

**SUMMARY OF
SIGNIFICANT DECISIONS IN
CALIFORNIA WORKERS'
COMPENSATION LAW
FOR THE YEAR 2012**

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

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

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Published Appellate and WCAB En Banc Opinions

Jurisdiction/Petition to Reopen

Contreras v. WCAB (2012) 77 CCC 1, Court of Appeal, Second Appellate District, Division Six, unpublished opinion.

Applicant, a farm worker, sustained an admitted injury for which he received an award of permanent disability. Exactly five years after the date of injury, he filed a petition to reopen for new and further disability in propria persona, attaching a copy of a medical report. Although his case had originally been tried at the Ventura district office of the WCAB, he filed his petition at the district office Los Angeles. Regulations in effect at the time required that his petition be filed at the district office of the WCAB where his case had originally been heard.

Applicant retained counsel and the matter eventually came on for trial at the Ventura district office. The sole issue was whether the WCAB had jurisdiction over the petition to reopen because it had not been filed in the proper venue. The WCJ found in favor of the defendant. Applicant petitioned for reconsideration on the ground that two years earlier, the venue rules had been changed so that a petition could be filed in any district office.

In a split decision, a majority of the WCAB panel found that former 8 CCR §§10390 and 10450 (WCAB Rules of Practice and Procedure) required the petition to reopen to be filed in the district office with venue of the matter. Noting that former §10390 authorized the WCAB to excuse a failure to comply based on mistake, inadvertence, surprise, or excusable neglect, the majority found that applicant had waived this issue by not submitting any such evidence at trial or in his petition for reconsideration. The dissenting Commissioner felt that applicant had shown mistake and excusable neglect even if he had not used those precise words. She also considered the fact that applicant was pro per and that the law favors adjudication on the merits.

The Court of Appeal found that the new venue provision allowing filing in any district office is not a rule that speaks to the rights and liabilities of the parties such that it can only be applied prospectively. Rather, it is a procedural change that may be applied retroactively to a pending action. Therefore, the WCAB erred in not applying the current venue regulation, 8 CCR §10397, to applicant's claim.

Additionally, the Court agreed with the dissenting Commissioner that applicant established adequate grounds for granting relief based on mistake, inadvertence, or excusable neglect. He testified that he personally went to the Los Angeles district office to file his petition. The petition was timely filed and supported by a physician's report. It was date stamped and not rejected by the WCAB district office at that time. It was a particularly harsh result to then reject his claim six years after the petition had been filed.

The Court therefore annulled the Board's decision and remanded the matter for a determination on the merits.

Liens/CIGA

CIGA v. WCAB (2012) 77 CCC 143, Court of Appeal, Second Appellate District, Division Two.

The employer's insurance carrier became insolvent and CIGA assumed liability for the applicant's claim. Applicant obtained treatment from various medical providers who separately entered into a collection agreement with Pinnacle Lien Services. CIGA claimed it was not responsible for payment of the Pinnacle claims on the ground that Insurance Code §1063.1(c)(9) excludes liability for "a claim by a person other than the original claimant under the insurance policy in his or her own name...and does not include a claim asserted by an assignee or one claiming by right of subrogation..."

The WCJ found against in favor of the lien claimants because the evidence in the form of contracts revealed that Pinnacle only represented the medical providers and transmitted the amounts collected to them, while retaining a percentage of the collected sums as payment for its services. The WCAB agreed and denied reconsideration, noting that that CIGA had failed to prove that legal title to the medical providers' claims had been transferred to Pinnacle which only acted as a collection agent. CIGA filed a petition for writ of review which was granted.

In determining whether an assignment has been made, the Court observed that the intention of the parties as manifested in the agreement is controlling. Here, the contract provided that each medical provider "is *the sole owner* of accounts receivable for which CLIENT desires PINNACLE to provide collection services." Furthermore, Pinnacle identified the medical providers as the lien claimants and itself as their "representative," a clear indication that it was pursuing recovery of the claims on behalf of the medical providers.

The Court went on to consider the language of the statute that CIGA claimed absolved it of liability. The term, "original claimant" is not defined in the CIGA statutes. However, a "claimant" is a person who institutes a liability claim. In the Court's view, a medical lien is a liability claim because employers have liability to medical providers and the insolvent insurer has an obligation to pay.

A "covered claim" must be instituted "under the insurance policy." This was satisfied in the present case because the lien is to be satisfied out of insurance proceeds. The original claimant must seek recovery "in his or her own name" and this occurred when the medical providers filed liens. Pinnacle fits the definition of "administrator" and "personal representative" because it was hired by the providers to administer their liens. Without this interpretation, a lien holder could not use the services of collection agencies.

Thus, the Court concluded that the liens are not barred and therefore affirmed the decision of the WCAB.

Psychiatric Injuries/Good Faith Personnel Actions

County of San Bernardino v. WCAB (McCoy) (2011) 77 CCC 219, Court of Appeal, Fourth Appellate District, Division Two.

Applicant asserted a claim for a psychiatric injury arising out of conflict with his supervisor. On the first day of trial, he added migraine headaches to the claim. The WCJ agreed with defendant that the injury was caused by a lawful, nondiscriminatory, good faith personnel action and therefore found that it was not compensable pursuant to Labor Code §3208.3(h). He also noted that the headaches were pre-existing and that the stress only resulted in a temporary exacerbation.

Applicant sought reconsideration, contending that the good faith personnel action defense did not apply to physical injuries, such as migraine headaches. The WCAB reversed the WCJ, finding that §3208.3(h) does not bar compensation for migraine headaches. The Board returned the matter to the trial level to determine entitlement to temporary disability and medical treatment. Defendant unsuccessfully petitioned for reconsideration and then filed a petition for writ of review that was granted by the Court of Appeal.

The Court first noted that in enacting Labor Code §3208.3, the Legislature made it clear that it intended to limit claims for psychiatric injuries. Therefore, it would be improper to interpret the statute in a manner that would lead to more or broader claims. The WCAB applied the statute as written since it contained no reference to migraine headaches. On the other hand, applicant made no claim that he suffered stress on the job from sources other than good faith personnel actions. The Court therefore concluded that the good faith personnel action defense precludes recovery for psychiatric injuries with resulting physiological manifestations solely caused by stress from such actions. Otherwise, a claimant could avoid the bar of the good faith personnel action defense by merely asserting internal problems and symptoms, such as upset stomach, headache and sleeplessness, but not injury to the psyche per se.

The Court stated that its holding does not undermine the rule that physical injuries or conditions aggravated by work-related stress are compensable because it is limited to cases, as here, where there is no evidence that the employee suffered on-the-job stress apart from that caused by the good faith personnel actions.

Payment of C & R/Stolen Checks

Barrett Business Services, Inc. v. WCAB (Rivas) (2012) 77 CCC 213, Court of Appeal, Second Appellate District, Division Three.

Applicant executed a power of attorney authorizing his attorney to sign legal documents on his behalf. Applicant moved and his attorney served notice of the change of address on

the employer, but not on its adjusting agent or defense counsel. In the meantime, the employer stopped using an adjusting agent but did not serve notice of that fact. Thereafter, applicant moved two more times, once to a local address and finally to Texas. These notices were served on defense counsel and the former adjusting agent.

The parties reached a settlement agreement. Defendant prepared the C & R and sent it to applicant's attorney bearing an obsolete address for the applicant. Counsel executed the C & R on behalf of his client and returned it to defense counsel who obtained the approval of the C & R on a "walk-through" basis. The employer mailed a check representing the proceeds of the C & R less attorney fees to applicant at the incorrect address. The check was fraudulently endorsed and cashed.

Applicant advised defendant that he had never received the settlement check. Defendant investigated and discovered that the incorrect address was a house that belonged to applicant's nephew with whom applicant and his wife had formerly lived. The nephew still lived at the house but applicant said that the endorsement on the check was not the nephew's signature.

The matter came on for trial on the issue of whether the defendant was obligated to replace the stolen check. The WCJ found the defendant liable because applicant was not at fault and the defendant was in a better position to pursue legal action against responsible parties. Defendant filed a petition for reconsideration which the WCAB denied. Defendant then sought judicial review.

The Court of Appeal cited California Uniform Commercial Code §3420 which provides in part that "[a]n action for conversion of an instrument may not be brought by . . . a payee or indorsee who did not receive delivery of the instrument either directly or through delivery to an agent or a copayee." Thus, where the issuer of the check, in this case the defendant, does not deliver the check to the payee applicant, the issuer remains liable to the payee on the underlying obligation.

