

SUMMARY OF
2006 SIGNIFICANT CASE DECISIONS
IN
CALIFORNIA WORKERS' COMPENSATION LAW

I Jurisdiction

A. Exclusive remedy doctrine, exceptions:

Mendoza v. Brodeur, (2006) 142 Cal. App. 4th 72; 71 Cal. Comp. Cases 1135 (Court of Appeal, First Appellate District)

Mendoza, an unlicensed roofer, was to be paid a set price for roofing Brodeur's house. After a few hours work and well before having worked for 52 hours, Mendoza fell 30' breaking his leg and ankle. He sued Brodeur alleging failure to provide safety protection, equipment, or safety plan causing his injury. The Superior Court granted defendant's motion for summary judgment – noting that plaintiff did not qualify as an employee under Labor Code Sections 3351(d) and 3352(h) and had not alleged a triable issue of fact for tort liability. Plaintiff appealed.

The Court of Appeal reversed holding that plaintiff was hirer's employee under Labor Code Section 2750.5. Because plaintiff did not meet the Labor Code §§ 3351(d) and 3352(h) thresholds for employment status, and defendant's homeowner's policy excluded workers' compensation coverage for those not meeting the 3351(d) threshold, defendant is uninsured as to this employment. The court further noted that Labor Code §2750.5 creates a conclusive presumption that a person who hired an unlicensed contractor for services for which a contractor's license is required is an employer, and the unlicensed service provider an employee. The summary judgment for defendant was reversed

Holford v. West Contra Costa Unified School District, (2006) 71 Cal. Comp. Cases 752 (Court of Appeal, First Appellate District, unpublished).

Plaintiff began work for defendant in 1973 and subsequently filed grievances regarding her performance evaluation and job classification. She believed that her employer harassed and retaliated against her for filing the grievances. In July 2001 her position was eliminated for lack of funding. When funding was restored, a less experienced teacher was hired to fill the position.. Plaintiff became severely depressed and in September 2003, was medically disabled due to work related stress. Plaintiff applied for disability benefits, but her application was denied because the employer advised its disability carrier that plaintiff had been terminated in July 2003. Plaintiff filed suit against her employer alleging that her employer had created a hostile work environment and had breached a commitment to make promotional and transfer decisions solely based on seniority. Plaintiff's first cause of action was for the employer creating an intimidating, hostile or offensive work environment. The second cause of action was for denial of sick leave, allegedly in violation of Education Code §44978. The third

cause of action was for “a pattern of harassment or retaliatory conduct because she had filed grievances.” The fourth cause of action was for intentional infliction of emotional distress “beyond all bounds of decency.” The fifth cause of action alleged that defendant permitted or condoned discrimination, retaliation, harassment, and intimidating conduct directed at plaintiff and negligently created an intimidating, hostile, or offensive working environment. Defendant sought judgment on the pleadings, arguing that the first, third, fourth, and fifth causes of action were barred by the exclusive remedy provisions of the workers' compensation act. The trial court granted the defendant's motion on the pleadings on the first, third, fourth and fifth causes of action without leave to amend. It noted that the exclusive remedy provisions of the Workers' Compensation Act barred the claims. The trial court also granted summary adjudication of the second cause of action finding that plaintiff was provided requisite sick leave. Plaintiff appealed.

The Court of Appeal noted that judgment on the pleadings is similar to demurrer, and is proper where the complaint does not state facts constituting a cause of action against defendant. Here, plaintiff's causes of action are based on alleged employer conduct that was a normal part of the employment relationship, and the exclusivity provisions of the workers' compensation act bar civil proceedings. It noted that the exclusive remedy for injury arising out of and occurring in the course of employment is workers' compensation, even though “the injury resulted from intentional conduct, and even though the employer's conduct might be characterized as egregious.” (*Shoemaker v. Myers*, (1990) 52 Cal. 3rd 1; 55 Cal. Comp. Cases 494 (*Shoemaker*)). The defense judgment was affirmed.

Ramirez v. Nelson, (2006) 138 Cal. App. 4th 890; 71 Cal. Comp. Cases 776 (Court of Appeal, Second Appellate District).

Defendants Thomas and Vivian Nelson were homeowners of a house with a number of trees in the back yard adjacent to high voltage electrical lines. In early February, the Nelsons entered an oral agreement with Julian Rodriguez to trim their back yard trees, including the eucalyptus. Julian Rodriguez had performed similar services for the Nelsons' and their neighbors in the past. Rodriguez arrived to start the work on February 14, 2002 with a crew of four, including Luis Flores. Plaintiffs Maria D. R. and Martin Flores are parents of decedent, Luis Flores. Flores started trimming the eucalyptus tree; the other crew members started work on other trees. Around noon, Ms. Nelson heard shouting in Spanish and went out to investigate. From her deck she could see Flores hanging from his safety harness. She called Mr. Nelson; he called 911. Flores had been killed by electrocution, no one saw how the accident happened, but he had been working about halfway up the tree, trimming branches over shoulder level using an aluminum pole. Julian Rodriguez was not a licensed contractor and did not have workers' compensation insurance. Maria D. R. and Martin Flores sued the Nelsons for wrongful death. A jury found the Nelsons to have been negligent, but found that their negligence was not a substantial factor in causing Luis Flores' death. Plaintiffs appealed.

The Court of Appeal found that the trial court erred in failing to instruct the jury that under Penal Code § 385, it is a misdemeanor for any person, personally or through an employee, to move any tool or equipment within 6 feet of a high voltage overhead line, and that under Evidence Code § 669 violation of a statute setting a standard of care, such as Penal Code §385, is negligence per se. Business and Professions Code §7026.1(c) requires that any person who contracts to trim trees over 15' in height obtain a license. Rodriguez was unlicensed. Therefore, Flores was an employee of the Nelsons under Labor Code § 2750.5 and (*State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Meier)*, (1985) 40 Cal 3rd 5; 50 Cal. Comp. Cass 562 (*Meier*). Workers' Compensation is not the exclusive remedy for this injury because Flores had worked less than 90 hours for the Nelsons in the 90 days preceding the injury. Had the jury been properly instructed on Penal Code §385, it could have found Nelsons' negligence to have been a cause of Flores death; thus the error in failing to give the instruction was not harmless. The judgment was reversed and the case remanded.

Sullivan v. Workers' Compensation Appeals Board, (2006) 71 Cal. Comp. Cases 1065 (Court of Appeal, Fifth Appellate District, unpublished).

Applicant alleged cumulative injury to his right arm from work as a security guard at the Table Mountain Rancheria, a federally recognized Indian tribe. He also filed a petition for enhanced compensation under Labor Code §132a for discrimination by his employer,. The case in chief was resolved by compromise and release for \$12,500 plus \$1,500 in attorneys' fees. Defendant contested the 132a claim asserting sovereign immunity. Applicant claimed that the tribe had waived immunity because they had entered into a compact with the State of California which waived such immunity for employees of the gaming operations. However, after trial, the WCJ determined that the applicant was an employee of the tribe, and not the gaming operations. Therefore, that waiver would not be applicable in this situation and applicant's claim against the tribe for violation of Labor Code §132a was barred. Both the WCAB and DCA affirmed the WCJ's decision in this case.

II Employment

California State Automobile Association Interinsurance Bureau v. Workers' Compensation Appeals Board (Hestehauge), (2006) 137 Cal. App. 4th 1040; 71 Cal. Comp. Cases 347 (Court of Appeal, First Appellate District).

Paul Hestehauge was employed by Wayne and Laurie Charkins as a painter in their residence on November 15, 2005. Mr. Hestehauge fell fifteen feet from a scaffold injuring his brain, head, left wrist and body. The work Mr. Hestehauge was performing for the Charkins required a contractor's license, but Hestehauge was unlicensed. Mr. Hestehauge sought workers' compensation benefits for his injury. At the time of his injury, Mr. Hestehauge had not worked a sufficient number of hours to be covered as a residential employee under Labor Code Sections 3351(d) and 3352(h) (the latter section

excluding any residential employee with less than 52 hours worked and \$100 earned in the ninety days prior to the injury). Notwithstanding the Labor Code Section 3352(h) exclusion, applicant was found to qualify for workers' compensation benefits under Labor Code Section 3715(b). The Workers' Compensation Judge found that applicant was excluded from benefits by the employment exclusion in Labor Code Section 3352(h), but entitled to benefits under Labor Code Section 3715(b). Section 3715(b) affords coverage under the workers' compensation act to household domestic servants working for one employer over 52 hours per week, gardeners working for an individual over 44 hours per month, or casual employees on projects contemplated to last over 10 days and include labor costs of over \$100.00. Section 3715(b) states in pertinent part that such employees are entitled:

“...[I]n addition to proceeding against his or her employer by civil action...to file his or her application with the appeals board for compensation. The appeals board shall hear and determine ...[the case] in like manner as in other claims, and shall make the award to the claimant as he or she would be entitled to receive if the employer had secured the payment of compensation, as required....”

The Charkins were insured as to residential employment by California State Automobile Association Inter-insurance Bureau. Defendant sought reconsideration, contending that Labor Code Section 3715 provides remedies for those employed by uninsured employers. Defendant also contended that the record did not establish that applicant's work for the Charkins would take more than 10 days to complete.

The Board granted reconsideration and found that the exclusion under Labor Code Section 3352(h) applied. It also found that Labor Code Section 3715(b) expressly provides that it was intended to “make no change in the law as it applies to those types of employees covered by this subdivision prior to the effective date of Chapter 1263 of [the Statutes of] the 1975 Regular Session.” The Board noted that Mr. Charkins is a California licensed glazing contractor. The Charkins met Mr. Hestehauge through Mr. Emmery, a California licensed painting contractor. The engagement under which Hestehauge was to paint for the Charkins was not written, and there was no agreement as to compensation for the job or by the hour. There was no inquiry as to whether Hestehauge had a contractor's license. Mr. Hestehauge's injury was incurred in the third hour of his work on the project. After Mr. Hestehauge's injury, the Charkins used a number of others to complete their painting project; the total number of work days of the others was three to five from Mr. Emmery, five work days for the dining room, and two work days for two people for the living room and family room. This project took twelve to fifteen work days to complete. Prior to January 1, 1977, residential workers whose employment was casual and not on the course of trade, business, profession, or occupation of the employer was excluded from coverage under the workers' compensation act by former Labor Code Section 3352(a). There was an exception in former section 3354 limiting “casual “ as used on Section 3352(a) to work of more than ten days duration or having a labor cost in excess of \$100.00. Other exceptions to the prior Section 3352(a) exclusion existed for child care and gardening. This exclusion and the exemptions applied for all employers until the effective date of AB469, which

expressly provided that the change in Labor Code Section 3715(b) was intended to make no change in the law prior to the effective date of Chapter 1263 of the [Statutes of the] 1975 Regular Session. That legislation also mandated that comprehensive liability homeowner's insurance cover residential employees. In response to the broadened definition of employee and potential liability for insured resident's insurers and uninsured residents (particularly renters), AB 133 was passed as urgency legislation, taking effect March 25, 1977, as Chapter 17 of the Statutes of 1977. AB133 placed the 52 hours worked or \$100.00 paid within ninety days before injury as a limitation in Labor Code Section 3352. After considering the legislative history and the mandate of liberal construction in Labor Code Section 3202, the Board found that the coverage afforded by Labor Code Section 3715(b) applies to both insured and uninsured residential employers. This was the September 23, 2005, Significant Panel Decision reported at 70 Cal. Comp. Cases 1294.

Prior to the date on which the Board's decision after reconsideration issued, defendant filed a petition for writ of review or mandate with the court of appeal. On September 27, 2005, the Court of Appeal denied review. (70 Cal. Comp. Cases 1547.) In December 2005, a writ of review was granted by the First Appellate District, Division Four, in the case to review the Board's determination of employment.

The Court of Appeal reversed the WCAB, holding that "Labor Code Section 3715 is part of the scheme for punishing uninsured employers and compensating their injured employees." It affords a dual remedy in compensation and civil liability for residential workers whose employer is uninsured and whose employment meets the criteria of Labor Code Section 3715(b). It continued:

"The genesis of the Appeals Board's (and Hestehauge's) belief that section 3715, subdivision (b), might apply in this case is a mystery." (71 Cal. Comp. Cases 347, at 351.)

Where a homeowner is insured through homeowners insurance or other workers' compensation insurance, Labor Code Sections 3351(d) and 3352(h) are the only relevant statutes for defining who is an employee. Labor Code Section 3715(b) applies only to uninsured homeowners.

JKH Enterprises Inc. v. Department of Industrial Relations, (2006) 142 Cal. App. 4th 1046; 71 Cal. Comp. Cases 1257 (Court of Appeal, Sixth Appellate District).

Joe K. Herrera had been sole proprietor of a courier service business called VIP Courier which had been the subject of a Division of Labor Standards Enforcement (DLSE) stop order for operating without workers' compensation insurance for his delivery drivers. Herrera then incorporated as JKH Enterprises, Inc. (JKH). JKH performed courier services transporting documents for businesses such as title companies and law firms. It classified its route drivers as independent contractors. Each driver filled out an "Independent Contractor Profile" and furnished evidence of automobile

insurance. Drivers picked up delivery items from locations designated by JKH and delivered the items to addressees. Some drivers had regular routes, and were paid a negotiated amount based on mileage, time, and usual volume of deliveries. Regular route drivers were not required to check in with JKH's dispatcher on a regular basis, and decided how best to cover their particular territories. They submitted document registers which JKH used for invoicing its clients. The document registers contained information about the time, mileage, and volume of customers' deliveries. JKH also had special drivers who checked in daily with JKH's dispatcher, advised of their availability for work that day, and were then directed where to report to pick up packages from JKH's customers for delivery. Special drivers were free to decline any delivery, even if they had reported their availability for work, and were paid a negotiated commission for deliveries performed. Sometimes regular route drivers would call dispatch to advise of their availability for "specials" for extra pay after they completed their regular route. All drivers provided their own vehicles, gas, auto maintenance, auto insurance, and cell phones. Some drivers also worked for other courier services, and two had their own business licenses as courier service businesses. No uniform or vehicle marking were used. No training other than how to complete log sheets was furnished by JKH. The drivers are paid twice monthly without deductions, and were issues IRS 1099 Forms rather than W2 forms at year end.

On September 8, 2004, a deputy labor commissioner conducted an inspection at JKH's office. He was advised by phone by Herrera that all the corporations drivers were independent contractors, that he was not required to have workers' compensation insurance, and that he did not have such coverage. The labor commissioner asked the dispatcher for some information on payment timing and method, and driver instructions. The information led the deputy labor commissioner to issue a stop order and penalty assessment. The penalty assessed was \$16,000.00, or \$1,000 per driver for the 16 drivers working on the date of the DLSE inspection. The deputy labor commissioner also served on JKH a subpoena *duces tecum* calling for production of names and addresses of drivers, time and billing records, and cancelled paychecks. Among the documents produced were the "Independent Contractor Profile" sheets.

JKH contested the stop order and penalty assessment, contending JKH's drivers were independent contractors. Following an administrative hearing, a hearing officer issued a decision upholding the stop order and penalty assessment. The decision found that the drivers were properly found to be employees under the test set forth in *S. G. Borello & Sons, Inc. v. Department of Industrial Relations*, (1989) 48 Cal. 3rd 341; 54 Cal. Comp. Cases 80 (*Borello*). The penalty was reduced by \$1,000 for one driver who had a separate business license and was driving on September 8, 2004. JKH filed a timely petition for writ of administrative mandate seeking a stay of the stop order and annulment of the penalty assessment.

The trial court, after hearing, denied JKH's petition, and issued a preliminary injunction enforcing the stop work order. The trial court used a substantial evidence standard for review of the DLSE order, rather than an independent judgment standard. JKH appealed.

The Appeals Court noted that there were two possible standards of review. An independent review standard applies if a fundamental vested right of the petitioner is involved, and a substantial evidence standard applies to review of the administrative decision if no such right is involved. Regardless of the standard at the trial court level, the appellate court always applies a substantial evidence standard in reviewing factual determinations of the trial court. A right is a fundamental vested right if "it is deemed to be of sufficient significance to preclude its extinction or abridgement by a body lacking judicial power." After discussion of applicable guidelines and precedents, the Court concluded that the case involved agency regulation of labor relation. The purpose of the DLSE order was not to put JKH out of business, but to induce compliance with Labor Code §3700. Therefore the substantial evidence standard applied by the trial court was correct. The determination at the administrative hearing was supported by substantial evidence. Here as in *Borello*, JKH retained all necessary control over the operation. Further, it paid drivers on a basis considering time spent, paid on regularly scheduled paydays, and had some drivers in its service for at least a couple of years. There was on this record substantial evidence to support the finding that 15 of JKH's 16 drivers were employees. The trial court's determination and order for preliminary injunction were affirmed.

City of Stockton v. Workers' Compensation Appeals Board (Jenneiahn), (2006) 135 Cal. App. 4th 1513, 71 Cal. Comp. Cases 5 (Court of Appeal, Third Appellate District)

Evidence did not support a finding that an injury incurred in an off duty basketball game arose out of and occurred in the course of employment where, even if the employee believed his employer expected him to participate in the game, that belief was not objectively reasonable.

III Insurance Coverage / California Insurance Guarantee Association:

A. CIGA, Exclusions from Covered Claims

Parkwoods Community Association v. California Insurance Guarantee Association, (2006) 141 Cal. App. 4th 1362; 71 Cal. Comp. Cases 1275 (Court of Appeal, First Appellate District).

Plaintiff had resolved a prior building defects suit with the developer and general contractor. The settlement called for payment which more than exhausted the coverage of the developer's and general contractor's general liability policy or policies. The settlement stipulated that the developer, general contractor and five subcontractor defendants were jointly and severally liable. There were five subcontractors who had been insured by Reliance Insurance. Reliance Insurance had been placed in liquidation and its liabilities for covered claims assumed by California Insurance Guarantee Association (CIGA). Under the contracts, the subcontractors had agreed to indemnify the developer and general contractor to the fullest extent allowed by California law. CIGA

had advised plaintiff prior to entry of the settlement that it contested any liability for contribution on the ground that the developer and general contractor had excess insurance which in fact paid \$925,000 of the settlement which was in excess of the general liability policy or policies limits. This suit was a declaratory relief action brought to resolve whether or not the claim for \$925,000 was a covered claim. Under the terms of the settlement, if CIGA were not liable to plaintiff for the \$925,000, this portion of the settlement proceeds would not be recoverable from any of the defendants. The trial court held that there was no other insurance of the subcontractors available to pay the claim, and CIGA was therefore liable for the \$925,000. CIGA appealed.

The Court of Appeal noted that other insurance coverage available to pay the claim was not limited to a policy of Reliance Insurance policy holders. It noted decisions in workers' compensation cases, where insurers of other employers were required to pay benefits which would otherwise have been payable by insolvent insurers of other employers. It found that plaintiff could not bootstrap its claim against CIGA by releasing its right to recover under an available policy and claiming as a result that there is no other coverage. Upon Reliance's insolvency neither the developer and contractor nor their insurers were entitled to obtain indemnity or contribution from CIGA. The trial court judgment against CIGA was reversed.

Seiler v. Cardiology Associates of Northern California, Zenith Insurance Co., and California Insurance Guarantee Association, (2006) 34 C.W.C.R. 192 (WCAB Decision after remittitur).

Applicant sustained cumulative upper back injury during a period of employment ending March 24, 2000 when the employer was successively insured by Zenith Insurance Company and Fremont Insurance Company. The case was resolved by stipulations, with the award to be administered by Zenith Insurance, subject to right of contribution. The contribution claim was heard and decided by an arbitrator. Two days after the issue was submitted for the arbitrator's decision, Fremont Insurance was placed in liquidation. Twenty days after the order of liquidation, on July 22, 2003, the arbitrator issued an order for contribution. No party timely sought reconsideration of the arbitrator's decision, but on August 7, 2003 (within twenty days of issuance of the order), California Insurance Guarantee Association (CIGA) petitioned for dismissal. Zenith objected, and on January 28, 2004, a WCJ denied CIGA's petition on the ground that the contribution order was final. The WCAB denied CIGA's petition for reconsideration. CIGA sought review. The Court of Appeal ordered the matter remanded with directions to issue a decision consistent with the decisions in *CIGA v. Workers' Compensation Appeals Board (Weitzman)*, (2005) 128 Cal. App. 4th 307; 70 Cal. Comp. Cases 556, and *CIGA v. Workers' Compensation Appeals Board (Hooten)*, (2005) 128 Cal. App. 4th 569; 70 Cal. Comp. Cases 551. The Board on remittitur found that (1) CIGA was statutorily prohibited from liability for benefits paid to applicant for cumulative neck and back injury ending on March 24, 2000, when there was "other insurance" available through Zenith under Insurance Code § 1063.1(c)(9)(i), (2) CIGA was not liable for reimbursement to solvent carrier pursuant to Insurance Code § 1063.1(c)(9)(ii), since

claim for reimbursement was not a claim of the original insured under insolvent carrier's policy, and (3) CIGA had no liability for solvent carrier's claim under Insurance Code § 1063.1(c)(5), as it was a claim for contribution or indemnity to an insurer.

Blue Cross of California v. Workers' Compensation Appeals Board (Gorgi), (2006) 71 Cal. Comp. Cases 1587 (Court of Appeal, Second Appellate District, writ denied).

