Since this tip was issued, the WCAB issued its en banc decision in Dubon II ruling that a Utilization Review decision is invalid and not subject to Independent Medical Review(IMR) only when it is untimely.(See # 18 SB 863 Practice Tip, dated 11/21/2014)

CAAA Bulletin

SB863 Practice Tips

1303 J Street, Suite 420, Sacramento, CA 95814 Ph (916) 444-5155

#8 SB 863 Practice Tip: Utilization Review - Validity Issues July 15, 2013

As of July 1, 2013, every dispute over a utilization review (UR) decision regarding medical treatment for a work injury must now be resolved pursuant to the new Independent Medical Review (IMR) process as set out in Labor Code §§ 4610.5 and 4610.6. This is the first in a four part series of Practice Tips reviewing the utilization review and independent medical review processes as adopted in SB 863.

The legislative intent in SB 863 made it clear that the goal of these changes was to provide for "[t]imely and medically sound determinations of disputes over appropriate medical treatment." [See SB 863, Section 1(f).] To meet this goal, not only is it imperative that a complete system of rules governing timely, valid utilization review decisions be adopted, but those rules must be strictly enforced so that injured workers have prompt access to medical care.

This Practice Tip provides in depth discussion on how to evaluate the validity of a utilization review decision. If you determine that a utilization review decision is invalid, this Tip details the steps you might consider to obtain prompt medical treatment for your client. However, this is only a quick review of the major issues, and readers are strongly urged to review the entirety of all statutory and regulatory changes.

With regard to regulations, as of the issue date of this Tip all emergency regulations adopted effective January 1, 2013 remain in effect. However, it is expected that permanent regulations will replace these emergency regulations soon. Consequently, where there are significant differences, these Tips will outline both the current rule (from the emergency rules) and the final rule (as currently proposed). If there are any additional changes to the permanent regulations when adopted, we will let you know. The complete text of all of the proposed and adopted regulatory changes can be accessed through the DWC website at: http://www.dir.ca.gov/dwc/dwcRulemaking.html.

Validity Considerations in Evaluating a Utilization Review Determination

The next two tips in this series will provide a detailed review of both the UR and IMR processes. However, a key point to remember is that ***if a utilization review decision is untimely or procedurally deficient, it is invalid and the WCAB still has jurisdiction over the medical treatment issue.*** Consequently, when an ***employer*** disputes a medical treatment recommendation through a UR process and issues a denial letter, the injured worker and/or his or her advocate need to review the

letter of denial to determine whether the denial is valid. Below is a list of some validity issues you can consider when reviewing your options for securing prompt and appropriate medical treatment for your clients.

1. Utilization Review Was Untimely **-** See LC §4610(g); CCR §9792.9.1(c)(3)

In some cases a UR decision is invalid because the letter issues late, or no letter issues at all. The mandate of adhering to utilization review timelines is detailed in the California Supreme Court decision in *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Sandhagen*) (2008) 44 Cal.4th 230 [73 Cal.Comp.Cases 981] and nothing in SB 863 changed this mandate.

In cases of expedited review, the law requires that a decision shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed ***72 hours*** after the receipt of the information reasonably necessary to make the determination. In cases of regular review, a decision shall be made ***not to exceed five working days*** from the receipt of the information reasonably necessary to make the determination, ***but in no event more than 14 days*** from the date of the medical treatment recommendation by the physician.

Note that some WCJs routinely ignore the five working day statutory mandate, admitting any determination made within 14 days. However, the regulations clearly state (§9792.10.1(c)(3)(B)) that the five working day time limit is validly extended ***only*** when additional appropriate and necessary information is requested within that five working day time limit. Similarly, the new provision in §9792.10.1(b) allowing deferral of UR if the claims administrator disputes liability for the claim requires that notice of a deferral must be issued within the same 5 working day time limit. Taken together these rules mandate that the claims administrator must take some action within 5 working days - either issue a UR determination, request additional necessary and appropriate information, or issue a deferral.

2. The Medical License/Specialty of the Reviewer Was Not Appropriate Compared to the Requesting Physician **-** See LC §4610(e) & CCR §9792.9.1(e)

Some UR decisions are made by a physician who is not competent to evaluate the medical treatment request, and in some instances a UR decision fails to include the physician's medical specialty. Both the statute and regulations governing UR require the medical review to be within the scope of the physician's practice. L.C. 4610(e) provides:

> "(e) No person other than **a *licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice,*** requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve."

Similarly, CCR §9792.9.1(e)(1) states:

> "(1) The review and decision to deny, delay, or modify a request for medical treatment must be conducted by a reviewer, ***who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice***."