Defendant argued that its obligation to applicant was discharged by mailing the settlement check to applicant at the address specified in the C & R, citing Civil Code §1476 which states: "If a creditor . . . at any time directs the debtor to perform his obligation in a particular manner, the obligation is extinguished by performance in that manner, even though the creditor does not receive the benefit of such performance."

In response, the Court pointed out that defendant drafted the C & R and not applicant. Applicant's attorney served the C & R on defense counsel and on the wrong adjusting agent because defendant did not serve notice of the change. Since defendant was on notice of the correct address in Texas, it could not be said that applicant directed defendant to perform its obligation in a particular manner. The WCAB's decision was therefore affirmed.

Psychiatric Injuries/Six Month Exclusion

State Compensation Insurance Fund v. WCAB (Garcia) (2012) 77 CCC 307, Court of Appeal, Second Appellate District, Division Three.

Applicant, an avocado picker, fell from a 24-foot ladder and suffered a head injury. Defendant admitted the head injury but denied the claim of psychiatric injury because applicant had been on the job for less than six months and was subject to the exclusion in Labor Code §3208.3(d). The matter came on for trial on the sole issue of whether applicant met the requirements for the exception to the six month exclusion for a “sudden and extraordinary employment condition. Defendant did not deny that the injury was sudden but disputed that it was extraordinary for an avocado picker to fall from a high ladder while picking avocados.

Applicant was the only trial witness. He testified that he had never fallen off a ladder and that he used a ladder daily in his job. At the time of his fall, he was standing on top of a 24-foot ladder picking avocados from a 35-foot tree. No one had ever advised him of the dangers of falling from a ladder and as far as he knew, none of the other avocado pickers had ever fallen. The employer had not held any safety meetings or provided him with a safety harness.

The WCJ found that the injury resulted from a sudden and extraordinary employment condition and found the psychiatric injury to be compensable. In a split decision, a majority of the WCAB panel denied reconsideration on the ground that the defendant had failed to offer evidence that the injury was not extraordinary. The dissenting Commissioner took the opposite point of view in the absence of evidence that such falls are rare. Defendant then sought judicial review.

The Court of Appeal reviewed the case law including *Wal-Mart Stores, Inc. v. WCAB* (2003) 68 CCC 1575, in which the Court suggested that the term, “sudden and extraordinary” excludes accidental injuries and applies only to extremely unusual events, such as gas main explosions or workplace violence. In *Matea v. WCAB* (2006) 71 CCC 1522, a rack of lumber suddenly fell on an employee’s leg while he was in a store aisle and this was found to be a sudden and extraordinary event. However, the Court noted an important distinction in that Matea’s injury occurred in a public place where the falling lumber would have struck anyone who happened to be in the way. In the present case, the injury occurred in the avocado grove where applicant and his co-workers were working on tall ladders. A fall under these circumstances could not be described as an uncommon, unusual and totally unexpected occurrence.

While it is true that the defendant did not introduce evidence that such falls are an industry hazard or that insurance costs reflect that risk, the Court noted that that was not the defendant’s burden. It was up to the applicant to prove that his psychiatric injury was caused by a sudden and extraordinary employment event and he did not carry that burden. His observations during his brief current employment and his prior unspecified fruit-picking experiences did not establish that his injury was caused by an event that was

uncommon, unusual and totally unexpected. Therefore, the Court annulled the Board's decision and remanded the matter with instructions to deny applicant's psychiatric injury.

Medical Provider Networks

Valdez v. WCAB (2012) 77 CCC 506, Court of Appeal, Second Appellate District, Division Seven.

After her injury, applicant treated in the employer's MPN for three weeks. She then retained counsel and her attorney referred her to a non-MPN doctor. The matter came on for trial on the issue of her claim for TD. Applicant testified that she changed doctors because the treatment provided by the MPN doctor was not helping her. The WCJ deferred the network control issue on the ground that it was not related to applicant's TD claim. He rejected the defendant's argument that the reports of the non-MPN doctor were inadmissible and awarded TD in accordance with those reports. The defendant sought reconsideration, insisting that the reports on which the decision was based were inadmissible and there was therefore no substantial evidence of TD.

In an en banc decision, a majority of the WCAB held that where there is a validly established and properly noticed MPN, the reports of non MPN physicians are not admissible into evidence and the defendant is not liable for their cost. Applicant filed a petition for reconsideration from the en banc decision which was granted for further study. The Board then a final en banc opinion in which it denied the applicant's petition and affirmed its original holding in all respects. Applicant sought judicial review which was granted.

In finding that out of network reports were inadmissible, the Board had relied on Labor Code §4616.6 which provides:

“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.”

Since “this article” refers to the Article of the Labor Code containing the MPN statutes, the Board reasoned that §4616.6 “precludes the admissibility of non-MPN medical reports with respect to disputed treatment and diagnosis issues.” Therefore, the reports from non-MPN physicians are inadmissible and may not be relied on to award compensation.

The Court of Appeal rejected this conclusion, noting that the only time the word, “report” is mentioned in the MPN statutes is in §4616.4(f) which requires the Independent Medical Review doctor to issue a “report” after the second and third opinion procedures have been completed. Thus, the Court concluded that the word, “reports” in §4616.6 doesn't refer to reports of other than MPN doctors but rather to reports other than that of the IMR doctor after the IMR process has been completed. The Court found this to be a reasonable interpretation because the IMR process was so thorough that additional

reports would be incapable of shedding further light on the controversy. Furthermore, if the Legislature had intended to exclude non-MPN reports from evidence, it would have said so.

The Board had also based its opinion on the premise that there could only be one PTP at a time and only the PTP can render an opinion on the medical issues necessary to determine entitlement to benefits. Thus, where the defendant has network control, the MPN doctor remains the real PTP, the non MPN doctor cannot become the PTP, and the reports of the non MPN doctors aren't admissible. In this regard, the Board relied heavily on the case of *Tenet/Centinela v. WCAB* (2000) 65 CCC 477. In *Tenet*, after the PTP found that the applicant was P & S, the applicant selected a new PTP without following the AME/QME procedure. The *Tenet* Court held that the applicant was not entitled to select a new PTP under these circumstances. The Court in *Valdez* rejected this rationale noting that while it was true that the *Tenet* Court found that the new doctor did not become the applicant's PTP, it was nowhere stated in the Court's opinion that the reports of the new doctor were inadmissible.

Finally, the Court stated that its conclusion was supported by Labor Code §4605 which authorizes an employee to provide, "at his own expense, a consulting physician or any attending physicians whom he desires." A rule excluding medical reports for the sole reason that the report was not prepared by an MPN physician would eviscerate this right. Therefore, the Board's decision was annulled and the case was remanded for further proceedings consistent with the Court's opinion.

Note: On October 10, 2012, the Supreme Court granted the defendant's petition for review of the Court of Appeal's decision in *Valdez* which automatically depublished the lower court's decision.

104 Week Cap on Temporary Disability

Meeks Building Center v. WCAB (Najjar) (2012) 77 CCC 615, Court of Appeal, Third Appellate District.

Applicant sustained a cumulative injury in June 2007, but continued to work his usual and customary job duties. In September 2007, he attended an evaluation with a PQME for which the defendant paid him \$64.71 in temporary disability to reimburse him for his lost wages. In March 2009, he was found to be temporarily disabled. The defendant commenced TD payments, but terminated them in September 2009. It was defendant's position that since the version of Labor Code §4656 in effect at the time capped TD at 104 weeks after the first payment, the time started to run with the \$64.71 payment in connection with the PQME exam. Applicant disagreed, claiming that the 104 weeks started to run in March 2009.

The WCJ reasoned that since Labor Code §4600 (e)(1) required defendant to pay all reasonable expenses related to the PQME evaluation "together with one day of temporary

disability indemnity for each day of wages lost in submitting to the examination, the September 2007 payment commenced the running of the 104 weeks and applicant was not entitled to further TD. On reconsideration, the WCAB reversed the WCJ, finding that the September 2007 payment was not the equivalent of TD within the meaning of Labor Code §4656. Defendant sought judicial review which was granted.

