ Comp. Appeals Bd.* (2007) 155 Cal.App.4th 44, 54 [mother of injured worker, who was also his conservator, could be reimbursed for monitoring and managing her son’s health care needs].) In *Henson v. Workmen’s Comp. Appeals Bd.* (1972) 27 Cal.App.3d 452, the worker’s treating physician knew that practical nursing services were required and that the worker’s wife was providing them. *Henson* found that the wife could be compensated for those services. (*Id.* at pp. 461-462.) *Smyers v. Workers’ Comp. Appeals Bd.* (1984) 157 Cal.App.3d 36 held that when a physician recommended or prescribed, for medical reasons, that housekeeping services be performed for the injured worker, those services could be reimbursed under section 4600 as medical treatment reasonably required to cure or relieve the effects of the injury. (*Id.* at pp. 41-43.)

Apparicio’s list of caregiver services provided by Pearson included numerous categories of caregiver services which do not appear to have qualified as medical treatment reasonably required by section 4600. The matter must be remanded to the WCAB to redetermine which of the caregiver services Pearson provided were “medical treatment” under section 4600 which the employer was required to provide or for which the employer was liable for reasonable expense incurred on behalf of the employee in providing treatment.

2. *The Services to Be Compensated, and the Rate of Compensation for Caregiver Services Provided by Pearson, Must Be Redetermined*

The WCAB affirmed the WCJ's finding that an appropriate rate for care provided by Pearson was \$30 per hour. The WCJ cited Dr. Barras's life care plan, which included licensed vocational nursing services that Dr. Barras valued at \$35 per hour. The WCJ also cited Pearson's testimony that State Farm provided services at a \$30 hourly rate during 2002 before terminating those services for reasons State Farm never explained. The WCJ found that this fact, and Dr. Barras's opinion that Pearson's services were in the nature of an LVN's services, provided substantial evidence to support a \$30 hourly rate. This finding was erroneous.

First, a \$30 hourly payment for services which are not included under section 4600, subdivision (a) is unreasonable and is an act in excess of the powers of the appeals board (section 5952, subdivisions (a) and (c)).

Second, the hourly rate of compensation was excessive for categories of services Pearson provided which were not LVN services.

3. *Conclusion*

The compensation of Pearson at a rate of \$30 per hour, seven days a week, 24 hours a day was not justified.

1. Under the circumstances of this case, an award of compensation based on caregiver services provided seven days a week, 24 hours a day is unreasonable;

2. Some services provided by Pearson, if medically necessary and reasonable, were compensable as medical treatment but not at an LVN hourly rate.

3. Other services provided by Pearson do not appear to have been medically necessary, and were not services that section 4600, subdivision (a) required the employer to provide or for whose expense the employer was liable.

The opinion and order denying reconsideration must be annulled and the matter remanded for proceedings to redetermine the compensation to be awarded lien claimant Pearson after appointment of a new medical examiner and preparation of a new report.

## V. DISPOSITION

The opinion and order denying reconsideration is annulled and the matter is remanded for further proceedings consistent with this opinion. The parties are ordered to bear their own costs.

### **CERTIFIED FOR PARTIAL PUBLICATION**

KITCHING, J.

We concur:

CROSKEY, Acting P. J.

ALDRICH, J.

**CERTIFIED FOR PUBLICATION**

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

CARLOS ALVAREZ,

Petitioner,

v.

WORKERS' COMPENSATION  
APPEALS BOARD; STATE  
COMPENSATION INSURANCE FUND  
et al.,

Respondents.

No. B218847

(W.C.A.B. Nos. ADJ3636557,  
LAO0863476)

PROCEEDINGS to review a decision of the Workers' Compensation Appeals Board. Anulled and remanded.

Law Offices of Carl A. Feldman, Carl A. Feldman, Susan Garrett for Petitioner.

Suzanne Ah-Tye, Patricia Brown Hein and David M. Goi for Respondents State Compensation Insurance Fund and Andromeda Entertainment Inc.

No appearance for Respondent Workers' Compensation Appeals Board.

