

**SUMMARY OF  
RECENT SIGNIFICANT DECISIONS IN  
CALIFORNIA WORKERS'  
COMPENSATION LAW**

**FEBRUARY 2009 - JANUARY 2010**

## **DISCLAIMER**

In this case law summary, the author has attempted to present an accurate summary of each case. However, at least to some extent, the summaries are dependent on the interpretation of the author, and cases are often subject to more than one interpretation. Furthermore, the reader should review the actual cases before citing them as authority since the summaries may contain errors, and cases are subject to being revised by the Courts after publication of the case law summary.

The opinions and analyses presented in this case law summary are those of the author alone and are not to be attributed to the Division of Workers' Compensation, the Workers' Compensation Appeals Board, any Workers' Compensation Administrative Law Judge, or Zenith Insurance Company.

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**Summary of  
Recent Significant Decisions in  
California Workers' Compensation Law  
October 2008 – September 2009**

- I. Jurisdiction and Venue**
- II. Employment**
- III. Insurance Coverage/California Insurance Guarantee Association**
- IV. Injury AOE/COE**

*Costco Wholesale v. WCAB (Slayton) (2009) 74 CCC 319, Court of Appeal, Fifth Appellate District, unpublished opinion.*

Applicant worked in the employer's deli department, but would cover for a lunch or break shift in the bakery department three or four times a week. Although it was company policy that employees were not allowed to make purchases in the store during their shifts, except for lunch and breaks, it was common practice for employees and even managers to set aside items during work hours they intended to purchase. Applicant paid for a cake during a break. When she finished her job duties 20 minutes before the end of her shift, she told a co-worker she was going to leave early, but would first get the cake and come back. Not finding the cake on the rack for pick up, she went behind the counter with the intention of finding the cake and packaging it herself. With the cake in hand, she fell and injured her knee.

Applicant was able to work the next day which was a Sunday, and on Monday reported the injury to a store manager who told her to see a doctor. She underwent knee surgery. However, the employer denied reimbursement on the ground that her picking up the cake was a violation of company rules even though she was not reprimanded in any way in regards to the event. The matter proceeded to trial. The WCJ found compensability and the WCAB summarily denied defendant's petition for reconsideration.

Defendant sought judicial review, contending that although the injury arose out of the employment, it did not occur in the course of the employment because applicant chose to purchase and pick up the cake and effectively ended the employment relationship when she decided to leave early. The Court did not find these arguments to be persuasive. Several employees and a manager had testified that it was common practice for employees to set aside items in the store for personal reasons during working hours. Thus, while applicant may have intended to leave shortly thereafter, substantial evidence

supported the WCAB's determination that she had not yet abandoned her shift and was instead merely setting aside the cake by retrieving it from the bakery. While she might have had a personal interest in purchasing the cake, she was simultaneously furthering the employer's business activities, which included producing, packaging, and selling cakes.

The petition for writ of review was denied and the matter remanded to the WCAB to issue an award of reasonable attorney fees in connection with answering the petition.

*American Home Assurance v. WCAB (Wuertz)* (2009) 74 CCC 1015, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant commuted 50 miles each way from his home to the employer's printing plant. He worked rotating 12 hour shifts plus overtime when available. The employer called a special meeting to discuss a customer complaint on a day that applicant was not scheduled to work either his regular shift or overtime. During such meetings, which only occurred 2 – 4 times a year, all of the machines were stopped so that the entire staff could attend. Otherwise, the machines ran 24 hours a day. En route to the worksite, applicant sustained a serious injury. He filed a workers' compensation claim that was denied by the employer's insurer on the ground that the going and coming rule barred injuries sustained during an ordinary commute.

The matter proceeded to trial and the WCJ found that the injury was compensable based on the special mission exception to the going and coming rule. The WCAB denied reconsideration and the defendant sought judicial review.

The Court of Appeal noted that the special mission exception to the going and coming rule requires that three requirements be met: (1) the activity is extraordinary in relation to the employee's routine duties, (2) the activity is within the course of the employee's employment, and (3) the activity was undertaken at the express or implied request of the employer and for the employer's benefit. The Court also noted that the timing is important because "the bother and effort of the trip itself is an important part of what the employee is eventually compensated for." Defendant did not dispute that applicant met the last two requirements, but contended that he was not engaged in a special activity that was extraordinary in relation to his routine duties.

The Court found that the WCAB reasonably concluded that attending the meeting, requiring the shutting down of equipment that only occurred a few times per year, was not a usual and routine employment duty. While it was true that applicant worked a lot of overtime, the evidence showed that he was not scheduled to work overtime on that particular day.

The Court distinguished *City of San Diego v. WCAB (Molnar)* (2001) 66 CCC 692 in which the Fourth Appellate District rejected the claim of a police officer who was injured on the way to testify in court on a day in which he was not otherwise scheduled to work. It noted that it was an integral part of the duties of a police officer to testify in court

whereas no testimony was offered suggesting applicant's attendance at the meeting was an integral and routine part of his job duties as a machine operator.

Therefore, the Court held that the WCAB's opinion was supported by substantial evidence and denied the petition for writ of review.

*Esquivel v. WCAB* (2009) 74 CCC 1213, Court of Appeal, Fourth Appellate District, Division One.

Applicant lived in San Diego and drove 130 miles to her mother's home in Hesperia for a weekend visit. Monday morning, she left to attend appointments with two of the medical providers with whom she was treating for an industrial injury. While still in Hesperia, she was involved in an automobile accident in which she was seriously injured. After a trial, the WCJ found that her motor vehicle accident injuries were a compensable consequence of her existing industrial injuries and awarded her TD and additional medical benefits. The defendant sought reconsideration of the WCJ's decision which was granted by the WCAB. The Board found that the accident occurred too remotely from applicant's home and her destination to reasonably assign the risk of injury en route to the employer.

Applicant petitioned the Court of Appeal for review of the Board's order and decision, contending that there is no geographic limit to an employer's risk of liability for new injuries sustained while en route to a medical appointment for treatment of an existing industrial injury, as long as the employee does not materially deviate from a reasonably direct route to the medical appointment.

The Court noted that none of the cases dealing with injuries sustained traveling to and from medical appointments address the question of a reasonable geographic distance and no statute or regulation contained an express geographic limitation on an employer's risk of incurring compensability liability for such injuries. However, it believed such a limitation was implied in Labor Code §4600 and the related regulation, 8 CCR §9780. Section 4600 gives an injured worker the right to be "treated by a physician of his or her own choice or at a facility of his or her own choice *within a reasonable geographic area.*" The term, "*reasonable geographic area,*" per §9780 is to be determined by giving consideration to the employee's place of residence, place of employment and place where the injury occurred; and the availability of physicians in the fields of practice, and facilities offering reasonably required treatment together with the employee's medical history and primary language. The Court believed a similar rule of geographic reasonableness should limit an employer's risk for compensability related to injuries sustained during travel to and from a medical appointment related to a compensable industrial injury.

Affirming the decision of the Board, the Court held that if the employee chooses for reasons unrelated to his or her need for medical treatment to travel to a distant location beyond the reasonable geographic area of his or her employer's compensability risk, and is injured while traveling an unreasonable distance from that distant location to a medical appointment for examination or treatment of an existing compensable injury, the

employer will incur no such liability under the Act. The Court did not adopt a specific tests for a reasonable geographic distance, but held that such determinations must be made on a case by case basis considering all relevant circumstances, including (but not limited to):

- “(1) the location of the employee’s residence;
- (2) the location of the employee’s workplace;
- (3) the location of the office of the employee’s attorney;
- (4) the location of the medical provider’s office,
- (5) the place where the new travel-related injury occurred;
- (6) the distance between the employee’s point of departure and the medical provider’s office along a reasonably direct route to that office;
- (7) the additional distance the employee travels in the event he or she deviates from that reasonably direct route while en route to the medical provider’s office;
- (8) the availability of medical providers in the fields of practice, and facilities offering treatment, reasonably required to cure or relieve the employee from the effects of the existing industrial injury; and
- (9) the reason or reasons for the employee’s travel beyond a reasonable geographic area within which the employer ordinarily should bear the risk of incurring compensability liability in the event the employee is injured while traveling to or from the medical appointment.”

## V. Evidence; Presumptions

### A. Evidence

*Lopez v. WCAB* (2009) 74 CCC 295, Court of Appeal, Third Appellate District, writ denied.

Applicant sustained an injury to his spine and lower extremities. The parties stipulated that his PD rated 38 percent and submitted the issue of apportionment. The WCJ found no basis for apportionment. Judicial notice had been taken of Defendant’s Exhibit H, consisting of a 2000 Stipulated Award for a prior back injury resulting in 40-percent PD. However, the WCJ excluded Defendant’s Exhibits I and J, which included a 1999 MRI of Applicant’s back and the 2000 medical report of Applicant’s QME that were part of the record and relied on by the WCJ in approving the 2000 Stipulated Award. The basis for the exclusion of these exhibits was defendant’s failure to identify the documents in the pre-trial conference statement submitted at the MSC, in violation of Labor Code §5502(e)(3).

Defendant filed a petition for reconsideration which was granted. After further study of the legal issues, the Board issued an opinion and decision in which it disagreed with the WCJ’s rejection of defendant’s exhibits. It noted that Evidence Code §452(d) provides, in part, that judicial notice may be taken of “Records of any court of (1) this state or (2) any

court record of the United States or of any state of the United States.” In addition, Evidence Code §453 requires that judicial notice *must* be taken if it is requested by a party and the party sufficiently notices the adverse party and gives the court sufficient information to enable it to take judicial notice. Both conditions were met in this matter.

Title 8 CCR §10751 provides that after a C & R or stipulations with request for award is filed, all medical reports become part of the legal file that includes the “record of proceeding. Section 10750 describes the documents which, in addition to the medical reports, constitute the legal file or record of proceedings. Whether or not formally admitted into evidence, the medical reports represented by Defendant’s Exhibits I and J were part of the evidence used by the WCJ to determine the adequacy of the stipulations and, pursuant to Evidence Code §453, were proper subjects of judicial notice. Therefore, the Board rescinded the WCJ’s decision and returned the matter to the trial level to take judicial notice and determine whether apportionment was justified, and if so, to what extent.

Applicant filed a petition for writ of review that was denied.

**B. Presumptions**

**VI. Res Judicata/Collateral Estoppel**

**VII. Discovery**

**VIII. Earnings/Compensation Rate**

**IX. Temporary Disability**

*Brower v. WCAB* (2009) 74 CCC 354, Court of Appeal, Sixth Appellate District, writ denied.

Applicant sustained an injury to his lumbar spine, underwent back surgery and was paid TD benefits for the full 104 weeks permitted under Labor Code §4656(c)(1). After the 104-week period had elapsed, he underwent further back surgery and was declared TTD by AME. Applicant contended that, since TD was discontinued, he was entitled to payments of PD notwithstanding the AME’s opinion that he was not yet P&S. The WCJ found that it was “premature to determine the extent of Applicant’s permanent disability.” Applicant petitioned for reconsideration and the WCJ recommended that his petition be denied as having no basis under the law, but added:

“Applicant sets forth the lamentable circumstances in which he finds himself with a good deal of eloquence. For the most part, I agree that the operation of section 4656 has placed the Applicant in an impossible position, a position that cries out for a remedy. No such remedy is available under existing law.”

The WCAB adopted the WCJ's report, but added some comments as follows:

“In this case, we determine applicant's disability status based on substantial medical evidence rather than lay theory. Per the AME, the applicant's disability is not yet permanent...and there is no evidence that applicant has a progressive or unusual condition that will never reach maximum medical improvement...The 4656(c)(1) cap on temporary disability was intended to be a significant narrowing of liability...and we cannot redefine permanent disability in order to avoid its application. The applicant remains temporarily totally disabled and he has not yet reached maximum medical improvement. Therefore, he is not entitled to permanent total disability indemnity. Accordingly, we will deny applicant's petition for reconsideration.”

Applicant filed a petition for writ of review arguing that the WCAB should have awarded PD in light of applicant's total loss of working capacity. However, his petition was denied.

*POM6 XYZZX v. WCAB (Morfin)* (2009) 74 CCC 663, Court of Appeal, Fourth Appellate District, Division Two, writ denied.

Applicant sustained industrial injury to his low back and left shoulder for which defendant paid him 104 weeks of TD and then terminated the payments pursuant to Labor Code §4656. Applicant argued that he was entitled additional TTD benefits beyond the 104-week limit, due to his pre-existing HIV status. Defendant contended that since applicant's HIV condition was not caused or exacerbated by the industrial injury, the exception to the TD cap did not apply. The WCJ found that applicant did not fall within the exception and was not entitled to further TD.

Applicant petitioned for reconsideration. He claimed that because of his HIV status, many forms of treatment for his industrial injury were contraindicated, resulting in prolonged delay in his functional recovery. In his report, the WCJ noted that the use of the word “shall” in Labor Code §3204 made it mandatory that the injury definition contained in Labor Code §3208 be used. Labor Code §3208 includes injuries or conditions “arising out of the employment.” Thus, for Applicant's HIV status to be considered an injury within Labor Code §4656, it must arise out of his employment.