Applicant alleged that he sustained two work injuries. At the time of his first alleged injury his employer was insured as to workers' compensation liability by Fremont Indemnity Company (Fremont); at the time of his second alleged injury his employer was insured as to workers' compensation indemnity by Legion Insurance Co. (Legion). Applicant received medical treatment paid for by Blue Cross of California (Blue Cross), the employer's group health plan. Blue Cross filed a lien seeking \$14,765.82 in reimbursement. Both Legion and Fremont became insolvent, and California Insurance Guarantee Association (CIGA) entered the proceedings. CIGA and applicant settled the cases in chief, leaving the Blue Cross lien unresolved. CIGA then contended that Blue Cross' claim was barred because Insurance Code §1063.1(c)(5) precludes CIGA from paying claims to insurers. Blue Cross was a health care service provider (HCSP), and was an insurer for purposes of Insurance Code §1063.1(c)(5).

The WCJ found that Blue Cross, as an HCSP, was an insurer for purposes of the Insurance Code §1063.1(c)(5) exclusion from covered claims, and that CIGA had no liability to Blue Cross. Blue Cross sought reconsideration contending that HCSPs are statutorily defined and regulated differently than insurers, and that its rights had been violated by approval of the compromise and release without determining CIGA's liability to it. The WCJ reported that the definition of insurance in Insurance Code §22 encompasses HCSPs, even though they may be subject to regulation and oversight by a department other than Department of Insurance. Because neither applicant nor CIGA had an obligation to reimburse Blue Cross there was not violation of Blue Cross due process right to approve the compromise and release prior to determining CIGA's non-liability.

California Insurance Guarantee Association v. Workers' Compensation Appeals Board (White) and *California Insurance Guarantee Association v. Workers' Compensation Appeals Board (Torres)*, (2006) 136 Cal. App. 4th 1528, 71 Cal. Comp. Cases 139 (Court of Appeal, Second Appellate District)

Employment Development Department (EDD) paid unemployment compensation disability benefits to White and Torres and filed liens in their respective workers' compensation cases. The insurers for White's and Torres' employers were insolvent, and their covered claims became the obligation of California Insurance Guarantee Association (CIGA). CIGA contested its liability for the liens, relying on *California Insurance Guarantee Association v. Workers' Compensation Appeals Board (Karaiskos)*, 117 Cal. App. 4th 350, 69 Cal. Comp. Cases 183. The WCAB held in both cases that *Karaiskos* applied only where the EDD lien was litigated after applicant's case in chief

was settled. Where the lien is litigated with other issues, the lien amount allowed is deducted from indemnity benefits awarded to applicant. CIGA sought review.

The Court held that the EDD lien is not a covered claim because EDD is a department of the State of California, and Insurance Code §1063.1(c)(4) exempts CIGA from liability for obligations to the state. The exclusion from liability exists whether the claim is litigation with or after the other issues in the case.

IV Injury AOE-COE:

A. Going and Coming Rule

Pettigrew v. Workers' Compensation Appeals Board, (2006) 143 Cal. App. 4th 397; 71 Cal. Comp. Cases 1248 (Court of Appeal, Third Appellate District).

Pettigrew was employed as a correctional officer in a state correctional facility. He had no job duties outside the correctional facility, and he was required to sign in at the facility to start his paid shift. On April 24, 2005, about 45 minutes before the scheduled start of his shift, applicant was driving to work in uniform under a cover jacket." He came upon an accident scene, and observed several other correctional officers in uniform at the scene. He stopped and removed his "cover jacket," intending to render such aid as might be necessary. This was consistent with provisions of ethics guides on a cadet workbook and law enforcement code of ethics, and an oath of employment calling for him to serve and protect the public. At the scene he directed a victim who appeared to have an eye injury to lie down in the back seat of his car until further assistance arrived. He was shining a flashlight at an unlit parked truck when an approaching vehicle struck the truck causing it to hit Pettigrew. Pettigrew was thrown into the air and landed on the other side of the freeway. Pettigrew sought workers' compensation for his injuries. A correctional lieutenant testified that if a correctional officer were late for the start of his shift as a result of rendering aid at an accident scene and reported the reason for his tardiness, he would not be docked pay for the work time missed. The same witness also testified that a correctional officer's duties and status as a peace officer begin when he enters the facility grounds and end when he leaves the grounds. A correctional sergeant testified that correctional officers are "private citizens" when off facility grounds. The WCJ found applicant was not injured in the course of his employment, and that no exception to the going and coming rule applied. Applicant sought reconsideration. The WCJ noted in his report and recommendation that applicant was not a peace officer while off facility grounds, was not required by his employment to stop and render aid, did not observe fellow correctional officers in need of assistance, and was rendering aid to non-correctional officers at the scene. The Appeals Board adopted the WCJ's report as the basis for denial of reconsideration. Applicant filed a petition for writ of review.

The Court of Appeal granted the writ. After review it found that while there was conflict in factual evidence, there was substantial evidence supporting the Board's decision, so the Board's determinations were not subject to reversal for lack of substantial

evidence. It concluded there was no basis to set aside the Finding and Order, and affirmed the decision that applicant was not injured in the course of employment.

B. Injury to the Psyche:

Sonoma State University v. Workers' Compensation Appeals Board (Hunton), (2006) 142 Cal. App. 4th 500; 71 Cal. Comp. Cases 1059 (Court of Appeal, First Appellate District)

Applicant was a police dispatcher at Sonoma State University who alleged three cumulative psychiatric injuries. The parties Agreed Medical Examiner found several psychiatric or psychological problems. Taken globally, the predominant cause of the problems was non-industrial. However, there was an adjustment disorder which had developed predominantly due to stress from having to cope with constant alarms. As to that one psychiatric diagnosis, work was 100% responsible for the injury. However, that particular injury was only 35% of the cause of applicant's permanent disability. The WCJ found compensable injury in the one cumulative claim involving the adjustment disorder. Defendant sought reconsideration contending that the Labor Code Section 3208.3(b) (1) threshold for compensability of psychiatric injury requires that the applicant must show that the predominant cause of the overall injury results from actual events of employment. Finding predominant cause in one particular element of the psyche is insufficient. The Workers' Compensation Appeals Board denied reconsideration. Defendant sought review.

The Court of Appeal granted defendant's Petition for Writ of Review. It found that the language of the statute was unclear as to whether the threshold could be met on a diagnosis by diagnosis basis or required preponderance of causation as to all emotional injury or injuries. Looking beyond the language of the statute, the Court noted that the stated purpose was "to establish a new, higher threshold of compensability for psyche injuries. A worker satisfies the requirement of Labor Code Section 3208.3 only where actual events of employment are predominant as to all causes combined of the psychiatric disability taken as a whole. The award was annulled.

Matea v. Workers. Compensation Appeals Board, (2006) ___ Cal. App. 4th ___; 71 Cal. Comp. Cases 1522, 34 CWCR 323 (Court of Appeal, Sixth Appellate District).

Applicant fell from a rack injuring his foot and leg. At the time of injury he had been employed by Home Depot for less than six months. He subsequently developed reflex sympathetic dystrophy (RSD) and became depressed as a result of his injury. The WCJ found applicant to be totally permanently disabled based on an AME report and an AVE's testimony. The WCJ found that the collapse of a shelf of lumber was a sudden and extraordinary event. Defendant sought reconsideration. The WCAB reversed the finding of injury to the psyche. Applicant regularly worked around stacks of lumber which could collapse, and applicant failed to prove that such collapse was extraordinary.

The Board directed the total disability award vacated, and the matter remanded. Applicant sought review.

The Court of Appeal granted review. It found that the collapse of the lumber in this instance was an uncommon, unusual, and unexpected event that met the standard of Labor Code Section 3208.3(d). Applicant's testimony met the burden of proving the event sudden and extraordinary, therefore the claim of injury to the psyche was not barred by Labor Code Section 3208.3(d). The finding of no compensable injury to the psyche was reversed and the matter was remanded for decision consistent with the opinion.

V Presumptions, Safety Members' Presumptions (Labor Code §§ 3212 – 3213.1):

City of Buenaventura v. Workers' Compensation Appeals Board (Deck), (2006)71 Cal. Comp. Cases 1322 (Court of Appeal, Second Appellate District, writ denied).

On December 1, 1996, applicant suffered a heart attack while employed as a police officer by City of San Buenaventura. Applicant filed claims for specific and cumulative injuries to his heart. A WCJ appointed Dr. Edward O'Neill "to act as an IME." Dr. O'Neill reported that applicant suffered from non-industrial hypertension which would have warranted work limitations, and had work related coronary artery disease that increased his disability to a limitation to light work (and in deposition testimony indicated it also warranted preclusion from undue emotional stress). Dr. O'Neill opined that the disability from the hypertension (precluding undue emotional stress and very heavy work) was separate from that caused by his coronary artery disease. After trial, an F&A issued on February 23, 2005, in which the WCJ awarded 67% permanent partial disability without apportionment under Labor Code Section 4663. The WCJ found that the anti-attribution clause of Labor Code Section 3212.5 precluded apportionment under Labor Code Section 4663, as amended by SB899. Defendant sought reconsideration, contending that Labor Code Section 4663, as amended, required apportionment based on causation of disability notwithstanding the anti-attribution clause in Labor Code Section 3212.5.

The Appeals Board granted reconsideration. In its decision, it held that if an applicable presumption statute contains an anti-attribution clause, apportionment under Labor Code Section 4663 is precluded; if the presumption contains no such clause, the provisions of Labor Code Section 4663 apply. It noted Dr. O'Neill's deposition testimony that following the heart attack, the limitation to light work and work precluding undue emotional stress would have been required whether or not applicant had suffered from hypertension. The WCJ's decision was affirmed. Defendant's request to require further development of the record denied, and the WCJ's report and recommendation adopted as basis for the Board's decision on that issue.

NOTE: On October 1, 2006, Labor Code Section 4663(e) was amended to extend the anti-attribution clause to all emergency services personnel – Labor Code Section 4663(e) as amended provides:

“Labor Code Section 4663 Subdivisions (a), (b), and (c) shall not apply to injuries or illnesses covered under Sections 3212, 3212.1, 3212.2, 3212.3, 3212.4, 3212.5, 3212.6, 3212.8, 3212.85, 3212.9, 3212.10, 3212.11, 3212.12, 3213, and 3213.2.”

VI Res Judicata and Collateral Estoppel

VII Conditions of Compensation

VIII Earnings; Indemnity Rate Determination

Signature Fruit Co. v. Workers' Compensation Appeals Board (Ochoa), (2006) 142 Cal. App. 4th 790; 71 Cal. Comp. Cases 1044 (Court of Appeal, Fifth Appellate District)

Applicant worked a July 29 through September 9 season with average in season wages of \$548.38 per week, and did not work during the remainder of the year. The WCJ awarded applicant temporary disability at the minimum rate of \$126 per week for periods of temporary disability during her off season. He Appeals Board granted defendant's petition for reconsideration, and affirmed. Defendant sought review.

The Court of Appeal reversed. It distinguished seasonal from intermittent employees (the latter being available for employment year round). Temporary disability during an employee's in-season period of regular employment is payable based on two-third of the employee's in-season average weekly earnings, subject to statutory minimum and maximum rates. Where, however, the employee has no off season earnings and does not compete in the open labor market during a portion of the year, the employee is not entitled to any temporary disability indemnity. Accord: Signature Fruit Co. v. Workers' Compensation Appeals Board (Bedoy) and Signature Fruit Company v. Workers' Compensation Appeal Board (Jacobo), (2006) 9 WCAB Reporter 10003 (Court of Appeal, Third Appellate District, unpublished). Contra: Magana v. National Union Fire Ins. Co. (2005) 33 C.W.C.R.190 (Magana). Magana holds that seasonal earnings should be annualized and a compensation rate of 2/3 annual average weekly earnings should be awarded year round.

IX Temporary Disability, Industrial Disability Leave, 4850 pay:

Watson v. City of Oakland, (2006) 34 C.W.C.R. 331 (WCAB Panel decision).

A police officer was injured on June 10, 2004, in a traffic accident while responding to a call in her patrol car. She was disabled for two to three weeks, and then returned to duty. On December 12, 2005, applicant was unable to continue working, and was placed on temporary disability pending spinal surgery. Defendant paid Labor Code Section 4850 benefits until June 10, 2006, then ceased payment based on the SB899 amendment to Labor Code Section 4656, limiting temporary disability payments to 104 weeks within two years of commencement of temporary disability. After Expedited Hearing the WCJ ruled that applicant was entitled to a full year of Labor Code Section 4850 benefits, for disability not limited to a period of two years from the first payment. Defendant sought reconsideration, contending that 4850 benefits are an equivalent to temporary disability indemnity. The WCJ noted that 4850 benefits are more expansive than temporary disability, in that they do not require any waiting period. She further noted that SB899 made no amendment to Labor Code Section 4850 to reflect the limitation imposed by the change in Labor Code Section 4656. The Board denied reconsideration, holding that salary continuation benefits paid under Labor Code § 4850 are not subject to the two-year limitation period for payment of temporary disability indemnity set forth in Labor Code § 4656, as amended by SB 899.

Rogelio v. Travel Nurse International, Connecticut Indemnity Co., (2006) 34 C.W.C.R. 188 (WCAB Panel Decision).

Applicant sustained upper extremities cumulative trauma while employed as a clerical assistant through November 7, 2001. Defendant provided treatment and temporary disability through April 2, 2002. On February 15, 2002, the treating physician reported that applicant's condition was "totally normal" and permanent and stationary. Applicant selected Dr. Victoria Barber from a QME panel. Dr. Barber examined applicant, and placed applicant's permanent and stationary date on October 14, 2002. Dr. Barber repeated this finding in three supplemental reports. Applicant selected a new treating physician who commenced treatment on June 10, 2003, and found applicant's condition permanent and stationary on October 27, 2004. The case was tried on issues including permanent and stationary date, temporary disability, permanent disability, need for further treatment, and credit for overpayment of temporary disability. The WCJ found that applicant had sustained 28% permanent partial disability, that her condition had been P&S on October 14, 2002, and that defendant was entitled to credit against all further indemnity due for temporary disability indemnity paid thereafter. Applicant sought reconsideration claiming a 2004 P&S date, temporary disability indemnity, and claiming that defendant was estopped to assert credit for temporary disability indemnity paid due to delay in making the claim for credit. The WCJ noted that applicant had selected all of the reporting physicians, and that the flare ups and treatment provided in 2003 by Dr. Baer were not outside the scope of what had been expected by QME Barber.

The WCAB held that evidentiary record supported determination of applicant's permanent and stationary date as 10/14/2002. That was date established by medical reports of panel qualified medical evaluator selected by applicant, and WCAB found it significant that applicant filled out questionnaires in October 2002 and April 2004, in

each of which she described precisely same level of abilities. The fact that applicant had sought further treatment in June 2003 indicated that applicant was experiencing flare-up in her condition, which Dr. Barber, the QME, had anticipated. The WCAB found that this flare-up did not indicate that applicant had ceased to be at maximum medical improvement after October 14, 2002. WCAB also held that defendant's overpayment of temporary disability indemnity from July 2003 to March 2004 could be asserted as credit against permanent disability indemnity. Defendant was not estopped to claim credit even though the claim was not made until one and a half years after overpayment. The Board distinguished a case in which estoppel was found where defendant was under an award of continuing temporary disability, delayed service of medical reports and filing of a petition to terminate liability. The WCAB found that applicant knew that her condition was permanent and stationary pursuant to reports of applicant's first treating physician, which gave permanent and stationary date. In this case, defendant did not have standing to file petition to terminate liability for temporary disability indemnity because there was not award of temporary disability indemnity; it had no choice but to wait until trial in order to assert claims of overpayment and credit.

City of Oakland v. Workers Compensation Appeals Board (Harger), (2006) 71 Cal. Comp. Cases 1319 (Court of Appeal, First Appellate District, writ denied).

Applicant was a firefighter for the City of Oakland, and sustained cumulative injury to his right shoulder during a period ending on June 24, 2004. Defendant paid Labor Code Section 4850 salary continuation (4850) benefits from June 26, 2004 through October 11, 2004, and then unilaterally ceased payment contending that applicant had received one year of 4850 benefits for this and his prior work injuries, and that Labor Code Section 4850 entitled applicant to one year of salary continuation benefits over the course of his career. A WCJ found that applicant was entitled to up to one year of 4850 benefits for the cumulative injury, regardless of any prior payments of 4850 benefits for prior injuries. Defendant sought reconsideration contending that the entitlement to 4850 benefits is based on the status of being disabled, not on occurrence of an injury. The WCJ recommended reconsideration be denied, and the Board adopted his report and recommendation as the basis for denying the petition. Defendant sought review; applicant filed an answer citing *Austin v. City of Santa Monica*, (1965) 234 Cal. App. 2nd 841, 30 Cal. Comp. Cases 468 (*Austin*). *Austin* holds that under Labor Code §§ 3751 and 3752, a city may not reduce a safety member's sick leave for days it pays 4850 benefits, but indicates in *dicta* that "the year (or less) during which workmen's compensation is to be paid under section 4850...is the aggregate of periods of temporary disability due to one injury." (30 Cal Comp. Cases 468, at 470.) Defendant's petition for writ of review was denied.

X Medical Treatment:

A. Reasonableness, ACOEM, and Utilization Review:

Sierra Pacific Industries v. Workers' Compensation Appeals Board (Chatham), (2006) 140 Cal.App.4th 1498; 71 Cal. Comp. Cases 714 (Court of Appeal, Third Appellate District).

Applicant was injured on September 22, 2003. He received chiropractic treatment. Defendant disputed the need for chiropractic treatment and applicant selected QME La Relle Plubell-Epperly, D. C., from a panel. Dr. Plubell-Epperly examined applicant in February 2004, and found applicant's past chiropractic case, 70 visits, had been needed. In deposition, Dr. Plubell-Epperly testified that she did not believe ACOEM applied, because the treatment had been furnished before its adoption. After trial the WCJ found that all of the disputed treatment had been provided before April 19, 2004, when ACOEM was adopted as the standard of reasonableness for medical treatment. There had been no timely utilization review. Relying on the treating chiropractor and QME, the WCJ found the treatment reasonable. Defendant's petition for reconsideration was denied.

The Court of Appeal granted review and reversed. It held that SB 899 generally applies prospectively from its date of enactment to all injuries on all disputes in which a decision was not final. (Chapter 34, Statutes of 2004, §47.) The court found that the word "prospectively" did not limit application to treatment furnished after the date of enactment, and rejected lien claimant's contention that its rights vested upon treatment, and were not subject to later statutory changes. The Court found the rationale of the decisions in *Kleeman v. Workers' Compensation Appeal Board*, (2005) 127 Cal. App. 4th 274; 70 Cal. Comp. Cases 133, and *Rio Linda Union School District v. Workers' Compensation Appeals Board*, (2005) 131 Cal. App. 4th 517; 70 Cal. Comp. Cases 999, controlling. It found that the three month delay in implementation of the presumption of correctness of the American College of Occupational and Environmental Medicine (ACOEM) guidelines did not indicate a legislative intent that Labor Code Section 4600 be applied only prospectively. The *Chatham* decision essentially holds that the ACOEM guidelines apply to all medical treatment disputes that are adjudicated after the April 9, 2004 effective date of SB 899, even though both the injury and the disputed treatment occurred before April 19, 2004.

County of Stanislaus v. Workers' Compensation Appeals Board (Credille), (2006) 71 Cal. Comp. Cases 1381; 34 C.W.C.R. 296 (Court of Appeal, Fifth Appellate District, writ denied).

Applicant had developed polio in 1956, and sustained a cumulative injury to her legs arising out of and occurring in the course of employment as a social worker from 1976 to February 11, 1993. She was awarded 1% permanent disability after apportionment, and future medical care. Defendant paid for adjustments to applicant's leg braces for nine years, but disputes liability for replacement of the braces when recommended. The Court affirmed a decision awarding a leg braces to applicant, even though she only had 1% PD in her lower extremities after apportionment of the vast majority of her disability to pre-existing post-polio syndrome. The Court also ordered 5801 attorney's fees. that "the

right of an injured employee to recover medical expense reasonably necessary to relieve from the effects of the injury is independent of the right to recover for disability and the issue of apportionment,” citing to *Cedillo v. Workmen's Comp. Appeals Bd.* (1971) 5 Cal.3d 450, 454; 36 Cal. Comp. Cases 497. Unlike permanent disability, medical treatment cannot be apportioned to non-industrial factors. (*Granado v. Workmen's Comp. Appeals Bd.* (1968) 69 Cal.2d 399, 405-406; 33 Cal. Comp. Cases 647.) Where an industrially related need for treatment has been established, an employer's liability for treatment cannot be avoided by asserting that the “natural progression of [the employee's] preexisting disease would have resulted in a need for the same level of medical care at the present time even if there had been no industrial injury.” (*Rouseyrol v. Workers' Comp. Appeals Bd.* (1991) 234 Cal.App.3d 1476, 1485; 56 Cal. Comp. Cases 624.)

Here, Credille had an FMT award that covered her lower extremities, and the reports of Drs. Rhoades and Barber constituted substantial evidence to support the WCAB's determination that new braces are reasonably required on an industrial basis.

State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Sandhagen) & Sandhagen v. Workers' Compensation Appeals Board, (2006) ___ Cal. App. 4th ___; 71 Cal. Comp. Cases 1541; 34 CWCR 317 (Court of Appeal, Third Appellate District).

Applicant suffered an industrial back injury on October 22, 2003. The consulting physicians issued a report on May 14, 2004 requesting an MRI to determine whether the applicant had a herniated disc at the location of his pain. The report was served on defendant, and was later FAXed to defendant on May 24, 2004. On June 21, 2004, the defendant's Utilization Review (UR) doctor denied authorization for the MRI. The WCJ determined at the Expedited Hearing on July 15, 2004 that the defendant had not complied with the Labor Code §4610 time deadlines and therefore, the reports generated from the UR review were not admissible into evidence.