3. All Relevant Medical Records in the Possession, Custody or Control of the Carrier Necessary to Perform an Adequate Review Are Not Provided to the Reviewer - See CCR §9792.9.1(e)(5)(D) and (f)

It is axiomatic that a reviewing physician can make a proper determination of the medical necessity of a treatment request only if provided with all of the relevant medical reports and records. This was confirmed in the 2012 panel decision of *Corona v. Los Aptos Christian Fellowship Childcare* (2012) Cal. Wrk. Comp. P.D. LEXIS 459. The Board panel held that the worker may "challenge the utilization review based upon procedural deficiencies at an expedited hearing pursuant to section 5502(d)...." The procedural deficiency in *Corona* was the failure to provide the reviewing physician "all of the relevant medical reporting and information that was in the defendant's possession as required by the utilization review process...." Note that the standard was that the defendant must provide to the reviewing physician all ***relevant*** medical reporting and information; failure to provide records that are immaterial to the specific treatment request will not invalidate the UR determination.

The scope of the records and information provided to the reviewing physician can be determined by reviewing the list of medical records detailed in the UR denial. Regulation section 9792.9.1(e)(5)(D) requires that the written decision modifying, delaying or denying a requested treatment authorization must include "a list of all medical records reviewed." If the list of reviewed medical records does not include all ***relevant*** medical records and information, or, as in some cases, if the UR decision does list any of the medical records reviewed, the UR decision is invalid.

4. The Criteria for Denial, Delay or Modification Is Not Adequately Communicated to the Requesting Physician - See LC §4610(g)(4) & CCR §9792.9.1(e)(5)(F)

If the written determination fails to fully explain how and why the requested treatment was not approved, it is invalid. As stated in LC 4610(g)(4),

> "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians ***shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity***. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision ***shall specify the reason for the decision and specify the information that is needed***."

Regulation §9792.9.1(e)(5)(F) provides further guidance as to what must be included in a written determination modifying, delaying, or denying a treatment request:

"(F) ***A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8.*** If a utilization review decision to modify, deny or delay a medical service is due to incomplete or insufficient information, the decision ***shall specify the reason for the decision and specify the information that is needed***."

5. A Notification to Physician and Employee of Additional Required Examinations or Testing Is Untimely or Incomplete - See LC §4610(g)(5) & CCR §9792.9.1(f)

The Labor Code establishes very specific requirements where the employer needs additional information or testing, and the regulations mirror these requirements. Labor Code §4610(g)(5) provides that if the employer has not received all reasonably necessary information and needs additional information, testing, or a consultation "the employer ***shall immediately notify the physician and the employee, in writing***, that the employer cannot make a decision within the required timeframe, and ***specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required***. The employer ***shall also notify the physician and employee of the anticipated date*** on which a decision may be rendered." In addition, after receipt of the requested information or testing, the employer must then meet the time limit applicable to all UR determinations – 5 working days but no later than 14 days.

6. The Criteria for Denial, Delay or Modification Is Not Based on the Medical Treatment Utilization Schedule - See LC §4610(f) & CCR §9792.9.1(e)(5)

Failure to apply the Medical Treatment Utilization Schedule and to disclose in the decision the basis for the decision to modify, delay or deny services results in an invalid UR denial. LC §4610(f) states, in part:

"(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services ***shall be all*** of the following:

. . . .

(2) ***Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27***.

. . . .

(4) ***Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review***."

7. A Communication With the Physician and Employee of a Decision to Modify, Delay or Deny a Treatment Request Was Untimely - See LC §4610(g)(3)(A) & CCR §9792.9.1(e)(3)

Pursuant to CCR §9792.9.1(e)(3):

"(3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny ***shall be communicated to the requesting physician within 24 hours of the decision***, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone ***shall be followed by written notice to the***

requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request."

It is imperative that physicians' offices document the date and time they receive communication by telephone, facsimile, or electronic mail and written notice of the UR decision. Failure to strictly comply with these timelines results in an invalid UR denial.

8. An IMR Application Form, Completely Filled out Except for the Signature, Is Not Included with the Utilization Review Denial - See LC §4610.5(f) & CCR 9792.9.1(e)(5)(G)

The Labor Code requires that the employer must provide a one-page IMR application along with any notification of a UR denial, delay, or modification. The regulations further define this mandate. In fact, two different sections of the emergency regulations now in place, §§9792.9(l) and 9792.9.1(e)(5), require that a written decision of non-certification must be sent to the employee ***and, if represented, to his or her attorney,*** and that this written decision must contain the IMR application form with all fields except the employee's signature already filled in by the claims administrator.

