An Examination of the Valdez Decision

California's Workers' Compensation Appeals Board (“WCAB”) has rendered an en banc decision on medical treatment and Medical Provider Networks (“MPNs”). The en banc decision of Elayne Valdez v. Warehouse Demo Services (ADJ7048296), (“Valdez”) [Attachment #1] is an important decision that will have a significant impact on the California workers' compensation system and attorneys who choose to take their clients out of the MPN and upon doctors and other providers (such as hospitals, durable medical equipment, pharmacy etc.) who provide care on a self-procured basis and depend on a lien to collect for their services. This is because Valdez held that reports are not admissible into evidence either on issues of medical treatment or compensation, and as a result, the en banc court opined, the defendant is not liable for either the cost of treatment or disability benefits based upon unauthorized, and therefore inadmissible, non-MPN physician reports.

It is expected that many providers will significantly decrease their non-MPN work. As a result the worker with a legitimate need for treatment, surgery, durable medical equipment and/or medication who cannot obtain services on a lien basis while the dispute is in the process of being resolved may have significant problems.

MEDICAL PROVIDER NETWORKS: THE BASICS

Since many employers do not comply with the notification requirements set for in the en banc decision Bruce Knight v. United Parcel Service and Liberty Mutual Insurance Company (2006) 71 Cal. Comp. Cases 1423 [Attachment #2] it is very easy in such a case for an attorney to bring a client out of the MPN. [Attachment #3: 36 Ways to Take Medical Control by Barry Hinden, Esq.]

By way of review, an employer may establish an MPN for medical treatment to its injured workers and may transfer an injured employee's care into an MPN for medical treatment so long as the employer complies with the Labor Code (“LC”) and regulatory requirements. (Attachment #4: LC §4616; 3550; 3551; See Attachment #15: 8 California Code of Regulations (“CCR”) §9767.1 – 9767.12 (MPN Regulations Effective October 8, 2010). Proper notice of the MPN must be provided to the employee at the time the MPN is set up, at the time of hire and at the time of the injury, and any time an employer changes its MPN.

Anytime prior to the injury, the employee has the right to pre-designate a regular personal physician for treatment in case of an injury and that physician need not be part of the MPN [Attachment #5: LC §4600(a) - 2(g)]. After the injured worker notifies the employer of the injury, the employer must arrange an initial medical examination within twenty four hours and the injured worker must be evaluated by a physician within seventy two hours. The employee must be notified that he/she may choose from the list of MPN providers and choose the doctor of their choice from that list and may transfer care
to that doctor after the initial visit set up by the employer (LC § 4616.3; 8 CCR §§9767.9 (a)(f); §9767.12).
The employer bears the burden of proving that they provided the injured worker with proper notice, and without proper notice an injured worker may be entitled to medical treatment from a physician of his choice outside of the MPN (Knight, supra.). While Knight is still the law of the land it must be viewed very carefully in concert with Valdez and other cases which allow the employers to correct deficiencies in their MPN notifications.

UNDERSTANDING THE EFFECT OF VALDEZ ON NON MPN PROVIDERS

It is important that doctors working outside the MPN understand that their world has been radically changed by the Valdez decision and that in order to get paid they have to be most vigilant at the outset of the case to have evidence that the MPN requirements were not met by the employer and the attorney for the injured worker has sent a “how and why” letter to the carrier setting forth the reasons for removing the injured worker from the MPN.

The most important question for doctors and other providers working outside the MPN have to ask is: if the injured worker is forced back into the MPN and/or the attorney agrees not to oppose having the injured worker return to the MPN, will the services provided outside the MPN be paid?

To understand why Valdez has had such an impact on those working outside the MPN, it is important for doctors to understand that en banc decisions are significantly different than panel decisions of the WCAB. “En banc” is a French term, meaning “on the bench”, and refers to a full court, or all the judges of the court. The way it works is the Chairman of the WCAB takes a vote of the seven commissioners (called members) on the Board, and if the majority agrees the case is heard by the WCAB as a whole for an en banc decision. Since 2003 there have been approximately 50 en banc decisions so it is not a common occurrence.

In the case of Valdez, the question presented to the entire board for an en banc decision was: if an applicant has improperly obtained medical treatment outside the employer’s MPN, are the reports of the non-MPN treating physicians admissible in evidence? Once the case is decided by the entire board, the en banc decision of the WCAB becomes the law and as such is binding precedent on all WCAB panels and workers’ compensation judges (LC§115; 8 CCR §10341).

