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**HIGHLY CONFIDENTIAL AND PRIVILEGED ATTORNEY-CLIENT COMMUNICATION**

TO: Client

FROM: Daniel R. Savocool

DATE: August 6, 2012

RE: Constitutionality of Proposed Labor Code Section 4610.6 (Independent Medical Reviews)

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You have asked us to provide our thoughts as to the constitutionality of the proposed new Labor Code section 4610.6 regarding independent medical review of the medical necessity of disputed medical treatment in connection with workers' compensation claims (hereinafter the "Mandatory IMR Proposal.")[1] A copy of the Mandatory IMR Proposal is attached as Tab A hereto. You have asked us to address anticipated constitutionality questions that might arise regarding the Mandatory IMR Proposal, as well as identify the main arguments both in favor of, and against, the constitutionality of same.

While we identify issues, they are not necessarily fatal to the concept of mandatory IMR and may possibly be cured by appropriate revisions, particularly in respect to subsequent review of IMR determinations. These changes may, however, implicate policy decisions regarding how much review the stakeholders are willing to permit, and by whom, that are beyond the scope of this memorandum.

Two important caveats about the following analysis: First, we have not been provided other proposed "new" provisions bearing on the subject of mandatory IMR, or advised if and how the existing Labor Code provisions regarding UR, medical treatment, and regarding reconsideration and judicial review, will also be amended.[2] Therefore, our analysis is confined only to the limited excerpt of the statute we have been provided (proposed new Labor Code Section 4610.6), and identifies the issues that arise from that section as written, *assuming that*

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[1] We have not been asked to address, and do not address, the proposed independent bill review (IBR) provision of proposed new Labor Code section 4603.6.

[2] We also have not been provided with proposed revisions to Labor Code sections 5900 through 5956 (regarding reconsideration and judicial review) which appear to be part of this change. Those revisions, bearing on the right and scope of subsequent review, could have a material impact on this analysis.

the Mandatory IMR Proposal is a logical evolution of the trend toward efficient, evidence-based medicine coupled with cost containment.

There is, however, an "outer limit" on how far the Legislature can go before it violates the constitutional mandate to create a "complete system of workers' compensation." The question, therefore, is whether the Mandatory IMR Proposal, specifically with regard to how medical necessity decisions are made and the scope of review, exceeds that "outer limit," particularly with respect to due process, in the nature of an unconstitutional delegation of authority without due process.

It is important to note that Article XIV, Section 4 specifically addresses the Legislature's authority to enact provisions regarding how disputes related to workers' compensation can be resolved. First, the Legislature must make "full provision for vesting power, authority and jurisdiction in an administrative body with all the requisite governmental functions to determine any dispute or matter arising under such legislation." Second, the Legislature is vested with plenary powers:

> ...to provide for the settlement of any disputes arising under such legislation by arbitration, or by an industrial accident commission, by the courts, or by either, any, or all of these agencies, either separately or in combination, and may fix and control the method and manner of trial of any such dispute, the rules of evidence and the manner of review of decisions rendered by the tribunal or tribunals designated by it; provided, that all decisions of any such tribunal shall be subject to review by the appellate courts of this State. The Legislature may combine in one statute all the provisions for a complete system of workers' compensation, as herein defined.

Under the Mandatory IMR Proposal, decisions regarding medical necessity are made by independent medical reviewers, not by a WCAB judge or panel. We do not see this, in and of itself, as a significant issue, primarily because the system already includes the use of qualified medical examiners ("QMEs") to determine medical necessity, albeit subject to review. We are not aware of any requirement that certain issues be heard or adjudicated only by WCAB judges, who themselves are not elected officials. We also believe that involving others in the process who are not technically trial judges, WCAB judges, or arbitrators is permissible. *See e.g. Costa v. WCAB* (1998) 65 Cal.App.4th 1177 ("Although article XIV, section 4 does not mention use of an ombudsman or mediation, or authorize the establishment of a private dispute resolution procedure, this does not render either section 3201.5 or the IBEW/NECA plan invalid.")