A minor change in the proposed permanent IMR regulations, §9792.9.1(e)(5)(G), clarifies that both the IMR application form and an envelope pre-addressed to the DWC must be provided to the employee, and if the employee is represented by counsel, to the employee's attorney.

9. Failure of Utilization Review Document to be Signed by the Physician – See LC §4610(e) and CCR 9792.7(b)(1)

In the case of *Academy of Arts College v. WCAB (Zedd)* (2011) 76 Cal. Comp. Cases 352 the court held that a UR denial was invalid because it was not signed by the physician. In this case, Applicant was awarded lumbar epidural steroid injections after a WCJ determined that the utilization review denial was not valid because the denial was signed by a nurse, not a licensed physician as required by Labor Code § 4610(e) and CCR § 9792.7(b)(1), and defendant did not show that the utilization review denial was reviewed by licensed physician.

Options If the Utilization Review Determination is Invalid

One approach to consider if a UR determination is invalid is to file a Declaration of Readiness to Proceed for either a Mandatory Settlement Conference or an Expedited Trial and seek an Order for the medical treatment. The WCAB still has jurisdiction over medical treatment issues up through the start of the IMR process (and thereafter, with some limited exceptions). The cases of *Corona v. Los Aptos Christian Fellowship Childcare* (2012) Cal. Wrk. Comp. P.D. LEXIS 459 and *Becerra v. Jack's Bindery, Inc.* (2012) Cal. Wrk. Comp. P.D. LEXIS 451 hold that it is appropriate for an employee to challenge a UR determination based upon procedural deficiencies at an expedited hearing pursuant to Labor Code §5502(d). Further, in *Becerra* the court ordered an attorney's fee for unreasonable delay in providing medical care emanating from a defective UR denial.

However, it is vitally important to note that in both of these cases it was clear that to succeed in securing an Order for medical treatment the applicant must have ***substantial medical evidence in support of the medical treatment request***. As stated in *Sandhagen*:

> "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)."
>
> (*Sandhagen*, 44 Cal.4th at p. 242)

If you file a DOR, you may also want to concurrently file an IMR Application. This will protect the record and make certain that you do not miss the IMR time limit (30 days) in case your argument that the UR decision is invalid fails. As these rules are just now being implemented, we are not aware of any case law on this subject. However, as noted by the WCAB in a proposed regulatory change (http://www.dir.ca.gov/WCAB/WCABRulesofPracticeProcedure2013/WCABRulesofPracticeProcedure2013_Sup_SOR.pdf), an untimely or procedurally deficient UR decision ***is not subject to IMR*** because IMR cannot be initiated without a valid utilization review decision. It remains to be seen what action, if any, the DWC will take when an IMR application is submitted concurrently with the filing of a DOR. One possibility is that the DWC will decide that due to the invalidity issue, the medical dispute should not be submitted to IMR until the legal or factual dispute is adjudicated.

The next practice tip in this series will issue in a few weeks, and will provide a roadmap of the utilization review process, including a comprehensive chart to guide you through the process.

Note: This practice tip is intended to be advisory only, and does not define or establish any new standard or duty for practitioners.

ADDENDUM – October 23, 2013

Subsequent to issuance of this tip, Judge Colleen Casey issued a decision on a case out of the San Francisco District Office of the WCAB detailing her findings that an invalid UR denial was within her jurisdiction, and subsequently found substantial medical evidence existed to Award the recommended medical care. The case did not go through the IMR process. Judge Casey cites several of the same cases identified in this tip in support of her decision. Her decision, which follows, is an excellent read and illustrates the application of the current state of law on a relevant fact pattern.

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

[redacted], Applicant, vs. [redacted] STATE COMPENSATION INSURANCE FUND, Defendants.	CASE NO. [redacted] San Francisco District Office **FINDINGS OF FACT/AWARD/ORDER**

The above-entitled matter, having been heard and regularly submitted, COLLEEN S. CASEY, Workers' Compensation Judge, now makes her decision as follows:

FINDINGS OF FACT

1. [redacted] while employed as a garbage collector on 12/5/2005 by Marin Sanitary Services, insured by State Compensation Insurance Fund, sustained injury arising out of and in the course of employment to his right knee.

2. Applicant has sustained his burden that the UR decision is invalid.

3. Applicant is entitled to the medical treatment requested in the Request for Authorization of Dr. Stevenson dated 6/3/2013 and Dr. Akizuki dated 7/13/2013, including but not limited to knee surgery and an adjustable bed.