The Valdez decision becomes the law even though it was a split, 4-1-1 decision with the majority of commissioners (Joseph Miller, James Cuneo, Deidra Lowe, Alfonso Moresi) in the majority, with Commissioners Frank Brass and Ronnie Caplane providing concurring and dissenting opinions. Commissioner Brass agreed with the majority but opined that admissibility of non-MPN reports should be on a cases by case basis, while
Commissioner Caplane opined that the reports of the non-MPN doctor were admissible, especially on issues of compensation, under LC §4605 [Attachment #6].

In the case of a panel decision, where three commissioners out of seven hear the appeal, that panel decision only applies to the underlying trial case that was appealed. Panel decisions are not binding precedent on other WCAB panels or on workers’ compensation administrative law judges (“WCJs”). The Valdez case specifically disavowed any panel decisions which were contrary to its holding in Valdez.

The effect of en banc ruling such as Valdez may be far reaching. The case affects the applicant attorney because if the report of the non-MPN doctor is not admissible the impairment rating and conclusions of that report are out and will not assist their client in getting a settlement the attorney believes is proper as many MPN doctors will fail to evaluate and report upon compensable consequences. For the non-MPN doctor, Valdez will not only have an effect upon future collections but upon accounts receivable of cases that have not yet been resolved. Finally, MPN doctors have to be concerned that MPN’s will start “tightening up” their MPN lists as a result of Valdez and remove doctors who appear to be “applicant oriented.”

Accordingly for non-MPN doctors, just having the patient referred for treatment is no longer the measure of getting paid at least something in a non-MPN case. Unless, the doctor and the lawyer work together and follow a repeated protocol for proving that the injured worker meets the legal criteria to leave the MPN and be treated by a non-MPN Primary Treating Physician (“PTP”), then the report will not be admissible, and as a matter of law as set forth in Valdez, the insurer does not have to pay the PTP bill or anyone the PTP referred to for services. As the en banc court stated in its opinion: “... the non-MPN physician is not authorized to be a PTP, and accordingly, is not authorized to report or render an opinion on “medical issues necessary to determine the employee’s eligibility for compensation” under LC §4061.5 and 8 CCR §9785(d) and further, … “where unauthorized treatment was obtained outside the MPN, a defendant is not liable for the cost of the inadmissible reports from non-MPN physicians.”

When the reports of the PTP (and those he referred to) are ruled inadmissible the lien providers have, according to Valdez, given away for nothing both their treatment and reporting services.

THE FACTS AND CONCLUSIONS OF THE VALDEZ CASE

On October 7, 2009, Elayne Valdez filed a claim for industrial injury to her back, right hip, neck, right ankle, right foot, right lower extremity, lumbar spine and both knees (the claim was accepted but the right ankle, both knees, and the right lower extremity were disputed), while employed as a demonstrator for Warehouse Demo Services. Valdez was treated for the back, right hip and neck by an MPN doctor for approximately three weeks. However, Valdez later testified that the treatment provided by the MPN doctor was not helping her, although she never spoke to the claims examiner about her
complaints. Valdez obtained counsel who referred her to a non-MPN physician who placed her on TTD.

One year later Valdez went to trial. Warehouse Demo Services argued that the reports of the non MPN doctors were not admissible and therefore no substantial evidence existed supporting an award of TTD. The WCJ determined the only issue before the court was whether payment for TTD (and an EDD lien) should be awarded, and deferred the issue of the MPN and self-procured medical treatment. Based on the non MPN reports, the WCJ awarded TTD along with reimbursement to EDD.

Warehouse Demo Services appealed asserting the reports of non MPN physicians were not admissible and therefore no evidence existed to support the WCJ’s opinion. The WCAB granted reconsideration and the Board agreed to hear the case for an en banc decision. On appeal, Warehouse Demo Services reiterated its argument that it made before the trial court and denied liability for the cost of the treatment and reports, and claimed it had no liability for TTD because the treatment and report costs and the TTD were the results of treatment and opinions that the court could not rely upon because they were authored by an unauthorized (non MPN) physician and as such were not admissible. Warehouse Demo Services was essentially arguing on reconsideration that the reports should not be admissible based upon the “fruit from the poisonous tree” argument. The defense also argued that the employee made no effort to utilize any of the internal MPN challenges to the initial PTP’s recommendations or treatment and simply started treating outside the MPN in violation of LC §4616.3(c), which states when an injured worker “disputes either the diagnosis or treatment prescribed by the treating physician,” he or she “may seek the opinion of another physician in the [MPN],” and of “a third physician in the [MPN],” if the diagnosis or treatment of the second physician is disputed.

