No: S294463

IN THE

Supreme Court

OF THE

State of California

ILLINOIS MEDWEST INSURANCE COMPANY AGENCY, LLC.

Petitioner

v.

ORLANDO RODRIGUEZ (Real Party In Interest)

WORKERS' COMPENSATION APPEALS BOARD

Respondents

W.C.A.B. No: ADJ11532204

HONORABLE DEAN STRINGFELLOW

AMICUS CURIAE APPLICATION AND BRIEF BY CALIFORNIA WORKERS' COMPENSATION INSTITUTE IN SUPPORT OF PETITIONER MIDWEST ILLINOIS INSURANCE COMPANY AGENCY, LLC

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APPLICATION FOR AMICUS CURIAE STATUS

To the Honorable Chief Justice and the Honorable Associate Justices of the Supreme Court for the State of California

On behalf of the membership of the California Workers' Compensation Institute ("CWCI"), we request permission to submit this amicus curiae brief in support of Respondent, Midwest Illinois Insurance Company Agency, LLC in the pending Petition for Review. Participation on the merits is necessary because the petition raises an ongoing issue regarding the authority of the Workers' Compensation Appeals Board to assume jurisdiction over medical treatment determinations contrary to specific public policy expressed by the legislature and to obtain uniformity of the law as there are multiple case pending before this Court and the Courts of Appeal and continuing litigation at lower levels which will continue absent a determination of this. Court

CWCI is a private non-profit research, information, and educational organization dedicated to improving the California workers' compensation system. Institute members include insurers writing 76% of California's workers' compensation premium, and self-insured employers with $92B of annual payroll (30.3% of the state's total annual self-insured payroll). CWCI further serves as a liaison for employer, labor, medical, regulatory, and legal communities within the workers' compensation system, and frequently provides written and oral testimony at legislative and regulatory hearings. Based upon its recognized expertise in workers' compensation, CWCI has been judicially permitted to join in multiple cases as amicus curiae before the California Supreme Court and Courts of Appeal.

Based upon its expertise in workers' compensation, the Institute has made multiple appearances as amicus curiae before the California Supreme Court and Courts of Appeal [including the cases of Christian v. WCAB (1997), SCIF v. WCAB (Stuart) (1998), Avalon Bay Foods v. WCAB (1998), Lockheed Martin v. WCAB (McCullough) (2002), Wal-Mart v. WCAB (Garcia) (2003), Honeywell v. WCAB (Wagner)(2005), Green v. W.C.A.B., (2005), Rio Linda School District v. WCAB (Schefiner) (2005), Nabors v. WCAB (2006), Yeager Construction v. WCAB (Gatten) (2006), Chang v. WCAB (2007), Vaira v. WCAB (2007), Brodie, et al. v. WCAB (2007), Palm Medical Group v. State Compensation Insurance Fund (2007), Smith & Amar v. WCAB (2007), Facundo-Guerrero v. WCAB (2008),State Compensation Insurance Fund v. WCAB (Sandhagen) (2008), Smith &Amar v. WCAB) (2009) , Benson v. WCAB (2009), Boughner v. WCAB (2009), Aguilar v. WCAB (2009), El Aguila Food Products v. WCAB (Cervantes) (2010), Hertz Corpv. WCAB (Aguilar) (2010), Milpitas Unified School Dist. V. WCAB (Guzman) (2010), Baker v. WCAB & XS. (2011),Ogilvie v. WCAB (2011), Valdez v. WCAB & Warehouse Demo. (2012), South Coast Framing v W.C.A.B. (2014), Travelers Casualty & Surety Company et al.v W.C.A.B. (2016), XL Specialty Insurance Co. v W.C.A.B. (2019), Zenith Insurance Company v. W.C.A.B. (2024)]

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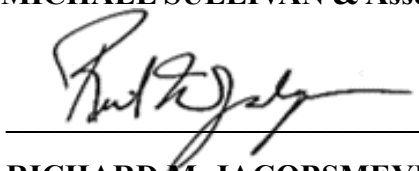


RICHARD M. JACOBSMEYER ESQ.