AWARD

AWARD IS MADE in favor of Applicant, [redacted] and against Defendant, STATE COMPENSATION INSURANCE FUND, of:

(a) Medical treatment as set forth above in Finding of Fact Number 3.

ORDER

IT IS HEREBY ORDERED that all exhibits listed above be admitted into evidence at this time.

Colleen S. Casey

9.9.2013

COLLEEN S. CASEY
WORKERS' COMPENSATION JUDGE

STATE OF CALIFORNIA

DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

[redacted]	)	[redacted]
	)	San Francisco District Office
Applicant,	)	
	)	
vs.	)	**OPINION ON DECISION**
	)	
MARIN SANITARY SERVICES and	)	
STATE COMPENSATION INSURANCE FUND,	)	
	)	
Defendants.	)	
	)	

OPINION ON DECISION

This case deals with an admitted right knee injury suffered by the injured worker (IW), [redacted] n 12.5.2005. The basic facts are not in dispute.

The injured worker is still undergoing treatment for his injury and is not yet considered permanent and stationary or maximally medically improved at this poin[redacted] primary treating physician (PTP) Dr. Stevenson properly submitted a valid Request for Authorization (RFA) adopting the secondary treating physician's (Dr. Akizuki's) recommendation for knee surgery. Initially the request was "conditionally" denied by the Utilization Review (UR) physician on 7.1.2013 and ultimately denied on 7.27.2013 after additional records were provided.

The issues for trial were set forth as follows:

1. **Is there a valid UR decision?**

2. **If the UR decision is valid, any appeal must be taken through the Independent Medical Review (IMR) process.**

3. **If the UR decision is not valid, the WCAB would retain jurisdiction over the medical treatment dispute. The issue then becomes whether or not the applicant has met his burden of proving that the medical treatment request is reasonably necessary to cure or relieve from the effects of the injury.**

HOLDING: For the reasons set forth below, the UR decision is deemed invalid. Therefore, after a thorough review of the medical evidence submitted, I hereby issue this decision approving the medical treatment requests, holding that the applicant had met his burden of proving that the medical treatment requests are reasonable and necessary to cure or relieve [redacted] from the effects of his industrial injury. (See LC 4600(a).) Set forth below is the analysis for my conclusion.

A. Is there a Valid UR determination?

The first issue to be decided in this case is whether there was a valid UR decision with regard to the request for knee surgery and an adjustable bed.

The chronology is set forth as follows:

6.3.2013	1st RFA sent by IW's PTP Dr. Stevenson (Exhibit "E")
6.19.2013	1st RFA received by SCIF adjuster
6.24.2013	Additional records sent to UR reviewer by SCIF (Exhibit "D")
6.25.2013	The UR reviewing company (CID) requests "specific details of requested right knee surgery." (Exhibit "C")
7.1.2013	UR "conditional" denial (required info allegedly not received) (Exhibit "A")
7.23.2013	2nd RFA sent by Orthopedic Surgeon Dr. Kenneth Akizuki (Exhibit "ZZ")
7.27.2013	Final UR denial of knee surgery (Exhibit "WW")

There are three reasons to support the argument that the UR decision is invalid:

1. <u>Violation of Regulation 8 CCR 9792.9.1(*l*)(3) - Incomplete Review of the Medical Records:</u>

    a. **1st RFA for Knee Surgery from Dr. Stevenson adopting the medical treatment request from knee surgeon Dr. Akizuki**

The medical treatment requests for knee surgery and the adjustable bed were first requested by the PTP, Dr. Stevenson ,on the proper RFA form on 6.3.2013 (Exhibit "E.") The SCIF claims adjuster forwarded this RFA and medical records to CID, the UR review company, for the UR physician to review. Subsequently, the SCIF claims adjuster sent the UR reviewer fifteen **additional** records to review per her transmittal letter of 6.24.2013 (Exhibit "D"). In that letter, she states, in part:

"REGULAR REFERRAL Due Date is 6.26.2013.
Please review the request from JEFFREY STEVENSON dated 6.3.2013 as indicated on the worksheet.
Additional records are attached for your review." (Emphasis added.)

At the bottom of this one page FAX transmittal letter is a list of fifteen "**additional** records" for the UR physician to review. (It should be noted, that there was no argument at trial that the UR doctor did not receive the **additional** records. In fact, there is a notation at the top of the Exhibit "D" page that the documents were "successfully Faxed.")

