ANOTHER INSTALLMENT IN THE *GEORGE THE BARTENDER* SERIES

For past installments of the *George the Bartender* series, please visit our web site at: http://www.kttlaw.us/memos.html

RE: GEORGE THE BARTENDER MEETS THE LABOR CODE §4062(b) SECOND OPINION SURGERY OPTION OR "TO CUT OR NOT TO CUT, THAT IS THE QUESTION!"

FROM THE LOBBY BAR AT THE HYATT:

After a hard day denying benefits I took my usual barstool at the Hyatt Bar and George the Bartender had my Beefeater's martini, straight up with two olives, waiting for me.

As I prepared to take the first sip of my martini in what I hoped would be golden silence, I heard someone literally crying in his beer down at the end of the bar. Looking up I gazed into the distraught face of George's primary treating physician, Dr. Nickelsberg, who was apparently moaning about the downturn in his business.

Knowing that any downturn in Dr. Nickelberg's business was good for the defense, I offered to buy the good doctor a drink so that I could learn about his latest lament.

The doctor proudly explained to me that he had a worldwide network of forty Outpatient Surgery Centers in Los Angeles and Orange Counties and during the "good old days" all forty Surgery Centers were able to pump out four low back surgeries per day, although this would be reduced to three if one of the surgeries happened to be a repeat low back surgery requiring fusions at multiple levels.

Dr. Nickelsberg went on to indicate that he was extremely proud of his enterprise which he has named the "S&M Surgery Centers" and that even after Outpatient Surgery Centers were subject to fee schedule, post January 1, 2004, he was making a very good profit based on the volume of spinal surgeries.

After downing another drink in one gulp, the doctor told me that his financial empire took a hit when defendants finally learned how to utilize the second opinion spinal surgery option of Labor Code §4062 as amended by the Legislature and effective January 1, 2004.[1]

Dr. Nickelsberg confided in me that certain defense attorneys, upon receipt of his reports recommending spinal surgery, were **immediately** reaching agreement with the applicant's attorney

---

[1] Labor Code §4062(b) provides in relevant part that the employer may object to a report of the treating physician recommending that spinal surgery be performed within ten days of the receipt of the report and that the ". . .parties shall seek agreement with the other party on a California Licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within ten days. . .an orthopedic surgeon or a neurosurgeon shall be randomly selected by the Administrative Director to prepare a second opinion report resolving the disputed surgical recommendation. . ."

as to an agreed orthopedic surgeon or neurosurgeon to resolve the question of whether or not said surgery was reasonable and/or necessary.

Dr. Nickelsberg went on to point out that the worst part of Labor Code §4062(b) is the following sentence:

> **The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the Appeals Board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by the subdivision. (Emphasis added)**

A depressed Dr. Nickelsberg admitted to me that on several cases surgery had been performed at one of his Outpatient Surgery Centers during the second opinion process and according to law he was now barred from receiving any payment for the surgery.

At this point in his story Dr. Nickelsberg was becoming so depressed that he started ordering shooters from George and washing them down with his supply of Vicodin that he always carries with him. Just then George's attorney approached us with a broad smile and told Dr. Nickelsberg that he has been able to manipulate the second opinion surgery provision of Labor Code §4062 so that Dr. Nickelsberg, who Ron uses in all of his cases, would be paid.

Ron explained that the solution was right there in Administrative Rule 9788.1 which provides as follows:

> **"An objection to the treating physician's recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in §9788.1." (Emphasis added)**

The form promulgated by the Administrative Director just for this purpose is Form 233.

Ron pointed out to Dr. Nickelsberg that defense attorneys or adjusters can no longer reach an informal agreement with the applicant's attorney to refer the applicant to an agreed doctor on the question of whether or not spinal surgery is reasonable or necessary. The defendants must first fill out Form 233 completely and that Administrative Rule 9788.1 eliminated defense attorneys from this process as the Rule provides that the form must be filed by way of a Declaration under penalty of perjury and that the Declaration can only "be executed by a principal or employee of the employer, insurance carrier, or administrator" which excludes attorneys representing the carrier, third party administrator or employer.

Ron went on to indicate that in most cases the ten days for objection will have passed by the time that the report recommending surgery is attached to the claims administrator's file.

Ron went on to note that Form 233 must be filled out completely by the Claims Administrator and that the original should be filed with the Administrative Director with copies to all parties, including the primary treating physician for the injured worker, and that the form requests that the Claims Administrator declare under penalty of perjury as to when the report of the primary treating physician was date stamped in to the Claims Office. Ron remarked gleefully that this was impossible with most large Claims Administrators as they were completely **"paperless"** and therefore it was impossible to stamp anything in.

