

Case No.: 06-16333

**United States Court of Appeals
for the
Ninth Circuit**

**Barbara Clark v. John Rea, director of the
California Department of Industrial Relations, et. al.**

**Appeal from the United States District Court
for the Eastern District of California**

Appellant's Brief

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JURISDICTIONAL STATEMENT

A. Basis for district court's jurisdiction

Jurisdiction was sought under the Fourteenth Amendment (under color of state law) for deprivation of a property interest in a workers' compensation judgment for medical care. U.S. CONST. amend. XIV. 42 U.S.C. § 1983, 42 U.S.C. § 1985 and 42 U.S.C. § 1986, et. al. were also cited as a jurisdictional basis.

B. Basis of Appeal's Court Jurisdiction

This case was dismissed pursuant to Federal Rules of Civil Procedure, Rule 12(b)(6) and 12(b)(7) and therefore this is an appeal of a final order of a district judge that granted dismissal pursuant to these Rules; see generally dismissal for failure to state a claim requiring de novo review, *Transmission Agency of California v. Sierra Pacific Power Co.*, 295 F.3d 918, 927 (9th Cir. 2002); and mixed questions of law and fact, see *Suzy's Zoo v. Commissioner*, 273 F.3d 875, 878 (9th Cir. 2001)(tax court's finding that taxpayer is a "producer").

C. Filing dates establishing timeliness for review

On August 14, 2006, this court issued an order staying appellate proceedings pending disposition of a motion for reconsideration. On October 13, 2006, the district court denied the motion for reconsideration of final orders issued on June 2 and June 6, 2006. On October 13, 2006 (Clerk's doc. no. 153) the district judge

denied all pending motions for reconsideration (see Fed.R.Civ.Proc. Rule 59(e) and 60(b)). Pursuant to order of this court (issued October 31, 2006) appellant's opening brief is due November 27, 2006.

D. Appeal of final orders issued by the district court

Final orders issued on June 5, 2006 and June 6, 2006 (Clerk's doc. no. 107 and 109, respectively) by the district court dismissing the action are on appeal in this instant pleading.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

- A. Did appellant have a property interest in obtaining spinal surgery (pursuant to (1) a Workers' Compensation Appeals Board Award and Order issued 8/22/2001, (2) Labor Code § 4600 and, (3) treating physicians' recommendation)?
- B. Did Appellee Hershewe act outside the scope of litigation privilege by engaging in unauthorized utilization review activity for the purposes of preventing the appellant's spinal surgery (a protectible entitlement) after February 17, 2006 making him a state actor?
- C. Does a private party Self Insurance Administrator becomes a state actor for the purposes of following the rules of conduct created by S.B. 228 for utilization review of workers' compensation claims when inclined to "*modify, deny, or delay*" recommended spinal surgery?

D. Did the State jointly participate with private parties to place the appellant in imminent danger?

E. Was there significant entwinement between Self Insurance Administrator appellee Pope and the Department of Industrial Relations granting state actor status upon appellee Pope?

STATEMENT OF THE CASE

A. COURSE OF PROCEEDINGS

Plaintiff filed this case on November 29, 2005 in the U.S. District Court for the Eastern District of California (Sacramento). The original pleadings asserted for jurisdiction sought under the Fourteenth Amendment (under color of state law) for deprivation of a property interest in a workers' compensation judgment for medical care. U.S. CONST. amend. XIV. 42 U.S.C. § 1983, 42 U.S.C. § 1985 and 42 U.S.C. § 1986, et. al. were also cited as a jurisdictional basis. Allegations were made that two private parties – a claims adjuster (defendant/appellee Pope) and an attorney (defendant/appellee Hershewe) – could be considered state actors with the California Department of Industrial Relations (defendant/appellee Rea in his official capacity as Director of Industrial Relations) in denying medical benefits in the form of spinal surgery to the plaintiff/appellant who claimed a property interest in said spinal surgery based upon an Award and Order issued by the California Workers' Compensation Appeals Board (WCAB).

On December 6, 2005, the appellant caused to be filed with the lower court a pleading entitled, MEMORANDUM in SUPPORT of motion for injunctive relief. (Entered: 12/07/2005, Clerk's doc. No. 5). This pleading contained the following language:

The Plaintiff's very life may be at stake as at any time the neck and spine injuries could cause a near fatal condition. Doctors have stressed to Ms. Pope [appellee] that the condition the Plaintiff is enduring is serious and has reached a state of criticality...

On February 3, 2006 the plaintiff/appellant's Third Amended Complaint (TAC) became the operative complaint (Clerk's doc. No. 48). Motions to Dismiss the TAC were filed by two defendants/appellees in separate motions; on March 21, 2006 by defendant/appellee Pope (Clerk's doc. No. 63), on April 12, 2006 by the appellee/defendant Department of Industrial Relations (Clerk's doc. no. 75). Defendant/appellee Hershewe's Motion to Dismiss seems mis-labeled as a "Request for Judicial Notice" (see Clerk's doc. no. 78, 4/15/2006). In sum, all motions asserted that private parties (Hershewe and Pope) could not be construed as state actors for the purposes of 42 U.S.C. § 1983, § 1985 and § 1986, et. al. and sought dismissal pursuant to Federal Rules of Civil procedure, Rules 12(b)(6) and 12(b)(7). The motion of the Department of Industrial Relations essentially claimed Eleventh Amendment immunity from suit in the federal courts.