In a denied workers' compensation claim for death benefits, a panel qualified medical evaluator (Lab. Code § 4062.2)<sup>1</sup> requested a copy of certain records in an ex parte telephone conversation with defense counsel. The claimant objected to the ex parte communication and petitioned, inter alia, for a new panel qualified medical evaluator under section 4062.3, subdivision (f), which prohibits ex parte communications between a party and a panel qualified medical evaluator and, in the event of a violation, allows the other party to seek a new panel qualified medical evaluator from another panel. The Workers' Compensation Appeals Board (WCAB) denied the petition, reasoning that the ex parte communication was initiated by the panel qualified medical evaluator and not a party, and involved administrative and not substantive matters or the merits of the claim.

The claimant petitioned for writ of review, contending that section 4062.3, subdivision (f) explicitly precludes any ex parte communication between a panel qualified medical evaluator and a party and that the WCAB may not add an exception not contained in the statute. Petitioner also asserted that the failure to enforce the prohibition against the ex parte communications denied him due process of law and was not based on substantial evidence. We hold that section 4062.3 expressly prohibits ex parte communications with a panel qualified medical evaluator, with the only exception being for communications by the employee or deceased employee's dependent in connection with an examination, and in the event of unauthorized ex parte communication permits the aggrieved party to obtain a new evaluation from another panel qualified medical evaluator. We therefore annul the WCAB's decision and remand the matter to the WCAB.

### **FACTUAL AND PROCEDURAL BACKGROUND**

Respondent Andromeda Entertainment, Inc. conducted business under the name Galaxy Ballroom. Maria Parades was a waitress for Galaxy Ballroom. She died from intracerebellar hemorrhage and hypertension on September 21, 2005. Carlos Alvarez

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<sup>1</sup> All further statutory references are to the Labor Code unless otherwise indicated.

(Alvarez or petitioner), her widower and guardian at litem of their two minor children, filed a claim for workers' compensation death benefits, alleging that Parades's death was caused by her work. The workers' compensation insurer, State Compensation Insurance Fund (Fund), denied the claim.

Donald Miller, M.D., was selected as a panel qualified medical evaluator pursuant to section 4062.2.<sup>2</sup> Dr. Miller issued a medical report dated September 20, 2008.

On December 4, 2008, Dr. Miller testified in his deposition that medical records indicated that Parades suffered from stress, severe headaches, and possible initial cerebral bleeding approximately three months before her death, and that one of Parades's sisters had said that a possible source of Parades's stress was the alleged sexual abuse by Alvarez of his daughter that had resulted in a restraining order against Alvarez. Dr. Miller, however, could not specify the medical record or cite the page that contained the sister's statement. Dr. Miller testified that he may have obtained from an "investigative report" or "background report" information that one of Parades's sisters had never heard Parades complain of harassment at work, but apparently Dr. Miller's medical report did not identify any investigative or background report as one of the documents he received or upon which he relied. Dr. Miller said that the report "may be . . . put away with all these records there on the side," and that he "would have to go through that whole stack." Dr. Miller could not identify his source of information in the "Review of Medical Records" section of his report, which summarized 635 pages of records sent to him by the defense attorney or insurance company. Dr. Miller said he would be willing to review

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<sup>2</sup> Section 4062.2, subdivision (b) states in part: "If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may commence the selection process for an agreed medical evaluator . . . . If no agreement is reached . . . either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation."

Section 4062.2, subdivision (c) adds in part: "Within 10 days of assignment of the panel by the administrative director, the parties shall confer and attempt to agree upon an agreed medical evaluator from the panel. If the parties have not agreed . . . each party may then strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator."

and clarify the records he had received or relied upon as required by section 4062.3, subdivision (d), including eight pages described only as “miscellaneous records”.<sup>3</sup>

On December 5, 2008, Dr. Miller telephoned the attorney for the Fund who had attended Dr. Miller’s deposition. Dr. Miller stated that the records could not be located and requested another copy.

In a letter dated the same day, defense counsel wrote opposing counsel that, at the conclusion of Dr. Miller’s deposition, the parties and Dr. Miller had agreed that Dr. Miller “would more specifically describe the 635 pages of records he testified he reviewed, as he believed he still had them. However, I just received a brief telephone call from Dr. Miller who stated that the records have not been found and presumably were shredded by his staff after his review.” Defense counsel suggested that the records would have to be resent if the parties desired more specificity, and that the adjuster should be contacted directly.