In listening to the ongoing dialogue between Dr. Nickelsberg and Ron, I could not help thinking that once again form was going to triumph over substance.

As I sipped on my second Beefeater martini I reflected on the history behind the delivery of medical treatment, pursuant to Labor Code §4600.

Prior to January 1, 1977, the employer/carrier had unlimited medical control and sadly our industry abused this privilege by utilizing extremely conservative treating physicians.

As of January 1, 1977, the State Legislature, under tremendous political pressure from labor and the California Applicants' Attorneys' Association, amended Labor Code §4600 to provide that an injured employee could designate a physician of his choice thirty days after notice of the injury was given to the employer/carrier. Therefore our medical control was reduced to thirty days.

In amending Labor Code §4600 to allow the applicant free choice of physician, the Legislature, of course, fully expected that the injured worker would select the best physician available to treat his and/or her particular condition.

The free choice amendment soon turned to **"fool's gold"** as the applicant's free choice of physician became a euphemism for the applicant's attorney's free choice of physician and suddenly the applicants' attorneys' medical legal doctors became treating physicians.

I assume that the Legislature, in allowing injured workers to select their own physicians, envisioned a system in which injured workers would select doctors such as Dr. Marcus Welby and Dr. Kildare, but instead we got Dr. Seuss.

Most applicant's attorneys and their doctors joined forces to create a system in which injured employees were put through a maze of endless **"shake and bake"** therapy, diagnostic testing and multiple invasive treatment procedures which regrettably resulted in repetitive unnecessary surgeries which only serve to pump up permanent disability benefits, create other so-called injuries by the doctrine of compensable consequences and balloon the monetary value of our industry to over thirty billion dollars.

Traditionally our State Legislature has allied itself with labor and the California Applicants' Attorneys' Association so the cries of the employers of the State for **"real reform"** went unheeded until the reforms of January 1, 2004 and April 19, 2004.

Prior to January 1, 2004, every medical delivery system in the United States was based on some type of medical protocols and/or evidence-based guidelines-- with the notable exception of the California Workers' Compensation system.

On January 1, 2004, AB228 became law which, in part, created a medical delivery system in workers' compensation in which medical protocols would be applied to the delivery of the medical benefit.

The initial evidence-based guidelines were, of course, the American College of Occupational and Environmental Medicine Guidelines (ACOEM) and these were in effect until the Administrative Director developed her own medical guidelines pursuant to Labor Code §5307.27.

As the Administrative Director has now promulgated Administrative Rules regarding evidence-based guidelines. These rules supersede the ACOEM Guidelines.[2]

Concurrent with the adoption of the ACOEM Guidelines on January 1,2004, the State Legislature also amended Labor Code §4062 by adding the second opinion surgery option in subsection (b) as follows:

> **The employer may object to a report of the treating physician recommending that spinal surgery be performed within ten days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California Licensed Board-Certified or Board-Eligible orthopaedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within ten days, or if the employee is not represented by an attorney, an orthopaedic surgeon or neurosurgeon shall be randomly selected by the Administrative Director to prepare a second opinion report resolving the disputed surgical recommendation. . . . the employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the Appeals Board or as a self-procured medical expense, or for periods of temporary resulting from the surgery, if the disputed surgical procedure is preformed prior to the completion of the second opinion process required by this subdivision.**

Had the ACOEM Guidelines and the second opinion surgery option been in place ten years ago, Senate Bill 899 may not have been necessary.

---

[2] Although the Administrative Director's Guidelines supersede the ACOEM Guidelines, these guidelines were adopted in full by the Administrative Director.

In my personal opinion, a heavily liberal legislature that traditionally sided with both labor and the California Applicants' Attorneys' Association became appalled when they were confronted with evidence that some physicians were simply lengthening treatment programs and performing repetitive and unnecessary surgeries to build up treatment costs as unprecedented majorities in both the House and Senate overwhelmingly passed Senate Bill 899, which was signed by the Governor on April 19, 2004.

We have used the second opinion surgery option quite frequently in our firm with great success. Upon receiving a recommendation for a spinal surgery, we immediately seek concurrence with the applicant's attorney as to a second opinion surgery doctor with great success.

Most applicant's attorneys have their client's best interests at heart and gladly agree on a competent and well-recognized physician to give a second opinion on spinal surgery.

However, procedural questions still remain as follows:

1. Upon receipt of the report of the primary treating physician recommending spinal surgery most defense attorneys fax a written objection to the applicant's attorney suggesting agreement to a second opinion physician. However, Administrative Rule 9788.1 provides that the objection "shall be written on the form prescribed by the Administrative Director" and this form is DWC Form 233. Therefore, there is a factual issue as to whether failure to utilize Form 233 constitutes a waiver of the second opinion option as specified in subsection (b) of Labor Code §4062.