B. DISPOSITION OF CASE BELOW

The case was effectively dismissed with issuance of two final orders by the district judge (see Clerk's doc. no. 107 and 109, June 5, 2006 and June 6, 2006 respectively).

STATEMENT OF FACTS RELEVANT TO THE ISSUES

The California Department of Industrial Relations (appellee) publishes Form A4-6(11/97) which states in relevant part (see pages 1-22 in appendix):

SELF INSURANCE PLANS, AGREEMENT OF ASSUMPTION AND GUARANTEE OF WORKERS' COMPENSATION LIABILITIES

NOW THEREFORE, it is understood and agreed that:

(1). In consideration of the Director of Industrial Relations of the State of California issuing a Certificate of Consent to Self-Insure to said Self-Insurer, the Undersigned agrees to assume and guarantee to pay, or otherwise discharge promptly, all the liabilities and obligations which said Self-Insurer may incur as a self-insurer of its California workers' compensation liabilities.

The State of California, Department of Industrial Relations, Self Insurance Plans, Form No. A4-1 (2/92), states in relevant part:

APPLICATION FOR A CERTIFICATE OF CONSENT TO SELF INSURE To the Director of Industrial Relations: The undersigned private employer hereby applies for Certificate of Consent to Self-Insure the payment of workers' compensation as provided by California Labor Code Section 3700.

The Department of Industrial Relations published a document, "INITIAL STATEMENT OF REASONS", Title 8, Chapter 8, Subchapter 2, Articles 1,6,9, and 12, which states at relevant part (see pages 23-28 in appendix):

Article 12, Necessity. The chief manner in which claims administrators demonstrate competence is by passing the Self Insurance Administration examination which tests technical knowledge related to claims handling and self

insurance regulations. The examination is administered by the Office of Self Insurance Plans. (emphasis added)

The Department of Industrial Relations published a regulation, 8 CCR § 15452, entitled “Administrator Competence”, which states in relevant part (see pages 29-30 in appendix):

(f) Each adjusting location of a third party administrative agency or a self-administered self insurer shall have at least one person who has passed the self insurance administrator’s examination. All workers’ compensation self insurance claims at such reporting locations shall be administered and adjusted under the direct supervision of a person who has passed the self insurance administrator’s examination. Supervision of claims decisions, setting of estimates of future liability of claims, and proper payment of benefits to injured workers shall be made or reviewed by a person who has passed the self insurance administrator’s examination.

(g) Lack of competent administrators at any adjusting location shall be good cause for revocation of the certificate to administer for that location and may be grounds to revoke the certificate to self insure. (emphasis added)

California Labor Code § 4600 states the following (see pages 112-117 in appendix):

- (a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.
- (b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American

College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines.

The California Legislature passed Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004) which adopted several provisions designated to control workers' compensation costs; pertinent sections of California's Code of Regulations (CCR) and Labor Codes (L.C.) were directly impacted by S.B. 228.

An administrative implementing regulation known as Title 8, California Code of Regulations (CCR), Section 9788.1 (8 CCR § 9788.1). 8 CCR § 9788 addressed changes created by S.B. 228 for a "*Spinal Surgery Second Opinion Procedure*" (SSSOP).

The California Department of Regulations published a memorandum on October 26, 2004 (10/26/2004) that states in relevant part (see pages 31-44 in appendix):

Section 9788.1. Employer's Objection To Report Of Treating Physician Recommending Spinal Surgery.

An objection to the treating physician's recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in Section 9788.11. The employer shall include with the objection a copy of the treating physician's report containing the recommendation to which the employer objects. The objection shall include the employer's reasons, specific to the employee, for the objection to the recommended procedure. The form must be executed by a principal or employee of the employer, insurance carrier, or administrator.

An Opinion and Decision After Reconsideration issued by the California Workers' Compensation Appeals Board (WCAB) in Brasher v. Nationwide

Studio Fund, OAK 0296709, WCAB describes the regulatory construct of 8

CCR 9788.1, not referenced for precedential value; quoted in relevant part

(see pages 118-128 in appendix):

“..The first track, the employer’s objection, is simple and direct. The single sentence in section 4062(a) provides that employer objections shall be subject to section 4062(b). Section 4062(b) and AD Rule 9788.1 spell out the employer’s and the AD’s responsibilities in resolving spinal surgery disputes: The employer may object on DWC Form 233 within 10 days of receipt of the treating physician’s recommendation.

A reason why an employer might bypass utilization review is that, if an employer undertakes utilization review and the utilization review report concludes that surgery is justified, the dispute over surgery is over.

The California Department of Industrial Relations published a document

“INITIAL STATEMENT OF REASONS”, Title 8, Sections 9792.11 to 9792.15

of the California Code of Regulations, which states in relevant part (see pages

45-52 in appendix):

Section 4610 of the Labor Code sets out the standards for the utilization review process for requested medical treatment in workers’ compensation cases. The section does not require every request or recommendation for treatment to be reviewed in the utilization review process.

b) decisions to delay, modify or deny care must be made only by competent medical personnel within the scope of their license and practice (Lab. Code section 4610(e); 8 Cal. Code Regs. section 9792.7(b)(2)). (effective September 22, 2005).

