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## AMBIGUITY OF SB 863 AND INEQUITABLE DEATH BENEFIT ERROR

### By SCOTT O'MARA

Previously, families of workers who have died because of their injuries became aware of the inconsistency in legislation pursuant to Labor Code §3501 and §4703.5, as in many situations surviving dependent children have been denied the economic value of death benefits in the event their parent or that individual providing benefits to them died because of a job-related injury. The Labor Code was amended in 2002 with the intent of expanding death benefits to children mentally or physically incapacitated from earning by continuing said benefits until their death.

However, the 2002 amendment created ambiguity which has been interpreted by some employers to provide benefits only to those children with no surviving total dependent parent or provider. Whereas a family unit with a partial dependent could receive the enhanced benefits up until the child reached the age 18 or beyond, depending on the child's capacity, the family with the greatest need — where there was total dependency and the surviving spouse or provider had limited or no income — was unable to receive benefits until the child reached the age of 18.

*On 2/20/13, Assemblyman Henry Perea drafted Assembly Bill 607 in an attempt to correct the wrongs which have existed since 2002.*

This inconsistency was brought to the attention of the San Diego and Imperial County Chapter of PORAC by this writer. Pursuant to direction from that chapter, legislative redrafting was done and submitted to PORAC. Utilizing their lobbyist, Aaron Read & Associates, PORAC has worked with Assemblyman Henry Perea, who drafted Assembly Bill 607 on 2/20/13 in an attempt to correct the wrongs which have existed since 2002. This bill was passed by the Assembly on 4/18/13, and then passed by the Senate on 8/26/13.

Independent Medical Review (IMR) is a new process utilized to validate or take issue with the medical care recommended by the injured worker's treating physician.

The protocol established by Senate Bill 863 provides that for new injuries as of 2013 and old injuries as of July 2013, if the treater makes a recommendation and the utilization review doctor does not concur, the California injured worker has limited rights to question the UR determination or provide additional information to justify the recommended care and treatment.

Prior to the passage of Senate Bill 863, if the injured worker's doctor had opined as to the need for medical care and the UR determination denied that care, the worker could utilize a doctor agreed upon by the parties, or a panel doctor from a list provided by the state, to resolve the issue. The parties also had the right to be aware of the credentials, qualifications and license of whatever doctor was used.

If the worker was not satisfied with the recommendations made by the Agreed Medical Examiner or panel doctor, he/she had the right to develop the record by re-examining the qualifications of the doctor and finding out what records that physician had reviewed, and then presenting this information before a judge and seeking the judge's opinion as to the necessity and appropriateness of the recommended medical care. Under this protocol, California injured workers had the right of due process.

*The program implemented by Senate Bill 863 eviscerated the due process protocol.*

However, the program implemented by Senate Bill 863 eviscerated the due process protocol. It stated that in the event the utilization review doctor disagreed with the treating doctor, the California injured worker's only remedy was to utilize the Independent Medical Review process. This process allows for a reviewing doctor who is not necessarily licensed in the state of California, and whose credentials for acting in this capacity are unknown. Whereas the specialty of the treating doctor recommending the medical care may enable that physician to have unique knowledge and experience as to a particular protocol of care, the IMR process does not require the reviewing doctor to have equal knowledge and experience. Furthermore, the identity of the IMR doctor and the information the doctor has reviewed are not made known to the injured worker. *This closed door — this blanket of secrecy — does not allow for due process or checks and balances.*

As a result of this wrongful legislation (Senate Bill 863), constitutional issues have arisen, and California injured workers have been denied the due process guaranteed by the California Constitution and the U.S. Constitution.

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However, new legislation — Senate Bill 626, introduced on 2/22/13 — has been offered by California State Senator Jim Beall to challenge the unconstitutionality of the Independent Medical Review system established by SB 863. SB 626 creates the right to appeal IMR decisions directly to the Workers' Compensation Appeals Board, thereby allowing for due process. This bill is currently held in abeyance as of 4/24/13.

