

**SUMMARY OF RECENT SIGNIFICANT  
DECISIONS IN CALIFORNIA WORKERS'  
COMPENSATION LAW  
2013**

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## **SUPREME COURT, APPELLATE, AND EN BANC CASES**

### **1. MPN**

#### **Valdez v. WCAB (Ca. Supreme Court) 78 CCC 1209:**

In the first en banc decision the WCAB held that section 4616.6 precluded the admission of reports from any doctor outside the MPN. The Board also acknowledged that reports of attending or examining physicians may be received as evidence under section 5703, subdivision (a), but reasoned that it would be an abuse of discretion to admit an unauthorized report.

In its second en banc decision on Valdez's recon, the WCAB acknowledged that though section 4616.6 bars the admission of "other reports" only in controversies arising from article 2.3, the Board had not relied "predominantly" on section 4616.6. It also considered the employee's right to change doctors within an MPN, the multiple-level article 2.3 process for obtaining second and third opinions and an independent medical review, the requirement that the primary treating physician render opinions on all medical issues relevant to a compensation claim (§ 4061.5), and the comprehensive medical evaluation process set out in sections 4061 and 4062 for resolving disputes over temporary and permanent disability. The Board stated that because section 4616.6 specifically precludes the admissibility of non-MPN medical reports on disputed issues of diagnosis, a report from a non-MPN treating physician finding an applicant to be temporarily disabled, for example, based on a different diagnosis from the MPN physician, should not be admissible under section 4616.6. The Board concluded by restating its view that when a validly established and properly noticed MPN is in place, no doctor outside the network may become the primary treating physician or submit an admissible report on medical issues relating to eligibility for compensation.

The Court of Appeal granted Valdez's petition for review and annulled the Board's decisions. The court stated it did not make sense to construe section 4616.6 as a general rule of exclusion, barring any use of medical reports other than those generated by MPN physicians. Section 4616.6 states nothing of the sort. If the Legislature intended to exclude all non-MPN medical reports, the Legislature could have said so and it did not." The Court of Appeal further held that nothing in the broader statutory scheme excludes reports by non-MPN doctors from the Board's consideration. It observed that during a comprehensive medical evaluation, the evaluator is provided with reports from the employee's treating physician, who is not necessarily a member of an MPN. (§ 4062.3, subd. (a).) The Court also noted that a rule barring reports from privately retained physicians would eviscerate employees' right under section 4605 to consult with any doctor at their own expense. Finally, the Court of Appeal found no support in Tenet for the WCAB's conclusion that Dr. Nario's report was inadmissible because he was not Valdez's primary treating physician.

After the Supreme Court granted the employer's petition for review, the 2012 Legislature revised the workers' compensation statutes by passing SB 863. This included amendment of section 4605.

Valdez's case is about the scope of section 4616.6, an article 2.3 provision that declares in its entirety: "No additional examinations shall be ordered by the appeals board and no other reports shall be admissible [sic] to resolve any controversy arising out of this article."

The question is whether section 4616.6 applies only in proceedings to resolve diagnosis and treatment disputes under article 2.3, or more broadly in proceedings to determine disability benefits.

The Board's interpretation of section 4616.6 was not only "clearly erroneous," it was "a manifest distortion," according to the Court. Therefore, the Court could not give weight to the interpretation, notwithstanding the Board's "extensive expertise in interpreting and applying the workers' compensation scheme." (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1331.)

Even before the recent amendment of section 4605, the idea that section 4616.6 bars the admission of reports from non-MPN doctors in proceedings to determine disability benefits was tenuous. By specifying that "no additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any controversy arising out of this article the Legislature limited the evidentiary exclusion to proceedings originating under article 2.3. That article does not address disability benefits, and here there were no article 2.3 proceedings. Thus the Court of Appeal correctly limited the scope of section 4616.6 to matters arising during the independent medical review process set out in article 2.3. As the Court of Appeal noted, the comprehensive medical evaluation process set out in section 4060 et seq. for the purpose of resolving disputes over compensability does not limit the admissibility of medical reports. Section 4062.3, subdivision (a) permits any party to provide the evaluator with "[m]edical and nonmedical records relevant to determination of the medical issue." Under section 4064, subdivision (d), "no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense," and "[a]ll comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the appeals board," except as provided in specified statutes. The Board is, in general, broadly authorized to consider "[r]eports of attending or examining physicians." (§ 5703, subd. (a).) These provisions do not suggest an overarching legislative intent to limit the Board's consideration of medical evidence.

The Legislature did not revise section 4616.6 to extend its reach beyond article 2.3 proceedings. Nor did it narrow employees' right to seek treatment from doctors of their choice at their own expense, or bar those doctors' reports from admission in disability hearings. Rather, it provided that privately retained doctors' reports "shall not be the sole basis of an award of compensation." (§ 4605.) The clear import of this language is that such reports may provide some basis for an award, but not standing alone.

The Court then rejected the employer's complaint that because Valdez was seeking reimbursement for Dr. Nario's fees, she was not really retaining him at her own expense and exercising her right to retain a private physician under section 4605. That issue had yet to be addressed below, and even where no reimbursement of medical fees was sought or awarded, the exclusionary rule the employer seeks to derive from section 4616.6 would bar the admission of reports from privately retained and compensated physicians in disability proceedings. Such a rule would be inconsistent with the terms of section 4605, as amended by Senate Bill 863.

The Supreme Court concluded that section 4616.6 restricts the admission of medical reports only in proceedings under article 2.3 to resolve disputes over diagnosis and treatment within an MPN. On remand to the Board, the amendments effected by Senate Bill 863 are applicable to Valdez's award, which is not yet final.

## **2. ADA**

**Vesco v. Superior Court of Ventura (Newcomb) (Court of Appeal Published) 221 Cal. App. 4<sup>th</sup> 275:**

California Rules of Court allows persons with disabilities to apply for accommodations to ensure they have full and equal access to the courts. The rules prohibit disclosure of applicant's confidential information to persons other than those involved in the accommodation process.

The trial court granted a motion for continuance to Newcomb. The petitioner received no prior notice and the court denied petitioner's request to review the medical documents on which Newcomb relied to obtain a continuance.

The court concluded that petitioner is a person involved in the accommodation process. Therefore petitioner has the right to notice, to review the document on which the real party in interest relies and an opportunity to be heard. The court issued a preemptory writ of mandate. They directed the superior court to vacate the order granting the continuance.

The parties were involved in a civil action. Vesco was the plaintiff and Newcomb the defendant. The matter was set for trial.

Newcomb file an ex-parte motion for accommodation under the ADA requesting a continuance of the trial based on her health. Vesco was not served with a copy of the motion nor notified of it until after the trial court granted the continuance.

Vesco was served with a minute order stating defendant Newcomb had made a confidential ADA request. As part of the court's response to the request, the trial date was continued.

Vesco filed an ex-parte application to examine and photocopy all documents in the trial court's possession concerning the request for ADA accommodation. Vesco claimed that Newcomb's sole intent was to delay the trials. She had a proven history of filing false documents with the court, and that Vesco needed to review her request to determine the basis for the court's order, and whether he should seek reconsideration or writ of review of that order.

The trial court denied Vesco's ex-parte application.

Vesco petitioned for writ of mandate for an order that the trial court allow him access to all materials relied on to grant the trial continuance. This request was summarily denied.

Newcomb made another confidential request for accommodation under the ADA. The court ordered the trial again continued so that it would have time to review the request. The court again continued the trial.

Vesco renewed his petition for writ of mandate.

Vesco contends the trial court erred in granting Newcomb's continuance without first allowing him the opportunity to review the documents on which she relies and the opportunity to be heard. Vesco claims he is prejudiced by the continuances.

The Rules of Court allow persons with disabilities covered by the ADA accommodations to ensure full and equal access to the judicial system. The application may be made ex parte. Under the appropriate circumstances the accommodation may be a trial continuance.

The rules further provide that the identity and confidential information may not be disclosed to the public or persons other than those involved in the accommodation process.

The question presented here is whether Vesco is a person involved in the accommodation process. The answer is obvious: It is his trial that is being continued and he is the person forced to make the accommodation.

When a party raises her physical condition as an issue in a case, she waives the right to claim that the relevant medical records are privileged. The reason for the waiver is self-evident. It is unfair to allow a party to raise an issue involving her medical condition while depriving an opposing party of the opportunity to challenge her claim. A challenge requires access to the medical records on which the party relies and an opportunity to be heard. Otherwise, the challenge is in name only. The fact application may be made ex parte does not dispense with the requirement of notice.

Vesco has the right to have his trial as soon as circumstances permit. It follows that he may challenge Newcomb's request for a continuance. He therefore must be given notice, an opportunity to be heard and an opportunity to view the medical records and other materials on which Newcomb relies. Of course, the trial court must protect Newcomb's privacy as far as practical. For example, it may hold the hearing in camera, order Vesco and his counsel may not disclose the contents of the medical records, seal the record of the proceedings, and take other steps it deems appropriate to accomplish this goal.

The petition was granted vacating the order and allowing petitioner notice and an opportunity to be heard.

### **3. Liens**

#### **San Diego Unified School District v. WCAB (Findlay) (Court of appeal unpublished) 2013 Cal. App. Unpub. LEXIS 8325**

Applicant sustained an admitted injury to his back. In 2002 a Pointe Loma doctor administered three epidural injections. Pointe Loma billed \$5980 for these injections. Defendant paid \$779.88 and Pointe Loma filed a lien for \$5200.12. The case proceeded to trial to determine value of the injections. Lien claimant introduced documents showing that the average amount paid in the Los Angeles area was \$3877.74. The defendant introduced a document showing the amounts generally billed and paid by other facilities and called their own expert from WellComp. He

testified that WellComp would calculate payment for epidurals by multiplying the amount listed for Medicare and multiplying by 2.5 then rounding to the nearest \$100. He testified that WellComp would have paid \$1800 for three injections. Based on the testimony the WCJ found that \$1650 was the reasonable value of an epidural injection. The judge awarded \$3300; less payments made, plus awarded lien claimant penalties and pre-award interest.

Pointe Loma filed for reconsideration. On recon the board affirmed the Judge's determination except granted recon to eliminate the award of penalties. A writ was filed and the appellate court issued an unpublished opinion.

The court found that it was proper for the judge to rely upon a range of evidence. Lien claimant did not submit any expert testimony to support its lien. The Judge utilized the expert testimony from WellComp and when the record was taken as a whole the board could find that \$1,650 was reasonable based upon the expert's testimony. In this case the expert testified that payment should be made at 100% for the first injection and then 50% for each injection thereafter which brought the court to find \$3300 to be reasonable for three injections. The court also found that lien claimant was entitled to pre-award interest under 9792.5 since the district never raised the legal grounds to support that the WCJ erroneously relied upon repealed statutory authority.

#### **4. Apportionment**

##### **Southern California Edison v. WCAB (Martinez)(Court of appeal unpublished) 78 CCC 825**

Applicant sustained a specific injury on 6/15/01 and a CT 2/98 through 5/21/04. The parties referred the medical issues to AMEs. Dr. Kanter in orthopedic medicine determined that applicant suffered 20% impairment. He apportioned between the specific injury, CT and nonindustrial causes. Dr. Friedman in psychiatry determined app had a 20% WPI and apportioned between the specific and CT in accordance with Kanter except did not find any of the disability to be non-industrial. The WCJ appointed Levine in rheumatology when the parties disputed whether applicant suffered from fibromyalgia. Dr. Levine found that applicant suffered from fibromyalgia and also opined that applicant suffered from psych and orthopedic problems due to the fibromyalgia. The doctor acknowledged that the AMA Guides do not address fibromyalgia but dissected out the major symptoms that interfere with activities of daily living. He noted the applicant would have 20% for sleep, 5% for IBS, 9% for decreased libido, and 3% for pain. She has a WPI of 50% from the fibro taking into account her sleep and arousal disorder, behavior disorder, chronic pain, sexual dysfunction, and IBS. He did not apportion. He then stated that the applicant was 100% disabled due to the CT and not due to the specific injury. This was due to the combination of orthopedic, psych and rheumatologic factors. She was unable to compete in the open labor market. The judge found that applicant sustained a 29% PD due to the specific injured and was 100% disabled due to the CT based on the finding of fibromyalgia. This was based on the determination of Dr. Levine, IME. The WCAB denied recon and the defendant filed a petition for writ. The appellate court granted the writ and issued an unpublished opinion.

The court stated that when a prior disability finding has been made the employer bears the burden of proving an overlap between the prior PD and the current PD. Once an overall has been established the presumption is that the PD still exists from the prior injury. Apportionment is required where successive injuries because P&S at the same time. These must be rated separately unless a doctor cannot parcel out the causation of disability. The court found that the evidence strongly suggests that the disabilities caused by the CT overlap with the specific. Many of the same body parts were claimed in the 2 injuries. The court felt that Dr. Levine's report supported the overlap and he erroneously failed to apportion to the specific injury. The court found that the WCJ ignored Levine's report which found that the applicant was 100% disabled due to the combination of orthopedic psych and rheumatologic factors and not solely due to fibromyalgia. The court determined that Levine's finding that there was not a specific injury was incorrect and that fibromyalgia was the cause of the applicant's 100% disability. On remand the WCJ should focus on the specific physical condition rated by Levine and rely on Friedman for assessment of Martinez's psych condition since this was outside of Levine's expertise. The court determined that Levine's report was not substantial evidence to support his conclusions. The decision was annulled and remanded.

## **5. Employment/Serious and Willful Misconduct**

### **CLP Resources v. WCAB (Mora) (Court of appeal unpublished) 78 CCC 1025**

Applicant was placed by a temporary agency, CLP Resources, to work for John Lieb. Applicant was injured on 12/8/09 while operating a table saw. The applicant filed a petition for S&W misconduct of CLP and Lieb. Applicant was seriously injured. Lieb was not properly served and not part of the litigation of the case.