On August 22, 2001 (8/22/2001) a Workers’ Compensation Appeals Board

administrative law judge issued a Findings of Award and Order (FAO) on

behalf of the appellant; stating in relevant part (see pages 53-55 in appendix):

Defendant contrary to well-established case law (and statute) unreasonably relied on purported limitations in the language of the WCJ¹'s "Opinion and Decision" and unreasonably delayed ... the provision of medical treatment. Defendant's reliance on its own improper and incorrect interpretations is unreasonable per se... [Order of Judge Barbara A. Stevens, 8/22/2001]

The defendants, the appellant's former employer, filed a Petition for Reconsideration of the 8/22/2001 FAO to the California Workers' Compensation Appeals Board (WCAB), which granted reconsideration for the limited purpose of amending the FAO of 8/22/2001 to allow a single penalty under Labor Code § 5814. In all other respects, the 8/22/2001 FAO was affirmed; citing in relevant part (see pages 56-60 in appendix):

The defendant's unreasonable conduct arises out of its erroneous belief that the award of further medical treatment was somehow limited to the treatment recommendations of two Agreed Medical Examiners and that no medical treatment beyond that was awarded. The failure to provide treatment and pay for applicant's mileage expenses can be traced to that single incorrect belief. [WCAB Opinion and Order, 11/6/2001.]

The defendants sought a *writ of review* of the 11/6/2001 WCAB Opinion and Order (cited above) that was denied by the California Court of Appeals for the Fifth District. Subsequently, the defendant appealed the decision to the California Supreme Court, and the *writ* seeking *certiorari* was denied (see pages 61-62 in appendix).

On December 6, 2005, the appellant caused to be filed with the lower court a pleading entitled, MEMORANDUM in SUPPORT of motion for injunctive

¹ WCJ = Workers' Compensation Judge

relief. (Entered: 12/07/2005, Clerk's doc. No. 5). This pleading contained the following language (see pages 63-76 in appendix):

The Plaintiff's very life may be at stake as at any time the neck and spine injuries could cause a near fatal condition. Doctors have stressed to Ms. Pope that the condition the Plaintiff is enduring is serious and has reached a state of criticality...

With every the passing of each day the Plaintiff steps closer to the possibility of death and irreparable harm.

The Plaintiff must now deal with the possibility that a routine jar to her neck, spine or head could indeed kill her..

Attached to the December 6, 2005 pleading (cited above) (Entered: 12/07/2005, Clerk's doc. No. 5) is a letter from the appellant to appelle John rea, dated December 5, 2005 which states in relevant part (see pages 77-80 in appendix):

4. Carol Pope simply re-directed the spinal surgeon to call the guardian ad litem who represents my interests in the Workers Compensation Appeals Board. I consider this re-direction and refusal to approve the spinal fusion procedure as bold face retaliation and recrimination for my efforts to seek redress in the federal courts. Once again, Carol Pope, purportedly licensed by the Department of Industrial Relations, has committed an egregious breach of professional responsibilities and ethics of a licensed claims adjustor. Once again, she has violated the retaliation prohibitions of 42 USC 1985. Once again, I am holding YOU accountable for the correction of civil rights violations committed against me.

5. It is clear to me that this "above the law" attitude of Carol Pope, in violation of 42 USC 1985, has been approved of and ratified by the Department of Industrial Relations. Therefore, I shall seek a temporary restraining order (TRO) from the federal courts to compel the dubious and reprehensible Carol Pope to do her stated job and approve a spinal surgery.

Attached to the December 5, 2005 letter (cited above) was a letter from Dr. Allen I. Salick, M.D, the appellant's treating physician, to Carol Pope, Senior Claims Examiner, stating in relevant part (see pages 81-83 in appendix):

Labor Code Section 4610(g)(1) requires that perspective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Your denial letter has exceeded this time frame therefore it is invalid.

The denial you issued is not sufficient and falls short of what is required pursuant to Labor Code Section 4610(g)(4). A modification, delay or denial for authorization shall include a clear and concise explanation for the reason for the decision and a description of the criteria or guideline used and the clinical reasons for the decision. Therefore, the denial you have issued is considered invalid and inadmissible.

On February 9, 2006 appellant forwarded a letter to appelle John Rea, acting Director of Industrial Relations a letter that stated in relevant part (see pages 88-89 in appendix):

Attached to this letter is a letter from Gil Tepper, M.D., dated 1-6-2006. The letter describes Dr. Tepper's unsuccessful attempts at contacting Ms. Carol Pope, co-defendant in lawsuit, and Dennis J. Hershewe, co-defendant in the lawsuit.

I hope you can appreciate just how elusive Mr. Hershewe and Ms. Pope really are[a]. The 1-6-2006 Gil Tepper, M.D. letter clearly points out that both Pope and Hershewe are evading calls, faxes and letters from Dr. Tepper. I am sure you are aware that Carol Pope obtained a "self insurance administrator's" (SIA) certification on June 5, 1999. This letter from Dr. Tepper should be placed in Carol Pope's permanent file kept with that SIA record. Ms. Pope's SIA records

may be evidence at an upcoming trial. I think these records should be preserved and safeguarded.