INTRODUCTION

The issue presented to this Court is whether the WCAB is empowered to return to itself power which was deliberately stripped away by the legislature in a series of legislative packages.

In 2003 in legislation designated as SB228, the Legislature created a mandatory system of review by employers, insurance companies and third-party claims administrators administrating workers' compensation benefits for making determinations regarding the reasonableness and necessity of medical treatment. Beginning on January 1, 2004, employers were required to submit requests for medical treatment to the claims administrator utilizing a Request for Authorization (RFA) (Cal Code Regs. Title 8, Section 9885.5 [1]). The employer, upon receipt of an RFA, had a specified timeframe depending on whether the request was prospective, retrospective or expedited to approve, modify, delay or deny the treatment request in the Request for Authorization. However, pursuant to the same code section, medical treatment could be delayed or denied only with a decision from a physician who reviewed the request and determined whether the medical treatment was consistent with the Medical Treatment Utilization Guidelines (MTUS) adopted by the administrative director under Labor Code §4604.5[2].

Under the scheme enacted effective January 1, 2004, the response to a request for medical treatment reviewed through Utilization Review (UR) could be appealed to the Workers' Compensation Appeals Board for a judicial review of whether the treatment was reasonable or necessary and in compliance with the MTUS (*State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Sandhagen) (2008) 44 Cal. 4th. 230, 73 Cal. Comp. Cases 981*).

[1] All references to regulations refer to the California Code of Regulations, Title 8.
[2] All references to code sections refer to the Labor Code unless otherwise indicated.

Under this process, issues involving medical determinations of whether treatment was reasonable and necessary continued to be extensively litigated before the Workers' Compensation Appeals Board with Workers' Compensation Judges making the medical determination of whether treatment was reasonable or necessary and consistent with the MTUS adopted by the administrative director.

In 2012, the legislature passed SB863. In that enactment, the legislature made significant alterations to the process for determining the reasonableness and necessity of medical treatment. The initial UR process of submission of RFAs, review by claims administrator's UR process and limiting denial or modifications based upon medical decisions by licensed physicians remained fundamentally unchanged. However, superimposed upon that process was a subsequent appeal process available to injured workers alone in the event they disputed a UR determination for modification or denial of requested medical treatment. If the employee wished to appeal the UR determination to deny or modify medical treatment, they must request review by an independent organization through Independent Medical Review (IMR) (Labor Code § 4610.5). The state selected a contractor to perform IMR, which reviews determinations by the employer's UR physician and determines whether the medical treatment requested was in compliance with the MTUS adopted by the administrative director and, hence, should be provided.

In addition, if the employee wished to dispute an adverse determination of IMR, a limited appeal was allowed to the Workers' Compensation Appeals Board on specifically identified factual issues, *but not on the medical determination made through IMR*. Even if the Workers' Compensation Appeals Board determined the IMR ruling was flawed and should be reversed, it could not make a determination regarding the medical necessity of the disputed medical

treatment but must refer the matter back to the IMR process for review by a different independent physician (Labor Code § 4610.6(h & i)

This process was consistent with the legislature's expressed policy that medical treatment decisions should be made by physicians rather than by lawyers and/or judges. This was expressed most succinctly in the Preamble Section 1 of SB863 which declared the legislative intent concerning medical determinations as follows:

> "…the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers injured in the course of employment…
>
> …that having medical professionals ultimately determined the necessity of requested treatment furthers the social policy of the state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and the provision(s) of the act establishing Independent Medical Review are necessary to implement that policy."