Applicant had been placed by CLP on temporary assignment in April of 2008. He was supervised by Lieb who provided the tools including the saw. CLP had instructed the applicant to contact Marlo Vasquez if there was any problem on the job such as a dangerous condition. In the third week there the applicant went to Vasquez to discuss unsafe conditions on the job. He told Vasquez there were a lot of things that were not right on the jobsite and Vasquez should "check it out". Mora was about to list the problems but Vasquez told him that "there was not work and he should be careful". Mora did not have an opportunity to report the problems to Vasquez. CLP never inspected the problem. Mora never told anyone about the dangerous condition at CLP. CLP had inspected the site in October of 2008 and had found no safety violation. After the injury CLP was cited for having an inadequate injury prevention program. The matter proceeded to trial and the Judge found that the applicant's injury was caused by the S&W misconduct of CLP. On reconsideration CLP pointed out that the judge stated that there was "is no clear evidence that any named management representative" of CLP "knowingly violated a safety order". The WCJ's decision was affirmed on reconsideration. CLP filed a writ. In an unpublished opinion that court re-iterates the standard for a claim of S&W misconduct. There must be a reckless disregard for the safety of the employees and an affirmative and knowing disregard for the consequences. The employer must know of the dangerous condition. The WCJ found at trial that there was no evidence that a CLP manager knew of the dangerous

condition. Mora further argued that CLP should be liable under the theory of joint and several liability in that when one employer “lends” an employee to another they become joint and severally liable for workers’ compensation benefits as the general and special employer. The court found that this did not apply in a case under L.C. Section 4553. Under this section the employee must prove such misconduct individually with respect to each employer. There is nothing in 4553 that allows for vicarious liability for the misconduct of a special employer. The principle of joint and several liability is not a means for establishing liability but a means for apportioning responsibility for payment once liability has been established.

## **6. Death Benefits**

### **South Coast Framing vs. WCAB (Clark) (Court of appeal unpublished) 2013 Cal. App. Unpub. LEXIS 8833**

In 2008 the applicant sustained an admitted injury to back, head, neck and chest after falling from a roof. Applicant was prescribed Amitriptyline, Neurontin and Vicodin for the injuries. He was also taking Xanax and Ambien prescribed by his personal doctor for anxiety and sleeping problems.

In July 2009 the applicant died from the combined effects of the medications and early pneumonia. Applicant’s wife and three minor children file for death benefits alleging the death was caused by the medications.

The parties utilized doctor Bruff as an AME. The doctor opined that the applicant died from an interaction of Ambien and Xanax. In deposition the doctor testified that it was possible the Amitriptyline could have contributed to the applicant’s death but the Ambien and Xanax “carried the day” but he stood by his initial report. Based on the AME’s deposition testimony the judge determined that the death was work related since the applicant took Amitriptyline as well as Ambien and Xanax. All of these drugs contributed to his death. The board denied recon. Defendants filed a petition for writ and the court issued an unpublished opinion.

The court explained that all that needed to be found was a causal connection between employment and the injury. So long as the industrial injury and employment generally constituted material factors in contributing to the employee’s death the proximate cause test of L.C. Sec.3600 is met. The court found that the board may not isolate a portion of the doctor’s report or testimony and disregard another portion that contradicts. Dr. Bruff testified that it is possible that amitriptyline contributed to the applicant’s death and it could be an incremental contributor but had only a small role. Although a precise percentage is not required an applicant must show a reasonable probability of industrial causation. The court found that even if Amitriptyline played a role at all it was not significant such that it constituted a material factor contributing to the death. The court, after review of the medical records found that there was insufficient evidence to establish that applicant used Ambien due to the industrial injury.

The court annulled the Board's order denying recon and remanded with directions to enter a new order denying the claim.

## **7. "Good faith" personnel action**

### **County of Sacramento v. WCAB (Brooks) (Court of appeal published) 78 CCC 379**

Applicant worked as a supervisor in the probation department. He observed what he believed violation of protocols and felt the response team which he supervised, resisted and undermined his authority and supervision.

The assistant chief deputy met with the applicant and gave him a memo entitled admonition and notice of internal affairs investigation. The memo advised the applicant of allegations made by a team member which formed the basis for the internal affairs investigation. The applicant asked to be reassigned or be placed on administrative leave pending completion of the investigation. The request was denied. However, the employer allowed the applicant to change shifts to avoid contact with the team member.

Applicant went to work and saw the team member was scheduled to work that same shift. Applicant was too upset to work and filed a claim.

The parties used an agreed medical examiner. The AME found the following factors caused applicant's disorder: (1) the team members complaint (2) the internal affairs investigation (3) applicants feeling that his supervisors were not supporting him.

The county denied liability for his claim arguing that it was barred by the personnel action defense of 3208.3.

The WCJ found industrial injury and that applicant's injury was not substantially caused by a good faith personnel action. The WCAB reversed and remanded the case for further development of the record with respect to personnel action defense.

The AME after remand submitted a supplemental report and had his deposition taken.

The case was again submitted and the WCJ again issued a decision in applicant's favor. The board affirmed the decision, with one dissenting Commissioner.

The WCJ found the County failed to meet its burden of proof establishing a personnel action was a substantial cause of the psychiatric injury.

The County again filed a petition for reconsideration. The county argued that a full and fair review the evidence would find the personnel action were the substantial cause of applicant's claim. The county did not specifically point to a medical opinion that substantiates their opinion.

The WCAB after reconsideration concluded that of all the events that caused applicant's injury only the internal affairs investigation was a personnel action. Since the investigation counted for

only one third of the causation the personnel action was not a substantial cause of the psychiatric injury. One commissioner dissented. Petition for writ of review was filed and granted. A personnel action has been defined as conduct attributable to management in managing its business, including such things as reviewing, criticizing, demoting, transferring or disciplining an employee. (*Larch v. Contra Costa County* 63 CCC 831; *Stockman v. State of California/Department of Correction* 63 CCC 1042).

Whether there has been a psychiatric injury must be established by expert medical opinion. (*Rolda v. Piney Bowes*, 66 CCC 241).

The Court of Appeal indicated that the board's determination that personnel actions did not substantially caused applicant's psychiatric injury was based on the medical reports and testimony of the AME. The Court of Appeal found these reports and testimony were so confusing and changing that the AME's opinion cannot be deemed to support the Board's conclusion that personnel actions were not a substantial cause of applicant's injury. Therefore they annulled the award of the appeals board.

The Court began by stating the findings that one third of applicant's injury was caused by the internal affairs investigation and the investigation was a personnel action unchallenged. Therefore, even if a small amount of the remaining causation can be attributed to personnel actions the personnel actions would be a substantial cause (at least 35%) of applicant's injury. To determine whether part of the remaining causation can be attributed to personnel actions the court stated they must consider what the record establishes as the cause of applicant's feelings that he was unsupported by his supervisor.

The court in finding the opinion of the AME was not substantial evidence stated as follows: The law does not accord to the expert's opinion the same degree of credence or integrity as it does the data underlying the opinion. Like a house built on sand, the expert's opinion is no better than the facts on which it is based. (*Kennemur v. State of California* 133 Cal.App3d 907,923).

Having found that the board's decision was not supported the court then turned to the question of the appropriate remedy. The faulty assumptions and contradictions in the AME reports and testimony concerning the cause of applicant's injuries establish that better medical evidence in the legal analysis is needed to decide the question of whether the injuries were caused by a personnel action. Accordingly, the appropriate remedy the court stated was to remand for further development of the record.

## **8. Employment**

### **Stewart Espinoza v. WCAB (Court of appeal unpublished) (78 CCC 89)**

The WCAB found that applicant, while an inmate of the Los Angeles County's Men's Central Jail, was not an employee of the County of Los Angeles at the time that he was injured while working as a cook in the jail.

Applicant filed a petition for review which was denied. The Supreme Court granted the petition for review and transferred the matter to the court to issue a writ.

The Court of Appeal upheld the decision of the WCAB.

The issue was whether the applicant was the county's employee and performing work voluntarily or whether he was required to work as a condition of his incarceration.

The Court of Appeal indicated the issue was primarily a problem of proof.

The County of Los Angeles enacted order 91 which provides that persons confined in the county jail may be compelled to perform labor under the direction of a county official. The order goes on to state that no prisoner engaged in labor pursuant to this order shall be considered an employee of, or to be employed by the county or any department thereof, nor shall any prisoner, within any of the provisions of the Workers' Compensation act.

The Court of Appeal concluded that order 91 is proof of the fact that the applicant was not performing work voluntarily but rather order 91 shows the applicant was required to work as a condition of his incarceration.

Applicant did not testify at the hearing. Instead there was an offer of proof that the WCJ stated as follows: "he thought his work was voluntary, and was never told his work was mandated by the terms of his incarceration. He received preferential treatment in exchange for the work."

The WCJ reasoned that order 91 provides that a jail inmate may be compelled to work, not that the inmates shall be compelled to work. The WCJ went on to conclude that there was no evidence that the applicant was compelled to work. He did not work in order to receive some extra benefits while in jail. Nothing indicates the terms of his sentence required him to work in the kitchen.

The WCAB disagreed and concluded that an inmate's work is not voluntary if it is performed subject to a county ordinance that requires an inmate to work while incarcerated. The WCAB's conclusion was that an inmate's work is not voluntary if it is performed subject to a county ordinance that requires an inmate to work while incarcerated.

The statutory compulsion to work further negates any consensual employment relationship under the facts of this court case.

The WCAB concluded that the existence of an ordinance requiring jail inmates to work, standing alone, warranted the conclusion that the inmates work is not voluntary. The WCAB rejected the theory that the word "may" in order 91 made the inmates work voluntary: if an inmate is directed to work by the sheriff, the work is necessarily not voluntary."

Although these common law contract requirements are not to be rigidly applied, a consensual relationship between the worker and his alleged employer nevertheless is an indisputable prerequisite to the existence of an employment contract pursuant to LC § 3351.

Whether a person incarcerated in a county jail is in a consensual employment relationship depends on the policy that the County is chosen to follow. The trial court must determine whether County inmate was an employee on a case-by-case basis using the general definition of

employee. (Parsons v. WCAB, 46 CCC 1304) in making this decision the trial court should consider the following questions: (1) did the county require plaintiff to work as a condition of incarceration? (2) did the plaintiff volunteer for assignment? And (3) What consideration was received, if any.

If the first question is answered in the affirmative, the inquiry is at an end. This is especially true in cases, such as the one before us, where the county has a declared policy, set forth in writing, that it requires jail inmates to work as a condition of their incarceration. If such a policy is in effect, inmates are simply not in a position to volunteer to work. It is to be kept in mind that the employment relationship is consensual, which means that the county must consent to the relationship. If it has a declared policy the contrary common employment relationship cannot exist.

Given that order 91 precludes the establishment of an employment relationship, it is not necessary to adjust the question whether applicant volunteered to work.

We conclude the WCAB decision is correct and that order 91 precludes the creation of an employment relationship.

The decision of the WCAB was affirmed.

## **9. CIGA**

### **State Farm v. WCAB (Lutz) (Court of appeal published) 78 CCC 758**

Applicant was injured on June 8, 1999 and June 20, 2000. Applicant was injured while working as a personal assistant to the president of Roto Rooter, Linda McDonald. The applicant was on the payroll of Roto Rooter. During 1999 and 2000 Roto Rooter was insured by Fremont and Paula insurance. Linda McDonald and her homeowner's insurance carrier, State Farm, were joined as additional parties to the claim.

The matter came on for mandatory settlement conference and the issue was whether the applicant was working as a domestic employee of Linda McDonald at the time of her injuries such that State Farm would provide coverage for the claim, or whether she was employed by Roto Rooter.

On February 15, 2002, in lieu of trial, the parties entered into joint stipulations with request for award. The parties stipulated the applicant was employed by Roto Rooter and Linda McDonald and sustained injury arising out of and occurring the course of employment. Paula insurance company agreed to administer the award. State Farm agreed to indemnify.

In June 2002 and July 2003, Paula and Fremont were liquidated. CIGA assumed administration of the claim. Since then, State Farm has been reimbursing CIGA for 25% of all benefits paid to the applicant.

In September 2003, CIGA filed a petition for dismissal, arguing that it should be dismissed because Paula Insurance Company had not provided workers' compensation coverage for residential or domestic employees. State Farm opposed the petition, contending the evidence

supported a finding of employment by Roto Rooter and coverage, and that the March 15, 2002 stipulated award was final and binding on CIGA. The record shows no action on this petition.

In February 2008, five years later, CIGA sought to be relieved as administrator of applicant's claim. The parties were unable to resolve the dispute concerning employment as a domestic employee versus employment with Roto Rooter.

On March 4, 2008 the WCJ ruled that the WCAB was without jurisdiction to rescind or alter the March 15, 2002, stipulated award, and that CIGA was bound by the stipulation. CIGA did not seek reconsideration of this award.

CIGA filed a petition for reimbursement and for change of administrator and that CIGA should be relieved of responsibility to pay benefits because of the presence of other insurance. .

The WCJ ruled the presence of other insurance in this case does not support good cause to dismiss CIGA. CIGA has already been determined to be bound by the stipulated award of March 15, 2002 and that determination having been made on April 8, 2008 without any appellate response, remains the law of this case, and the motion of CIGA to be dismissed is therefore denied.

CIGA then sought reconsideration.

The WCJ recommended that the WCAB deny reconsideration reasoning that the 2008 decision on jurisdiction to rescind altar or amend the 2002 stipulated award is the law of the case. The WCAB adopted the recommendations and denied the petition for reconsideration.

CIGA did not file a petition for writ of review with the Court of Appeal.

In January 2010 CIGA proceeded to trial on the applicant's claim of permanent disability, future medical treatment lien claim by EDD and other related issues.

On April 27, 2010 the WCJ issued his decision granting the applicant permanent disability of 39% and awarding benefits against CIGA for future medical treatment. The WCJ ordered CIGA to reimburse EDD for disability payments provided to the applicant. CIGA sought reconsideration.

The WCJ recommended that reconsideration be granted in part to correct certain miscalculations he made in the amount of permanent disability and eliminate CIGA's obligation to reimburse the EDD. The WCJ also clarified that CIGA is the party liable for the benefits to the applicant and that State Farm remains obligated as a co-defendant to CIGA for 25%, but not the applicant. The WCJ recommended denial of CIGA's petition for reconsideration in all other respects.

On January 18, 2011 the WCAB adopted the WCJ's recommendations in all respects and modified the WCJ's award accordingly.

On April 18, 2011 CIGA filed another declaration of readiness on the issue of reimbursement. The WCJ denied CIGA's request for trial of its claim for reimbursement and/or contribution. They found that the respective liabilities the parties had previously been finally determined and could not be litigated by way of seeking contribution or reimbursement.