The January 6, 2006 letter (cited above) written by Dr. Gil Pepper, M.D.

stated in relevant part (see pages 90-91 in appendix):

This supplemental is drafted to record the insurer's inability to comply with Labor Code 9792.6(c)(1)...Please note that the aforementioned procedure was formally requested in writing on 9/21/05 was sent by way of U.S. mail on 11/16/05 and facsimile on 10/13/05 as well as by personal telephone calls by my authorization staff on 10/13/05, 10/17/05, 10/24/05. Lizzette from our authorization department received call back from adjuster Carol Pope who stated to call defense attorney Dennis Hershewe at 818-700-8430 first call was made on 10/24/05 left message with Rema, second call was made 10/31/05 left message with Rema, third call was made 11/7/05 left message with Rema. Called adjuster Carol Pope on 11/23/05 since we did not have a response back from defense attorney Hershewe also left message for adjuster. At [as] of the date of this letter, we have received no response.

A letter dated April 4, 2006 written by appellee Hershewe to the appellant's Primary Treating Physician (PTP), Dr. Allen I. Sallick, requested the PTP's review of a deposition of Dr. James L. Strait taken 10/5/2004. The letter requested that PTP Dr. Sallick review page 39, lines 4 to 25 of said deposition, stating (see pages 92-93 in appendix):

“..The defendant objects to your report of February 7, 2006. Enclosed for your review (for at least the third time) is the deposition of the agreed medical examiner, Dr. James Strait. Dr. Strait's deposition was taken on October 4, 2004. In the deposition of October 4, 2004 Dr. Strait testifies as follows:

Page 39, lines 4 through 25:...

Q: And is there anything that would indicate she would be a candidate for any type of surgical procedure when you looked at those films?

A: No.

...The defendant has already filed a previous objection to Dr. Pepper's report. Dr. Pepper did not review all of the MRI's in this case...”

On April 17, 2006 PTP Dr. Sallick replied to Mr. Hershewe that he had indeed reviewed the subject deposition Dr. Strait. Dr. Salick wrote (see pages 94-96 in appendix):

..she actually has a significant disc disease and she is probably a surgical candidate...I have no objection to epidural injections being performed in lieu of surgery she has had tremendous relief from [in] the past from epidural injections, so why would one want to withhold this type of treatment...

On May 3, 2006, the appellant testified before the California Senate committee chaired by Senator Richard Alarcon, the author of S.B. 228. In pertinent part the appellant testified (see pages 97-103 in appendix):

The claims adjuster's refusal to accept a medical opinion (from a Panel QME) has created a horrible situation involving disputes over payment of medical expenses...

A letter, dated May 4, 2006, was sent by the appellant to Carrie Nevans, acting Administrative Director of the Division of Workers' Compensation (Department of Industrial Relations); quoted in relevant part (see pages 104-105 in appendix):

As part of my testimony I attached an exhibit from the Panel qualified medical examiner (QME) report issued by Dr. Robert Reed dated November 10th, 2005. Dr. Reed's report addressed my spinal surgery injury and requirement for medical treatment...

Note: It is curious to note that the claims adjuster in my case does not share the opinion of Dr. Reed on this point and has denied treatment. However, your comments at the hearing seem to indicate that such an action by a claims adjuster would be improper...

Appellant provided a letter dated May 10, 2006 (5/10/2006) to the California Department of Industrial Relations that stated in relevant part (see pages 106-108 in appendix):

I call to your attention Section 9788.1 ... I take note that your offices have NEVER objected to the treatment recommendations of the above referenced report... Therefore, please make arrangements for me to obtain the spinal surgery described in the above referenced report..

On June 27, 2006, the Miracle Mile Medical Center in Los Angeles conducted an MRI Study of the Cervical Spine of the appellant, completed 6/27/2006, finding that, “There is a broad based asymmetric posterior disc protrusion/extrusion at C6-C7 level which at its maximum on the right side measures about 3.5 mm and is causing pressure over the anterior aspect of the thecal sac and encroaches into and causes subtotal obliteration of the right neural foramen (see pages 109-111 in appendix).”

SUMMARY OF THE ARGUMENT

By examining the conduct of all three appellees against the procedures provided by the State (pursuant to S.B. 228 and its relevant subsidiary 8 CCR § 9788, addressing statutory procedures for *delaying, modifying, or denying* spinal surgery requested by a treating physician) the court can determine if the appellant had a (1) protectible property interest, (2) that she was deprived of, (3) without benefit of due process. See *Latimer v. Robinson*, 2005 WL 1513103 (6th Cir. 2005).

The decision of the Self Insurance Administrator/claims adjuster, appellee Pope, and an attorney, appellee Hershewe, (who were alleged to be co-conspirators to

deny the appellant her protectible property interests in obtaining medical care) not to follow a statutorily created utilization review framework, while influenced not to follow said regulatory framework by the State, (appellee Rea) conferred state actor status on all three.