After defendant filed a Petition for Reconsideration, the Appeals Board issued its initial decision en banc, and affirmed the WCJ's findings. In *Sandhagen I*, (at 69 Cal. Comp. Cases 1452), the Board found that Labor Code Section 4610 provides that the UR decision must be made no later than 14 days after receipt of the treater's request. Since the UR decision in this case exceeded that 14 day period, the defendant did not comply with the UR deadline, and therefore the UR report was not admissible.

The Board explained that the §4610 deadlines ensure the constitutional mandate of expeditious delivery of medical treatment to the injured worker. If defendants want to pursue the UR process, they must do so promptly and the deadlines set forth in §4610 are mandatory. If a defendant fails to meet a UR deadline, any UR report generated therefrom will not be admissible as evidence.

The Appeals Board did provide an alternative if a defendant fails to meet a UR deadline, the defendant may still utilize the AME/QME procedures set forth under Labor

Code §4062. However, any UR report that is not generated in compliance with the UR deadlines must not be provided to the AME or QME, as it would then constitute “back door” evidence which is prohibited.

In addition, if defendants utilize the AME/QME procedures, they must comply with the time periods in §4062(a), which provides,

“If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney.”

In this case, the Appeals Board stated, the defendant received the treater’s request on or before May 24, 2004 and did not notify the applicant within 20 days of this date of their objection to the request. Therefore, defendant would be “precluded from obtaining a QME report in rebuttal to” the treating physician’s request.

The Appeals Board noted in its initial decision that although the defendants in this case had not met the Labor Code §4062 time limits, this limitation period may be extended for “good cause or mutual agreement.” The Board recognized that “the statutory procedures established by §§4610(g)(1) and 4062(a) are relatively new and that no binding Appeals Board or Court of Appeal decision has previously interpreted the interplay between them.” Therefore, the Board found “good cause” to extend the time limits in this case and the case was returned to the trial level to allow defendants a “reasonable opportunity” (20 days from the date of the Board’s decision) to obtain a section 4062(a) evaluation.”

Review under Labor Code §4610 should generally precede the AME/QME process. In cases of prospective review of medical treatment, such as in this case, the statutory language provides the AME/QME option to employees only, and not to employers. Section 4610 (g)(3)(A) provides that “if the request is not approved in full, disputes shall be resolved in accordance with Section 4062.” Therefore, if the UR review doctor approves the treater’s recommendation in full, the defendant must comply with that authorization, and is not permitted to move on to the AME/QME process. This is confirmed by the language in §4062(a) that provides, “If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision.” There is no corresponding language if the employer objects to the UR determination.

The Board rescinded the WCJ’s determination that applicant was entitled to the disputed medical treatment. It gave defendant a reasonable time to obtain a §4062(a) evaluation to assess reasonableness of the recommended treatment. Both parties sought review.

In *Sandhagen II*, the Appeals Board found that where the Board grants reconsideration, rescinds a WCJ's decision, and returns the matter for further proceedings, no final order has generally entered, even if the decision makes procedural or evidentiary rulings. Under such circumstances no substantive right or liability has been determined, and the determination is not a final award or order from which reconsideration can be sought.

After determining that the Petition for Reconsideration should be dismissed, the Board reviewed the language of Labor Code Sections 4610 and 4062. Utilization review is not a pre-requisite to declaring a dispute and proceeding under Labor Code Section 4062 when – (1) it is the applicant who disputes the recommendation of the treating physician, and (2) where defendant never or not timely used the utilization review process in Labor Code Section 4610.

A Petition for Writ of Review was granted on July 18, 2005. On November 14, 2006, the Court of Appeal affirmed the Board's en banc decisions. Utilization review of a treatment recommendation is discretionary, not mandatory. Either party may make a Labor Code §4062 objection to a treating physician's recommendation. Untimely utilization review physician's reports are inadmissible.

Finklang v. American Medical Response, (2006) 34 C.W.C.R. 52 (WCAB Panel decision)

Applicant sustained a back injury on January 17, 2001. Defendant accepted liability for the injury. The Primary Treating Physician recommended Botox injections to control spasm at the site of a stimulator site. Two QME's evaluated applicant's orthopedic condition. One did not comment on the Botox treatments, the other found them to have been beneficial in reducing spam and reasonably necessary. WCAB held that presumption of correctness of ACOEM Guidelines on issue of extent and scope of medical treatment, as set forth in Labor Code § 4604.5(c), applied only after substantial expert medical evidence has been produced to demonstrate applicability of Guidelines to recommended treatment, when WCAB found that applicant had presented substantial medical evidence demonstrating that Botox injections were reasonable and necessary to cure or relieve effects of industrial injury, specifically, to control muscle spasms caused by stimulator implanted in applicant as result of back injury, that defendant produced no substantial medical evidence demonstrating applicability of Guidelines to recommended treatment or how that treatment fell outside mandates of Guidelines, and that defendant was incorrect in arguing that expert medical opinion was not necessary to establish applicability of Guidelines to recommended treatment; alternatively, WCAB held that, even if presumption of Labor Code § 4604.5(c) were to apply, applicant had offered medical evidence sufficient to rebut presumption. Liability for the Botox injection was disputed. The WCJ found the Botox treatments reasonable, and ordered reimbursement for the cost. Defendant sought reconsideration contending that ACOEM did not recommend Botox injections for treatment of back pain, and ACOEM was rebuttably

correct as to reasonableness. The WCJ reported that defendant had not established the facts supporting application of the presumption of correctness of ACOEM. There was no medical evidence that ACOEM addressed the reasonableness of Botox for back treatment. There was expert medical evidence in the form of the PTP and QME reports indicating the treatment was reasonable; if the presumption had been applicable it would have been rebutted. The Board denied reconsideration.

B. Medical Provider Networks:

Knight v. United Parcel Service and Liberty Mutual Insurance Company, (2006) 71 Cal. Comp. Cases 1423; 34 C.W.C.R. 297 (WCAB en banc). Filed and served on October 10, 2006

Applicant fell injuring his right arm and shoulder on February 22, 2005. UPS referred him to U.S. HealthWorks for treatment, and they referred him to Dr. A. Zoppi, M. D. for consultation. In April 2005, applicant elected Dr. Robert Hunt as his physician. There was no indication that applicant had been advised of his rights under Labor Code §§ 4616-4616.7, including right to change physicians with a network or obtain second and third opinions. Defendant declined to accept liability for Dr. Hunt's services because he was not a member of Liberty Mutual's Medical Provider Network (MPN). Applicant's counsel made multiple telephone and mail requests for a list of Liberty Mutual's MPN provider list from May 11, 2005 through June 9, 2005, and then advised defendant that applicant was selecting Dr. Jacob Rabinovich as his treating physician.

Five days later defendant advised applicant that he was directed to obtain treatment through defendant's MPN, but not advise where or how to obtain treatment, nor identify any MPN physician. Dr. Rabinovich then recommended surgery.

On October 7, 2005, applicant requested an expedited hearing, and after hearing the SCJ found that defendant had waived the right to have applicant treated through the MPN and was liable for self procured treatment during the time it failed to authorize treatment by Dr. Hunt and then Dr. Rabinovich. Defendant sought reconsideration contending applicant had received appropriate notices and should be directed to obtain treatment through its MPN network. Defendant's petition for reconsideration was granted.

In its en banc decision the Board unanimously held that defendant had not provided applicant with required notices concerning its MPN and was liable for self procured medical treatment. Where the employer has knowledge of the injury, it is obliged under Labor Code §4600 to promptly notify the employee how and where to obtain medical treatment. Failure to provide information on how and where to obtain treatment renders the employer liable for self procured medical treatment. Notice where treatment is to be furnished through an MPN includes notice of right to change physician with the group, and means of access to the list of participating providers, as required by Labor Code Section 4616.3 and Rules and Regulations of the Administrative Director §9767.12. The Board affirmed the WCJ's decision.

Andrade v. Ito-Ozawa Farms, (2006) 34 C.W.C.R. 132 (WCAB Panel decision)

Applicant injured his back on April 13, 2005. The employer referred him to a physician at a group where several physicians were members of defendant's Medical Provider Network (MPN). Defendant did not advise applicant of his right, after his first visit, to select a primary treating physician (PTP) of his choice within the MPN, nor did it advise of the method by which a list of participating providers could be obtained. Three weeks post injury, applicant's counsel wrote to defendant requesting it to provide another PTP within the MPN. Two weeks later applicant's counsel designated Dr. Daniel Capen as applicant's physician of choice. Defendant objected, and ten weeks later offered applicant a choice of two MPN physicians. Five months later the issue was tried, and the WCJ allowed applicant his physician of choice outside the MPN. Defendant sought reconsideration. WCJ reported that applicant was entitled to select physician outside defendant's medical provider network, because applicant, following his initial evaluation by network physician to whom defendant sent him, requested to exercise his right to change physicians within network by requesting that defendant provide another physician within network, and that defendant failed either make timely reply to applicant's request or to provide complete list of network physicians. In such circumstances applicant was free to select a physician of choice without regard to MPN membership. *Mc Coy v. I.A.C.*, (1966) 64 Cal 2nd 83; 31 Cal. Comp. Cases 93. The Board denied reconsideration adopting the WCJ's report as its basis.

Pyle v. San Juan Unified School District, (2006) Cal. Comp. Cases advance sheets, vol 71, no. 11, p. xiii (WCAB Panel decision).

The WCAB, rescinded a WCJ's finding that denied award of attorney's fees under Labor Code §4607, where it found that defendant insurer's failure to provide a medical provider network (MPN) in which applicant would be able to obtain treatment without undue difficulty constituted constructive institution of unsuccessful proceedings to terminate the WCAB award for continuing medical treatment to applicant. Such conduct warranted the Board, pursuant to Labor Code § 4607, to determine amount of attorney's fees reasonably incurred by applicant in resisting proceeding to terminate medical treatment and to assess such fees as costs against defendant, when it found that the defendant, after creation of its medical provider network, stopped paying the non-network physician with whom applicant had been treating, that First Health, on behalf of defendant, gave applicant list of network physicians, that applicant contacted every physician on list, and found that none of those physicians would treat her.

Smith v. State of California, California Youth Authority, (2006) Cal. Wrk. Comp. P.D. LEXIS 12. **REVERSED**, see p. 66.

The majority of a WCAB panel affirmed a WCJ's finding that Labor Code § 4607 did not allow for award of attorney's fees where applicant had an award for medical treatment of a June 1997 neck, shoulder and psyche injury, and in 12/2004 applicant had injured his lower back at home. Applicant's physician had sought authorization from defendant for epidural injections as part of 1997 award of future medical treatment, and defendant denied authorization contending that the need was due to the 2004 back injury not the 1997 work injury. Applicant had initiated proceedings before WCAB to obtain authorization. WCJ directed the parties to use same agreed medical evaluator as had been used in proceedings that led to 1997 award, and that agreed medical evaluator opined that epidural injections in low back were covered by 1997 award. Applicant's request for attorney's fees for services rendered in obtaining this treatment was not authorized by Labor Code § 4607 because, defendant here was not seeking to terminate medical care but merely questioning whether epidural injections were reasonably required to cure or relieve applicant from effects of the admitted industrial injuries to his right shoulder and neck. (Accord: *Stranahan v. California Highway Patrol*, (2006) Cal. Wrk. Com. P. D. LEXIS 38.)

C. PPO Agreement limiting reimbursement to providers

D. Treatment costs for services prior to OMFS coverage:

Roberson v. Select Temporary Services, Atlantic Mutual Insurance Company, (2006) 34 C.W.C.R. 190 (WCAB Panel decision).

Applicant sustained injury to his back and right shoulder on April 2, 1998. Medical treatment, including a September 9, 2009 shoulder surgery was furnished by the insurer. The facility where the shoulder surgery was performed, Point Loma Surgical Center, billed \$17,500 for use of its facilities for the procedure. Defendant paid \$3,746.42. Point Loma filed a lien for the balance. All other disputes were resolved. The reasonable value of the services of Point Loma was tried, and testimony received from an attorney heading defendant's bill review company, and a comparative study was offered by lien claimant. The WCJ found that while the Official Medical Fee Schedule (OMFS) for ambulatory surgery center charges was not effective until January 1, 2004, its guidance could reasonably be applied to services provided before that date. He ordered that the charges be adjusted in accordance with the fee schedule. Lien claimant sought reconsideration. The WCJ reported that the OMFS was adopted 113 days after the date of service, and there was no evidence of change in the value of services in the interim. He further reported that neither lien claimant nor defendant had offered substantial evidence of reasonable value, but defendant's expert showed that lien claimant's charges were excessive. The WCAB denied reconsideration, adopting the report and recommendation as its basis for decision.

E. Second opinion on spine surgery (Labor Code Section 4062(b))

Brasher v. State Compensation Insurance Fund, (2006) 71 Cal. Comp. Cases 1282; 34 C.W.C.R. 263 (WCAB significant panel decision).

Applicant sustained injury to her spine on April 22, 2002. On February 10, 2006, applicant's treating physician requested authorization to implant a spinal cord stimulator. Defendant submitted the recommendation and obtained a timely Utilization Review denial. On February 21, 2006, defendant filed an Objection to Treating Physician Recommendation for Spinal Surgery (DWC Form 233) with the Administrative Director. The medical unit did not supply a 4062(b) second opinion physician, but advised the defendant that the applicant had to appeal the UR denial by having the treating physician file an appeal if the physician still wishes to continue with the appeal. Only after this second round would the time (10 days) to request a second opinion physician run. On March 3 the treating physician again recommended the surgery, and on March 24, the defendant again objected. On April 4, the medical unit appointed Dr. Benjamin Shortz to provide the second opinion. Applicant requested an Expedited Hearing which was held on April 18. The WCJ found the defendant's conduct timely, and the action requiring the treating physician's review and comment or re-recommendation after review of the UR denial to be contemplated by Labor Code §§ 4062 and 4610. The medical unit's actions through appointment of Dr. Shortz were therefore appropriate and timely. Decision on the need for surgery was deferred pending receipt of Dr. Shortz opinion. Applicant sought reconsideration contending that the medical unit should have appointed the second opinion physician without requiring a second recommendation by the treating physician. Applicant further contended that the medical unit's failure to timely act should result in defendant being liable for the procedure.

The Board granted reconsideration for study. It held that in response to a treating physician's recommendation of spinal surgery, a defendant has options of (1) authorizing the surgery, (2) objecting to surgery pursuant to Labor Code §4062(b) and filing the DWC Form 233 within ten days of receipt of the recommendation, (3) submitting the recommendation for Utilization Review, (4) pursuing both option (2) and (3) either simultaneously or in timely succession. If defendant denies surgery pursuant to a timely utilization review, applicant must object within ten days of the denial, and the matter then goes for resolution under Labor Code §4062(b). It noted that where utilization review is invoked to review a recommendation for spinal surgery, there was an apparent conflict between Labor Code Sections 4062(b) and 4610(g) (3) (A). The Board found that the medical unit's failure to provide a second opinion physician upon receipt of defendant's first filing the DWC Form 233, delayed commencement of the 45 days for resolution of the dispute, and was an unwarranted obstacle for the employee seeking surgery. The Board held that in many instances an employer may not choose to invoke UR because there is no provision for an employer to dispute its UR physician's recommendation, and a non-examining UR opinion authorizing surgery precludes its right to a second opinion by a California board certified or eligible specialist. Further UR may prove untimely, preventing the employer from making a timely 4062(b) objection. Here, defendant met its obligations on a timely basis, and the process should continue to allow completion of the record with the second opinion physician's report.

XI Medical Legal, QME Process:

A. Labor Code Section 4062.

Cortez v. Workers' Compensation Appeals Board, (2006) 136 Cal. App. 4th 596; 71 Cal. Comp. Cases 155 (Court of Appeal, Second Appellate District).

Mr. Cortez suffered an injury to his back arising out of and occurring in the course of his employment on June 29, 1999. The employer provided medical treatment, and an orthopedic consultation. Following the consultation, the parties entered into stipulations with request for award based on the recommendation of the orthopedic consultant. It was stipulated that further medical treatment was required, and that a specific AME would be used if treatment of more than conservative nature were disputed. Subsequently, applicant filed a petition to reopen alleging new and further temporary disability and injury to the psyche. The orthopedic AME found further permanent disability. Defendant offered applicant agreed medical examiners in psychiatry, and when no agreement was reached, arranged a defense QME in psychiatry.

Applicant's counsel advised that his client would not attend the defense QME because SB899 had repealed the QME procedure for represented injured employees, and the new procedure provided by the legislation was expressly applicable only to employees with injuries on or after January 1, 2005. Defendant then re-scheduled the evaluation and filed a petition for order to compel attendance or suspend proceedings. The matter was set for conference, and after hearing, the WCJ ordered applicant to attend, citing Labor Code Section 5701. Applicant sought removal contending

Nunez v. Workers' Compensation Appeals Board, (2006) 136 Cal. App. 4th 58; 71 Cal. Comp. Cases 161 (Court of Appeal, Second Appellate District).

Applicant was injured on July 15, 2002. She was represented by counsel, and when a dispute arose over scope of medical treatment, applicant's counsel and defendant did not agree to an agreed medical evaluator. Defendant scheduled a QME evaluation to be performed by Dr. Zapanta. On January 10, 2005, defendant requested applicant submit to re-evaluation by Dr. Zapanta; applicant did not attend. On January 25, 2005 defendant filed a "Petition for Order Compelling Attendance at Medical Examination," and a proposed order for the WCJ's signature. The order directed applicant to attend a rescheduled examination or suffer proceedings to be suspended pursuant to Labor Code §4054. The Petition was filed at a walk through on January 26, 2005, and the WCJ signed the proposed order, striking the warning that proceedings were subject to suspension if applicant failed to attend the examination. Applicant sought reconsideration or removal. The WCJ recommended that the petition be denied based on *Simi v. Sav-Max Foods, Inc.*, (2005) 70 Cal. Comp. Cases 217 (WCAB en banc) (*Simi*). *Simi* held that the new procedure under SB899's amendment to Labor Code §§ 4060 and 4062 for selecting

QME's in represented injured workers' cases applied by its terms only to injuries on or after January 1, 2005. Therefore, to prevent a void in access to QMEs, the prior statutes continue to apply to selection of QMEs in represented injured cases where the date of injury was on or before December 31, 2004. The Board dismissed the petition for reconsideration and denied removal. Applicant filed a petition for writ of review.

The Court found that the Board's rationale in *Simi* was correct. The Court also found that the walk through procedure did not deny due process where applicant had time to present her petition for removal or reconsideration after the order issued, and did so. The order was affirmed.

Ward v. City of Desert Hot Springs, (2006) 71 Cal. Comp. Cases 1313; 34 C.W.C.R. 266 (WCAB Significant Panel Decision).

Applicant claimed a cumulative psychiatric injury from work through June 8, 2005. Defendant arranged an evaluation by Dr. Stuart Meisner, Ph.D.; applicant on advice of counsel declined to attend the evaluation. Applicant's counsel contended that for injuries after January 1, 2005, Labor Code §§ 4060(c) and 4062.2 precluded the evaluation defendant had arranged, and required the parties to either agree to an AME or select a QME from a panel furnished by the medical unit. Defendant sought an order compelling attendance at the requested evaluation pursuant to Labor Code §4064(d). After hearing the WCJ denied the petition, noting that the procedures in Labor Code §§ 4060(c) and 4062.2 were mandatory, and could not be circumvented by an evaluation under Labor Code Section 4064(d). Labor Code §§4060(c) and 4062.2(a) state that medical evaluations "shall be obtained only" by the procedure that the sections specify. The failure to amend Labor Code §4064(d) when the procedures for medical legal evaluation of represented injured workers was amended by SB899 creates a conflict, and the more recently amended statutes prevail. Any report on compensability obtained under Labor Code §4064 is inadmissible. The Board denied defendant's petition for removal and dismissed defendant's petition in the alternative for reconsideration.

XII Liens and Lien Claimants:

Paramount Farms v. Workers' Compensation Appeals Board (Lopez), (2006) 71 Cal. Comp. Cases 1397; 34 CWCR 291 (Court of Appeal, Fifth Appellate District, unpublished)

Applicant sustained injury to his right index and middle fingers on September 21, 2002. The case in chief was resolved by compromise and release(C&R) approved on August 30, 2004. The C&R provided that defendant would hold applicant harmless on liens of Accident Help Hotline, Valley Interpreting, and Employment Development Department (EDD). The Valley Interpreting lien in the sum of \$12,084.33 was for 103 sessions of chiropractic treatment or physical therapy from October 31, 2002 through

September 5, 2003. After lien hearing, the WCJ reduced the liens, and awarded the reduced amounts against Paramount Farms, pursuant to the hold harmless agreement. She awarded Valley Interpreting \$90 per session for sessions between November 19, 2002 and September 5, 2003. Paramount Farms sought reconsideration from the award of the EDD and Valley Interpreting liens. The WCAB denied reconsideration, adopting the WCJ's report and recommendation as the basis for its decision. Paramount filed a Petition for Writ of Review.

The Court of Appeal declined to "unravel" the C&R to let defendant out of its hold harmless agreement as to the EDD lien. It did reverse and remand the allowance to Valley Interpreting finding that "the WCAB did not sufficiently state the evidence relied upon and specify in detail [as required by Labor Code §5908.5, the basis for] its award for interpreter fees" of over \$12,000.00.; and remanded the issue to the WCAB "to conduct any further proceedings as it deems appropriate, including granting reconsideration and taking additional evidence or briefing."