CIGA then petitioned the WCAB for reconsideration.

On December 19, 2011 the WCAB granted reconsideration, notwithstanding its contrary decision 11 months earlier, against CIGA on the question of whether they could pursue a reimbursement claim under Insurance Code section 1063.1 (c) (9). The WCAB noted that CIGA was not a party to the 2002 stipulation and was not seeking to amend the earlier stipulation. Instead CIGA was seeking to enforce a statutory right under Insurance code section 1063.1 to obtain reimbursements from a solvent insurer that is available to provide benefits to the applicant within the meaning of the statute. The WCAB reasoned that the 2002 stipulated award and the five-year limitation period of LC 5804 were not dispositive of CIGA's petition for reimbursement. The applicant was jointly employed by Linda McDonald and Roto Rooter when she was injured. Because the applicant had two employees each employer and their respective insurers on those dates of injury as a matter of law were jointly and severally liable for workers' compensation benefits. The WCAB reasoned that the 2002 stipulation did not change State Farm's joint and several liability to the applicant. The WCAB concluded there had been no earlier final decision on CIGA's petition to obtain reimbursements for State Farm. Thus, there is no basis for denying the petition for reimbursement on the grounds of res judicata or collateral estoppel as concluded by the WCJ. The WCAB rescinded the WCJ's decision and returned the case to the trial level for further proceedings on CIGA's reimbursement.

Thereafter, State Farm petition for reconsideration. The WCAB denied State Farms petition for reconsideration. State Farm filed a petition for writ of review.

The Court of Appeal granted the writ. The Court of Appeal indicated the issue is whether CIGA's reimbursement claim is barred by res judicata or latches.

The characterization of an order or decision as final and susceptible to judicial review has critical consequences. The failure of an aggrieved party to seek judicial review of a final order of the WCAB bars later challenge to the propriety of the order or decision before even the WCAB or the court.

CIGA contends that State Farm cannot point to any place in the record where CIGA's right to reimbursement was raised and litigated prior to the WCAB's decision on December 9, 2011. CIGA denies that CIGA's right to reimbursement was litigated in April 2008, June 2, 2009 or January 2011. The Court of Appeal disagreed.

The Court of Appeal indicated they need not address the ultimate question of whether State Farm is jointly and severally liable for hundred percent of the applicant's claim, or whether it's homeowners insurance policy is "other insurance" under Insurance Code § 1063.1 (c) (9), because CIGA did not preserve its right to pursue these issues. Right or wrong, the WCJ's decision in 2008, and the WCAB's 2009 and 2011 decisions are final and CIGA may not invoke the jurisdiction of the WCAB or this court to review the lawfulness of those decisions..

The Court of Appeal found that CIGA's reimbursement claim was barred by the principles of res judicata therefore they need not address State Farm's alternative contentions.

The Court of Appeal annulled the order of the WCAB remanded the matter for further proceedings consistent with its opinion and awarded costs to State Farm.

## **10. Apportionment**

### **Steel v. WCAB (Borman) (Court of appeal unpublished) 78 CCC 751**

Applicant sustained a continuous trauma injury to his ears (hearing loss), bilateral upper extremities, neck and head.

The applicant was examined by three different AME's.

The AME for the hearing loss apportioned 40% of the permanent disability to non-industrial factors. The opinion was based on the doctor's conclusion that the high frequency progressive hearing loss was consistent with noise exposure. Further the doctor noted an explosion at the factory in December 1994 resulting in 22% hearing loss. He indicated the applicant's hearing loss got gradually worse after that specific event. The AME was of the opinion that the further hearing loss after the specific injury was the result of both noise exposure and degenerative changes. The AME found 100% hearing loss and apportioned 60% to the noise exposure at work and 40% due to other factors.

The WCJ following the hearing found the applicant rebutted the DFEC and found 100% loss of earning capacity. The WCJ based that finding on a vocational expert's testimony showing that there was no job on the open labor market that could accommodate the applicant's difficulty. Defendant filed a petition for reconsideration arguing that 40% of the hearing loss should have been apportioned to non-industrial factors.

WCJ in his report indicated that he was not bound by the findings of the AME when there is convincing vocational testimony regarding loss of earning capacity. In this regard the WCJ relied on expert testimony that the appearance of the implants themselves act as bar too employment due to the prominent appearance on both sides of his head which is still quite an uncommon sight.

The WCAB denied reconsideration adopting and incorporating the opinion of the WCJ.

Defendants filed a writ of review which was granted.

The Court of Appeal indicated they did not take issue with the WCJ's conclusion that the applicant could rebut the rating schedules DFEC by offering vocational expert testimony showing a hundred percent loss of earning capacity.

The Court of Appeal indicated however the WCJ failed to address the issue of apportionment.

Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to non-industrial factors. Apportionment is the process employed by the board to segregate the

residuals of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility.

Therefore, evaluating physicians, the WCJ, and the Board must make an apportionment determination by finding what approximate percentage of permanent disability was caused by the direct result of the industrial injury and what approximate percentage of permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.

Apportionment is excused only under extremely limited circumstances, when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentage as to which each distinct industrial injury causally contributed to the employee's overall permanent disability.

In this case the WCJ and WCAB ignored substantial medical evidence presented by the AME in hearing loss showing that the one-hundred percent loss of hearing could not be attributed solely to the current cumulative trauma injury.

The Court of Appeal rejected the applicant's argument that the medical report of the AME was not substantial evidence on apportionment.

The Court of Appeal found the WCAB's failure to portion the hearing loss is contrary to law and the award was annulled.

The matter was remanded for an award consistent with the opinion.

## **11. Rating/AMA Guides**

### **City of Sacramento v. WCAB(Cannon)(Court of appeal unpublished) ADJ7238353**

Applicant police officer sustained an admitted injury to his left foot that resulted in plantar fasciitis. The AME found 0% WPI because the AMA guides did not provide a schedule to moderate plantar fasciitis. In a supplemental report the AME using an alternative rating found a 7% WPI by analogy to gate arrangement in the guides

The WCJ found no PD based on the initial AME report.

Applicant filed a petition for reconsideration. The WCAB granted reconsideration and indicated that WPI should have been 7% rather than 0%. The Board returned the matter to the trial level for a new decision consistent with the AME's revised opinion.

The defendants in this case argued that an alternative rating under the guides could only be applied to the situation in which the case is complex or extraordinary. They argued in this case the plantar fasciitis was neither complex nor extraordinary.

The WCAB rejected this argument. The WCAB indicated that the language of Guzman indicates that a physician has the ability to rate an impairment by analogy, within the four corners of the guides, where a strict application of the guides does not accurately reflect the impairment being assessed. The WCAB indicated they rejected the argument that the case must be complex or extraordinary.

The WCAB ruled in this case that the test is whether the 7% WPI more accurately reflected applicant's impairment and thus the medical report is substantial evidence.

As to the second issue in this case when a rating is unscheduled in the guides the WCAB indicated the guides were not all-inclusive. For impairments that were not listed the evaluating physician was then mandated to use his clinical judgment and expertise to determine a WPI utilizing the four corners of the guides. When the rating is available the physician must rate by analogy. The WCAB found the AME's opinion to be substantial evidence and remanded the decision to the trial court for a decision consistent with the board's opinion.

The board concluded in this case that if an impairment is not listed in the guides the physician can use an alternative rating based on analogy within the four corners of the guides.

In rebutting the rating the physician must show that an alternative rating more accurately reflects applicant's disability and the alternative rating must within the four corners of the guides. If the medical report adequately explains the basis for the rating and how and why the rating more accurately reflects applicant's disability the report will be found to be substantial evidence rebutting the guides.

Defendants filed a petition for writ of review which was granted by the appellate court and an unpublished opinion was issued upholding the board's decision.

## **12. Petitions for costs**

### **Martinez v. Ana Terrazas; All State Insurance (En Banc) 78 CCC 444**

The WCAB held: (1) a claim for medical-legal expenses may not be filed as a petition for costs under section 5811; and (2) medical-legal lien claimants who withdraw their liens and filed petition for costs prior to this decision may pursue recovery through the lien process if they comply with the lien activation fee requirements of LC section 4903.6 and if their liens have not otherwise been dismissed.

New Age filed a lien for document copy services. Lien claimant filed a 5811 petition for costs for the same expenses it previously sought to recover by its lien. They did not withdraw the lien. The WCJ denied the petition for costs stating the lien claimant filed their lien prior to January 1, 2013. As such, it is a cost filed as a lien and is subject to the fee requirement of LC section 4903.06 (a).

Lien claimant filed a petition for reconsideration.

The WCAB held that as a matter of law; in light of the separate procedures that the legislature has established for the recovery of those expenses, it would be an abuse of discretion to permit

medical-legal expenses to be claimed under labor code section 5811. In particular, they found no reason for the WCAB to exercise its discretion where the apparent intention of a petition for costs is to avoid the statutory-mandated lien activation fee.

Although the case presently before the WCAB related to copy service expenses claim through a medical-legal lien filed before January 1, 2013 under former section 4903 (b), the board emphasized that the decision applies to all medical legal expense claims, regardless of: (1) whether a pre-January 1, 2013 lien was filed; (2) when the claimed medical-legal expense might have been incurred; or (3) the nature of the medical, legal expenses claim.

Copy service costs incurred to obtain medical records are medical-legal expenses. Therefore the copy service cost claimed by lien claimant may not be pursued under 5811.

Medical/legal lien claimants who withdrew their liens and filed petitions for costs prior to this decision may pursue recovery through the lien process if they comply with the lien activation fee requirements of LC section 4903.06 and if their liens are not otherwise been dismissed.

Footnote number six:

As amended by SB 863, section 5811 (b) (2) (C) qualified interpreter services rendered during a medical treatment appointment or medical legal examination. Under proposed rule 10451, which had not been adopted by vote of four Appeals Board members, interpreters would have been allowed to file petitions for costs for services rendered at medical treatment appointments and medical legal examinations. Of course, the issue of whether interpreters may file such petitions for costs is currently before the WCAB. However, the WCAB hereby gives notice to the workers' compensation community that our present view that while certain interpreter service may be claimed through a petition for costs under 5811 (e.g., interpreter appearance at depositions and WCAB hearings), claims for interpreter services at medical treatment appointments and/or medical-legal examination must be pursued through the specific statutory schemes established by the legislature and not through a petition for costs. The WCAB further observed, that even if proposed rule 10451 was in effect it would not have authorized petitions for costs by copy service for medical-legal expenses.

## **DENIALS OF WRITS OF REVIEW**

### **13. Prohibited ex parte communication with an agreed medical examiner**

#### **Martin Trapero v. North American Pneumatics, State Compensation Insurance Fund, (W/D) 77 CCC 183**

The applicant's attorney handed a recently-procured vocational evaluation report to defense counsel a few minutes prior to AME's deposition and presented the report to AME during deposition. The defendants objected to the report being presented to the AME at the deposition. The defendants moved for a new AME based on the ex-parte communication. The WCJ denied

the motion. The WCAB granted removal on its own motion and rescinded WCJ's finding. The WCAB held that the applicant's attorney violated Labor Code § 4062.3 because (1) the vocational reports fell within the definition of "information" described in Labor Code § 4062.3, as it was a "nonmedical record relevant to determination of a medical issue" under Labor Code § 4062.3(a)(2), (2) under Labor Code § 4062.3(c), the parties must agree on what information is provided to the AME and by springing the vocational report on defense counsel when the AME was about to be deposed deprived defense counsel of opportunity to determine if he would agree to provide this information to the AME, and (3) the vocational report should not have been provided to the AME during the deposition, because defense counsel objected to provision of this "information". The WCAB granted defendants' motion for a new AME based on the ex-parte communication

This case stands for the proposition that a party cannot serve "**information**" on opposing counsel just prior to or at the deposition of an AME. The case sets up the procedure that if a party wishes to present any "information" to an AME at a deposition they will have to serve the information on the opposing party prior to the deposition or give them notice of the information they want to present and give them ample time to agree and if they do not agree the information cannot be shown to the AME at the deposition. Absent an agreement a party would have to petition the WCAB to present the information to the AME.

If the other side does not agree the moving party will have to file a **petition with the WCAB**.

#### **14. Substantial evidence**

##### **County of Sacramento v. WCAB (Smith)(W/D) 78 CCC 45**

Applicant claimed an industrial injury as a result of sinus symptoms from exposure at work. The parties went to an AME. The AME reported there was no evidence of an industrial injury and that applicant's sinus problems resulted from long-standing non-occupational asthma. The AME noted there was no greater amount of mold inside applicant's work environment versus outdoors. In his deposition the AME indicated applicant was exposed to mold much greater outside of work than inside. The AME was of the opinion that employment was not a causative factor in her sinus problems and there was no industrial injury.

Applicant's PTP testified that it was medically probable that the mold exposure in the work place was a contributing factor to the development of her sinus problems.

The WCJ issued a decision finding injury based on the PTP.

Defendant sought reconsideration.

The WCJ recommended that reconsideration be denied. The WCJ explained that defendant's position that applicant sinus problems were not industrially caused was based on an incorrect standard of causation. According to the WCJ, to establish industrial causation applicant need not prove that her mold exposure was materially greater than the mold exposure incurred by the general public, but rather only at the actual exposure at work was a contributing cause to her sinus injury. Additionally, the WCJ noted that an employee who suffers from a pre-existing condition is entitled to workers' compensation benefits if an industrial injury occurs, even if such injury would not occurred to an employee did not have the pre-existing condition.

The WCJ noted that although an AME's opinion should normally be followed, absent good cause to reject it, in this case there was good cause in that the AME used the incorrect legal theory.

In a split decision the WCAB denied reconsideration. The WCAB agreed with the WCJ that the medical report of an AME should ordinarily be followed but in this case it was unpersuasive because the AME used an incorrect legal theory. The WCAB found the medical report of the PTP to be the more persuasive.

The dissenting Commissioner felt the AME report was substantial evidence and should have been followed as the AME was chosen for his expertise and neutrality.