The lack of meaningful review by the WCAB of the IMR determination, however, may create due process concerns. Under the Mandatory IMR Proposal, the determination of the independent medical review organization "shall be deemed" to be the determination of the administrative director ("AD.") Labor Code section 4610.6(g). The "deemed" determination by the AD, in turn, can only be reviewed by the Board, and only set aside upon proof by "clear and convincing evidence" that the determination (1) was obtained by fraud; (2) was subject to material conflict of interest, or (3) was the result of basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability. *Id.*

Article IX, Section 4 requires that "all decisions of any such tribunal shall be subject to review by the appellate courts of this State," and we understand that the existing provisions of Labor Code sections 5950 through 5956 regarding review of WCAB determinations will be revised to allow for limited judicial review of IMR decisions. However, the Labor Code provides that factual determinations of the WCAB are binding and unless that section is revised to address the mandatory IMR determinations we do not envision significant court review of medical necessity determinations.[5]

Importantly, Article IX, Section 4, qualified by the requirement of judicial review, authorizes the Legislature to "fix the manner of review" of decisions rendered by the "tribunal." Thus, one could argue that the Legislature is authorized to limit reviews of medical determinations by independent medical reviewers to very narrow grounds. Of concern, however, is that if an independent medical reviewer makes a factual error, even a glaring error, there appears to be no process for that error to be reviewed, much less overturned. There is no right to a hearing on that basis. Coupled with the absence of any examination, and the absence of any interaction between the injured worker seeking care and the reviewer (all decisions are made based on medical records and reports only), we think this is a significant issue, and may give rise to due process arguments.[6]

We understand and recognize that the Mandatory IMR Proposal is fashioned upon the IMR provisions found in group health care, including Health & Safety Code sections 1374.30-1374.36. There are fundamental differences, however, between the group health context and the California workers' compensation system; most significantly, a state constitutional mandate for a "complete system of workers compensation" that does not exist for group health. Furthermore, IMR in group health has consensual elements not present here, along with federal regulation. The constitutional mandate alone presents some unique challenges to any expedited determination of entitlement to benefits under a mandated review process with a limited scope of review.

There are other differences between the Mandatory IMR Proposal, as written, and the IMR provisions found in group health care. For one, the group health IMR process is a voluntary one that, by its own terms, is binding only on the insurance plan. An enrollee may also choose other recourse (*e.g.*, arbitration if provided in the plan), either immediately after a claim is rejected or after he or she is dissatisfied with the results of the IMR administrative process.

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[5] Labor Code section 5953 provides that "[t]he findings and conclusions of the appeals board on questions of fact are conclusive and final and are not subject to review. Such questions of fact shall include ultimate facts and the findings and conclusions of the appeals board on questions of fact are conclusive and final and are not subject to review. Such questions of fact shall include ultimate facts and the findings and conclusions of the appeals board. The appeals board and each party to the action or proceeding before the appeals board shall have the right to appear in the review proceeding. Upon the hearing, the court shall enter judgment either affirming or annulling the order, decision, or award, or the court may remand the case for further proceedings before the appeals board."

[6] This appears to be a significant change in the law. To our knowledge, no provision of the existing Labor Code allows for the binding determination of an entitlement question with no review except based upon a showing of bias, fraud or conflict of interest.

Admittedly, however, such secondary review would involve an exceedingly high standard for overturning a determination of entitlement by a plan administrator (it must be found to be "arbitrary and capricious".)[7]