The Court stated:

"While not clear, the WCAB appears to have found interpreting services performed at Accident Helpline reimbursable under WCAB Rule 9795.3, subd. (a)(2). Pursuant to the cross-referenced regulation in that subdivision, a 'comprehensive medical-legal evaluation,' a 'follow-up medical-legal evaluation,' or a 'supplemental medical-legal evaluation' must result in a 'narrative medical report prepared and attested to' by the examining physician. (Cal. Code. Regs, tit. 8, §9793, subds. (c), (f), & (l).) However, according to Paramount Farms, no narrative medical reports were prepared in the vast majority of Lopez's visits with Accident Helpline. Apparently, the WCAB nevertheless considered Lopez's repeated physical therapy appointments with Accident Helpline follow-up medical-legal evaluations eligible for reimbursable translation services.

"Based on our preliminary review of WCAB Rule 9795.3, we agree with Paramount Farms that if Accident Helpline did not produce narrative medical reports for Lopez's visits, then Paramount Farms was not required to pay for interpreting services at those visits which it did not authorize."

Zenith Insurance Co. v. Workers' Compensation Appeals Board (Capi), (2006) 138 Cal. App. 4th 373; 71 Cal. Comp. Cases 374 (Court of Appeal, Fourth Appellate District).

Applicant sustained a back injury on January 11, 2002. He received outpatient treatment from a number of providers, including Beach Cities Surgery Center (Beach Cities) and Pain Intervention Therapy of San Diego (PIT). Applicant's case in chief was settled, leaving disputes between Beach Cities, PIT and Zenith over claims for facilities fees. At lien conference Zenith advised that it contested Beach Cities' and PIT's entitlement to any reimbursement because they were not properly licensed, that it had filed civil litigation against Beach Cities and PIT, and requested a stay to allow discovery

and to allow the civil litigation to proceed to resolution. The WCJ denied the request for stay. After trial, the WCJ allowed Beach Cities \$22,100 and PIT \$24,000. Zenith sought reconsideration contending the stay should have been granted, and that Beach Cities and PIT had not met their burden of proof of entitlement because they failed to prove that they were properly licensed or accredited. The WCJ recommended reconsideration be denied because the issues were not framed at time of trial, and because defendant should not be allowed to shift the burden of proof of objection to a defect in licensing or accreditation to lien claimants. The Board denied reconsideration adopting the WCJ's report as its basis.

The Court of Appeal annulled the decision. It noted that the burden of proof of an issue in workers' compensation rests with the party or lien claimant "holding the affirmative of the issue." Where the injured worker does not prosecute his claim, the lien claimant bears the burden of proof of injury, entitlement to benefits, and reasonable value of services. These elements include requirement that the lien claimant prove the services were properly provided. It is unlawful under the Health and Safety Code to operate an outpatient medical facility, including an ambulatory surgical center or surgical clinic, without proper licensure or accreditation. In order to establish a right to reimbursement, the lien claimants had the burden of proving they were properly licensed or accredited. Here, they failed to do so. Therefore, the Board's award was not supported by substantial evidence. Zenith's failure to artfully or particularly frame the issue did not obviate the duty of the lien claimant to meet its burden of proof. The Board decision was annulled.

Premier Medical Management Systems, Inc. v. California Insurance Guarantee Association, (2006) 136 Cal. App. 4th 464; 71 Cal. Comp. Cases 210 (Court of Appeal, Second Appellate District).

Premier Medical Management Systems, Inc. (Premier) bills for and represents in lien proceedings before the Workers' Compensation Appeals Board five physicians who provided treatment to injured workers for numerous work injuries. California Insurance Guarantee Association (CIGA) assumes liability for covered claims of liquidated workers' compensation insurers which had been licensed to do business in California. In September 2002 Explorer Insurance Company (Explorer) and Insurance Company of the West (ICW) sought consolidation of cases involving their liabilities to Premier. Explorer and ICW contended that Premier and its associates were engaged in an unlawful fee sharing and referral practices, prohibited by Business and Professions Code §650, making their practice of medicine, chiropractic, and physical therapy unlawful. Explorer and ICW also contended that Premier had a pattern of making improper and excessive charges. Over Premier's objection, the WCAB ordered consolidation, and ordered the liens stayed. Premier and five member physicians responded by filing a civil suit alleging violation of the Racketeer Influenced and Corrupt Organizations Act, and other state and federal code violations, and negligent interference. The suit named as defendants CIGA, Explorer and ICW, and 18 other insurers or permissibly self insured employers. Ten of the defendants joined in a motion to strike the complaint as a "anti-SLAPP lawsuit." The trial court denied the motion to strike. Defendants appealed.

To prevail in an “anti-SLAPP” motion, the court must find that defendant has shown that the challenged cause of action arises out of protected activity, and if that test is met, that the plaintiff has not demonstrated a probability of prevailing on its claim. Free speech is one of the protected activities. Defendants contend that Premier’s entire suit is subject to dismissal under the anti-SLAPP statute because all of the conduct complained of consists of defendant’s acts and communications in defending their positions in proceedings before the Workers’ Compensation Appeals Board. Premier contended that the conduct underlying its complaint was anticompetitive activity occurring outside the normal claims handling process.

The Court noted that the only anticompetitive activity alleged by Premier was not complained of in the complaint. To avoid dismissal, “plaintiff must demonstrate that the complaint is legally sufficient and supported by sufficient prima facie showing of facts to sustain a favorable judgment if the evidence is credited.” The Court was convinced that the suit resulted from defendants’ efforts in litigating lien claims before the Workers’ Compensation Appeals Board. The motion therefore met the first test. Defendants asserted affirmative defenses to each of Premier’s causes of action. Seeking redress from a court or administrative agency is free speech, and privileged under Civil Code §47 or the *Noerr-Pennington* doctrine. The Court concluded that defendants’ conduct was privileged activity, and defendants had demonstrated a probability of prevailing upon this defense. Therefore, the order of the trial court denying dismissal was reversed. Moving defendants were allowed costs and fees on appeal.

XIII Vocational Rehabilitation:

Fresno Unified School District v. Workers’ Compensation Appeals Board (Butcher), (2006) 71 Cal. Comp. Cases 1391 (Court of Appeal, Fifth Appellate District, writ. den.)

The Rehabilitation Unit & WCJ found applicant’s claim for Vocational Rehabilitation barred by Labor Code Section 5410. Applicant had amended a petition to reopen within 5 years of date of injury to claim Vocational Rehabilitation. The WCAB reversed, finding Labor Code §5404.5 allowed the claim. By amending her Petition to Reopen her underlying disability claim to request VR before the last finding of permanent disability, applicant’s request was timely under former Section 5405.5. Section 5405.5 provided that an injured worker could initially request VR services within one year either from the last finding of permanent disability or from the approval of a compromise and release of other issues [see, e.g., *Youngblood v. WCAB* (1989) 216 Cal.App.3d 764, 772; *Sanchez v. WCAB* (1990) 217 Cal.App.3d 346, 354]. (Although Section 5405.5 was repealed effective January 1, 2004, and has not been reenacted, subdivision (f) of Section 139.5, as reenacted by SB 899, states: “The time within which an employee may request vocational rehabilitation services is set forth in former Section 5405.5 and Sections 5410 and 5803.”)

Paramount Farms v. Workers' Compensation Appeals Board (Velasquez), (2006) 71 Cal. Comp. Cases 1406; 34 C.W.C.R. 293 (Court of Appeal, Fifth Appellate District, unpublished)

Applicant (Velasquez) sustained industrial injuries to her neck and left upper extremity on June 1, 2001, and cumulatively through September 20, 2001 while employed by Paramount Farms (Paramount). Paramount agreed that Velasquez was entitled to vocational rehabilitation (VR) and the parties selected Metropolitan to serve as the qualified rehabilitation representative (QRR). Thereafter, however, Velasquez interrupted VR for about two years. During these two years, Paramount “developed a problematic relationship” with Metropolitan on “multiple other cases.” Therefore, when in July or August 2005 Velasquez resumed VR, Paramount asked her to agree to a new QRR. When there was no informal agreement, Paramount filed an RU-103 asking the rehabilitation unit (RU) to appoint an independent vocational evaluator (IVE). The RU, after a rehabilitation conference issued a determination and order denying that request. Paramount appealed to the WCAB. The WCJ granted Paramount’s appeal, annulled the Determination and Order, and ordered the RU to appoint an IVE, pursuant to Rules and Regulations of the Administrative Director § 10127.2 [requiring the RU to appoint an QRR within 15 days of being requested “whenever” a dispute arises]. However, the WCJ also concluded that the delay in VR services was due to Paramount’s “squabble with the previously-acceptable” QRR. Therefore, he awarded Velasquez Vocational Rehabilitation Maintenance Allowance (VRMA) at the temporary disability indemnity (delay) rate outside the \$16K cap. The WCAB denied Paramount’s recon; Paramount filed a Petition for Writ of Review.

Preliminarily, the Court pointed out that although AB 227 and SB 899 eliminated VR for injuries on or after 1/1/04, the repealed Vocational Rehabilitation statutes – including 4642 – remain applicable to pre-1/1/04 injuries. In support of this, the Court cited to *Godinez v. Buffets, Inc.*, (2004) 69 Cal. Comp. Cases 1311 (Significant Panel Decision) and quoted its statement: “[E]ven though these sections were repealed in 2003 and not reenacted in 2004, they still have a shadowy existence for injuries prior to January 1, 2004. Like ghosts ‘doomed for a certain term to walk to the night’ (*Hamlet I, v*), these statutes have no material existence but linger until their work is done.”

Paramount argued that it was not liable for VRMA at the TD rate because the delay in VR was due to the RU’s failure to appoint an IVE within 15 days of Paramount’s request (i.e., it was powerless to appoint an IVE itself, and the RU’s failure to appoint on was an unforeseeable supervening cause). The Court rejected Paramount Farms’ argument that it was the RU by failing to appoint an IVE, not Paramount Farms, that caused the delay. The Court stated:

“Paramount Farms overlooks the obvious. The parties previously agreed that Metropolitan would provide Velasquez with vocational rehabilitation services. After Velasquez requested to reinitiate vocational rehabilitation, Paramount Farms *unilaterally* chose not to reengage Metropolitan. Moreover, Paramount Farms’ reasons for refusing to work with Metropolitan had no correlation with Velasquez’s case; Paramount Farms

admits in its Petition for Writ of Review that it sought a new vocational rehabilitation vendor because it 'developed a problematic relationship with Metropolitan, the QRR, *on multiple other cases.*' (Emphasis added.) While Velasquez could have agreed to another QRR, she did not, and as the WCJ explained, Velasquez was under no legal obligation to do so after having previously agreed on Metropolitan. The WCAB's determination the delay was caused by Paramount Farms' own actions is well-supported by the record."

As to the contention that the RU action was an unforeseeable supervening cause, the Court also rejected the argument, stating:

"... Paramount ... again overlooks the obvious. On November 23, 2005, the WCJ issued his findings and ordered the Rehabilitation Unit to 'promptly appoint an Independent Vocational Evaluator unless the parties are able to agree on reinstatement of the agreed QRR or selection of an agreed successor.' On December 16, 2005, Paramount Farms placed the validity of that order in question by filing a Petition for Reconsideration. After the WCAB denied reconsideration on January 20, 2006, Paramount Farms filed the present Petition for Writ of Review with this court. The WCJ's order therefore was never final ... The Rehabilitation Unit's alleged failure to appoint an IVE for Velasquez is at least partially attributable to Paramount Farms' actions disputing the WCJ's decision. ... Were the issue properly before us, we would not agree with Paramount Farms that the Rehabilitation Unit's failure to appoint an IVE was an unforeseeable supervening cause that should relieve Paramount Farms from increased VRMA benefits."

Paramount Farms' Petition for Writ of Review was denied.

Gamble v. Workers' Compensation Appeals Board, (2006) 143 Cal. App. 4th 71; 71 Cal. Comp. Cases 1015 (Court of Appeal, Fourth Appellate District).

Gamble was concurrently employed as a freight agent for United Airlines and as a teacher and dean at the Los Angeles Unified School District (LAUSD). He sustained injury to his back in the course of his United Airlines employment, and was found to be medically eligible for vocational rehabilitation from the freight agent job. Applicant continued to be employed in his LAUSD job. The Rehabilitation Unit ordered provision of vocational rehabilitation. Defendant appealed. The Workers' Compensation Judge found the order to provide vocational rehabilitation was correct, but allowed defendant credit for earning at LAUSD against obligation for VRMA. Applicant sought reconsideration. The WCJ rescinded his decision and after further proceedings, affirmed the RU determination directing services and denying credit. Defendant sought reconsideration. A panel reversed the WCJ's decision and allowed the defendant credit for his second income against obligation for VRMA. Applicant sought review.

The court of appeal noted that partial temporary disability indemnity is calculated on a wage loss basis, and that two appellate cases carried that method of computation over into VRTD computation where applicant continued to be partially employed. It noted

that permanent partial disability is not subject to offset for wages, and that VRMA like permanent partial disability is payable after an employee reaches maximum medical improvement with residual impairment impacting employability. Had the legislature wanted VRMA to be subject to reduction for wages earned, it would have provided in Labor Code §139.5(d) language similar to that in Labor Code §4657. Wages earned at a separate job which pre-existed the injury and coexisted with applicant's employment at United are not grounds for refusing or reducing VRMA. The Board's decision was annulled and the matter remanded for further proceedings.

Enoch v. Workers' Compensation Appeals Board, (2006) 71 Cal. Comp. Cases 904; 34 C.W.C.R. 182 (Court of Appeal Fifth Appellate District, unpublished) .

Applicant sustained injury to his right shoulder on March 13, 1996. He returned to work in November 1997, and experienced increased symptoms. He left work in March 2001. On August 13, 2001, a physician reported that applicant was medically eligible for vocational rehabilitation. Vocational rehabilitation services were furnished until interrupted. On January 18, 2002 applicant requested to resume vocational rehabilitation. On January 31, 2002 applicant filed an Application for Adjudication of Claim alleging a cumulative trauma injury through March 2001. On May 4, 2002, applicant filed a request for dispute resolution (RU-103). Defendant did not respond to the request. The Rehabilitation Unit on June 9, 2004 ordered vocational rehabilitation maintenance allowance paid at the delay rate from August 31, 2001.

On June 17, 2004, defendant filed an appeal from determination and order of the rehabilitation unit listing in the caption the WCAB case number for the cumulative injury case. Defendant did not serve the appeal on the Rehabilitation Unit. Applicant contended the appeal was untimely due to filing with the wrong case number and failure to timely serve the Rehabilitation Unit. The WCJ agreed that failure to timely serve the Rehabilitation Unit was fatal to the appeal. Defendant sought reconsideration. The WCJ vacated his decision, because it had issued in the CT claim case. The WCJ then issued the same decision in the specific injury case; he noted that but for the procedural flaws, defendant's arguments might well have been valid. Defendant sought reconsideration.

The Board granted reconsideration and reversed, holding that the requirement that the Rehabilitation Unit be served with a copy of the appeal was not jurisdictional, and that use of the wrong case number was a "minor irregularity." Applicant sought review. The Court of Appeal in a memorandum opinion denied review holding that neither use of the wrong case number nor failure to serve the Rehabilitation Unit deprived the Board of jurisdiction where the appeal was timely filed. The Board had properly allowed to allow defendant to cure its failure to serve the Rehabilitation Unit. Not only did defendant use the wrong case number, but so did applicant, the hearing reporter, and the WCJ. The procedural errors, the court noted did not result in prejudice to any party.

Costa v. State Compensation Insurance Fund, (2006) 34 C.W.C.R. 225 (WCAB en banc)

After hearing, the WCJ submitted rating instructions requesting that the disability evaluation specialist rate the impairment described as a Qualified Medical Examiner, and consider 50% of the resulting disability to have been caused by / apportionable to the injury. The rater returned a formal rating of 6% after apportionment. Applicant's counsel requested cross examination of the rater. At that hearing, the rater testified that she had applied the future earning capacity (FEC) factor from the rating schedule, and had made no empirical study of her own as to the adequacy of the FEC. Ann Wallace, Ph.D., testified that applicant's earnings had been reduced by 50% by the effects of the injury, and an appropriate FEC adjustment to the impairment rating would have been between 315 and 50%. The WCJ refused to admit in evidence a report prepared by Dr. Wallace, a deposition of a co-author of the 2003 Evaluation of California's Permanent Disability Rating Schedule, a document referred to in Labor Code Section 4660(b)(2); a comparative study of ratings under the 1997 and 2005 rating schedules; or an article on differences in disability and impairment ratings. The WCJ awarded 6% in accordance with the rater's recommended rating, resulting in an indemnity of \$4,800.00, less attorneys' fee. Applicant sought reconsideration challenging adequacy of the FEC adjustment and contending that application of the 2005 schedule to pre-2005 injuries was inappropriate. The petition requested the Board to compel production of any empirical data supporting the table of FEC adjustments in the 2005 rating schedule. The Workers' Compensation Appeals Board granted reconsideration, assigned the matter for en banc decision, and on August 6, 2006, issued a Notice of Intention to admit the documentary evidence offered and excluded from evidence by the WCJ.

Aldi v. Carr, McClellan, Ingersoll, et. al., Republic Indemnity Co. of America, (2006) 71 Cal. Comp. Cases 783 (WCAB en banc).

Applicant sustained cumulative injury while employed as a legal secretary through November 18, 2002. At a hearing on January 6, 2006, the parties submitted for decision the issue of which rating schedule should apply to determine the permanent disability applicant sustained. The report of the case indicates that applicant sustained some temporary disability commencing in 2003, but does not indicate when that disability ended nor whether a comprehensive medical-legal report or report of the treating physician indicating existence of permanent disability issued.

The WCJ concluded that Labor Code Section 4660, as amended by SB 899, directed application of the 2005 rating schedule to pre-2005 injuries only if the Administrative Director adopted a revised rating schedule before the end of 2004. The Administrative Director had not adopted a revised schedule until January 1, 2005, and therefore all injuries occurring prior to January 1, 2005 were ratable only under the 1997 (old) rating schedule. Defendant sought reconsideration or removal.

The Appeals Board granted reconsideration and assigned the case for en banc decision. It found the issue a making the determination a final decision subject to reconsideration. It sets forth at length the WCJ's Opinion on Decision discussing Labor Code Section 4658, the SB899 amendment to Labor Code Section 4660, and his interpretation of Labor Code Section 4660(d) and (e), and three interpretations of Labor Code Section 4660(d). The WCJ had found the third interpretation he considered as the most reasonable because it "harmonizes and gives effect to each word in the second and third sentences." Under this interpretation, the revised schedule would have been applicable to pre-2005 injuries only if the revised schedule had issued before January 1, 2005. The Appeals Board noted that the second sentence of §4660(d), as amended, was carried forward from former §4660(c), and requires that any revision of the rating schedule apply prospectively and apply only to injuries incurred after the date of adoption of the revision. The Appeal Board went on to observe that the third sentence of §466(d), as amended, provides a clear and specific exception, and directs that the 2005 schedule apply in the absence of specified conditions set forth in the sentence. Thus, there is no conflict between the second and third sentences of §4660(d), as amended, but a general proposition set forth in the second sentence subject to an exception set forth in the third sentence. Further, the Appeals Board noted that provisions of SB 899 make clear that it was intended to apply prospectively from date of enactment to all injuries, regardless of date of injury, except as otherwise provided, and this intent had been carried into regulation in §9805 of the Rules and Regulations of the Administrative Director. The WCJ's Finding of Fact that all pre-2005 injuries were ratable under the 1997 schedule was rescinded, and the matter remanded for further proceedings to determine whether the any exception in the third sentence of §4660(d) applied.

Shayesteh v. Abbott Laboratories, (2006) 34 C.W.C.R. 330 (WCAB Panel decision).

Applicant sustained a work injury to her neck and back on July 29, 2004, which resulted in accepted liability for temporary disability from August 2, 2004 through June 12, 2005. Defendant paid temporary disability during that period. The WCJ determined permanent partial disability using the 1997 Schedule for Rating Permanent Disabilities. Defendant sought reconsideration contending that the injury became permanent and stationary in 2005, and should have been rated under the 2005 schedule. The Board affirmed the WCJ's application of the 1997 Rating Schedule, rather than the 2005 Rating Schedule where temporary disability commenced prior to January 1, 2005. WCAB concluded that applicant's duty to provide a Labor Code § 4061(a) benefit notice regarding payment of permanent disability was triggered as soon as temporary disability payments commenced On August 2, 2004, and, therefore, a condition of Labor Code § 4660(d) existed to trigger application of the 1997 Schedule.

Biller v. Workers' Compensation Appeals Board, (2006) 71 Cal. Comp. Cases 513 (Court of Appeal, First Appellate District, writ denied)

Applicant injured his low back on July 29, 2003. He underwent an applicant's QME evaluation by Dr. Bagherian on December 23, 2004. Dr. Bagherian found applicant's condition to be permanent and stationary on December 23, 2004, but his report was not signed or issued until after January 1, 2005. The WCJ relied upon Dr. Bagherian and applied the 1997 Permanent Disability Rating Schedule (PDRS). Defendant sought reconsideration. The Board granted reconsideration. The WCJ reported that the 1997 PDRS should apply because the date of evaluation rather than the date of issuance, particularly with the vagaries of transcriptionists schedules and holiday vacations, should control instead of date of issuance of the report. The Board noted that there was no comprehensive medical legal report and no report by the treating physician indicating existence of permanent disability. The majority of the panel felt the clear statutory language required application of the 2005 PDRS. Applicant filed a Petition for Writ of Review. The Court of Appeal noted the Writ was incomplete under California Rules of Court, rule 57 (a)(1)(B), and denied review.