The Court of Appeal noted that the purpose of temporary disability indemnity is to provide interim wage replacement assistance to an injured worker during the period of time he or she is healing and incapable of working. In this case, the applicant's inability to work for which the TD payment was made was not the result of physical incapacity but rather a scheduling conflict. The \$64.71 payment was not wage loss to compensate for work incapacity, but rather a medical-legal benefit to enable him to prove his claim. His entitlement was not contingent on inability to work or even on having sustained an industrial injury.

Thus, the Court found that the September 2007 payment did not trigger the 104 week cap on TD and affirmed the decision of the WCAB.

15% PD Increase/Decrease

City of Sebastopol v. WCAB (Braga) (2012) 77 CCC 783, Court of Appeal, First Appellate District, Division Five.

Applicant, a fire captain, missed no time from work following his industrial injury. Relying on a WCAB panel decision, *Tsuchida v. County of Los Angeles* 2009 Cal. Wrk. Comp. P.D. LEXIS 399, the WCJ found that he was entitled to the scheduled rate without the decrease. In a split decision, a majority of the WCAB panel agreed with the WCJ noting that "a game of 'gotcha' with applicants who have not lost time from work does not further the purpose of this statute."

The dissenting Commissioner would have applied the 15 percent decrease. Interestingly, the dissenter had been on the *Tsuchida* panel and participated in the unanimous decision. However, in considering the issue further, he changed his mind and offered the following rationale:

Pursuant to Labor Code section 4660(a), permanent disability includes the employee's "diminished future earning capacity." If an applicant is able to continue in his pre-injury employment and perform full duties, he has less diminished future earning capacity than an employee who cannot. In addition to providing employers with an incentive to return employees to work, Labor Code section 4658(d) adjusts an injured worker's compensation to better reflect his or her diminished future earning capacity.

The defendant filed a Petition for Writ of Review that was granted by the First Appellate District Court of Appeal. The Court found that where the employee missed no time from work, an employer who made a timely return to work offer was not entitled to take the 15% decrease. Accordingly, the Court affirmed the WCAB's Opinion and Order Denying Petition for Reconsideration. The Court reasoned that Labor Code §4658(d) was enacted to provide employers with an incentive to return injured employees to work. If an injured worker remains on his regular job and never loses any time from work as a result of the injury, he does not "return to work" in any common understanding of that phrase.

The Board had found that if there was no lost time, the employer didn't get a decrease and the employee didn't get an increase. However, the Court noted in a footnote that since the applicant did not challenge the WCJ's finding that he was not entitled to a 15 percent increase, that finding was not at issue on appeal.

Medical Treatment

Adventist Health v. WCAB (Fletcher)(2012) 77 CCC 935, Court of Appeal, Third Appellate District.

Applicant suffered an industrial back injury that left her in a state of constant pain. She moved to Maryland and became engaged in a protracted battle with the insurance carrier concerning her medical treatment. Her designated PTP failed to comply with the reporting requirements and she was ordered to select a new PTP. However, she had great difficulty finding a PTP who was willing to treat her and also comply with California workers' compensation law.

She agreed to see a former PTP with whom she had been dissatisfied, on a temporary basis in order to obtain pain medication. The doctor included in his reports an unflattering account of his contact with applicant. He also mentioned that her tolerance for opioid medications was increasing such that she was having "mini-withdrawal symptoms," and that she appeared to be depressed. Applicant complained about the doctor and refused to see him again. She filed a DOR and the matter came on for a hearing on the issue of her entitlement to medical treatment.

As a result of the hearing, the WCJ ordered the defendant to reimburse the applicant for treatment she had paid for with a partner of the removed PTP who, like his colleague, had not provided any medical reports. He also ordered the defendant not to include the unflattering reports of the temporary PTP in the reports that would be sent to any future doctor out of fear that they might cause another doctor to be prejudiced against the applicant. The defendant filed a petition for reconsideration that was denied by the WCAB and then sought judicial review.

The Court of Appeal characterized the WCJ's decision as a "creative and compassionate solution" to the problem and noted that the WCAB's decision was neither unreasonable nor unjust. However, by returning to the associate of the physician who had been administratively removed, the applicant had flouted the administrative order. More

significantly, by seeking treatment from providers who failed to submit treatment plans or medical records, she denied the defendant the ability to comply with utilization review. Moreover, her health might have been compromised if her other physicians either were not apprised of the temporary PTP's concerns about her course of treatment or disregarded that advice. Therefore, she was not entitled to reimbursement for her out of pocket medical expenses.

Likewise, the Court found no legal basis for excluding certain reports from the medical record that the defendant was required to transmit to a PTP that applicant might select in the future. The information contained in those reports, including the treatment recommendations and the doctor's difficulties in dealing with the applicant, might assist in developing a treatment plan that would help applicant to deal with her chronic pain.

The Court annulled the decision of the WCAB and noted that the parties would have to resolve the problem themselves if the WCJ's creative solutions were rejected by the defendant and "within the confines of our highly regulated system, the WCAB does not have the authority to sanction those efforts."

Liens/Burden of Proof

Torres v. AJC Sandblasting (2012) 77 CCC 1113, WCAB En Banc Opinion.

Applicant claimed to have sustained an industrial injury which the defendant disputed. A lien claimant hired a collection agency to collect on its bill for MRIs of the spine and hip. The collection agency entered its appearance and filed a lien on behalf of the medical provider together with a copy of an unsigned "Health Insurance Claim Form." The matter came on for a lien conference and the lien claimant listed as its trial exhibits the claim form and two MRI reports. The parties stipulated that applicant claimed to have sustained an injury and listed as issues the reasonableness and necessity of the treatment as well as reasonable value per the Official Medical Fee Schedule.

At the lien trial, the lien claimant presented no witnesses and only offered into evidence the insurance claim form listing dates of service, procedure codes and its charges plus penalties and interest. The defendant offered no evidence at all. The WCJ warned the lien claimant that if it insisted on proceeding to trial without any relevant evidence, he would assess sanctions and costs for frivolously wasting the time of the WCAB. The lien claimant's representative chose to ignore the WCJ's warning so he submitted the dispute for decision and issued a Notice of Intention to impose sanctions in Minutes of Hearing of the trial.

The lien claimant didn't to respond the Notice of Intention. The WCJ denied the lien, finding that the lien claimant failed to carry its burden of proof. He also sanctioned the lien claimant \$750.00 and ordered it to pay the defendant's attorney fees. The lien claimant then file a petition for reconsideration in which it argued that all it had to do was present its bill and the burden then shifted to the defendant to prove that its services were

neither reasonable nor necessary. Thus, it argued, it was the defendant and not the lien claimant that failed to carry its burden of proof.

The Board first discussed an old Supreme Court case called *Kaiser Foundation Hospitals v WCAB (Keifer) (1974) 39 CCC 857*, in which the Court observed that a lien claimant could establish a prima facie case merely by showing that it provided treatment for an injury that was claimed to be industrial. The “*Keifer doctrine*” was nullified by the 1993 amendments to Labor Code §§3202.5 and 5705 providing that lien claimants have the burden of proof. The Board noted that over the years, this principle has been emphasized in numerous WCAB and appellate decisions that have made it crystal clear that lien claimants and not defendants have the burden of proof in lien disputes.

At trial, the defendant did not stipulate to injury AOE/COE and the lien claimant didn’t present any evidence of industrial causation. Therefore, it did not carry its burden of establishing the threshold element of a compensable injury. Even if it had proved an injury, it also had the burden of proving that the medical services were necessary. The insurance claim form that was its sole evidence was totally inadequate for this purpose. Additionally, it presented no evidence that its charges were reasonable.

In the petition for reconsideration, the lien claimant had argued for the first time that the MRIs were requested by the PTP. However, it provided no explanation as to why that argument was not raised at trial and why it did not offer supporting evidence. The fact that it listed the MRI reports in the Pre-Trial Conference Statement but chose not to offer them at trial was irrelevant since all parties are charged with exercising reasonable diligence in presenting their cases. Thus the Board upheld the WCJ’s disallowance of the lien based on the lien claimant’s failure to carry its burden of proof.

Since the lien claimant’s evidence was utterly incapable of proving the elements of its case and since the WCJ issued a warning to this effect prior to the trial, the lien claimant’s insistence on proceeding to trial was in bad faith, a waste of the Court’s time, indisputably without merit, and frivolous. Since the arguments it presented in its petition for reconsideration fell into the same category, the Board questioned whether the \$750.00 sanction was adequate. It further questioned whether the lien claimant should be the sole recipient of the sanction since the collection agency and its hearing representative seemed equally culpable. Therefore, the matter was sent back to the trial level for the WCJ to redetermine both the amount of the sanction and who should be sanctioned.

