CASE NO. A141435

COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION ONE

FRANCIS STEVENS

Petitioner,

vs.

WORKERS' COMPENSATION APPEALS BOARD OF THE STATE OF CALIFORNIA, AMINISTRATIVE DIRECTOR DIVISION OF WORKERS' COMPENSATION; OUTSPOKEN ENTERPRISES and STATE COMPENSATION INSURANCE FUND,

Respondents,

WORKERS' COMPENSATION APPEALS BOARD
WCAB No. ADJ 1526353 (SFO 0441691)

AMICUS CURIAE BRIEF BY CALIFORNIA WORKERS' COMPENSATION INSTITUTE and PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA In Support Of RESPONDENTS STATE COMPENSATION INSURANCE FUND and ADMINISTRATIVE DIRECTOR DIVISION OF WORKERS' COMPENSATION

[Submitted Concurrently With Application for Leave to File]

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California Workers' Compensation Institute &
Property and Casualty Insurers Association of America

TO BE FILED IN THE COURT OF APPEAL **APP-008**

COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION TWO	Court of Appeal Case Number: A141046
ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*: Michael A. Marks, Esq. SBN:071813 Law Office of Allweiss & McMurtry 18321 Ventura Blvd, Suite 500, Tarzana, CA 91356 TELEPHONE NO.: (818) 343-7509 FAX NO. *(Optional)*: E-MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*: Property Casualty Insurers Assn. of America (amicus)	Superior Court Case Number: ADJ 1310387 *FOR COURT USE ONLY*
APPELLANT/PETITIONER: Francis Stevens RESPONDENT/REAL PARTY IN INTEREST: Workers' Compensation Appeals Board	

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

(Check one): ☑ INITIAL CERTIFICATE ☐ SUPPLEMENTAL CERTIFICATE

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1. This form is being submitted on behalf of the following party (*name*): Property Casualty Insurers Association of America

2. a. ☑ There are no interested entities or persons that must be listed in this certificate under rule 8.208.

   b. ☐ Interested entities or persons required to be listed under rule 8.208 are as follows:

Full name of interested entity or person	Nature of interest *(Explain):*
(1)	
(2)	
(3)	
(4)	
(5)	

☐ Continued on attachment 2.

The undersigned certifies that the above-listed persons or entities (corporations, partnerships, firms, or any other association, but not including government entities or their agencies) have either (1) an ownership interest of 10 percent or more in the party if it is an entity; or (2) a financial or other interest in the outcome of the proceeding that the justices should consider in determining whether to disqualify themselves, as defined in rule 8.208(e)(2).

Date: 5/21/2014

Michael A. Marks, Esq
(TYPE OR PRINT NAME)

▶ _____
(SIGNATURE OF PARTY OR ATTORNEY)

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APP-008 [Rev. January 1, 2009]

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Cal. Rules of Court, rules 8.208, 8.488
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1. This form is being submitted on behalf of the following party (*name*): California Workers' Compensation Institute

2. a. ☑ There are no interested entities or persons that must be listed in this certificate under rule 8.208.

   b. ☐ Interested entities or persons required to be listed under rule 8.208 are as follows:

Full name of interested entity or person	Nature of interest *(Explain):*
(1)	
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Date: 5/21/2014

Michael A. Marks, Esq
(TYPE OR PRINT NAME)

▶ [signature]
(SIGNATURE OF PARTY OR ATTORNEY)

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The Legislative Adoption of Independent Medical Review Per SB863 Is The Result of Decades of Studies and Reforms Implementing A Treatment Dispute Resolution Process That Is Faster, Less Expensive, Objective, Results in Higher Quality Treatment Without Encumbrance, and Accomplishes Substantial Justice

The workers' compensation act as originally enacted gave employers control over the selection of medical providers for the life of the claim [stats 1913, Chapter 175, Sec. 15(a)], and the employer was liable for employee-selected treatment expenses only where the employer had neglected or refused to provide the necessary service [*see,Leadbettor v. IAC.* (1918) 179 Cal 468, 177 P 44.]. After more than half a century of employer control, in 1975 the employee was given control over provider selection after 30 days from the date the injury was reported to the employer (stats 1975, Chapter 1529, Section 1, amending Labor Code Section 4600(c); *and see, State Comp. Ins. Fund v. WCAB* (*Silva*) (1977) 71 Cal.App.3d 133 [42 Cal.Comp.Cases 493].