In spite of the clear legislative mandate removing the ability to make determinations regarding the necessity of medical treatment from the Workers' Compensation Appeals Board, the Appeals Board has, on its own, created a broad exception without any supporting legislation or affirming case law which allows it to make determinations regarding specific forms of medical treatment it deems to be "continuing care". The foundation for the Appeals Board's assertion of this authority is based upon its decision in a case designated a significant Panel decision[3]. In that decision, the Workers' Compensation Appeals Board determined if a claims administrator authorized a specific form of treatment; in that case assignment of a nurse case manager; the claims administrator was not allowed to seek Utilization Review to determine

[3] *Patterson v. The Oaks Farm (2014) 79 Cal. Comp. Cases 916*

whether continuing such treatment was reasonable or necessary and must continue to authorize that treatment until the employer was able to make a demonstrated showing of change in circumstances justifying the change in treatment, whether reduction or termination. While *Patterson* did not specifically apply to a case involving UR, the Workers' Compensation Appeals Board has in multiple subsequent cases, ruled employers could be barred from relying on the statutorily mandated Utilization Review process and consistently found it had jurisdiction to make medical determinations regarding treatment and issue its own award for continuing treatment.

The Court of Appeal's decision in this matter correctly applies the plain language of the workers' compensation statutes, upholding a legislative framework meticulously designed to remove medical necessity determinations from the purview of the Workers' Compensation Appeals Board (WCAB) and place them exclusively in the hands of medical professionals. The Petition for Review asks this Court to reverse this correct interpretation and instead create a broad, extra-statutory exception for "ongoing treatment" which has no basis in the law and which violates the specific public policy the Legislature specifically set out in adopting SB 863.

Petitioner's position, if adopted, would require this Court to ignore the Legislature's clear and repeated mandates, invalidate the core purpose of the 2004 and 2013 reforms, and judicially legislate from the bench. The issue is not, as Petitioner frames it, whether catastrophically injured workers are entitled to continuous care; the issue is who decides if that care remains medically necessary. The Legislature has unequivocally answered that question: physicians, through the mandatory Utilization Review (UR) and Independent Medical Review (IMR) process. The Court of Appeal properly enforced this legislative intent, and its decision does not warrant reversal

ARGUMENTS OF CASE

I. THE COURT OF APPEAL CORRECTLY ENFORCED THE UNAMBIGUOUS STATUTORY MANDATE THAT DISPUTES OVER MEDICAL NECESSITY ARE RESOLVED EXCLUSIVELY THROUGH THE UR/IMR PROCESS.

The right to workers' compensation benefits is "entirely statutory." (*Stevens v. Workers' Comp. Appeals Bd.* (2015) 241 Cal.App.4th 1074, 1087). Through Senate Bill 863 (2013), the Legislature fundamentally reformed the process for determining the medical necessity of treatment. The legislative intent behind these reforms was explicit: to replace a "cumbersome, lengthy, and potentially costly" litigation-based system with an efficient, standardized, and physician-driven process. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Sandhagen)* (2008) 44 Cal.4th 230, 238).

The Legislature expressly found that "having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care." (Stats. 2012, ch. 363, § 1(e)).

To that end, the statutory language is unmistakable. Labor Code section 4610.5, subdivision (e), unequivocally states: "A utilization review decision may be reviewed or appealed only by **independent medical review.**.." (emphasis added). The statute provides no exception for "ongoing," "continual," or "life-sustaining" care as argued by Petitioner and the .WCAB. The Legislature, in its comprehensive overhaul of the system, could have easily carved out such an exception but chose not to[4]. The Court of Appeal correctly refused to recognize an exception where the Legislature provided none.

[4] Petitioner's argument also ignores the Legislature is perfectly cognizant of the need for some exceptions in its statutory scheme for workers compensation and has carved out exceptions where legislatively desired including an

This statutory scheme does not, as Petitioner suggests, leave injured workers without a remedy. It provides a specific and exclusive remedy available only to the employee: IMR[5]. The Court of Appeal's decision simply enforces the system the Legislature created.

II. PETITIONER'S INTERPRETATION OF LABOR CODE SECTION 4610(k) IS A FUNDAMENTAL DISTORTION OF THE STATUTORY TEXT THAT WOULD REQUIRE JUDICIAL LEGISLATION.