Importantly, in the en banc ruling the court made the assumption that the MPN was properly established and the injured worker was properly noticed by the employer, but like the WCJ in the underlying case, the WCAB deferred a determination on the MPN issue and remanded the case back to the trial court to determine whether the MPN was valid.

The majority of the Commissioners in Valdez set forth some major conclusions:

**Conclusion #1:** There exists in the Labor Code a mechanism where injured workers can change doctors within the MPN and/or rely on the second opinion, third opinion or could request an independent medical review of the treatment recommendations as a 4th level of dispute resolution. In this case, the court implied that Valdez should have told her doctor or the claims adjuster that the treatment was not working, and then if she disagreed with the diagnosis or treatment of the doctor she could either change doctors within the MPN or seek the remedy set forth in LC §4616.3(c) which was to seek a second, third or independent medical review to resolve any of her diagnosis or treatment concerns. In short, her complaint that treatment was “not working” should have been resolved within the MPN.
Conclusion #2: If the issue cannot be resolved within the MPN, the commissioners strongly assert that pQME/AME process set forth in LC§4061 and §4062 is the remedy when there is a dispute regarding medical treatment, diagnosis and/or disability issues. Summing up the position of the Commissioners the majority wrote: "It is those applicants who have chosen to disregard a validly established and properly noticed MPN, despite the many options to change treating physicians and challenge diagnosis or treatment determinations within the MPN, and to dispute temporary or permanent disability opinions under sections 4061 and 4062 outside the MPN, who have removed themselves from the benefits provided by the Labor Code." The Valdez court continues: “…Therefore, the non-MPN physician is not authorized to be a PTP, and accordingly, is not authorized to report or render an opinion on “medical issues necessary to determine the employee’s eligibility for compensation” under LC §4061.5 and 8 CCR§9785(d). Moreover, for disputes involving temporary and/or permanent disability, neither an employee nor an employer are allowed to unilaterally seek a medical opinion to resolve the dispute, but must proceed under sections 4061 and 4062. Accordingly, the non-MPN reports are not admissible to determine an applicant’s eligibility for compensation, e.g., temporary disability indemnity.”

Conclusion #3: The Commissioners reject the argument that LC §4605 and §5703(a)[Attachment #7] allow the admissibility of a non-MPN doctor's report because the injured worker received the treatment and report from the non-MPN doctor at the injured worker's expense.

Conclusion #4: Valdez focused on LC §4616.6 which states: "no additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any controversy arising out of this article”. Thus, says the en banc decision “section 4616.6 precludes the admissibility of non-MPN medical reports with respect to disputed treatment and diagnosis issues” … and … “the MPN statutes contain specific provisions for addressing disputes over treatment and diagnosis within the MPN, and section 4616.6 provides that “[n]o additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any controversy arising out of this article.” Thus, while medical treatment and diagnosis issues must be resolved within the MPN, as discussed below, disputes concerning temporary or permanent disability are to be resolved under sections 4061 and 4062, i.e., outside the MPN”. [Underline and emphasis added].

In summary of conclusion #4, the language of LC §4616.6 according to the en banc decision precludes admissibility of non-MPN medical treatment reports with respect to disputed treatment and diagnosis issues. Accordingly, Valdez has the potential to limit admissible medical treatment evidence to the reports of only MPN authorized physicians.

Conclusion #5: Valdez has a significant impact on the utilization review (“UR”) process for MPN doctors. In order to understand the impact upon UR the Supreme Court decision in State Comp. Ins. Fund vs. Sandhagen (2008) 44 Cal.4th 230(See Attachment #16) must be reviewed. Sandhagen made it clear that any issue or dispute over requested medical treatment must be handled solely through the UR process. Before the
Establishment of the UR process, a claims adjuster could object to treatment. Sandhagen, in brief, held that through the enactment of LC §4610 the Legislature established that every employer must create and use a UR process. The Legislature also enacted LC §4604.5 which pertains to medical guidelines which states that the Medical Treatment Utilization Schedule (“MTUS”) and the accepted portions of ACOEM are presumptively correct as a matter of law.

As a result of the enactment of LC §4610, the role of the claims adjuster was limited to approving the treatment, but any delay, modification or denial of treatment had to come from a licensed physician in the time frames set forth in LC §4610. The Supreme Court decision held that UR decisions not in compliance with the timeframes in LC §4610 could not be admissible in court or be commented upon by the AME, QME or independent medical reviewer. As the Supreme Court stated: “[t]aken together, the language of sections 4610 and 4062 demonstrates that (1) the Legislature intended for employers to use the utilization review process in section 4610 to review and resolve any and all requests for treatment, and (2) if dissatisfied with an employer’s decision, an employee (and only an employee) may use section 4062’s provisions to resolve the dispute over the treatment request. An employer may not bypass the utilization review process and instead invoke section 4062.”