The WCAB summarily denied reconsideration. Applicant filed a petition for writ of review that was denied.

*AA Gonzalez, Inc. v. WCAB (Morfin)* (2009) 74 CCC 760, Court of Appeal, Fourth Appellate District, Division Three, writ denied.

Applicant, a plasterer/hose tender was injured when a hose pumping stucco exploded with great force into his eyes. After an expedited hearing, the WCJ found that applicant was entitled to more than 104 weeks of TD pursuant to the high velocity eye injury exception to the exception to the 2 year TD cap in Labor Code § 4656(c)(1). Defendant

filed a Petition for Reconsideration, contending that Applicant did not suffer a high velocity eye injury; and that the high velocity eye injury exception cannot be applied because the provision is too vague to be enforced.

In her reconsideration report, the WCJ noted that there are many legal terms or descriptions which are determined on a case-by-case basis. In this case, the Legislature's intent can be determined from the plain meaning of the statute. Clearly, the Legislature intended to extend TD for certain major injuries that are listed in the statute. The WCAB adopted and incorporated the WCJ's report without further comment. Defendant's petition for writ of review was denied.

*Morris v. WCAB* (2009) 74 CCC 794, Court of Appeal, First Appellate District, Division Five, writ denied.

Applicant sustained a CT during the period ending 9/17/2001, for which she received an award. Her treating physician reported on 11/5/05 that she had sustained a new CT involving a different body part and that she was TTD as a result. Applicant then claimed a new injury for a CT to her shoulder ending 10/25/05. On 1/11/2006, defendant paid applicant one day of TD for the period 12/14/2005 through 12/18/2005, based on the treating physician's report of 11/5/05. Applicant underwent surgery on 4/28/08 for which defendant denied TD based on the 104 week cap in Labor Code §4656.

At an expedited hearing, the claims supervisor appeared and testified that she didn't know why they had paid that one day of TD. The WCJ issued a decision finding that applicant was not entitled to further TD based on the "black letter of the law" that, although unfair, must be followed. Applicant's petition for reconsideration was denied as was her petition for writ of review.

## **X. Medical Treatment**

### **A. In General**

*Criswell v. WCAB* (2009) 74 CCC 144, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant sustained an admitted industrial injury to her left hand, left knee, left ankle, low back, and neck in 2000. The AME who evaluated her in 2003 did not describe any problems with her left ankle, but noted a potential need for surgery on her left knee. A stipulated award then issued providing for further medical treatment. In 2005, she fell after her ankle gave out. She was reevaluated by the AME who couldn't find a causal connection between the original injury and her more recent left ankle sprain.

In 2007, the PTP recommended concurrent surgeries to both the knee and ankle. The defendant denied authorization based on the opinion of the AME. The PTP was deposed and he didn't not find a causal connection either. He felt that the ankle surgery would

“help the rehabilitation on the knee significantly,” but he was unable to confirm that it was “reasonably, medically probable” that there would be additional problems with physical therapy and recovery of the knee if the ankle surgery was not performed.

In 2008, a WCJ approved a stipulated award providing that defendant would authorize surgery for applicant’s left knee, as requested by the PTP. Defendant refused to authorize the ankle surgery and applicant requested an expedited hearing. The WCJ ruled that applicant was entitled to left ankle surgery along with the left knee surgery, based on her testimony that her left ankle simply “gave out on her” due to her altered gait resulting from her industrial injury. Defendant filed a petition for reconsideration. In a split decision, the WCAB agreed with defendant and reversed the WCJ. Applicant then sought judicial review.

The Court of Appeal rejected applicant’s argument that defendant must provide surgery to her ankle either as a compensable consequence of her industrial injury or to cure or relieve the effects of the 2000 knee injury, noting that neither the AME or the PTP was able to find a causal connection and the PTP did not believe she would be in any danger from not treating the left ankle. The Court was also persuaded by defendant’s argument that applicant waived treatment to the left ankle by entering into the 2008 stipulated award that provided for surgery for the knee only.

The petition for review was denied.

**B. ACOEM Guidelines/Utilization Review**

**C. Spinal Surgery Second Opinion**

Cervantes v. El Aguila Food Products, Inc. (2009) 74 CCC 1336, WCAB En Banc Opinion.

Applicant’s PTP recommended spinal surgery in a January 16, 2009 narrative report that did not clearly state at the top that he was requesting authorization for surgery. On February 25, 2009, he sent the carrier a fax captioned “WRITTEN REQUEST FOR SURGERY AUTHORIZATION,” which referenced his earlier reports and requested authorization for an “L4-5 + L5-S1 posterior lumbar interbody fusion with pedicle screw fixation.” On March 4, 2009, the carrier obtained a report from a UR doctor who concluded that the requested surgery “is not recommended as medically necessary” based in part on the ACOEM Guidelines.

At an expedited hearing, applicant argued that defendant’s UR denial was untimely, as to the PTP’s January 2009 report. Defendant contended that the PTP’s original report was not a valid request for authorization. Thus, its UR report was timely as to the February 2009 fax and applicant should have initiated the second opinion process at that point, but didn’t. The WCJ awarded the surgery, finding that the PTP’s request was reasonable and

the UR report “not persuasive.” The legal issues were declared to be moot. Defendant filed a petition for reconsideration.

The WCAB interpreted certain provisions of Labor Code §§4610 and 4062, and considered the interrelationship of these provisions together with the application of relevant AD Rules, in the context of a treating physician’s request for authorization of spinal surgery. Based on Labor Code §§4062(a) and 4610, as well as the Supreme Court’s decision in *State Compensation Insurance Fund v. WCAB (Sandhagen)* (2009) 73 CCC 981, the Board first concluded that a defendant must conduct UR whenever an injured employee’s treating physician recommends spinal surgery.

If UR approves the spinal surgery request, the defendant must authorize the surgery. The Board found this to be in accord with the language of §4062(b) that the purpose of the spinal surgery second opinion procedure is to obtain a report “*resolving the disputed surgical recommendation.*” Also, §4610(g)(3)(A) states that “[i]f a request to perform spinal surgery *is denied,*” then “*disputes shall be resolved* in accordance with [section 4062(b)].” Therefore, if UR approves the surgery, there is clearly no dispute to resolve. Furthermore, given both the purpose and timelines of both statutes, the Board also concluded that if a defendant fails to timely complete UR it must authorize the spinal surgery.

The WCAB next concluded that in the sole context of a recommendation for spinal surgery, it is only the defendant, and not the injured employee, that may object under Labor Code §4062 based on the opening statement in §4062(b) that “*[t]he employer may object* to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report.” In this regard, the Board noted the legislative framework for spinal surgery cases is simply different than it is for non-spinal surgery cases because, at every step, section 4062(b) places the onus on the defendant. This also demonstrated by the obligation of the defendant to file a DOR if the second opinion does not recommend the surgery. Furthermore, the general procedure of §4062(a) for “employee” objections to UR determinations is utterly inconsistent with the specific and expeditious 45-day procedure of section 4062(b) for spinal surgery cases.

Pursuant to Labor Code §4062(b), a defendant must both complete its UR and, if there is a UR denial, make its section 4062(b) objection within 10 days of its receipt of the treating physician’s report recommending spinal surgery. While §4610(g)(1) requires UR to be completed “*no ... more than 14 days from the date of the medical treatment recommendation by the physician*” it also requires that UR decisions “*shall be made in a timely fashion that is appropriate for the nature of the employee’s condition.*” Therefore, in spinal surgery cases, a UR decision that is “timely” made within 10 days of the receipt of the treating physician’s report is “appropriate for the nature of the employee’s condition.” Therefore, if a treating physician seeks authorization for spinal surgery through a narrative report, the narrative report must clearly state at the top that authorization for spinal surgery is being requested.

If the defendant fails to meet the 10-day timelines or to comply with Ad Rule 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery. Rule 9788.1 expressly requires a defendant to include: (1) a copy of the treating physician's report; (2) an employee-specific reason for its objection; and (3) distinct and particularized declarations under penalty of perjury regarding when the treating physician's report was received and when the defendant served its objection. Requiring use of the form adopted by Rule 9788.11 gives clear notice to the AD – and to the employee or the employee's attorney – that an objection to the treating physician's spinal surgery recommendation is being made. A failure to comply with those Rules is the functional equivalent of no timely objection.

The Board expressly disapproved of *Brasher v. Nationwide Studio Fund* (2006) 71 CCC 1282, Significant Panel Decision, to the extent it holds: (1) a defendant may opt out of UR and instead dispute the requested spinal surgery using only the procedure specified in section 4062(b); and (2) if a defendant's UR denies spinal surgery, it is the *employee* that must object under *section 4062(a)*.

Turning to the merits of the case, the Board recognized that defendant's position was then fully consistent with *Brasher*. In light of these holdings, the Board rescinded the Finding and Order determining that applicant was entitled to lumbar spinal fusion surgery and gave the defendant 10 days from the date of its *receipt* of this opinion within which to object to the PTP's surgery recommendation and commence the spinal surgery second opinion process. The matter was remanded to the WCJ for further proceedings and a new decision, consistent with this opinion.

## **XI. Medical Evidence**

## **XII. Lien Claims and Costs**

*Marin Surgery Center v. WCAB* (2009) 74 CCC 552, Court of Appeal, First Appellate District, Division Three, writ denied.

After the case in chief resolved, a lien claimant filed a DOR and obtained a hearing date. Neither party appeared at the hearing and the WCJ issued a notice of intention to dismiss the lien. Lien claimant objected on the basis that the defendant could not locate its file and did not know which attorney would be representing its interests at the hearing. Therefore, it "made sense" that the hearing should be continued or taken off the calendar.

The WCJ dismissed the lien, not finding lien claimant's explanation to constitute good cause. Lien claimant then filed a petition for reconsideration, contending that the policy of courts in California was that dismissals should be freely vacated when justice dictated. The WCJ recommended that reconsideration be denied, commenting that lien claimant's argument was based on the premise that the parties could determine among themselves

what constituted a good cause to continue or take the case off the calendar. The WCJ found such a position to be “simply unacceptable.”

After initially granting reconsideration for further study, the WCAB affirmed the WCJ’s order of dismissal. The Board indicated that it was not persuaded “that an agreement to continue the matter between lien claimant and the defendant constitutes good cause” to set aside the notice of intention or the decision to dismiss the lien claim because “it is the WCJ rather than the parties who determines whether or not a lien trial is continued.”

Lien claimant filed a petition for writ of review which was denied by the Court of Appeal.

*Pain Center of Ventura County v. WCAB* (2009) 74 CCC 304, Court of Appeal, Second Appellate District, Division Six, writ denied.

After applicant’s case resolved by C & R, a lien trial was held concerning the reasonable value of the facility fee charges of an outpatient surgery center for a liposuction procedure. Defendant had paid the lien claimant \$1,040 of its \$16,636 bill, but disputed the balance. The WCJ denied the lien on the basis that the lien claimant failed to prove that it was properly licensed or that the accrediting agency was approved by the Medical Board, and that it had a fictitious name permit (FNP) issued by the Medical Board. Additionally, it failed to prove that its charges were reasonable.

Lien claimant filed a petition for reconsideration which was granted by the WCAB. The Board rescinded the WCJ’s F & O, finding that the accrediting agency was recognized by the Medical Board and that the lien claimant did not need an FNP at the time the services were rendered. Under *Stokes v. Patton State Hospital* (2007) 72 CCC 996, Significant Panel Decision, a facility that provides only an “outpatient setting” is not required to have an FNP. Since the surgery center was only claiming entitlement to a facility fee, it would not be required to produce an FNP from the Medical Board. The lien claimant presented documents that suggested it was accredited, but it did not place into evidence a copy of any actual certificate of accreditation in effect on the date of the procedure. The Board therefore returned the matter to the WCJ to further address the accreditation issue as well as the reasonableness of the charges.

The matter was retried and the WCJ found that the lien claimant had carried its burden of proving that it was accredited. However, it did not prove that its charges totaling \$16,636 were reasonable for the services provided to the applicant and the defendant established that a reasonable charge was \$5,000.00. The surgery center again petitioned for reconsideration.

In his report, the WCJ analyzed the evidence presented in the case. The lien claimant presented no evidence except for the total amount of the billings to establish that the fees it was charging were reasonable, without itemizing the costs of the individual services. Defendant’s witness testified in great detail concerning the criteria that was used to determine the reasonable value. The \$1,040 payment was based on 200 percent of the

Medicare fee schedule. Subsequently, the witness conducted a comparable study in which she contacted various inpatient surgery centers by telephone. The basic fees charged by each hospital were substantially less than the fees claimed by the lien claimant. The witness then contacted doctors and outpatient surgery centers and asked each to provide an overall quote for the cost of the surgery. After deducting the physician and other charges not associated with the facility fee, the charges ranged from \$3,100.00 to \$3,900.00. The lien claimant presented no rebuttal evidence to this testimony.