Petitioner's central argument for creating decisional finality for treatment approvals rests on a gross misreading of Labor Code section 4610(k). This argument completely ignores the statutory language, is contrary to the expressed public policy behind the statutory changes enacted in SB 863 and asks the Court to rewrite the law.

Section 4610(k) states that a UR decision "modifying or denying" a treatment request "shall remain effective for 12 months from the date of the decision... unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision."

By its own plain terms, this subdivision does not apply to treatment approvals. It is a shield for employers and the system against repeated, unmeritorious requests for treatment that has already been deemed medically unnecessary by a UR physician. It prevents an employee from "doctor shopping" or resubmitting identical requests in the hope of a different outcome.

exception for "catastrophic injuries" in Labor Code § 4660.1(c)(2)(B) in the same Act which created the IMR process. (SB 863)

[5] It should also be noted many Utilization Review programs also provide an additional, internal, appeal of an adverse medical determination. Unlike IMR which must be initiated by the injured worker or a designated representative, Internal UR appeals may be initiated by the injured worker's physician. 8 CCR § 9792.10.1, In common practice many physicians avail themselves of this process at the same time their patient in pursuing IMR. As with IMR, internal UR appeals are ONLY available to the injured worker or their physician by not to the employer. If the internal appeal reversed the UR determination the injured worker is entitled to the treatment.

Petitioner asks this Court to read the word "approvals" into the statute. To do so would be to fundamentally alter its meaning and purpose, transforming it from a provision limiting repetitive requests into one that grants indefinite entitlement to care without any showing for the necessity of the treatment or any medical supervision as to the appropriateness of treatment under Labor Code § 4604.5. This is a policy argument which must be directed to the Legislature. As the Court of Appeal correctly noted; this Court "has no power to rewrite the statute so as to make it conform to a presumed intention which is not expressed." (*California Teachers Assn. v. Governing Bd. of Rialto Unified School Dist.* (1997) 14 Cal.4th 627, 633.) The Legislature's omission of "approvals" from section 4610(k) was deliberate, reflecting an intent that all new requests for treatment remain subject to medical review.

III. THE COURT OF APPEAL'S DECISION DOES NOT PRODUCE ABSURD RESULTS BUT UPHOLDS THE LEGISLATURE'S INTENDED FRAMEWORK FOR ONGOING CARE.

Petitioner argues that the Court of Appeal's straightforward application of the statute produces absurd and devastating results, creating a "cliff-edge" where life-sustaining care can be terminated. This mischaracterizes both the decision and the statutory scheme. The system is not blind to the needs of catastrophically injured workers; it simply dictates that medical professionals, not judges, make the decisions about their ongoing care. There is no provision allowing an employer or insurance company to terminate care on its own whim, any such determination must be medically based and subject to further review and potentially appeal by the employee.

The Medical Treatment Utilization Schedule (MTUS), which is presumptively correct on the issue of medical necessity pursuant to Labor Code § 4604.5, explicitly anticipates the need for ongoing care and provides the mechanism for its review. The MTUS guideline for traumatic

brain injuries recommends evaluation of the "duration of home health care services... should be performed at regular intervals." This guideline demonstrates that the Legislature's physician-driven system is designed to manage, not terminate, ongoing care. It ensures that treatment remains medically necessary and adapts to a patient's evolving condition, preventing the permanent lock-in of a specific treatment modality that may no longer be appropriate or effective

The so-called "absurdity" is nothing more than the Legislature's carefully balanced system at work. Each new request for a specific duration of care, even if for a continuing condition, is a new request that triggers the employer's obligation to have its medical necessity reviewed by a physician. If that review results in a denial, the employee has the right to a prompt appeal to IMR—with another, independently selected physician. This process is the opposite of absurd; it is a rational, evidence-based system that effectuates the Legislature's stated goals of providing the "highest quality of medical care" and represents the exclusive process for resolving medical disputes (*King v. CompPartners, Inc.*, 5 Cal. 5th 1039).