## **15. AOE/COE/Off-duty recreational activity**

### **City of Anaheim v. WCAB (Quick) (W/D) 78 CCC 41**

Applicant, a police officer, alleged he suffered industrial injury when he collapsed from heat stroke while participating in 120-mile challenge cup relay. On the day of his collapse, applicant was one of a team of 20 off-duty police officers participating in the relay from the Anaheim Police Department.

The matter proceeded to trial on the issue of AOE/COE. The evidence established that the Anaheim team ranked in the top 10 in the relay each year, which was a source of pride for the department. The evidence indicated the race was very important to the Anaheim Police Department. Team members schedules were changed to accommodate training, including on-duty training. City-owned vans were used at the race. The B team was comprised of ranking officers, including the chief, who ran un-time qualifiers and paid their own way. Applicant was approached to be on the team after they found out he and his daughter entered a family 5K race and he had the fastest time. Applicant believed if he turned down the chance to be on the team he would let people down and that his career would be negatively affected. Applicant told his wife that he thought he had to participate in the relay because he was asked to do so, and failure to participate would not be good for his career. Testimony was offered by three witnesses that a LC section 3600(a) (9) notice stating the injuries might not be covered by workers' comp was not posted.

The WCJ found industrial injury.

Defendant filed a petition for reconsideration.

The case *Ezzy v. WCAB* (48 CCC 611) is the leading case on injuries during off-duty recreational activities. The case sets forth a two element test. First, whether the employee subjectively believed their participation in the activity was expected by the employer. Second, whether that belief was objectively reasonable.

In the *Ezzy* case the court indicated that the legislature recognize the potential use by employers of indirect means to encourage participation in an activity and that such indirect encouragement changes the voluntary character of such participation. The legislature intended that injuries occurring under such circumstances should be considered work-connected and must fall within the coverage of the workers' compensation scheme.

In this case the applicant felt that indirect encouragement as soon as they heard about the family 5 K race, and the results revealed that he was the department's best runner. The news spread throughout the department's and rank-and-file, supervisors and co-workers encouraged him to go out for the team.

Although the evidence was in dispute whether running enhanced Anaheim officers careers the evidence was strong that the Anaheim Police Department's performance was a big deal and involvement was high from the chief on down. Runners were elite, aloud to train while on duty, and to juggle schedules to accommodate the training.

The burden rests upon an employer to ensure that no subtle or indirect pressure or coercion is applied to induce involuntary participation by an employee.

The employer has a duty to post a notice regarding the possible non-compensability of the injuries. Three witnesses testified they had not seen the notice. While the failure to post notices does not constitute a waiver, the court in the Ezzy case found it makes an action by the employer which tends to encourage participation in athletic events appear more coercive in effect.

The evidence in this case established the applicant subjectively believed he was required to participate in the relay race and be on the team. The evidence further showed the employer encouraged the officer's participation in the relay which impacted the voluntary nature of the participation. By not posting notices, the police department failed to tell team members that they were running at their own risk. The WCAB found that applicant's belief was objectively reasonable.

## **16. Petition to reopen based on change of law**

### **Adams v. WCAB (W/D) 78 CCC 152**

Parties entered into Stipulated Award that applicant sustained an industrial injury to his heart and high blood pressure, causing 79% PD. An amended stipulated award issued for 95% PD.

In paragraph 9 of the amended Stipulated Award the parties stipulated that the amended Stipulated Award superseded and replaced the original Stipulated Award, that the body part of "asthma/pulmonary sequela" was added, that there was an increase in PD from 79% to 100% PD less 5% non-industrial apportionment for a PD award of 95%, and the settlement is based upon the findings of Dr. McHenry and Dr. Nacouzi as to the heart which brings the rating to 79%, Dr. Mustacci finds 50% whole body impairment to the pulmonary system which brings the award to 100% PD. 5% was apportioned to non-industrial factors and 95% industrial PD rating out of 100% total PD.

Applicant filed a petition to reopen, alleging the change in condition evidence by the increased need for medication and change in the law based on the enactment of LC§ 4663(e). Applicant alleged that the passage of LC §4663 (e) that provided that LC § 4663 apportionment did not apply to safety officers because of the presumption of compensability and the non-attribution clause was a change of law.

The matter proceeded to trial, at which time the parties stipulated that applicant was medically 100% permanently totally disabled from competing in the open labor market. Defendant

maintained the applicant was 100% PD when the amended Stipulated Award was issued and that therefore applicant's level of PD was unchanged.

The WCJ found in relevant part that the applicant sustained new and further disability in the form of a psychiatric injury, causing PD of 96% and need for further future medical treatment.

The WCJ found no good cause to reopen under LC§ 5804 based on a change of law, since the provisions of under LC § 4663 (e) were in effect at the time of the Amended Stipulated Award. Additionally the WCJ concluded that the stipulation of the hundred percent PD, less apportionment of 5% to non-industrial causes, was not based on any medical evidence in the record, but rather appears to be a compromise resolving the risks of litigation. Therefore, the WCJ found no good cause to set aside the stipulation.

Applicant filed a petition for reconsideration. The WCAB granted reconsideration and affirmed the WCJ's findings.

The WCAB observing that the court in Alexander (Department of Corrections and rehabilitation fee WCAB (Alexander) (73 CCC 1294) the addition of LC § 4663(e) was not a change in law, but merely a declaration of existing law, and therefore concluded there was no good cause to reopen the stipulation for change of law.

Moreover the WCAB was not persuaded the applicant establish good cause to reopen based on mistake of fact. Moreover despite applicant's argument that the amended stipulations were not supported by any medical evidence in the record, stipulations are not always based on evidence. Rather, a stipulation is an agreement between opposing parties, usually entered into in order to expedite hearings and in order to avoid delay, expense or difficulty in the proceedings and serves to obviate need for proof or to narrow the range of issues. (Wheatherall 65 CCC 1)

A stipulation may also lawfully include or limit issues or defenses to be tried and is not deemed amended to conform to proof because the point of his stipulation is to obviate the need for proof.

Moreover the appeals board has the discretion to reject factual stipulations, it may only do so only with good cause and absent that good cause, stipulations are binding on the parties.

Finally, the WCAB disagreed with the WCJ's position that there was 100% PD region-of-the-body pursuant to LC§ 4664(c) (1). The parties may have stipulated to overall PD of 100%, the awards themselves added up to only 95% PD. Moreover, the WCAB noted that LC§ 4664 (c) (1) the accumulation of all permanent disability award is 100 percent PD.

The writ of review was denied

## **17. Liens/Assignments**

### **Caballero v. WCAB (W/D) 78 CCC 686**

Applicant sustained a specific injury to his neck, back, and upper extremities on 4/8/2002. The case was settled by compromise and release.

Dan Ho, D.C. filed a lien for payment of chiropractic services rendered to treat applicant's injury. Dr. Ho was represented by a person who was not a member of the California State Bar or the bar of any other state.

The original compensation insurer in this case became insolvent and its obligations were assumed by CIGA.

CIGA filed a petition to compel Dr. Ho and his representative to attend a deposition. CIGA filed a first amended petition to remove Dr. Ho as a proposed deponent, since he resided outside the United States, but continued requests for attendance by the representative at the deposition. CIGA indicated in relevant part that it sought to depose the representative regarding the fee contract between Dr. Ho and the representative. CIGA contended in pertinent part that it was not liable to pay claims to an assignee, except under special circumstances not present in this case, and that Dr. Ho assigned his claim to the representative.

The representative filed a petition to quash the taking of deposition and for an award of sanctions and attorney fees. The representative contended in relevant part that there existed a confidentiality privilege regarding his communications with Dr. Ho and that non-attorney lay representatives were entitled to keep confidential all communications with the persons or parties they represented before the WCAB.

Following a hearing the WCJ issued an order denying CIGA's petition to compel deposition and granting the representatives petition to quash the deposition. The WCJ's order did not mention sanctions. CIGA filed a timely petition for removal or in the alternative for reconsideration.

The representative also filed a timely petition for reconsideration on the WCJ's failure to mention sanctions and that was equivalent to a denial.

The WCJ in his report on reconsideration indicated that he did not intend to rule on the sanctions issue and recommend granting the hearing representatives petition to defer the issue of sanctions.

The WCJ indicated regarding the deposition that there was a significant question of fact as to whether the representative was an assignee. CIGA did not support the statement that the representative was an assignee with any declarations, affidavits or documentation. Additionally, the WCJ indicated in pertinent part that to receive a contingent fee for payment for collecting does not make the attorney or representative an assignee. The WCJ also indicated that the representative had an attorney work product privilege comparable to that of an attorney work product privilege.

The WCAB granted reconsideration. The WCAB ordered the hearing representative to make himself available to be deposed by CIGA regarding the nature of his agreement with Dr. Ho. The WCAB further ordered however that any such deposition could not include any questions concerning his confidential communications with Dr. Ho regarding any other aspect of the lien claim and its merits with any dispute regarding the scope of the deposition to be addressed by the WCJ in first instance.

The WCAB indicated in relevant part that the WCJ should have allowed the deposition of the representative regarding the question of whether Dr. Ho assigned his lien to the representative.

In the leading case of CIGA the WCAB (Jenkins) (77 CCC 14) the court recognized that if such an assignment occurs the liens would no longer be covered claims for which CIGA would have been liable. In that case however they found no assignment.

The WCAB indicated in relevant part that the Jenkins court provided a discussion of the law to be applied in considering whether an assignment has occurred and the court indicated the test is as follows: ; (1) one of the chief incidents of ownership of property was the right to transfer it; (2) this “chief incident” applied equally to tangible and intangible forms of property, including causes of action; (3) an assignment was a commonly used method of transferring a cause of action; (4) an assignment could be complete or partial; (5) an assignment for collection vests legal title in the assignee that is sufficient to enable the assignee to maintain an action in the assignee’s own name, but the assignee retains the equitable interest in the thing assigned; and (6) determining whether an assignment has been made, the intention of the parties is controlling.

Applying Jenkins the instant case, the WCAB concluded that CIGA was entitled to make reasonable inquiry to determine whether the lien in this case was assigned. If a written representation agreement between the representative and the doctor is not produced, CIGA’s inquiry may include deposing the representative in order to determine if the lien claim was assigned to him as discussed in Jenkins.

The WCAB indicated they found no case that dealt specifically with confidential communications between non-attorney lay representatives who practice before the WCAB and the persons or entities they represent.

The WCAB stated in reaching their decision they found it unnecessary to determine if there is a confidentiality privilege that applies to communications between the representative and the doctor because they limited the scope of CIGA’s inquiry to questions concerning the assignment and they specifically disallowed questions concerning confidential communications between the representative and the doctor regarding any aspect of the lien in its merits.

In this way CIGA may obtain sworn testimony from the representative about the nature of his assignment with the doctor, but it may not pursue questions that involve confidential communications between them regarding the merits of their lien or matters not involving the nature of their agreement.

The representative filed a petition for writ of review. The writ was denied.

## **18. Liens**

### **Marriott International v. WCAB (Torres) (W/D) 78 CCC 240**

Applicant suffered an admitted industrial injury to the low back.

The WCJ issued an F & A in which he found temporary disability: 10% permanent disability and need for future medical treatment.

The WCJ issued a supplemental F & O determining that, based on the opinion of defendants QME spinal surgery performed by Dr. Chen at the Pleasanton Surgery Center was not medically reasonable or necessary and they were not entitled to recover their lien.

The WCJ issued an order approving compromise and release for \$9000.

Dr. Vaughan filed a lien seeking payment of \$1445 for anesthesiology services provided to the applicant in connection with his surgery performed at Pleasanton Surgery Center.

At the trial, the parties stipulated among other things, that at the time the doctor provided the anesthesiology services he was unaware as to whether defendant had authorize the surgical procedure and whether defendant would pay for the procedure. The doctor made an offer of proof that it was the custom and practice for anesthesiologists to be called in to perform anesthesiology services in connection with surgical procedures at the Pleasanton Surgery Center without knowing whether the surgical procedure for which they were providing services was authorized by the carrier.

The WCJ issued an F & O, finding that the defendant was estopped to deny liability for the lien and the doctor was entitled to be paid \$1445 in connection with the anesthesiology services he provided to the applicant. The WCJ further found the lien was timely filed under LC § 4903.5.

Defendants filed a petition for reconsideration.

The WCJ in his recommendation on reconsideration indicated the finding of an estoppel was justified by the evidence and supported by the decision in the case *Aguirre v. Pioneer Packing* (ADJ 2946461) in which the WCAB panel held that the same doctor, who had no opportunity to determine whether the surgery had been authorized, was entitled to payment for his anesthesiology service. The panel in the *Aguirre* case concluded that the anesthesiology services provided by the doctor at the time the applicant's treating physician performed surgery on the applicant's back was reasonable at the time the services are rendered, given that doctor had no basis to question the adequacy or necessity of the surgery performed by the treating physician.

The WCJ indicated he could discern no logical reason to distinguish the instant case from the *Aguirre* case.

In both cases the defendant had received the treating surgeon's request for authorization to perform the surgical procedure more than once in the months preceding the surgery, but had not responded with a written refusal or authorization.

In this case the applicant's authorized PTP referred applicant to Dr. Chen would recommend the procedure for the applicant. The recommendation for the procedure was made by Dr. Chen in his report and noted with approval by applicant's PTP in his reports. There is no evidence that defendant objected in writing to the recommended treatment until after the surgery.

The WCJ concluded that the defendant was liable for the services of the anesthesiologists.

The WCAB indicated that *Aguirre* was not binding precedent, and should not be construed to carve out an exception to the general principle that medical treatment is not compensable when it is neither authorized nor necessary except under the narrow circumstances of this case, where the existence of the surgical practice make it impractical for an anesthesiologist ascertain whether the treatment has been authorized, the employer's neglected to timely object to the recommended surgical procedure, and the anesthesiologists acted in good faith in providing the services.

The WCAB observed that neither the Compromise and release nor the order approving was ever served on the anesthesiologist before his lien was filed. Therefore pursuant to LC § 4903.5 (a), the lien not was not untimely. Moreover, the WCJ noted that under LC 4904 a constructive lien was established when the doctor billed defendant for the services in connection with the surgery, defendant acknowledged the billing. The WCJ found the lien was not barred by the statute of limitations.

The WCJ found no merit to the contention that the lien should be barred under the doctrine of laches because defendant presented no evidence to establish prejudice and defendant was aware of the lien throughout the action.