In a letter dated December 9, 2008, counsel for Alvarez responded that defense counsel had “clearly violated the Labor Code by having an ex parte conversation with the Panel QME.” Alvarez subsequently filed a petition objecting to the ex parte communication between Dr. Miller and defense counsel. Alvarez requested that Dr. Miller’s report be stricken; that a new panel qualified medical evaluator be selected; and that penalties and sanctions be imposed, including costs and attorney’s fees under sections 4062.3 and 5813.<sup>4</sup>

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<sup>3</sup> Section 4062.3, subdivision (d) provides: “In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following: (1) All information received from the parties. (2) All information reviewed in preparation of the report. (3) All information relied upon in the formulation of his or her opinion.”

<sup>4</sup> Section 4062.3 provides in part: “(e) All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator. (f) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or a qualified medical evaluator in violation of subdivision (e),

At trial, defense counsel testified that Dr. Miller called on her direct line and advised that his office could not locate some records previously sent. Defense counsel testified further that telephone calls from doctors are not customary, and it took a “couple of beats” to identify the caller. Defense counsel’s practice is to terminate an inappropriate call as soon as possible. When defense counsel realized who was calling, she terminated the call as soon as possible. She testified that the call lasted less than one minute. Defense counsel informed Dr. Miller that counsel for Alvarez would be contacted to see how getting another copy of records to the doctor should be handled. Defense counsel said to Dr. Miller that he should not be calling directly. According to defense counsel, Dr. Miller only requested medical documents that Dr. Miller’s office could not locate, and there was no discussion about the merits of the case or anything else. Immediately after the call, defense counsel sent a letter to opposing counsel referring to the conversation and stating that as a result, if opposing counsel desired more specificity, the documents would have to be resent to Dr. Miller and that opposing counsel should contact the adjuster.

The workers’ compensation administrative law judge (WCJ) issued Findings And Order that there was no improper ex parte communication between defense counsel and the panel qualified medical evaluator in violation of section 4062.3. The WCJ also

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the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation. (g) The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the medical evaluation, additional discovery costs, and attorney’s fees for related discovery.”

Section 5813, subdivision (a), provides: “(a) The workers’ compensation referee or appeals board may order a party, the party’s attorney, or both, to pay any reasonable expenses, including attorney’s fees and costs, incurred by another party as a result of bad-faith actions or tactics that are frivolous or solely intended to cause unnecessary delay. In addition, a workers’ compensation referee or the appeals board, in its sole discretion, may order additional sanctions not to exceed two thousand five hundred dollars (\$2,500) to be transmitted to the General Fund.”

denied Alvarez's petition to strike Dr. Miller's report and request for penalties and sanctions. In his opinion, the WCJ explained that the Findings And Order were based on the credible and un rebutted testimony of defense counsel.

Alvarez petitioned the WCAB for reconsideration, contending that the Dr. Miller's ex parte conversation with defense counsel regarding the records violated the express provisions of section 4062.3. Alvarez contended further that the WCJ exceeded his authority by adding exceptions to the plain language of section 4062.3, which prohibits all ex parte communications with the panel qualified medical evaluator, unless by the employee or employee's dependent if the employee is deceased, in connection with an examination. Alvarez noted that the new qualified medical evaluator regulations also prohibit all ex parte communications and that a single violation may result in a penalty. (Cal. Code Regs., tit. 8, §§ 35, subd. (b)(1), 41, subd. (b), 60, subd. (b)(7).)

In the report on reconsideration, the WCJ stated that if every ex parte communication with a panel qualified medical evaluator violated section 4062.3, administrative matters such as scheduling appointments, confirming appearances or receipt of records would require conference calls or correspondences between parties, which would be contrary to meeting statutory deadlines and providing benefits to employees expeditiously. The WCJ explained that ex parte communications are not prohibited or improper when they involved only administrative or procedural matters and not the merits of the case or either side gains an advantage.