In compliance with emergency Regulation 8 CCR 9792.9.1(*l*) (3), the UR reviewer must set forth a "list of all medical records reviewed." The pertinent part of the regulation states as follows:

> "(*l*) A written decision modifying, delaying or denying treatment authorization under this section, sent on or after July 1, 2013, shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:...
>
> (3) A list of all medical records reviewed."

Curiously, if one compares the list of fifteen <u>**additional**</u> records to review FAXed by SCIF from Exhibit "D" with the list of nineteen records reviewed by the UR physician (Exhibit "A" - - UR "conditional" denial") one will note that **not ONE of these fifteen <u>additional</u> records is listed on Exhibit "D" as having been reviewed by the UR physician.**

A sample of the fifteen **additional** medical records FAXed by SCIF, but **not listed as reviewed** by the UR physician, includes, but are not limited to the following:

- Report of Dr. Stevenson dated 6.3.2013
- Report of Dr. Stevenson dated 5.30.2013
- Report of Dr. Stevenson dated 5.6.2013
- Report of Dr. Stevenson dated 4.18.2013
- Report of Dr. Stevenson dated 3.28.2013
- Report from SOAR Medical Center 4.15.2013
- Report from SOAR Medical Center 3.20.2013
- Report from Terra Linda Occupational 4.2.2013
- Report from Dr. Akizuki dated 3.14.2013

Either the UR physician reviewed the records and violated the regulation by not listing these **additional** fifteen records as reviewed. Or he simply ignored the records and did not review them at all. Either way, his UR decision is tainted by this violation.

Since the UR physician received these fifteen **additional** records just two days prior to the assigned due date, the UR reviewer must have felt pressured to respond. When a UR reviewer requires more information, the time frame to respond may be extended per emergency regulation 8 CCR 9792.9.1(c) (3) (B) & (C) which provides:

> "(B) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the DWC Form RFA to make the proper determination.
>
> (C) If the reasonable information requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the completed DWC Form RFA is not received within 14 days from receipt of the completed DWC Form RFA, **the reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested**, or the reviewer may issue a decision to delay as provided in subdivision (f) (1) (A)." (Emphasis added.)

Essentially, this regulation states that if the UR reviewer needs more information, he may request that information, and if that additional information is not received within 14 days of receipt of

[redacted]

the RFA, he is permitted to "conditionally" deny the request, upon receipt of the additionally requested information. This is what appears to have occurred in this case.

On 6.25.2013, the day after the UR physician received the **additional** fifteen records from the SCIF adjuster, the UR reviewer issued a generic request for "specific details of the proposed right knee surgery." (Exhibit "C").

Then, several days later, on 7.1.2013, the UR physician issued a "conditional" denial, claiming that the medical treatment request might be reconsidered upon receipt of additional information. (Exhibit "A")

It is not clear as to why the UR reviewer did not list in his "review of records" the fifteen **additional** records FAXed to him on 6.24.2013 by the SCIF claims adjuster. (See last page of "conditional denial" - Exhibit "A") Perhaps if he had reviewed these records, he would not have needed additional information in the form of "specific details of the proposed right knee surgery." In any event, what did occur is clearly a violation of the UR process regulations.

b. 2nd RFA for Knee Surgery from Dr. Stevenson on behalf of knee surgeon Dr. Akizuki

Given that the first RFA was conditionally denied based on the UR reviewer's request for more "specific details" of the right knee surgery, a 2nd RFA was submitted by the orthopedic surgeon, Dr. Akizuki on 7.23.2013 (Exhibit "ZZ"). Four days after this request, on 7.27.2013, a final UR denial issued. (Exhibit "WW").

Again, it does not appear as if the UR physician reviewed the **additional** fifteen records FAXed to him by SCIF on 6.24.2013 (Exhibit "D"). If ones compares the list of fifteen records FAXed to the UR physician by SCIF on 6.24.2013 (Exhibit "D") with the list of twenty-one records reviewed by the UR physician in his final UR denial dated 7.23.2013 (Exhibit "WW"), one will note that **not ONE of the fifteen additional records from Exhibit "D" is listed on the UR denial (Exhibit "WW") as having been reviewed by the UR physician.**

As stated above, either the UR physician reviewed the records and violated the regulation by not listing these additional fifteen records as reviewed. Or he simply ignored the records and did not review them at all. If the latter is true, then the UR reviewer did not review of all pertinent records for a complete medical history

Either way, the UR decision is tainted by this violation.

2. **Violation of Regulation 8 CCR 9792.9.1(*l*)(5) - Request for additional information was so vague and ambiguous that it was non-compliant**

As stated above, the UR reviewer somehow skipped over the medical records FAXed to him by SCIF on 6.24.2013 (Exhibit "D"). On 6.25.2013, the UR physician requested more information (Exhibit "C") as follows:

> "Please provide further information regarding specific details of the proposed right knee surgery."