Furthermore, there was evidence that the surgery center would accept Medicare patients as a vastly reduced amount, and while the WCJ did not construe this evidence to mean that the Medicare standard rate of payment should apply in this case, he did consider this as a factor in determining what constituted a reasonable facility fee. Taking everything in consideration, the lien claimant was awarded \$5,000, less credit to defendant for sums already paid. The WCJ also determined that the lien claimant was not entitled to interest under Labor Code § 4603.2 because defendant objected to the billings and paid the amount it believed was reasonable.

The WCAB adopted the WCJ's report and denied reconsideration without further comment on the issues, other than citing *Tapia v. Skill Master Staffing* (2008) 73 CCC 1338, Appeals Board en banc opinion. The lien claimant then filed a petition for writ of review that was denied.

*Comprehensive Outpatient Surgery Center v. WCAB (Osborne)* (2010) 75 CCC \_\_\_\_, Court of Appeal, Second Appellate District, Division Eight, writ denied December 14, 2009.

Pursuant to a referral from her PTP, applicant underwent treatment in lien claimant's pain management program that included "percutaneous epidural and decompression neuroplasties, local facet blocks and rhizotomies." She was referred to an AME who issued a report indicating that the pain management treatments were not indicated on an industrial basis under the ACOEM Guidelines. After the case in chief resolved, the matter proceeded to a lien trial in which no evidence was presented regarding whether UR was conducted before Applicant was referred to an AME. The WCJ denied recovery of the lien on the ground that the treatment was not reasonably medically required.

Lien claimant filed a Petition for Reconsideration, contending that it was entitled to recover on its lien since the defendant failed to conduct UR in accordance with *State Compensation Insurance Fund v. W.C.A.B. (Sandhagen)/Sandhagen v. WCAB* (2008) 73 CCC 981. The WCJ recommended that reconsideration be denied on the ground that the AME referral predated the Supreme Court's decision in *Sandhagen*. However, even if *Sandhagen* were applicable, there was nothing to preclude applicant from seeking an AME opinion. The WCJ commented that the parties should be encouraged to resolve disputes through the AME process, and lien claimants should not be rewarded, based on alleged procedural defects, for providing unreasonable and unnecessary treatment to injured workers.

The WCAB denied reconsideration and adopted and incorporated the WCJ's report without further comment. Defendant's petition for writ of review was denied.

### **XIII. Vocational Rehabilitation**

*Beverly Hills Hotel v. WCAB (Boganim)* (2009) 74 CCC 927, Court of Appeal, Fifth Appellate District.

Applicant filed Applications for Adjudication for two injuries occurring in 1990 and 1991 which were found by the WCJ to be compensable. He requested vocational rehabilitation services that were denied by the defendant. He filed a request with the Rehabilitation Unit as a result of which the RU ultimately issued a Determination that applicant was entitled to VR benefits and services. Defendant appealed the Determination to the WCAB and, after a trial *de novo*, the Determination of the RU was upheld in an F & A that issued in January 2008. The WCJ also found that applicant was entitled to VRMA at the TD rate from July 27, 1998, or until he met with an agreed qualified rehabilitation representative.

Defendant filed a petition for reconsideration which was affirmed by the WCAB in October 2008 after reconsideration was granted. None of the parties raised before the Board the issue of whether as of and after January 1, 2009, applicant had a valid award of VR services or benefits. On November 20, 2008, defendant filed a petition for writ of review. The Court of Appeal requested that the parties brief the issue of the effect on the repeal of former Labor Code §139.5. On June 10, 2009, the Board issued its en banc opinion in *Weiner v. Ralphs Co.* (2009) 74 CCC 736, holding that the repeal of former §139.5 terminated any rights to VR benefits or services provided for or by orders or awards that were not final before January 1, 2009.

Defendant contended that the repeal of §139.5 ended all rights that would have derived from that statute, that there is no saving clause concerning the repealed statute, and that the law in effect at the time of the Court of Appeal's decision must be applied. Applicant argued that the repeal of §139.5 as of January 1, 2009, did not affect awards affirmed by the Board before that date. Furthermore, it maintained that an employee must have a remedy to enforce a right when an employer was aware of an obligation to provide benefits and failed to comply with that obligation.

The Court cited to the principle that "when a pending action rests solely on a statutory basis, and when no rights have vested under the statute, 'a repeal of such a statute without a saving clause will terminate all pending actions based thereon.'" Workers' compensation awards may become null by subsequent legislation enacted prior to a final judgment as occurred in those cases in which there was not a final award before the new apportionment provisions of SB 899 took effect. Because this matter was still subject to review by the Court after January 1, 2009, former §139.5, could no longer be applied or enforced in this case.

The Court also noted that there was no indication, express or implied that the Legislature intended to save VR rights or remedies after the date of the repeal. In effect, it preserved

or saved VR claims for nearly five years after VR was abolished, but did not save non-final VR rights past January 1, 2009. Furthermore, Section 47 of the legislation states:

“The amendment, addition, or repeal of, any provision of law made by this act shall apply prospectively from the date of enactment of this act, regardless of the date of injury, unless otherwise specified, but shall not constitute good cause to reopen or rescind, alter, or amend any existing order, decision, or award of the Workers’ Compensation Appeals Board.”

Contrary to applicant’s assertions, the Court found that Labor Code §5502 which provides for expedited hearings for VR disputes has no applicability to the continuing application of a repealed statute. Nor could §139.5 (f), which provided, “the time within which an employee may request vocational rehabilitation services is set forth in former section 5405.5 and sections 5410 and 5803” be deemed a saving clause because it too was repealed. The Court likewise rejected applicant’s argument that former Labor Code §4642 functions as a so called “ghost statute” to confer jurisdiction to hear disputes involving VR services.

The Court concluded that applicants had rights to VR awards up to January 1, 2009. After that, there were no such statutory rights available as to claims that were not vested by that date. Thus, neither the Board nor this court has jurisdiction to award such rights. The Board’s decision was therefore annulled.

*Weiner v. Ralphs Company* (2009) 74 CCC 736, WCAB en banc opinion

Applicant sustained an orthopedic injury in 2002 that was initially disputed, but accepted in 2005 at which time vocational rehabilitation services commenced and continued until March 2008 when defendant requested closure. On July 7, 2008, the matter came before the RU for a conference in which the only issue addressed was applicant’s claim for retroactive VRMA from the date of request in 2003 until the date in 2005 that defendant began providing benefits. The RU issued its determination ordering payment as requested by applicant on July 9, 2008 and defendant filed a timely appeal on July 29, 2008. A conference scheduled for September 8, 2008 was continued to October 14, 2008 at defendant’s request due to its attorney’s calendar conflict. Finally, the matter come on for trial on November 24, 2008, at which time the matter was submitted for decision.

The WCJ issued his decision on January 13, 2009 awarding the requested retroactive VRMA at the TD rate. Defendant filed a petition for reconsideration, asserting various arguments based on the fact that the Legislature repealed the VR statute, Labor Code §139.5, effective January 1, 2009, and therefore, all rights to VR benefits were abolished as of that date, unless those rights were vested through a final order. Applicant answered, asserting various arguments in opposition. The WCAB, sitting en banc, issued an order allowing amicus briefs in order to obtain in put from the community before issuing a final decision.

In its opinion and decision after reconsideration, the Board held that the repeal of Labor Code §139.5 terminated any rights to vocational rehabilitation benefits or services pursuant to orders or awards that were not final before January 1, 2009. It is settled law that the right to workers' compensation benefits is wholly statutory and that a statute may be repealed at any time, except when vested rights would be impaired. This principle has been addressed in a number of cases involving SB 899, including the repeal of statutes governing penalties and apportionment.

The repeal of a statute "without a saving clause" will terminate all pending actions based on the statute. When the Legislature repeals a statute but intends to save the rights of litigants in pending actions, it may accomplish that purpose by including a saving clause in the repealing act or in any other act on the same subject passed by the Legislature at the same legislative session. The Board found that the Legislature did not adopt a saving clause to protect vocational rehabilitation rights in cases still pending as of the January 1, 2009 effective date of the repeal of §139.5. By providing in April 2004 that §139.5 would not be repealed until January 1, 2009, the Legislature, in effect, "saved" both pending and impending vocational rehabilitation claims for a period of nearly five years. This gave affected employees a reasonable time within which to avail themselves of vocational rehabilitation before the repeal would take effect, and there is no evidence that the Legislature intended to *indefinitely* save non-final and non-vested vocational rehabilitation rights *beyond* January 1, 2009.

The Board rejected applicant's contention that Labor Code §§5502(b)(3), 5410 or 5803, constitute saving clauses that protect non-final and non-vested vocational rehabilitation claims after January 1, 2009 since none of these sections were part of SB 899, which contained the provision repealing section 139.5, nor were they part of any other legislative act relating to workers' compensation passed during the 2003-2004 legislative session or thereafter.

The Board also rejected the argument that the vocational rehabilitation statutes that were repealed in 2003 continue to function as "ghost statutes" after January 1, 2009. The "ghost statute" rationale was first presented in *Godinez v. Buffets, Inc.* (2004) 69 CCC 1311, a significant panel decision in which former Labor Code §4645(d), was deemed to retain a "shadowy existence" for injuries prior to January 1, 2004, in spite of its 2003 repeal. While the "ghost statutes" were necessary for a period of time when there was no other operative law, the Board concluded that, as of the January 1, 2009 effective date of former §139.5's repeal, the former rehabilitation provisions no longer have a "ghost statute" effect. Otherwise, this would lead to the utterly absurd result that a statute that was repealed in 2003 (i.e., former section 4642) would still be given legal effect, even though the statute on which its "preternatural continued legal effect" was entirely based (i.e., former §139.5) is also now repealed.

After the repeal of Labor Code §139.5, the WCAB lost jurisdiction over vocational rehabilitation issues, except to enforce or terminate vested rights. Labor Code §5300(a) only gives the Board jurisdiction over the recovery of "compensation" or concerning any right or liability arising out of or incidental thereto. The Board concluded that

§§5502(b)(3) and 5803 give it jurisdiction to conduct hearings and make determinations regarding the enforcement or termination of vested VR rights. However, even if an injured employee timely “institute[d] proceedings” under §5410, the employee lost the right to maintain those proceedings if no final order had issued before the January 1, 2009 effective date of the repeal of §139.5.

Applicant contended that he should not be denied retroactive VRMA at the TD rate because defendant failed to pay those benefits without any reasonable basis before January 1, 2009 and because the September 8, 2008 hearing before the WCJ on defendant’s VR appeal was delayed due to defendant’s counsel’s request for a continuance. However, the Board found that defendant had the right to raise subject matter jurisdiction for the first time on appeal and that that jurisdiction over VR issues cannot be conferred by waiver, estoppel, stipulation, or consent.

The Board concluded that applicant’s inchoate statutory right to recover retroactive VRMA at his TD rate had not vested through the entry of a final order or award as of the January 1, 2009 effective date of the repeal of Labor Code §139.5. Therefore, the repeal operated to extinguish his inchoate right. The Board therefore reversed the WCJ’s January 13, 2009 decision and vacated the July 9, 2008 determination of the Rehabilitation Unit.

#### **XIV. Permanent Disability**

##### **A. In General**

*Rivera-Sanchez v. WCAB* (2009) 74 CCC 20, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant sustained an admitted injury to his upper back. The PTP concluded that his subjective complaints were “out of proportion” to what he observed objectively from his physical examination. He was evaluated by a QME who likewise did not detect any objective factors of disability, but found permanent disability based on subjective factors.

The matter came on for trial and the WCJ awarded 28 percent permanent disability based on the opinion of the QME noting that while applicant’s subjective complaints might have produced a rating in the pension range, the QME’s subjective factors were in accord with the true measure of his disability.

Defendant petitioned for reconsideration on the basis that the QME had not reviewed certain x-rays. The WCJ therefore vacated the decision and ordered additional x-rays to be taken and forwarded to the QME. The QME was deposed and testified that he did not find applicant’s subjective complaints to be credible and that he would not change his factors of disability.

The case was transferred to a new WCJ since the former one had retired. He issued a new decision again awarding 28 percent permanent disability. Defendant again petitioned for reconsideration essentially contending that the WCJ had failed to give reasons for the opinion. A new rating was obtained which, based on the rating instructions, amounted to 38 percent permanent disability. The WCJ issued a new award for 38 percent permanent disability, but vacated the award and set the matter on calendar for the cross-examination of the rater after he belatedly learned that the defendant had moved to strike the recommended rating. After the rater explained his methodology, the WCJ reissued his prior decision concluding that applicant sustained 38 percent permanent disability.

Defendant again petitioned for reconsideration which was granted by the WCAB. Reversing the WCJ, the Board explained that “in light of the entire record, including the severity of the mechanism of injury and applicant’s low pain threshold or exaggerated complaints, we conclude, based on the range of evidence, that the injury caused 28 percent permanent disability.” Applicant then sought judicial review, contending, in essence, that the Board failed to explain how it arrived at 28 percent permanent disability within the range of the evidence. The Court of Appeal granted the writ.