The Sandhagen decision was clear that the Legislative intent behind Senate Bill 899 was to control costs while providing employees with prompt access to medical care and rapid resolutions through the UR process to treatment requests.

So how does Valdez interact with Sandhagen? If the MPNP PTP submits a request for treatment (which is compliant with the MTUS and the accepted portions of ACOEM) the requested treatment under LC §4604.5 is presumptively correct. Under Sandhagen, the employer must perform UR, if the claims adjuster, or the UR physician approve the treatment, there is no problem. However, if the UR physician denies, delays or modifies treatment that is in compliance with the MTUS and the accepted portions of ACOEM, or if the UR is not in compliance with the timelines set forth in LC §4610, the UR decision is contrary to the holding in Sandhagen that the UR determination must be prompt.

A UR determination that is not timely approved may be construed as a refusal or a denial of care. That denial or refusal brings the discussion back to Valdez which states: “An employer or its insurer is obligated to provide all medical treatment “that is reasonably required to cure or relieve the injured worker from the effects of his or her injury.” (Lab. Code, §4600(a).) Section 4600(a) further provides: “In the case of his or her neglect or refusal to reasonably do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.”

Therefore, if the failure to perform UR correctly, as set forth in LC §4610 and Sandhagen, the injured worker may then be able to take medical control.
POSSIBLE RATIONALE FOR DENYING UR TO EMPLOYERS FOR MPN PROVIDERS

The MPN is made up of doctors who have been chosen by the insurance companies to be on the MPN and can be dismissed, without cause, at any time by the insurance company pursuant to the Labor Code. Therefore, the MPN doctor has a vital interest to remain in the MPN. In short, if the insurance company chose the provider to be on the MPN, they cannot second guess their treatment decisions with a second bite at the apple with UR or a third bite of the apple with a pQME. Such an outcome (using UR and the QME process) would defeat the goal of Senate Bill 899 which was to provide prompt care through the MPN providers and return the injured worker to his/her job quickly without much TTD. To bypass LC §4616.6 with the LC §4062 process would defeat the treatment process envisioned by Senate Bill 899 and LC §4616. Therefore, Valdez is saying that for MPN providers UR determinations and pQME’s are not admissible. Consequently, if the carrier performs UR on a treatment issue of the MPN provider and the treatment is denied that may provide a violation of Valdez because of the denial or refusal of care and allow the attorney for the injured worker to take medical control and refer to a non-MPN provider.

POSSIBLE APPEAL ISSUES

Valdez will be appealed to the District Court of Appeals (“DCA”). One argument will surely be the majority of the commissioners have, de novo, legislated from the bench because of their treatment of LC §4605. LC §4605 states that “nothing contained in this chapter shall limit the right of the employee to provide, at his own expense, a consulting or any attending physicians whom he desires.” The Commissioners hold that LC § 4605 fails because it doesn’t use the word “treating.” On the other hand, the Commissioners agree that it would be unconstitutional to prohibit an injured worker from selecting, at his own expense, any doctor he wanted for treatment.

The constitutional argument to the DCA will be that the Fourteenth Amendment of the United States Constitution prohibits through its right to privacy, an injured worker (or any other citizen for that matter), to be forced to “treat” with a physician against their will, and indeed permits people to treat with any physician they choose (at their own expense). In the workers’ compensation realm, that means that if the injured worker does not want to treat with the MPN doctor, they are free to pay from their own pocket with the physician of their choice.

The argument will also revolve around the admissibility of non-MPN doctor reports set forth in the concurring and dissenting opinion of Commissioner Caplane. LC § 5703(a) provides that “[t]he appeals board may receive as evidence… [r]eports of attending or examining physicians.” Her arguments that 1) the majority’s opinion “takes away the discretion of the WCJ under this section to admit the reports of non-MPN treating physicians on these issues in all cases where there is a validly established and properly noticed MPN; and 2) the opinion of the majority the injured worker “would have to return to the MPN before he or she is eligible to receive compensation, which may needlessly
delay the resolution of a case and the provision of benefits to injured workers” is a potent argument on appeal as the opinion of the majority may be in conflict with the California Constitution, Article XIV section 4, which provides that the system must accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character.

