IN THE COURT OF APPEAL
STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT
DIVISION FOUR

Case No. A119814

Appeal from the Decision of Workers' Compensation
Administrative Law Judge Susan V. Hamilton
WCAB Case No. SFO 0489218

Jose Facundo-Guerrero,

Petitioner,

vs.

Workers' Compensation Appeals Board,
Nurserymen's Exchange, Argonaut Insurance,

Respondents.

APPLICATION FOR LEAVE OF COURT TO FILE BRIEF AS *AMICUS CURIAE* AND PROPOSED BRIEF OF *AMICUS CURIAE* BOEHM & ASSOCIATES IN SUPPORT OF PETITIONER JOSE FACUNDO-GUERRERO

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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT, DIVISION FOUR

JOSE FACUNDO-GUERRERO, Petitioner vs. WORKERS' COMPENSATION APPEALS BOARD, NURSERYMEN'S EXCHANGE, ARGONAUT INSURANCE, Respondents.	1st Civil No.: A119814

III.

APPLICATION OF BOEHM & ASSOCIATES TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PETITIONER

TO THE HONORABLE CHIEF JUSTICE AND THE HONORABLE ASSOCIATE JUSTICES OF THE FIRST DISTRICT COURT OF APPEAL, DIVISION FOUR, FOR THE STATE OF CALIFORNIA:

Boehm & Associates ("Boehm") respectfully requests leave to file an Amicus Curiae brief in support of Petitioner, Jose Facundo-Guerrero.

1. The present controversy impacts the medical benefit delivery system and the overall workers' compensation scheme under the Workers' Compensation Act in a manner directly relevant to many of Boehm's clients.

2. Boehm represents hundreds of providers and payers of medical care to injured workers who for varied reasons have been unreimbursed by apparently liable employers and their insurers. Boehm's clients include employee benefit plans including many union benefit plans, major hospitals including UC system hospitals, publicly mandated and privately owned hospitals, HMOs such as Kaiser Permanente, and governmental agencies such as the United States Department of Veterans Affairs and the California Department of Healthcare Services. As a lien claimant representative, Amicus has played an active role in all phases of litigation and is uniquely familiar with the current state of California workers' compensation law in its application to lien claimant medical providers.

3. Amicus will speak for the interests of medical providers generally.

4. Issues raised in the present case address the constitutionality and propriety of the statutory limitation on employer liability for specified types of medical care to 24 visits found in Labor Code § 4604.5, subdivisions (d)(1) and (d)(2). These limitations are not scientifically based

and contradict the Constitutional mandate and the overall workers' compensation scheme as a whole. As such, the statute creates conflict of laws that must be resolved.

5. Boehm is familiar with certain of these questions of law, and how their resolution may affect the rights of medical providers and payers.

6. Amicus status has been granted to Boehm in other matters including Beverly Hills Multispecialty Group, Inc. v. WCAB (1994) 26 Cal.App.4th 789.

7. WHEREFORE, Boehm & Associates respectfully requests permission to file an *amicus curiae* brief in support of petition herein, under such terms and conditions as this Court shall deem proper.

DATED: March 14, 2008.

Respectfully submitted,

By: _____

Robert Feinglass
State Bar No.: 126720
Attorney, Boehm & Associates

IV.

ISSUES PRESENTED

1. May the Legislature establish without due process dispute resolution procedures an absolute numerical limit on the number of treatments to cure or relieve from the effects of work-related injuries in the medical treatment modalities specified in Labor Code § 4604.5, subdivision (d)(1)?

2. May the Legislature shift the cost of additional reasonably necessary care in those modalities to cure and relieve onto the injured employees themselves or onto the public at large?

V.

SUMMARY OF ARGUMENT

In the last decade of the twentieth century there was a great surge in the stock market, often termed the "dot-com bubble." California's workers' compensation insurance industry, in reality organs for investment of premiums with pay-outs to insureds as no more than a cost of accumulating funds to invest, lobbied successfully for deregulation of the industry for the purpose. Profits were extravagant by prior standards, and "loss-leader" premium rates were offered to employers, to be made up by investment returns. When the "bubble" burst, and a period of contraction and

consolidation of the market began, the drumbeat of "skyrocketing" workers' compensation costs, always a refrain, became a *cause celeb*. As we know, the result was the reform legislation of 2002-2004, culminating in SB 899, of which Labor Code §4604.5, subdivision (d)[1], the statute here in issue, is a part.