Chilton v. Amulet Mfg. Co. & State Compensation Insurance Fund, (2006) Cal. Comp Cases advance sheets vol. 71 no. 10, p. xi. (WCAB Panel decision).

Applicant had admitted orthopedic and alleged internal injuries. She was referred to an internist who reported she had recovered from one internal medical condition, and was permanent and stationary from another internal medical condition which was wholly non-industrial. The WCJ found the internist's report was not a comprehensive report finding permanent disability within the meaning of Labor Code Section 4660(d), and obtained a rating of the work related disability under the 2005 PDR schedule. Applicant sought reconsideration. A majority of commissioners on a WCAB panel granted applicant's petition for reconsideration, rescinding WCJ's finding that 2005 rating schedule governed present case, and held that 1997 rating schedule governed industrial injury that occurred in 2003 because the internist's report issued on 10/27/2004, constituted a comprehensive medical legal report triggering an exception to use of the 2005 PDR schedule. The 2005 rating schedule applies when (1) there has been either no comprehensive medical-legal report, or (2) no report by treating physician indicating existence of permanent disability, or (3) employer is not required to provide notice to injured worker required by Labor Code § 4061.

Torres v. SDM Precision Products, State Compensation Insurance Fund, (2006) 34 C.W.C.R. 226 (WCAB panel decision)

Applicant was found to have sustained cumulative injury through August 31, 2002. Defendant's Labor Code 4060 evaluator had found in a March 18, 2004 report, that applicant had sustained no compensable injury. After other medical reports were obtained, the parties went an agreed medical examiner (AME) who, in a post-January 1, 2005, report opined that applicant had sustained injury AOE-COE, sustained temporary disability through March 1, 2004, and sustained permanent disability described in the report. After hearing, the WCJ found injury, awarded 16% permanent partial disability

based on objective and subjective factors of disability found by the AME, and found no liability for temporary disability. Applicant sought reconsideration contending that the work preclusions described by the AME should have been rated, that temporary disability should have been awarded, and that the rating should have been determined under the 1997 rating schedule. The WCAB granted reconsideration and rescinded WCJ's decision. It held that pre-SB 899 rating schedule applied to present case, in which industrial injury occurred in 2002 and in which defendant's evaluating physician issued AOE/COE report on 3/18/2004, even though that report found that applicant's injury was not industrial. The Board held that the post-SB 899 rating schedule applies only when (1) there has been either no comprehensive medical-legal report, or (2) no report by treating physician indicating existence of permanent disability, or (3) employer is not required to provide notice to injured worker required by Labor Code § 4061, and when WCAB found that defendant's evaluating physician's 3/18/2004 report was "comprehensive medical-legal report." Here the March 18, 2004 report was a comprehensive report requiring that the 1997 rating schedule be used in assessing extent of permanent disability.

XV Apportionment (including retroactive application of new statutes; "causation" apportionment; apportionment to prior rated disabilities.)

A. Labor Code Section 4663:

Franey v. Environmental Filtration, (2006) 34 C.W.C.R. 186 (WCAB Panel decision).

Applicant sustained a back injury on December 8, 1998. Medical treatment, including surgery, was furnished by Dr. John Lettice, M. D. The surgery consisted of multi-level laminectomy, and L5-S1 discectomy and fusion. Applicant was referred to an Agreed Medical Examiner (AME), Dr. Michael Klassen. Dr. Klassen found no significant pre-existing disability, impairment, or limitations, but noted that the L5-S1 fusion was provided to correct a spondylolisthesis. He opined that 30% of the permanent disability was due to the spondylolisthesis, because it "sets you up for back problems. The WCJ awarded 46% permanent disability after apportionment of 30% of the overall disability under Labor Code Section 4663. Applicant sought reconsideration. The WCJ set aside his award and awarded 65% permanent disability without apportionment. Defendant sought reconsideration. In his report and recommendation the WCJ noted that the AME did not discuss whether or why the surgery or post surgical outcome would likely have been different in the absence of the spondylolisthesis. The Workers' Compensation Appeals Board held that agreed medical evaluator's opinion apportioning 30-percent of applicant's permanent disability stemming from a 12/8/98 back injury to pre-existing asymptomatic spondylolisthesis, did not constitute substantial evidence to support a finding of apportionment, when agreed medical evaluator did not adequately explain how and why the pre-existing condition caused applicant's current disability or provide a basis for his 30-percent apportionment.

E. L. Yeager Construction v. Workers' Compensation Appeals Board (Gatten), (2006) 34 C.W.C.R. 319 (Court of Appeal, Fourth Appellate District, ordered published, 12/15/06)

An "independent medical examiner" opined that 20% of applicant's permanent disability was a result of pre-injury degenerative disc disease which had cause episodic minor pain prior to the injury. The WCAB on reconsideration found the apportionment unsupported. Defendant sought review. The Court of Appeal noted that the standard set forth in Escobedo v. Marshalls, (2005) 70 Cal. Comp. Cases 604, is an appropriate interpretation of Labor Code Section 4663. In this case however, the court felt the opinion of Dr. Akmakjian pointing to prior symptoms did support the recommended apportionment, and reversed the Board's decision.

Kien v. Episcopal Homes Foundation, (2006) 34 C.W.C.R. 228 (WCAB panel decision)

Applicant injured her left knee on September 6, 1999. On November 15, 2000 the parties submitted stipulations with request for award providing for 36% permanent partial disability and further medical treatment; apportionment was not expressly addressed. The Stipulations were approved on December 14, 2000. On November 19, 2001 applicant filed a petition to reopen for new and further disability. Applicant's knee condition progressed to the point where, on November 17, 2003, she underwent a total knee replacement surgery. Applicant's condition was found permanent and stationary in August 2004. The parties AME opined that applicant had degenerative arthritis prior to the work injury, and that made injury more likely and more difficult to relieve following an injury; re recommended that 25% of the permanent partial disability be apportioned to the pre-existing arthritis. The WCJ awarded permanent disability without apportionment. The Board granted reconsideration and concluded that the WCJ's decision should be affirmed. It held that SB 899 provisions could not be applied retroactively to recalculate the level of permanent disability or revisit issue of apportionment determined under prior Stipulated Award. It also held that the apportionment to the pre-existing arthritis was invalid where the arthritic joint had been replaced as reasonable and necessary treatment of the work injury.

B. Labor Code Section 4664:

Kopping v. Workers' Compensation Appeals Board, (2006) 142 Cal. App. 4th 1099, 34 C.W.C.R. 251 (Court of Appeal, Third Appellate District).

Applicant sustained a back injury in employment by the California Highway Patrol in 1996. The injury resulted in 29% permanent partial disability. In 2002 he sustained another back injury and an AME opined that applicant had recovered from the 1996 injury and now had disability which rated 27%. After trial the WCJ found that applying Labor Code Section 4664(b) applicant had no ratable permanent disability as a result of the 2002 injury. Applicant sought reconsideration, and the Board granted reconsideration and rescinded the WCJ's decision. The Board noted that Sanchez and Strong require that

prior disability be presumed to continue, and overlapping disability be apportioned out. It found that the AME's report, issued before the effective date of SB899, was inadequate, and ordered development of the record. Applicant sought review.

The Court found that the succeeding sentences in Labor Code §4664(b) do not impose burdens on different parties (as indicated in *Sanchez*), it is not for the employee to disprove overlap, but for the defendant to establish both the existence of a prior award and extent of overlap of the disabilities. The statute prevents the employee from showing medical rehabilitation.

Pasquotto v. Hayward Lumber, (2006) 71 Cal Comp. Cases 223 (WCAB en banc). [Petition for writ filed 4/12/06 as *Hayward Lumber v. Workers' Compensation Appeals Board(Pasquotto)*]

Applicant sustained a low back injury on May 9, 1998. MRI testing showed moderate degenerative changes at L4-5, L5-S1, and disc herniations at L5-S1, L4-5, and L3-4. A CT scan confirmed the MRI, and showed disc bulges at each level from L2 to S1. In 1999, applicant and his employer's compensation carrier entered into a compromise and release agreement for \$35,000, less credit for P.D. advances. On October 15, 1999 a WCJ issued a Order Approving Compromise and Release. Applicant was hired by Hayward Lumber as a driver on October 19, 1999. In December 2001 applicant further injured his back while he and a co-worker were delivering a 10' by 4" strong wall. On August 2, 2002 applicant sustained another work injury to his back when bending to move some lumber. In 2003 applicant underwent a left L5-S1 microdiscectomy. In 2004 one QME was of the opinion that applicant had permanent disability precluding heavy work, and that half was apportionable to the 1998 injury and half to the injuries at work for Hayward Lumber. The treating physician reported that applicant had permanent disability precluding heavy work, was limited to lifting no more than 30 pounds, and should avoid repetitive bending, all of which disability was caused by the injuries at Hayward Lumber.

After trial the WCJ instructed that applicant had present disability as described by the treating physician, and that apportioned from that should be a preclusion from heavy work due to the 1998 injury. The disability evaluation specialist found that all of the applicant's disability was apportioned out to the 1998 injury, leaving a rating of 0% for these injuries. The WCJ then issued a joint F&A finding, in part, that applicant was not entitled to a permanent disability award for the 2001 and 2002 injuries. The opinion and findings were ambiguous as to whether the apportionment was made pursuant to Labor Code Section 4663 or 4664. The opinion indicated that defendant had established existence of a prior award of permanent disability within the meaning of Labor Code §4664(b) which was conclusively presumed to still exist. Applicant sought reconsideration contending the SB899 changes to apportionment should not be applied because the injuries occurred prior to 2004, that Labor Code Section 4664 (b) was inapplicable because there was not prior award, or if it were applicable that it created a rebuttable presumption which was rebutted by the medical evidence. The Board granted

reconsideration, obtained additional briefs on applicability of Labor Code Section 463, as amended, and assigned the matter for en banc decision.

The Board held that an Order Approving Compromise and Release, without more, is not an award of permanent disability within the meaning of Labor Code Section 4664. It noted that there was no stipulation to a degree of permanent disability nor a segregation or specification of how much of settlement proceeds were consideration for permanent disability indemnity. Moreover to allow extrinsic evidence of the parties intentions (even if consistent) would result in delays and expenses inconsistent with the mandate that compensation proceedings “accomplish substantial justice... expeditiously...” The Board further held that lack of a prior award did not preclude apportionment to the prior work injury under Labor Code Section 4663, but for causation of disability under §4663, the concept of medical rehabilitation was available. The WCJ’s decision was reversed and the matter remanded to determine whether the recommended apportionment was valid or the applicant’s claims of medical rehabilitation credible.

C. Computation of indemnity for successive injuries:

Nabors v. Workers’ Compensation Appeals Board, (2006) 140 Cal. App. 4th 217; 71 Cal. Comp. Cases 704 (Court of Appeal, First Appellate District).

Danny Nabors sustained a low back injury on May 2, 1996, for which he received a stipulated award of 49% permanent partial disability issued in 2001. That disability resulted in an award of \$42,476. While employed by the same employer, Mr. Nabors sustained cumulative injury to his low back through August 19, 2002. When permanent and stationary after the cumulative injury applicant was limited to sedentary work with use of a cane. The cumulative injury case was tried on September 29, 2004, after enactment of Labor Code Section 4664 (effective April 19, 2004). The WCJ issued rating instructions directing that 49% be apportioned to the 1996 injury pursuant to the 2001 award. The disability evaluation specialist reported that the current disability rated 80% before apportionment and a net of 31% after subtraction of the percentage of disability in the 2001 award.

Applicant sought reconsideration contending that with the repeal of former Labor Code Section 4750, *Fuentes v. Workers’ Compensation Appeals Board*, (1976) 16 Cal. 3rd 1, 41 Cal. Comp. Cases 42 (*Fuentes*), contending that determination of apportionment by subtracting the percentage of disability not due to the current injury from the percentage of disability before apportionment, and awarding compensation based on the percentage of disability that is the remainder [i.e. the net after subtraction]) was no longer controlling. The case was assigned for decision by the Board *en banc*.

The Board noted that the language of new Labor Code Sections 4663(c) and 4664(b) mandates that the percentage of non-industrial or previously awarded industrial permanent disability be subtracted from the overall percentage, and that the employer shall only be liable “for the ‘percentage of permanent disability’ directly caused by the

new industrial injury.” (70 Cal. Comp. Cases 856, at 861.) The Board stated that the repeal of Labor Code Section 4750 did “not change the Legislative intent underlying apportionment statutes.” (70 Cal. Comp. Cases 856, at 862.) The Board (split 4 to 2) concluded that:

“When the WCAB awards permanent disability after apportionment, the amount of indemnity due applicant is calculated by determining the overall percentage of permanent disability and then subtracting the percentage of permanent disability caused by other factors under section 4663(c) or previously awarded under section 4664(b); the remainder is applicant’s final percentage of permanent disability for which indemnity is calculated....” (70 Cal. Comp. Cases 856, at 862.)

Chairman Rabine dissented contending that Formula B (entitling applicant to 31/80ths of the indemnity payable on an 80% award) from the *Fuentes* case should be applied; that percentage in Labor Code Sections 4663(c) and 4664(b) did not have the same meaning as percentage in Labor Code Section 4658. Commissioner Caplane dissented opining that applicant should be award the difference in indemnity between the current overall disability and the amount of the prior (31%) award. [Interestingly, the all of the commissioners on the panel which had previously followed Commissioner Caplane’s formula in the Board’s January 5, 2005 decision in *Dykes* were in the majority, calling for application of the *Fuentes* formula in this case.] Applicant sought review.

The Court of Appeal granted review. It noted that while the petition for writ was pending, the Court of Appeal, Fifth District, had issued its opinion in *E & J Gallo Winery v. Workers’ Compensation Appeals Board (Dykes)*, (2005) 134 Cal. App. 4th 1536, 70 Cal Comp. Cases 1644, (*Dykes*) holding that where an employee sustains multiple injuries while working for the same self insured employer, the employee is entitled to compensation for the total disability, less credit for the prior awards. The Court found that nothing in the record or briefings persuaded it from diverging from the reasoning and results in *Dykes*. The Court reviewed the *Dykes* decision and rationale at length, and found no basis for limiting its application to injuries in the course of employment by a single self insured employer. The Court rejected contentions by CWCI that SB899 intended to limit application of the *Wilkinson* doctrine, and that any combination of disabilities from successive injuries violated Labor Code Section 3208.2. The Court set aside the Board’s determination, and directed that applicant be awarded indemnity and life pension based on an overall 80% disability

E & J Gallo Winery v. Workers’ Compensation Appeals Board (Dykes), (2005) 134 Cal. App. 4th 1536; 70 Cal Comp. Cases 1644 (Court of Appeal, Fifth Appellate District).

As indicated above this is a 2005 decision. It was discussed in the 2006 DWC Educational Conference, and is included here to show the line of authority competing with *Nabors*, *Brophy*, *Welcher*, etc.

David Dykes injured his back in September 1996 in the course of work as a winery employee for E & J Gallo Winery (Gallo). A stipulated award of 20½% permanent partial disability

resulted in payment to him of \$11,680 in indemnity. In January 2002, Mr. Dykes' condition had improved and he testified that the restrictions previously imposed for his back injury were lifted.

In October 2002, Mr. Dykes again injured his back. He was found to have an overall spinal disability rating 73% before apportionment. If entitled to an unapportioned award, applicant would have received \$230 per week for 453.5 weeks [and thereafter a life pension of 19.5% of \$257.69, but the court opinion does not mention the life pension until late in the decision.] The indemnity for 453.5 weeks at \$230 per week is \$104,305.00. The WCJ awarded that sum allowing credit for the \$11,680.00 pain on the prior award. Defendant sought reconsideration contending that pursuant to Labor Code Section 4664 the prior award of 20½% disability should have been subtracted from the overall 73% disability and indemnity awarded based on 53% disability after apportionment. The WCJ submitted a Report and Recommendation reiterating her calculation without addressing the calculation issue. On January 5, 2005, prior to issuance of the Board's en banc decision in *Nabors v. Piedmont Lumber & Mill Co.*, (2005) 140 Cal. App. 4th 217; 70 Cal. Comp. Cases 856 (*Nabors*), the Board denied reconsideration, incorporating the report and recommendation as the basis for its decision. Defendant filed a Petition for Writ of Review.

The Court of Appeal granted review. It noted in its opinion that it was determining the appropriate method of apportioning liability between injuries as "conjured" by the Legislature. It noted that SB899 was enacted and became effective on April 19, 2004, as a comprehensive plan to reform the workers' compensation system. The reforms included provisions to amend the standards of apportionment. Under pre-SB899 law, apportionment was concerned with pre-existing or independently progressing disability. Under SB899, apportionment was concerned with cause or pathology. (Citing *Marsh v. Workers' Compensation Appeal Board*, (2005) 130 Cal. App. 4th 906, 70 Cal. Comp. Cases 787. (*Marsh*)) Under prior law, an employer could be liable to the full extent an industrial injury accelerated, aggravated, or lighted up a nondisabling preexisting disease, condition or physical impairment. Former Labor Code Section 4750 prevented an industrially injured employee suffering from a previous permanent disability or physical impairment from receiving a workers' compensation award greater than he or she would otherwise receive for the later injury alone. The prior law limited the employer's liability to only "that portion due to the later injury as though no prior disability or impairment had existed." Under post SB899 law, apportionment is "based on causation and the employer shall only be liable for the **percentage** of the permanent disability directly caused by the injury arising out of and occurring in the course of employment." (Slip decision page 4, Labor Code Sections 4663(a) and 4664(a).) The court discusses the duty imposed by Labor Code Section 4663 for physicians to discuss causation of disability to be considered complete on the issue of permanent disability.

Turning to the question at issue, apportionment between successive work injuries, the Court noted that Labor Code Section 4664 added a new conclusive presumption effecting the burden of proof that a prior permanent disability exists whenever an employee has received a prior permanent disability award. Apportionment may be based either on non-industrial factors of causation sufficiently described by the medical evidence (Labor Code Section 4663(c)) or disability previously awarded to the employee under a prior workers' compensation claim (Labor Code Section 4664(b)). The SB899 changes in apportionment standards apply to all cases not final on April 19, 2004, regardless of date of injury. (Citing *Marsh and Rio Linda Union School District v. Workers' Compensation Appeals Board (Scheftner)*, (2005) 131 Cal. App. 4th 517, 70 Cal. Comp. Cases 999. (*Scheftner*))

The parties agree that Labor Code Section 4664 requires apportionment to Mr. Dykes' prior back disability award. Gallo contends that the clear language of Labor Code Section 4664

requires that the percentage of prior disability must be deducted to arrive at the percentage of permanent disability directly caused by the new injury. The Court noted that in construing application of legislation to undisputed facts it should: (1) “give great weight to the construction of the WCAB except where an interpretation contravenes the Legislature’s intent as evidenced by clear and unambiguous statutory language; (2) vie a particular provision [of law] in the context of the entire statutory scheme...and harmonize it with the statutory framework as a whole;” (3) “consider the consequences that will flow from a particular statutory interpretation which, when applied, will result in wise policy rather than mischief or absurdity,” and (4) liberally construe workers’ compensation statutes in favor of the injured worker.

The law with respect to apportionment between successive work injuries which became permanent and stationary at different times under pre-SB899 law was controlled by *Fuentes v. Workers’ Compensation Appeals Board*, (1976) 16 Cal. 3rd 1, 41 Cal. Comp. Cases 42 (*Fuentes*). *Fuentes* dealt with the then new exponentially progressive workers’ compensation disability schedule for permanent partial disabilities. The California Supreme Court in that case considered three potential methods for computing indemnity for awards of permanent disability after apportionment. Method A, which the court adopted, provided that the percentage of disability to be apportioned be subtracted from the percentage of disability before apportionment, and that indemnity payable for the percentage of disability that was the difference be awarded. In *Dykes*, applying Method A would result in 20½% being subtracted from 73% leaving 52.5% [except that under the 1997 schedule, all disabilities are rounded to a whole percentage]. The award for 52.5% would be \$48,662.50. *Fuentes* proposed Method B would determine the number of weeks of indemnity payable for the disability before apportionment, and multiplies that number by the percentage of the overall disability that was industrially related. In *Dykes* that would be $([73-20\frac{1}{2}] / 72) = 0.72$. 72% of 453.5 weeks, or 326.25 weeks payable at \$170 per week resulting in an award of \$55,462.50. *Fuentes* proposed Method C would compute the monetary value of the overall disability and subtract the monetary value of percentage of disability to be apportioned out. The *Fuentes* decision rejected proposed Methods B and C, stating Method A was “required by the express and unequivocal language of Section 4750.” *Dykes* contends that the repeal of Labor Code Section 4750 can only be construed to show intent that injured workers be compensated in an amount more closely related to the full extent of their disability without considering the former overriding policy of encouraging the hiring of disabled workers. The *Fuentes* decision “found formulas B and C too closely aligned with the amount of compensation the employee would receive without apportioning the award.” Under prior Labor Code Section 4750 compensation for a subsequent disability was to be computed “as though no prior disability or impairment had existed.” New Labor Code Section 4664 turns the mandate to compute compensation “as though no prior disability or impairment had existed” on its head by conclusively presuming that any previously awarded permanent disability continues.