Under that so-called employee "free choice" model, disputes were adjudicated before a workers' compensation judge and ultimately decided by the Workers' Compensation Appeals Board (WCAB) based upon opposing and conflicting expert opinions on medical necessity or price, there being no

clear definition of what constitutes "reasonable and necessary medical treatment." This process was commonly referred to as "dueling docs." Over time, this practice was found to be time consuming and expensive; often resulting in arbitrary and inconsistent judicial decisions on medical issues, with poor treatment outcomes for workers and employers. In response to studies showing a system plagued with high costs, low benefits, long delays, poor outcomes and endless litigation, the California legislature has since repeatedly revised the procedures to improve delivery of quality medical treatment and resolve treatment-related disputes in a manner consistent with the Constitutional mandate (Cal. Const., art. XIV, § 4.).

In 1993, the California Legislature enacted major reforms that included a presumption that the *findings* of the treating physician were correct.[1] In 1996, WCAB *en banc* interpreted that to be a presumption of *correctness on all medical treatment issues*[2] and limited a payer's ability to challenge the treating physician unless it was clearly erroneous, incomplete or legally incompetent, a nearly impossible burden. The theory was that the

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[1] CA Labor Code Section 4062.9 [Stats. 1993 ch. 121] (subsequently repealed)

[2] *Minnear v. Mt. San Antonio Community College District* (1996) 61 Cal. Comp. Cases 1055 (Appeals Board en banc opinion)

patient's treating doctor knows what's best. But in a system fraught with misplaced incentives, that theory failed to recognize (a) the fee-for-service financial incentives to the treating doctors to provide excessive, unnecessary, unproven, ineffective and sometimes harmful forms of care that prolonged work loss time and produced increased permanent disabilities, (b) the employee's and their attorney's financial incentive to use treating physicians with poorer medical outcomes that increased disability awards and inflated settlements and attorney contingent fees, (c) the greater employer-employee frictional costs from the increasingly contentious adversarial system which produced poorer return-to-work outcomes for employees and thus increased economic hardship on workers due to job losses, and (d) that the result would be a system with disproportionately high administrative costs, with poorer medical outcomes, relatively low worker benefit rates, and lengthy delays of benefit determinations with negative impact on medical rehabilitation.

Following that judicial expansion of the statutory presumption, there was an unprecedented surge in medical benefit costs. With treating doctors now firmly in control of all medical decision-making and no standard definition of what constituted "reasonable and necessary medical treatment",

the fox was truly in charge of the hen-house. Predictably, between 1996 and 2002, the estimated average ultimate per-claim cost of medical care in indemnity claims increased by an astonishing 267% and studies revealed a clear association between the significant cost increase trend and expansion of the treating physician presumption of correctness on all medically related issues.[3],[4]

A 1999 follow-up study by the Commission on Health and Safety and Workers' Compensation regarding the impact of the 1993 reforms and the treating-physician presumption concluded it was an abysmal failure and recommended it be curtailed.[5] That report states, in its executive summary,

> Numerous parties have challenged the value of the change in the treating physician role and particularly the presumption given to the reports. These complaints generally involve 1) a perception of the low

[3] Gardner, L., Swedlow, A. The Effect of 1993 – 1996 Legislative Reform Activity on Medical Cost, Litigation and Claim Duration in the California Workers' Compensation System. *Research Note*. CWCI. May 2002.

[4] Neuhauser, F. Doctors and Courts: Do Legal Decisions Affect Medical Treatment Practice? An Evaluation of Treating Physician Presumption in the California Workers' Compensation System. A Report for the California Commission on Health and Safety and Workers' Compensation. November 2002.