The WCAB denied Alvarez's petition for reconsideration and agreed with the WCJ's report that the ex parte communication was initiated by Dr. Miller and concerned an administrative rather than a substantive matter. The WCAB explained that, "The purpose of section 4062.3 is to protect the impartiality of the medical-legal process, and a 'party' who initiates communication without prior notice to the opposing party may be perceived by the QME as attempting to influence the process. That did not happen here. (See *Carchidi v. Workers' Comp. Appeals Bd.* (1998) 63 Cal.Comp.Cases 291 [writ

denied].)”<sup>5</sup> The WCAB added that the ex parte communication related back to an administrative matter discussed at the deposition, which was not ex parte. The WCAB also concluded that section 4062.3 is concerned with a *party* initiating an ex parte communication, which did not occur here.

#### **A. Standard of Review and Statutory Interpretation**

We review a decision by the WCAB based on factual findings under the substantial evidence standard of review. (*Gaytan v. Workers’ Comp. Appeals Bd.* (2003) 109 Cal.App.4th 200, 214, “While workers’ compensation is liberally construed with the purpose of extending benefits to industrially injured workers (§ 3202; *Arriaga v. County of Alameda* (1995) 9 Cal.4th 1055, 1065 [40 Cal.Rptr.2d 116, 892 P.2d 150]), an appellate court is not bound to accept factual findings if unreasonable, illogical, arbitrary, improbable, or inequitable considering the entire record and overall statutory scheme.” (*Gaytan v. Workers’ Comp. Appeals Bd.*, *supra*, 109 Cal.App.4th at p. 214.) “In contrast, interpretation of governing statutes is decided de novo by the appellate court, even though the WCAB’s construction is entitled to great weight unless clearly erroneous. (*Boehm & Associates v. Workers’ Comp. Appeals Bd.* (1999) 76 Cal.App.4th 513, 515-516 [90 Cal.Rptr.2d 486] (*Boehm*); *Ralphs Grocery Co. v. Workers’ Comp. Appeals Bd.* (1995) 38 Cal.App.4th 820, 828 [45 Cal.Rptr.2d 197] (*Ralphs Grocery Co.*)).) When interpreting a statute, the Legislature’s intent should be determined and given effect. (*Moyer v. Workmen’s Comp. Appeals Bd.* (1973) 10 Cal.3d 222, 230 [110 Cal.Rptr. 144, 514 P.2d 1224] (*Moyer*)).) The best indicator of legislative intent is the plain meaning of the statutory language, when clear and unambiguous. (*DuBois v. Workers’ Comp.*

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<sup>5</sup> In *Carchidi v. Workers’ Comp. Appeals Bd.*, *supra*, 63 Cal.Comp.Cases 291, the WCAB determined that an agreed medical evaluator’s report was admissible to determine that the employee’s injury did not arise out of or in the course of employment when a job analysis was sent by the defendant ex parte to the medical evaluator with no intent to influence the physician’s opinion, the medical report was not admitted to determine qualified injured worker status, and the employee did not attempt to end the evaluation for months after receiving the report.

*Appeals Bd.* (1993) 5 Cal.4th 382, 387-388 [20 Cal.Rptr.2d 523, 853 P.2d 978] (*DuBois*); *Moyer, supra*, 10 Cal.3d at p. 230; *Boehm, supra*, 76 Cal.App.4th at p. 516.) Finally, the statute should be interpreted consistently with its intended purpose, and harmonized within the statutory framework as a whole. (*DuBois, supra*, 5 Cal.4th at p. 388.)” (*Gaytan v. Workers’ Comp. Appeals Bd., supra*, 109 Cal.App.4th at pp. 214-215; see *Signature Fruit Co. v. Workers’ Comp. Appeals Bd.* (2006) 142 Cal.App.4th 790, 800-801.)

### **B. Statutory Language Governs**

Section 4062.3, subdivision (e) provides in pertinent part, “All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party.” Section 4062.3, subdivision (f) begins by stating, “Ex parte communication with an agreed medical evaluator or qualified medical evaluator selected from a panel is prohibited.”