While there is no case to our knowledge addressing a directly analogous statutory scheme, there is some authority for the view that statutes limiting the review of factual determinations to only a showing of fraud, corruption, or misconduct of the fact finder are suspect. For example, in *Bayscene Resident Negotiators v. Bayscene Mobilehome Park* (1993) 15 Cal. App.4th 119, the Court of Appeal struck down on due process grounds a city ordinance which required binding arbitration of mobile home rent disputes. The court noted that the ordinance did not provide judicial review of the evidence, but rather the issues were limited to "fraud, corruption or other misconduct of the arbitrator." The Court of Appeal also noted that of the nine California statutes that it reviewed that required compulsory arbitration, six were subject to judicial review (*e.g.*, Business & Professions Code section 6200(c) (arbitration of attorney fee disputes); Labor Code sections 5270, 5275, 5277 (workers' compensation claims that may be submitted to arbitration)) and two others involved implied consent to arbitration without judicial review (*e.g.*, Public Contract Code section 10240 (contracts with state agencies)). The court found that in only one situation, uninsured motorist arbitration, had the Legislature imposed compulsory binding arbitration on nonconsenting parties.

In contrast to *Bayscene*, in *Costa, supra*, 65 Cal.App.4th 1177, the court upheld a mandatory dispute resolution provision applicable to workers' compensation. In that case, an electrician filed a claim for benefits with the WCAB and requested an expedited hearing because he was in "'dire need of medical treatment, including home care.'" *Id.* at 1181. The court considered the constitutionality of provisions in a collective bargaining agreement that required employees to exhaust contractual grievance and arbitration procedures before exercising their constitutional right of review by the WCAB. Because the applicable constitutional provision specifically authorized the use of arbitration to resolve workers' compensation claims (see above) and the arbitration decisions were subject to review by the WCAB and the Courts of Appeal, the court held that the provisions were lawful.

More recently, in *The Hess Collection Winery v. Agricultural Labor Relations Board* (2006) 140 Cal.App.4th 1584, Hess Collection brought a constitutional challenge of Labor Code sections 1164, *et seq.*, which created a "binding" mediation scheme for disputes between agricultural employers and unions. In upholding the statute, and noting the Legislature's broad authority over employment, the Court of Appeal noted that the statutory scheme allowed for several levels of review of a mediator's decision. First, either party could petition the Agricultural Relations Board for review on a number of grounds, including (1) a provision of the agreement was unrelated to wages, hours, or other conditions of employment, (2) a provision of the agreement was based upon clearly erroneous findings of material fact, or (3) a provision of

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[7] We assume that new Labor Code section 4610.5 addresses credentials and standards for determinations similar to those in the group health IMR process, such as whether the disputed health care service is medically necessary based on peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service, nationally recognized professional standards, expert opinion, and generally accepted standards of medical practice. These provisions, which we have not been provided, could have a bearing on the due process issue as well.

the agreement was arbitrary or capricious in light of the mediator's findings of fact. If the Board determined that a *prima facie* ground for review was shown it could grant review and order the mediator to modify the terms of the agreement and issue a new report (from which either party could again seek review on either of the foregoing grounds). The parties also had the right to seek Board review of the mediator's report on the grounds that (1) the report was procured by corruption, fraud, or other undue means, (2) there was corruption in the mediator, or (3) the rights of the petitioning party were substantially prejudiced by misconduct of the mediator. Finally, after Board review, and the mediator's report becomes a final order, either party could petition the Court of Appeal or the Supreme Court for a writ of review. Judicial review extended no further, however, than to determine whether (1) the Board acted without, or in excess of, its powers or jurisdiction, (2) the Board did not proceed in the manner required by law, (3) the order or decision of the Board was procured by fraud or was an abuse of discretion, (4) the order or decision violates a constitutional right of the petitioner. Finding that this multi-level review framework is not quasi-judicial, but rather quasi-legislative in character, and there was no unlawful delegation of legislative power, the Court of Appeal upheld the constitutionality of the law.[1]

In some respects, the Mandatory IMR Proposal falls between *Bayscene, Costa* and *Hess Collection.* The WCAB judges are, essentially, removed from the factual process, delegating the authority to make medical determinations to reviewers, with very limited review by the AD or the Board. Unlike the multi-level review considered in *Hess Collection*, there is no process for rectifying clearly erroneous findings of material fact at the AD or Board level. As in *Costa*, the provisions of Labor Code sections 5900 through 5956 provide for writ review of WCAB determinations, therefore providing the required right to judicial review. But, Section 5953 makes the findings and conclusions of the appeals board on questions of fact conclusive, therefore making it difficult to rectify fact errors on judicial review. Read together with Labor Code section 4610.6, one might argue that the right of review is therefore extremely limited, as it was in *Bayscene*, with no avenue for meaningful review and correction of factual errors. Therefore, we think there could be an issue with the proposed IMR process, as we understand it.