The reform legislation returned the medical care delivery system to its pre-1976 posture by turning over control of care to employers through Medical Provider Networks ("MPNs") by which employers may pre-screen medical practitioners with whom injured employees are permitted to treat. Guidelines have been authorized that are presumptively correct for treatment. Utilization review is now ubiquitous. These measures provided employers with dramatically increased control over the course of medical care and its cost, and this was an objective of the reform legislation.

The Legislature also acted, however, against three specific treatment modalities, without regard to reasonable medical necessity or dispute resolution procedures. In § 4604.5, subdivision (d), the Legislature set an absolute[2] numerical cap on three modalities including chiropractic services that have been characterized as "physical medicine," for which it declared

[1] Unless otherwise specified, all statutory references are to the Labor Code.
[2] There are two exceptions. Pursuant to § 4604.5, subdivision (d)(2), the employer may, at its sole discretion, authorize additional treatment in writing. Pursuant to § 5307.27, post-surgical

that employer liability for provision of reasonable medical would cease after 24 treatments in each without regard to the medical propriety of such a "cap." This limit is unprecedented in our State's workers' compensation system. It is final for the injury for life and not rebuttable. It is not based upon any scientific evidence relating such a cap to overall cost containment much less medical efficacy. No rational relationship has been shown between the goal of medical cost containment and the absolute cap. The injured employee is thus left without an opportunity to be heard as to whether additional such care is medically appropriate to cure or relieve from his or her work-related injury.

Indeed, the California Workers' Compensation Institute ("CWCI"), an insurance industry organ, has filed an amicus brief for respondent herein distinguishing between the actual services, and the practitioner. In its attack on the medical judgment of chiropractors, CWCI has accepted the medical viability of the physical medicine modalities, but wants the discretion to utilize them to remain solely with employers without dispute resolution machinery if the injured employee disagrees. This admission by the insurance industry of the viability of the physical medicine modalities refutes the entire premise of the cap.

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services may be provided in accordance with medical treatment guidelines to be established by

In a system whose primary function is timely delivery of medical care to facilitate return to function and employment, subdivision (d) is an anomaly, standing in prima facie contradiction to the constitutional command for "full provision" of medical care without undue encumbrance.

It has always been an axiom of the workers' compensation system in California that the employer bears full responsibility for the cost of benefits, including medical care, available to injured employees. See, for example, §§ 3751 and 3752.

In light of the system of controls of medical costs now in place, and the constitutional right of injured employees to full provision of reasonably necessary medical care to cure and relieve from the effects of industrial injury, and in light of the constitutional mandate that employers shall bear the expense of medical treatment and not pass it along to the employee or the general public, Labor Code § 4604.5, subdivision (d), must be annulled as unconstitutional.

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the Administrative Director.

VI.

ARGUMENT

A. There is no Rational Relationship between the 24-Visit Cap on Physical Mecicine Treatments and the Legitimate Cost-Saving Concerns of the Legislature

The contention on the part of respondents and their *amici* (collectively, "respondents") is that there is statistical evidence of overuse of chiropractic care in California's workers' compensation system. Respondents have failed to demonstrate that there is a rational relationship between the goal of cost containment and the cap on physical medicine modalities without regard to medical and work history, medical expertise, or dispute resolution procedures. Chiropractic usage has increased in California, but the evidence cited fails to establish that chiropractic care has driven up the overall cost of care, or that there has been no reduction-- including in the present case-- in the frequency of more invasive, and much more expensive, inpatient surgical interventions as an alternative to physical medicine. Without such solidly reasoned evidence, the contentions remain without basis. Lumbar diskectomy and arthroplasty, for example, potential treatments for spinal conditions such as applicant's herein, are much more expensive than even a great deal of chiropractic care. Each of these procedures is routinely billed by hospitals, exclusive of surgeon and

anesthesiologist fees, at upwards of $100,000; add to that substantial aftercare (quite likely including physical and occupational therapy, also limited by subdivision (d) of § 4604.5). Assume further, *arguendo*, that the employer who rejects liability for care of a work-related injury retains entitlement to limit reimbursement for even necessarily self-procured care at the dramatically reduced rates that the Workers' Compensation Official Medical Fee Schedule ("OMFS"). These are the privileged rates accorded by statute to employers who timely accept liability for the work-related injuries of employees and authorize care. Those rates are often a fraction of billed charges, but still somewhere in the tens of thousands of dollars for the spinal procedures cited.

By contrast, the maximum OMFS fee for a chiropractic visit is $92.00. Under § 4604.5, subdivision (d), the maximum payout to a chiropractor would be 24 X $92.00 = $2,208.00. The average payout, according to respondent's CWCI *amicus* brief (at page 5), is presently $2,066 per claim, less than the maximum under the statute. It should not be forgotten however that averages cover a range of charges, so that many chiropractic charges will be less, while some conditions will, as a matter of reasonable medical necessity, require more treatment. Respondents and their *amici* (collectively, "respondents") have not demonstrated a rational

relationship between the concern of the Legislature to reduce employer/insurer costs and the cap contained in the offending statute.