While this case was pending review, the Workers’ Compensation Appeals Board examined the appropriate method of calculating apportionment in *Nabors*. A majority of the commissioners concluded that because both Labor Code Sections 4663 and 4664 provide for apportionment “as a ‘percentage’ of permanent disability,” the policy considerations that led the Supreme Court in *Fuentes* to adopt Method A still apply. The Board found “no evidence that the Legislature intended to change the formula endorsed by the Supreme Court in *Fuentes*.” In *Nabors*, two commissioners dissented, one concluding that new sections 4663 and 4664 require application of Method B, and one Method C.

The Court in *Dykes* found that in repealing former Labor Code Section 4750, the basis for the finding in *Fuentes* had been eliminated and it was no longer controlling. The new mandates that causation of disability be considered and prior awarded disability be presumed to continue

provides employers incentive to hire the disabled. Further, in the interval since adoption of Labor Code Section 4750, because discrimination against the disabled has been expressly outlawed by other statutory schemes, and employers can avoid costly job displacement benefit liability by retaining disabled workers. The Court concluded that the Legislature “contemplated a variation in determining apportionment by repealing section 4750. In the limited circumstances where an injured employee received a prior disability award while **“working for the same self-insured employer”** section 4664 contemplated accumulating successive multiple disability awards rather than subtracting percentage levels of disability. Since *Fuentes* was decided not only has the exponentially greater number of weeks of indemnity for higher percentages of disability continued, but in addition the maximum compensation rates for each week of indemnity increases at specific levels. A question not considered by the *Fuentes* court is whether the compensation rate should be determined by the percentage of disability before or after apportionment. This change results in a greater difference between the *Fuentes* Methods B and C formulas. There are now five variables possible ranging from *Fuentes* Method A and an award for the unapportioned disability with credit for the prior award. For an overall disability in excess of 70% consideration must be given to the life pension provided by Labor Code Section 4659. “Section 4659 is silent with respect to whether the 70-percent-level-of-permanent-disability trigger applies before or after apportionment. The life pension for a 73% award in Dykes situation (date of last injury and earnings) would produce a \$50.25 per week life pension. Considering that the employer is only to be held for the percentage of disability directly caused by its work injury and the mandate of liberal construction, the Court found that only Method C ensures that an employee is adequately compensated and that the employer is directly liable for the percentage of disability directly caused by the work injury. All other formulas move the applicant down the progressive disability tables, “shortchanging him or her as though no prior injury or disability existed. This was mandated by former Section 4750, but is not permitted when the prior disability must be recognized and is presumed to have continued. Any algebraic formulation other than awarding indemnity for the overall disability less credit for prior payment creates a windfall to the employer and places an unreasonable burden on the employee who must compete in the labor market with a permanent disability. The Court noted that on the record in this case, under prior Labor Code Section 4750 no apportionment would have been allowed because of evidence of medical rehabilitation from the prior work injury. Applicant would have received the \$104,350 indemnity plus life pension with no offset for the prior award. New Labor Code Section Applicant is also entitled as a matter of law to the life pension for a 73% permanent disability, even though no life pension was awarded by the WCJ or Board. The Board’s decision denying reconsideration is affirmed.

Welcher v. Workers’ Compensation Appeals Board, (2006) 142 Cal. App. 4th 818, 71 Cal. Comp. Cases 1087 (Court of Appeal, Third Appellate District)

In 1990 Mr. Welcher sustained arm and leg injuries resulting in a stipulated award of 62:2% for which \$32,193 in indemnity was payable. A cumulative trauma through 2001 left him with an overall 71% disability before apportionment, or a net 8% increase resulting in liability for indemnity in the sum of \$3,360.00. Applicant argued he should have been awarded \$67,972, plus life pension. Strong sustained three successive injuries with the same employer, following which he had 34:2%, 42% after apportionment, and 70% overall disabilities. In the final case, applicant was awarded 10% after

apportionment, and claimed he should have been awarded 70% less credit for indemnity previously paid. Lopez was totally disabled following an injury, but 21% was apportionable to other causes. She was awarded 79% permanent disability pursuant to *Nabors*, but contended she should have been awarded \$172.20 per week for life, less \$12,080, the value of a 21% award. Williams sustained successive back injuries during the course of work for one employer. He was awarded 28% for the first injury, and found to have 43% overall disability after the second. He was awarded 15% after apportionment in the second injury case, and contended he should have been awarded indemnity for a 43% disability less credit for the dollar value of the 28% award. In the four consolidated cases the court found no intent in SB899 to abandon *Fuentes*. The language of the statute compels continued use of the *Fuentes* Formula A (subtracting prior disability percentage from overall percentage, and awarding indemnity based on the percentage value of the difference.) Review was granted by the Supreme Court on November 15, 2006.

Brodie v. Workers' Compensation Appeals Board, (2006) 142 Cal. App. 4th 658; 71 Cal. Comp. Cases 1007 (Court of Appeal, First Appellate District).

Applicant sustained a specific injury to his neck, back, and right knee in December 2000, and a cumulative injury to his back through September 2002. He had previously been awarded 44% disability for prior injuries to the same body parts during a thirty year career as a firefighter. After the 2000 and 2002 injuries, applicant's overall disability was 74%. The WCJ awarded 29:2% disability, producing \$20,867.50 in indemnity. The WCJ indicated in her Opinion on Decision that she felt bound to follow the en banc decision in *Nabors v. Piedmont Lumber & Mill Co.*, (2005) 70 Cal. Comp. Cases 856 (*Nabors*). Applicant sought reconsideration, which was denied. The Board noted that while review had been granted in *Nabors*, the Board is required to follow its en banc decisions until a stay is issued or the decision overruled. Applicant then filed a Petition for Writ of Review.

The Court of Appeal granted review. It found that *Fuentes* turned on the interplay between Labor Code §4658 and former Labor Code §4750. SB 899 had repealed §4750. "Amendment of a statute that has received judicial construction is an indication of legislative intent to change the law." [Citation omitted.] The new law can be interpreted to permit several different approaches to apportionment. The court found "formula C" (the Dykes approach) "to be the method that best effectuates the directive of section 4664, subdivision (a) when apportioning responsibility between a current and prior disabling injury. In a footnote, the Court indicated that applying "formula C" in multiple employment or multiple carrier cases did not appear to be a problem to it.

Review was granted by the Supreme Court on November 15, 2006.

Davis v. Workers' Compensation Appeals Board, (2006) and Torres v. Workers' Compensation Appeals Board, (2006) ___ Cal. App. 4th ___; 34 CWCR 320 (Court of Appeal, Sixth Appellate District)

Davis had an initial injury resulting in 35% permanent disability, and a subsequent injury resulted in an overall total permanent disability. Torres sustained an initial injury resulting in 24% permanent disability, and a subsequent injury leaving an overall 52% disability. In each case the WCAB applied "formula A," subtracting the prior percentage of disability from the overall disability and awarding indemnity based on the percentage which was the difference between the prior and overall disability ratings. In Davis the difference between "formula A" and "formula C" was between 65% producing \$65,662.50 and an estimated \$420,649 total disability award. In Torres the difference was between 28% producing \$16,277.50 under "formula A" and \$31,360, after credit for the prior award under "formula C." Both consolidated cases involve successive injuries with different employers/insurers. Applicants appealed.

The court noted the consideration of formulas A, B, and C in *Fuentes*, and the conclusion that only formula A was consistent with Labor Code §4750. It noted the discussions in appellate decisions to date following SB899. It concluded that the plain language of Labor Code §4664(a) provides that an employer is liable for the "percentage of permanent disability" directly caused by the industrial injury. The same phrase, percentage of permanent disability is used in Labor Code §4658 to set the number of weeks of indemnity payable. The repeal of Labor Code §4750 does not mandate a change in meaning of the phrase "percentage of permanent disability." "Liability of an employer for an injury is limited to that which is the result of that particular injury when considered by itself, and not in conjunction with or in relation to a previous injury." (*Gardner v. I. A. C.*, (1938) 28 Cal. Comp. Cases 682.) The plain language of Labor Code §§ 4663 and 4664 reflects an intent to retain the rule in *Fuentes* in determining apportionment and indemnification for a subsequent work injury.

XVI Death Benefits:

Six Flags, Inc. v. Workers' Compensation Appeals Board (Rackchamroon), (2006) 34 C.W.C.R. 326 (Court of Appeal, Second Appellate District)

Bantita Rackchamroon was struck by a moving ride and killed in the course of her employment at Six Flags, Inc. on April 9, 2004. A WCJ awarded \$250,000.00 to decedent's estate pursuant to Labor Code Section 4702(a)(6)(B), as amended in 2003, and also awarded \$125,000 to the Death Without Dependent Unit (DWD) pursuant to Labor Code Section 4706.5(a). Defendant sought reconsideration. The Board found the award to both the estate and the DWD were mandated by explicit statutory provisions, and denied reconsideration. Defendant sought review claiming that the award to the state was beyond the power of the legislature under the California Constitution.

The Court of Appeal granted review. It noted that since its inception, California Constitution Article XIV, §4, has allowed benefits to workers and their dependents, and in 1972, the Constitution was amended to allow awards to the state in limited circumstances, and in 1974 the Labor Code was amended to require payment to the state in death cases where there are no dependents. In 2002 legislature added decedent's estates as beneficiaries, where there are no dependents. As had been the case in 1919 and 1929 where legislation to create new beneficiaries had been found unconstitutional, the 2002 legislation requiring payment to the estate of a deceased employee is beyond the compensation bargain of awarding limited benefits to injured employees. Estates are not dependents, and an award to an estate which may pass to any person or entity does not further the goals of the workers' compensation program. The Court held that Labor Code Section 4702(a)(6)(B), as amended is unconstitutional, and annulled the award to the estate.

Liening v. Pacific Lumber Company, (2006) 34 C.W.C.R. 108 (WCAB Panel decision). Death Benefits--Suicide--Willful and Deliberate--Majority of WCAB panel held that WCJ's conclusion that deceased's suicide was hasty and impetuous, without deliberation and without advance planning, was supported by substantial evidence, so that Labor Code § 3600(a)(6) was no bar to applicant/surviving spouse's recovery of death benefits, when majority of WCAB panel found that persuasive medical opinion supported conclusion that applicant's suicide was compensable consequence of previous industrial injury.

XVII Hearings, Discovery Closure:

A. Venue:

Domino's Pizza v. Workers' Compensation Appeals Board (Kerr), (2006) ___ Cal. App. 4th ___; 71 Cal. Comp. Cases 1387 (Court of Appeal, Second Appellate District, initially unpublished, certified for publication 11-20-2006)

State Compensation Insurance Fund (SCIF) timely objected pursuant to Labor Code §5501.5(c) to the employee's choice of venue in Grover Beach (Luis Obispo County) under §5501.5(a)(3). Applicant's counsel apparently maintained offices in both San Luis Obispo and Santa Barbara Counties. SCIF argued that venue was mandated in Goleta (Santa Barbara County) because the applicant resided and was injured in Santa Barbara County.

Labor Code Section 5501.6 states, in part:

"(a) An applicant or defendant may petition the appeals board for a change of venue and a change of venue shall be granted for good cause. The reasons for the change of venue shall be specifically set forth in the request for change of venue. [¶]

“(b) If a change of venue is requested for the convenience of witnesses, the names and addresses of these witnesses and the substance of their testimony shall be specifically set forth in the request for change of venue.”

The PWCJ (Judge LeCover) denied SCIF's petition without prejudice, explaining that the parties were closer to Grover Beach [the office in San Luis Obispo County], than Goleta [the office in Santa Barbara County].

SCIF then filed a petition for removal. The WCJ concluded in his report and recommendation on removal that the petition was not supported by facts, but that if petitioner would present facts showing substantial prejudice or irreparable harm in having the matter proceeding in Grover Beach, he would reconsider the matter. In his report, the WCJ concluded that Grover Beach "is the most convenient office for all parties to have the case heard." The WCAB denied removal, and adopted and incorporated the WCJ's report as the basis for its decision. SCIF sought review.

Apparently quoting from another WCAB panel decision which reached the same result (*Peter Lee v. Teamwork Business Services, Inc. and S.C.I.F.* (GRO 024627, March 2, 2001), SCIF's Exhibit 5 to its petition for writ of review and cited by PWCJ LeCover in initially denying SCIF's venue change), the Court stated:

“Board opined that, notwithstanding the provisions of section 5501.5, it has discretion to concurrently consider whether there is good cause for removal under section 5501.6. Board stated that issues of judicial economy, convenience and ‘simple practicality’ dictate this procedure and result. We disagree.”

The Board's order denying removal was annulled, and the matter remanded with direction to remove the case to Santa Barbara County.

B. Privacy vs. right to discovery

Morales v. Aisin Electronics, Travelers Insurance, (2006) 34 C.W.C.R. 230 (WCAB panel decision).

Applicant sustained injury AOE-COE to her spine and right arm on October 9, 2003. During deposition, applicant was asked whether she had a family physician, whether she had ever been hospitalized, whether she had ever undergone surgery, and whether she had received treatment in a hospital emergency room. Applicant's counsel objected to the questions, and a WCJ issued a discovery order directing applicant to appear for further deposition and answer the four questions. Applicant's counsel sought removal, alleging the discovery order was too broad and violated her right to privacy and the physician-client privilege. The WCAB granted removal, and rescinded the WCJ's discovery order. It noted that filing a workers compensation claim does not constitute an unlimited waiver of the doctor-patient privilege; statutory privileges are protected in

workers' compensation proceedings, including discovery. The Board held that the parties should be permitted to attempt to narrow the scope of the questions so that applicant could provide answers consistent with her right to privacy and physician-patient privilege, while allowing defendant to obtain relevant medical evidence. The scope of inquiry should be limited to evidence that has a bearing on the alleged work injury and the parts of body placed in issue.

C. Discovery:

Weber v. John Crane, Inc., (2006) 143 Cal. App. 3rd 1433; 34 C.W.C.R. 307 (Court of Appeal, First Appellate District)

Plaintiffs were a 40 year asbestos worker and his wife who filed a civil suit for damages against numerous makers and suppliers of asbestos products. During deposition, the worker testified that he had not heard defendant's corporate name, could not recall whether he was exposed to any asbestos as a result of defendant's act(s) or failure to act, and did not recall working with or around a product marketed by defendant. He further testified that he believed the U. S. Navy would have records showing that defendant had supplied products used where he worked, and knew identities of other workers who might know whether defendant's products had been used where he worked. Defendant's motion for summary judgment was granted by the trial court. Plaintiff appealed.

The Court of Appeal reversed. It held that defendant had failed to establish that the worker would not, with further discovery, have been able to show, with reasonable medical probability, that his exposure to products marketed by defendant had caused (or contributed) to his asbestosis and mesothelioma. .

D. Disqualification of WCJ:

Robbins v. American Manufacturers Mutual Insurance Company, (2006) 71 Cal. Comp. Cases 1291; 34 CWCR 270 (WCAB Significant Panel Decision)

In defending a cumulative injury claim, American Manufacturers Mutual Insurance Company was represented by the law firm of Trovillion, Inveiss, et. al. Applicant requested an expedited hearing, but the Presiding Judge directed that the matter be set for Mandatory Settlement Conference, and it was assigned to WCJ Ordas. The MSC was continued once to a later date before the same WCJ, and upon receipt of the notice of the second conference, defendant's counsel filed a Petition for Disqualification under Labor Code §5311 and Rule 10452. The petition alleged that the WCJ was biased against the law firm of Trovillion, Inveiss, et. al. and frequently recused himself from cases in which they represented a party because of that bias. The WCJ submitted a Report and Recommendation admitting past bias against the law firm of Trovillion, Inveiss, et. al., but denying any present bias. The WCJ indicated that five or more years earlier, certain

attorneys had instituted ethics complaints against him and his wife. In June 2001, he had advised the Presiding Judge that he would recuse himself because of bias on account of the complaints. He noted a panel decision indicating that where married WCJs work at the same WCAB District Office, a petition for automatic reassignment under Rule 10453 by an attorney against one of the spouses constituted a valid basis for disqualification of the other spouse. Thus, beginning in June 2001, WCJs Ordas and Udkovich recused themselves from trial hearings, but not other types of hearings, where the formerly complaining counsel appeared. In December 2005, new Court Commissioner Keven Star had advised that the ability to perform judicial duties without bias or prejudice was a minimum qualification for service as a workers' compensation judge. After this announcement, the WCJ's determined that they were no longer biased nor encumbered by past bias in hearing cases involving the previously complaining attorneys. The Board issued a notice of intent to submit, allowing time for counsel to submit evidence of actual or continuing bias. Petitioner responded that where after four and a half years of repeated and unequivocal statements of bias, where only time and the Court Commissioner's statement that bias must be avoided as a condition of employment, any statement of impartiality might reasonably be questioned. Petitioner was entitled to disqualify a WCJ a reasonable person would conclude, at best, that that an appearance of bias or impropriety would always continue. The court administrator's edict did not erase the actual bias demonstrated by four and half years of consistent admission of it.

The Board noted that bias or prejudice against a party is a basis for disqualification, but that C. C. P. §641 does not specify that prejudice against a party's counsel is a basis. In contrast C. C. P. §§ 170.1 and 170.6 do provide that bias against an attorney is ground for disqualification of a Superior Court judge. The Board found that the Code of Judicial Ethics requires disqualification if a judge has actual bias against a parties' lawyer or if there is substantial doubt as to the judge's capacity to be impartial. After a lengthy discussion of disqualification or recusal for bias or appearance of bias, the Board found no actual bias, but sufficient appearance of bias to justify granting the petition to disqualify.

XVIII Compromise and Release

XIX Findings and Awards and Orders

XX Reconsideration

Mc Auliffe v. Workers' Compensation Appeals Board, (2006) 71 Cal. Comp. Cases 696 (Court of Appeal, Third Appellate District, unpublished).

Applicant sustained an injury to her right hand and wrist while clearing a jammed machine at work on June 12, 2001. After a period of temporary disability, applicant was released to work without restrictions on April 12, 2002. The employer's manager, John Rashan, told applicant "there was no work for her at all," and terminated applicant upon her release. After her attorney contacted the employer, applicant was offered a job on

May 19, 2002, as a driver at a pay rate \$2.00 per hour less than her pre-injury job. On August 20, 2002, applicant's physician placed her back on disability; applicant never returned to work for Century Graphics. Applicant filed a 132a claim. The case in chief was resolved by compromise and release.

Applicant filed a declaration of readiness to proceed, and the matter was set for a mandatory settlement conference (MSC) on November 30, 2004. Defendant failed to appear. On December 7, 2004, an officer of the employer, Katz, wrote that the employer had not received notice of the hearing. The Board had served notice of hearing on defendant at its address of record at the time, and no mail had been returned. The 132a claim was set for trial on January 19, 2005, and again defendant failed to appear. Applicant made an offer of proof, which was accepted. On January 20, 2005, Katz wrote that he appeared on January 20, 2005, and was unaware until he attempted to sign in that it was not the 19th. He further alleged in his letter that defendant had not received notice of the hearing, that there had been an incorrect address used on past communications, and that some notifications had gone to State Fund's counsel who was not representing Century in the 132a claim. Shortly thereafter, Katz sent a further letter objecting to the offer of proof, and apologized for missing the January 19, 2005 hearing.

The matter was set for further trial hearing on June 15, 2005. At that hearing, applicant testified consistently with the offer of proof, there was brief, non-productive cross examination, and the parties rested. The matter was submitted. The WCJ found applicant's termination in April 2002 was a prima facie 132a violation, and defendant failed to show business necessity for the termination. Applicant was awarded \$10,000 in 132a penalty less \$2,000 in attorney's fees, but was denied sanctions. Defendant, by its officer, Katz, filed a letter on July 1, 2005, requesting reconsideration. The request was not served on applicant, was not verified, and did not allege statutory grounds for reconsideration. The WCJ issued a Report and Recommendation treating the letter as a Petition for Reconsideration. The WCJ found Katz' allegations baseless and flatly contradicted by the record. Katz filed an unverified, ex parte, response to the WCJ's report. The second letter contended that applicant was not terminated, but immediately offered other employment in the company, and alleged that the department in which applicant had worked was disbanded. He alleged the WCJ had disregarded pay records of applicant's earnings as a driver, and that he had been prevented from testifying on behalf of the employer while appearing as its representative.

The Workers' Compensation Appeals Board granted reconsideration, and set aside the 132a determination and award. It found that applicant failed to indicate a date of termination, and that the record showed she was placed in the alternative position as a driver, and that her old department had been closed by May 19, 2002. The pay reduction in the alternative assignment was a detriment without discrimination on the employer's part. Applicant sought review contending that the lack of verification and service of Katz' letters precludes the Board's action.

The Court of Appeal granted applicant's petition for writ of review. It noted that Labor Code §5905 requires service of a petition for reconsideration on all parties. Katz'

letter requesting reconsideration was not served on applicant until enclosed with the WCJ's report and recommendation. Lack of service precluded applicant from answering the contentions in Katz' letters, and no opportunity was afforded to her to respond prior to or after the Board granted the petition. This was not a "mere irregularity" but an omission of substance that denied a fundamental right. Failure to verify a petition for reconsideration is not a jurisdictional bar, but has required dismissal if the party is given reasonable time to correct the defect and fails to do so. The court further noted that Katz claim of being prevented from testimony was not consistent with the record – no request to allow his testimony had been made at hearing. Katz letter did not allege grounds for reconsideration. Given the lack of notice, failure to verify, and lack of articulated grounds for reconsideration, the petition for reconsideration should have been dismissed. The Court ordered the petition for reconsideration be dismissed.