A second, but related constitutional argument that could be made pertains to the right to equal protection under the Federal and California constitutions. We do not see a colorable equal protection challenge to the Mandatory IMR Proposal, given the facts as we know them. Indeed, the non-discrimination provision of proposed Labor Code section 4610.6 would seem to insulate the statute from an equal protection claim.

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[1] It should be noted that statutory scheme in *Hess Collection* was found constitutional by a 2-1 majority. In a strong dissent, Judge Nicholson concluded that the law was an unconstitutional delegation of power, and believed that the statutory framework did not have sufficient constitutional checks on the power of the "private mediator." He also believed that the law violated the equal protection rights of agricultural employers. Hess Collection petitioned for review in the Supreme Court, but the petition was denied. *Hess Collection Winery v. Cal. Agric. Labor. Rels. Bd.* (2006) 2006 Cal. LEXIS 11206.

## II. Constitutional Strengths and Weaknesses

As you have requested, below are specific arguments in support of the constitutionality of the Mandatory IMR Proposal, and specific issues you should anticipate.[9]

The following are the most compelling reasons in favor of the constitutionality of the Mandatory IMR Proposal as currently written:

- The Legislature has broad plenary power.
- Article IX, Section 4 authorizes the Legislature to establish the appropriate manner of resolving disputes, and may "fix the manner of review" of decisions. This means that the Legislature can decide who makes medical determinations.
- Mandatory IMR decisions will be subject to judicial review. Both employers and employees will retain the right to reconsideration by the WCAB, and judicial review.
- The IMR process is non-intrusive provision that simply puts medical decisions in the hands of qualified medical people, instead of judges, and is merely a refinement on the QME process currently used.
- The Court of Appeal decision in *Facundo-Guerrero* confirmed that there are no constitutional entitlements to a particular benefit or process, such as an entitlement to the current UR process.
- IMR determinations are common in other regulated contexts, like the group health plans.
- Proposed Labor Code section 4610. 6 is nondiscriminatory on its face, with a right of review of discriminatory decisions.

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[9] It would be advisable to develop a strong factual record in the legislative history regarding why evidence-based mandatory IMR is justified. We have been advised that others are attending to this, but if you want to bring us into the process, we would be happy to assist as needed, specifically in preparation for any testimony in support of the legislation. While some courts will consider anything in the legislative process as appropriate legislative history, the Court of Appeal has specifically addressed the standards for what can be considered in *Kaufman and Broad Communities, Inc. v. Performance Plastering* (2005) 133 Cal.App.4th 26, as follows. Appropriate legislative history generally includes such things as conference committee and legislative reports and analyses; legislative counsel's digests, opinions and summaries; floor statements; house journals and final histories; the legislative analysts' reports, and statements by sponsors, proponents and opponents of a bill communicated to the legislature. Items not appropriately considered legislative history include authoring legislator's files, letters, press releases and statements not communicated to the legislature; documents with an unknown author; letters to the governor; memoranda from proponents or opponents to the bill's author, and statements by interested parties that are not communicated to the legislature.

- The IMR process replaces the more cumbersome UR process, which has not been declared unconstitutional.

- Proposed Labor Code section 4610. 6 does not reduce existing benefit levels.

- The IMR process specifically addresses conflicts of interest issues.

The following are the most compelling reasons against the constitutionality of the Mandatory IMR Proposal as currently written:

- Generally, allowing reviewers to make medical necessity decisions on the basis of paper record only, coupled with an absence of a meaningful right of review even for factual errors, potentially conflicts with Article IX, Section 4's requirement to provide for a "complete system" of workers compensation.