[5] CHSWC - Report on the Quality of the Treating Physician Reports and the Cost-Benefit of Presumption in Favor of the Treating Physician (August 1999)

quality of the treating physicians' reports and 2) the problem of poor quality reports being given special authority. Many observers feel that presumption has led to problems with "doctor shopping" by the party with medical control and increased litigation.

However, quality is only one consideration. The legislation in part meant to reduce the frequency of medical reports by reducing the incentive of any party to request a report from a second (or third) forensic physician. Since the original report by the treating physician is presumed correct, it is less likely that a second report will prevail in a dispute and hence less likely that one will be requested.

The Commission on Health and Safety and Workers' Compensation undertook an effort to evaluate the quality of treating physician reports and the cost-benefit of the PTP presumption under 4062.9

...

In short, changes to the status of the PTP made during the 1993 reforms have resulted in medical-legal decisions based on poorer quality reports without any apparent cost savings. In addition, there is consensus within the WCQB (sic) that presumption has increased litigation and curtailed the discretion of Workers' Compensation Judges to craft reasonable decisions within the range of evidence.

In view of these findings the preliminary recommendation is to curtail the presumption given to the findings of the primary treating physician.

Confronted with the insatiable appetite of the fox, in 2003 and 2004, the Legislature at first limited the treating physician presumption of correctness and then repealed it altogether, replacing it with a clear definition of what constitutes "reasonable and necessary medical treatment", adopting an objective Medical Treatment Utilization Schedule (MTUS)

comprised of medical treatment guidelines using evidence-based, peer reviewed and nationally recognized standards of medical treatment against which treating doctor recommendations in any given case must be evaluated to determine if it was medically appropriate. [6] As summarized in the

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[6] Assembly Bill 749 (2003) and Senate Bill 899 (2004).; CHSWC summarized the benefits of evidence-based medical decision-making as follows [Evaluating Medical Treatment Guideline Sets for Injured Workers in California (2005) *prepared by RAND Institute for Civil Justice, at the request of CHSWC*, Pg. 10,11)

> "… physicians and other health care professionals are relying more and more upon evidence from clinical research studies to support their diagnostic and therapeutic choices. Within health care, this represents "a significant cultural shift, a move away from unexamined reliance on professional judgment toward more structured support and accountability for such judgment" (Field and Lohr, 1990).
>
> Use of the best available evidence to support medical professionals' decision-making is often referred to as evidence-based medicine (Sackett et al., 1996), the objective of which has been defined as "to minimize the effects of bias in determining an optimal course of care" (Cohen, Stavri, and Hersh, 2004). Bias, meaning lack of objectivity and other factors that may distort conclusions, can exist at any stage in the medical decisionmaking process, from research through guideline development and clinical care.
>
> There are many sources of bias in evaluating tests and therapies. Preconceived notions on the part of sponsors, researchers, and participants can influence the apparent efficacy of a therapy. Baseline patient characteristics, the natural course of illness, and chance may suggest an effect when there is none, or the absence of an effect when one exists. These problems can be alleviated by careful study design, particularly by the gold-standard design: the randomized controlled trial. In randomized controlled trials, participants are randomly

Legislative Counsel's Digest to SB228 (Stats 2003, Ch. 639), adoption of a medical treatment utilization schedule began with a process for the Commission on Health and Safety and Workers' Compensation to study nationally recognized standards for medical treatment, make recommendations for adoption of such schedules by the Administrative Director, and upon adoption those standards carry a presumption of correctness to be applied in connection with employer utilization review. Among other things, CHSWC recommended interim adoption of the treatment guidelines of the American College of Occupation and Environmental Medicine (ACOEM) with supplementation from treatment guidelines by the American Academy of Orthopedic Surgeons (AAOS) for spinal surgery[7] while the Administrative Director developed its own final treatment guidelines. CHSWC, at Pgs 5-6 of that report, emphasized the role of mandatory use of evidence-based treatment guidelines as the basis for

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assigned to receive either the therapy under study or a comparison therapy, which can be an accepted therapy or a placebo. While weaker designs can also mitigate bias, they often do so incompletely (Campbell and Stanley, 2005)