The WCAB denied reconsideration and adopted and incorporated the judge's opinion.

The writ was filed and denied.

## **19. Apportionment/earning capacity**

### **Pacific Compensation Insurance v. WCAB (Nilsen) (W/D) 78 CCC 722**

The WCJ found 100% PD with no apportionment. The WCJ in his opinion on decision based his decision on the unrebutted testimony of the vocational rehabilitation expert that applicant lacked any future earning capacity and therefore was 100% permanently and totally disabled. The vocational rehabilitation expert testified that although applicant had pre-existing medical conditions those conditions did not cause a loss of earning capacity, because applicant demonstrated good, solid, consistent earnings over an extended period of time before the industrial injury.

Defendants filed a petition for reconsideration.

The WCJ stated before the industrial injury the applicant had an earning capacity of \$100,000-\$120,000 per year, and that there was no evidence that applicant previously lacked earning capacity or that applicant's prior impairments caused a loss of earning capacity. The WCJ concluded that applicant's industrial injury was the cause of his loss of earning capacity.

The WCAB agreed with the WCJ. In this case the WCAB indicated the applicant sustained a specific injury to his spine and then as a compensable consequence, sustained a separate injury in the form of chronic pain syndrome which was treated by extensive narcotics. There is no medical evidence that applicant had a chronic pain syndrome prior to the industrial injury. The PQME found that 100% of applicant's chronic pain syndrome was industrially related and based on the chronic pain syndrome applicant was 100% totally permanently disabled. The PQME also concluded that none of applicant's chronic pain syndrome could be apportioned. The psychiatrist found the interrelationship between the applicant's psychological condition and his chronic pain syndrome and found that applicant psychological condition was 100% industrially related. The orthopedist found applicant's high use of narcotics made it impossible for him to return to work in the labor market. The WCJ wrote in his opinion on decision that was adopted by the Appeals Board that there was no evidence that the non-industrial portions of impairment caused any of the total loss of earning capacity.

## **20. Rating**

### **Athens Administrators v. WCAB (Kite) (W/D) 78 CCC 213**

Applicant suffered an admitted bilateral hip injury.

The QME issued a report finding applicant had 20% WPI with respect to each hip pursuant to the AMA guides. The QME added the two hips together finding a 40% WPI for both hips. In his report the QME explained that in his opinion, the best way to combine applicant's impairments to the right and left hips would be to add them together as opposed to using the Combine Values Chart, which would result in a lower WPI.

The matter proceeded to trial on two issues. One issue was PD and the other issue was the 15% increase pursuant to labor code section 4658(d) (2). The WCJ issued an award of 46% PD based on the opinion of the QME and that adding the two hips together would produce the most accurate reflection of applicant's PD.

The WCJ also awarded the 15% increase in PD based on defendant's failure to send the return-to-work offer until well beyond 60 days after applicant condition became permanent and stationary. Defendants had argued applicant already returned to work prior to when the notice would have had to go out and therefore there was no need for the notice as he had already returned to work and there was no incentive for the offer of regular work.

Defendant filed a petition for reconsideration.

The WCJ recommended that reconsideration be denied.

The WCJ indicated that it was proper to combine the two hip disabilities by adding them together. The schedule provides that impairments are generally combined using the reduction formula. The WCJ observe there are several different ways disabilities may be combined.

Although the 2005 schedule provides that impairments and disabilities are generally combined using the reduction formula, the WCJ pointed out that the 2005 schedule is rebuttable. The AMA guides express favor toward the combined values method, the multiple disabilities table is a guide and the physician may under certain circumstances employ different method of determining impairment if they remain within the four corners of the guides.

The WCJ pointed out he was persuaded by the QME's reasoning and analysis that the impairment resulting from the applicant's left and right hip injuries is most accurately reflected by simple addition rather than that used by the combined values formula.

Regarding the 15% increase in PD the WCJ indicated the plain language of the statute requires a 15% increase in PD in any case where the return-to-work offer is not made within 60 days of the permanent and stationary report even in those cases in which the applicant is already returned to work at the time the notice would have to be sent.

The WCJ states that this case is an attempt by defendants to broaden the holding in City of Sebastopol (77 CCC 783), to provide no need for the notice when the applicant has already returned to work prior to the permanent and stationary date but did missed time from work.

The judge pointed out in this case by the time the return to work offer was triggered the employer could see the applicant had already returned to his regular job and therefore could not be said to have incentives to make the offer of employment.

The employer did not at that time provide any PD advances. Thus, defendant cannot legitimately claim to have lack of incentive to reduce a benefit it was not providing.

The judge indicated it would appear that the purpose of the statute and the regulations would be thwarted and there may in fact be a disincentive for the employee to return before the permanent and stationary date. The WCJ applied the statute literally.

The petition for reconsideration and writ were denied.

## **21. Apportionment**

### **City of Cathedral City v. WCAB (Fields) (W/D) 78 CCC 696**

Applicant, a police officer was found by the WCAB to be entitled to a 74% award of PD as a result of a specific injury and a CT injury rather than separate permanent disability awards, when the AME in internal medicine established that the applicant's disability from the two injuries was so intertwined that injuries could not be rated separately.

Applicant sustained admitted industrial injuries on March 18, 2009 and a CT injury from June 18, 2004 through March 18, 2009 while employed as a police officer.

The AME in internal medicine in his initial report wrote that the PD from applicant's internal conditions for the two dates of injury were so "inextricably intertwined" that they could not be separately rated.

The AME in internal medicine reserved the right to change his opinion after reviewing the medical report of the AME in orthopedics.

The AME in orthopedics apportioned 90% of the orthopedic disability to the specific injury and 10% to the continuous trauma injury.

The doctor subsequently received the medical evidence of the orthopedic AME. After reviewing that report the AME in internal medicine did not follow that apportionment contained in the orthopedic AME's report but instead found that the disability arising from applicant's internal injuries was so "inextricably intertwined" that no apportionment could be made.

In his deposition the AME in internal medicine indicated in his opinion the injuries were so "inextricably intertwined" from an internal medical standpoint that they could not be rated separately.

When told by the defense attorney that LC 4663 and the "Benson case" require an apportionment between the two injuries he said he would put the apportionment at 90% to the specific injury and 10% to the CT. Although providing the numerical apportionment he indicated he did not agree with the numbers and again stated he did not see a rationale for the apportionment and it was not possible to apportion in this case.

The WCJ found 65% PD was a result specific injury, and 23% was a result of the CT injury.

The WCAB granted reconsideration and concluded that applicant was entitled to a single combined award.

The WCAB indicated that the apportionment given by the doctor was based on a mis-characterization of the requirements of LC§ 4663 and the “Benson” case that was given by the defense attorney in his question to the physician. The defense attorney stated in his question that the “Benson” case and LC § 4663 require an apportionment of disability between separate industrial injuries.

The WCAB stated in “Benson” they held that where it is determined that permanent disability arises from separate industrial injuries there must be a separate determination of the cause of each disability to each injury. All questions of law and fact must be separately decided for each injury and separate awards of PD must be issued.

However, an exception to this requirement arises when the reporting physician is unable to medically parcel out the degree to which the injuries each are contributing to the employer’s overall PD. In that event the applicant may be entitled to a combined award.

The WCAB concluded because the AME found that applicant’s injuries could not be separately rated based on incorrect assumption that he was required to provide a number the record did not support the WCJ’s apportionment.

The WCAB found the AME’s opinion on apportionment was not based on substantial evidence.

The WCAB issued an amended 74% rating. The writ was denied.

## **22. Access standards for MPN**

### **Robles v. WCAB (W/D) 78 CCC 168**

Applicant lives in Ventura, but his place of employment was Santa Monica. Defendant’s MPN has one spinal orthopedic PTP located within 15 miles or 30 minutes from applicant’s residence, but at least three orthopedic PTP located within 15 miles or 30 minutes of applicant’s workplace.

Applicant sought to treat outside the MPN. The matter proceeded to expediting hearing. Applicant argued that defendant’s MPN did not comply with the access standards because it did not provide a sufficient number of physicians within 15 miles or 30 minutes of applicant’s residence.

Relevant Regulations and code Sections:

9767.5(a) states: a MPN must have at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (b) and (c).

9767.5(b) states: an MPN must have a PTP and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee’s residence or workplace.

9767.5(c) states: a MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of the covered employee’s residence or workplace.

Labor code section 4016(a) (2) provides in part that medical treatment for injuries to be readily available.

LC 4616 (a) (1) provides in part as follows: The number of physicians in the MPN shall be sufficient to enable treatment for injuries or conditions to be provided in a timely matter. The provider network shall include an adequate number and type of physicians, as described in section 3209.3, or other providers, as described in section 3209.5, to treat injuries experienced by injured employees based on the type of occupation or injury in which the employees engaged, and the geographic area where they employees are employed.

4616 (g) requires the A/D in consultation with the Department of Health Care to adopt regulations implementing this article which includes labor code section (a) (2).

The WCJ stated while the court agreed, such an interpretation would allow for better access to medical care, especially in this case where the injured employee lives approximately 50 miles away from the workplace, the plain meaning of the words in the regulation do not permit such an interpretation. The subsection sets forth certain conditions, which if met, satisfy the mandate of the regulation. Rule 9767.5 mandates an MPN have three primary treating physicians within 30 minutes or 15 miles of each employee's residence or workplace. The use of the conjunction "or" is indicative of the use of an option for purposes of meeting the conditions of the regulation. The regulation is directed to the employer/carrier as to MPN's access specification. It does not speak to provide any option to the injured employee in that regard. The regulation was intended to require the MPN to provide physicians within the mileage/time specifications for both the residents and the workplace then presumably the conjunctive "and" would have been utilized in drafting the regulation.

The WCJ found that defendant's MPN was in compliance with the access standards set forth in 9767.5(a) and (b) because the MPN had three orthopedic surgeons located in within 15 miles of applicant's workplace. Applicant filed a petition for reconsideration. The applicant argued that for defendants MPN to be in compliance they must provide a minimum of three physicians within 15 miles or 30 minutes of applicant's residence, rather than only within 15 miles or 30 minutes from his workplace.

Sub-section (c) which is the most lenient in terms of minute/mileage requirements was not at issue. Since the utilization of a primary treating physician is at issue, the more restrictive sub-section (b) was the focus of the case.

The effect in this case being that if the injured employee chooses the mandate to apply to his residence within the MPN does not meet the requirement of this section.

The WCJ indicated that while it can certainly be argued that requiring an employee to travel 47 to 50 miles to get treatment does not meet the "readily available" requirement, the issue of whether regulation sections 9767.5 (a) (b) adequately implement the "readily available" requirement from LC section 4616(a) (2) was not specifically raised as an issue in this case at the time a trial.

The WCAB granted reconsideration and adopted and incorporated the judge's report. The WCAB additionally noted there appeared to be a conflict between the relevant statutory and regulatory law.

Specifically, the WCAB observed in pertinent part that LC section 4616 (a) (1) in part states that the number of physicians in MPN shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number and type of physicians, as described in section 3209.3, or other providers, as described in section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.

The WCAB concluded, to the extent that regulation 9767.5(b) exceeds the scope of LC section 4616(a) (1), the statute is controlling. The WCAB noted that the defendant complied with LC section 4616(a) (1) requirement that its MPN maintain an adequate number and type of physician to treat injuries within the geographic area where the applicant was employed.

Yet, while section 4616(a)(1) only requires that an MPN include an adequate number and type of physicians to treat within the geographic area where the employees are employed, A.D. rule 9767.5(b) expands that provision to require the appropriate number of physicians within 30 minutes or 15 miles of the employee's "resident or workplace".

However, regulations must be within the scope of the authority conferred by the statute and reasonably necessary to effectuate the purpose of the statute.

The writ was denied.

### **23. QME/Records**

#### **Matthies v. WCAB (W/D) 78 CCC 718**

Applicant suffered an injury to her back neck and hips. Applicant was examined by a QME in the field of chiropractic. The QME concluded the applicant was TTD to present and continuing.

Before the QME evaluation, the claims adjuster sent a letter to the QME with a copy to the applicant, outlining her theory of the case and proposing questions to be answered by the QME. Later, she sent a letter to the applicant, enclosing medical records that were concurrently sent to the QME. On three subsequent dates, the claims adjuster sent the QME subpoenaed records from multiple sources. Applicant was sent copies of all the transmittal letters, but there was no proof in the record as to whether applicant was sent copies of the subpoenaed records referred to in the transmittal letters.

According to the review of records by the QME in his report, the record sent to him by the claims adjuster included medical and non-medical records pertaining to an alleged prior injury and QME reports in psychology.

At an expedited hearing, while she was still unrepresented, applicant objected to the QME reports on the grounds that it was a supplemental report prepared after review of unauthorized medical records. The WCJ overruled the objection and admitted the report into evidence. Applicant attempted to raise the issue of a new QME Panel, but the WCJ declined to rule on that issue because it could not be addressed at an expedited hearing.

Applicant retained an attorney and filed a motion to disqualify the QME and obtain a new panel QME. Applicant alleged that defendant inappropriately send records to the QME in violation of LC section 4062.3(f). This issue and the issue of TD were set for trial.

The WCJ issued an F & A ordering the DWC medical unit to issue a new QME panel in the field of chiropractic and awarding TD to present and continuing.

Defendant filed a petition for reconsideration.

In a split decision the WCAB amended the TD award.

However, the WCAB affirmed the WCJ's finding regard a replacement QME panel, concluding that applicant did not receive timely or adequate notice of medical and non-medical record sent by the claims adjuster to the QME nor notice of her right to object to the provision of these records to the QME, as required by LC 4062.3 and regulation 35(c).

The WCAB concluded that in this case the only evidence in the record demonstrated that no medical and non-medical records were sent to the applicant 20 days prior to being sent to the QME.

Furthermore, the adjuster failed to serve the applicant with a log listing each item in the record being provided to the QME.

In addition, and most important, the adjuster did not inform the applicant that if he or she did not want the QME to see the information to be provided, she had 10 days to object.

The WCAB reversed on the issue of TD to present and continuing as there was no current medical evidence as to support temporary disability. The WCAB did uphold the award of the WCJ of prior TD.

The dissenting Commissioner agreed with the panel on the new QME panel, but disagreed on the issue of TD and indicated there was substantial evidence to support a finding of continuing TD.