References to the denial of medical treatments for the appellant occur in the Third Amended Complaint (Clerk's doc. no. 60) at para.s 41, "refuse medical treatments"; 42, "deny plaintiff access to medical treatments"; 43, "to prevent the plaintiff from receiving prompt medical care"; 67, "for the purpose of denying medical care to the plaintiff"; 71, "to prevent her from obtaining medical care"; 74, "deny WCAB Awards and Orders and deny medical treatments"; 81, "That both OSIP and DIR were aware that Pope's private actions and behavior.."; 86, "force her to live in pain"; 87, "and deny her medical care"; 89, "to live in non-stop pain from her neck, spine and jaw injuries"; 91, "with full knowledge of the OSIP and California DIR"; 95, "Plaintiff has written more than fifty (50) letter to California DIR and OSIP"; 98, "dozens of letters were sent to California DIR and OSIP "; 101, "That Andrea Hoch of the DWC and employees of California DIR and OSIP for the purposes of neutralizing the Plaintiff's complaints..".

Unlike private medical judgments in *Blum v. Yaretsky*, 457 U.S. 991 (1982), whose "decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State..(see footnote 19 [emphasis added])", the utilization review standards in California relevant to the appellant's spinal surgery were established by the State. It is reprehensible that the regulatory agency entrusted to create a utilization review

framework (see S.B. 228) would not take any action against those members of the workers' compensation community (appellees Pope and Hershewe) who were accused of blatantly violating said regulations.

Further, it was alleged in the appellant's MEMORANDUM in SUPPORT of motion for injunctive relief. (Entered: 12/07/2005, Clerk's doc. No. 5) via attached letter to appellee John Rea (see letter of 12/5/2005, pages 15, 16, 17 and 18 of 21) that appellee Pope was engaged in retaliatory conduct in violation 42 U.S.C. § 1985 against the appellee for filing the lower court lawsuit.

Therefore, the State of California (via appellee John Rea) is sufficiently connected to the private actors (appellee Pope and appellee Hershewe) as all three ignored their statutorily created duties under utilization review framework authorized by S.B. 228.

ARGUMENT

- A. Appellant had a property interest in obtaining spinal surgery (pursuant to (1) a WCAB Award and Order issued 8/22/2001, (2) Labor Code § 4600 and, (3) treating physicians' recommendation). Appellees persisted in blatantly depriving appellant of her firmly established right to spinal surgery.**

CONTENTION: As a threshold issue appellant establishes her protectible property interest in obtaining spinal surgery as an entitlement. On September 22,

2005, spinal surgeon Dr. Gil Tepper, M.D. recommended spinal surgery for appellant and said recommendation was approved by appellant's treating physician Dr. Allen I. Salick, M.D on February 7, 2006 (see pages 84-87 in appendix). Appellant's former employer did not timely object to the treatment recommendation pursuant to 8 CCR § 9788.1, "within ten days of the treating physician's report" (see pages 31-44 in appendix). See letter of Dr. Allen I. Salick, M.D., dated November 1, 2005, appearing on pages 19 and 20 of 21, Clerk's doc. no. 5, filed 12/6/2005. After the period for timely objection lapsed, the appellant claims that her protectible property interest in spinal surgery began. Appellant claims that Labor Code § 4600 (see pages 112-117 in appendix), the 8/22/2001 Award and Order (see pages 53-55 in appendix) and appellant's treating physician's recommendation for spinal surgery (see pages 84-87 in appendix) (which was not timely disputed by appellant's former employer per 8 CCR § 9788.1) created entitlement to spinal surgery (having "asserted a recognized liberty or property interest" and that she was "intentionally or recklessly deprived of that interest even temporarily," through the actions of the appellees without due process. See *Woodard v. Andrus*, 419 F.3d 348, 353 (5th Cir. 2005)).

STANDARD OF REVIEW: Questions of law are reviewed de novo. See *United States v. Carranza*, 289 F.3d 634, 643 (9th Cir. 2002) and *Harper v. U.S. Seafoods*, 278 F.3d 971, 973 (9th Cir. 2002). In the public benefit entitlement context, procedural due process requires "ascertainable eligibility standards" to be articulated and implemented, in order to guarantee objectivity and provide adequate notice. *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978); *Mathews v.*

Eldridge, 424 U.S. 319, 334-35 (1976). Here appellant had achieved the “ascertainable eligibility standards” and secured a protectible property interest to spinal surgery by obtaining the 8/22/2001 Award and Order, by the statutory authority of Labor Code 4600, by the treating physician’s recommendation for spinal surgery and by the absence of a timely objection by her former employer. In order for a property interest in a government benefit to exist, a person “must have more than an abstract need or desire for it. . . . He must, instead, have a legitimate claim of entitlement to it.” *Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 577 (1972). The appellant asserts she has met all the requirements of establishing her protectible property interest in an entitlement to spinal surgery on or about February 17, 2006.

B. Appellee Hershewe acted outside the scope of litigation privilege by engaging in unauthorized utilization review activity for the purposes of preventing the appellant’s spinal surgery (a protectible entitlement) after February 17, 2006.

CONTENTION: 8 CCR § 9788.1, Employer's Objection To Report Of Treating Physician Recommending Spinal Surgery, (see pages 31-44 in appendix)

expressly places a timeframe for the objection to any recommendation for spinal surgery by a treating physician. Appellant’s former employer waived its rights to challenge the “reasonableness or necessity” of said spinal surgery recommendation by its failure to object to same via the State’s statutory “utilization review” scheme embodied in 8 CCR § 9788.1. Therefore, as of February 17, 2006, ten days after

the treating physician's recommendation for spinal surgery, and in absence of the employer's objection the appellant's entitlement to spinal surgery began.