The statutory language clearly evidences the intent of the Legislature to prohibit unauthorized ex parte communication, whether written or oral, between a party and an agreed or panel qualified medical evaluator. The regulations pertaining to qualified medical evaluators, although effective February 17, 2009—after the event in issue here—reflect the prohibition of ex parte communications with a qualified medical evaluator as

set forth in section 4062.3,<sup>6</sup> and provide that even a single violation can result in discipline.<sup>7</sup>

Section 4062.3 does not provide that some ex parte communications are permissible, as suggested by the WCJ and WCAB. Although section 4062.3 sets forth detailed procedures by which parties are to disclose information and records to the medical evaluator and provides remedies for violations of those procedures, the statute does not distinguish between ex parte communications on the basis of whether the communication was initiated by a party or by the medical evaluator. To hold that the statute does not proscribe ex parte communications initiated by the medical evaluator

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<sup>6</sup> California Code of Regulations, title 8, section 41(b) provides: “Evaluators selected from a QME panel provided by the Administrative Director shall not engage in ex parte communication in violation of Labor Code section 4062.3.”

California Code of Regulations, title 8, section 35(b)(1) provides: “All communications by the parties with the evaluator shall be in writing and sent simultaneously to the opposing party when sent to the medical director, except as otherwise provided in subdivisions (c), (k) and (l) of this section.”

California Code of Regulations, title 8, section 35(k) provides: “The Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator. Oral or written communications by the employee, or if the employee is deceased by the employee’s dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication.”

<sup>7</sup> California Code of Regulations, title 8, section 60(b) provides in part: “The Administrative Director may, based on a complaint by the Medical Director, and following a hearing pursuant to section 61 of Title 8 of the California Code of Regulations, suspend, terminate or place on probation a QME found in violation of a statutory or administrative duty as described in the Administrative Director Sanction Guidelines for QMEs under section 65 of Title 8 of the California Code of Regulations. Such violations include, but are not limited to [¶] . . . [¶] (7) one finding by the Appeals Board of ex parte contact by the QME prohibited by Labor Code section 4062.3.”

would suggest that a party is excused from the proscriptions of section 4062.3 and may discuss the merits of the case with the medical evaluator based solely on the fortuity that the medical evaluator initiated the conversation. To so hold would undermine the statute's purpose.

Section 4062.3 also does not state that ex parte communications are permissible if the subject matter is administrative or procedural rather than substantive or on the merits. The only statutory exception to the proscription against ex parte communications is set forth in section 4062.3, subdivision (h)<sup>8</sup> which concerns communication by the employee or the deceased employee's dependent in the course of or in connection with the examination.

Neither the WCJ nor the WCAB may graft exceptions to a clear statutory prohibition language to accomplish a presumed legislative purpose or intent that does not appear on the face of the statute or from the legislative history. (See *Burden v. Snowden* (1992) 2 Cal.4th 556, 562; *California Teachers Assn. v. Governing Board of Rialto Unified School Dist.* (1997) 14 Cal.4th 627, 633; *California Teachers Assn. v. San Diego Community College Dist.* (1981) 28 Cal.3d 692.) There is nothing in the legislative history of which we are aware that supports the interpretation by the WCJ or WCAB.

When the Legislature has intended to provide an exception to the prohibitions on ex parte communications, it has expressly so stated. For example, as noted, section 4062.3, subdivision (h) states, "Subdivisions (e) and (f) shall not apply to written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination." The Legislature has set forth exceptions to prohibitions on ex parte communications in other statutes. Under the Administrative Procedures Act (Gov. Code, § 11340 et seq.), the Legislature provided that ex parte

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<sup>8</sup> Section 4062.3, subdivision (h) states: "Subdivisions (e) and (f) shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination."

communications otherwise precluded are permissible, inter alia, if “the communication concerns a matter of procedure or practice, including a request for a continuance, that is not in controversy.” (Gov. Code, § 11430.20, subd. (b); see *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2006) 40 Cal.4th 1.) Business and Professions code section 19872, subdivisions (a), (b) and (c), prohibits ex parte communications with the Gambling Control Commission “upon the merits” of an application. Public Resources Code section 30324 allows ex parte communications with a Coastal Commission member only if disclosure is made within a specified period. (See also, e.g., Water Code, § 8578; Pub. Res. Code, §§ 663.1, 663.2, 30324; Pub. Util. Code, §§ 1701.1, subds. (a), (c)(4), 1701.3, subd. (c).) The California Rules of Professional Conduct prohibit lawyers from having ex parte communications with a judge “upon the merits of a contested matter.” (Rules Prof. Conduct, rule 5-300(B).) The California Code of Judicial Ethics provides that a judge “shall not initiate, permit, or consider an ex parte application communications . . . except . . . (d) A judge may initiate ex parte communications, where circumstances require, for scheduling, administrative purposes, or emergencies that do not deal with substantive matters” so long as certain conditions are met. (Cal. Code Jud. Ethics, canon 3B(7)(d).) The California Ethics Standards for Neutral Arbitrators in Contractual Arbitration, promulgated pursuant to Code of Civil Procedure section 1281.85, subdivision (a) provides in Standard 14, subdivision (a) that an arbitrator “must not initiate, permit, or consider any ex parte communications,” except that “(b) [a]n arbitrator may communicate with a party in the absence of other parties about administrative matters, such as setting the time and place of hearings or making other arrangements for the conduct of the proceedings, as long as the arbitrator reasonably believes that the communication will not result in a procedural or tactical advantage for any party.” None of these express exceptions is contained in section 4062.3.