Appellate Cases Originating Outside of California Workers' Compensation

Discovery/Attorney Work Product Privilege

Coito v. The Superior Court of Stanislaus County; State of California (2012) 54 Cal. 4th 489, Supreme Court of California.

Ms. Coito, the plaintiff, filed a complaint against several defendants for the wrongful death of her 13-year old son who drowned in a river. During discovery, disputes arose concerning the parties' obligation to disclose information obtained in connection with witness interviews. The defendant objected to the plaintiff's requests for discovery of these items, invoking the work product privilege. The trial court sustained the objection, concluding as a matter of law that the recorded witness interviews were entitled to absolute work product protection and that the other information sought was work product entitled to qualified protection. A divided Court of Appeal reversed, concluding that work product protection did not apply to any of the disputed items. The Court of Appeal issued a writ of mandate directing the trial court to grant the motion to compel discovery.

The Supreme Court granted review in order to decide what work product protection, if any, should be accorded two items: 1) recordings of witness interviews conducted by investigators employed by defendant's counsel, and 2) information concerning the identity of witnesses from whom defendant's counsel had obtained statements.

The Court concluded that the Court of Appeal erred. In light of the legislatively declared policy and the legislative history of the work product privilege, it held that the recorded witness statements are entitled as a matter of law to at least qualified work product protection. The witness statements might be entitled to absolute protection if the defendant could show that disclosure would reveal its "attorney's impressions, conclusions, opinions, or legal research or theories," as set forth in Code of Civ. Proc. §2018.030(a). If not, then the items may be subject to discovery if the plaintiff could show that "denial of discovery will unfairly prejudice [her] in preparing [her] claim ... or will result in an injustice." (CCP§ 2018.030(b).)

As to the identity of witnesses from whom defendant's counsel had obtained statements, the Court held that such information is not automatically entitled as a matter of law to absolute or qualified work product protection. In order to invoke the privilege, defendant must persuade the trial court that disclosure would reveal the attorney's tactics, impressions, or evaluation of the case (absolute privilege) or would result in opposing counsel taking undue advantage of the attorney's industry or efforts (qualified privilege).

Therefore the judgment of the Court of Appeal was reversed and the matter remanded for further proceedings to determine whether the disputed materials should be produced.

Jurisdiction

Matthews v. National Football League Management Council; Tennessee Titans
(2012) 77 CCC 1, United States Court of Appeal for the Ninth Circuit.

Plaintiff played football in the National Football League (NFL) from 1983 to 2002, playing for teams in Texas and Tennessee, including the Tennessee Titans. During this time period, he played 13 games in California. In 2008, he filed for workers' compensation benefits in California, claiming pain and disability resulting from injuries incurred while he was employed at "various" locations over 19 years of "playing and practicing professional football." He did not allege that he sustained any particular injury in California.

The Titans and the National Football League Management Council (NFLMC) filed a grievance against Plaintiff. They argued that by applying for workers' compensation benefits in California, Plaintiff breached his employment agreement, which provided that all workers' compensation claims would be decided under Tennessee law. Pursuant to a binding arbitration clause in the NFL collective bargaining agreement, the parties arbitrated their dispute.

The arbitrator found that the choice of law clause in Plaintiff's contract constituted a "promise to resolve workers' compensation claims under Tennessee law" and that by pursuing benefits under California law, Plaintiff was in violation of the agreement. The arbitrator ordered Plaintiff to "cease and desist" from seeking California benefits. Plaintiff filed suit in Federal District Court to vacate the arbitration award. The Court denied his motion and Plaintiff appealed.

Plaintiff argued that the award violated California public policy barring contractual waiver of workers' compensation benefits and federal labor policy providing that an employment agreement may not preempt state minimum labor standards. He also claimed that the award was in manifest disregard of the *Full Faith and Credit Clause of the United States Constitution*.

Regarding the waiver, the plaintiff relied on Labor Code §5000 which provides that any contract or agreement, express or implied, made by any employee to waive California Workers' Compensation benefits, is null and void. However, the Court did not read California's policy so broadly. Rather than guarantee a universal right to seek California workers' compensation benefits, the statute establishes a rule that an employee who is otherwise eligible for California benefits cannot be deemed to have contractually waived those benefits, and an employer who is otherwise liable for California benefits cannot evade liability through contract. The "no waiver" rule applies only when an employee's workers' compensation claim is subject to California law.

The Court used the same rationale to reject the plaintiff's argument that federal labor policy provides that an employment agreement may not preempt state minimum labor standards. Since it was not clear that Plaintiff's workers' compensation claim fell within

the scope of California workers' compensation, he failed to show that an arbitration award preventing him from seeking California benefits deprived him of something to which he was entitled under state law.

The *Full Faith and Credit Clause* states that "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State." Plaintiff cited U. S. Supreme Court cases that he claimed established that "California has the absolute right to apply its workers' compensation laws within its borders and to prohibit any employee from waiving those rights." The Court disagreed, noting that the Supreme Court did not hold that California had an "absolute right" to apply its law, irrespective of the extent of its contacts with the employee or employment relationship in question. To the contrary, in each cited case, the Court emphasized California's substantial interest in the controversy before it.

The Court therefore affirmed the order of the arbitrator that Plaintiff was to cease and desist from pursuing workers' compensation benefits in California.

Unpublished Appellate Opinions

Serious and Willful Misconduct

C. C. Myers v. WCAB (Lockwood) (2012) 77 CCC 129, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant was injured while engaged in placing heavy steel plates along the walls of a hole that had earlier been excavated. An excavator with the bucket removed was used to transport the steel plates to the hole where applicant and his foreman were standing at the edge. Unbeknownst to the foreman who was looking at the approaching excavator, applicant had kneeled down to push a rock into the hole, placing his leg in the path of the excavator. The foreman did not look around to make sure the way was clear and the excavator ran over applicant's foot. He eventually required an amputation of his leg below the knee.

Applicant filed a petition for increased benefits for the serious and willful misconduct of the employer under various theories including the fact that the employer had not had a "spotter" available to function as an extra set of eyes for the operator. The WCAB agreed and found in applicant's favor. The employer then sought judicial review.

After the Court thoroughly reviewed the case law relating to serious and willful misconduct, it disposed of a number of minor evidentiary arguments before addressing the crucial issue raised by the defendant: Whether or not, under the totality of the circumstances, there was a basis for concluding that the foreman, as the employer's

managing representative, “turned his mind” to the fact that the work was being performed in such a way as to expose applicant to danger requiring the use of a spotter.

The Court observed that this issue is twofold. First, it must be determined whether the employer, through its managing agent, the foreman, turned its mind to the existence of a danger to its employee. Only if this question was answered in the affirmative could the Court proceed to the second question which is whether the employer took reasonable precautions to protect the employee against such danger.

The Board found that the foreman must have turned his mind to the danger because he was on site at the time of the accident. However, the Court felt there had to be something more in that he must also have turned his mind to some particular danger posed by the nature of the work they were performing at the time. The Court found that something more in the tight quarters they were working in, the ambient noise, the approach of darkness, the fact that the crew had been working for 13+ hours, and the need to get the job done that day.

Regarding the second question, the employer presented no testimony that the use of a spotter was unnecessary under the circumstances presented. In fact, the foreman testified that he and another employee were acting as signalmen to alert the operator when to move the excavator. However, he also testified that he did not perform that function at the time of the accident. Therefore, the Court affirmed the Board’s decision.

AOE/COE/Medical Causation

American Medical Response v. WCAB (Westerman) (2012) 77 CCC 413, Court of Appeal, Second Appellate District, Division Four, unpublished opinion.

Applicant worked long hours as a paramedic. His job was stressful. He lifted heavy weights and was sedentary for long periods of time. He gained significant weight during the employment. Returning home after a 36 hour shift, he suffered a stroke. He was hospitalized for two months. He was unable to return to work and required home care.

Applicant’s treating physician felt that the stroke was caused by hypertension, diabetes, stress and weight gain. The PQME rejected the PTP’s opinion as speculative. He believed that the condition that brought about the stroke was a “paradoxical embolus.” As a result of long sitting, he developed a clot in his leg that traveled through a hole in his heart to his brain. The existence of the hole in his heart could be documented by a shunt study with an echocardiogram and the PQME recommended that this test be performed. In his deposition, the doctor testified that if the applicant didn’t have a hole in his heart, there would be no explanation for the stroke. However, he also testified that he believed his theory to be correct to a reasonable medical probability.