Appellee Hershewe, engaging in the "*denial, modification and delaying*" of the treating physician's recommendation for spinal surgery, sent a letter, dated April 4, 2006, (see pages 92-93 in appendix) to the appellant's treating physician objecting to the February 7, 2006 recommendation for spinal surgery (see pages 84-87 in appendix). Albeit nearly fifty (50) days tardy, the Hershewe letter (4/4/2006), concerned the "*denial, modification and delaying*" of spinal surgery (using the word "objection"). Utilization review activity to "*deny, modify, or delay*" is an activity outside the scope of those activities protected by litigation privilege and activity within the scope of the State's statutorily created utilization review framework. The court's attention is directed to the phrase "*delay, modify or deny*" as used in the following State regulation:

Section 4610 of the Labor Code sets out the standards for the utilization review process for requested medical treatment in workers' compensation cases. ... Where, however the employer, insurer or other entity subject to Labor Code section 4610 is inclined to *delay, modify or deny* the requested treatment, the employer or employer's agent (insurer, third party administrator or utilization review vendor) is required to use a decision-making process that conforms to the provisions of section 4610. ... b) decisions to *delay, modify or deny* care must be made only by competent medical personnel within the scope of their license and practice (Lab. Code section 4610(e); 8 Cal. Code Regs. section 9792.7(b)(2)). "*INITIAL STATEMENT OF REASONS*" for the implementation of Title 8, Sections 9792.11 to 9792.15.

Appellee Hershewe's letter of April 4, 2006 (see pages 92-33 in appendix) "objects" to spinal surgery and offers an alternative opinion from another spinal surgeon; however, 8 CCR §9788.2: Qualifications of Spinal Surgery Second Opinion Physicians provides for the "(b) The Administrative Director shall maintain a list of qualified surgeons who have applied, and whom the Administrative Director has found to be eligible to give second opinions under Labor Code § 4062 (b) after random selection by the Administrative Director". Further, appellee Hershewe while engaging in the practice of utilization review violated State created regulations limiting decisions to "*deny, modify or delay*" medical treatment to qualified medical personnel. As articulated in the "INITIAL STATEMENT OF REASONS" for the implementation of Title 8, Sections 9792.11 to 9792.15 of the California Code of Regulations; quoted in relevant part:

"..Section 4610 of the Labor Code sets out the standards for the utilization review process for requested medical treatment in workers' compensation cases. .. Where, however the employer, insurer or other entity subject to Labor Code section 4610 is *inclined to delay, modify or deny the requested treatment*, the employer or employer's agent (insurer, third party administrator or utilization review vendor) *is required to use a decision-making process that conforms to the provisions of section 4610. ... b) decisions to delay, modify or deny care must be made only by competent medical personnel within the scope of their license and practice (Lab. Code section 4610(e); 8 Cal. Code Regs. section 9792.7(b)(2));..*" [emphasis added]

As no person who is not a licensed physician may “*delay, modify or deny*” medical treatment recommendations from other physicians (see 8 CCR § 9792.7(b)(2)² (see also Labor Code § 4610(e)³), it is presumed by the appellant, that appellee Hershewe attempted to “*delay, modify or deny*” the medical recommendation for spinal cervical fusion surgery by relying on the opinion of Dr. James L. Strait, given in a deposition on 10/4/2004 as a form of an illegitimate SSSOP. However, Dr. Strait’s (who is NOT a spinal surgeon) opinion was NOT correctly procured via the Administrative Director, Division of Workers’ Compensation, Department of Industrial Relations, pursuant to 8 CCR § 9788.1 (see pages 31-44 in appendix). There simply is no other method to object to recommended spinal surgery (under the aegis of S.B. 228) but to have the Administrative Director procure a surgeon from a state maintained list of qualified spinal surgeons.

² 9792.7(b)(2) This subdivision provides that no person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician’s practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

³ Labor Code § 4610(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

Therefore, appellee Hershewe navigated around the requirements of S.B. 228 (as articulated in 8 CCR § 9788.1) by “*objecting*” (*delaying, denying, modifying*) to the treatment recommendations of the treating physician with the illegitimate second opinion (under the pretense of *utilization review*) he had obtained from Dr. Strait (via deposition taken on 10/4/2004); albeit the plaintiff had a right to obtain a legitimate second spinal surgeon’s opinion (via the SSSOP) a statutory rule of conduct created by State law (see S.B. 228). In essence, appellee Hershewe had become a self-proclaimed utilization review organization (URO).

STANDARD OF REVIEW: Appellee Hershewe was “mandating a different outcome to be reached” (*Kentucky Dept. of Corrections v. Thompson*) to prevent, thwart, avert and impede appellant’s pending spinal surgery with absolutely no justification to do so. See also *Olim v. Wakinekona*, 461 U.S., at 249 -250 (interstate prison transfer left to "completely unfettered" discretion of administrator). Appellee Hershewe’s conduct is rightly characterized as a “[m]issue of power, possessed by virtue of state law and made possible only because the wrongdoer is clothed with the authority of state law.” *United States v. Classic*, 313 U.S. 299, 326, 61 S.Ct. 1031, 1043 (1941). “[U]nder color of law means the ‘pretense’ of law....Acts of officers who undertake to perform their official duties are included whether they hew to the line of their authority or

overstep it.” *Screws v. United States*, 325 U.S. 91, 111, 65 S.Ct. 1031, 1040 (1945)(plurality opinion).