2. Assuming that DWC Form 223 is required, Administrative Rule 9788.1 provides that "the form must be executed by a principal or employee of the employer, insurance carrier, or administrator." This could (as George's attorney did) be read as a non-delegable duty that the objection must be completed by either the employer, insurance carrier or administrator and could not be completed by the defense attorney.

3. Administrative Rule 9788.1 provides that the employer, insurance carrier or administrator must complete one of two declarations under penalty of perjury and, in fact, states as follows:

   "The declaration must be executed by a principal or employee of the employer, insurance carrier or administrator" and again this would appear to exclude the defense attorney.

It would appear to be the clear intent of Administrative Rule 9788.1 that the Claims Administrator declare under penalty of perjury when the report of the treating physician was received (the actual day) recommending said spinal surgery and when the objection was served on the Administrative Director.

Administrative Rule 9788.1 mandates that an objection to the report of the treating physician recommending spinal surgery received by the Administrative Director "more than ten days after the date

of receipt of the treating physician's report is untimely unless it bears a post mark no later than the tenth day after the date of the receipt of the treating physician's report."

Please note that DWC Form 233 contains two separate declarations, i.e., Version A is to be completed by the Claims Administrator or employee of the Claims Administrator who has personal knowledge as to when the physician report was received (which would appear to be highly unlikely in most cases) and Version B is the "date stamped method" which was referred to by George's attorney.

Therefore, there may be a real issue in completing either of these declarations with a Claims Administrator that is completely paperless and all mail is electronically sent to a facility or location other than the claims office and/or out of state.[3]

With the incredible volume of mail received electronically, via facsimile and by United States Mail by Claims Administrators large and small in this state, it would certainly seem logical that defense attorneys should be able to assist in utilizing the second opinion surgery options as presented by Labor Code §4062(b) in guiding the Claims Administrator through the second opinion surgery maze.

DISCLAIMER

As I am dictating this memo to Kim, the breathtakingly beautiful cocktail waitress at the Hyatt Bar without notes or a Labor Code, I probably erred with respects to dates, Labor Code Sections and Legislative bills.

After all, I am 64 years old. However, I do believe I have the basic chronology down as to the journey of the WC Medical Delivery System in California to date.

I entered the workers' compensation system when I signed on with this firm on November 7,1973 and in the first years of my practice, believe it or not, the employer/carrier exercised medical control for the life of the claim. In the 197O's, we did not have the proliferation of newsletters, electronic mail, workcompcentral.com, etc., so news of legislative and judicial events came to us a lot slower than it does now.

Shortly before the applicant was able to exercise medical control after thirty days from notice to the employer of the injury, most of us in California were oblivious of this important legislative change to Labor Code §4600.

I remember quite distinctly that this announcement was made in late 1976 at what was then the Annual Joint Meeting of the Claims Association and the Defense Attorneys' Association. This seminar traditionally was held at the Sheraton Universal in Universal City. This dinner function was attended

[3] When Labor Code §4062(b) was added to the Labor Code in 2004, we did call the DWC and were given an advisory opinion that DWC Form 233 could, in fact, be filled out by the attorney representing the carrier or employer, as long as the information contained was developed through the personal knowledge of the Claims Administrator.

by the entire industry, including judges, applicant attorneys, defense attorneys and, of course, claims adjusters.

We were addressed that night by then Administrative Director, Mr. James Decker, who promptly announced that as of January 1, 1977, injured workers would have a free choice of medical after thirty days from notice of the injury.

Ironically, the loudest cheer went out from the claims adjusters present as they would no longer have to deal with volumes of calls from injured workers on a daily basis complaining about the treatment programs or their doctors.

Thanks to the important reforms of AB228 (effective January 1, 2004) and SB899 (effective April 19, 2004), we may have reached an acceptable solution to the delivery of the medical benefit to injured workers of this state, i.e., the creation of a Medical Provider Network (MPN) which gives an injured worker the ability to select the primary treating physician in various specialties from a large network of physicians in a convenient geographical area.

In my opinion, the MPN is a mirror image of our non-occupational healthcare system. The MPN is better than the HMO, not as good as a Point of Service Plan, but fits right in the middle as it is equivalent to the managed care PPO Network.

Although we certainly abused the delivery of medical treatment to injured workers when we had lifetime medical control, the pendulum certainly swung the other way during the 199O's and early on in the twenty-first century. On many of my cases, I continually saw a diagnosis that I never saw in my early days in the system, i.e. "failed back syndrome."

Maybe we got it right this time! Make mine a double George.

Joe Truce