The Court noted that the WCAB relied on a Supreme Court opinion in *U.S. Auto Stores v. WCAB*. (1971), 36 CCC 173, in which it held that a WCAB “decision is supported by substantial evidence if the degree of disability found by the referee is within the *range* of evidence in the record. It is not necessary that there be evidence of the exact degree of disability.” Since both doctors concluded that applicant had an unusually low pain threshold or had exaggerated his symptoms, this cast doubt on the accuracy of their medical diagnoses and justified a lower permanent disability rating the range of the medical evidence. The Court also noted that while applicant “would likely prefer a 38 percent permanent disability rating, he does not present a legal basis for this court to vacate the WCAB’s finding of fact.”

The petition for writ of review was therefore denied.

*County of Los Angeles v. WCAB (LeCornu)* (2009) 74 CCC 419, Court of Appeal, Second Appellate District, Division Seven.

Applicant sustained multiple orthopedic injuries as well as injury to his psyche. The primary issues of PD, apportionment, and further medical treatment were submitted for decision on the medical record, which included the medical reports of AMEs in orthopedics and psychiatry. The orthopedic AME apportioned 10 percent of the cervical disability and 25 percent of the lumbar disability to nonindustrial factors. The doctor found no basis for apportioning the disability referable to the upper extremities, knees and left hip. The AME in psychiatry apportioned 30 percent of the disability to various nonindustrial factors arising both before and after the injury. The psychiatric AME also expressed the opinion that applicant was not feasible to return to any job in the open labor market.

The recommended rating of Applicant's PD, after apportionment and calculated pursuant to the Multiple Disabilities Table, was 96 percent. Despite the recommended rating, the WCJ found that Applicant's injuries caused 100-percent PD, based on the fact that the multiple disabilities table was a guideline. The WCJ also relied on the AME's determination that Applicant was unable to return to the open labor market and on the principles in *LeBoeuf v. W.C.A.B.* (1983) 48 CCC 587.

Defendant filed a petition for reconsideration, contending that the rule in *LeBoeuf* is no longer viable after SB 899's amendments to Labor Code §4660, which provided a new PD schedule, and that, pursuant to the new apportionment requirements in Labor Code §4663, a defendant may only be held liable for PD directly caused by Applicant's industrial injury.

The WCAB disagreed with defendant, noting that applicant's permanent disability rating was based upon the 1997 rating schedule; not the rating schedule developed pursuant to amended Labor Code §4660. The Board went on to state:

“The rules provide that the Multiple Disabilities Table is a guide only, and that “the final rating will be the result of consideration of the entire picture of disability and diminished ability to compete in an open labor market.” In reaching the 96% permanent disability rating, the disability evaluation specialist followed the requirements of Labor Code section 4663 and apportioned to applicant's non-industrial disabilities, as outlined by the AMEs. However, he did not also factor in the applicant's “diminished ability to compete in an open labor market.” This diminished ability constitutes an additional factor which was directly caused by applicant's industrial injury. It falls within the WCJ's discretion to consider this factor in determining the final permanent disability rating. Reaching the determination that applicant is 100% permanently disabled, the WCJ appropriately exercised her discretion. This is consistent with *Labor Code section 4662*, which directs the WCJ to determine the existence of permanent total disability “in accordance with the fact.””

The WCAB denied the petition for reconsideration. Defendant filed a petition for writ of review that was denied by the Court of Appeal.

*Bontempo v. WCAB* (2009) 74 CCC 419, Court of Appeal, Second Appellate District, Division Four.

Applicant sustained a specific knee injury in 2003 and a cumulative trauma to his respiratory system ending in 2005. Applicant was evaluated by AMEs. In the pre-trial stipulations, it was agreed that the specific knee injury would be rated under the 1997 PD schedule whereas the pulmonary claim would be rated under the 2005 schedule. Regarding the pulmonary claim, while “nature and extent of permanent disability” was raised as an issue, the parties did not specifically include Labor Code §4658(d), the 15 percent increase or decrease, depending on whether the employer offers the injured employee regular work, modified work or alternative work within 60 days of the

disability becoming P & S. However, the parties stipulated that applicant was being paid \$253 in weekly benefits, an amount that included the additional 15 percent prescribed by §4658. The matters were submitted for decision without testimony or any evidence other than the medical reports.

The WCJ awarded permanent disability that did not include the additional amount under §4658(d). Applicant filed a petition for reconsideration contending that the WCJ should have awarded an additional 15 percent on the pulmonary claim. He did not claim entitlement to a similar adjustment for the orthopedic claim. Defendant argued that §4658(d)(2), had not been raised as an issue in either the pre-trial conference statements or on the record at the hearing. Defendant further contended that no evidence had been submitted which would have permitted the WCJ to resolve the issue, even had it been properly raised. The WCAB agreed with defendant and denied the petition. Applicant then sought judicial review, claiming that the increase should have been applied on both the orthopedic and the pulmonary claim.

The Court of Appeal sent a letter asking the parties and the Board to address whether “the provisions of Labor Code section 4658, subdivision (d)(2) and (d)(3) [are] mandatory by operation of law, thus requiring the 15 percent increase or decrease in permanent disability indemnity to be addressed and/or awarded in the Opinion on Decision and Findings and Award.” The Board responded with a letter stating that “if all the criteria in either section 4658 (d)(2) or (d)(3) have been met, the corresponding 15 percent increase or decrease must be applied, i.e., it is mandatory. However, . . . it will not necessarily be apparent from the record whether sections 4658(d)(2) or 4658(d)(3) should apply.” The Board contended the record did not contain sufficient evidence to permit a determination of whether to apply the provisions.

The Court noted that the defendant accepted applicant’s offer of proof that if he were called to testify, he would testify in accord with the histories recited in the reports of the AMEs which stated that he had been off work since 2005 and the employer “did not have a position for him.” This undisputed evidence combined with the stipulations of the parties that the defendant was paying the additional 15 percent prescribed by §4658(d)(2), was sufficient to put any question regarding the provision’s applicability before the WCJ for adjudication and resolution in applicant’s favor.

The Court found the pretrial conference statement promulgated by the DWC to be ambiguous because there is no simple method for the parties to communicate the presence or absence of an offer to work. Instead, the WCAB apparently expected the parties to check the “other issues” box and write in an explanation whereas the average practitioner would probably believe that checking the boxes was sufficient. Therefore, the Court concluded that when the parties check the boxes labeled “permanent disability” and “apportionment” in the pretrial conference statement, the WCJ is to calculate permanent disability payment under the applicable formula and the evidence presented, which necessarily includes consideration of the 15 percent increase or decrease in Labor Code §4658(d)(2) and (d)(3).

While agreeing with applicant that Labor Code §4658(d)(2) applies to his claim, the Court did not agree that the entire pulmonary PD award should be increased by 15 percent because the statute does not require payment of the additional amount until 60 days have passed after the P & S date without an offer of employment. The Court likewise rejected applicant's claim concerning the orthopedic disability because the issue was not raised on reconsideration. Even if the Court had ruled on the merits, §4658(d) only applies to injuries occurring on or after January 1, 2005.

The Board's decision was annulled with respect to the award for the pulmonary impairment only. The matter was remanded for recalculation of the permanent disability award for the pulmonary claim in accordance with the views expressed in the Court's opinion.

### **B. Application of Proper PDRS**

*Muraoka v. WCAB* (2009) 74 CCC 440, Court of Appeal, Second Appellate District, Division Four, unpublished opinion.

Applicant sustained a cumulative trauma injury ending in September 13, 2003 to her spine and bilateral upper extremities. She underwent bilateral carpal tunnel release surgeries in May 2004 and July 2005. The matter proceeded to trial on multiple issues including the question of whether the 1997 or 2005 permanent disability rating schedule applied. In an April 28, 2004 report, the PTP stated,

“Based on my clinical evaluation of the patient, it is my medical opinion that within a reasonable medical probability, the patient has suffered permanent disability as a result of the injury(s) sustained on 1998-9/17/03.”

In a September 23, 2004 report the doctor stated he was not yet able to determine the extent of permanent disability. Therefore, relying on these two reports, the WCJ believed there was no substantial medical evidence showing the existence of permanent disability or a permanent loss of functional capacity prior to 2005. Accordingly, the WCJ found that the 2005 PDRS would apply to the determination of permanent disability.

Applicant filed a petition for reconsideration which the panel majority voted to deny. The dissenting Commissioner argued that a determination whether a treating physician's report provided substantial evidence of permanent disability required consideration of the entire record, and that this record supported the conclusion that applicant had sustained permanent disability prior to January 1, 2005. Applicant then filed a petition for writ of review which was granted.

The Court of Appeal first noted that whether permanent disability exists is a question of fact, and in order to comply with Labor Code §4660(d), the physician must indicate only the likely existence of permanent disability, not the extent of the final ratable permanent disability. Furthermore, the assessment does not require a finding that the worker be permanent and stationary, because the statute does not require a medical determination of

the amount of permanent disability, only an indication of the existence of permanent disability. The Court reviewed the entire medical record and concluded that substantial medical evidence supported the PTP's finding of permanent disability prior to January 2005. Thus, the applicable rating schedule was the 1997 PDRS.

The Board's decision was annulled and the case remanded to the trial level for further proceedings consistent with the Court's opinion finding that the 1997 PDRS should be applied.

*Snedecor v. WCAB* (2009) 74 CCC 944, Court of Appeal, Second Appellate District, Division One, unpublished opinion.

Applicant injured his cervical spine and work and underwent a cervical discectomy and fusion at C5-6 and C6-7, which required grafts and internal fixation of an anterior plate with four 14 millimeter screws. On September 30, 2004, computer range of motion testing for the cervical spine suggested an 18 percent whole person impairment under the AMA Guides. On November 9, 2005, the surgeon indicated that applicant's condition was permanent and stationary with work restrictions of no lifting more than 10 pounds, forceful pushing and pulling, prolonged periods of upright cervical support and cervical motion extremes. His whole person impairment was 28 percent based on "alteration of motion segment integrity secondary to surgical fusion."

The matter proceeded to trial on issues that included whether the 2005 or prior schedule applied. Relying on *Genlyte Group, LLC v. WCAB (Zavala)* (2008) 73 CCC 6, as well as applicant's testimony and the opinion of the surgeon, the WCJ determined that applicant's injury resulted in 65 percent permanent disability under the 1997 schedule.

Defendant petitioned for reconsideration and contended that the WCJ incorrectly applied the 1997 schedule because the record does not contain any medical reports "indicating the existence of permanent disability" prior to January 1, 2005. In his report and recommendation, the WCJ reasoned that the computer range of motion testing, the fact that defendant sent applicant a NOPE letter advising him of his eligibility for vocational rehabilitation, and the fact that he underwent a cervical fusion were all indications of permanent disability prior to January 1, 2005.

The WCAB granted reconsideration, reversed the WCJ and remanded the matter back to the trial level for a finding of permanent disability under the 2005 schedule, stating the following:

"It is not within the WCJ's authority to find an indication of the existence of permanent disability from diagnostic reports, absent medical opinion in a comprehensive medical-legal or treating physician's report. Further, defendant's duty to provide applicant with the NOPE letter was not triggered by a medical finding that applicant was a qualified injured worker, but by the fact that he had been out of work for the requisite period of time. A presumption of QIW status on

that basis is not the equivalent of substantial medical evidence indicating the existence of permanent disability.”

Applicant filed a petition for writ of review which was granted. The Court of Appeal rejected the WCAB’s rationale concerning the diagnostic testing, noting that the doctor had incorporated the test results in his report and therefore the finding that the WCJ relied solely on the diagnostic testing was not supported by substantial evidence.

Regarding the other findings of the WCAB, the Court also noted that the Board failed to address the question of whether cervical fusion, limited range of motion and whole person impairment under the AMA Guides may be equal, compared or analogized to factors indicating the existence of spinal permanent disability under the 1997 schedule and Labor Code §4660(d). Furthermore, since there arises a rebuttable presumption of “medical eligibility” for vocational rehabilitation where aggregate temporary total disability exceeds 365 days, the WCAB did not explain how this presumption was rebutted by Snedecor not being identified as a “qualified injured worker” by medical opinion

The Court annulled the decision of the WCAB and remanded the matter to determine whether the 1997 or 2005 schedule applies.

### **C. Rebutting the PDRS**

*Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 CCC 474, 74 CCC 1080, WCAB en banc opinion.

Applicant Almaraz, sustained an industrial back injury that required surgery. He was evaluated by an AME who concluded that he had a 12 percent WPI. He also found that applicant was permanently limited to light duty work and no prolonged sitting activities. At trial, the parties stipulated that, before apportionment, applicant’s injury would rate 17% under the 2005 PDRS and 58% under the 1997 schedule. Applicant argued that the WCAB has the discretion to award permanent disability based on his work restrictions, instead of by multiplying his AMA Guides impairment by the appropriate diminished future earning capacity (DFEC) adjustment factor per the 2005 Schedule. In awarding 14 percent PD, after apportionment, the WCJ that he was not at liberty to deviate from the criteria established by the Legislature.

Applicant sought reconsideration, contending that AME Guides is not conclusive and un rebuttable; that they need not be blindly followed where the Guides does not completely and fairly describe and measure the injured employee’s impairment; and that where the Guides does not fairly and accurately reflect the injured employee’s impairment, other measures of disability should be used. No answer to the petition was received.