Applicant filed a writ which was denied.

## **24. Temporary disability**

### **Gerawan Faming v. WCAB (Mendez) (W/D) 78 CCC 995**

Applicant sustained an admitted industrial injury to his knees on June 23, 2011 while employed as a seasonal farm labor.

Applicant was provided with medical treatment and received ongoing wages from the date of his injury through October 16, 2011. The applicant had no work during the calendar years 2009 and 2010 and defendant's 2011 farming season ended on October 3, 2011.

Applicant was found TD by his treating physician as of November 22, 2011.

On October 24, 2011 applicant's surgeon certified the applicant for modified work. Defendant informed the applicant that he was being terminated for providing false information to his doctors regarding a prior 2006 industrial back injury and denying the prior injury to defendants

investigator. Neither the relevant medical records nor the investigator's report were offered into evidence.

Applicant credibly testified that he did not believe the doctors need to know about his back injury as it had nothing to do with his knees.

The matter proceeded to trial on the period of temporary disability. The WCJ found applicant was entitled to TD benefits from November 22, 2011 through September 1, 2012. The WCJ found that applicant's termination for allegedly providing false information about his claim did not provide ample justification for denial of TD benefits and that applicant had a reasonable expectation of continued employment and was too entitled to TD.

Defendants filed a petition for reconsideration.

Defendant first argued applicant was not entitled to TD benefits for the off-season. The WCJ indicated the defendant did offer testimony that the farming season ended on October 3, 2011 to support the position the applicant would have not received wages after that date. The WCJ noted that applicant was being paid ongoing benefits after the season creating a reasonable inference that applicant might have been retained as an employee even in the off-season.

Moreover, applicant's testimony that some crews continued to work during the off-season to do the pruning and perform other duties indicated to the WCJ that applicant may have potentially continued to work.

Defendants next argued that applicant was not entitled to any TD after his termination because he was terminated for cause and therefore suffered no wage loss. The WCJ determined notwithstanding defendant's offer of credible testimony on the issue of termination, the WCJ found applicant's failing to mention the prior injury was reasonable under the circumstances. Because applicant's conduct was found to be reasonable the WCJ concluded that the termination did not bar his entitlement to TD benefits.

Defendant's next argued that applicant received EDD benefits for some of the period and this would be a duplication of benefits. The WCJ indicated there was no evidence presented by either party connecting applicant's receipt of EDD benefits to his industrial injury. Additionally it was unclear whether the EDD payments were a form of unemployment or SDI benefits.

The WCAB denied reconsideration incorporating the report of the WCJ.

The writ was denied.

The Court of Appeal in denying the writ indicated that the court's decision in *Signature Fruit v. WCAB* (71 CCC 1044) which found that employee's right to temporary disability during a particular off-season was substantial evidence when the evidence supports a finding that the employee intended to remain in the labor market. In that case they concluded the employee was not entitled to receive temporary disability for the off season when there was no question that she would not have been working and earning income whether injured.

## REPORTED WCAB AND PANEL DECISIONS

### **25. Ex-parte communication**

#### **Frost v. East Bay Municipal Utility District (BPD) 41 CWCR 14**

Applicant was injured on 4/2/2006. He was sent to Robert Heeps, M. D. as a QME in psychiatry. The physician had difficulty getting a history from the applicant and telephoned his wife for additional information. In a report dated 5/11/12 he wrote that applicant was suffering from a depressive disorder predominantly cause by his work injury. He indicated in his report that he spoke to the wife separately and she had confirmed that the applicant was very depressed and is a different person since the injury.

Defendants petitioned for a replacement panel in psychiatry on the grounds that the applicant had engaged in an ex part communication with the QME.

The QME in response to the petition indicated that the applicant asked him to speak to his wife during the examination because he was concerned that he might leave things out due to his poor memory. He further indicated it was commonplace for a psychiatrist or psychologist to interview family members, if one is available in order to obtain complete information about the patient's mental state. He indicated in 20 years as a QME he had done this many times and no one had objected. He indicated he spoke to the applicant's wife for less than five minutes during the examination. The only additional information she provided was that when she sends the applicant to the store to get something, he later calls and asked what he should get. This provides evidence in support of the applicant's statement that his memory is very poor and he forgets what he is doing or what he is talking about.

The WCJ found the contact between the QME and the wife did not constitute ex parte communication within the meaning of LC section 4062.3, and he denied defendants petition for a replacement panel.

Defendant filed a petition for removal.

The WCJ in his report observed that WCAB rule 10301(x) defines a party as any person claiming to be an injured employee or the dependent of a deceased employee, a defendant, or in certain circumstances lien claimant. The WCJ indicated that the wife was not a party to the action and for therefore there was no violation of LC 4062.3.

In addition the WCJ indicated that the section applies to communications before or after the medical evaluation. In this case the communication took place in the course of the examination. The WCJ further concluded that the defendant was not prejudiced by the communication. The defendant could take the deposition of the wife and the QME. He recommended the petition be denied.

The WCAB denied the removal. The WCAB indicated that the QME's communication with the wife happened neither before nor subsequent to the medical evaluation. To be a violation of LC

4062.3(e), the communication would have had to have been before or after the examination. The necessary trigger for the application LC 4062.3(f) was not present.

They declined to agree with the WCJ that the applicant's wife was not a party for the purposes of 4062.3(f).

## **26. Penalties**

### **Romano v. The Kroger Company, dba Ralph's Grocery Company (BPD) 41 CWCR 93**

Applicant injured his left shoulder and neck on December 20, 2003. While applicant was hospitalized for surgery, applicant contracted methicillin-resistant infection. Applicant was hospitalized for the infection. Medi-Cal paid for the hospitalization when defendants refused to pay. Applicant was transferred from that hospital to County Villa Oxnard Manor, which was not equipped to deal with this condition, later to St. John's Regional Center, after a visiting friend discovered blood in applicant's catheter bag, and later still to Care Meridian, facility with only one doctor.

The WCJ found the applicant had sustained an industrial injury to his left shoulder and cervical spine with subsequent industrially related staph infection resulting in a compensable consequence injury to his neck, cardiovascular system, pulmonary system, thoracic spine with resulting paralysis. The WCJ awarded reimbursement for self-procured medical treatment and future medical treatment and ordered the defendant to pay or just all medical legal liens.

Defendant continued to deny or delay care. Defendant paid nothing for nearly two years, delayed providing some medical services, and refused to authorize others. Several times defendant's claims adjuster denied treatment without consulting with a medical professional and without referring the request to UR.

On April 26, 2007, UR approved a motorized wheelchair with a tilt, but it was not delivered until four months later.

In the summer of that year, one of applicant's treating physician recommended a Bi-Pap machine a breathing apparatus that helps its user get more air into his lungs. Defendant refused to provide it.

On April 24, 2008 applicant was hospitalized for the infection which cause congestive heart failure. Defendant neither authorized nor paid for the hospitalization.

Applicant died on May 2, 2008.

The WCJ following a hearing issued a Supplemental Findings and Award that found that defendant had unreasonably denied or delayed furnishing medical treatment on 11 separate instances, awarded the maximum permissible penalties pursuant to LC 5814 for each delay, and awarded applicant an attorney fees pursuant to 5814.5 at the rate of \$350 an hour.

Defendants petition for reconsideration.

The WCAB concluded that the WCJ's decision was fully justified by the evidence. In fact, the panel said that they had rarely encountered a case in which the defendant had exhibited such disregard for its legal and ethical obligation to provide medical care to a critically injured worker. The WCAB also referred the case to the audit unit.

The WCAB found that the claims adjuster denial based on her own evaluation of medical records without consulting applicant's physician was unreasonable. Further the WCAB rejected as a viable excuse for delay defendant's assertion that its delay in authorizing and paying for treatment was justified because the adjuster had no clue as to why applicant was being hospitalized. LC 4600 does not permit a defendant to bury its head in the sand in order to dodge its obligations. Defendant cited no evidence that made any serious investigation into the cause of applicant's April 2008 hospitalization.

The WCAB pointed out that LC 5814 penalties are not paid to the lien claimants but to the injured employee and accordingly rejected defendant's argument that the penalty for the delay in paying Medi-Cal for the payments that Medi-Cal made to the providers should have been ordered paid Medi-Cal.

The panel was not persuaded that applicant's death affected defendant's liability for penalties. Section 4700 provides that the death of an injured employee does not affect the liability of the employer for medical and hospital treatment under 4600 – 4614.1 and disability payments under 4650 – 4664. Defendants argue that because 5814 was not within 4600 – 4614.1 or 4650 – 4664, liability for penalties did not survive the death of the injured employee, but the panel concluded that LC 5814 penalties are part and parcel of the original compensation awarded. (Mote, 62 CCC 891)

Defendants also claim the penalties were barred by LC 5814 (g) statute of limitations; which provides that penalties may not be awarded more than two years from the date the payment of compensation was due. This provision is a statute of limitations and is an affirmative defense. An affirmative defense is waived if not timely raised. Although defendant mentioned 5814 (g) in their trial brief they did not raise the defense at the mandatory settlement conference or at the formal hearing. Any 5814 (g) defenses were therefore not raised and were waived.

In response to defendant's argument that the delays found by the WCJ were not separate and distinct, the panel noted *Christian v. WCAB* (Supreme Court, 62 CCC 576) held that multiple penalties may be assessed against a defendant if the unreasonable delay or refusal of benefits is attributable to separate and distinct acts by the employer. A separate and distinct act of misconduct occurs when there is an unreasonable delay or refusal to pay after such conduct had already been found to be unreasonable and a prior penalty was imposed, or where the defendant had intervened in some analogous significant event between the first act for which a penalty was imposed and the second. Delays in providing different medical services may constitute separate and distinct acts of misconduct. Under Mote defendant's continued delays in paying for medical care were separate and distinct acts justifying additional penalties.

On the other hand, the panel found some validity in defendant's complaint that its failure to pay for one of the hospitalizations at St. John's Regional Medical Center was part of the basis for one

of its failures to reimburse Medi-Cal. The defendant could not be penalized twice for the same delay and the panel agreed to amend the WCAB's finding to exclude St. John's billings in calculating the penalty for delay in reimbursing Medi-Cal.

As to defendant's contention that the attorney fee allowed was excessive the panel said it was premature because the WCJ had not determined the amount of the fee to be awarded. The WCJ only found the fee would be calculated at \$350 per hour. The rate was not challenged in defendant's petition for reconsideration and therefore any objection as to the rate was waived.

Defendant failed to comply with WCAB rules 10842, 10846, and 10852.

In this case over 100 documents were received into evidence. In describing the evidence the petitioner made no reference to the record, referred generally to an exhibit without any identifier, or identified the document without giving the exhibit number. A petitioner cannot shift its responsibility by attempting to place on the board the burden of discovering the evidence that justifies its position. It is not the duty of the board to search the record for the evidence.

The WCAB upheld the findings of the WCJ in all respects but one. The WCAB amended the findings of the WCAB to provide that one of the hospitalizations at St. John's Regional Medical Center was not separate and distinct from other failures to reimburse Medi-Cal.

The panel also referred the claims administrator to the Audit Unit pursuant to LC section 129 (b) (3) in light of defendant's unreasonable delays and denials and its willingness to ignore the 2006 Findings and Award issued by the WCAB.

## **27. Lien Assignments**

### **Barrientos v. Alamo Motor Lodge; SCIF (BPD) (2013 Cal. Wrk. Comp. P.D. LEXIS 285):**

Lien claimant PharmaFinance is a valid assignee of Curt's Compounding Pharmacy and filed its lien on 9/30/2011

Lien claimant Med RX is a valid assignee of Rahil Kahn M.D., and filed its lien on 6/14/2012.

Both lien claimants timely served copies of their respective assignments.

Lien claimants PharmaFinance and Med RX contend that the application of LC§ 4903.8 to bar their respective recoveries for assignors Curt's Compounding Pharmacy and Rahil Kahn M.D. is constitutionally prohibited.

Defendant contended at trial that the WCAB lacked jurisdiction to award the two lien claimants based on LC§4903.8 (a). Defendant contended LC § 4903 (b) requires that payment shall be made to the "person originally entitled" unless it has been shown there is a valid assignment and they have ceased "doing business in that capacity" at the time the expenses were incurred.

Lien claimant claimed their only obligation was to serve a copy of the assignment by January 1, 2014 or with the filing of a declaration of readiness or at the time of a lien hearing whichever is earliest pursuant to LC section 4903(b) (3).

The WCJ found the lien claimant had a valid assignment and had timely serve the assignment.

The WCJ determine that LC §4903 further requires that payment shall be made to the “person originally entitled” unless it has been shown that there was a valid assignment and they had “ceased doing business.” In this case the WCJ ruled there had been a valid assignment but that the entity and not “ceased doing business” and therefore payment could only be made to the “person originally entitled.”

The WCJ also determined that the section should be retroactively applied based of on the language contained in subsection (f) which reads: “This section shall take effect without regulatory action. The appeals board and the administrative director may promulgate regulation and forms for the implementation of this section.” No provision was found in the statutory language to permit an exception for a lien assigned prior to enactment of the statute.

The WCJ therefore denied both liens.

The lien claimant made the following contentions on reconsideration which were denied by the appeals board.

Lien claimant contended that the statute could not be applied retroactively. Lien claimants argued the statutes state that it does not apply to dates of service prior to 1/1/2013” The WCJ indicated there is nothing in the statute to support the assertion that it does not apply to dates of service prior to 1/1/13 unless otherwise specified. No exception is set forth for any particular dates of service. To find that certain dates of service are not covered by statute would be rewriting the code section.

The WCJ further indicated that in California Worker’s Compensation Reform, rights and benefits have been extinguished an example being vocational rehabilitation.

Lien claimant also contended that the decision required a determination of the meaning of “ceased doing business.” The WCJ indicated lien claimants never claim that Curt’s or Dr. Kahn “ceased doing business” and therefore the WCJ did not have to make a determination of the plain meaning of the statute.

Lien claimant contended that this is irrelevant since the “original providers” had in fact sold all right, title and interest in the accounts receivable to predict pay to petitioner’s without recourse.

No opinion was given by the judge on the constitutional challenge.

The WCJ recommended that reconsideration be denied.

The WCAB denied reconsideration.