The so-called physical medicine modalities have an obvious and significant place in the drive for cost reduction, particularly in avoiding the necessity for more extreme and expensive care, particularly surgery. In the case of spinal conditions treated by chiropractic, moreover, there is already heightened statutory scrutiny of the need for these expensive and dangerous procedures. Section 4604.5, subdivision (d) only makes it more difficult to find a viable alternative to such invasive procedures. If there were no valid role for chiropractors in the care of injured employees, the Legislature would not have characterized them as "physicians" for Labor Code purposes in §3209.3.

What remains then are the questions, how much treatment and what kind? As we know, competent expert opinion may differ. Protocols are or will be in place shortly, and treatment is now with MPNs pre-approved by the employer, as in the present case. With multiple other protections in place against overtreatment, there is no basis on which to find a rational relationship between the legislative goal of reducing workers' compensation costs and the 24-visit cap on *all* chiropractic treatment per injury for the life of the injured.

B. The Absence of Dispute Resolution Procedures in § 4604.5, Subdivision (d), Implicitly Rejects the Need for Medical Expertise in Determining Appropriate Treatment

The 24-visit cap set by the Legislature in § 4604.5, subdivision (d) conflicts prima facie with the California Constitutional mandate for "full provision of…medical…and other remedial treatment as is required to cure and relieve from the effects of…[industrial] injury." This command was "expressly declared to be the social policy of the State, binding upon all departments of the State government." Article XIV § 4.

As explained by the California Supreme Court in S.G. Borello & Sons, Inc. v. Dept. of Industrial Relations (1989) 48 Cal.3d 341, 354,

> The purposes of the [Workers' Compensation] Act are several. It seeks (1) to ensure that the cost of industrial injuries will be a part of the cost of goods rather than a burden on society….

Similarly, in Universal Studios, Inc. v. WCAB (Lewis) (1979) 99 Cal.App.3d 647, 658, the court of appeal affirmed in pertinent part that one constitutional purpose of the Act is specifically to prevent injured employees "from being public charges."

As in the present case, 4604.5, subdivision (d) will in many instances create a situation in which more than 24 chiropractic visits for an industrially injured employee will be appropriately prescribed and provided, avoiding surgeries. If so, who is to pay the bill? If, as here, an employer rejects

liability during the pendency of a claim, but the need for timely medical treatment reasonably requires that the injured self-procure his or her care in excess of the statutory limit, who will be responsible for the treatment cost? Will the injured employee have to pay for services rendered to cure or relieve an industrial injury? This result would be in violation of the constitutional requirement of full provision and § 4600, subdivision (a), as interpreted by this very court in Bell v. Samaritan Medical Clinic, Inc. (1976) 60 Cal.App.3d 486. Will the providing chiropractic practitioner have to choose between foregoing payment for his services and refusing to treat a patient in need of treatment? Will an injured employee's private insurance, which typically excludes work-related care from its coverage, be asked to pay such uncovered bills? Will the injured become a charge of the state in violation of express public policy and consistent case law by turning to Medi-Cal for payment of industrially necessitated care from which the employer has been excused by the Legislature?

All of these questions can be answered by a statute with provision for the resolution of disagreements. The present statute merely creates the questions.

As has been pointed out in other briefing in this case, the California Constitution acts as a restriction on the powers of the Legislature[3] in that "`it is competent for the Legislature to exercise all powers not forbidden by the Constitution of the State, or delegated to the [federal] government, or prohibited by the Constitution of the United States.'" [citations] Here, by contrast, the legislature's action directly contradicts the plain "full provision" language of our Constitution.

The Legislature has enacted an arbitrary law that is poorly tailored to address its concern in the area of medical treatment.

C. Adjusters are not Qualified Medical Evaluators

For purposes of workers' compensation administration, § 3209.3 defines a "physician" to include chiropractic practitioners "licensed by California state law and within the scope of their practice as defined by California state law." Consistent with that provision is § 4603.2, subdivision (a), requiring all treatment to be authorized or provided by a "physician" selected as the primary treating physician. While a chiropractor may fulfill the conditions set forth in those statutes, an insurance adjuster does not. At the conclusion of 24 treatment visits, § 4604.5, subdivision (d)(2) provides that the *employer* has been vested with the sole discretion to make medical

[3] See, City & County of San Francisco v. WCAB (Wiebe) (1978) 22 Cal.3d 103, 113

decisions regarding further care without any basis to ascertain competency in the area of medical expertise. Physicians' reports are subject to rigorous standards for determining acceptability of a medical opinion. Both educational qualifications and a demonstration of a thorough knowledge of the employee's relevant medical and work history are required. See, § 4628 and 8 Cal.Code Regs. § 10606. The employer or adjuster has been given no standards at all, and as we can see from the present case, the employer has no qualifications for making a competent determination based upon medical facts and reasoning.