Applicant Guzman, sustained an admitted cumulative trauma to her bilateral upper extremities ending in 2005. She was referred to an AME who concluded that the injury

caused a 3 percent WPI for each upper extremity. He also stated that her bilateral upper extremity injury precluded her from “very forceful, prolonged repetitive and forceful repetitive work activities.” In his report, the AME made the following comment:

“You are aware by now that there is often a discrepancy between the disability and the impairment. The type of problem [applicant] has is legitimate but does not rate very much (if anything) under the AMA Guides. Based on her ADL [(i.e., activities of daily living)] losses, each upper extremity would have a 15% WPI ... . This is not a method that is sanctioned by the AMA Guides.”

After a trial, the WCJ instructed the rater to rate in accordance with the opinion of the AME. On cross-examination, she essentially testified that she felt it would be inappropriate to assign a 15 percent WPI to each upper extremity, but if she were allowed to consider the AME’s opinion in that regard, the final PD rating, after adjustment, would be 39 percent. The WCJ awarded 12 percent PD, stating that without a significant amount of objective data he was unwilling to accept the AME’s opinion, standing alone, against that of the Legislature.

Applicant Guzman also filed a petition for reconsideration, quoting extensively from the AMA Guides. She essentially argued that the Guides support the opinion of the AME and therefore, because a 15 percent WPI per upper extremity was found to be appropriate by the AME, through the exercise of his clinical judgment, she should be found to have 39 percent permanent disability, after adjustment for age and occupation, in accordance with the rater’s statement at her cross-examination. Defendant filed an answer. The WCJ reported that since the rater offered her expert opinion that the AMA Guides does not sanction the AME’s alternative method of rating impairment, it would be an abuse of discretion not to follow the rater’s expert opinion evidence.

The WCAB, sitting en banc, granted reconsideration and in a decision after reconsideration (74 CCC 470) held as follows:

- “(1) the AMA Guides portion of the 2005 Schedule is rebuttable;
- (2) the AMA Guides portion of the 2005 Schedule is rebutted by showing that an impairment rating based on the AMA Guides would result in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee’s permanent disability; and
- (3) when an impairment rating based on the AMA Guides has been rebutted, the WCAB may make an impairment determination that considers medical opinions that are not based or are only partially based on the AMA Guides.”

The Board went on to state:

“In the cases before us, however, we explicitly emphasize that we are not determining whether the standards for rebutting the AMA Guides portion of the

2005 Schedule have been or may be met. Instead, in each case, we are remanding to the assigned workers' compensation administrative law judge (WCJ) to decide these questions in the first instance.

Further, we expressly proclaim that our holding does *not* open the door to impairment ratings directly or indirectly based upon any Schedule in effect prior to 2005, regardless of how "fair" such a rating might seem to a physician, litigant, or trier-of-fact."

The defendant in *Almaraz* filed a petition for reconsideration. The Board granted that petition and in the *Guzman* case, granted reconsideration on its own motion. The Board gave the parties additional time to file briefs and further gave interested parties the same time period to file amicus briefs in the joint opinion (74 CCC 470). After reviewing the briefs, the Board issued a new opinion clarifying and modifying the original en banc decision.

In its new decision, a majority of the Board (four Commissioners) held that:

(1) The language of Labor Code section 4660(c), which provides that "the schedule ... shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule," unambiguously means that a permanent disability rating established by the Schedule is rebuttable.

(2) The burden of rebutting a scheduled permanent disability rating rests with the party disputing that rating.

(3) One method of rebutting a scheduled permanent disability rating is to successfully challenge one of the component elements of that rating, such as the injured employee's whole person impairment (WPI) under the AMA Guides.

(4) When determining an injured employee's WPI, it is not permissible to go outside the four corners of the AMA Guides; however, a physician may utilize any chapter, table, or method in the AMA Guides that most accurately reflects the injured employee's impairment. In light of these holdings, we now specifically reject the "inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability" standard set forth in our February 3, 2009 opinion."

The majority went on to state the following:

"We emphasize that our decision does *not* permit a physician to utilize any chapter, table, or method in the AMA Guides simply to achieve a desired result, e.g., a WPI that would result in a permanent disability rating based directly or indirectly on any Schedule in effect prior to 2005. A physician's opinion regarding an injured employee's WPI under the Guides must constitute substantial evidence; therefore, the opinion must set forth the facts and reasoning which

justify it. Moreover, a physician's WPI opinion that is not based on the AMA Guides does not constitute substantial evidence."

Three Commissioners dissented, disagreeing with the majority that a party may never go outside the AMA Guides to rebut a scheduled permanent disability rating. The dissenting Commissioners would affirm the holding of the original joint en banc decision that a scheduled permanent disability rating may be rebutted if it is shown that the rating would result in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability.

In the dissenting opinion, a number of cases were cited that stood for the proposition that The Board may not rely upon alleged limitations in the PDRS to deny the injured worker a permanent disability award which accurately reflects his true disability. Furthermore, several other jurisdictions have allowed departures from the AMA Guides under some circumstances even though those jurisdictions have or have had statutes or regulations that either require use of the Guides or generally call for its use. Consequently, the dissenters reasoned, it follows that a scheduled permanent disability rating predicated on the AMA Guides should be subject to the same standard of rebuttal.

The majority responded that the cases cited in the dissenting opinion are inapposite because they interpreted former Labor Code §4660, which focused on diminished ability to compete in the open labor market in determining an injured employee's scheduled permanent disability rating, and not current §4660, which focuses on WPI under the AMA Guides and DFEC in determining permanent disability.

*Ogilvie v. City and County of San Francisco* (2009) 74 CCC 478, 74 CCC 1127, WCAB en banc opinion.

Applicant sustained an admitted industrial injury to her right knee, low back and neck. Both applicant and defendant obtained reports from QMEs who provided ratings under both the 1997 and 2005 PD schedules. Both also obtained reports of vocational experts who concluded that applicant's diminished future earnings capacity, resulting from her injury, was in the area of 51 to 53 percent. At trial, the parties stipulated to a compromise figure of what her PD would rate under the 2005 schedule, agreeing to 28 percent after adjustment for age and occupation and after apportionment. They also agreed that the reports of their vocational experts could be submitted without testimony.

The WCJ issued a Findings and Award of 40 percent PD, after adjustment for age and occupation and after apportionment. In essence, the WCJ found that applicant had rebutted the 2005 Schedule because the amount of PD she would receive if the 28 percent agreed scheduled rating was used would not fairly, adequately and proportionally compensate her for her lost future earnings. In arriving at the 40 percent rating, the WCJ took into consideration three alternative rating methods.

The first method was to consider that the percentage of an injured worker's diminished future earning capacity could be the measure of the worker's permanent disability rating.

Thus, a loss of 51 to 53 percent would justify a 51 to 53 percent PD award. The second method the WCJ considered was to take two thirds of the dollar value of lost future earnings, as estimated by the experts, and award the percentage of PD that would produce an award in that amount.

In connection with the third method, the WCJ took the two thirds of the dollar value of lost future earnings he found under his second method, above, and observed that this figure is 4.29 times higher than the dollar value of the award for the agreed scheduled rating. He used this figure to calculate a new DFEC adjustment factor that was multiplied by the 28 percent agreed scheduled rating. Considering all of these methods, he concluded that a 40 percent rating after apportionment “is the most fair and adequate rating in light of the evidence of actual diminished future earnings in this case.”

Both applicant and defendant filed petitions for reconsideration from the WCJ’s decision. The Board granted reconsideration and in an en banc decision (74 CCC 248), held as follows:

“(1) the diminished future earning capacity (DFEC) portion of the current Schedule for Rating Permanent Disabilities (Schedule or 2005 Schedule) is rebuttable;

(2) the DFEC portion of the 2005 Schedule ordinarily is *not* rebutted by establishing the percentage to which an injured employee’s future earning capacity has been diminished;

(3) the DFEC portion of the 2005 Schedule is *not* rebutted by taking two-thirds of the injured employee’s estimated diminished future earnings, and then comparing the resulting sum to the permanent disability money chart to approximate a corresponding permanent disability rating; and

(4) the DFEC portion of the 2005 Schedule may be rebutted in a manner consistent with Labor Code section 4660 – including section 4660(b)(2) and the RAND data to which section 4660(b)(2) refers. Further, the DFEC rebuttal approach that is consonant with section 4660 and the RAND data to which it refers consists, in essence, of:

(1) obtaining two sets of wage data (one for the injured employee and one for similarly situated employees), generally through the Employment Development Department (EDD);

(2) doing some simple mathematical calculations with that wage data to determine the injured employee’s individualized proportional earnings loss;

(3) dividing the employee’s whole person impairment by the proportional earnings loss to obtain a ratio; and

(4) seeing if the ratio falls within certain ranges of ratios in Table A of the 2005 Schedule. If it does, the determination of the employee's DFEC adjustment factor is simple and relates back to the Schedule. If it does not, then a non-complex formula is used to perform a few additional calculations to determine an individualized DFEC adjustment factor."

Both parties again petitioned for reconsideration which was granted by the WCAB. The Board gave the parties additional time to file briefs and further gave interested parties the same time period to file amicus briefs in the joint opinion (74 CCC 478). After reviewing the briefs, a majority of the Board issued a new opinion clarifying and modifying the original en banc decision as follows:

"(1) the language of section 4660(c), which provides that "the schedule ... shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule," unambiguously means that a permanent disability rating established by the Schedule is rebuttable;

(2) the burden of rebutting a scheduled permanent disability rating rests with the party disputing that rating; and

(3) one method of rebutting a scheduled permanent disability rating is to successfully challenge one of the component elements of that rating, such as the injured employee's DFEC adjustment factor, which may be accomplished by establishing that an individualized adjustment factor most accurately reflects the injured employee's DFEC. However, any individualized DFEC adjustment factor must be consistent with section 4660(b)(2), the RAND data to which section 4660(b)(2) refers, and the numeric formula adopted by the Administrative Director (AD) in the 2005 Schedule. Any evidence presented to support a proposed individualized DFEC adjustment factor must constitute substantial evidence upon which the Workers' Compensation Appeals Board (WCAB) may rely. Moreover, even if this rebuttal evidence is legally substantial, the WCAB as the trier-of-fact may still determine that the evidence does not overcome the DFEC adjustment factor component of the scheduled permanent disability rating. Otherwise, we affirm our prior decision."

One Commissioner wrote a dissenting opinion, disagreeing with the majority's restrictions on the nature and scope of the evidence a party may offer in rebuttal.. Because section 4660 does not define "permanent disability," the language of Labor Code §4660(b)(2) cannot limit the nature and scope of the evidence a party may offer in rebuttal to a scheduled permanent disability rating. A party has the right to offer expert testimony and if this expert evidence is credible and legally substantial, the WCAB may accept the percentage of lost future earning capacity as establishing the injured employee's percentage of PD. Since the experts took into account all of the factors set forth in Labor Code §4660(a), these experts' opinions constituted proper rebuttal to the scheduled permanent disability rating.

**D. Life Pension**

*Duncan v. WCAB* (X.S.) (formerly known as XYZZX SJO2) (2009) 74 CCC 1427, Court of Appeal, Sixth Appellate District.

Applicant sustained an industrial injury on January 20, 2004 that became P & S on October 20, 2006. Applicant and the Subsequent Injuries Benefit Trust Fund (SIBTF) stipulated that applicant's previous permanent disability combined with his industrial disability resulted in a combined total permanent disability of 100 percent. Thereafter a dispute arose concerning the application of Labor Code §4659(c) which provides that for injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a total permanent disability indemnity or life pension shall have that payment increased annually commencing on January 1, 2004, and each January 1 thereafter.

The WCJ interpreted the statute to mean that each payment of total permanent disability indemnity or life pension that is received on or after January 1 following the date of injury shall be increased, no matter when the first such payment is received. Thus, applicant would receive his first cost of living adjustment (COLA) on January 1, 2005. The SIBTF sought reconsideration and the WCAB sustained the decision of the WCJ, stating that this would ensure that severely injured workers are protected from inflation, no matter when they receive their first payment.

The SIBTF filed a petition for writ of review, arguing that §4659(c) provides for annual increases in weekly benefit payments only after an injured employee is entitled to such benefits, and that, a worker does not have a right to receive total disability indemnity until he or she is P & S. Applicant contended that the COLA should take place on the January 1 following the date of injury which is the only interpretation that will allow the injured workers' benefit level to keep pace with inflation over time. The Court granted the writ.

The Court found good public policy reasons for rejecting the SIBTF's argument. For an employee whose injury leads to total permanent disability that does not become P & S for a number of years, setting the COLAs from the P & S date causes that worker to see his or her payment exposed to the ravages of inflation over time, eroding the real value of the benefits. For the permanently disabled worker who is entitled to a life pension, delaying until the first life pension payment the addition of the COLAs is even worse. The Court gave as an example a partially disabled worker who is injured after January 1, 2004, and whose permanent disability is 99 percent, noting that the number of weeks to pay out permanent disability payments before the life pension starts is just over 17 years.