California Insurance Guarantee Association, et. al. v. Workers' Compensation Appeals Board (Norwood), (2006) 71 Cal. Comp. Cases 808 (Court of Appeal, First Appellate District, writ denied)

Applicant sustained injury to her back and right leg on January 1, 1996; she alleged a compensable consequence psychiatric injury. After trial, the WCJ issued an F&A which indicates on the proof of services was filed and served on October 5, 2005, but on which the date of WCJ's signature was October 6, 2005. The WCJ found, in part, that applicant had sustained injury to her psyche, and was entitled to temporary and permanent disability benefits, further medical treatment and attorney's fees. On December 1, 2005, California Insurance Guarantee Association (CIGA) filed a petition for reconsideration. It contended that it had not been timely served with the F&A because the WCJ's signature was dated October 5, 2005, while the proof of service indicated service on the previous day. In its verified Petition for Reconsideration, defendant's counsel alleged that the F&A was received on November 14, 2005. It also alleged that it was not properly designated in the case caption of the F&A. It further alleged that the finding of psychiatric injury violated Labor Code Section 3208.3(d) because the orthopedic injury occurred prior to applicant having completed six months of employment by the employer. If finally challenged an order to repay EDD for benefits furnished. The WCJ recommended the petition be denied. Whether the F&A was served on October 5 or 6 would in the WCJ's opinion, have been material if defendant's petition had been filed on October 31, but was not prejudicial when the petition was filed on December 1, 2005. The caption was consistent with earlier court documents to which CIGA had made no objection or had made no request for correction. Finally, applicant had returned to work after her injury, and had met the six month threshold after the date of the original orthopedic injury. The WCJ concluded that she had no power to correct any error in directing reimbursement to EDD.

The WCAB granted reconsideration. It held that where the date of signing by the WCJ of the F&A showed on its face that service could not have been made when indicated on the proof of service, defendant's declaration was sufficient to show the F&A was received on November 14, 2005, and defendant's petition was timely filed. The

Board deferred and remanded the determination with respect to the EDD lien, noting that at trial the parties stipulated to defer all liens. The Board noted that appellate cases are pending on whether EDD is entitled to reimbursement from CIGA for benefits furnished during periods an applicant is entitled to TD from CIGA. It found applicant's total employment by defendant employer was for a period in excess of nine months and the claim for psychiatric injury was therefore not barred by Labor Code §3208.3(d). CIGA filed a Petition for Writ of Review. The writ was denied, with applicant's allowed costs but denied requested attorneys fees on appeal.

XXI Reopening:

Vargas v. Atascadero State Hospital, (2006) 71 Cal. Comp. Cases 500 (WCAB en banc)

On March 22, 1995, applicant sustained injury to her left upper extremity, neck, and left ear. In 1998 applicant was awarded 67% permanent disability, based on defendant's proposed rating under former Labor Code Section 4065 (baseball arbitration). The neck and left shoulder would each have rated 65% adjusting to a final rating of 71% had the matter been determined on a formal rating. Applicant filed a timely petition to reopen, alleging new and further temporary and permanent disability, injury the psyche and TMJ syndrome. The cases tried on the Petition to Reopen on March 2, 2004, apportionment was in issue. The WCJ allowed defendant time for a defense QME on the TMJ syndrome. Applicant sought removal.

The Board assigned the matter for en banc decision and issued its decision and order denying removal, holding that: (1) The standards for apportionment under SB899 apply to the issue of increased permanent disability alleged in a petition to reopen pending at or after April 19, 2004, the time SB899 became effective; (2) the new apportionment standards cannot be used to revisit or recalculate the level of permanent disability or apportionment determined under an award issued and final before April 19, 2004; (3) any apportionment for the increased permanent disability is determinable under Labor Code §§4663 and 4664, without reference to how or if apportionment was determined in the original award

XXII Miscellaneous Supplemental Proceedings:

Lazan v. County of Riverside, (2006) 140 Cal. App. 3rd 453; 71 Cal. Comp. Cases 766 (Court of Appeal, Fourth Appellate District).

Lazan worked as a deputy sheriff for County of Riverside from 1989. On June 4, 2001, she was involved in a collision between her patrol car and another patrol car, sustaining back injury. Applicant had been involved in two prior off work vehicle accidents, and had strained her back on other prior occasions. Initial x-rays following the June 4, 2001 injury showed moderate to severe degenerative disc disease at L4-5 and L5-S1, and "tiny" disc protrusions at L3-4 and L4-5. When permanent and stationary,

applicant was precluded from heavy lifting, repetitive bending, or prolonged standing or sitting. In 2002 applicant applied for disability retirement. While appealing denial of that request, applicant, in April 2003 withdrew her appeal and requested reinstatement. Applicant was assigned to Jurupa Valley Station, and worked there beginning May 12, 2003. She provided her supervisor a copy of her medical work preclusions. After an hour long discussion, the supervising captain wrote that there was no permanent modified duty position at the station, and they were unable to accommodate applicant's restriction. Applicant was told to go home. Two months later, on July 14, 2003, the county advised applicant it had not refused to return her to active duty, and had a position available. Applicant was assigned to a temporary clerical position. On August 20, 2003, defendant advised applicant of her potential eligibility for vocational rehabilitation. On March 1, 2004, the county sent applicant another letter advising her of her eligibility for vocational rehabilitation, and advising that it did not have a job available within her work limitations.

Applicant demanded that the county file an application on her behalf for disability retirement. The county responded that the March 1, 2004 letter was required by former Labor Code § 4637, and did not represent a change of the county's position that applicant was able to perform the duties of a deputy sheriff. On June 1, 2004, applicant filed a petition for writ of mandate seeking to direct the county to apply for her disability retirement, and for damages. On June 1, 2004 the trial court found that the county had effectively separated applicant by failing to reinstate her employment, and that the clerical assignment failed to satisfy the requirement that reinstatement be to a job with the same classification, salary, benefits, and promotional opportunities. The writ of mandate issued, and applicant was allowed to seek attorneys' fees. The county appealed arguing that it believed applicant could perform the duties of a deputy sheriff and therefore had no duty to apply for applicant's disability retirement. The Court of Appeal found that the county's notices advising applicant of her right to vocational rehabilitation, coupled with its failure to identify a position to which applicant could return with her restrictions amounted to a determination on the county's part that applicant was disabled. Under provisions of Government Code Section 21153, the county therefore had an obligation to apply for disability retirement on her behalf. Actual separation from county employment is not controlling where, as here, the county had reviewed applicant's limitations and determined she was unable to perform the duties of a deputy sheriff. This was clear from the May 12, 2003 memo from the supervising captain of the Jurupa Valley Station where applicant had been directed to report, and in fact reported for work. Notwithstanding its attempt to take inconsistent positions on the issue, where the count in fact had not restored applicant to a job with the same classification, salary, benefits, and promotional opportunities, it was required to apply for disability retirement for her. The writ of mandate was the appropriate remedy. The trial court's judgment was affirmed.

XXIII Contribution

XXIV Subrogation

XXV Credit, Restitution, and Fraud

People v. Thompson, (2006) 136 Cal. App. 4th 24; 71 Cal. Comp. Cases 35 (Court of Appeal)

A civil action for violation of Insurance Code Section 1871.7 for acts made criminal by Penal Code Section 550(a) does not violate the exclusive remedy doctrine, and the appropriate standard for proof in the civil action is preponderance of the evidence.

XXVI Special Benefits

A. FEHA Liability

Gelfo v. Lockheed Martin, (2006) 140 Cal. App. 4th 34; 71 Cal. Comp. Cases 726 (Court of Appeal, Second Appellate District).

Plaintiff was employed as a metal fitter at Lockheed from 1980 to 1984, and 1997 to 2000. During the second period of his employment he was promoted to senior metal fitter. In September 2000 plaintiff sustained a back injury at work. In October 2000, Plaintiff was laid off and placed on a recall list with eligibility for rehire for five years. Applicant disability from his back injury became permanent and stationary in November 2000, and he was released to work with preclusion from repetitive lifting of over 50 pounds. At defendant's request, applicant underwent a qualified medical evaluation in May 2001. The Qualified Medical Examiner (QME) found applicant permanent and stationary, precluded from heavy work, and a medically eligible for vocational rehabilitation (QIW). Four months later, after re-examination, plaintiff's treating physician found him precluded from heavy lifting, repeated bending and stooping, prolonged standing or sitting, and QIW. IN the treating physician's opinion plaintiff had lost 75% of pre-injury capacity for lifting. Plaintiff participated in three months of vocational rehabilitation. Concurrently, plaintiff engaged in physical activities without limitation by his back injury. In January 2002, plaintiff received a workers' compensation award of 42:2% and resulting indemnity of \$36,000. In September 2001, plaintiff enrolled in a plastic parts fabricator and assembler class offered by defendant. Plaintiff completed the course without limitation, and at his graduation on February 12, 2002, was offered a job as a fabricator subject to security and medical clearance. Two days later plaintiff was advised by defendant's labor relations department that the offer was revoked based on medical restrictions imposed by his physician for his prior back injury. Plaintiff advised defendant he felt great; he went to his physician and related that he felt no further need for restrictions. Plaintiff claimed he was released without restriction by his physician in February 2002; there is no indication this release was served on defendant. The physician agreed that the work restrictions were no longer necessary. In July 2002, defendant's Placement Review Committee considered whether an accommodation was possible within the limitations set forth in the medical record.

After multiple internal party discussions, Lockheed determined that it could not accommodate the preclusion from heavy work activities and prolonged standing or sitting, other than lifting, within any job in the fabricator classification. In July 2002 defendant advised applicant it could not offer modified or alternative employment within his limitations. It invited plaintiff to advise it if plaintiff became aware of a reasonable accommodation that would permit plaintiff to perform the essential functions of a fabricator within his medical restrictions. Plaintiff responded that month requesting defendant to reconsider its decision because it was misinformed as to his restrictions. He pointed out that he had successfully completed the training class without incident, and that he was working in a job with duties similar to a fabricator with a different employer. In September defendant replied that based on the treating physician's deposition testimony, no reasonable accommodation was available.

After unsuccessful pursuit of administrative remedies, plaintiff filed an FEHA suit on March 30, 2003. Defendant was granted a summary judgment on a cause of action for wrongful termination barred by the statute of limitations. The three remaining causes of action were tried over a period of six days in July 2004. The trial court found that plaintiff did not have an actual disability, but the claim that defendant discriminated because it regarded applicant as a person with a disability went to the jury. The jury returned a verdict in defendant's favor. Plaintiff appealed.

The Court found the court's finding of no actual disability supported by the record, but found that the court should have made a finding with respect to the "regarded as" aspect of plaintiff's claim. The court also found the instructions erroneous and verdict form confusing. Based on the jury form, the jury found defendant did not "mistakenly" believe plaintiff was limited in ability to work by his back injury. If further held that where accommodation is requested, an employer must explore reasonable accommodations for and engage in interactive dialogue with applicant or employees whom it regards as disabled. The Court of Appeal reversed the trial court as to plaintiff's cause of action under Government Code §12940, subdivisions (a), (m), and (n), and remanded for further proceedings.

Daidone v. City of Glendale, (2006) 71 Cal. Comp. Cases 910 (Court of Appeal, Second Appellate District, unpublished).

Plaintiff was a 23 year employee of defendant. In October 1998, he was promoted to electrical line mechanic. In December 1998 Daidone suffered a right ankle and knee injury when he fell from a pole. In February 1999, he suffered a right arm injury. Daidone complained through 1999 of neck and shoulder pain. Daidone's treating physician recommended work restrictions, which the city accommodated. The treating physician later opined that Daidone was unable to continue in his position and should look for another job. An AME found applicant precluded from heavy lifting, precluded from prolonged positioning of the neck, particularly in extension, and no prolonged work or heavy lifting at or above shoulder level. The AME indicated that Daidone could continue in his modified work assignment indefinitely. Approximately two months later,

the city concluded that Daidone could not resume work as an electrical line mechanic. The city and its workers' compensation adjuster had discussions with Daidone about alternative work from October 1999 through April 2000, when Daidone was placed in a modified permanent position. One of the positions discussed was at the Howard dispatch center. A supervisor there, Wolf, told Daidone that the center did not want handicapped employees; a supervisor of the dispatch operations, Hernandez, also told Daidone that he did not want to hire anyone with a work restriction. Subsequently a position which had been discussed in October 1999 came open and was filled by another city employee. Daidone was not given pre-notice posting notification of the vacancy, and did not apply for it. Plaintiff complained of employment discrimination. After investigation, Wolf and Hernandez were disciplined, and the city created a station electrician/operator position to accommodate employees like Daidone. Daidone filled that position, but could not participate in regular standby work. In 2002 another position opened at Howard center, but Daidone did not apply for it. In November 2002 Daidone filed a DEFH complaint seeking the difference between his post injury wages and what he alleged he would have earned at Howard center. He claimed the city had imposed excessive work limitations on him, unjustifiably causing him to leave his electrical line mechanic position. The trial court denied the claim, and plaintiff appealed. Applicant further claimed on appeal that the trial court had imposed the burden of proof of ability to perform his prior job on the wrong party.

The Court of Appeal found that the city had appropriately relied upon the opinions of two physicians familiar with Daidone's condition to conclude that Daidone was unable to continue as an electrical line mechanic. It concluded that the preclusion from standby duty, often requiring single handed lifting of 100 pound nitrogen barrels, was reasonable given applicant's medically imposed limitations. It further found that once a reasonable accommodation had been provided, the employer was under no continuing duty to seek the most preferred position or accommodation. The city acted in good faith and reasonably accommodated Daidone's disability. After Daidone accepted the permanent senior inspector job and told city personnel he was pleased with the accommodation, the city was not required to continue to search other departments for other accommodating positions or give him preferential treatment in promotional examination(s) or placement. The decision of the trial court was affirmed.

B. Civil liability immunities:

Priebe v. Nelson, (2006) 39 Cal 4th 1112; 71 Cal. Comp. Cases ___; 34 CWCR 234 (Court of Appeal, Appellate District).

Plaintiff was a kennel worker bitten by a 75 pound Staffordshire terrier owned by Nelson. The bite resulted in foot, ankle, and nerve injuries that could result in life long pain. The owner was sued on theories of negligence and under Civil Code §3342, which imposes strict liability on a dog's owner for damages resulting from a dog's bite. Defendant contended that by accepting the dog for boarding, the kennel assumed the risk, absolving the owner of liability. Before trial, *voir dire* included inquiries on strict

liability; at the conclusion of the trial the judge refused to instruct the jury on provisions of Civil Code §3342, or on strict liability if the owner knew the dog was vicious. The jury returned a defense verdict. Plaintiff appealed. A motion for new trial was granted, but judgment notwithstanding the verdict (JNOV) denied. Both the Court of Appeal and California Supreme Court affirmed. The courts held that assumption of the risk is a recognized defense to an action brought under the dog bite statute where, as a matter of law, defendant should be excused from the usual duty of care based on clear statutory or public policy consideration. Such situations include those covered by the Fireman's Rule and the Veterinarian's Rule. This is extended to situations where a dog has been entrusted to trained professionals in exchange for compensation, including veterinarian and / or kennel care. In such situations where the owner has relinquished control and custody, the owner is relieved of liability because he or she is no longer in a position to supervise or prevent the animal's misconduct. At the re-trial the owner has the opportunity, not afforded at the first trial, to prove that the owner failed to warn the kennel staff of the dog's vicious propensities.

Michael v. Denbeste Transportation Inc., (2006) 137 Cal. App. 4th 1082; 71 Cal. Comp. Cases 378 (Court of Appeal, Second Appellate District)

Michael was a truck driver who sustained a ten foot fall injury from a loaded trailer on a construction site while trying to install a manual roll tarp over the loaded trailer. The site of the accident was property owned by Filtrol Corporation (Filtrol). Filtrol had contracted with Aman Environmental Construction, Inc. (Aman), to decontaminate and demolish its old plant on the site. Filtrol also contracted with Secor International, Inc. (Secor) to provide technical oversight of the decontamination. Aman adopted a "Site Specific Health and Safety Plan" (SSP) which in part required fall protection procedures at locations where a fall hazard of 6 feet or more existed. Aman hired Chemical Waste Management (CWM) to provide transportation and disposal of the waste materials. CWM hired Denbeste to perform the hauling, and Denbeste hired Michael under a "sub-haul agreement" under which Michael provided his own tractor to pull a Denbeste owned trailer. Their agreement provided that the trailer would be tarp covered when loaded with waste materials. Michael had no experience with the type of tarp or bow system provided with the roll tarp, but was given a "few minute instruction course" on the trailer by a Denbeste mechanic. The instruction did not include getting into or out of the trailer bed, nor how to place the bows to support the tarp.

Denbeste's on-site truck boss observed Michael over the course of weeks, and observed that he walked with a pronounced limp. For a time, Michael used a ladder to place the bows and tarp, but his was discontinued a too time consuming. In September 2001, Michael strained his ankle when he slipped off the Denbeste trailer. Before January 18, 2002 Michael and Denbeste's on-site truck boss discussed getting a newer trailer or automatic tarping system. On January 18, 2002, Michael was wearing a Tyvec suit and respirator. While placing bows to support the tarp at the rear of the trailer, Michael lost his footing and fell 10 feet to the ground. As a result of the fall, Michael was paralyzed from the chest down.

Michael filed a civil suit for personal injury against Aman, Secor, CWM and Denbeste. Each defendant answered and sought summary judgment against plaintiff, asserting the *Privette* doctrine. Denbeste also asserted primary assumption of the risk and an contractual release. The trial court granted defendants' motions for summary judgement. Secor was found to have no employees and to have entrusted no work at the site. Aman and CWM were found shielded by the *Privette* doctrine (an employee of a contractor may not sue the hirer of the contractor under the peculiar risk doctrine set forth in Restatement Second of Torts §§ 413 and 416). Plaintiff appealed. The Court of Appeal sustained the summary judgements in favor of Aman, Secor and CWM, and reversed and remanded the judgment with respect to Denbeste to resolve the issue of employee vs. independent contractor relationship, a triable issue of fact.

C. Post Injury Reinstatement/Termination

Stevens v. County of Tulare, (2006) 38 Cal 4th 793; 71 Cal. Comp. Cases 571 (California Supreme Court).

Plaintiff began work for defendant as a detention specialist in December 1994. He worked in close proximity to inmates, transported inmates and wrote reports. He worked armed. In 1995 and 1996 he sustained thumb injuries. On his return to work after the 1996 injury, plaintiff was assigned to light duty in a housing unit control room. His work entailed pushing buttons to open and close security doors for other detention officers. Plaintiff complained that his duties were inconsistent with his restrictions. A specialist reported that plaintiff could perform no more than 15 to 20 minutes of continuous upper extremity activity, then required a break. The physical also opined that plaintiff's current assignment allowed him breaks at intervals consistent with his needs. In September 1997, plaintiff was asked by a supervising sergeant how he was doing. He showed the sergeant his thumb. Another supervising sergeant reported that plaintiff complained that he was suffering pain in performing the assignment, and had noted that Plaintiff's thumb was red and swollen at the end of a shift. He reportedly boasted that he would "own the county" as a result of damages for discrimination if he were reassigned. A sergeant reported these boasts. On September 12, 1997, a captain advised Plaintiff by letter reciting Plaintiff's medical restrictions, the employer's accommodation, Plaintiff's September 8, 1997 discussion with a sergeant in which plaintiff allegedly claimed the assignment was inconsistent with the restrictions, Plaintiff's September 10, 1997 alleged comment at the end of a shift that his thumb was swollen. Plaintiff was advised not to return to work until further notice, until his hand improved sufficiently to allow him to work without restrictions, or to a point where he could perform the central control modified duties without further complaint or injury. He was directed to submit time sheets showing "OFF DUTY/SICK/PERSONAL" status. He was advised that there was a dispute concerning whether he was then entitled to Labor Code Section 4850 benefits. At hearing the captain testified that the letter was intended to ensure plaintiff was aware of the county's concern that he not further injure his thumb. It was not a dismissal and left open the possibility of plaintiff's return in either light duty or full detention officer

duty. Plaintiff did not return to work, but testified at trial that he had not been terminated. Plaintiff received sick pay followed by 4750 pay at his full salary rate through December 19, 1998. He then participated in vocational rehabilitation and completed a plan to become a computer technician. In November 1998, plaintiff applied for a disability retirement, when this was denied, he demanded reinstatement. On December 5, 2002, the county advised plaintiff by letter that it was ready to reinstate plaintiff. Plaintiff was requested to contact a designated person to review restrictions and discuss arrangements for his return to work. The letter advised that if no contact was made by December 20, 2002, the sheriff-coroner would assume he was not interested in returning. Plaintiff's counsel contacted the designated person. When no reinstatement was accomplished by May 23, 2003, plaintiff filed a petition for writ of mandate seeking reinstatement. Government Code Section 31725 requires that where an employee is dismissed for disability and a disability retirement is denied by the retirement system, the employee is entitled to reinstatement. The trial court found that plaintiff had not been dismissed from employment, had always had a physician's clearance to perform the modified duties at central control. Because plaintiff did not seek a new medical evaluation or seek reinstatement to the modified or regular duties after the September 12, 1997 letter, the only reasonable determination is that plaintiff could have been performing the modified duties at the control room all along. Plaintiff appealed, and the Court of Appeal reversed.

The Court of Appeal reversed finding that the modified light duty in the housing unit had been approved, but not the work at central control. Therefore the reassignment placed plaintiff in the position of either absenting himself or working injurious duties. Defendant appealed. The Supreme Court granted review. It noted that although plaintiff testified that he feared the work at central would be more demanding on his hand, there was other substantial evidence that the duties at central were not more arduous. The difference, according to one witness was that the requests for door opening at the housing unit came principally from inmates, but the requests at central came entirely from custodial staff. The Supreme Court found the trial court's factual determination based on conflicting testimony to be supported. Plaintiff contended on appeal that while he had not been formally dismissed or terminated, Government Code §31725 applied where the employer takes the employee off active duty. The court found that the letter of September 12, 1997 was not a dismissal. Plaintiff's authorities, the Court finds dealt with situations of assumed dismissal. The Court went on to hold that notification in benefit notices from the workers' compensation administrator that there was not work available within his restrictions was not a dismissal. The protections of Government Code §31725 were not triggered.