## **28. Discovery**

### **Holz v. Gottchalks (BPD) 41 CWCR 41**

Applicant sustained a cumulative injury to his back. Applicant was sent to an agreed medical examiner who found disability of 28% +2% for chronic pain.

The matter proceeded to hearing on December 10, 2012. The parties stipulated to a 30% rating. Applicant indicated he was going to call a vocational expert to rebut the DFEC portion of the rating. At the hearing the WCJ denied defendant's motion to compel applicant to attend an evaluation by a vocational expert selected by defendant and continued the case to March 18, 2013.

The WCJ reasoned that he lacked the authority to order applicant to be evaluated by defendant's vocational expert. He conceded that there were instances where discovery is allowed even though not specifically authorized by statute, but did not consider that to be the situation in this case.

Defendants petitioned for removal.

The WCAB agreed with the defendants that although there was no specific authority for an order compelling an applicant to attend an evaluation by vocational expert the WCAB had such power and that such an order was required by due process and for fairness.

LC section 5708 provides as follows:

All hearings and investigations before the appeals board or a WCJ are governed by this division and by the rules of practice and procedure adopted by the appeals board. In the conduct thereof they shall not be bound by the common law or statutory rules of evidence and procedure, but may make inquiry in the matter, through oral testimony and records, which is best calculated to ascertain the substantial rights of the parties and carry out justly the spirit and provisions of this division.

WCAB rule 10348 provides: In any case that has been regularly assigned to a WCJ, the Judge shall have full power, jurisdiction and authority to hear and determine all issues of fact and law presented and to issue any interim, interlocutory and final orders, findings, decisions and awards as may be necessary to the full adjudication of the case.

The WCAB reasoned that these provisions provide ample authority for a WCJ to compel applicant to be evaluated by vocational expert when rebuttal of the DFEC adjustment is an issue.

The WCAB rejected applicant's reliance on a privacy clause that involved a physical examination. Defendants were not seeking a physical examination and even suggested the evaluation could be done by telephone. The panel concluded, if an applicant places correctness of a DFEC adjustment at issue and has retained a vocational expert who has interviewed the applicant; an evaluation by defendant's vocational expert is best calculated to ascertain the substantial rights of the parties and to carry out justly the spirit and letter of the Worker's Compensation Law.

The WCAB removed the case to itself and rescinded the WCJ's order and ordered the applicant to attend an evaluation and/or phone call evaluation with defendant's vocational expert.

## **29. Depositions/employer presence**

**Yera v. J.C. Penney, National Union Fire Insurance Company of Pittsburgh, Pennsylvania, (BPD)2013 Cal. Wrk. Comp. P.D. LEXIS 189**

The WCAB granted removal and rescinded WCJ's order denying defendant's motion to compel applicant/sales assistant with alleged injuries to her neck, upper extremities, chest, nervous system and other body parts during period 3/22/2011 to 5/11/2012, to attend her deposition in presence of employer representative store manager, and held that applicant was required to proceed with deposition, when WCAB concluded that applicant was not excused from attending deposition when she did not request a protective order prior to deposition, there was no evidence from applicant identifying any right to privacy that would or could be affected if the store manager were present during deposition, and the only reason provided by applicant for not proceeding with the deposition was that applicant would feel intimidated by store manager's presence, and the WCAB found that such a summary assertion of subjective feeling was not a sufficient basis to exclude the store manager from the deposition, especially given that applicant was represented by counsel and had remedies available to address any improper behavior that may occur at the deposition.

## **30. Vocational experts**

**Suarez v. Barrett Business Services (BPD) 2013 Cal. Wrk. Comp. P.D. LEXIS 129**

WCJ found applicant was 100% permanently disabled pursuant to the case of LeBouef (48 CCC 587).

The WCAB reversed and found the vocational expert relied upon by the WCJ did not constitute substantial evidence.

The WCAB stated that the vocational expert failed to address applicant's management skills in concluding that applicant had no transferable skills. Further, the vocational expert relied on the Agreed Medical Examiner's report for the proposition that applicant could not be retrained but the report did not constitute substantial evidence to support that proposition. The vocational expert noted that applicant was receiving Social Security benefits but did not address how this affected applicant's motivation to work. The vocational expert documented the applicant did not know how to use a computer, did not discuss impact of this non-industrial factor on applicant's ability to be rehabilitated.

The WCAB based on all the above found the testimony of the vocational expert was not substantial evidence.

### **31. Serious and willful**

#### **Ellefson v. County of LA (BPD) 41 CWCR 152**

Applicant was injured when an intoxicated co-employee fell on her. The normal issues were resolved by a stipulated award.

Applicant filed an application for increase benefits pursuant to LC § 4453, alleging that her injury had been caused by the employer's serious and willful misconduct.

At the hearing the applicant testified that her desk faced that of the co-employee who every day during the four months leading up to her injury was drinking at work. The co-employee was abusive and would step on her feet, pinch her and would pull her hair. She complained about the conduct to her supervisor and made 32 complaints in writing. Her supervisor told her that the problem had been reported to the administration, which had been dealing with the co-employee's drinking problem for 17 years.

Her supervisor testified at the hearing that the applicant complained that the co-employee was an alcoholic but did not say that he was abusive. She further testified that her boss in the human resources department was aware of the applicant's complaints but they did not consider the co-employee to be a danger to fellow employees. She testified that she had heard that human resources was trying to send him for treatment. Although applicant told the co-employee's supervisor that she's felt unsafe working so close to him, they responded that no one is going to do anything. The co-employee's former supervisor said she remembered his red eyes, incomplete work, slurred speech, and unstable appearance in meetings.

Applicant testified that the co-employee was walking down the hallway drinking what smelled like tequila. He staggered and fell onto applicant and the chair broke and applicant's face hit the desk and she fell to the floor with him on top of her.

The WCJ found applicant's injury was not caused by defendant's serious and willful misconduct.

Applicant filed a petition for reconsideration.

The WCJ in his report concluded that there was no question that the co-employee was intoxicated on the date of applicant's injury or that his intoxication was a recurring problem. The WCJ indicated there was no evidence that his intoxication caused injury to other employees during that time. In the absence of any such evidence or evidence that the co-employee had caused any injury or was involved in any accidents that would lead one to believe an injury was likely, the WCJ concluded that it cannot be said the employer knew that his intoxication would likely cause an injury to the applicant.

The WCAB granted reconsideration and issued a finding of serious and willful misconduct and applicant's entitlement to increased compensation.

The WCAB citing the leading case of Mercer-Frazier Company v. IAC (18 CCC 3) stated that negligence, however gross is not enough to sustain a finding of serious and willful misconduct. For serious and willful misconduct to be found it must be shown that the employer (1) knew of the dangerous condition, (2) knew that the probable consequences of the condition would involve serious injury to an employee, and (3) failed to take corrective action. John-Manville v. WCAB (44 CCC 878).

In this case the majority said the defendant had ample knowledge that an employee was frequently intoxicated and creating a danger to those around him. At least five individuals with supervisory responsibility were aware of the problem as well as the human resources department.

Defendants also knew that the probable consequence of his inebriation would involve serious injury. He harmed applicant in the past by stepping on her toes and pulling her hair. A supervisor testified that the co-employee seemed unsteady at work. It was certainly probable that a person who is unsteady on his feet would eventually fall and it would not be surprising if he fell on someone sitting nearby.

Defendant knew of the danger posed by the co-employee's activities and was aware of the probability of his continued drinking would result in serious injury.

Applicant's uncontradicted testimony that the response to her complaints to her supervisors was that no one was going to do anything demonstrated that defendants deliberately failed to take corrective action. There was no evidence that the defendant took any action to prevent the co-employee from drinking at work.

A finding of serious and willful misconduct may be based on evidence the employer deliberately ignored.

### **32. Utilization Review/ Home health care**

#### **Salguero v. ins. Company of the West (BPD) 41 CWCR 246**

This is an interesting case involving 24 hour home healthcare in which the defendants failed to timely UR the request. The WCJ ruled that even in a case where there has been a failure to timely UR the applicant has the burden of proving the treatment is reasonable and necessary and contained in the MTUS. Because the treatment in this case was not approved by the MTUS the treatment was denied even though the UR was untimely. The WCAB adopted the judge's opinion

Applicant sustained an injury resulting in his losing parts of the fourth and fifth fingers on his left hand on June 5, 2009. The applicant also claimed psychiatric and internal injuries.

The applicant was hospitalized by his treating psychiatrist after indicating that he was going to kill himself by jumping off a freeway overpass. The treating physician opined that the applicant was suffering from depression and was a significant risk for suicide.

By contrast, the physician who treated applicant in the hospital reported the applicant's self-esteem, appetite and sleep had improved; had a positive outlook; and he denied any current suicidal or homicidal thoughts.

The treating physician opined that the applicant had to remain in a safe and controlled environment and be closely monitored. She recommended 24/7 home care assistance and added medications that should be provided by an LVN or psychiatric technician. The applicant's claim was closed on February 28, 2013 at least initially, by a compromise of disputed claims for \$10,000 and a stipulated award of 53% PD and further treatment for the hand and psyche.

On June 6, 2013 orthopedic treating physician diagnosed posttraumatic stress disorder and a major depressive disorder without psychotic features. He opined the patient required 24/7 home care assistance by a psychiatric technician or LVN and which is necessary to cure or relief from the effects of his orthopedic injury.

There was no utilization review or other competent medical evidence with regard to the home healthcare requests.

The matter proceeded to expedited hearing and the WCJ ordered referral for stellate block procedure and hand surgery but denied the request for home healthcare.

Applicant filed a petition for reconsideration.

The WCJ in his report wrote that the issue was the quantum of proof required to support authorization for medical procedure that is not been met with a timely UR denial. The WCAB reasoned that under LC 4600 (b) medical treatment reasonably required to cure or relief from the effects of an industrial injury means treatment that is based on the guidelines adopted by the administrative director, and that under Sandhagen an injured employee has the burden of proving that the treatment is medically reasonable and necessary.

The WCJ said these principles have been applied to deny authorization for a given modality of treatment in the absence of timely UR. Moreover, even if the UR were to be deemed untimely or otherwise invalid, the applicant still has the burden of proving that the requested treatment conforms with the requirements of LC 4604.5 by showing that it is in accord with the appropriate guidelines or by rebutting a contract by contrary guideline

The WCJ observed there was no reference to the guidelines any of the medical reports in the record. He saw no support in any of the guidelines for 24/7 home care as a modality of treatment for depression. Specifically, there was no mention of any such modality in chapter 15 of the ACOME guidelines. Further, the chronic pain medical treatment guidelines ( AD rule 9792.2 4.2) provides that home health services medical treatment is recommended only for housebound patients up to no more than 35 hours a week and the medical treatment does not include shopping, cleaning, laundry, or personal care what some services are all still needed.

The treating physician indicated the most helpful care would be psychopharmacological management and cognitive therapy to encourage applicant to relate more with others and to

implement coping mechanisms for his pain and other stressors. The WCJ reasoned, however, that the nursing assistance sought would function only as an unarmed guard designed to protect the patient from self-destructive impulse over medication. There was, moreover, nothing to indicate the applicant was likely to mistakenly overdose medication or that he had done so in the past. The physician who treated the applicant when he was hospitalized or his treating physician commented on the need for around-the-clock care. The conclusion of the need was little more than a mere conclusion and thus not substantial evidence.

Finally the WCJ declared that he was unable to see a description of what a psychiatric technician does in the treatment guideline. A psychiatric technician generally functions in an institutional setting working in concert with doctors and nurses. The mere fact that the psychiatric technicians are trained to handle disturbance and suicidal patients did not make their constant presence in applicant's home reasonable and necessary treatment.

A board panel reviewed the record and for the reasons stated by the WCJ which they adopted and incorporated denied reconsideration.

## **UNREPORTED WCAB PANEL DECISIONS**

### **33. Penalties**

#### **Robertson v. Veterinary Centers of America; Zurich (BPD) ADJ 7275781**

The case stands for the proposition that defendants are not liable for a LC § 4650 (d) automatic penalty if they have a legitimate dispute as to injury or indemnity benefits and once the dispute is resolved defendant pays the benefits within 14 days.

Failure to pay the LC § 4650 (d) penalty can be the basis for a LC § 5814 penalty.

Defendant contended they did not unreasonably fail to pay a LC § 4650 (d) penalty, because none was due. Defendant argues they disputed the period of disability until the time of the decision of the WCJ and paid the award within 14 days of its issuance.

LC § 4650 (d) states that when an indemnity payment is not timely paid, "the amount of the late payment shall be increased 10% and shall be paid, without application to the employee...."

Unlike a penalty under LC § 5814, which applies when benefits are unreasonably delayed or denied, LC § 4650(d) is an "automatic, strict liability penalty." (Rhiner 58 CCC 172)

However, a LC § 4650(d) increase will not be imposed "when injury or indemnity benefits are disputed.... Until the dispute is finally resolved." (Lenion, Appeals Board en banc, 69 CCC 995)

The WCAB indicated that in this case defendant was disputing the period of temporary disability and claimed an overpayment of temporary disability. It appeared to the WCAB from the record that the parties had a genuine dispute about the days when applicant was working, and thus about the dates on which temporary disability was due. If so, defendant was not liable for the 10% increase.

Although the WCJ suggested in his report that the Leinon case only concerns disputed injuries, not accepted claims such as the one in this case. The Leinon case states that LC § 4650(d) is not applicable when “injury or indemnity benefits are disputed”, defendant is not necessarily liable for a 10% increase even though it accepted applicants claim. In the case of Mike v. WCAB (68 CCC 266, W/D) it was found that when defendant excepted the claim but disputed the temporary disability rate, and, after a finding of a higher rate, paid the difference within 14 days no automatic penalty was required.

If defendant failed to pay undisputed indemnity, however, then a LC § 4650(d) increase is appropriate. Furthermore, when a defendant automatically fails to add a required LC § 4650 (d) penalty, they may be subject to a separate penalty under LC section 5814. A portion of a payment that has been unreasonably delayed or refuse must be increased up to 25% or \$10,000, whichever is less, and defendant may be liable for a reasonable attorney’s fees incurred in enforcing payment. (LC §§ 5814, 5814.5) LC § 5814 (d) (a) states that the payment shall be reduced by any amount paid under LC § 4650(d) on the same benefit payment.