[7] See, CHSWC recommendation: CHSWC recommendations to DWC on Workers' Compensation medical treatment guidelines (Nov. 2004), pg. 5

medical decision-making through the utilization review process, stating as follows:

> The effect of the recommended structure of the guidelines in UR should be to encourage efficient processing of requests for authorization, allowing reviewers to reject treatments that are inconsistent with a clear guideline and putting the burden on the treating physician to document and justify deviations from the guideline. .... If the opinion of the treating physician is not backed by citations to scientific evidence, it may be outweighed by the opinion of a UR physician based on his or her expertise plus references to controlling principles of medicine. Where higher-quality evidence is available, the highest-quality evidence that is applicable to an individual case should determine the treatment.

Despite having defined "medical treatment that is reasonably required to cure or relieve the injured worker" as meaning "treatment that is based upon the guidelines adopted by the administrative director" per Lab. C. 5307.27 and returning to employer control of medical treatment through Medical Provider Networks[8], disputes continued to be adjudicated through a process that was still considered too lengthy, expensive, and an often unsatisfactory path for injured workers and claims administrators. Many felt that expert witnesses and the decisions of judges often failed to adequately consider and

[8] *See* Labor Code Section 4600(c), 4604.5 and 4610, et seq. establishing employer's right to create a Medical Provider Network of exclusive providers of medical treatment unless the employee had pre-designated his/her personal physician.

apply the statutory guidelines, and consequently that the opinion of the judge routinely failed to enforce the statutory medical standard of care established by the MTUS as "evidence-based medicine". The workers' compensation judiciary's inconsistent and unpredictable enforcement of evidence-based treatment guidelines[9] further undermined the legislative purposes behind adoption of the Medical Treatment Utilization Schedule and undoubtedly encouraged even more litigiousness.[10]

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[9] *Compare* , *Lamin v. City of Los Angeles* (2004) 69 Cal.Comp.Cases 1002 (Appeals Board panel decision); *Los Angeles Times v. Workers' Comp. Appeals Bd. (Herbinger)* (2005) 70 Cal.Comp.Cases 504, writ denied; *Regents of the University of California v Workers' Comp. Appeals Bd. (Macari)* (2005) 70 Cal.Comp.Cases 1733, writ denied; *ICW Group/Explorer Insurance Co. v. Workers' Comp. Appeals Bd. (Ulloa)* (2005) 70 Cal.Comp.Cases 1176, writ denied.

[10] The workers' compensation judiciary appears embarked on a mission to similarly endorse increased litigiousness and undermine the new IMR dispute resolution system enacted by SB863, as it asserts original jurisdiction over treatment disputes contrary to the express purpose behind Labor Code 4610.6(h) that medical treatment disputes not be resolved by judges but instead by physicians. *See, e.g.,* Gomez v. Facilities Support (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 149, Weilman v. United Temporary Services (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 163, Page v. Barman Transport (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS ___, Tabaracci v. Waste Management (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS ___; The case relied upon by these lower level decisions is Dubon v. World Restoration, Inc., (2014) 79 Cal. Comp. Cases 313 and is currently under appeal.

Against this backdrop, additional CHSWC studies recommended use of independent medical review to resolve treatment disputes that continued despite the employer's utilization review processes, noting that,

> ...external review of medical-necessity issues could reduce the complexity of California's dispute-resolution process, increase the timeliness and appropriateness of medical necessity appeal determinations, and reduce medical cost-containment expenses. There are various models that use external review organizations in deciding medical-necessity disputes. **Timely and impartial independent medical review (IMR) decisions would improve the quality of medical-necessity decisions because such issues would be decided by medical experts instead of judges** in an administrative process.[11]

A series of studies found that although the implementation of the MTUS and Medical Provider Networks were associated with an initial overall reduction of medical treatment and frictional costs, this was short-lived. These reforms also were associated with an immediate and sustained increase in employer medical cost containment expenses (i.e., utilization review and bill review), a form of frictional cost, which nearly tripled

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[11] Medical Care Provided Under California's Workers' Compensation Program: Effects of the Reforms and Additional Opportunities to Improve the Quality and Efficiency of Care, CHSWC 2011 Report, Summary at Pgs. xviii-xxvix,(emphasis added)

between 2002 and 2010.[12] In addition, inconsistent decisions by the WCAB on application of the MTUS and medical billing issues cast doubt on whether non-medical adjudicators such as judges were the optimal choice for medical dispute resolution.