Moreover, California Code of Regulations, title 8, section 10718 prohibits ex parte communications with a “regular physician” (section 5701) or qualified medical evaluator when the employee is unrepresented (section 5703.5) “with respect to the merits of the

case unless ordered to do so by the Workers' Compensation Appeals Board.” This regulation, or a variation of it, has been in effect for a number of years.<sup>9</sup> With this background, the Legislature in section 4062.3 prohibited ex parte communications without limiting the prohibition to communications on the merits. That further suggests that the Legislature did not intend such a limitation in connection with section 4062.3.

The WCJ relied upon *Mathew Zaheri Corp. v. New Motor Vehicle Bd.* (1997) 55 Cal.App.4th 1305, in which the court affirmed a trial court decision denying a writ of mandamus to set aside a New Motor Vehicle Board decision because of an ex parte communication between the franchisor's counsel and the administrative law judges. Counsel for the franchisor had told the administrative law judge that he feared for his safety. The trial court determined that the communication did not violate the terms of the Administrative Procedures Act then in effect and applicable to the Vehicle Code. The court said the ex parte communication was a non prejudicial breach of legal ethics, but did not constitute a statutory violation, and was not a miscarriage of justice. Here, in contrast, we deal with a violation of an express statutory provision and not just an ethical lapse.

Prejudice, or lack thereof, is not a consideration. Although the violation might seem innocuous, there is no way for the WCAB to determine what exactly was said during the communication or the effect of the communication. (See *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.*, *supra*, 40 Cal.4th at p. 16.) Although we have no basis to believe and do not imply that defense counsel was not truthful in her testimony, it is nevertheless possible that the only sources of information regarding the content of an oral ex parte communication—those who participated in it—will have an incentive to deny that any impropriety occurred. One can hardly blame an advocate for being skeptical when the only evidence available on an issue is the unverifiable, denial of a statutory violation by his or her adversary. As a

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<sup>9</sup> See, e.g., former Cal. Code of Regs., title 8, section 10718 (1981); *Boardman v. Industrial Acc. Com.* (1956) 140 Cal.App.2d 273, 275-277 [Regulation in effect then had no limitation for the merits for ex parte communications].

result, under the rule proposed by the WCJ and WCAB, the mere act of inquiring into whether the subject of an ex parte communication was substantive or procedural undermines the appearance of impartiality and the legitimacy of the judicial process. It is to avoid such difficulties that section 4062.3 prohibits ex parte communications and mandates that all communications between counsel and the medical evaluator “shall be *in writing* and shall be served on the opposing party when sent to the medical evaluator.” (§ 4062.3, subd. (e), italics added.)

That the panel qualified medical evaluator felt comfortable with communicating ex parte with counsel for one party about the former’s purported sources of information might also be disquieting to the other party. The subject of the records was a sensitive one. Dr. Miller testified about certain statements by or concerning the decedent’s family members and attributed them to records. But he could not identify or locate the records upon which he purportedly relied, and that is why he made the ex parte call to the defense counsel. Defense counsel said that if the parties “desire more specificity in the doctor’s description of the records he reviewed, we will have to resend them.” This seems to suggest that a decision was reached between Dr. Miller and defense counsel—and to the exclusion of petitioner’s counsel—as to how to proceed with respect to the documents. Even if the communication might appear relatively harmless, we do not know how it might affect petitioner’s strategy, if at all. The subtle effects of any ex parte communication may be why the Legislature prohibited unauthorized ex parte communication.