Kelly v. County of Los Angeles, (2006) 141 Cal. App. 4th 910; 71 Cal. Comp. Cases 934 (Court of Appeal, Second Appellate District).

Plaintiff was a licensed vocational nurse in a Los Angeles County hospital beginning in 1979. In 1990 she was struck by a combative patient and suffered injuries to her shoulders. She received workers' compensation benefits, and continued to suffer some shoulder pain. She resumed work. In 1991 plaintiff sustained a back injury, and returned

to work with restrictions in 1992. As an accommodation, plaintiff was assigned to a data entry position with the title and salary of LVN II. In 1994 applicant developed bilateral wrist pain, and was diagnosed with de Quervain's tenosynovitis. In 1995 applicant underwent surgeries on both wrists, and was left with limitations precluding "repetitive gripping and grasping, use of pounding or vibrating tools, and data entry." The county advised plaintiff that her modified work was not compatible with her current wrist restriction. She was asked to code her time card "Industrial Accident" and contact Rancho Los Amigos Medical Center (RLAMC) for possible vocational rehabilitation. Applicant did not construe the letter as a termination notice. Applicant entered into a vocational rehabilitation plan calling for training as a medical lab technician and phlebotomist. The plan called for formal training to take place between July 8, 1996 and December 20, 1996, followed by eight weeks of placement services, followed by 30 days on the job monitoring. Whether placement was to be with the County or in other private employment was not set forth in the plan. RLAMC's return to work coordinator testified that, after successful completion of training, appropriate work at RLAMC is the primary objective with other County employment as a secondary fall back. In November 1996, the parties settled the applicant's case for her 1990 injury by stipulation to 46% permanent partial disability. Upon completion of training, applicant sent out 17 resumes and made a phone call to the RLAMC lab where a person answering the phone said there were no openings. Plaintiff made no contact with the return to work coordinator or nurse manager. Applicant did not seek outside employment.

In June 1998 plaintiff applied for a service connected disability retirement. On her application she alleged she had been on industrial leave through July 1997, and could no longer perform the duties of an LVN. The county retirement board denied plaintiff's application in March 1999. It relied in part upon a panel physician who reported that plaintiff had attempted to deceive him during the examination and was not substantially impaired. The board found plaintiff was substantially able to perform LVN duties. Plaintiff appealed. After hearing, a referee prepared a proposed decision denying the retirement application on the ground that applicant could substantially perform the duties of an LVN and had not been truthful with medical examiners. Both Plaintiff and the county filed petitions for writ of mandate seeking to compel the retirement board to find plaintiff eligible for service connected disability retirement. After hearing the petitions for writ of mandate were denied.

On September 10, 2003 plaintiff filed a petition for writ of mandate directing mandatory reinstatement, back pay, and benefits. Three months later the county advised plaintiff it had identified a position as an LVN consistent with applicant's limitations. She could enter that position with benefits and salary from July 21, 2003 (the date the petitions for writ of mandate seeking disability retirement were denied). The county contended this offer made the September 2003 petition moot. Plaintiff disagreed contending she was entitled to pay and benefits from March 19, 1996 through July 20, 2003. The trial court agreed with plaintiff, and found the March 1996 letter placing her on industrial accident leave an effective dismissal. Defendant appealed.

The Court of Appeal found that plaintiff had not been dismissed. It found the county was unable to accommodate applicant's temporary limitations. It offered vocational rehabilitation with placement directed toward finding a county position congenial itself

Bounjour v. Los Angeles Unified School District, (2006) 71 Cal. Comp. Cases 1412; 34 CWCRCR 312 (Court of Appeal, Second Appellate District, unpublished)

Applicant was a special education trainee who filed a claim for stress, and whose physician restricted her from "any supervision that might aggravate her stress." A QME found applicant to have "a serious characterological disorder." Two years later another examiner found applicant unfit to resume work as a special education trainee. Following additional evaluations and tests, the employer sent applicant a "Notice of Potential Eligibility for Vocational Rehabilitation." Applicant filed a civil suit for wrongful termination. The trial court granted defendant's motion for summary judgment. The employee appealed.

The Court of Appeal sustained the summary judgment holding that giving notice of potential entitlement to a workers' compensation benefit did not constitute a termination for disability.

XXVII Penalties, Sanctions & Contempt:

A. Penalties under Labor Code Section 132a

Anderson v. Workers' Compensation Appeals Board, (2006) 71 Cal. Comp. Cases 1359 (Court of Appeal, Second Appellate District, writ denied; review in Supreme Court granted 10/19/06).

The WCAB found that the defendant had not discriminated against applicant in violation of Labor Code section 132a, it requiring applicant to use vacation time when attending medical appointments for his injury, but allowing non-industrially injured workers to use sick time for medical appointments. Applicant did not show he had a right to use sick time for his appointments. Defendant's policy with respect to non-industrial injury or illness medical appointments was apparently consistent with both the Municipal Code and the contract (Memorandum of Understanding [MOU]) between the City and Local 620 of the Employees Association.

Among other things, the WCJ concluded that under the Supreme Court's decision in *Lauher* (2003) 68 CCC 831, 844, the applicant had failed to demonstrate that because of his industrial injury, he had been deprived of a benefit or right to which he would otherwise be entitled. The WCJ reasoned that the City was not legally obligated to allow non-industrially injured workers to use sick leave for medical appointments, and in conferring that right by contract, the City was not required to extend it to industrially injured workers.

B. Penalties under Labor Code Section 5814

New United Motors Mfg., Inc. v. Workers' Compensation Appeals Board (Gallegos), (2006) 141 Cal. App. 1533; 71 Cal. Comp. Cases 1037 (Court of Appeal, First Appellate District)

Applicant and defendant entered into stipulations on which an award issued in 2001. The award included provision for permanent disability, and payments on the award were made until September 2002. In September 2002 a new adjusting agency took over administration of defendant's claims, and indemnity payments ceased. On August 12, 2003, applicant's counsel requested a benefit statement; the print out was provided in September. In November applicant's counsel wrote to defendant's counsel inquiring why only half the permanent disability indemnity had been paid. Forty-seven days later defendant paid \$13,381.43 in accrued unpaid indemnity and \$1,304.14 in Labor Code Section 4650(d) penalty. [There is no mention of payment of interest on the delayed post award indemnity.] Applicant's counsel filed a petition for Labor Code Section 5814 penalty and 5814.5 attorney's fees. After hearing, the WCJ imposed a 25% penalty on the delayed permanent disability indemnity. Defendant sought reconsideration contending that where it made payment of the delayed indemnity with 10% enhancement within 90 days of discovery of its breach of duty and before a petition for penalty was filed, it was not liable for further penalty under Labor Code Section 5814. The WCJ indicated in her Report and Recommendation that Labor Code Section 5814(b) should not apply because it was applicant's counsel who discovered the delay, and that even after notification, defendant unreasonably delayed payment when it waited 47 days to pay the arrearage. The WCAB affirmed the award. Defendant sought review.

The Court of Appeal granted review and reversed the award of the 25% penalty. It found the Board's non-application of Labor Code Section 5814(b) based on the applicant's counsel's discovery of the delay, rather than defendant's discovery, was not warranted by the plain language of the statute. Under §5814(b) where the delayed compensation and a 10% self imposed penalty is paid within 90 days of discovery of the delay, regardless of the source of knowledge of the delay, no further penalty can be awarded. The court remanded the matter for determination of the Labor Code Section 5814.5 attorney's fee. The CWCR editors believe no §5814.5 fee is warranted because not §5814 penalty was obtained. However, absent applicant's counsel's action the "discovery" of the failure to pay the indemnity awarded may never have been occurred, and the Labor Code §4650(d) enhancement never been paid.

McCarthy v. Workers' Compensation Appeals Board, (2006) 135 Cal. App. 4th 1230; 71 Cal Comp. Cases 16 (Court of Appeal)

The Court of Appeal agreed with the Board's decision in *Abney v. Aera Energy*, (2004) 69 Cal. Comp. Cases 1552 (WCAB en banc) that Labor Code Section 5814, a

amended by SB 899 applies to all determinations of penalty for unreasonable delay or denial of compensation made after June 1, 2004, regardless of the date of delay or denial.

All Tune & Lube, Erie Insurance Group v. Workers' Compensation Appeals Board, (2006) 71 Cal Comp. Cases 795 (Court of Appeal Second Appellate District, writ denied).

Applicant was totally disabled by a work injury to his head, neck, back, right shoulder, right leg, hip, eyes, and psyche. He was rendered blind. On November 7, 2001, defendant was ordered to provide 12 hour per day home health and nursing care and other medical treatment and appliances. A penalty of 10% was imposed upon permanent disability indemnity and attorneys fees, and in August 2002, the parties settled a claim of penalty for failure to provide home health and nursing care for \$235,000. In June 2003 the parties settled claims for further treatment, appliances, transportation costs, credit discrepancies, and claim of penalties and interest for delay in providing treatment and services for an additional \$235,000. Subsequently defendant stipulated to reimburse applicant for \$142,349.46 in transportation, medical costs and attendant care incurred by applicant, and to provide applicant an accounting of benefits. Defendant failed to comply with the stipulation, paying only \$96,000, failing to furnish certain items including a computer, scanner, and seeing eye dog, and failing to provide the ordered accounting for a year.

After trial an F&A issued on July 11, 2005, finding delays or refusals of various benefits unreasonable, and reserving jurisdiction to determine the amount of penalties pending receipt of an accounting. On October 12, 2005, the WCJ issued another F&A assessing \$10,000 penalties under Labor Code Section 5814 (As amended by SB899) for delay of (1) home health care and nursing; (2) non-payment for physical therapy, (3) non-payment of transportation costs, (4) failure to provide psychiatric treatment and therapy for applicant's wife, (5) a Zone diet previously ordered by the Board to be provided, and sanctions for failure to timely provide a benefit statement. Defendant sought reconsideration contending that the Award violated the \$10,000 cap on 5814 penalty imposed by the amendments in SB899, that it had self imposed a penalty for delay in providing the Zone Diet and the further penalty violated §5814(e), and that the order to provide treatment for applicant's wife was beyond the power of the Appeals Board, so defendant's failure to provide such treatment was not unreasonable, and that the imposition of sanctions was improper. The WCJ recommended that reconsideration be denied. The WCJ reported that *Christian v. W.C.A.B.* (1997) 15 Cal 4th 505, 62 Cal. Comp. Cases 576 still support award of multiple penalties for separate and distinct acts of delay in provision of benefits. Here, the penalties resulted from different acts of delay or refusal to provide awarded benefits. There was medical evidence that medical evidence showed the treatment ordered for applicant's wife would be beneficial to applicant. The sanction was warranted by defendant's failure timely to provide a benefit statement when ordered, and when provided the statement did not adequately explain the reported payments. The WCAB denied reconsideration adopting the WCJ's report as its basis for decision. Defendant raised the same issued in a Petition for Writ of Review. The Court

denied the writ and granted applicant's counsel's request for fees under Labor Code §5801.

C. Penalties under Labor Code Section 4650(d)

D. Penalties for failure to secure payment of compensation:

See *JKH Enterprises Inc. v. Department of Industrial Relations*, (2006) 142 Cal. App. 4th 1046; 71 Cal. Comp. Cases 1257 under "Employment", above.

E. Sanctions under Labor Code Section 5813:

Ira D. Johns v. Workers Compensation Appeals Board (Stephenson), (2006) 71 Cal. Comp. Cases 1327 (Court of Appeal, Second Appellate District, writ denied)

Ira Johns (Johns) was engaged as defendant's counsel in a workers' compensation case. At applicant's deposition the deposition reporter recorded discussion of the possibility of settlement of the case and possible request for continuance of a scheduled January 5, 2005 Mandatory Settlement Conference (MSC). On January 5, 2005, applicant and applicant's counsel appeared for the MSC; applicant's counsel telephone Johns, and Johns represented in the phone discussion that he had not been served with notice of the MSC, that the MSC was not on his office calendar, and he requested the matter go off calendar. At applicant's counsel's request the MSC proceeded, and the matter was set for trial. Johns was allowed time to note issues or stipulations or lest trial exhibits on a pre-trial statement up to twenty days before trial. Johns filed a petition for removal (required by rule to be verified) alleging that he had no notice or knowledge of the January 5, 2005 MSC in the matter. Applicant's counsel filed an answer attaching those portions of the deposition transcript which reported the discussion in which Johns knowledge of the MSC and possible continuance were set forth. The Petition for Removal was denied. On March 8, 2005, the WCJ issued a notice of intention to impose sanctions for the false declaration in the Petition for Removal. Hearing on the issue of sanctions was held on September 6, 2005, and testimony was received on the issue. On December 27, 2005, Findings and Award issued determining in part that Johns had engaged in a frivolous or bad faith litigation tactic by making false statements in the Petition for Removal and subsequent declarations, and imposing a \$1,000 fine.

Johns sought reconsideration contending that he was not served notice of the MSC because his address was not entered in the official address record in the case until January 5, 2005; that he was not present when the MSC was discussed, it had been another member of his firm present at the deposition discussion, and that the Petition for Removal was not intended to and had not resulted in any delay in litigation because it had been denied. The WCJ recommended the petition be denied. He noted in his report that the fact the case was not delayed was not determinative, but that the sanction had been imposed for the serious dishonest conduct of petitioner. It was clear from a letter from

petitioner's associate to applicant's counsel advising they would request continuance of the January 5, 2005 MSC, that the petitioner's firm was aware of the January 5, 2005 hearing. The more persuasive evidence on Johns' presence during discussion of the MSC at the time of applicant's deposition was applicant's counsel's testimony. Reconsideration was denied. Johns' petition for writ of review was denied.

XXVIII. Statutes of Limitations:

Valdez v. Himmelfarb, (2006) ___ Cal. App. 4th ____; 71 Cal. Comp. Cases 1574; 34 C.W.C.R. 336 (Court of Appeal, Second Appellate District); 3

Applicant sustained injury to his low back in July 2001, while working at a restaurant. An Application for Adjudication of Claim was filed within a month of the date of injury. In August 2002 applicant learned that his employer had been uninsured at the time of injury. In May 2003, applicant filed a civil suit for the damages resulting from his injury. A trial judge granted defendant's motion for summary judgment, finding that plaintiff had actual or constructive notice that the employer was uninsured by December 20, 2001, and failed to file the civil suit within one year of knowledge of injury. The judge also imposed \$54,601 in sanctions against plaintiff and his attorney. Plaintiff appealed.

The Court of Appeal reversed. It held the applicable statute of limitations for liability under Labor Code Section 3706 is three years as provided by Code of Civil Procedure §338(a). The shorter statutes of limitations periods in Code of Civil Procedure § 335.1 (two years for personal injury), or § 340(a) (for an action on a penalty or forfeiture, if the action is given to an individual). Further, the Court of Appeal found that the statute of limitations was tolled by the filing of the Application for Adjudication of Claim before the Workers' Compensation Appeals Board. The tolling of the statute of limitations for the civil action took effect upon filing of the application, and would have ended upon a determination that would trigger the workers' right to seek a tort remedy – e.g. a final determination of non-insurance of the employer. (*Elkins v. Derby*, (1974) 12 Cal. 3rd 410, 39 Cal. Comp. Cases 624.) The summary judgment was reversed, plaintiff awarded costs on appeal, and the trial court directed to reconsider its sanction order.

XXIX. Attorneys and Attorneys' fees:

Erickson v. Southern California Permanente Medical Group/Kaiser, (2006) 71 Cal. Comp. Cases ___ (WCAB Significant Panel Decision)

During the time the issue of how to calculate permanent disability indemnity for successive injuries is deferred until the Supreme Court issues its decision(s) in *Brodie, Welcher*, et. al., the WCJ may issue an interim attorneys fee.

In the Matter of Hoffman, (2006) 71 Cal. Comp. Cases 609 (WCAB Significant Panel Decision).

Hoffman was admitted to the California Bar in December 1972. In 1985 he pled guilty to three felony charges. In April 1985 he voluntarily became an inactive member of the Bar, and on June 27, 1986, Hoffman resigned from the Bar with disciplinary charges pending against him. No record of any petition under Workers' Compensation Appeals Board Rules of Practice and Procedure §10779, for permission to appear as a representative before the Workers Compensation Appeals Board. As a former member of the state bar who resigned from the Bar with disciplinary charges pending such petition and approval of the Board is a pr-requisite to appearance by such individuals.

In 1989, Hoffman began appearing as a representative for lien claimants. In June 2004, a firm for which Hoffman worked gave notice of representation of a lien claimant in a Goleta case. On January 20, 2005 Hoffman appeared at hearing as a representative of the lien claimant. On January 26, 2005, Hoffman appeared at hearing as representative for another lien claimant in another case. On at least two further occasions the firm for which Hoffman worked filed notices of representation in cases pending at the Oakland district office. With respect to each notice of representation, Hoffman denied that he signed the notice of representation, but acknowledged that other staff members of the firm were authorized to sign for him. On June 13, 2005, a trial hearing was held on the issue of why Hoffman should not be barred from appearing for violation of Rule 10779, and his status as a former attorney who had resigned while disciplinary charges were pending and had not sought or obtained Board approval to appear. The WCJ found Hoffman had violated Rule 10779, and barred him from further appearances until he petitions for and obtained Board approval to appear. The Appeals Board noted that the Court of Appeal had in *Benninghoff v. Superior Court*, (2006) 136 Cal. App. 4th 61 (*Benninghoff*), limited right of "defrocked" attorneys to act as representatives even in administrative law proceedings where parties are allowed to represent themselves. It held that "defrocked" former attorneys are not permitted to appear as representatives on behalf of any party or lien claimant. The bar extends beyond appearances at hearings, and precludes filing of pleadings, negotiating or settling claims, preparing stipulations, appearing at depositions, or engaging in discovery activities. Were Hoffman to petition for authorization to appear, he should address whether *Benninghoff* invalidated Rule 10779 and precluded the Board from allowing "defrocked" attorneys appearing before the Board.

Smith v. Workers' Compensation Appeals Board and *Amar v. Workers' Compensation Appeals Board*, (2007) ___ Cal. App. 4th ___, 72 Cal. Comp. Cases ___ (Court of Appeal, Second Appellate District, published 1/17/07)

Smith had sustained injury to his right shoulder, neck, and psyche for which he was awarded benefits including future medical treatment. Eight years after the injury, the employer's adjusting agency refused to authorize epidural injections into Smith's back requested by the treating physician. Smith's attorney commenced proceedings to enforce

the award of medical treatment. Applicant was ordered to undergo examination by an Agreed Medical Evaluation (AME). When the AME recommended that the injections were needed to relieve back pain resulting from the work injury, defendant provided the injections. The WCJ denied applicant's attorney's request for fees under Labor Code Section 4607. Because the defendant had not denied all medical treatment, but merely challenged the need for one procedure, the denial did not amount to a petition to terminate treatment. The Workers' Compensation Appeals Board affirmed the denial. Applicant's counsel sought review.

Amar had sustained injury to his right foot for which further medical treatment was stipulated to be necessary. Medical care included treatment for a weight loss program and non-industrial diabetes, both of which were related to his industrial foot injury. After the stipulated award, defendant relied on utilization review to deny weight loss and diabetes care. No petition to terminate the award for medical treatment was furnished. After proceedings to enforce the award, the WCJ ordered the weight loss program be provided, found the diabetes control no longer required to treat the foot injury, found defendant had not unreasonably delayed provision of treatment, and denied a request for attorneys fees under Labor Code Section 4607. The Workers' Compensation Appeals Board denied reconsideration. Applicant's counsel sought review.

The Court of Appeal granted review, and reversed, allowing the applicant's counsel attorneys fees under Labor Code §4607. It held that there is no significant difference between a carrier denying all treatment awarded, and a carrier informally denying some of the treatment that is a necessary part of medical care previously awarded. This is tantamount to a petition to deny medical care even though the carrier continues to provide treatment for some of applicant's medical care. The court notes *United Airlines, RSKCo. v. W.C.A.B. (Dickerson)*, (1999) 64 Cal. Comp. Cases 1511 (writ denied) which construed the denial of some medical treatment on the ground it was not reasonably required to cure or relieve the effects of injury to be a constructive petition to terminate medical treatment. It also cites *Honeywell v. Workers' Compensation Appeals Board (Wagner)*, (2005) 35 Cal.4th 24; 70 Cal. Comp. Cases 97, which laid to rest the doctrine of constructive filing of DWC Form 1 (Claims Forms) as triggering the presumption of compensability under Labor Code 5402.) The Court concluded:

“...[I]t would be absurd to deny attorney fees to industrially injured workers simply because the carrier withdrew care without bothering to file a formal petition to do so. If attorney fees are available to counsel who oppose formal petitions, they should be available to counsel who must initiate proceedings to challenge the informal denial of medical care.

“California's workers' compensation law functions in large part through the expertise, dedication and professionalism of the attorneys who represent the parties involved in individual cases. Attorneys representing insurance carriers are not expected to work for free. Neither are applicants' attorneys. Insurance carriers who fail to provide previously awarded medical care may not avoid attorney fees to

successful applicants' attorneys through the expedient of an informal denial, even when they do so in good faith.”

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