However, the Court also rejected the applicant's contention that the COLA should begin on the January 1 following the date of injury noting that by the plain words of the statute, once the life pension or total permanent disability payment is set, that payment has to be increased by COLAs starting from January 1, 2004. Since the amount of a payment is a function of the employee's average weekly wage and the date of injury, payments are set as of the date of injury and not on any later date.

The Court observed that the Legislature could have written the statute to include the date of injury, or the P & S date, or the date when the life pension starts to commence the COLAs, but it didn't do that. Rather, the Legislature chose January 1, 2004, as the start date of the first COLA. Therefore, the Court held that when an injured worker's total permanent disability payment, or life pension payment is calculated, that payment is subject to a COLA starting from January 1, 2004, and every January 1, thereafter.

Accordingly, the Board's decision was annulled and the case remanded for further proceedings.

## **XV. Apportionment**

### **A. Labor Code §4663 (Successive Industrial Injuries)**

*Forzetting v. WCAB* (2009) 74 CCC 689, Court of Appeal, Second Appellate District, Division Six, unpublished opinion.

Applicant sustained two specific industrial back injuries while working for the same employer. The parties agreed that applicant's PD as a result of both injuries was 70 percent. However, the WCJ instructed the rater to perform separate calculations based on the Appeals Board's en banc decision in *Benson v. Permanente Medical Group* (2007) 72 CCC 1260 and the AME's apportionment opinion that 23 percent of the overall PD was attributable to the first injury and 47 percent to the second. The resulting F & A awarded applicant \$55,330 in PD benefits as opposed to the \$98,095 he would have received from a combined award.

Applicant filed a petition for reconsideration, contending that in *Benson*, the WCAB made an unconstitutional change to the law established by *Wilkinson v. WCAB* (1977) 42 CCC 406. The Board granted the petition to correct some clerical errors, but otherwise affirmed the WCJ. It noted that the Board does not have the power to declare a statute unconstitutional. Applicant filed a petition for writ of review that was initially denied. However, the Supreme Court ordered the Court of Appeal to vacate its denial and grant the writ.

Applicant contended that the decisions in *Brodie v. WCAB* (2007) 72 CCC 565 and *Benson* were unconstitutional because SB 899 did not explicitly repudiate *Wilkinson*. Applicant also contended he was being denied equal protection because he was being treated differently than a worker with the same level of disability who was only injured once.

The Court of Appeal found that although the Legislature did not expressly overturn *Wilkinson* in SB 899, the passage of this legislation completely undermined the bases for combining such awards. SB 899 is rationally related to the legitimate governmental interest of reducing workers' compensation costs, and a worker injured twice is often

situated differently than a worker injured just once. Now, each injury must be separately apportioned for cause under sections 4663 and 4664, and PD awards may not be combined. Therefore, the Court reaffirmed the decision of the Board.

*Vilkitis v. WCAB* (2009) 74 CCC 695, Court of Appeal, Second Appellate District, Division Six, unpublished opinion.

Applicant sustained a specific injury and a cumulative trauma ending on the same date. The WCJ issued two separate awards, determining that his specific injury caused 62 percent permanent disability and his CT caused 14 percent. Applicant petitioned for reconsideration, contending that the separate ratings should have been combined to produce a single award of 71 percent pursuant to *Wilkinson v. WCAB* (1977) 42 CCC 406. The WCAB adopted the WCJ's recommendation and denied applicant's petition. Applicant filed a petition for writ of review that was initially denied. However, the Supreme Court ordered the Court of Appeal to vacate its denial and grant the writ.

Reviewing the history of Labor Code §4663, the Court noted that before SB 899, apportionment was concerned with the severity of the disability itself, however it may have been caused, and not its etiology. SB 899 repealed §4750, replaced §4663, and added § 4664. Although the new statutes did not expressly abrogate *Wilkinson*, the Court found their provisions to be completely antithetical to it. Current §§4663 and 4664 require physicians to consider each industrial injury sustained, and apportion the injured worker's disability for cause. The required segregation of each disability by apportionment for cause comports with the Legislative purpose of decreasing the cost of workers' compensation to employers by ensuring that they pay only for the particular disability caused by the particular, current injury sustained during the employment.

The Court also cited the anti-merger provision of Labor Code §5303 which it found to be inconsistent with *Wilkinson* and consistent with the passage of SB 899. Accordingly, the Board's decision was affirmed.

*Benson v. WCAB* (2009) 74 CCC 113, First Appellate District, Division Two.

Applicant, a file clerk, whose job involved repetitive neck and upper extremity motion, was reaching up over her head, pulling out a plastic bin, when she felt a pain in her neck. She filed an Application for Adjudication claiming a specific injury and ultimately underwent a three-level fusion of the cervical spine. She was evaluated by an AME who concluded that she had sustained both a specific injury and a cumulative trauma which became permanent and stationary at the same time. Regarding apportionment, the AME concluded that her semi-sedentary restriction was equally caused by both injuries.

At trial, Defendant contended that the apportionment provisions in SB 899 abrogated the rule in *Wilkinson v. WCAB* ((1977) 42 CCC 406, and mandated that Applicant receive two separate awards of 31% permanent disability. The WCJ found that the *Wilkinson* rule was still viable and that separate awards of permanent disability were not required.

Accordingly, she issued a single Award based on the combined permanent disability of 62%. Defendant then sought reconsideration.

A majority of the Appeals Board, sitting en banc, noted that under the rule set forth in *Wilkinson*, an injured worker could receive a single combined Award of permanent disability where successive injuries to the same body part became permanent and stationary at the same time. When *Wilkinson* was decided, former Labor Code § 4750 had provided that if an injured worker suffered from a previous permanent disability or physical impairment, the employer could only be held liable for the disability arising out of the immediate industrial injury. In its opinion in *Wilkinson*, the Supreme Court concluded that “[i]f the worker incurs successive injuries which become permanent *at the same time*, neither permanent disability is ‘previous’ to the other, and section 4750 hence does not require apportionment.”

SB 899 repealed Labor Code § 4750 and changed the rules of apportionment. Under new section 4663, apportionment must be based on causation and must be determined based on the approximate percentage of permanent disability caused by the direct result of injury and the percentage caused by other factors. New § 4664 provides that an employer is now only “liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.”

In *Brodie v. WCAB* (2007) 72 CCC 565, the Supreme Court made the following observation:

“[t]he plain language of new sections 4663 and 4664 demonstrates they were intended to reverse [certain] features of former sections 4663 and 4750”...and that, in enacting SB 899, the Legislature created a new “causation regime,” requiring that all potential causes of permanent disability be separately addressed and considered when apportioning disability pursuant to newly revised Labor Code section 4663...”

“...the new approach to apportionment is to look at the current disability and parcel out its causative sources – nonindustrial, prior industrial, current industrial – and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them. Thus, repeal of section 4750 was necessary to effect the Legislature’s purposes in adopting a causation regime.”

The Appeals Board recognized that in *Brodie*, the Court considered the question of whether the repeal of § 4750 required the rejection of the formula in *Fuentes v. WCAB* (1976) 41 CCC 42, but found the Legislature’s “silence” on the subject to evidence no such intent. However, the Board found no such silence in connection with the *Wilkinson* issue. Rather, it found that “the plain language of the sections expresses – or, at least, necessarily implies – a legislative intent to abrogate the rule in *Wilkinson* due to the new causation regime created by SB 899.” The statutory language “unambiguously mandates

apportionment to causation of disability in all cases, including successive industrial injuries to the same body part that become permanent and stationary at the same time.”

Additionally, SB 899 clearly stated its intent to provide immediate relief from the crisis of skyrocketing workers’ compensation costs. In successive injury cases, a single combined Award of permanent disability is dramatically more costly than two separate smaller awards. The Board further rejected the argument that Labor Code § 4663 did not provide for apportionment to causation where the employee’s “other factors” of disability are concurrent with the disability caused by the industrial injury. Subdivision (c) specifically requires a physician to determine what percentage of disability *was caused by each industrial injury*, regardless of whether any particular industrial injury occurred before or after any other particular industrial injury or injuries.

In *Wilkinson*, the Supreme Court had reasoned that any attempt by a physician to allocate the combined disability between multiple injuries may be “impossible or inequitable” and “is likely to be no more than speculation and guesswork.” However, in all workers’ compensation claims, including those involving successive industrial injuries, § 4663 now specifically requires that a reporting physician “shall ... address the issue of causation of the permanent disability.” The Board observed that medicine is not an exact science and there will always be an element of speculation. This does not mean that a physician’s conclusions are speculative when based on medical judgment and expertise.

In spite of its previously expressed conclusions, the Board majority made the following comment:

“Nevertheless, in a successive injury case, a physician might conclude that at least *some* of the employee’s permanent disability is causally related to each of the injuries, but, as suggested by *Wilkinson*, the physician might not be able to medically parcel out the degree to which each injury is causally contributing to the employee’s overall permanent disability, even after complying with the statutory mandate of consulting with another physician – or referring the employee to another physician – in order to assist with the apportionment determination. In such an instance, the physician’s apportionment “determination,” within the meaning of section 4663, could properly be that the approximate percentages of disability caused by each of the successive injuries cannot reasonably be determined. As a result, the employee would be entitled to an undivided (i.e., joint and several) award for the combined permanent disability, because the respective defendants would have failed in their burdens of proof on the issue of apportionment.”

Thus, the WCJ’s finding that applicant is entitled to a combined Award of 62% permanent disability was rescinded and the F & A was amended to provide for separate awards of 31% permanent disability for each industrial injury.

Applicant filed a petition for writ of review with the Court of Appeal which affirmed the WCAB’s decision in an opinion that essentially reiterated the en banc opinion.

**B. Labor Code §4663 (Nonindustrial Factors)**

*California Department of Corrections and Rehabilitation v. WCAB (Garza)* (2009) 74 CCC 134, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant, a correctional officer, was found to have sustained a 2003 cumulative trauma injury to his heart, cardiovascular and internal systems, hernia, and psyche. The WCJ also concluded that Labor Code §4663(e), applicable to certain public safety officers, precluded apportioning out nonindustrial causes to applicant's hypertension, heart, and cardiovascular injuries from his overall level of disability, resulting in an award of 97 percent permanent disability.

Defendant filed a petition for reconsideration contending §4663(e) does not apply retroactively to injuries occurring before January 1, 2007. In his report and recommendation, the WCJ cited the Third Appellate District's decision in *Department of Corrections and Rehabilitation v. WCAB (Alexander)* (2008) 73 CCC 1294, which had been filed only six days earlier, holding that §4663(e) "was declarative of existing law, and so was retroactive." Even absent *Alexander*, the WCJ believed that the Legislature sufficiently declared a retroactive intent so as to impose the provision to injuries occurring before its enactment date. After defendant's petition was summarily denied by the WCAB, it sought judicial review.

The Court of Appeal noted that while Senate Bill 899 contained far-reaching reforms concerning the law of apportionment, it did not affect various statutory presumptions applicable to certain public safety officers under Labor Code §§3212 et seq. Furthermore, some of the presumptions in the public safety occupational series contain an additional secondary benefit of eliminating the possibility of apportioning any of the industrial injury to prior industrial diseases.

The heart trouble presumption applicable to correctional officers contained in §3212.2 does not contain an anti-attribution clause. Therefore, immediately after SB 899 was enacted, the WCAB would not have been prevented from apportioning applicant's disability. However, in 2006, the Legislature enacted Assembly Bill 1368, effective January 1, 2007, which added subdivision (e) to section 4663 and provided that the apportionment provisions of that section "shall not apply to injuries or illness covered under" sections 3212 through 3213.2. The last sentence of the bill states: "It is the intent of the Legislature that this act be construed as declaratory of existing law."

The *Alexander* Court incorrectly assumed that §3212.2 contained a non-attribution clause and the Court therefore agreed with defendant that *Alexander* was "inexact" in concluding Assembly Bill No. 1368 limited apportionment under §3212.2. Nonetheless, it agreed with the WCAB's decision not to apportion applicant's heart-related injuries based on the alternate reasoning set forth by the WCJ since this and other courts have found that §4663 applied retroactively to all cases pending and not yet final at the time of its enactment on April 19, 2004.

Commenting that it would “not second-guess the Legislature’s objective and design,” The Court denied the petition for writ of review.

*Grimaldo v. WCAB* (2009) 74 CCC 324, Court of Appeal, Second Appellate District, Division Four, unpublished opinion.

Applicant was injured when a metal grate from a stove fell on his left foot after which he continued working. Three weeks later he requested medical treatment after he slipped at work and noticed an open wound on his left great toe. His glucose level was tested and was diagnosed with uncontrolled diabetes. Because the pain in his great toe caused him to put undue pressure on the lateral side of his left foot, he developed infections and ulcerations in that area. After several surgical amputations, his left leg was amputated below the knee.