This request for additional information does not comply with emergency Regulation 8 CCR 9792.9.1(*l*) (5) which provides:

> "(*l*) A written decision modifying, delaying or denying treatment authorization under this section, sent on or after July 1, 2013, shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:
>
> ....
>
> (5) A clear, concise, and appropriate explanation of the reasons for the claims administrator's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. **If a utilization review decision to modify, deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.**" (Emphasis added.)

The UR physician's generic request for "specific details of the proposed right knee surgery" is so vague and ambiguous that it does not comply with the regulation's mandate to "specify the information that is required." The question becomes, how is the PTP supposed to comply with this request for "specific details of the proposed right knee surgery" when that information had previously been provided on more than one occasion?

Perhaps, if the UR reviewer had reviewed the records FAXed to him by SCIF on 6.24.2013, he would not have required additional "specific details of the knee surgery." In any event, the UR physician should have been more specific in his request for additional information in order to comply with 8 CCR 9792.9.1(*l*)(5) to allow the PTP to respond with appropriate specific information needed by the UR physician. As such, the UR process was unnecessarily delayed due to this violation of the above cited regulation.

3. **No substantial evidence was provided to show compliance with LC 4610(g)(3)(A) & 8 CCR 9792.9.1(e) (3):**

In addition to the above violations of the regulations governing the UR process, it is also noted that the UR decisions were not FAXed to the physician pursuant to LC 4610(g)(3)(A) and 8 CCR 9792.9.1(e)(3).

LC 4610(g) (3) (A) provides in relevant part:

"...Decisions resulting in modification, delay, or denial of all or part of the requested health care **service shall be communicated to physicians initially by telephone or facsimile**, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director...." (Emphasis added.)

No substantial evidence was presented at trial to establish that either of the UR decisions were FAXed to the PTPs.

In order to determine how the defense must prove that the UR decision was FAXed to the PTP, I referred to emergency regulation 8 CCR 9792.9.1(a) (1) which sets forth what is required in order to prove that a DWC Form RFA has been FAXed to the claims adjuster as follows:

"The copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted."

This standard of proving a FAX has been sent which has been set forth in this regulation 8 CCR 9792.9.1(a) (1) seems reasonable. Since it applies to primary treating physicians FAXing documents to claims adjusters in order to commence the UR process, it would seem logical to apply this same standard in reverse, to claims adjusters or UR reviewers FAXing documents to physicians at the end of the UR process.

In order to comply with this regulation, defendant should have produced one of the following documents:

- A copy of the cover sheet for the UR decision with a notation of the particulars of the transmission; or
- The UR decision with "an unsigned copy of the affidavit" or
- A certificate of transmission; or

- A FAX transmission report with the telephone number to which the form was transmitted on the report.

No document was produced at trial to comply with any of these four options.

Curiously, both Exhibit "A" and Exhibit "WW" would comply with this mandate. However, **the FAX cover sheet for BOTH of these exhibits indicate that the FAX is from the UR reviewing company CID, to the SCIF adjuster, and not to the PTP**. The latter is what is required by the Labor Code and the UR process regulations. The UR company, CID and/or defendant obviously have this capability since they provided evidence in this format for Exhibit "A" and Exhibit "WW."

To substantiate that a FAX of the UR decision was sent to the PTP, defense offered a log of activity by the UR reviewing company, CID, into evidence. (Exhibit "F.") In order to substantiate this document, the SCIF claims adjuster, Ms. Jinky Filoteo testified at trial that Exhibit "F" is a business record of CID and this is how the UR reviewing company substantiates their FAX transmissions. However, Ms. Filoteo does not work for CID and was not the person who input the data into this unverified activity log. Her testimony was solely based upon what she was told by Todd Andrew, the director of clinical operations of the UR reviewing company.

At page 4 of the Summary of Evidence, Ms. Filoteo's testimony was summarized as follows, "The witness looked at Exhibit "F", a log of entries by CID. She states that it establishes that the requesting doctor was faxed the UR decision pursuant to the entry by a CID employee. CID does not have a receipt from the fax or any sort of certificate of transmission that the fax had been sent. But she asked for confirmation that the fax had been sent from Todd Andrew. He said that it was, in fact, faxed to the doctor."

The above testimony in this instance is hearsay, and is allowed into evidence in workers' compensation cases, but the trier of fact must weigh such evidence and decide whether it is credible, and whether it can be relied upon for a determination of fact.