In response to the CHSWC recommendations regarding independent medical review and independent bill review, in late 2012, another round of reforms began to take shape in the form of Senate Bill 863. In section 1 of SB 863, the Legislature expressly stated the rationale for creating Independent Medical Review as follows:

> (d) That **the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers** injured in the course of employment.
>
> (e) That **having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care** and that the provision of the act establishing independent medical review are necessary to implement that policy.

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[12] Ireland, J., Swedlow, A., Gardner, L. Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System. CWCI, June 2013.

(f) That the performance of independent medical review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that **independent medical review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code that will be more expeditious, more economical, and more scientifically sound than the existing function** of medical necessity determinations performed by qualified medical evaluators appointed pursuant to Section 139.2 of the Labor Code. **The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of qualified medical evaluators can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise** of specialists that are not available through the civil service system.

(g) That the establishment of independent medical review and **provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws** of this state and to control the manner of review of such decisions. (SB863, Stats 2012, Ch. 363, emphasis added)

In its annual report for 2012, CHSWC described the impact of the new independent medical review component of SB863, comparing the current system with the new system, as follows:

> **Under the current system, it typically takes nine to 12 months to resolve a dispute over the treatment needed for an injury**. The process requires: (1) negotiating over selection of an agreed medical evaluator; (2) obtaining a panel, or list, of state-certified medical evaluators if agreement cannot be reached; (3) negotiating over the

selection of the state-certified medical evaluator; (4) making an appointment; (5) awaiting the examination; (6) awaiting the evaluator's report, and then if the parties still disagree; (7) awaiting a hearing with a workers' compensation judge; and (8) awaiting the judge's decision on the recommended treatment. In many cases, the treating physician may also rebut or request clarification from the medical evaluator, and the medical evaluator may be required to follow up with supplemental reports or answer questions in a deposition.

SB 863 replaces those eight steps with an IMR process similar to group health that takes approximately 40 (or fewer) days to arrive at a determination so that the appropriate treatment can be obtained. IMR can only be requested by an injured worker following a denial, modification, or delay of a treatment request through the utilization review (UR) process. Employers and insurance carriers cannot request review of treatment authorizations.

An injured worker can be assisted by an attorney or by his or her treating physician in the IMR process. There is a right to appeal an IMR determination, to the trial level WCAB, on the basis of fraud, conflict of interest, or mistake of fact. The reviewer's underlying medical decision-making, however, cannot be overturned by a judge. The remedy, if an appeal is granted, is referral to a different reviewer for another review.

IMR will not be available in cases in which there is a dispute over anything other than the medical necessity of a particular treatment requested by the injured worker's physician (such as cases where the injury itself is in dispute. (emphasis added)

As noted in the legislative history[13], the intent behind adoption of independent medical review with limited appellate review was as follows:

> SB 863 proposes to change the way medical disputes are resolved. Currently, when there is a disagreement about medical treatment issues, each side attempts to obtain medical opinions favorable to its position, and then counsel for each side tries to convince a workers' compensation judge based on this evidence what the proper treatment is. This system of "dueling doctors" with lawyers/judges making medical decisions has resulted in an extremely slow, inefficient process that many argue does not provide quality results. Long delays in obtaining treatment result in poorer outcomes, reduced return to work potential, and excessive costs in the system, none of which are good for injured workers. SB 863 would instead adopt an independent medical review system patterned after the long-standing and widely applauded IMR process used to resolve medical disputes in the health insurance system. Thus, a conflict- free medical expert would be evaluating medical issues and making sound medical decisions, based on a hierarchy of evidence-based medicine standards drawn from the health insurance IMR process, with workers' compensation-specific modifications. The bill contains findings that this system would result in faster and better medical dispute resolution than existing law.
>
> The IMR system is designed to ensure that medical expertise is used to resolve medical disagreements. Thus, the decision from the IMR is final and binding on the parties. Nonetheless, in the exercise of the Legislature's plenary authority to establish a workers' compensation system that includes a review of decisions, there is a process to appeal the IMR result, but this review process does not allow the second-guessing of medical expertise. Rather, the appeal is limited to circumstances where there was fraud, conflict of interest, discrimination based on protected classes, or clear mistakes of facts that do not involve medical expertise.