Also, according to the Legislative Counsel's Digest, SB 626 would require that "medical treatment utilization reviews and independent medical reviews be conducted by physicians or medical professionals . . . who hold the same California license as the requesting physician". That would establish parity between the requesting and reviewing physicians. Without that parity, the recommendation of a highly-

qualified specialist could be denied by a general practitioner lacking the specialized knowledge needed to make an adequate decision regarding the need for treatment. Furthermore, requiring that the reviewing physician be licensed in California would eliminate the potential inequity created by using reviewers licensed in states with more relaxed medical standards. In addition, SB 626 would delete the requirement that the names of the reviewers be kept confidential.

*SB 626 would allow for a fair and equitable review by doctors of equal caliber in determining the necessity and appropriateness of medical care.*

Thus, SB 626 would allow for a fair and equitable review by doctors who are of equal caliber in determining the necessity and appropriateness of medical care, and also allow for due process if the injured worker has additional factors to present to the judge regarding the need for medical care. This would prevent IMR reviewers from being immune to any challenges regarding their determinations. Ultimately, the changes introduced by this legislation would help injured workers to return to work more quickly with less residual disability.

Senate Bill 626 also would neutralize a harmful aspect of Senate Bill 863 by deleting the earlier bill's prohibition on increases in impairment ratings for psychiatric disorder. Unfortunately, some injured workers with serious medical conditions develop ancillary problems in the form of psychiatric disorder. For injuries occurring prior to 2013, workers could receive care and treatment to cure or relieve the effects of psychological/psychiatric injury, and also receive an economic component in recognition of the devastating effect of such injuries. SB 863 had removed the right to receive the economic component. SB 626 would restore this benefit.

Finally, Senate Bill 626 allows a chiropractor to continue to serve as a primary treater, even after 24 visits, if the chiropractor complies with the reporting requirements established by the Administrative Director.

The changes proposed in Assembly Bill 607 and Senate Bill 626 will help to restore the checks and balances necessary to ensure proper and timely care for California injured workers and be a very positive step towards entitling them to a fuller cup of justice.

## MEDICAL DEVICE LITIGATION
### By MICHAEL PADILLA

It should be remembered that injuries caused by medical devices do not fall under California's Medical Injury Compensation Reform Act of 1975 (*a.k.a.* MICRA). MICRA is a particularly harsh set of laws that restrict cases brought against healthcare providers for professional negligence. This is significant because under California's MICRA statute, general damages are capped at $250,000, no matter how serious the harm done.

In medical device litigation, the plaintiff is entitled to recover the full measure of their harm as judged by a jury — assuming, of course, they can prove the product is defective.

*In medical device litigation, the plaintiff is entitled to recover the full measure of their harm as judged by a jury — assuming, of course, they can prove the product is defective.*

A number of medical devices are in the media at this time because they have proven to be defective and have harmed a considerable number of people. An example includes the metal-on-metal hip replacement cases brought against DePuy Hip/Johnson & Johnson/Biomet and other manufacturers.

Recently, the first vaginal mesh implant case went to trial in New Jersey with the jury returning a verdict against a Johnson & Johnson subsidiary in the amount of $3.35 million for the harm done to the 47-year-old plaintiff, and an additional $7.76 million in punitive damages. The woman in that case suffered constant pain and endured 18 corrective surgical procedures following placement of the device.

The jury verdict held that Johnson & Johnson and its subsidiary failed to fully inform physicians and their patients regarding the truth concerning the catastrophic complications that can result from vaginal mesh implants. The award was for $1.1 million for pain and suffering; $180,000 for lost wages; $500,000 for future lost wages; $385,000 for past medical expenses; $1,000,000 for future medical care and treatment; and $180,000 for the husband's loss of his wife's companionship and conjugal affections.

Certain medical device manufacturers are protected by Federal preemption and are only subject to suit if it can be established that they have committed a fraud on the FDA. These manufacturers are those that have put their product through a full pre-market approval (PMA) procedure. That procedure could take up to three years to bring a medical device to market after it has been fully clinically tested under the auspices of the FDA.

The vast majority of medical devices, however, enter the market through a short-term 510(k) procedure. This procedure involves a representation from the manufacturer that their devices are "substantially equivalent" to predicate devices which the FDA had earlier approved. 510(k)-approved medical devices remain subject to the state's product liability laws, with the manufacturer exposed to responsibility for all harm caused by a product that proves defective in either design or manufacture.

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**NOTICE**

*Making a false or fraudulent Workers' Compensation claim is a felony subject to up to 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.*