The matter came on for trial and the WCJ found that overall, the medical evidence supported a finding that the injury to the foot lit up a diabetic condition resulting in prolonged and poor healing which led to the amputations. Defendant filed a petition for reconsideration which was granted by the WCAB. The Board issued a new decision finding that the diabetes complicated the healing and contributed to the need for medical treatment, but that it did not arise out of and occur in the course of the employment. Applicant then sought judicial review.

The Board based its decision on the opinion of defendant’s QME which it found to be well-reasoned and persuasive. The QME reported that the injury was not significant in any way in the development of the infection of the foot, which had probably been ongoing for a long period of time prior to the injury. However, his characterization of the injury was not supported by the initial treatment reports. He also expressed the opinion that the diabetes pre-existed the job, but there was no evidence of this in the record.

The QME also cited risk factors in that applicant’s mother had diabetes and that he was previously 60 pounds heavier. However, he did not state with reasonable medical probability that applicant would have had the onset of diabetes at the time that he did absent the industrial injury. Furthermore, the employer’s medical records showed no change in applicant’s weight. Therefore, the QME’s medical history was not substantiated by the record.

The Court noted that well-established authority holds that the acceleration, aggravation or “lighting up” of a preexisting disease is an industrial injury. The standard is whether the medical evidence indicates that within reasonable medical probability the normal progression of the nonindustrial disease or condition would have resulted in disability regardless of the industrial injury. The QME did not address whether applicant’s diabetes was lit up by the injury that was conceded to be work-related. Therefore, the QME’s conclusions did not provide substantial medical evidence to support the Board’s decision.

The Court annulled the Board’s decision, reinstated the decision of the WCJ and remanded the matter to the trial level for further proceedings on the remaining issues.

*Continental Casualty v. WCAB (Goodin)* (2009) 74 CCC 435, Court of Appeal, Fourth Appellate District, Division Two, unpublished opinion.

Applicant was exposed to fumes and chemicals in her employment after which she developed respiratory symptoms that progressed to the point where she could no longer work. Testing by the AME revealed sensitivity to various plant and animal substances. She also had a sporadic history of smoking. As a result, the AME apportioned 60 percent of her residual disability to personal non-industrial factors and 40 percent to causation occurring on the job, stating that he had reached this conclusion as his “best medical judgment. In his deposition, he testified that exposure to substances such as bleach, disinfectant, and ammonia could have “aggravated” applicant’s condition.

The matter came on for trial and the WCJ found applicant to be 100 percent permanently disabled, without apportionment, noting that the AME had failed to adequately to explain how he had reached the figures of “60-40” in apportioning applicant’s disability to nonindustrial and industrial causes. The WCJ was also skeptical of the proposition that Applicant’s measured susceptibilities to nonindustrial inhalant allergens could have had a more powerful effect than her exposure to harsh chemicals. Defendant petitioned for reconsideration which was denied and thereafter filed a petition for writ of review.

The Court first noted that its task was to determine whether substantial evidence supports the finding that *no* apportionment was appropriate was supported by substantial evidence, and concluded that it was not. The *only* evidence in the record concerning the causative factors of Applicant’s pulmonary disability came from the opinion of the AME. The WCJ did not reject the general conclusion that some apportionment would be appropriate. Rather, the problem for her was that the AME did not explain why he assigned the percentages of disability that he did to the non-industrial factors and the industrial exposure.

If the WCJ was dissatisfied with evidence before her, she had the power to further develop the record. However, she could not simply ignore the AME’s opinion on apportionment because it was the *only* evidence in the record with respect to the issue of whether or not Applicant’s disability was partially apportionable to nonindustrial causes. Therefore, the matter was remanded to the WCAB to enter a new award and finding of apportionment.

**C. Labor Code §4664**

**XVI. Death Benefits**

*City of Los Angeles v. WCAB (Foster)* (2009) 74 CCC 1299, Court of Appeal, Second Appellate District, Division Seven.

At the time of her death in 2004, the deceased employee was not married, had no children or other dependents, and died intestate. Defendant began advancing death benefits to the

employee's mother, pursuant to Labor Code §4702 (a)(6)(B) which, if There were no dependents, required payment of the death benefit to the estate of the deceased employee. The DIR Death Without Dependents Unit (DWD) filed an application for adjudication seeking payment of death benefits pursuant to §4706.5(a) which, if there were no dependents, required payment to the DWD. Subsequently, the employee's mother filed an Application for Adjudication as administrator of her daughter's estate.

In 2006, Labor Code §4706.5 was amended to provide that the section did not apply "if a death benefit is paid to any person under paragraph (6) of subdivision (a) of Section 4702." Later that year, a different division of the Second Appellate District held section 4702(a)(6)(B), unconstitutional because the state Constitution does not identify workers' estates as a permissible class of beneficiaries. (*See Six Flags, Inc. v. WCAB* (2006) CCC ) The DWD's claim proceeded to trial and the WCJ ordered defendant to pay DWD the statutory benefit less the sums that previously paid to the employee's estate.

After the DWD petitioned for reconsideration, the WCAB reversed the WCJ and ordered the defendant to pay the full benefit to DWD under Labor Code §4706.5(a), with no credit for sums paid in death benefits to the estate pursuant to §4702(a)(6)(B). The Board noted that prior to the decision in *Six Flags*, both statutes were in effect and obligated the defendant to pay benefits to both DWD and the deceased's estate. It reasoned that a deceased employee's estate cannot be the employee's dependent under §§3501 through 3503, as the Court held in *Six Flags*. Therefore, payment of a death benefit to an estate does not constitute payment of a death benefit to a dependent as referenced in §4706.5(a). Defendant petitioned for reconsideration of the Board's decision and its petition was denied. It then sought judicial review.

The Court of Appeal noted that by a 1972 Constitutional amendment, the Legislature was empowered to "to provide for the payment of an award to the state in the case of the death, arising out of and in the course of the employment, of an employee without dependents." Thus, when the Legislature enacted §4706.5, it intended to authorize payment of a statutory death benefit to the state only if there was no person qualified to claim a death benefit under §4702. The Court also noted that when subdivision (a)(6) was initially added to §4702, the same legislation also created a new subsection (c) to Labor Code §3501, conclusively presuming the surviving parent or parents of a deceased employee to be wholly dependent for support upon the deceased employee in the absence of real dependents. Thus, the employee's mother was actually a dependent at the time of her daughter's death.

The Court further noted that the ballot argument in favor of the proposition that amended the State Constitution spoke in terms of "legal heirs," not "dependents." Applicant was the deceased employee's legal heir and any accrued benefits would have been paid to her, rather than to DWD. Therefore, the Court concluded that if §4706.5 is interpreted consistently with the legislative history of the 1972 constitutional amendment, death benefits cannot escheat to the State if a benefit is paid to a deceased employee's dependents or legal heir.

Finally, the Court found that the Legislature's declaration that §4706.5, subdivision (h), clarifies existing law, although not binding, is a significant factor in construing the scope of the escheat statute.

The Court agreed with the WCAB that no authority exists for allowing a credit or ordering a partial payment to the DWD. Therefore, the WCJ's award of the death benefit to the DWD less a credit to defendant for the payments to the applicant could not be justified. The Legislature required the payments at the time they were made and intended that they would displace any obligation to the DWD. Because the defendant in fact paid the estate pursuant to Labor Code §4702(a)(6)(B), no payment at all was due the DWD. Therefore, the order of the WCAB awarding a death benefit to the DWD Unit was annulled.

**XVII. Hearings**

**XVIII. Compromise and Release**

**XIX. Findings and Awards and Orders**

**XX. Reconsideration/Removal/WCJ Disqualification/Judicial Review**

*Rider v. WCAB* (2009) 74 CCC 1227, Court of Appeal, Fifth Appellate District, unpublished opinion.

The WCJ found that in spite of an opinion by an AME that 75 percent of applicant's disability was pre-existing, the record was insufficient to support apportionment to nonindustrial causes. Defendant sought reconsideration and the WCAB remanded the matter to the WCJ for further development of the record. Applicant then filed a petition for writ of review contending that defendant failed to meet its burden of proving apportionment and that the WCAB acted in an impermissible and arbitrary manner by remanding the matter to the WCJ.

The Court of Appeal noted that whether petitioning the WCAB under Labor Code §5900 or an appellate court under §5950, a petition to the reviewing tribunal only lies from a decision that "conclusively determines, for purposes of the compensation proceeding, a substantive issue basic to the employee's entitlement to benefits." Here, the WCA issued an intermediate procedural order on an evidentiary matter that did not deprive the parties of any substantive rights and failed to affirmatively dispose of any threshold issues in determining applicant's entitlement to workers' compensation benefits. Lacking a final order, decision, or award of the WCAB to review, the Court denied the writ.

**XXI. Reopening****XXII. Statute of Limitations**

*Santa Barbara County v. WCAB (Santos)* (2010) 75 CCC \_\_\_\_, Court of Appeal, Second Appellate District, Division Six, writ denied December 22, 2009.

Applicant, while unrepresented, filed a claim form dated May 8, 1997, claiming that she suffered a cumulative trauma due to stress on November 10, 1996, her last day of employment. On 5/13/97, applicant received a letter from defendant indicating that her claim was on delay status. Defendant claimed and applicant disputed that she was also sent an information pamphlet at that time. On 6/10/97, defendant sent another letter to applicant, notifying her that her psyche claim was denied on the ground that it was substantially caused by a good faith personnel action. Pursuant to the recommendation of her treating psychologist and with the assistance of a DWC clerk, she filed an Application for Adjudication on July 21, 1998. According to Applicant, she had general knowledge as to what a statute of limitations is, but no knowledge of its affect on her claim if she failed to act within a certain time frame.

The WCJ found that defendant was estopped from asserting the statute of limitations as a defense because it failed to establish that it gave Applicant adequate notice of her rights or to establish that Applicant had actual knowledge of those rights. Defendant then filed a petition for reconsideration contending that it was error to conclude that the case was not barred as having been filed more than one year after the date of her injury, since Applicant received adequate notice of her rights upon receipt of a pamphlet issued by the California Workers' Compensation Institute (CWCI) describing her rights and responsibilities with regard to the one-year statute of limitations in *Labor Code § 5405*.

The WCAB agreed with the WCJ, finding that defendant was required by 8 CCR §9882 to provide applicant with specific notices, including written information concerning the time limits for filing a claim. The panel found the CWCI pamphlet, rather than give adequate notice, leads to "good faith confusion."

Defendant filed a petition for writ of review that was denied.

**XXIII. Contribution****XXIV. Subrogation/Third Party Actions**

*Baur v. WCAB* (2009) 74 CCC 919, Court of Appeal, Third Appellate District.

Applicant, a police office, was injured on the job during an altercation with a suspect. The employer provided workers' compensation benefits. Applicant then filed a civil

lawsuit against the suspect whose insurance company became insolvent. As a result, applicant settled his lawsuit with CIGA for \$50,000.00 and the employer agreed to release its lien. The employer then claimed a credit pursuant to Labor Code §3861, equal to applicant's net recovery, after costs and attorney fees, against its liability for future workers' compensation benefits. Applicant contended that the credit was not allowed because the Insurance Code prohibits subrogation on a settlement paid by CIGA.

The dispute proceeded to trial and the WCJ granted the credit, finding that "CIGA is not involved nor a party to this [workers' compensation] action." Applicant filed a petition for reconsideration which the WCAB denied, adopting the reasoning of the WCJ. Applicant then petitioned the Court of Appeal for a writ of review which the Court issued in order to determine the legality of the awarded credit.

The Court first noted that under the plain language of Labor Code §3861, the employer was entitled to a credit against its liability for future workers' compensation benefits in an amount equal to applicant's net recovery in his civil case. Notwithstanding, applicant insisted that the credit provision of §3861 should not apply to CIGA on the basis that in reaching the settlement, CIGA valued the case at approximately \$123,000, and the \$50,000 it was agreeing to pay was only for amounts not covered by other insurance. Applicant argued that since the \$50,000 could not include future medical costs, which is the responsibility of workers' compensation, the credit should not be allowed.

The Court rejected this argument, noting that the statute grants the workers' compensation defendant a credit for "any recovery" received by way of settlement. This means the employer is entitled to a credit whether the tortfeasor's insurer was a solvent company or CIGA and whether the recovery was for general or special damages.

The \$50,000 that CIGA paid applicant was a covered claim because it was the obligation of an insolvent carrier that met the statutory criteria under Ins. Code, § 1063.1(c)(1). Therefore, CIGA was required to pay it. The purpose of the Insurance Code provisions defining "covered claims" and the exclusion of subrogation claims is to protect CIGA's coffers by allowing CIGA to remain an insurer of last resort. Here, the denial of the credit would not save CIGA a penny. It would simply mean that applicant would get both the money from CIGA *and* additional workers' compensation benefits from his employer. This would place applicant in a better position than if the third-party carrier had remained solvent. The Court saw no justification in the law for making such a distinction.

The order of the WCAB was affirmed and the defendant was awarded its costs on appeal.

## **XXV. Credit/Restitution/Fraud**

*J. C. Penney Company v. WCAB (Edwards)* (2009) 74 CCC 826, Court of Appeal, Third Appellate District.