Appellee Hershewe’s attempts at the “*denial, modification and delaying*” of the treating physician’s recommendation for spinal surgery is an undeniable use of the pretext of state law and therefore appellee Hershewe should be considered a “state actor” for the purposes of this court’s inquiry. “The purpose of utilization review, and the sole authority conferred upon a URO [utilization review organization], is to determine “whether the treatment under review is reasonable or necessary for the medical condition of the employee””. See *American Mfrs. Mut. Ins. Co. v. Sullivan, Ibid.*) (emphasis added). As appellee Hershewe engaged in utilization review activities, denial of the appellant’s spinal surgery was “..*caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or a person for whom the State is responsible.*” *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982).

C. A private party Self Insurance Administrator becomes a “state actor” for the purposes of following the rules of conduct created by S.B. 228 and implemented as the Spinal Surgery Second Opinion Procedure defined by 8 CCR § 9788.

CONTENTION: S.B. 228 created a statutorily authorized utilization review process, embodied primarily in Labor Code § 4610. The utilization review process is subject to mandatory time frames and the use of standardized forms (in some

cases). Section 4610, subdivision (g)(1) requires an employer to timely *approve, modify, delay, or deny* treatment requests. One such standard is known as the “Spinal Surgery Second Opinion Procedure” as defined by 8 CCR § 9788. 8 CCR § 9788.1, entitled, “*Employer’s Objection To Report of Treating Physician Recommending Spinal Surgery*”, requires “..(a) [a]n objection to the treating physician’s recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in Section 9788.11. (see pages 31-44 in appendix)” The Spinal Surgery Second Opinion Procedure (SSSOP), as defined by 8 CCR § 9788 et. al., imposed upon the individual handling the appellant’s medical claim a State instituted rule of conduct. Appellee Pope (a Self Insurance Administrator)⁴ managed the appellant’s workers’ compensation claim. Appellee Pope was bound by the State created rule of conduct for obtaining a second spinal surgeon opinion when she was inclined to “*deny, modify or delay*” the treatment recommendations of the appellant’s treating physician. Appellee Pope attempted to delegate her claims administration responsibilities to appellee Hershewe when she instructed spinal surgeon Dr. Gil Tepper, M.D. to contact appellee Hershewe to obtain authorization for spinal surgery (see letter of appellant February 9, 2006 (see pages 88-89 in appendix) to the Department of Industrial Relations with the enclosed January 6, 2006 letter of Dr. Tepper (see pages 90-91 in appendix).

⁴ 8 CCR § 15452, entitled “Administrator Competence” (see pages 29-30 in appendix).

STANDARD OF REVIEW: Appellee Pope’s status as a “state actor” is a question of fact and requires a fact-bound inquiry. A mixed question of law and fact occurs when the historical facts are established, the rule of law is undisputed, and the issue is whether the facts satisfy the legal rule. *Pullman-Standard v. Swint*, 456 U.S. 273, 289 n.19 (1982); *United States v. Lang*, 149 F.3d 1044, 1046 (9th Cir. 1998). Unlike private medical judgments in *Blum v. Yaretsky*, 457 U.S. 991 (1982) (whose “decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State..(see n19)”) the standards under S.B. 228 were established by the State; e.g. Spinal Surgery Second Opinion Procedure as defined by 8 CCR § 9788 et. al. Indeed, relying on *Polk County v. Dodson*, 454 U.S. 312 (1981), the *Yaretsky* court observed that a public defender relied on professional canons of ethics “rather than dictated by any rule of conduct imposed by the State (see n21)”. In *American Manufacturers Mutual Insurance Company, et. al. v. Delores Sullivan*, 526 U.S. 40 (1999). 139 F.3d 158, reversed; the Supreme Court noted: “..The decision to withhold payment...is made by concededly private parties, and “turns on .. judgments made by private parties” without “standards...established by the State.” *Blum*, 457 U.S., at 1008...” [emphasis added]. State standards exist (SSSOP embodied in 8 CCR § 9788 et. al.), unlike the statutory scheme in Pennsylvania described in *American Mfrs. Mut. Ins. Co. v. Sullivan, Ibid.*).

D. State jointly participated with private parties to create a dangerous placing the appellant in imminent danger.

CONTENTION: Under the implementation of S.B. 228 the Administrative Director, Division of Workers' Compensation was overtly and significantly entrusted with the public function to obtain second spinal surgeon opinions from a state controlled list of qualified spinal surgeons. See 8 CCR § 9788.2:

Qualifications of Spinal Surgery Second Opinion Physicians. The Administrative Director was warned in writing on two occasions (May 4, 2006 (see pages 104-105 in appendix) and May 10, 2006 (see pages 106-108 in appendix)) and appellee Rea was warned in writing on at least one occasion (February 9, 2006 (see pages 88-89 in appendix)) that the Self Insurance Administrator appellee Pope was not conforming to state instituted regulations governing conduct for those inclined to “*deny, modify, or delay*” medical treatment of injured workers.