**KEY POINTS FOR NON-MPN PROVIDERS**

**THE LIEN HOLDER MUST REVIEW THE SETTLEMENT AGREEMENT OF THE CASE IN CHIEF**

It is the position of some defense attorney(s) that where the employee has obtained treatment outside the MPN pursuant to LC §4605 and the physician has a lien, the employer should withhold sufficient sums from PD to cover the lien claim. The failure to withhold the lien amount may expose the employer to the treatment expenses. If in the settlement documents the employer (perhaps by oversight) agrees to hold the employee harmless on the lien claims then that agreement makes the employer responsible for the bill as it puts the employer in the employee’s position.

**MAKE SURE YOU ARE NOT DEALING WITH A VALID MPN AT THE OUTSET OF TREATMENT AND THERE HAS BEEN A DENIAL OR REFUSAL OF CARE BY THE CARRIER.**

As the Valdez court held, “Of course, where an applicant has refused at the outset to treat within a validly established MPN, the fact that there has been no PTP within the MPN, does not render the non-MPN doctor a PTP”. It is important that the attorney’s office complete the Employee Notification Form [Attachment #8] and send it to the physician’s office. Many physician offices will complete the Employee Notification Form in their office with the injured worker. Remember there may be a discrepancy between the answers to the form completed at the attorney’s office and the form completed at the doctor’s office. That discrepancy may become an issue at the time of trial.

It is best as a standard operating procedure to have the attorney complete the Employee Notification Form at the time of intake and forward a copy to the doctor’s office with the initial referral information.

Tied to proper notification is the Knight case which holds: “failure to provide the required notices to an employee of rights under the MPN which results in a neglect or refusal to provide reasonable medical treatment renders the employer or insurer liable for reasonable medical treatment self-procured by the employee.” As stated by the majority in the Valdez decision: “… where there has been no neglect or refusal to provide reasonable medical treatment, a defendant is not liable for the medical treatment procured outside the MPN.” Simply stated, in cases requiring MPN notification, the failure to
notify alone is not sufficient for the attorney to gain medical control. Thus without a letter from the attorney to the insurance carrier documenting a neglect or refusal to provide reasonable medical treatment taking a lien for medical treatment should not be risked.

As mentioned above, following the Valdez decision, it is important for the attorney to send the carrier a letter detailing the reasons why he is taking the injured workers out of MPN control. The letter should be sent to the doctor’s office as part of the initial referral packet. Again, if the lien provider is to prevail on a lien a paper trail from the outset of the transfer out of the MPN is essential. Remember, an argument is no substitute for evidence. The MPN issue requires evidence to prove the case, the lien claimant must have that evidence or with Valdez collecting on a lien is a losing proposition. In this instance, the lien holder cannot substitute an argument in a trial brief or a petition for reconsideration for needed evidence.

MAKE SURE YOU DISCUSS WITH THE ATTORNEY AT THE OUTSET OF NON-MPN TREATMENT WHETHER OR NOT THE DEFICIENT MPN NOTIFICATION CAN OR CANNOT BE CORRECTED.

Be aware that the courts have held that some defective notifications can be corrected and that the employer/carrier is only liable for treatment expense to the non-MPN provider until the correction is complete. The 5th DCA in the unpublished decision, Cynthia Krause vs. WCAB (Wal-Mart) (2010) 75 Cal. Comp. Cases 683 [Attachment #9] held that “Knight did not declare that a defective notice could not be corrected.” This has an important bearing on the Valdez opinion with regard to remanding the issue of MPN validity back to the trial court: “… should the evidence fail to determine the existence of a validly established and properly noticed MPN, then the applicant may continue to treat outside the MPN until the defendant is in compliance with the MPN regulations (see Babbit v. Ow Jing dba National Market (2007) 72 Cal.Comp.Cases 70 (Appeals Board en banc)).” [Attachment #10] Pursuant to 8 CCR §9767.9 (b) until the injured/employee is transferred into the MPN, the non MPN PTP may make referrals to providers within or outside the MPN.

In the Supreme Court ruling of Zeeb vs. WCAB (1967) 67 Cal. 2d 496[Attachment #11] the injured worker had received treatment from a PTP selected by the carrier until the condition appeared to become stable. Several months later Zeeb returned to the employer selected PTP who refused to provide treatment because he believed the new occurrence was not due to the industrial injury. The injured worker then selected a doctor of his choice and self-procured treatment. He was granted reimbursement by the WCAB for self-procured medical treatment. After the WCAB ruling the employer refused to authorize treatment with the self-procured PTP and notified the injured worker that it was authorizing further treatment only by the doctor it had originally selected. The injured worker refused to change doctors and he went to the WCAB which ordered him back to the employer controlled PTP. He appealed the ruling of the WCAB and the case was eventually accepted by the Supreme Court. The Supreme Court held that where the
employer or carrier refused to provide medical treatment necessitating an injured worker procure his own treatment, the treatment should continue with the PTP chosen by the injured worker, in the absence of a change of condition or evidence that the treatment given by the employee selected PTP is defective, or unless additional treatment is necessary.