Similarly, our Supreme court has held that

> [N]ot all expert medical opinion constitutes substantial evidence upon which the Board may rest its decision. Medical reports and opinions are not substantial evidence if they are known to be erroneous, or if they are based on facts no longer germane, on inadequate medical histories and examinations, or on incorrect legal theories. Medical opinion also fails to support the Board's findings if it is based on surmise, speculation, conjecture, or guess." Hegglin v. WCAB (1971) 4 Cal.3d 162, 169.

Under the present statute, the employer representative will not be required to establish qualifications, demonstrate comprehensive knowledge of the medical and work history of the injured, or defend medical opinions because the Legislature made no provision for any dispute resolution at all

with regard to the propriety of chiropractic care. The contested statute is without dispute resolution provisions and therefore denies due process to injured employees and their physical medicine practitioners. Even as physicians with an M.D. or D.O. degree are accorded greater deference in determining what is reasonable medical care, disputes between them are mediated by evidentiary and practice requirements, and decided by dispute resolution procedures. Physical medicine, however, has been transformed by statute into an object of implicit discrimination and its fate (and the fate of the injured employee in need of timely, reasonably required care to cure or relieve) lies in the hands of the unqualified, financially interested, employer. The constitutional mandate for full provision of industrial medical care is contradicted by turning medical decisions over to untrained, adversely interested parties to see to the cure and relief of industrial injuries in which, as here, physical medicine care is reasonably medically required on both a past and future basis. There is no rational basis for empowering unqualified designates to determine need for care in this manner.

D. The Real Effect of § 4604.5, Subdivision (d) is Impermissibly to Apportion Costs of Industrial Medical Care

The actual effect of § 4604.5, subdivision (d) is to apportion the cost of reasonably required physical medicine care between the employer and the injured worker together with his or her providers and private insurers or

Medi-Cal. The employer has liability only for the first 24 visits, and after that, the injured, or some other entity or person on behalf of the injured, must pay for the rest.

From this perspective, the principle that medical care is not apportionable has been abrogated by the statute. In Granado v. WCAB (1968) 69 Cal.2d 399, 405-406, the California Supreme Court affirmed that while some workers' compensation benefits may be apportioned, liability for costs of industrial care may not be apportioned: "`All' of the doctor treatment shall be at the expense of the employer….so long as the treatment is reasonably required to cure or relieve from the effects of the industrial injury, the employer is required to provide the treatment."

E. To the Extent that § 4604.5, Subdivision (d) Causes Costs of Care to Become the Responsibility of the Federal Government, that Statute Violates California's Commitment to Maximize Recovery of Federal Funds

To the extent that industrially injured employees must rely on Medicaid (Medi-Cal in California) to pay for physical medicine care in excess of 24 visits, § 4604.5, subdivision (d) conflicts with California's commitment to the federal government made when it accepted federal funding for the program.

In conflict with the operation of § 4604.5, subdivision (d), the State of California has made a commitment to maximize recoveries of Medicaid

funds from responsible third parties. In workers' compensation matters, the third party is the employer. Where physical medicine care exceeds 24 treatment visits, and the injured employee becomes Medi-Cal eligible, quite possibly as a result of work injury and disability, the statute shifts the cost of reasonably required industrial medical care onto Medi-Cal.

The federal Medicaid program was enacted at 42 U.S.C. 1396, Title XIX of the Social Security Act. It is a cooperative federal-state program providing medical assistance to needy people. State participation is voluntary, but participating states must comply with Medicaid statutes and regulations. Most notably for the present litigation, 42 U.S.C. 1396a, subdivision (a)(25) requires:

> (A) that the state or local agency administering such [Medicaid] plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan … [and]
>
> (B) that in any case where such legal liability is found to exist … the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.

The congressional legislative history of 42 U.S.C. 1396a (a)(25) moreover states:

> **Medicaid is intended to be the payor of last resort**, that is, other available resources must be

> used before Medicaid pays. (S.Rep.No. 99-146, at 312 (1985) reprinted in 1986 U.S.C.C.A.N. 279.) (Emphasis added.)