Applicant was injured in 2003. He had knee surgery in 2005. Back surgery was recommended, but a second opinion doctor recommended against the surgery in 2006.

The PTP then recommended an evaluation for an implanted pain medication pump and found temporary disability through June 2006. In 2007, applicant was seen by an AME who expressed the opinion that his condition had become P & S six months after his knee surgery in February 2005. In the meantime, defendant paid TD benefits until March 2005.

The matter came on for trial and the WCJ awarded TD up to the date of the AME's evaluation in February 2007. The WCJ reasoned that applicant was entitled to TD while he was awaiting authorization for surgery and after the surgery was not authorized, the PTP indicated that he continued to be TD. Applicant was eventually referred to the AME to resolve the dispute. However, the WCJ felt it was contrary to the spirit of Labor Code §4062 to permit a retrospective determination of a P & S date when there was substantial evidence to support ongoing TD. Defendant was subsequently allowed a credit only for that TD paid after the AME's evaluation.

Defendant filed a petition for reconsideration, arguing there was no substantial evidence to support the WCJ's finding concerning the P & S date. The WCAB, in pertinent part, affirmed the award and order, and defendant then sought judicial review.

Defendant claimed that the WCJ's opinion was internally inconsistent because the PTP's reports did not constitute "substantial evidence to support ongoing temporary disability." However, the Court noted that the denial of the credit did not require a finding of substantial evidence of ongoing TD. Rather, the WCAB's decision to deny a full credit for overpayment necessarily rests on the theory that the policy of Labor Code §4062 bars recovery of an overpayment, rather than a theory that there was no overpayment.

Labor Code §4062, in pertinent part, provides that if the employer objects to a medical determination made by the PTP, it must notify the other party in writing of the objection within 20 days of receipt of the report, which time limits may be extended for good cause or by mutual agreement. The Court considered the effect of failing to object within the time limits of the statute and concluded that if either the employer or the employee fails to object to a medical determination within the ambit of §4062 within the prescribed time, they may not attack that determination thereafter.

However, the Court also found that this principle did not justify extending the P & S date until the time that the AME rendered an opinion that the applicant's condition was P & S. The PTP found TD through June 2006 and therefore, denial of the credit could not be justified beyond that date. Applicant's argument that the credit should be denied on the basis of estoppel was rejected by the Court since there was no evidence that defendant was actually aware, or was even in a superior position to have known, that applicant's condition had become P & S.

The decision and award of the WCAB was annulled and the matter remanded for further proceedings to determine the amount of the credit in accord with the views expressed in the Court's opinion.

**XXVI. Special Benefits****A. Labor Code § 132a**

*Cantrell v. WCAB* (2009) 74 CCC 819, Court of Appeal, Fifth Appellate District, unpublished opinion.

The employer had a corporate policy of requiring its employees to submit to drug testing: 1) at initial hiring, 2) upon promotion into a salaried management or other safety sensitive position, 3) if involved in an accident or injury at work, and 4) if suspected of violating the policy. Any violation of the policy, including refusing to submit to a request for a drug test, constitutes grounds for immediate termination.

Applicant sustained an industrial injury just before midnight. He was taken by ambulance to a local hospital, treated and released the following morning. He claimed that he asked for a drug test at the hospital and made additional requests for a drug test from three management employees, all to no avail. When he returned to work three days later, the store manager informed him that he had been terminated.

The employer's risk manager claimed that no request had been made for authorization of a drug test. She further claimed that she called applicant and he agreed to come to the store to pick up his paperwork for the drug test, but that he never showed up. There is no evidence or allegation suggesting applicant was using illicit or unprescribed drugs.

Applicant filed two petitions for increased benefits under Labor Code §132a. One petition alleged that the employer "wrongfully assigned [him] to take a post-accident drug test after [he] had claimed a work injury." The other petition alleged he was wrongfully discharged "because he claimed a work injury and was unable to perform." Finding the employer's testimony to be more credible than that of applicant, the WCJ concluded that applicant failed to meet his burden of proof.

Applicant petitioned for reconsideration. The WCAB summarily denied the petition after acknowledging that the WCJ's credibility determinations were entitled to great weight. Applicant then filed a petition for writ of review.

The Court of Appeal noted that §132a's anti-discrimination language is "meant to prohibit treating injured employees differently, making them suffer disadvantages not visited on other employees because the employee was injured or had made a claim." The WCJ, and thus the WCAB, never inquired into whether the employer's drug testing policy discriminated against applicant as a result of sustaining an industrial injury and if so, whether the employer demonstrated that its conduct was necessary and directly linked to the realities of doing business. The Court therefore found that the WCAB's failure to set forth its reasoning in adequate detail, as required by Labor Code §5908.5, constituted a sufficient basis to annul the decision and remand for a statement of reasons.

*Gelson's Markets v. WCAB (Fowler)* (2009) 74 CCC 1313, Court of Appeal, Second Appellate District, Division Three.

In 2007, applicant received a stipulated award for his industrial neck injury that had required a cervical fusion. He inquired about returning to work and obtained a release from the PTP, dated June 20, 2005 that recommended a minor work restriction. Defendant's risk manager thought that the release was unclear and didn't provide sufficient information. In a telephone conversation, the PTP told her he wasn't sure he had the applicant's job description and thought applicant should remain TTD rather than return to work. After applicant was informed that the company could not accommodate his restrictions, he brought in a new release from the PTP stating that he could return to work without restrictions.

Defendant wrote to the PTP, asking if applicant could perform the essential functions of the job, either with or without reasonable accommodation. The doctor responded, merely stating that he reviewed the job description of employee's job duties with the applicant and that applicant was of the impression that he could carry out his job duties. The PTP did not respond to a request that he provide his expert medical opinion about whether applicant could return to work and with what restrictions. The employer did not return applicant to work.

The parties referred applicant to an AME who reported on July 19, 2006 that there was no need for work restrictions, but also found a 25 percent loss of pre-injury capacity for various activities. He felt that an attempt to return applicant to his usual and customary job duties was warranted, but if there was any increase in his symptomatology then he would be a QIW. Defendant still did not return applicant to work because, as distinct from applicant's opinion, it still had received no physician's medical opinion as to whether applicant could return to work.

In his deposition, the AME testified that he thought applicant could probably perform his usual and customary job. Based on the AME's deposition testimony, Defendant returned applicant to work on January 8, 2007. The WCJ found that defendant was justified in not returning applicant to work after receiving the releases from the treating physician because they were ambiguous and contradictory. However, because the AME's report was not ambiguous as to applicant's ability to return to work, defendant's failure to reinstate him after July 19, 2006, violated Labor Code §132a. He awarded the \$10,000.00 penalty and back wages from the date of the AME's report to the date he returned to work.

Defendant petitioned for reconsideration. The WCAB granted reconsideration to address the issue of the back wages. Contrary to the WCJ, the Board found that defendant discriminated against applicant when it refused to return him to work after receiving the release from the PTP. The Board therefore amended the award of back wages to begin on June 20, 2005 rather than on July 19, 2006.

Defendant then sought judicial review, claiming that the WCAB erred in finding a violation of Labor Code §132a because applicant presented no evidence of disparate treatment by the employer because of his industrial injury. The Court agreed, finding that the Board failed to apply the standard established by the California Supreme Court in *Department of Rehabilitation v. WCAB (Lauher)* (2003) 68 CCC 831. Prior to *Lauher*, the law had been that an employee could establish a prima facie case of a violation of section 132a by showing that as the result of an industrial injury, the employer engaged in conduct detrimental to the worker. The *Lauher* Court changed that standard when it concluded that the prohibited discrimination occurs when the injured worker's "employer single[s] him out for disadvantageous treatment because of the industrial nature of his injury."

Here, applicant made no showing that the employer treated him differently from nonindustrially injured employees. Specifically, he made no showing that the employer would have returned to work a nonindustrially injured employee whose physician provided the same releases, but discriminated against applicant by not returning him to work. Thus he did not make a prima facie case of discrimination in violation of §132a and did not shift the burden to the employer to establish an affirmative defense. Accordingly, the WCAB's award was annulled.

**B. Labor Code §4553**

*Sanchez v. WCAB* (2009) 74 CCC 1441, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant was seriously injured when he was crushed by an eight-ton compactor driven by a co-worker. Both employees had been hired four days previously as general laborers. In spite of his lack of experience with heavy equipment, the employer consented to allow applicant's co-worker to operate the eight-ton compactor after the supervisor spent five to ten minutes showing him how to operate the controls which primarily consisted primarily consisted of left, right, forward, and backward, with a two-inch emergency stop push-button near the forward and reverse lever.

The co-worker reportedly expressed concern about his ability to navigate the eight-ton compactor in proximity to applicant, who was operating a smaller walk-behind roller, but the supervisor directed him to "get back up on the compactor and operate it." He brought the compactor too close to applicant, panicked and hit the wrong button, causing the compactor to move forward rather than backward, injuring applicant.

Applicant settled his case and proceeded to trial on the issue of his serious and willful misconduct claim. After several days of trial, the WCJ concluded that the actions or inactions of the employer's supervisor "while negligent, do not rise to the level of serious and willful misconduct." Applicant petitioned for reconsideration, but the WCAB denied his petition.

The Court of Appeal granted applicant's petition for writ of review. After stating that a finding of serious and willful misconduct requires deliberate disregard of a condition that will likely cause injury, the Court noted that applicant was effectively asking that the WCAB's finding of negligence be disregarded. In finding that the employer was merely negligent, the WCJ relied on the fact that the compactor did not appear to be a complicated piece of machinery to operate, and that another coworker testified that he observed the co-worker operating the machine efficiently the entire morning before the accident. Furthermore, the co-worker did not make a credible witness and according to witness testimony, did not appear to be concerned about operating the equipment.

While the record reflected ample evidence of employer negligence, the Court found no indication that any representative of the employer knowingly or deliberately acted with a positive, active, wanton, reckless and absolute disregard of possibly damaging consequences. Finding substantial evidence to support the WCAB's adoption of the WCJ's findings, the Court denied the petition.

#### **XXVII. Penalties/Sanctions/Contempt**

##### **A. Labor Code §§ 5814 and 5814.5**

##### **B. Labor Code § 5813**

#### **XXVII. Attorneys/Attorney Fees**

*Smith/Amar v. WCAB* (2009) 74 CCC 575, Supreme Court

In *Smith*, Applicant received an Award for permanent partial disability and future medical treatment for his industrial injury to his right shoulder, neck and psyche. Eight years later, the carrier refused to furnish epidural injections for his back. Applicant contacted the attorney who originally handled his workers' compensation case. He was examined by an agreed medical examiner who concluded that he needed the injections to relieve his back pain, which was precipitated by work-related injuries. Defendant then authorized the injections without a formal hearing.

In *Amar*, Defendant refused to pay for a weight loss program and treatment of Applicant's non-industrial diabetes. The diabetes treatment was found to be unnecessary, but the weight loss program was ordered to be reinstated.

In both cases, the WCJs found that the applicants did not establish the right to attorney fees pursuant to Labor Code §4607: in *Smith*, because the denial of care was not the result of a formal petition to terminate medical treatment, and in *Amar* because the defendant's conduct was not unreasonable. The applicants' petitions for reconsideration were denied and they sought judicial review.

The Court of Appeal rejected Defendant's argument that Labor Code §4607 should not be construed to authorize attorney fees because the statute, read literally, does not provide for them unless the attorney is opposing a formal petition to terminate care. It was felt that it made no sense to award attorney fees where all care is denied, but not to allow fees if only some of the treatment is denied. Similarly, it would be absurd to deny attorney fees simply because the carrier withdrew care without bothering to file a formal petition to do so. The Court held that Defendants who fail to provide previously awarded medical care may not avoid attorney fees to successful applicants' attorneys by an informal denial of care, even when they do so in good faith. Defendants filed petitions for rehearing in the Supreme Court which were granted.

The Supreme Court disagreed and did not find it to be irrational that the Legislature might have elected to treat the more dramatic step of seeking to terminate an award differently than disputes over specific treatment requests. Furthermore, the applicants had ignored the existence of other statutes, such as Labor Code §5814.5, which require the Board to award fees when benefits have been unreasonably delayed or refused.

The Legislature recently established a utilization review process for handling employees' medical treatment requests and the utilization review scheme contains a procedure for resolving disputes over treatment requests that uses doctors, rather than judges, as the adjudicators. Finally, the available legislative history of section 4607 is consistent with a plain language interpretation. The statute was 4607 was modeled after another attorney fees provision, Labor Code §4651.3, which authorizes an award of fees when an employer unsuccessfully files a petition alleging that an employee's disability has decreased or terminated. The fact that the Legislature used both "decrease" and "terminate" in §4651.3, but only "terminate" in §4607 suggests that it knew how, if it so chose, to fashion a broader remedy.

The Supreme Court held that in light of the unambiguous statutory language and the legislative history, Labor Code §4607 authorizes an award of attorney fees only to employees who successfully resist efforts to terminate their award of medical treatment. It does not permit an award of fees to employees who successfully challenge the denial of specific treatment requests. Therefore, the judgment of the Court of Appeal was reversed.

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