In spite of the fact that applicant did not undergo the test, the WCJ found that he had sustained a compensable industrial injury. He based his opinion on the premise that the PQME had ruled out all non-industrial causes of applicant’s stroke and with reasonable

medical probability found that it was due to a paradoxical embolus. The WCAB summarily denied defendant's petition for reconsideration. The defendant then sought judicial review.

Defendant contended that the opinion and conclusion of the PQME did not constitute evidence without the diagnostic test. It further contended that it had authorized and agreed to pay for the echocardiogram shunt test. However, applicant's attorney advised that the Guardian Ad Litem refused to allow applicant to undergo the recommended diagnostic test, due to his alleged fragile health condition. In response, applicant denied that he had refused to submit to the test.

The Court noted that other than the allegations in the pleadings, there was no evidence that the defendant had authorized the test and requested that applicant undergo it. Likewise, there was no evidence that the applicant had refused to submit to the test. Defendant could have sought an order that applicant take the test or demonstrate a sound reason for not doing so. However, no such request was made. Therefore, the Court did not have to address the question of unreasonable refusal of a diagnostic test for the legal effect thereof.

Regarding the substantial evidence issue, the Court agreed with the Board. The law only required reasonable medical probability, not certainty. After all other potential causes had been ruled out by the PQME, it was reasonably medically probable that the cause of the stroke was the paradoxical embolus and the doctor so stated in his deposition.

The decision of the WCAB was affirmed. The Court declined to sanction the defendant under Labor Code §5803 or to find there was no reasonable basis for the petition and award a fee under §5801.

Repeal of Vocational Rehabilitation

The Kroger Company v. WCAB (Velasquez) (2012) 77 CCC 495, Court of Appeal, Second Appellate District, Division Two, unpublished opinion.

In 2005, applicant was awarded benefits by the Rehabilitation Unit. Defendant timely appealed the order. The matter came on calendar twice in 2007, but was ordered taken off calendar for further discovery. Defendant filed DORs in 2008 and 2009 to which applicant objected on the ground that discovery had not been completed.

The first hearing on the merits took place on April 26, 2011. Defendant argued that because it had taken a timely appeal from the Rehabilitation Unit's award and because that appeal was still pending on January 1, 2009, the award was not final on the date Labor Code section 139.5 was repealed and respondent was therefore not entitled to rehabilitation benefits. The WCJ found against the defendant on the ground that it had failed to file a DOR with its appeal as required by 8 CCR §10955. The WCAB denied reconsideration and adopted the report of the WCJ. Defendant sought judicial review.

The Court of Appeal cited the case of *Beverly Hilton Hotel v. WCAB* (2009) 74 CCC 927, in which it was held that vocational rehabilitation awards that were final by January 1, 2009 could be enforced, but for rehabilitation awards that were not final by that date, neither the WCAB nor a court had the jurisdiction to award such benefits.

The Court found that that there was no defect in the defendant's notice of appeal and that it was timely filed. However, the WCJ and the Board imposed a further jurisdictional requirement of filing a DOR, based on an administrative regulation. This conclusion, in the opinion of the Court, was not logical. There was no basis for giving 8 CCR §10955 a jurisdictional effect. While the failure to file a DOR may have resulted in staying the appeal until the defect was cured and might have even given rise to sanctions, it was quite another matter to actually void the appeal. The Rehabilitation Unit dealt with the appeal as one that was properly perfected. Furthermore, applicant made no mention of 8 CCR §10955 in the response he filed to the defendant's appeal.

The Court annulled the decision of the WCAB and remanded the matter with instructions.

Serious & Willful Misconduct/Statute of Limitations

T & T Construction v. WCAB (Hillman) (2012) 77 CCC 501, Court of Appeal,
Third Appellate District, unpublished opinion.

Applicant sustained an industrial injury on August 25, 2008 that resulted in his death. On August 20, 2009, his widow's attorney filed a petition for serious and willful misconduct but didn't serve it on the employer. Subsequently, on November 6, 2009, an amended petition was filed with the WCAB and served on the employer. The employer argued that because the petition was not served within the statutory one year period, the claim was barred by the statute of limitations. The issue was submitted for decision without testimony and the WCJ found that the claim was not barred. On reconsideration, the WCAB adopted the report of the WCJ in which he stated that the delay did not seem sufficiently egregious to warrant barring a claim that was timely filed. The employer then sought judicial review.

The Court of Appeal noted that the statute, Labor Code §5407, requires that proceedings be "commenced" within 12 months from the date of injury. It cited two civil cases for the proposition that the term, "commenced" connotes filing and not both filing and service. The employer had relied on language in Labor Code §5400 that provides that "no claim to recover compensation shall be maintained unless . . . there is served upon the employer notice in writing." However, §5401 goes on to say that The failure to give notice under section 5400, or any defect or inaccuracy in a notice is not a bar to recovery . . . if it is found as a fact in the proceedings for the collection of the claim that the employer was not in fact misled or prejudiced by such failure."

The Court therefore found that service is not essential to the commencement of an action and the adequacy of notice is measured by whether the employer was misled or prejudiced by the defect. The WCJ found that the employer wasn't aggrieved by the

belated service and the employer didn't contest that finding. Therefore, the petition for writ of review was denied.

AOE/COE/Going and Coming Rule

California Department of Corrections and Rehabilitation v. WCAB (DeCoursey)
(2012) 77 CCC 767, Court of Appeal, Fourth Appellate District, Division Two,
unpublished opinion.

Applicant was a correctional officer at a facility located in a relatively remote area. There were nine officers who staffed the facility in three shifts that were rotated every three months. Each shift had to be fully staffed. The officers sometimes swapped shifts which was beneficial to the employer because it reduced overtime costs. The officers were permitted to swap shifts without first obtaining approval.

Applicant swapped shifts at the request of another officer. On his way to work, he was involved in an accident in which he was seriously injured. The WCAB found that the "special mission" exception to the going and coming rule applied because the swapping of the shifts was done with the implied approval of the employer and for the employer's financial benefit. Additionally, the Board found that the commute was extraordinary since the change of shift forced the applicant to commute in dark, frosty and cold weather. Defendant sought judicial review of the Board's decision.

The Court of Appeal noted that the going and coming rule bars injuries sustained during the commute to and from work. However, an exception is made in the case of commutes constituting a special mission. To support the existence of a special mission, the underlying activity must be (1) special, that is, extraordinary in relation to the employee's routine duties, (2) within the course of the employee's employment, and (3) the activity was undertaken at the express or implied request of the employer and for the employer's benefit.

The Court found that shift swapping was clearly of benefit to the employer in that it helped to ensure employees would be present for each shift without the supervisor having constantly to shuffle schedules to accommodate absences and, to an uncertain extent, it may have helped it to avoid incurring overtime payment. However, it could not conclude that applicant was rendering extraordinary service to his employer simply by showing up for work in another employee's place to perform routine duties. Shifts were rotated every three months and swapping shifts was a generally accepted practice and consistent with the customary manner in which the facility operated.

Regarding the road conditions on the morning of the accident, the Court observed that the Board had confused the requirements for the special risk exception to the Going and Coming Rule which requires proof that (1) but for the employment, the injured worker would not have been at the location where the injury occurred, and (2) the risk was distinctive from that of the public generally. The Court did not find that the road conditions existing at the time of the commute justified application of the special risk

exception. The risk that applicant faced was no different than that of anyone else on that road that morning.

Finally, the Court noted that it would be anomalous to hold that an employee who has agreed to work the shift of another employee is entitled to workers' compensation benefits for injuries received while traveling to work, whereas the other employee whose place he is taking would not be entitled to such benefits if injured during his commute. Thus, the Board's order was annulled.

A dissenting opinion expressed the opinion that applicant's trip was a special activity that was not only encouraged and authorized by his employer, but was performed for the direct benefit of his employer.

Employment

County of Riverside v. WCAB (Taylor) (2012) 77 CCC 1033, Court of Appeal, Fourth Appellate District, Division Two, unpublished opinion.