In a certain number of cases involving chiropractic care, pursuant to the present offending statute, the State will violate the obligations it assumed when it accepted federal funds for the Medi-Cal program.

F. Section 4604.5, Subdivision (d) Leads to "Absurd Consequences"

One benchmark of statutory interpretation is a determination, whether a given interpretation leads to "absurd consequences." County of Orange v. FST Sand & Gravel (1998) 63 Cal.App.4th 353, 356. If it does, then the interpretation is deemed incorrect. Here, there is no issue of interpretation; the language of the statute is clear enough. The absurd consequences, however, have already manifested.

1. In a liability-denied case, under subdivision (d) the employer gets to control self-procured medical care while taking no responsibility for payment

Applicant was required to self-procure care when the employer denied liability for a period of 78 weeks from notice on April 1, 2005 to acceptance of liability on September 26, 2006. During that period when the employer chose to deny liability, according to the present statute, the injured had to follow the arbitrary, poorly tailored rule of § 4604.5, subdivision (d), or risk having to pay for his own medical care.

2. The employer profits by the beneficial effect of treatment it does not pay for

Under the offending statute, the employer is entitled to walk away from charges for treatment that actually does cure and relieve from the effects of industrial injury, reducing permanent and temporary disability liability. This is another absurd result of the statute.

3. The principle, that "the right of reimbursement exists even where the employer's refusal is made in good faith and is a reasonable determination in view of the information available to him" is defeated by the statute. Zeeb v. WCAB (1967) 67 Cal.2d 496

Zeeb is a pre-1976 case decided during a period in which, like our present case, the employer that accepts liability for industrial injury is entitled to control medical care. Thus the principle enunciated has special resonance for our own period. The present statute in issue denies this important principle, another absurd result.

4. "Where self-procured treatment proves successful, the employee has the benefit of hindsight in proving that treatment furnished was inadequate." White v. WCAB (1969) 75 Cal.Rptr 809, 34 Cal.Comp.Cases 169, 171

The principle, that actually effective care to cure or relieve is reimbursable, even though denied by the employer, will also be abrogated, without reasonable basis. This again leads back to the situation in which the injured employee is made responsible for his own industrial medical care, another absurd result.

5. The applicant's primary treating physician is not permitted to treat his patient

The injured employee selected Marijan Pevec, D.C., as his treating physician within the meaning of § 3209.3, subdivision (a) and § 4603.2(a). Once the employer accepted liability in late 2006, it paid Dr. Pevec for 24 visits per § 4604.5, subdivision (d), and refused to pay the remainder, and refused as well to pay for further visits for future care, although the undersigned understands, on information and belief, that the Agreed Medical Examiner in this case has recommended substantial future chiropractic care for this patient.

VII.

CONCLUSION

Untoward consequences of the operation of § 4604.5, subdivision (d) fly in the face of the overall workers' compensation scheme. The provision is manifestly neither expeditious nor without undue encumbrance. It denies fundamental due process rights in the most basic and important function of the entire workers' compensation system, the timely delivery of appropriate medical care to injured workers. Section 4604.5, subdivision (d) is

antithetical to the purpose and the mandate for full provision of medical care, and should be annulled.

DATED: March 14, 2008.

Respectfully submitted,

By: _____

Robert Feinglass
State Bar No.: 126720
Attorney, Boehm & Associates

VIII.

CERTIFICATE OF COMPLIANCE

(California Rules of Court, Rules 8.204 and 8.520)

I, Robert Feinglass, certify that the foregoing brief compliance with the paper type, format requirements and the length limitation as set forth in Rules 8.204(b) and (c) and 8.520(c) of the California Rules of Court. The brief is printed on white, recycled paper of at least 20 pound weight. The text of the brief is proportionately spaced, has a conventional typeface of 13 points or more and, according to Word, the word-processing software used to compose the documents, exclusive of the Table of Contents, the Table of Authorities, and Application for Leave of Court of File Brief as *Amicus Curiae* and this Certification of Compliance, contains 3,484 words. This number is less than the 14,000 word limit set forth in Rules 8.204(c) and 8.520(c).

DATED: March 14, 2008

Respectfully submitted,

By: _____

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PROOF OF SERVICE BY MAIL
STATE OF CALIFORNIA, COUNTY OF SAN FRANCISCO

I am employed in the County of San Francisco; I am over the age of eighteen years and not a party to this action. My business address is 130 Frederick Street, #101, San Francisco, CA 94117.

On March 14, 2008, I served the within:

APPLICATION FOR LEAVE TO FILE AMICUS BRIEF AND AMICUS BRIEF

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

Executed on March 14, 2008, at San Francisco, California.

_____
Sylvia Tucker