The record in this matter according to the WCAB was not entirely clear. They could not determine whether defendant, by making a claim of overpayment for particular dates, was contesting applicant’s eligibility for temporary disability on those days or were arguing that an overpayment occurred for some other reason. The question is whether defendant failed to make indemnity payments that were undisputed at the time they were delayed beyond the usual 14 day deadline. The fact that defendant requested a credit for overpayment is not dispositive. A credit for overpayment of temporary disability is discretionary and must be approved by the WCJ. (Herrera 34 CCC 382)

The WCAB therefore remanded the matter for supplemental Findings and award. Upon return to the trial level, the WCJ should determine whether there was actually a dispute about indemnity benefits and issue a new decision accordingly.

### **34. Applicant’s liability for self-procured medical treatment**

#### **Mendez-Correa v. Vevoda Dairy; Zenith Insurance (BPD) ADJ 6588140**

Applicant sustained an admitted injury on 7/31/08 to his nose and back. Applicant received treatment in the MPN and was declared MMI. Applicant, pro per, obtained a QME who also determined applicant was MMI. Applicant moved and obtained counsel who designated Dr. Ahmed as the PTP, over defendant’s objection that the applicant was treating outside of the MPN. The matter proceeded to trial and the WCJ found 7% PPD with need for future medical care and that applicant “self-procured medical treatment outside of defendant’s MPN at his own expense under L.C 4605” and that “self-procured medical treatment liens for treatment obtained outside of the MPN are not the liability of defendant and are disallowed”. Applicant filed a petition for reconsideration.

The WCAB found that just because an applicant self-procures medical treatment it does not mean that the IW is liable for payment under LC 4605. 4605 allows an IW to select a physician at their own expense. 4903 allows the appeals board to determine and allow as liens the reasonable expense incurred by or on behalf of the injured worker. If there is a question if treatment was self-procured by the applicant the appeals board has the authority to hear and

determine those issues per 4903. Regardless if a lien is filed the injured worker is only liable for medical treatment that he or she intended to self-procure at his or her own expense per 4605. When a provider treats an industrially injured worker and takes certain actions such as submitting reports and billing statement to the carrier and accepts payments from the carrier and/or seeking payment by filing a lien claim the WCAB obtains exclusive jurisdiction over the payment dispute. If applicant intentionally self procured medical treatment pursuant to 4605 he would be personally liable under that section for the cost of the treatment and the appeals board would have no jurisdiction to demine its reasonable value/or to hold defendant liable. In this case there was no evidence that applicant intended to self-procure medical treatment from any lien claimants at his own expense pursuant to 4605.

The WCJ's decision was therefore partially rescinded as to the determination to liability for self-procured medical treatment.

### **35. Discovery/Attorney-client work product**

#### **Brumm v. State of California (BPD) ADJ 7490993**

The facts show defendant took the statements of fifteen witnesses in a case in which AOE-COE was disputed. The applicant made a discovery request for production of the witness statements and refused to have his deposition taken until the production of witness statements by defendant.

The WCJ ruled that attorney client work product privilege did not preclude disclosure of the witness statements and justice would best be served by disclosing the witness statements but not until after the deposition of the applicant.

Defendants did not appeal the portion of the decision requiring disclosure the witness statements.

Applicant appealed and argued that defendant would have an unfair vantage, and would be able to ask questions out of context, which would produce inadvertent inconsistencies, which would then be a basis for a medical opinion. Applicant referred to this as a "discovery by surprise".

The WCJ indicated the applicant was not entitled to discovery of the witness statements until after the deposition.

Applicant argued based on the case of Hardesty v. McCord (41 CCC 111), that discovery is designed to facilitate pre-trial preparation, eliminate surprise and encourage settlement. The applicant's attorney argued that allowing the discovery of the statements prior to the deposition would avoid surprise. The applicant's attorney indicated that the case of Hardesty stood for the proposition that there was a need to safeguard against unfair surprise.

The WCJ indicated that one of the principal purposes of discovery was to do away with the theory of surprise at trial. In this case there is no threat of surprise at trial. Hardesty stands for the proposition of the need to safeguard against unfair surprise is at trial, and does not prevent any and all surprise. The process of discovery by which a party discovers unknown information inherently leads to some amount of surprise. The applicant will have an opportunity to respond before trial. The judge concluded that the arguments for disclosure of the statements before the

deposition of the applicant fail to show significant prejudice or irreparable harm. Any surprise can be remedied by further discovery.

The WCAB denied removal finding no significant prejudice or irreparable harm

NOTE: Based on the Supreme Court case of *Coito v. The Superior Court of Stanislaus County; State of California* (2012) 54 Cal. 4<sup>th</sup> 489, witness statements in Worker's Compensation cases are discoverable as ruled by the WCJ in this case.

The question is can defendants delay production of the statements until after the deposition of the applicant. The outcome of this case is consistent with the cases on films that concluded that films are discoverable but defendants have a right to first take the deposition of the applicant as long as the deposition is schedule with in a reasonable time after the requests for films.

### **36. "Good Faith" personnel action**

#### **Gibson v. state of California (BPD) ADJ 737724**

If you admit a psych injury you cannot raise "good faith" personnel action as an affirmative defense and you cannot apportion to a "good faith" personnel action.

Defendant stipulated to injury to psyche at MSC. Defendant then attempted to raise "good faith" personnel action as an affirmative defense. Because the defendant stipulated that applicant sustained an industrial injury to her psyche, defendant cannot maintain a "good faith" personnel action defense.

In this case the applicant was examined an AME in psychiatry. The AME appointed a psychologist to do psychological testing. The psychologist came up with different results on the level of PD. The WCAB ruled that an AME was chosen by the parties because of their expertise and neutrality. Therefore the opinion of the AME should ordinarily be followed unless there is a good reason to find them unpersuasive. (*Power v. WCAB*) (51 CCC 114). However the medical report of the AME must be substantial evidence. The parties selected the AME. Defendant cannot substitute the opinion of the psychologist chosen by the AME to conduct testing for the opinion of the AME chosen by the parties. The AME report was substantial evidence.

Defendant argued they were deprived due process by the closure of discovery on the issue of applicant's psychiatric disability. The board emphasized that if defendant wanted to conduct discovery to develop an affirmative defense they should not have stipulated to an industrial injury. Stipulations between party litigants are binding on the parties unless upon a showing of good cause the parties are given permission to withdraw from the agreement.

Furthermore, even if defendant showed that some portion of applicant's injury was caused by good faith personnel action, labor code section 3208.3 does not provide for apportionment for "good faith personnel" actions, the issue only applies to causation of injury not causation for apportionment. In general "good faith personnel actions" are related to injury in the course and scope of employment.

### **37. Apportionment/Conclusive presumption**

#### **Angel Valenzuela vs. State of California (BPD) ADJ 1415058**

The WCJ found the applicant totally disabled within the meaning of LC § 4662, and that apportionment as described in the decision in the Benson case (74 CCC 113) is not applicable to this case.

Defendant filed a petition for reconsideration contending that a finding of total permanent disability pursuant to LC § 4662 allows apportionment between industrial injuries.

The WCAB found that a finding of total permanent disability “in accordance with the fact” as provided in section 4662 does not preclude apportionment of permanent disability between industrial injuries as described in Benson. However such apportionment must be supported by substantial evidence in the light of the record. In the opinion of the board the record in this case was not complete and there was no substantial evidence so the matter was remanded for further proceedings on all issues including apportionment.

LC § 4662 describes for specific circumstances where total permanent disability is conclusively presumed. Those four circumstances are as follows: (a) Loss of both eyes or the sight thereof. (b) loss of both hands or the use thereof. (c) an injury resulted in a practically total paralysis. (d) an injury to the brain resulting in incurable mental incapacity or insanity.

A plain reading of LC § 4662 shows that only those four listed disabilities obtain the conclusive presumption because the last section of LC§ 4662 provides that, “in all other cases, permanent total disability shall be determined in accordance with fact.” Thus in all other cases where permanent total disability is determined in accordance with facts the permanent disability is not conclusively presumed to be total.

In this case the determination of permanent total disability was based on the evidentiary record and determined in accordance with fact. For this reason, the permanent total disability found by the WCJ is not “conclusively presumed” to be total pursuant to LC§ 4662.

Permanent disability is subject to apportionment based upon its causation, including in cases where the injured worker’s overall permanent disability is 100%. Thus, apportionment must be addressed regardless of whether the total permanent disability is determined by rating the employee’s whole person impairment, or otherwise in accordance with the fact pursuant to the last sentence in LC§ 4662.

The board then stated that LC § 4664 (c) (1) provides that the accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100% over the employee’s lifetime unless the employee’s injury or illness is conclusively presumed to be total pursuant to LC 4662.

In this case the WCJ did not address the evidence concerning the issue of apportionment because he concluded there was no basis for apportionment when total permanent disability is determined in accordance with the facts under the last sentence of 4662. Because that legal conclusion is

incorrect the case is returned to the trial level for a new decision based on substantial medical evidence.

### **38. Apportionment/Burden of Proof**

#### **Joyce Jackson v. County of Los Angeles (BPD) (ADJ 4418855)**

The parties agreed to Roger Sohn M.D. as AME in orthopedics and Dr. Wolf as AME in psychiatry.

Dr. Sohn wrote a report finding 50% of applicant's spinal disability was apportioned to her industrial injury and 50% to degenerative changes due to stenosis in her back. Dr. Wolf did not follow Dr. Sohn's apportionment. Defendant did not take Dr. Wolf's deposition.

The WCJ issued a decision following the reports of Dr. Sohn and Dr. Wolf.

Defendants filed a petition for reconsideration arguing that Dr. Wolf the AME in psychiatry should have followed Dr. Sohn's apportionment as the psychiatric injury must follow the apportionment of the physical injury.

The WCAB indicated that defendant has the burden of proof on apportionment. (Pullman Kellogg v. WCAB (Normand) (45 CCC 170).

Defendant cites no statutory or case authority establishing that, where an employee suffers a physical injury that affects his or her psyche, the apportionment of the psychiatric disability must follow the apportionment of the physical injury, as matter of law.

Dr. Wolf was fully aware that Dr. Sohn had apportioned 50% of applicant's back disability to industrial causation and 50% to degenerative changes and stenosis. Dr. Wolf, however, did not adopt Dr. Sohn's apportionment opinion.

If defendant believed that Dr. Wolf should have apportioned applicant psychiatric disability in keeping with Dr. Sohn's apportionment of the orthopedic disability, defendant had ample opportunity to test its belief by taking a deposition of Dr. Wolf, but it failed to do so. (Foremost Dairies v. IAC (McDannald) (30 CCC 320). Defendant's failure to cross-examine Dr. Wolf by deposition, therefore, precludes it now from complaining on reconsideration.

(Telles Transport v. WCAB (Zunida) 66 CCC 1290) ("Under the doctrine of waiver, a party loses the right to appeal an issue caused by affirmative conduct or by failing to take the proper steps to avoid or correct the error. Similarly, under the doctrine of invited error, a party is estopped from asserting prejudicial error where his own conduct caused or induced commission of the wrong.) (9 Witkin, Cal. Procedure (5th ed. 210) Appeal, § 39) ("Where a party by his or her conduct induces the commission error, the party is estopped from asserting it is a ground for reversal". This application of estoppel principle is generally known as the doctrine of invited error.)

### **39. AMA Guides/5<sup>th</sup> vs. 6<sup>th</sup> Edition**

#### **Frazier v. State of Ca. Dept. of Corrections (BPD) (ADJ 8008017):**

The WCJ issued a decision finding 44% PD based on the AME in internal medicine. The AME in internal medicine based his decision on using the AMA guides 6th edition based on Almaraz/Guzman that a 24 WPI more accurately reflecting applicants whole person impairment. The AMA guides 5th edition rated 30% WPI or 20% WPI both of which the AME said did not accurately reflect applicants disability. The AMA guides 6th rated 24%. The WPI of 24% adjusted to 44% PD rating. The WCJ based on the AME found 24 WPI. Defendants petitioned for reconsideration. The WCAB denied the petition for reconsideration.

The WCAB then granted reconsideration on their own motion.

The WCAB now indicates on further reflection they believe they should have granted reconsideration in the first instance. Because they are still within the 60 days of WCAB jurisdiction they granted reconsideration on their own motion.

The WCAB concluded indicated that LC § 4660 provides that for physical injury or disfigurement the descriptions and measurements of physical impairments and the corresponding percentage of impairments published in the AMA Guides 5th addition shall be use.

The WCAB indicated that the word “shall” is mandatory and the term “may” is permissive. Therefore the plain language of LC §4660 is that the 5th edition of the AMA Guides shall (must) be used for determining the appropriate WPI of an injured employee. There is no language permitting the use of any prior or subsequent edition of the AMA guides.

The WCAB indicated that the en banc decision in Almaraz/Guzman II must be read that in determining the injured employees WPI it is not permissible to go outside the four corners of the 5th edition of the AMA Guides, although a physician may utilize any chapter, table or method in the 5th addition of the AMA Guides that most accurately reflects the injured employee’s impairment. The board went on to state there is nothing in the Court of Appeals decision in Almaraz/Guzman II that suggested WPI’s may be based on anything other than the 5th Edition of the AMA Guides.

The board recognized that when Senate bill 899 was passed the 6th edition of the AMA Guides did not yet exist. Nevertheless, if the legislature changes the law in certain respects when a particular statute or subject is before it, but does not change it in other respects, this indicates an intent to leave the law as it stands in the aspects not amended. Furthermore SB 863 created a new section 4660.1 which provides that permanent disability rating shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the AMA Guides 5th addition. Therefore when the legislature amended LC 4660 and added 4660.1 they made no provision for allowing for the use of any other edition of the AMA Guides other than the 5th addition. The changes made in SB 863 demonstrate the legislature intended to continue to use the 5th edition of the AMA Guides.

Therefore the board concluded the medical report of the AME which went outside of the four corners of the 5th edition of the AMA Guides does not constitute substantial evidence as a matter of law as it rests on an incorrect legal premise. The WCAB therefore granted reconsideration and returned the matter to the trial level for further proceedings. They indicated the WCJ may elect to decide the issue on the existing record or exercise his discretion to allow further development of the record.

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