In Javier Lara vs. Watkins Manufacturing (ADJ2689070 (SDO 0361034)) the WCAB granted reconsideration by the WCAB and dealt with the issue of whether the notice required by LC §3551, which was addressed in the Supreme Court Zeeb decision, and in Lara was not provided to the injured worker, whether the failure of notification was sufficient for the employee to gain medical control. The panel remanded the case back to the trial court to decide whether the proper notices were given to the injured worker, and if so the consequences of the failure and whether the failure was "cured" by any subsequent notice provided by the defendant.

Unlike Zeeb who was sent to one employee selected physician and had no other choice the Lara panel reasoned that the MPN statutes, unlike the employer controlled process under the earlier statutes, allows injured workers to obtain second and third opinions from other MPN physicians regarding diagnoses or treatment plans thereby addressing the concern expressed by the Supreme Court in Zeeb that “the purpose of securing proper medical care and speedy recovery” might be adversely affected by a change in treating physicians. According to the Lara panel, the MPN provisions assure that injured workers continue to receive appropriate medical treatment even if a pre-existing physician-patient relationship is disturbed. Further, the Lara panel continues to note that the MPN statutes and regulations identify four specific situations under 8 CCR 9767.9 (such as serious and chronic) where continued treatment is allowed for a period of time with the physician selected by the employee.

In the en banc ruling of Babbitt the WCAB held that the unique aspects of the MPN statutes an employer or insurer is not required to demonstrate that there has been a change of condition or defective or incomplete medical treatment before transferring an injured worker into an MPN. The en banc panel held … “unlike the statutes considered by the Supreme Court in Voss, Zeeb and McCoy, the MPN statutes do not give the employer complete control over the identity of a treating physician. To the contrary, injured workers under the MPN statutes have the right to select an MPN physician with recognized expertise or specialty in treating the particular injury or condition in question.”

UNDERSTAND LC §4060 [Attachment #12] AND LC §5402 [Attachment #13]

LC §4060 applies to the acceptability of a claim. It is important to understand the difference between a claim denial and a dispute. Assume that the injured worker files a claim for an injury to their knee and wrist. The insurer can accept the claim for the knee, but dispute the wrist body part. It is still an accepted claim. LC §4060 states that it (LC
§4060) “shall not apply where injury to any part or parts of the body is accepted as compensable by the employer.”

The employer has 90 days from notice of the injury to either accept or deny the claim (LC §5402). If there is no denial within 90 days the claim, in the vast majority of cases, is automatically accepted as a matter of law. If the employer has not accepted the claim MPN control cannot be exercised by the employer and the injured worker can choose a non-MPN PTP. This is where knowledge of LC §5402 is essential. Even though the claim has not been accepted or denies the employer must authorize treatment within one working day of knowledge of the injury and continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected the employer is liable for $10,000 of ACOEM compliant medical treatment. If any part of the claim is accepted at the outset the $10,000 set forth in LC §5402 does not apply.

1. The en banc ruling in Amelia Mendoza vs. Huntington Hospital (2010) 75 Cal.Comp.Cases 634 invalidated 8 CCR §30(a) for being inconsistent with the Labor Code. 8 CCR §30(a) did not allow an employer or insurer to obtain a QME after they denied the claim. The law now allows the employer to obtain a pQME to decide a LC §4060 issue. Prior to Mendoza that right on AOE/COE denied claims belonged exclusively to the injured worker as a result of the Supreme Court decision in Sandhagen. Sandhagen still is the law of the State with regard to treatment disputes. Self-insured employers and carriers once there is a dispute raised by a denial of a treatment request by utilization review cannot avail themselves of LC §4062 to challenge an injured worker's treatment request.

Once the employer accepts the claim they can transfer the care into their MPN. Most of the cases evaluated by injured workers who seek counsel are or will be serious and chronic in nature and therefore covered by 8 CCR §9767 (e) (2) which requires 90 days for the injury to be designated chronic. It is imperative that the non-MPN PTP notify the carrier in writing that the condition of the injured worker is serious and chronic. Recent decisions by the WCAB have held that if no notification of the serious and chronic condition is made by the doctor the provision is determined to be waived.