- Insufficient review process, even if coupled with reconsideration or writ procedures of Labor Code section 5950 *et seq.*

- Factual determinations made by the IMR would be conclusive on the AD, and reviewable by the WCAB based on fraud or mistake, and even then must have clear and convincing evidence. Fact determinations by the WCAB are binding and nonreviewable under Labor Code section 5953. Therefore, factual errors by the IMR are not reviewable or correctable.

- There is no provision for the injured worker to have any input whatsoever regarding the medical necessity determination. No examination.

- No standards for qualifications of reviewers, basis of determination, etc.

- Not required to follow accepted standards, published guidelines, etc.

We hope that this is useful to you. Please advise if you would like to discuss.

# TAB A

These are the provisions for limited judicial review of non-judicial decisions. The nonjudicial decisions are in independent bill review (IBR – proposed Labor Code Section 4603.6(f)), and the far more important area of independent medical review (IMR – proposed Labor Code Section 4610.6). We have not yet edited the existing statutes regarding reconsideration and judicial review. Those are in Labor Code sections 5900-5956. We suggest that IMR be revised to meet the minimum due process standard of judicial review, and then it be copies over into IBR.

4603.6. (a) When the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the second review pursuant to Section 4603.2 or 4622. If the provider fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue must be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622.

(b) A request for independent review shall be made on a form prescribed by the administrative director, and shall include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final explanation of the second review. The administrative director may require that requests for independent bill review be submitted electronically. A copy of the request, together with all required documents, shall be served on the employer. Only the request form and the proof of payment of the fee required by subdivision (c) shall be filed with the administrative director. Upon notice of assignment of the independent bill reviewer, that requesting party shall submit the documents listed in this subdivision to the independent bill reviewer within ten days.

(c) The provider shall pay to the administrative director a fee determined by the administrative director to cover the estimated cost

of independent bill review and administration of the independent bill review program. The administrative director may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation adopted by the administrative director. If any additional payment is found owing from the employer to the medical provider, the employer shall reimburse the provider for the fee in addition to the amount found owing.

(d) Upon receipt of a request for independent bill review and the required fee, the administrative director or the administrative director's designee shall assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the independent reviewer assigned.

(e) The independent bill reviewer shall review the materials submitted by the parties and make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination. If the independent bill reviewer deems necessary, the independent bill reviewer may request additional documents from the medical provider or employer. The employer shall have no obligation to serve medical reports on the provider unless the reports are requested by the independent bill reviewer. If additional documents are requested, the parties shall respond with the documents requested within 30 days and shall copy the other party with any documents submitted to the independent reviewer. If additional documents are requested, the independent reviewer shall make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination within 90 days of the receipt of the administrative director's assignment. The written determination of the independent bill reviewer shall be sent to the administrative director and copied to both the medical provider and the employer.

(f) The determination of the independent bill reviewer shall be deemed a determination and order of the administrative director. The determination is final and binding on all parties unless an aggrieved party files with the appeals board an appeal from the medical bill review determination of the administrative director within 20 days of

the service of the determination. The medical bill review determination of the administrative director shall be affirmed by the appeals board unless it is proven by clear and convincing evidence that the determination was obtained by fraud.

4610.6. (a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity defined in subdivision (c) of section 4610.5.

(d) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily

function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a an appeal to the workers' compensation appeals board from the medical review determination of the administrative director, filed with the appeals board and served

on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be set aside only upon proof by clear and convincing evidence that the determination was obtained by fraud, was subject to material conflict of interest, or was a result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability. If the determination of the administrative director is reversed the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In no event shall the appeals board make a determination of medical necessity contrary to the determination of the independent medical review organization.

(i) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this paragraph unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within twenty days. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(j) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors. The

administrative director may require insurers and self-insured employers or their adjusting agents to deposit an amount not to exceed the administrative director's estimate of the per-case fees anticipated three months in advance.

(k) The administrative director is authorized to publish the results of independent medical review determinations after removing individually identifiable information.