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Request for Depublication
[Rule 8.1125]

Hon. Chief Justice Tani Cantil-Sakauye
and Associate Justices
Supreme Court of California
350 McAllister Street
San Francisco, CA 94102

Re: Kirk King, et al. v. CompPartners, Inc, et al.
Fourth District, Div. 2 – E063527

Dear Chief Justice and Associate Justices:

This office represents the California Workers' Compensation Institute, and on their behalf, and for the reasons outlined below, we submit this letter pursuant to Rule 8.1125 to urge this Court to order the opinion below depublished.

The California Workers' Compensation Institute is a private, nonprofit organization of insurers licensed to write workers' compensation in California, as well as public and private self-insured employers, who serve as associate members. Its members include insurers writing 70% of California's workers' compensation premium, and self-insured employers with $42B of annual payroll (24% of the state's total annual self-insured payroll. CWCI's primary function is to generate reliable, objective data that can be used to identify and monitor system-wide trends, assist members in assessing their own operations, and to analyze key issues of interest to the workers' compensation community and public policymakers. As a research institute, CWCI routinely publishes reports which spotlight issues and identify trends within the system. That research helps build consensus on practical solutions, and is often used to evaluate the impact of various

legislative and regulatory proposals. At the same time, CWCI provides a voice for industry perspectives and concerns through legislative and regulatory testimony and amicus briefs in key court cases such as this one.

This case came before the Court at an early stage of development as a result of a demurrer, and the briefing reflects expertise in civil litigation and procedure but not in workers' compensation. As a result, in the view of the CWCI, the Court's rationale reflects what we see as a foundational lack of full awareness of the unique nature of the highly regulated workers' compensation Utilization Review process, and the different adversarial roles of the advocates involved, including treating physicians vs. utilization review physicians. Because of those subtle differences, the decision below may become a blunt instrument to dismantle the decades of legislative reforms leading up to the adoption of UR as a means to enforce higher quality medical decision-making and improve outcomes through "evidence based medicine", and thus the decision threatens the entre workers' compensation medical delivery system. Because of that implication, and the absence of detailed analysis of the role of utilization review in workers compensation, we request depublication.

Regarding both the "exclusive remedy" and the "duty" issue which are at the heart of the opinion below, the historically adversarial roles of treating physicians and evaluating physicians in the workers' compensation system have evolved over many years, and multiple legislative reforms recognize those adversarial roles … one advocating for the patient and the other advocating for the employer. Though not as detailed and exhaustive as a legal brief, below we highlight both the legislative and regulatory backdrop which we feel were absent from the parties' briefing and Court's analysis, and thus warrant depublication.

The workers' compensation act as originally enacted gave employers control over the selection of medical providers for the life of the claim [stats 1913, Chapter 175, Sec. 15(a)], and the employer was liable for employee-selected treatment expenses only where the employer had neglected or refused to provide the necessary service [*see*, *Leadbettor v. IAC*. (1918) 179

Cal 468, 177 P 44.]. After more than half a century of employer control, in 1975 the employee was given control over provider selection after 30 days from the date the injury was reported to the employer [(stats 1975, Chapter 1529, Section 1, amending Labor Code Section 4600(c); *and see, State Comp. Ins. Fund v. WCAB* (*Silva*) (1977) 71 Cal.App.3d 133 [42 Cal.Comp.Cases 493].

Under that so-called employee "free choice" model, disputes were adjudicated before a workers' compensation judge and ultimately decided by the Workers' Compensation Appeals Board (WCAB) based upon opposing and conflicting expert opinions on medical necessity or price, there being no clear definition of what constitutes "reasonable and necessary medical treatment." This process was commonly referred to as "dueling docs." Over time, this practice was found to be time consuming and expensive; often resulting in arbitrary and inconsistent judicial decisions on medical issues, with poor treatment outcomes for workers and employers. In response to studies showing a system plagued with high costs, low benefits, long delays, poor outcomes and endless litigation, the California legislature has since repeatedly revised the procedures to improve delivery of quality medical treatment and resolve treatment-related disputes in a manner consistent with the Constitutional mandate (Cal. Const., art. XIV, § 4.).