UNDERSTAND LC §4600, §4061 and §4062

For disputes involving treatment and temporary disability issues, LC §4062(a) provides “that a medical evaluation shall be obtained pursuant to sections 4062.2 for represented employees. For disputes involving permanent disability, section 4061(c) provides that a medical evaluation shall be obtained pursuant to sections 4062.2 for represented employees”.

Recall that under LC §4060 that the carrier can accept the claim, but dispute a body part. In such a case can the attorney for the injured worker take medical control and refer to the non-MPN doctor? Moreover, in such a case will the non-MPN doctor and the services to which he/she refers be paid?
This will become an issue for the WCJ at trial. If the reports are admitted the lien claimants will almost certainly have a recovery. If the reports are not admissible recovery is unlikely. However, various scenarios make this clear cut distinction anything but clear.

Take a usual situation. A body part is in dispute in an otherwise accepted claim. The lawyer takes medical control and refers the injured worker to a non-MPN doctor. The non-MPN doctor places the injured worker on TTD. The carrier refuses to recognize the non MPN doctor as the PTP and denies TTD. The injured worker qualifies for EDD. Ten months later with EDD running out the case comes up for an expedited hearing on the issue of TTD. Prior to the hearing defense counsel tells counsel for the injured worker that the carrier will pay back TTD if the injured worker returns to the MPN. The injured worker returns to the MPN. The case in chief settles on a QME report and the issue of the medical liens is deferred. The lien goes through the court process with the defendants raising Valdez as well as other cases supporting their position that the non MPN doctor had no right to be the PTP. Will the liens of non-MPN providers be paid?

The defense will argue that under 8CCR § 9785(d)), the PTP “shall render opinions on all medical issues necessary to determine the employee’s eligibility for compensation” and that “[n]o other [PTP] shall bedesignated by the employee unless and until the dispute is resolved.” The defense will likely quote Tenet/Centinela Hospital Medical Center v. WCAB (Rushing) (2000) 80 Cal.App.4th 1041 which held: “When there are disputes about the appropriate medical treatment, temporary or permanent disability, vocational rehabilitation, the disability rating, or the need for continuing medical care, Labor Code sections 4061 or 4062 apply. (Keulen v. Workers’ Comp. Appeals Bd., supra, 66 Cal.App.4th at p. 1096.) Sections 4061 and 4062 of the Labor Code establish the procedures for resolving such disagreements. Rushing was, therefore required to follow the Labor Code sections 4061 and 4062 procedures to resolve the dispute before she could legitimately select a new [PTP].”

The argument by the lien holder is that by delaying care for a disputed body part until an AME/QME resolves the dispute is unfair to the injured worker, a violation of their constitutional rights; their rights under LC §3202; and represents a denial or refusal of care by the carrier.

To expand on the above paragraph, it is imperative that the non-MPN lien holders have very experienced lawyers or representatives defend their lien. The arguments are:

1) Because the carrier disputed the body part the MPN PTP never provided treatment and therefore Tenet and 8 CCR §9785 (d) and LC §4616.3 (c) do not apply;

2) Failure to provide treatment for a disputed body part represents a denial or refusal of care under Knight;

3) LC §4600(a) requires an employer (or the insurer) to provide all medical treatment “that is reasonably required to cure or relieve the injured worker from the effects of his or
her injury” … and …“in the case of his or her neglect or refusal to reasonably do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment;”

4) Not proving prompt care for an injury takes away the rights of the injured worker under the California Constitution, Article XIV, Section 4 (See Attachment #17), which provides that the system must accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character;

5) LC §3202 provides that worker compensation laws shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment. The Supreme Court has “consistently held that the Workers' Compensation Act is to be construed liberally for the purpose of extending its benefits for the protection of persons injured in the course of their employment (Zeeb vs. WCAB (1967) 67 Cal. 2d 496).

6) The employer/carrier is required to provide more than a passive willingness to provide treatment to an injured worker. In the Supreme Court case of Braewood Convalescent Hospital vs. WCAB(1983) 34 Cal. 3d 159 [Attachment #14] the injured worker while employed as a cook slipped and sustained injuries to his back and right elbow. At that time the injured worker, who had been chronically overweight since childhood, weighed approximately 422 pounds. Diet plans failed and the injured worker found his way to Duke University where he lost 175 pounds at the Duke University Obesity Clinic. By November 1979, the injured worker could no longer afford to continue with the Duke clinic. The injured worker filed a claim for reimbursement for his expenses while at Duke including medical, lodging, special diet and transportation costs. The case made its way to the California Supreme Court where reimbursement was affirmed. The court held that LC §4600 requires more than a passive willingness on the part of the employer to respond to a demand or request for treatment, but rather requires some degree of active effort to bring to the injured employee the necessary relief.