With regard to ex parte communications with a judge or arbitrator, the judge or arbitrator, based on his or her training and experience, would be expected to be able to draw a distinction between purely procedural and scheduling matters on the one hand and matters affecting the merits on the other hand. So it is understandable why the Legislature carved out the exceptions to ex parte communications in that context. But medical evaluators do not have the same background that judges and arbitrators have to draw such distinctions. In a field that is dependent on expert medical opinions, the impartiality and appearance of impartiality of the panel qualified medical evaluator is

critical. Thus, there are justifications for a strict rule prohibiting all ex parte communications in this context.

In view of our conclusion, we do not reach the due process or substantial evidence issues.

### **DISPOSITION**

The ex parte communication between Dr. Miller and defense counsel violated provisions of section 4062.3, subdivisions (e) and (f). Alvarez is entitled to a new panel qualified medical evaluator. The decision of the WCAB is annulled and the matter is remanded for further proceedings consistent with this opinion. Petitioner is awarded his costs.

### **CERTIFIED FOR PUBLICATION**

MOSK, J.

We concur:

ARMSTRONG, Acting P. J.

FERNS, J.\*

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\* Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

**TITLE 8. INDUSTRIAL RELATIONS**  
**DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS**  
**CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR**

Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure

§31.5. QME Replacement Requests

(a) A replacement QME to a panel, or at the discretion of the Medical Director a replacement of an entire panel of QMEs, shall be selected at random by the Medical Director and provided upon request whenever any of the following occurs:

- (1) A QME on the panel issued does not practice in the specialty requested by the party holding the legal right to request the panel.
- (2) A QME on the panel issued cannot schedule an examination for the employee within sixty (60) days of the initial request for an appointment, or if the 60 day scheduling limit has been waived pursuant to section 33(e) of Title 8 of the California Code of Regulations, the QME cannot schedule the examination within ninety (90) days of the date of the initial request for an appointment.
- (3) The injured worker has changed his or her residence address since the QME panel was issued and prior to date of the initial evaluation of the injured worker.
- (4) A physician on the QME panel is a member of the same group practice as defined by Labor Code section 139.3 as another QME on the panel.
- (5) The QME is unavailable pursuant to section 33 (Unavailability of the QME).
- (6) The evaluator who previously reported in the case is no longer available.
- (7) A QME named on the panel is currently, or has been, the employee's primary treating physician or secondary physician as described in section 9785 of Title 8 of the California Code of Regulations for the injury currently in dispute.
- (8) The claims administrator, or if none the employer, and the employee agree in writing, for the employee's convenience only, that a new panel may be issued in the geographic area of the employee's work place and a copy of the employee's agreement is submitted with the panel replacement request.
- (9) The Medical Director, upon written request, finds good cause that a replacement QME or a replacement panel is appropriate for reasons related to the medical nature of the injury. For purposes of this subsection, "good cause" is defined as a documented medical or psychological impairment.

(10) The Medical Director, upon written request, filed with a copy of the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021 [see 8 Cal. Code Regs. §§ 14006 and 14007) and the most recent DWC Form PR-2 ("Primary Treating Physician's Progress Report" [See 8 Cal. Code Regs. § 9785.2) or narrative report filed in lieu of the PR-2, determines after a review of all appropriate records that the specialty chosen by the party holding the legal right to designate a specialty is medically or otherwise inappropriate for the disputed medical issue(s). The Medical Director may request either party to provide additional information or records necessary for the determination.

(11) The evaluator has violated section 34 (Appointment Notification and Cancellation) of Title 8 of the California Code of Regulations, except that the evaluator will not be replaced for this reason whenever the request for a replacement by a party is made more than fifteen (15) calendar days from either the date the party became aware of the violation of section 34 of Title 8 of the California Code of Regulations or the date the report was served by the evaluator, whichever is earlier.

(12) The evaluator failed to meet the deadlines specified in Labor Code section 4062.5 and section 38 (Medical Evaluation Time Frames) of Title 8 of the California Code of Regulations and the party requesting the replacement objected to the report on the grounds of lateness prior to the date the evaluator served the report. A party requesting a replacement on this ground shall attach to the request for a replacement a copy of the party's objection to the untimely report.