Applicant was a member of a group known as the "Mounted Posse Program" established by the Sheriff of defendant County. The mission of the posse is to assist the Sheriff's Department in its mission and operations. Members are trained in such functions as traffic control and crowd management, crime scene protection, dealing with the public, and first aid. All riders and their horses must regularly be tested for "qualification" skills, which include simulated exposure to gunfire. During training, applicant's horse spooked at the firecrackers. She was thrown and suffered injuries.

The WCJ found that applicant was not a covered employer. However, the WCAB granted her petition for reconsideration and reversed, relying chiefly upon Labor Code §3366, which provides for employee status to persons "engaged in the performance of active law enforcement service as part of the posse comitatus or power of the county". Defendant sought judicial review.

The Court of Appeal disagreed that the "mounted posse" of which applicant was a member was the same thing as a "posse comitatus." The concept of the "posse comitatus" derives from the common law and involves "the duty, of every citizen, when called upon by the proper officer, to act as part of the posse comitatus in upholding the laws of his country" in such activities as helping to apprehend escaped criminals and assisting in preventing the commission of any criminal offense. Per Penal Code §150, a refusal to "join the posse comitatus or power of the county" is punishable by a fine. Applicant's membership in an auxiliary group, which exists at least in part for ceremonial and publicity purposes, is not the same as being engaged in assisting law enforcement in an evolving, and possibly precarious, situation.

Applicant's situation is governed by Labor Code §3352(i) which excludes from the definition of "employee" "[a]ny person performing voluntary service for a public agency . . . who receives no remuneration for the services other than meals, transportation,

lodging, or reimbursement for incidental expenses.” While applicant was providing a valuable service, so do all volunteers. The law provides no basis for treating a volunteer to the Sheriff’s Department differently from a volunteer at a school or a public hospital.

The Board had also relied on the case of *Laeng v. WCAB* (1972) 37 CCC 185, in which the Supreme Court held that a “tryout” in which the employment applicant attempts to demonstrate particular skills constitutes service to the employer. The Court found this case not to be applicable because applicant was not applying for a regular position as a sheriff’s deputy. Rather, she was training her horse in order to maximize its performance in a volunteer auxiliary group. The Court therefore annulled the WCAB’s decision.

Denials of Writs of Review

Writ denied cases are not written opinions of the Courts of Appeal, but are editorial summaries of WCAB decisions. These cases are citable and may serve as guidance, particularly for otherwise unsettled issue, but do not constitute binding legal precedent.

Apportionment

Slagle v. WCAB (2012) 77 CCC 467, Court of Appeal, Second Appellate District, Division Six, writ denied.

Applicant was referred to an AME to evaluate his industrial injury to his right hip and knee. The AME apportioned 20 percent of the PD to factors unrelated to the industrial injury. In his deposition, the doctor testified that at the time of his knee surgery, Applicant had degenerative changes that couldn’t possibly have developed in the time that had elapsed since the injury. Upon questioning by Applicant’s attorney about the relationship between the degeneration in Applicant’s knee and his age, the doctor said, “the degenerative findings in his knee are related to the fact that he’s 64 years old. I don’t think it is unremarkable for a 64-year-old person to have some degenerative changes in their knee.”

In her decision, the WCJ followed the AME’s opinion on apportionment. Applicant filed a petition for reconsideration arguing that the apportionment constituted unlawful age discrimination under Government Code § 11135. The WCAB granted reconsideration, but agreed with the WCJ’s opinion that the AME had not apportioned to age. The Board noted that while there may be a relationship between age and degenerative changes, apportionment to degenerative changes that is supported by substantial evidence in the record does not constitute age discrimination in every case involving an older person. Applicant filed a petition for writ of review that was denied.

Liens/Home Health Care

Allgreen Landscape v. WCAB (Mota) (2012) 77 CCC 541, Court of Appeal, Fourth Appellate District, Division Three, writ denied.

Applicant suffered a devastating industrial injury that resulted in an award of 89 percent PD plus future medical treatment. Thereafter, Applicant's wife filed a lien for reimbursement of home health care that she had provided to her husband. At the lien trial, she offered un rebutted testimony that she came to the United States after being granted legal permission to do so, in order to care for him. She was taught how to bathe him, take him for a walk, and what to do when he left the hospital. Since that time she had taken care of him day and night. She offered expert testimony to establish the value of her services.

The WCJ found in applicant's favor for services performed within the time limits of the lien statute of limitations in Labor Code §4903.5. However, she disallowed the prior charges. Both Applicant and Defendant petitioned for reconsideration. Defendant contended that it had no liability for home health care because such services were not requested by a PTP subject to the UR process, that requiring it to pay Mrs. Mota would constitute a constructive retroactive hiring in violation of the Immigration Reform and Control Act of 1986, and that the majority of services provided by Mrs. Mota were rendered at the level of an unskilled healthcare worker rather than at an LVN level. Applicant contended in substance that her claim for reimbursement for services provided outside of the statute of limitations was not barred. The WCJ recommended that reconsideration be denied.

The WCAB granted reconsideration and found that defendant had presented no authority for the proposition that it is not liable for any medical services for which it has not had the opportunity to engage in utilization review. In fact, the initial phase of the home care services predated UR. Furthermore, at no time had Mrs. Mota been an employee of the defendant. If a physician renders medical treatment, that physician does not become the defendant's employee.

Regarding defendant's contentions concerning the level of care, applicant had been evaluated by an AME who stated he required "an LVN for the purpose of home health care, and that care should be provided the patient during the wakeful hours, approximating 16-18 hours per day, depending on the patient's time when he retires to slumber and awakens in the morning." Defendant did not cross-examine the AME on his opinion.

Regarding applicant's petition, the Board disagreed with the WCJ's interpretation of Labor Code §4903.5. The lien was filed more than 6 months after the C & R and more than five years after the date of injury. However, since her services have been provided continuously to date, she had an unlimited period of time to file her lien within one year from the date of services. Defendant had argued that the only logical interpretation of the statute was that the lien claimant is limited to those services rendered in the year

preceding the fling of the lien. The Board felt that interpretation might be plausible in the case of services intermittently provided, but not if the services were continuous.

Defendant filed a petition for writ of review which was denied. The Court found no reasonable basis for the petition and awarded attorney fees to the applicant.

Statute of Limitations

County of Orange v. WCAB (Barrow) (2012) 77 CCC 558, Court of Appeal, Fourth Appellate District, Division Three, writ denied.

Applicant, a deputy sheriff, was diagnosed with spindle cell sarcoma of the lining of the heart in March 2001. He filed a claim form for chest pain/pressure at work. In June 2008, he suffered a heart attack at work. The following month he retained counsel and filed four Applications. He later underwent a heart transplant in 2010. The AME diagnosed coronary artery disease, pulmonary disease, and esophagitis all of which were induced by the radiation treatment for his spindle cell cancer. Defendant denied the claims based on the statute of limitations.

Applicant testified that he did not litigate his cancer claim in 2001 because he was focused on getting back to work and getting better. He did not pursue his case after he returned to work because he was not aware that he had a basis for a claim since his condition had improved. He did not learn that his cancer may have caused his heart problems until 2008. Between 2007 and June 2008 he was told his cancer treatment may have damaged his heart. Applicant did not recall receiving defendant's letters denying his claim in 2001.

After a trial, the WCJ found that applicant sustained a CT injury from 10/26/84 to 3/28/2001 in the form of spindle cell carcinoma, coronary artery disease, pulmonary restrictive lung disease, radiation-induced cardiomyopathy, and esophagitis. The WCJ found that the date of injury pursuant to Labor Code §5412 was the date in 2009 that the AME found a CT. Defendant filed a petition for reconsideration.

The WCAB noted that the date of a CT injury under Labor Code §5412 is the date the employee first suffered disability and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by employment. Pursuant to §5405 the one year statute of limitations in CT cases begins to run when there is a concurrence of both knowledge and disability. The burden of proof rests with defendant to establish that applicant knew or reasonably should have known, at the time he was diagnosed with cancer, that the cancer was caused by his employment.

Applicant's un rebutted and credible testimony indicated that after his boss became aware of his cancer; his boss presented him with a claim form for his signature. Applicant further testified that he did not know what was wrong with him or whether it was work related, and that when his boss provided the claim form, they did not discuss it. After the applicant returned to work following his successful cancer treatment, he was not aware

that he was pursuing a claim for a work injury against his employer. The application was filed July 2008.