IV. THE PATTERSON DOCTRINE WAS CORRECTLY REJECTED AS AN ANACHRONISM INCOMPATIBLE WITH CURRENT LAW.

The decade of "uniform WCAB jurisprudence" Petitioner cites is built on a single, non-binding panel decision—*Patterson v. The Oaks Farm,* (2014) 79 Cal.Comp.Cases 910—that is factually and legally incompatible with the post-2013 statutory landscape and which has never been formally endorsed by any appellate court. As the Court of Appeal detailed, Patterson involved a pre-2013 injury and a dispute over a non-medical termination of services that never proceeded through the UR process.

Its reasoning cannot survive the clear and express mandate of Labor Code section 4610.5, which established utilization review followed by IMR as the exclusive process for making

determinations of medical necessity. Allowing a non-binding, factually distinct WCAB panel decision to override subsequent, unambiguous legislative enactments would turn statutory construction on its head. The Court of Appeal correctly recognized that *Patterson, cited supra,* is an artifact of a prior legal process and has no applicability to injuries and UR determinations governed by the current statutory framework.

V THE W.C.A.B.'S RATIONAL FOR ITS PATTERSON DECISION IS BUILT UPON CIRCULAR LOGIC BASED UPON A LEGAL FALACY

The Appeals Board rationale for this usurpation of authority, as expressed in the brief of the WCAB to the Appellate Court, is the determination as to whether there has been a change in the employee's condition to justify altering or terminating the previously provided medical treatment was a legal determination and not a medical one. This, however, represents a fallacy in the WCAB's reasoning. The issue of whether there is a significant change in the applicant's condition to alter treatment is by its very nature a *medical determination* and one which the WCAB is specifically prohibited from making based upon the entire scheme set out in SB863.

It is further noted the WCAB's shifting of the burden to the employer to demonstrate a change of circumstances sufficient to alter or terminate previously provided medical treatment is inconsistent with the California Supreme Court holding in *Sandhagen, cited supra*. In its decision the Supreme Court specifically held medical treatment is to be provided consistent with the Medical Treatment Utilization Schedule and in disputing a UR determination it was the employee's burden to present affirmative evidence the medical treatment requested was consistent with reasonable and necessary medical treatment as defined by the MTUS. The Board's holdings relying on *Patterson, cited supra,* in shifting the burden to the defendant to show medical treatment is not consistent with the *Sandhagan, cited supra,*, is contrary to expressed legislative intent and is therefore contrary to both case and statutory law.

The WCAB's reliance upon its own rationale in *Patterson, cited supra,* constitutes a circular logic which was not logical to begin with and has resulted in increased litigation over issues involving medical treatment contrary to the expressed legislative intent expressed in SB228 and SB863. The Board asserts it has authority under *Patterson, cited supra,* to do what it said it could do under Patterson*, cited supra,* but cites no statutory, case law or regulatory authority to support that supposed authority. The intent in the passage of SB863 could not be more clearly set out to express the legislative policy medical determinations should be made by medical professionals and not by judicial personnel whether Workers' Compensation Judges or the Commissioners at the Workers' Compensation Appeals Board. The Board's usurpation of the authority to make medical determinations is an effort to return authority to itself to make medical determinations such as existed before the passage of SB863.

One of the hallmarks of the *Patterson, cited supra,* decision which has been applied in numerous subsequent cases is a requirement by the employer to show a "change of circumstances" in order to terminate or limit previously authorized care. However, not only is there a lack of definition for the so-called "change of circumstances" requirement, but even a determination regarding change of circumstances requires a medical determination as to whether there is a medical basis justifying a change of medical treatment. Such a determination is not for the WCAB to make, but a medical determination required to be made by a physician according to Labor Code § 4604.5 pursuant to §4610. Workers' compensation judges and the WCAB, however, are not obligated to and make no reference to the MTUS in issuing their determinations to enforce the rationale of *Patterson*. Instead, the Board or Trial Judges solely looked to see whether the treatment was previously authorized and then make a medical determination as to whether there is sufficient medical evidence for the treatment to be altered or

terminated. The WCAB cites no case or statutory authorities for its ability to make medical determinations in its reliance on *Patterson, cited supra*, but simply cites *Patterson* as its own authority to make those determinations.