(13) The QME has a disqualifying conflict of interest as defined in section 41.5 of Title 8 of the California Code of Regulations.

(14) The Administrative Director has issued an order pursuant to section 10164(c) of Title 8 of the California Code of Regulations (order for additional QME evaluation).

(15) The selected medical evaluator, who otherwise appears to be qualified and competent to address all disputed medical issues refuses to provide, when requested by a party or by the Medical Director, either: A) a complete medical evaluation as provided in Labor Code sections 4062.3(i) and 4062.3(j), or B) a written statement that explains why the evaluator believes he or she is not medically qualified or medically competent to address one or more issues in dispute in the case.

(16) The QME panel list was issued more than twenty four (24) months prior to the date the request for a replacement is received by the Medical Unit, and none of the QMEs on the panel list have examined the injured worker.

(b) Whenever the Medical Director determines that a request made pursuant to subdivision 31.5(a) for a QME replacement or QME panel replacement is valid, the time limit for an unrepresented employee to select a QME and schedule an appointment under section Labor Code section 4062.1(c) and the time limit for a represented employee to strike a QME name from the QME panel under Labor Code section 4062.2(c), shall be tolled until the date the replacement

QME name or QME panel is issued.

(c) In the event the parties in a represented case have struck two QME names from a panel and subsequently a valid ground under subdivision 31.5 arises to replace the remaining QME, none of the QMEs whose names appeared on the earlier QME panel shall be included in the replacement QME panel.

#### NOTE

Authority cited: Sections 133, 139.2, 4061, 4062, 4062.3, 4062.5, 5307.3 and 5703.5, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

#### HISTORY

1. New section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).
2. Amendment of subsections (b), (b)(1) and (b)(3) and new subsections (b)(4)-(5) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

## **TITLE 8. INDUSTRIAL RELATIONS**

### **DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS**

#### **CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR**

##### Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure

#### **§31.7. Obtaining Additional QME Panel in a Different Specialty**

(a) Once an Agreed Medical Evaluator, an Agreed Panel QME, or a panel Qualified Medical Evaluator has issued a comprehensive medical/legal report in a case and a new medical dispute arises, the parties, to the extent possible, shall obtain a follow-up evaluation or a supplemental evaluation from the same evaluator.

(b) Upon a showing of good cause that a panel of QME physicians in a different specialty is needed to assist the parties reach an expeditious and just resolution of disputed medical issues in the case, the Medical Director shall issue an additional panel of QME physicians selected at random in the specialty requested. For the purpose of this section, good cause means:

(1) An order by a Workers' Compensation Administrative Law Judge for a panel of QME physicians that also either designates a party to select the specialty or states the specialty to be selected and the residential or employment-based zip code from which to randomly select evaluators; or

(2) The AME or QME selected advises the parties and the Medical Director, or his or her designee, that she or he has completed or will complete a timely evaluation of the disputed medical issues within his or her scope of practice and areas of clinical competence but recommends that a new evaluator in another specialty is needed to evaluate one or more remaining disputed medical conditions, injuries or issues that are outside of the evaluator's areas of clinical competence, and either the injured worker is unrepresented or the parties in a represented case have been unable to select an Agreed Medical Evaluator for that purpose; or

(3) A written agreement by the parties in a represented case that there is a need for an additional comprehensive medical legal report by an evaluator in a different specialty, that attempts to select an Agreed Medical Evaluator pursuant to Labor Code section 4062.2 for that purpose have failed and the specialty that the parties have agreed upon for the additional evaluation; or

(4) In an unrepresented case, that the parties have conferred with an Information and Assistance Officer, have explained the need for an additional QME evaluator in another specialty to address disputed issues and, as noted by the Information and Assistance Officer on the panel request form, the parties have reached agreement in the presence of and with the assistance of the Officer on the specialty requested for the additional QME panel. The parties may confer with the Information and Assistance Officer in person or by conference call.

#### NOTE

Authority cited: Sections 133, 139.2, 4061, 4062, 4062.3, 4062.5, 5307.3 and 5703.5, Labor Code. Reference: Sections 139.2, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

#### HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).