Defendant relied on the case of *Neilsen v. WCAB* (1985) 50 CCC 104 in which it was held that the applicant's knowledge that his condition was industrial was sufficient, even in the absence of medical confirmation. However, in that case, the applicant testified that he knew right from the start that his disability was caused by his job. The Board found the present case to be much more similar to *City of Fresno v. WCAB (Johnson)* (1985) 50 CCC 53. In *Johnson*, the court found that the applicant could not be charged with knowledge that his disability was work-related without being advised of causation by a physician, unless the nature of the applicant's disability and his qualifications, training, or intelligence were such that he should have recognized the relationship between his job and his injury.

In this case nothing in the record proved that applicant's training, intelligence and qualifications should have enabled him to recognize the causative relationship between his employment and the disability that was caused by his cancer prior to being so advised by a physician. The Board also found it "somewhat paradoxical" for defendant to suggest that applicant should have recognized the industrial source of his medical problems when defendant denied the injury. Thus, the WCAB affirmed the decision of the WCJ. The defendant filed a Petition for Writ of Review that was summarily denied.

General and Special Employment/CIGA

County of Los Angeles v. WCAB (Polanco) (2012) 77 CCC 644, Court of Appeal, Second Appellate District, Division Two, writ denied.

Applicant claimed to have sustained industrial injuries while working for defendant County through a temporary agency. The insurance carrier for the temporary agency became insolvent and liability for its claims was assumed by CIGA. Relying on Insurance Code §1063.1(c), CIGA argued that the self-insured County was liable for any benefits payable to Applicant because it constituted "other insurance."

The WCJ found that the County was liable for providing workers' compensation benefits. In his opinion on decision, he reviewed the law concerning general and special employers. The insurer of the general employer which in this case was the temporary agency, is liable for the entire cost of compensation unless the special employer had the employee on its payroll the time of injury. In that case the special employer's insurer is solely liable. The County never had the applicant on its payroll. However, as a result of the general employer's insolvency, its claims were taken over by CIGA. Thus it was necessary to determine whether the self-insured County qualifies as "other insurance" such that CIGA would be relieved of liability.

In order to avoid its joint and several liability, the special employer must establish that it excluded itself from such liability. It is not enough to merely show the general employer obtained workers' compensation coverage. CIGA's liability cannot be determined solely

by looking at the terms of the agreement between the general and special employer. There must be evidence of the intention to expressly exclude the special employer from liability.

In this case the contract with the temporary agency did obligate the agency to procure workers' compensation insurance for benefit of the County's special employees. The contract did include an indemnification provision for the benefit of the County. Nonetheless, the WCJ concluded that this was not sufficient to overcome the presumption that the County remains jointly and severally liable to the injured worker as a matter of law. The contract provision merely identified the rights and liabilities of the general and special employers as between themselves and left intact their legal responsibility to the employees.

The application for a certificate of consent to self-insure from 1979 was introduced into evidence, but contained nothing that indicated the intent to exclude temporary employees. No explanation was offered as to why such provision could not somehow have been inserted in the application or in the accompanying attachment. There was no indication of any legal prohibition against excluding the temporary employees. Applicant was an employee of the County as well as of the temporary agency. Thus, the County was jointly and severally liable to that employee as its employer, and it offered no evidence showing that that avenue of recovery was unavailable to applicant whatever the County's recourse with respect to the temporary agency.

The County filed a Petition for Reconsideration contending that liability should have been imposed on CIGA. The WCJ indicated in his report and recommendation that the County was clearly a special employer and the general employer was to cover the applicant for workers' compensation benefits. However there is nothing to indicate that the County meant to relieve itself of its joint and several liability to the applicant if the carrier was unable to provide the benefits. While the County may have reasonably expected PDQ and its carrier to be in a position to pay workers' compensation benefits there is no evidence to indicate that the County did not intend to be available as a secondary source if necessary. As such, the county is available as insurance within the meaning of insurance code 1063.1 (c) (9).

The WCAB denied reconsideration. The defendant then sought judicial review which was denied.

104 Week TD Cap

Rhine v. WCAB (2012) 77 CCC 666, Court of Appeal, Second Appellate District, Division Six, writ denied.

Applicant sustained an industrial back injury on 3/17/2009. Defendant paid temporary disability and then terminated the temporary disability benefits because of the 104 limitation period had been reached. Thereafter, applicant underwent spinal fusion surgery. He claimed temporary disability beyond 104 week based on defendant's alleged

unreasonable delay in providing medical care, and contended in pertinent part that defendant was estopped to deny the additional TD. The WCJ found no additional temporary disability benefits were payable based on the clear language of Labor Code §4656(c)(2) limiting TD to 104 weeks.

Applicant sought reconsideration, contending that the delay in providing him with appropriate medical treatment inhibited his return to the labor market which constituted a detriment that supported a finding of estoppel. He also contended that the 104 week limitation was a statute of limitations.

The WCJ recommended that reconsideration be denied. She indicated there was no suggestion in the record that applicant would have actually undergone surgery sooner or that the outcome would have been different. Therefore, there was no showing of detrimental reliance. Nor was there any legal basis to support the proposition that a delay in medical treatment alone is sufficient to estop the defendant from asserting the 104 week limitation on TD. There is no legal basis to support that proposition. The WCJ added in relevant part that the applicant received all TD benefits allowable under the law. Furthermore, to treat the 104 week cap on TD as a statute of limitations would be to reject the clear meaning of the statute.

The WCAB denied reconsideration. The applicant filed a Petition for Writ of Review that was also denied.

Death Benefits

Davis v. WCAB (2012) 77 CCC 722, Court of Appeal, Second Appellate District, Division Two, writ denied.

The employee sustained a fatal industrial injury. The parties stipulated that Milan Davis, a minor child, was a total dependent and Carol Davis was a partial dependent. The WCJ awarded death benefits of \$250,000 to Milan and \$25,000 to Carol. Milan claimed entitlement to death benefits pursuant to Labor Code §4703.5 which provides for payment of benefits “until the death of a child physically or mentally incapacitated from earning.” He presented testimony that he had been diagnosed with Asperger’s syndrome. The WCJ deferred the determination of that issue until Milan reached age 18.

Applicant Carol filed a petition for reconsideration claiming that she should have been awarded \$40,000 and not \$25,000, because that figure represents the difference between the maximum death benefit of \$290,000 and the \$250,000 that Milan was awarded. Defendant also sought reconsideration of the Order reserving jurisdiction over Milan’s claimed entitlement under Labor Code §4703.5.

Regarding Carol’s petition, the WCAB pointed out that \$290,000 is the maximum amount for more than one total dependent. In cases of one total dependent and one or more partial dependents, the total death benefit can range from a minimum of \$250,000 to a maximum of \$290,000. However, each individual partial dependent is still subject to

the \$25,000 limit set forth in Labor Code §4703. These limits operate independently of one another and are not mutually exclusive. Therefore in this case it was proper for the WCJ to award \$25,000 to the partial dependent.

Regarding the defendant's petition, the WCAB granted reconsideration, rescinded the reservation of jurisdiction, and returned the matter to the trial level so that the WCJ could decide the issue. The Board concluded that it was Milan's burden to present evidence showing that it is reasonably probable that he will be incapacitated from earning after he reaches the age of majority. Having failed to present such evidence, any claim for additional benefits beyond the amount specified in Labor Code §4702 or beyond his 18th birthday must be denied.

Both applicants filed petitions for writ of review that was denied. Carol's petition was denied and the Court noted that Labor Code §4703 places an absolute limit on death benefits for a partial dependent. However, Milan's petition was denied as premature because there was no final decision or award of the WCAB.

Jurisdiction

Insurance Company of Pennsylvania v. WCAB (Sepulveda) (2012) 77 CCC 734, Court of Appeal, Fourth Appellate District, Division Three, writ denied.

On April 5, 2007 the parties entered into a Stipulated Award of TD which listed three case numbers. However, the only signatures on the stipulations were those of the applicant's attorney and the attorney for one of the defendants. Applicant subsequently claimed a new period of TD. After a trial, the WCJ found that the WCAB did not have jurisdiction to award further TD more than five years after the dates of the injuries. Applicant petitioned for reconsideration claiming that the Stipulated Award was not a final award.