I did find Ms. Filoteo to be a credible witness, and I do believe she was truthful when she related what Mr. Andrew told her. However, Mr. Andrew did not testify under oath, therefore I could not observe **his** demeanor and credibility. He also did not testify or even convey to Ms. Filoteo that he was the one who personally FAXed the UR decision to the PTP. Therefore, the hearsay evidence in this instance is not sufficiently reliable to support the proposition by defense that the UR decisions were FAXed to the PTP, within twenty-four hours of the decision per LC 4610(g) (3) (A) and 8 CCR 9792.9.1(e) (3).

In addition, it should be noted that many of the entries for the activity log (Exhibit "F") indicate an entry by a particular individual, but the two entries for the FAX transmission of both the 1st UR conditional denial dated 7.1.2013 and the 2nd UR final denial dated 7.27.2013 indicate that the data was transmitted by "CID Automated Services," not an actual person. This document lacks adequate foundation and does not constitute substantial evidence that a FAX was sent to the doctor in compliance with LC 4610(g) (3) (A) and 8 CCR 9792.9.1(e) (3).

On this basis, as well, as the violations discussed above, the UR decision is determined not valid. (See ***Becerra v. Jack's Bindery, Inc.*** (2012) 2012 Cal Wrk Comp PD Lexis 451, where the UR decision was deemed invalid, in part, because "there is no evidence that the denial was timely transmitted to Dr. Rottermann by telephone, facsimile or otherwise as required by the rules of the Administrative Director.")

B. **The UR Decision is Determined to be Not Valid:**

Given the above cited violations of at least three of the UR process regulations and at least one violation of the Labor Code, the UR decision is determined to be invalid.

Since the UR determination is not valid, the UR decision is inadmissible as evidence on the issue of whether medical treatment should be authorized. (See ***SCIF v. WCAB (Sandhagen),*** (2009) 74 CCC 835.)

It appears that the appropriate forum to determine whether or not a UR determination is valid is before the WCAB. (See ***Corona v. Los Aptos***, (2011) 2011 CWC PD LEXIS 156.)

A significant violation of the regulations of the UR process is sufficient to determine the UR decision invalid. (See ***Academy of Arts College v. WCAB (Zedd),*** (2011) 76 CCC 352.)

If the UR determination is deemed invalid, then the WCAB trier of fact may issue a decision on the medical treatment dispute, if applicant presents at trial "substantial evidence in support of the requested treatment." (See ***Becerra v. Jack's Bindery,*** (2012) 2012 Cal Wrk Comp PD LEXIS 451.)

As set forth above, there have been several violations by defendant of the UR process, therefor the UR determination is deemed invalid. Since a valid UR decision is a prerequisite to IMR, the IMR process is not to be utilized in this case to appeal the UR denial. Per the case law cited above, the appropriate forum for a determination of the medical treatment dispute is the WCAB trier of fact.

Therefore, the final issue to be determined in this case is the dispute over the medical treatment request, which is set forth below.

C. **Medical Treatment Is Ordered Authorized:**

Substantial evidence has been offered at trial to support the request for authorization of knee surgery, the adjustable bed, and all other requests related to the surgical procedure as specifically set forth in the Request for Authorization (RFA) of Dr. Stevenson dated 6.3.2013 (Exhibit "E") and the Request for Authorization of Dr. Akizuki dated 7.23.2013 (Exhibit "ZZ").

1. **Request for Knee Surgery**

a. **Was there a proper medical treatment request?**

The first issue to be decided under this section is whether there was a valid MEDICAL TREATMENT request. The following criteria must be met:

- The medical treatment request must be on the required RFA form.
- The PTP must make the request.
- Since the secondary PTP, orthopedic surgeon Dr. Akizuki, is making the medical treatment request, his opinion can't be relied upon, unless his findings have been adopted by the PTP (Dr. Stevenson) LC 4061.5; 8 CCR 9785(d)-(g).

As discussed in greater detail herein, all of these criteria have been met in this case. The medical treatment requests were made on the required RFA form. The PTP, Dr. Stevenson submitted the initial RFA and Dr. Stevenson adopted the opinion of the secondary PTP, orthopedic surgeon Dr. Akizuki that the knee surgery was required.

b. **Was the medical treatment requested reasonable and necessary?**

Included in orthopedic surgeon, Dr. Akizuki's RFA of 7.23.2013 (Exhibit "ZZ") is his medical report dated 7.18.2013, wherein he **thoroughly** explains the basis for his conclusion that [redacted]eeds the Autologous Chondrocyte Implantation(ACI) / Tibial Tubercle Osteotomy (TTO) surgery for his right knee. Dr. Akizuki explains, in part, as follows:

> "The patient has had long standing right knee pain since 2005. He underwent cortisone shots, therapy, massage, pain medications at the time. He eventually underwent right knee scope in March of 2013 and intraoperative findings did confirm cartilage wear of trochlear. The patient also did physical therapy and massage, cortisone shot back in March which did not give him much relief from pain. He continues to manage and to work on modified duty. He medicates with Percocet and Dilaudid."