The argument by the lien holder is that by delaying care for a disputed body part until an AME/QME resolves the dispute is unfair to the injured worker, a violation of their rights under LC §4600(a); their constitutional rights; their rights as set forth by the Supreme Court in Braewood; a violation of their rights under LC §3202; and a denial or refusal of care by the carrier.

THE ROLE OF EXPEDITED HEARINGS

Valdez may have a chilling effect on hospitals (and surgeons) providing surgical care on a lien basis. The validity of an MPN is not one of the listed issues in the CCR for expedited hearing and decision. However, where an injury to any part or parts of body is accepted as compensable and the issues include medical treatment or temporary disability for a disputed body part, the case may be set for Expedited Hearing. However, the assigned WCJ may re-designate the Expedited Hearing as a Mandatory Settlement Conference which may take longer than an expedited hearing to schedule.
Following the release of Valdez by the WCAB some carriers have sent letters to non-MPN providers from carriers stating that their reports are inadmissible. Not necessarily so. Only a judge can determine whether a report is inadmissible, and before that happens the issue of inadmissibility has to come before the WCJ in some kind of proceeding. This is why it is so important to have someone very experienced in the law represent the non-MPN provider at the Board.

Additional notice obligations are triggered at the time of injury. Within one working day of receiving notice of injury, the employer must provide the employee with a claim form, information about benefits, including use of the MPN, available to the employee and the workers' compensation process. (LC §§5401; 5402; 138.3; 138.4)

**BURDEN OF PROOF**

In regard to notice, the burden of proof rests on the party holding the affirmative of the issue. (Lab. Code, §5705.) In the event of a dispute about whether the injured worker was provided notice of rights under an MPN, the employer carries the burden of proof. The burden of proof is very important given the Valdez issue. Valdez states clearly the MPN must not only be properly noticed to the injured worker as set forth above and in 8 CCR 9767.9, but also must be properly established by the carrier with the State [Attachment #15: 8 CCR §9767.1 – 9767.12 (MPN Regulations Effective October 8, 2010]. As a result, once the issue of non-compliance with the parameters established by Valdez is raised in an issue pending before the WCAB, the burden shifts to the carrier and it is their burden to prove compliance.

**SOME PRACTICAL CONCERNS**

Burden means a lot legally, but a word about the lien crisis and the WCAB. WCJs do not want to be collection officers; they want to solve the problems for the injured workers. In Los Angeles 25% of the WCAB time (500 cases a month) there are 600,000 unresolved liens with 19,000 more that have not been filed because of the lack of WCAB personnel with 4000 new liens being filed every month. One retired WCJ has indicated the lien log jam is one of the greatest crisis faced by the WCAB, and she believes that many of the liens that are filed are without merit and only to have the carrier pay something to avoid the cost of litigation. In is not a great leap to believe that many WCJs on the bench have a similar view of lien litigation. Accordingly, non-MPN providers may find themselves in court with very busy and very frustrated judges. In this environment the non-MPN provider has to make absolutely sure that he/she has corrected all potential deficiency in the a solid paper trail that can prove the basis for the non-MPN lien. Remember, following Knight, it is important not just to show notice deficiencies that were not corrected, but to show how those notice deficiencies resulted in a denial or refusal of care to support your lien.

Finally, not all lawyers are equal in their attention to detail or protecting the rights of the non-MPN provider. The first obligation of a lawyer, as it should be, is to the client. Workers’ Compensation is not a system where there are many (if any) independently
wealthy people, or even financially well off people are using the system. Claimants in the system are for the most part living paycheck to paycheck. If the injured worker who is TTD does not receive benefits because they are not in the MPN and as a result cannot pay their living expenses or support their family (to the degree of putting food on the table) the attorney is very likely to put an injured worker back in the MPN.

Therefore, it is most important, indeed critical that at the first visit for treatment and/or evaluation every injured worker outside the MPN should have the paperwork completed by the non-MPN PTP for State Disability (if the injured worker qualifies) so that if TTD benefits are cut off, State Disability will fill the gap for up to one year. For the injured worker who does not qualify for State Disability, most attorneys will have the injured worker obtain care within the MPN even though it may result in a lower impairment rating at the conclusion of the case. Perhaps the number one reason that injured workers leave their attorney and substitute another attorney is when a regular benefit check is not coming to the client to “keep food on the table.”

Finally, the non-MPN must be careful at every level, the post Valdez world is taking every non-MPN provider into uncharted territory.