STANDARD OF REVIEW: A statutorily created plan for obtaining second spinal surgeon opinions was created by S.B. 228; this process, directly involving the Administrative Director, Division of Workers' Compensation, “establish[es] ‘substantive predicates’ to govern official decision making . . . [and] mandate[s] the outcome to be reached upon a finding that the relevant criteria have been met.” Kentucky Dept. of Corrections v. Thompson, 490 U.S. 454, 462 (1989) (relying on Hewitt v. Helms, 459 U.S. at 472).

“When state actors knowingly place a person in danger, the due process clause of the constitution...render[s] them accountable for the foreseeable injuries that result from their conduct.” *Johnson v. Dallas Independent Sch. Dist.*, 38 F.3d 198, 199 (5th Cir. 1994). Taking no action to remedy the non-compliance of appellee Pope, when notified in writing, provided “..significant encouragement, either overt or covert, that the choice in law be deemed to be that of the State.” *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 1156 (1978) (quoted in *American Mfrs. Mut. Ins. Co. v. Sullivan, Ibid.*). As the Supreme Court recognized in *Monroe v. Pape*, 365 U.S. 167 (1961), “[i]t is abundantly clear that one reason the legislation was passed was to afford a federal right in federal courts because, by reason of prejudice, passion, neglect, intolerance or otherwise, state laws might not be enforced and the claims of citizens to the enjoyment of rights, privileges and immunities guaranteed by the Fourteenth [451 U.S. 527, 535] Amendment might be denied by the state agencies.” *Id.*, at 180.

E. Significant entwinement between the Self Insurance Administrator and the Department of Industrial Relations grants state actor status upon appellee Pope

CONTENTION: Appellee Pope has held the Self Insurance Administrator credential granted by the Office of Self Insurance Programs, Department of Industrial Relations, since June 5, 1999 (see pages 88-89 in appendix). The

regulatory scheme created to grant the status of self-insured employer⁵ upon appellee Pope's employer is entwined within the person of appellee Pope. For instance, appellee Pope's employer is required by the State to employ a Self Insurance Administrator⁶ as a prerequisite to obtaining self-insured status⁷ under Labor Code § 3700.

STANDARD OF REVIEW: In *Brentwood Academy v. Tennessee Secondary School Athletic Association*, 531 U.S. 288 (2001) 180 F.3d 758, reversed and remanded, a new “entwinement test” was articulated to examine the functionality

⁵ Department of Industrial Relations Form A4-6(11/97) is entitled “SELF INSURANCE PLANS, AGREEMENT OF ASSUMPTION AND GUARENTEE OF WORKERS’ COMPENSATION LIABILITIES”:

(1). In consideration of the Director of Industrial Relations of the State of California issuing a Certificate of Consent to Self-Insure to said Self-Insurer

⁶ Department of Industrial Relations, “INITIAL STATEMENT OF REASONS”, Title 8, Chapter 8, Subchapter 2, Articles 1,6,9, and 12, states at relevant part: The chief manner in which claims administrators demonstrate competence is by passing the Self Insurance Administration examination which tests technical knowledge related to claims handling and self insurance regulations. The examination is administered by the Office of Self Insurance Plans. (emphasis added) (see pages 1-22 in appendix).

⁷ 8 CCR § 15452, entitled “Administrator Competence”, states in relevant part: (f) Each adjusting location of a third party administrative agency or a self-administered self insurer shall have at least one person who has passed the self insurance administrator’s examination. All workers’ compensation self insurance claims at such reporting locations shall be administered and adjusted under the direct supervision of a person who has passed the self insurance administrator’s examination. Supervision of claims decisions, setting of estimates of future liability of claims, and proper payment of benefits to injured workers shall be made or reviewed by a person who has passed the self insurance administrator’s examination. (see pages 29-30 in appendix).

between the state and private actors associated with the state when the Supreme Court granted certiorari and reversed a decision of the Sixth Circuit, holding that a private athletic association was a state actor under 1983 and the Fourteenth Amendment, despite the association's nominally private character, in light of the "pervasive entwinement" of public institutions and public officials in association's composition.

CONCLUSION

A fact-bound inquiry is needed to fully understand and demonstrate the relationship between the three appellees. The appellant requested a fact-bound inquiry in responses to the Motions to Dismiss, but the fact-bound inquiry into the state actor status was never approved. This is a reversible error that can be easily corrected by remanding this case to the district court for further proceedings to develop an evidence-based inquiry into the state actor question.

Drawing all inferences favorable to the non-moving party (in this case the appellant) it appears to be an abuse of discretion to dismiss this instant lawsuit on an issue requiring a fact-bound inquiry.

Therefore, this Court should remand these proceedings to the lower court with instructions to resume proceedings for the purposes of allowing appropriate discovery to ascertain the subtleties of the relationship existing between the three appellees.

CERTIFICATE OF COMPLIANCE

I hereby certify, under the penalties of perjury, that this brief conforms to the typeface and page requirements articulated FRAP 28.1(e) and 32(a). 14 point Times New Roman typeface has been used in this brief.

Barbara Clark

CERTIFICATE OF SERVICE

I hereby certify, under the penalties of perjury, that true and correct copies of the foregoing pleading have been placed with the U.S. Postal Services with first class postage affixed and mailed to:

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Hereby certified on this ____ day of November, 2006.

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APPENDIX