In 1993, the California Legislature enacted major reforms that included a presumption that the findings of the treating physician were correct.[1] In 1996, WCAB *en banc* interpreted that to be a presumption of correctness on all medical treatment issues [*Minnear v. Mt. San Antonio Community College District* (1996) 61 Cal. Comp. Cases 1055 (Appeals Board en banc opinion)] and limited a payer's ability to challenge the treating physician unless it was clearly erroneous, incomplete or legally incompetent, a nearly impossible burden. The theory was that the patient's treating doctor knows what's best. But in a system fraught with misplaced incentives, that theory failed to recognize (a) the fee-for-service financial incentives to the treating doctors to provide excessive, unnecessary,

[1] CA Labor Code Section 4062.9 [Stats. 1993 ch. 121] (subsequently repealed)

unproven, ineffective and sometimes harmful forms of care that prolonged work loss time and produced increased permanent disabilities, (b) the employee's and their attorney's financial incentive to use treating physicians with poorer medical outcomes that increased disability awards and inflated settlements and attorney contingent fees, (c) the greater employer-employee frictional costs from the increasingly contentious adversarial system which produced poorer return-to-work outcomes for employees and thus increased economic hardship on workers due to job losses, and (d) that the result would be a system with disproportionately high administrative costs, with poorer medical outcomes, relatively low worker benefit rates, and lengthy delays of benefit determinations with negative impact on medical and vocational rehabilitation.

Following that judicial expansion of the statutory presumption, there was an unprecedented surge in medical benefit costs. With treating doctors now firmly in control of all medical decision-making and no standard definition of what constituted "reasonable and necessary medical treatment", medical costs spiraled out of control while patient outcomes continued to be poor. Predictably, between 1996 and 2002, the estimated average ultimate per-claim cost of medical care in indemnity claims increased by an astonishing 267% and studies by both CHSWC and CWCI revealed a clear association between the significant cost increase trend and expansion of the treating physician presumption of correctness on all medically related issues.

A 1999 follow-up study by the Commission on Health and Safety and Workers' Compensation regarding the impact of the 1993 reforms and the treating-physician presumption concluded it was an abysmal failure and recommended it be curtailed.[2] Confronted with spiraling costs and poor outcomes, in 2003 and 2004, the Legislature at first limited the treating physician presumption of correctness and then repealed it altogether, replacing it with a clear definition of what constitutes "reasonable and necessary medical treatment", by adopting an objective Medical Treatment

[2] CHSWC - Report on the Quality of the Treating Physician Reports and the Cost-Benefit of Presumption in Favor of the Treating Physician (August 1999)

Utilization Schedule (MTUS) comprised of medical treatment guidelines using evidence-based, peer reviewed and nationally recognized standards of medical treatment against which treating doctor recommendations in any given case must be evaluated to determine if it was medically appropriate. [3] As summarized in the Legislative Counsel's Digest to SB228 (Stats 2003, Ch. 639), adoption of a medical treatment utilization schedule began with a process for the Commission on Health and Safety and Workers' Compensation to study nationally recognized standards for medical treatment, make recommendations for adoption of such schedules by the Administrative Director, and upon adoption those standards carry a presumption of correctness to be applied in connection with employer utilization review. CHSWC, at Pgs 5-6 of that report, emphasized the role

[3] Assembly Bill 749 (2003) and Senate Bill 899 (2004).; CHSWC summarized the benefits of evidence-based medical decision-making as follows [Evaluating Medical Treatment Guideline Sets for Injured Workers in California (2005) *prepared by RAND Institute for Civil Justice, at the request of CHSWC*, Pg. 10,11)