CONCLUSION

> "A fundamental rule of statutory construction is that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law." (*DuBois v. Workers' Comp. Appeals Bd*. (1993) 5 Cal.4th 382, 387) (*DuBois*). In interpreting a statute, the text of the statutory language is typically the best and most reliable indicator of the Legislature's intended purpose. (*Larkin v. Workers' Comp. Appeals Bd*. (2015)62 Cal.4th 152, 157.) "When the language is clear and there is no uncertainty as to the legislative intent, we look no further and simply enforce the statute according to its terms." (*DuBois*, at p. 387–388.)

In this matter, as well as numerous other cases, the WCAB has not only sought to exert authority not given to it by statute but has done so in direct conflict with the expressed specific intent of the Legislature that the Appeals Board is not to make medical decisions

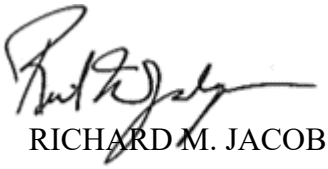
For the foregoing reasons, the Court of Appeal's decision should be affirmed. The decision correctly interprets the unambiguous statutory framework established by the Legislature, which vests the authority to determine medical necessity exclusively with medical professionals through the UR and IMR processes.

The Petitioner's arguments invite the Court to engage in judicial legislation, ignore plain statutory language, and create a public policy exception which the Legislature has declined to provide.

The proper venue for such policy arguments is the Legislature, not this Court.

Respectfully Submitted:

Michael Sullivan and Associates



RICHARD M. JACOBSMSYER

Attorney for Amicus Curiae

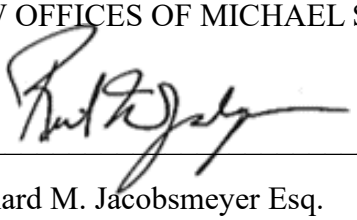
CERTIFICATE OF WORD COUNT

I certify that, according to the computer program used to prepare this brief, the INTRODUCTION, contains 3277 words, not including the cover, the Tables of Contents, Application for Amicus Curiae Status and Authorities, this certificate, and the signature block.

I declare under penalty of perjury under the laws of the state of California that the foregoing is true and correct.

Executed this _28_ day of MARCH, 2026 at Walnut Creek, California.

LAW OFFICES OF MICHAEL SULLIVAN & Associates



Richard M. Jacobsmeyer Esq.
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CERTIFICATE OF INTERESTED PARTIES

I am the attorney for the Amicus Curiae in this action.

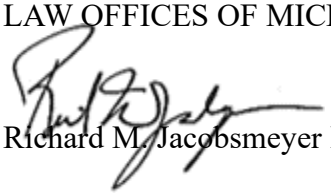
This declaration is being submitted on behalf of CALIFORNIA WORKERS COMPENSATION INSTITUTE.

There are no interested entities or persons that must be listed in this certificate under rule 8.208

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

Executed this 28 day of MARCH, 2026 at Walnut Creek, California.

LAW OFFICES OF MICHAEL SULLIVAN & Associates



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I am over the age of eighteen years and not a party to the within entitled action. Michael Sullivan & Associates LLP's business address is: 266 Grand Avenue, Suite 200, Oakland, CA 94610.

On **3/28/26**, I served the foregoing document(s) described as AMICUS CURIAE APPLICATION AND BRIEF VIA TRUEFILING in the matter of Supreme Court Case No. S294463, Illinois Midwest Insurance Agency LLC v. Workers' Compensation Appeals Board (Orlando Rodriguez, real party in interest) on the parties to this matter as follows:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

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