Included in Dr. Stevenson's RFA of 6.3.2013 (Exhibit "E") is his determination that he adopts Dr. Akizuki's recommendation for the ACI/TTO knee surgery. Dr. Stevenson explains in part, "The surgeon noted that he [redacted] had extensive changes as well as a significant osteochondral defect and that arthrotomy and reconstruction of the defect and possibly placement of hardware would be required for long-term result."

When the RFAs were sent through the UR process, the UR reviewer denied the request for knee surgery in his report dated 7.27.2013. (Exhibit "WW") At page 4 of this report, the UR reviewer states that the MTUS does not provide recommendations for this type of surgery, "therefore, alternative guidelines were consulted."

All of the guidelines consulted by the reviewer indicate that use of ACI surgery "for knee injuries is recommended as a second-line therapy after failure of initial arthroscopic or surgical repair." (See 3rd paragraph of page 4 of his 7.27.2013 report Exhibit "WW".) Later in the paragraph, the reviewer writes, **"It is possible in this case that ACI might be a reasonable consideration..."** (Emphasis added.)

The only qualification to certifying this procedure for [redacted] appears to be that the UR reviewer is of the opinion that **"There is insufficient evidence at present to say that ACI is cost-effective."** (Emphasis added.) This last line can be found in the middle of this 3rd paragraph of page 4 of his 7.27.2013 report (Exhibit "WW".) This conclusory statement by the UR reviewer is without any explanation whatsoever, which is contrary to the case of ***Escobedo v. Marshall,*** (2005) 70 Cal Comp Cases 604 (WCAB en banc) which mandates that all medical conclusions be supported by a "how and why" explanation.

In fact, [redacted] does seem to meet all of the criteria for use of the ACI/TTO knee surgery as set forth by the UR reviewer. See the last paragraph of page 4 of the UR reviewer's denial dated 7.27.2013 (Exhibit "WW") wherein he sets forth these criteria, a summary of which is as follows:

- Conservative therapy has failed. (It has for [redacted] as documented by his PTPs' reports.)
- [redacted] is capable of preforming rehab protocols. (The medical evidence supports this.)
- Surgical interventions have failed. (In March 2003, [redacted] underwent an arthroscopy procedure, but it did not relieve his symptoms.)

Therefore, based on the reasons stated above, [redacted] sustained his burden of proving with substantial medical evidence that the knee surgery requested is reasonable and necessary to relieve from the effects of his admitted industrial injury.

Since the knee surgery is ordered to be authorized, all requests made in the RFA related to the surgery are also ordered authorized.

2. **Request for Adjustable Bed:**

In his RFA dated 6.3.2013 (Exhibit "E"), [redacted] PTP, Dr. Stevenson requested an adjustable bed to allow more comfortable positioning, and noted at page 4 of his report that the "Official Disability Guidelines (ODG) does support special beds in cases such as this where there are special needs. A special need here is to be able to elevate his knee and ankle and not unduly pressure previously damaged tissue."

Dr. Stevenson preceded this statement with considerable detail and explanation of his conclusion as to why an adjustable bed was reasonable and necessary to relieve [redacted] of the effects of his industrial injury.

In denying this request for an adjustable bed, the UR reviewer stated in his report of 7.1.2013 (Exhibit "A") that "a search of California Chronic Pain Medical Treatment Guidelines, ACOEM, ODG, National Guideline Clearinghouse, and National Institute of Health Pub Med revealed no scientific evidence to support the use of an adjustable bed for the treatment of osteoarthritis of the leg." But actually, the ODG **does** support use of an adjustable bed as discussed above by the PTP Dr. Stevenson.

D. **Conclusion**

I conclude that the UR decision was invalid and inadmissible at trial. The injured worker has met his burden of proving that the medical treatment requested is reasonable and necessary. Therefore, all of the medical treatment requested in the RFA of 6.3.2013 and the RFA of 7.23.2013 is hereby ordered authorized.

Colleen S. Casey 9/9/2013

COLLEEN S. CASEY

WORKERS' COMPENSATION JUDGE