> "… physicians and other health care professionals are relying more and more upon evidence from clinical research studies to support their diagnostic and therapeutic choices. Within health care, this represents "a significant cultural shift, a move away from unexamined reliance on professional judgment toward more structured support and accountability for such judgment" (Field and Lohr, 1990).
>
> Use of the best available evidence to support medical professionals' decision-making is often referred to as evidence-based medicine (Sackett et al., 1996), the objective of which has been defined as "to minimize the effects of bias in determining an optimal course of care" (Cohen, Stavri, and Hersh, 2004). Bias, meaning lack of objectivity and other factors that may distort conclusions, can exist at any stage in the medical decisionmaking process, from research through guideline development and clinical care.
>
> There are many sources of bias in evaluating tests and therapies. Preconceived notions on the part of sponsors, researchers, and participants can influence the apparent efficacy of a therapy. Baseline patient characteristics, the natural course of illness, and chance may suggest an effect when there is none, or the absence of an effect when one exists. These problems can be alleviated by careful study design, particularly by the gold-standard design: the randomized controlled trial. In randomized controlled trials, participants are randomly assigned to receive either the therapy under study or a comparison therapy, which can be an accepted therapy or a placebo. While weaker designs can also mitigate bias, they often do so incompletely (Campbell and Stanley, 2005)

of mandatory use of evidence-based treatment guidelines as the basis for medical decision-making through the utilization review process, stating as follows:

> The effect of the recommended structure of the guidelines in UR should be to encourage efficient processing of requests for authorization, allowing reviewers to reject treatments that are inconsistent with a clear guideline and putting the burden on the treating physician to document and justify deviations from the guideline. …. If the opinion of the treating physician is not backed by citations to scientific evidence, it may be outweighed by the opinion of a UR physician based on his or her expertise plus references to controlling principles of medicine. Where higher-quality evidence is available, the highest-quality evidence that is applicable to an individual case should determine the treatment.

Despite new legislation which for the first time defined "medical treatment that is reasonably required to cure or relieve the injured worker" as meaning "treatment that is based upon the guidelines adopted by the administrative director" per Lab. C. 5307.27 and returning to employer control of medical treatment through Medical Provider Networks[4], disputes continued to be adjudicated through a process that was still considered too lengthy, expensive, and an often unsatisfactory path for injured workers and claims administrators. Many felt that expert witnesses and the decisions of judges often failed to adequately consider and apply the statutory guidelines, and consequently that the opinion of the judge routinely failed to enforce the statutory medical standard of care established by the MTUS as "evidence-based medicine". The workers' compensation judiciary's inconsistent and unpredictable enforcement of evidence-based treatment guidelines further undermined the legislative purposes behind adoption of the Medical Treatment Utilization Schedule and undoubtedly encouraged even more litigiousness. Against this backdrop, additional CHSWC studies recommended even stronger enforcement of "evidenced based medicine"

[4] *See* Labor Code Section 4600(c), 4604.5 and 4610, et seq. establishing employer's right to create a Medical Provider Network of exclusive providers of medical treatment unless the employee had pre-designated his/her personal physician.

through use of independent medical review to resolve treatment disputes that continued despite the employer's utilization review processes,[5] and this led to yet another reform in SB863.

While the above referenced legislative changes were occurring, there were corresponding judicial decisions and regulatory changes impacting the adversarial roles of treating physicians and evaluating physicians in the workers' compensation system in regard to the shift to and enforcement of principles of "evidence based medicine". From a judicial decision standpoint, perhaps the two most significant decisions regarding the proper role of a UR reviewer/physician are *Simmons v. State of California* (2005) 70 Cal. Comp. Cases 866 (Appeals Board *en banc* opinion), and *McCool v. Monterey Bay Medicar* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 578 (Appeals Board noteworthy panel decision). In *Simmons* the Appeals Board substantially limited the permissible parameters of a utilization review physician's role, and reinforced the view that a utilization review physician is not a treating physician and thus UR reports are not generally to be considered *except* on the limited issue of whether the treating physician's recommended course of care meets the standard of "evidence based medicine" as adopted by the MTUS. *McCool*, which involved a UR doctor's failure to recommend a medication weaning program, underscores that the remedy for that failure is "future decisions which violate section 4610(c) may be referred to the Administrative Director to review defendant's written policies and procedures and potentially assess penalties for abuse of the UR process." Thus, we submit that the UR failure is an integral part of the workers' compensation system which has a remedy and should be governed by the "exclusive remedy."