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[13] Assembly Committee on Insurance, August 31, 2012 Hearing

The procedural changes in the medical treatment dispute resolution process as embodied within SB863 thus reflect the legislature's adoption of the CHSWC solution to the fact that, despite multiple historical attempts to cure the chronic ills of the medical treatment delivery and dispute resolution systems, typical dispute timing still took 9-12 months (SB863 was designed to reduce that to down to 40 days), was encumbered to the extent it commonly required an 8-step process (SB863 reduced that down to two involving IMR and a limited appeal), and produced inconsistent results not linked to high quality medical care (SB863 links medical treatment to established evidence-based treatment guidelines with proven effectiveness, with medical treatment decisions made by physicians thus providing "substantial justice").

CONCLUSION

Against this historical backdrop, and the alarming unwillingness of the workers' compensation judiciary to endorse and enforce evidence-based medicine as the gold standard for reasonable and necessary medical treatment, the Legislature sought to remedy the problem by curtailing the

an administrative process substituting physician experts in evidence-based medicine instead of WCALJ's with no such expertise.[14] As persuasively demonstrated by the arguments in the briefs submitted by State Compensation Insurance Fund and the Acting Administrative Director, the procedures enacted are within the plenary power granted to the legislature within Cal. Const., art. XIV, § 4.

Dated: June 2, 2014.

ALLWEISS & McMURTRY
A Professional Corporation

Michael A. Marks, Esq.

[14] Labor Code Section 4610.5, 4610.6,, as enacted by Stats 2012 ch. 363, SB863.

VERIFICATION & WORD COUNT

I, Michael A. Marks, swear that I have read the within *Amicus Curiae* application and brief and know the contents thereof; that the within Argument & Authorities contains 3,636 words, based on the automated word count of the computer word-processing program; that I am informed and believe that the facts and law stated therein are true and on that ground allege that such matters are true; that I make such verification because the officers of California Workers' Compensation Institute and Property Casualty Insurance Association of America are absent from the County where my office is located and are unable to verify the petition, and because as their attorney I am more familiar with such facts and law than are the officers.

Sworn and executed this 2nd day of June, 2014, at Essex,

Vermont.

By: /s/ Michael A. Marks
Michael A. Marks

DECLARATION OF SERVICE

The undersigned declares that on June 2, 2014, electronic filing and service of the Application Of CALIFORNIA WORKERS' COMPENSATION INSTITUTE and PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA For Leave To File *Amicus Curiae* Brief In Support Of RESPONDENTS STATE COMPENSATION INSURANCE FUND and ADMINISTRATIVE DIRECTOR DIVISION OF WORKERS' COMPENSATION as well as the AMICUS CURIAE BRIEF BY CALIFORNIA WORKERS' COMPENSATION INSTITUTE and PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA In Support Of RESPONDENTS STATE COMPENSATION INSURANCE FUND and ADMINISTRATIVE DIRECTOR DIVISION OF WORKERS' COMPENSATION were electronically performed through the TrueFiling electronic system of the court for service pursuant to California Rules of Court 8.71. and served by USPS addressed as follows:

Workers Compensation Appeals Board ATT: WRIT SECTION 455 Golden Gate Avenue, 9 th Floor San Francisco, CA 94142-9459	David M. Goi, Esq. State Compensation Insurance Fund 5880 Owens Drive Pleasanton, CA 94588
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