The differing roles of the treating physician vs. the utilization reviewer are further evident from the regulatory framework for treatment decisions, which reinforce that it is the treating physician's obligation to make a "request for authorization" supported by documentation justifying

[5] *See gen.,* Medical Care Provided Under California's Workers' Compensation Program: Effects of the Reforms and Additional Opportunities to Improve the Quality and Efficiency of Care, CHSWC 2011 Report, Summary at Pgs. xviii-xxvix,(emphasis added)

the request [8 CCR 9792.6.1(t)(2)], an employer's obligation to subject that request to "utilization review", a utilization reviewer's obligation to test the request for compliance with the applicable regulatory treatment guidelines within five (5) days [8 CCR 9792.9.1(c)(3)] and to report that conclusion to the treating physician by phone/fax/e-mail within 24 hours and then confirmed in writing to the physician, employee and their attorney/representative within 24 hours or two business days of the decision (depending on the circumstances) [8 CCR 9792.9.1 (d)(2) or 9792.9.1(e)(3)], including the means to contact the UR doctor by phone for a "peer-to-peer" discussion [9792.9.1(e)(5)(K)]. If the treating physician disagrees with the UR reviewer, that's when they can discuss, and obtain approval for a plan of care that meets the regulatory standards. If not, then an appeal process exists. [8 CCR 9792.9.1(e)(5)(G), 9792.10.1][6] If, after being advised that the medication was certified as medically necessary, the treating physician felt weaning was needed, the "peer-to-peer" is where that could have occurred. If not through the "peer-to-peer", the treating physician could have submitted a weaning recommendation for expedited review based upon "an imminent and serious threat to his or her health" under 8 CCR 9792.9.1(c)(4) and received a decision within less than 72 hours. All that occurred in t his case is that the UR reviewer found the medication request did not meet the regulatory standards under the MTUS. The UR reviewer did not undertake any other role. Without analyzing the clearly adversarial nature between the plaintiff/ treating physician vs the employer's utilization reviewer, the reasoning behind the conclusion that the UR reviewer owes a duty to the plaintiff is absent.

Further, the Court's construction of what is within the exclusive remedy of the workers' compensation act also reflects a foundational lack of full awareness of the scope of employer liability. This is apparent from the Courts observation that,

The seizure injury did not occur in the course of Kirk's job because

[6] The Division of Workers' Compensation's PowerPoint presentation on this process can be found on their website at https://www.dir.ca.gov/DWC/educonf22/UR-IMR/UR-IMR.pdf. They specifically encourage treating doctors to use the "peer-to-peer" process.

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

But the compensability under the workers' compensation laws extends far beyond whether the individual was working at the time of the seizures. The employer is liable under workers' compensation for the consequences of subsequent negligently provided medical treatment … when clearly not working [Herlick, California Workers' Compensation Handbook, (2006) §4.11. Or if an industrial injury contributes to a subsequent non-industrial accident, that too becomes a "compensable consequence" of the industrial injury and thus the employer's liability … despite the fact that claimant was not working at the time [Beaty v. Workers' Comp. Appeals Bd 80 Cal. App. 3d 397]. And too, the employer is liable for the seizure disorder resulting from withdrawal of medication for the industrial injury herein … when not working. As such, the utilization review process which caused the harm is "tethered to a compensable injury" [*Charles J. Vacanti, M.D., Inc. v. State Comp. Ins. Fund (2001) 24 Cal. 4th 800, 815],* so much so that it may also be subject to an anti-SLAPP motion under Code of Civil Procedure § 425.16. Without analysis of these unique workers' compensation aspects which may not have been brought to the Court's attention, the Court's reasoning that the workers compensation act should not be the plaintiff's exclusive remedy appears incomplete.

Finally, we understand that the Court's original proposed opinion in this case was to uphold grant of the demurrer but allow the filing of an amended complaint, via an unpublished opinion. Defendant did not request oral argument, but when the Court issued its decision it was unexpectedly certified for publication. As recognized in the Advisory Committee comments to Rule 8.264, "the publication status of an opinion may affect a party's decision whether to file a petition for rehearing and/or a petition for review". We also submit that it could similarly impact a party's decision whether to waive oral argument.

For the foregoing reasons, and to avoid establishment of unfortunate precedent that may result from lack of full appreciation of the workers' compensation system as it relates to the issues, CWCI asks this Honorable Court to change the publication status of the Court of Appeal decision herein, so that it is NOT CERTIFIED FOR PUBLICATION.

Respectfully submitted,

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