The WCJ recommended that reconsideration be denied as to the defendant whose attorney signed the stipulations. However, he recommended that it be granted in the other two cases. He noted that the WCAB has no jurisdiction when a final award and order issues, unless a petition to reopen has been filed within five years from the date of injury. To be awarded additional TD after a final award has issued the applicant must file a petition to reopen within five years of the date of injury. Furthermore, the TD period must begin prior to the expiration of the five years and continue beyond that point without a break.

The WCJ further noted that neither Labor Code §5410 nor §5803 provide that the WCAB loses jurisdiction until a final adjudication of all issues occurs. Although the WCJ indicated the stipulated award was final in the case that was the subject of the Stipulated Award, he acknowledged that there was no final resolution of TD with respect to the two injuries that were not part of the stipulations. The WCAB did not lose jurisdiction over those two claims. Based on applicant's credible testimony and the treating physician's reports, the WCJ concluded that applicant was entitled to the additional TD.

The WCAB granted reconsideration and agreed with the WCJ's recommendation. The Board noted, pursuant to Labor Code §4656, there is no time limit on TTD payments and they may be awarded to an applicant who suffered an injury between January 1, 1979 and April 19, 2004. The Board explained that it has jurisdiction to award TD for a period that commences more than five years after the date of injury if the issue of entitlement to TD remains pending and unresolved when there has been no prior decision and when jurisdiction has continued. The Board also noted that it was not required to make an initial determination regarding TD within five years from the date of injury. Therefore, there was jurisdiction to make an award of additional TD.

Defendant filed a petition for writ of review which was summarily denied.

Psychiatric Injuries/Six Month Exclusion

Production Framing Systems v. WCAB (Dove) (2012) 77 CCC 756, Court of Appeal, Third Appellate District, writ denied.

Applicant was injured while working with 10 other workers to tilt a heavy prefabricated wall that was lying on the ground into an upright position. When the wall had been lifted to a 45 degree angle, a bolt came loose, causing one of the other workers to change his position so that the wall fell on applicant, striking his right shoulder and neck, and pinning his leg beneath the wall.

In addition to his orthopedic injury, applicant claimed a psychiatric injury which the defendant denied. The matter proceeded to trial and the WCJ found that he had been on the job with the special employer for less than 6 months, although he had worked for the general employer whose claims were covered by CIGA for more than 6 months. The WCJ found that the injury was not sudden and extraordinary and was therefore barred by Labor Code §3208.3(d). An award for benefits was made solely against the insurer for the special employer. Both applicant and the insurance carrier sought reconsideration. The WCJ recommended that his decision be amended to include the psychiatric injury.

The WCAB granted reconsideration and analyzed the facts in order to determine whether the collapse of the wall was sudden and extraordinary. There was no doubt that it was a sudden occurrence when some of the men that were lifting the wall let go. The Board cited language in *Matea v. WCAB (2006) 71 CCC 1522* as follows:

“[W]e believe that the Legislature intended to except from the six-month limitation psychiatric injuries that are caused by “a sudden and extraordinary employment condition,” and not by a regular or routine employment event ...

“[I]f an employee carries his or her burden of showing by a preponderance of the evidence that the event or occurrence that caused the alleged psychiatric injury *was something other than a regular and routine employment event or condition, that is, that the event was uncommon, unusual, and occurred unexpectedly,* the

injury may be compensable even if the employee was employed for less than six months. (emphasis added)”

Here, applicant testified that in his more than ten years of experience as a carpenter and foreman on construction sites he had been involved in lifting numerous walls, but had never heard of a wall falling. Further support was provided by the report and testimony of CIGA’s construction expert who expressed the opinion that the event was extraordinary. Likewise, applicant’s foreman testified that he had never heard of a wall falling while working for this or any other employer.

Thus, the WCAB held that Applicant met his burden of proving that his psychiatric injury was caused by a sudden, unusual, unexpected, and extraordinary employment condition. It additionally held that the carrier for applicant’s special employer, was “other insurance” and CIGA was not liable for benefits. The insurance carrier filed a Petition for Writ of Review which was denied. The Court found no reasonable basis for the petition and remanded the matter to the WCAB to make an award of attorney fees.

Res Judicata

City of Pasadena v. WCAB (Williams) (2012) 77 CCC 822, Court of Appeal, Fourth Appellate District, Division Three, writ denied.

Applicant asserted a CT injury to the heart in the form of hypertensive heart disease while employed as a police officer from 6/1/82 to 12/1/2002. On 10/25/06, Applicant had obtained a stipulated Award in connection with a prior claim of a CT from 6/1/82 to 5/29/2002 that included hypertension. Defendant contended that the current claim was barred by res judicata. The WCJ agreed with defendant and found that Applicant’s claim of heart injury was subsumed in the prior stipulated Award and barred by res judicata. Applicant sought reconsideration of this finding.

The WCAB found that hypertension and hypertensive heart disease were not the same thing. It noted that case law has established that the mere existence of hypertension does not equate to “heart trouble” and thus trigger the heart trouble presumption of Labor Code §3212. The fact that hypertension sometimes develops into heart disease does not negate the fact that they are distinct conditions. Therefore, the claim was not barred by the doctrine of res judicata.

Defendant sought reconsideration of the WCAB’s decision which was denied. It then filed a Petition for Writ of Review which was also denied. The Court found no reasonable basis for the petition.

Statute of Limitations

Geran v. WCAB (2012) 77 CCC 999, Court of Appeal, Second Appellate District, Division Seven, writ denied.

Applicant worked in the wardrobe department of a studio, delivering costumes and supplies to the set. Her job required heavy lifting and carrying. She developed physical problems that ultimately caused her to stop working in 2005. She testified that she realized that the job was causing injury and in 2006 her doctor told her that her physical problems were work-related.

The WCJ found that applicant's claim was not barred by the one-year statute of limitations in Labor Code §5405 because while she knew her injuries were work-related, she did not know she was entitled to workers' compensation benefits. Defendant petitioned for reconsideration and in a split decision, the WCAB reversed the trial judge.

The Board majority found that applicant's date of injury was no later than 2006 when her doctor advised her of the connection between her disability and her former job duties. Thus, her Application filed in 2010 was time barred. While applicant claimed that the statute was tolled by defendant's failure to put her on notice of her rights, she introduced no evidence to prove that defendant had knowledge or notice of her injury sufficient to trigger a duty to investigate.

The dissenting Commissioner felt that the statute of limitations doesn't begin to run until the employee is aware of a legal entitlement to workers' compensation and therefore, would have affirmed the WCJ's decision. In response, the majority commented that applicant's deposition testimony supported a conclusion that she was aware of her legal rights. Even if she wasn't, the panel majority declined to follow any prior panel decisions that held that the running of the statute of limitation was contingent on the applicant having her full legal rights explained to her by an attorney.

Applicant filed a Petition for Writ of Review that was denied.

Jurisdiction

Barrow v. WCAB (2012) 77 CCC 988, Court of Appeal, Fourth Appellate District, Division Three, writ denied.

Applicant claimed to have sustained an industrial injury while employed as a professional football player in various locations by various teams, including that of the out of state defendant. The matter was tried and the only relevant witness was applicant's long time agent, a Los Angeles attorney who had negotiated all of applicant's contracts. Applicant communicated by telephone to the agent, at his office, that he had accepted defendant's offer of employment, and the agent had communicated that acceptance to defendant via an exchange of faxes.

The WCJ found that California had subject matter jurisdiction over the dispute. Defendant filed a Petition for Reconsideration. The WCAB granted reconsideration and rescinded the WCJ's decision, finding, in relevant part that applicant's contract of hire with defendant was not made in California, and that the WCAB had no jurisdiction over applicant's claim against defendant for an alleged industrial injury sustained outside California.

Neither defendant nor applicant was located within California at the time of acceptance of the contract and the only connection to California came through the actions of applicant's agent. The WCAB acknowledged that agents may bind parties to an employment contract for the purposes of WCAB extraterritorial jurisdiction and indicated further that California had adopted the rule that an oral contract consummated over the telephone is deemed made where the offeree utters the words of acceptance. However, since applicant travelled from his home to Texas to sign the contract two days after the agent's communication of the acceptance, the Board concluded that the parties believed the contract required that applicant personally express his acceptance.

Applicant filed a Petition for Writ of Review that was denied by the Court of Appeal.

Compromise & Release Agreements

Save Mart Supermarkets v. WCAB (Stewart) (2012) 77 CCC 915, Court of Appeal, Third Appellate District, writ denied.

Defendant paid applicant \$5,818.92 in PD advances. Subsequently, the parties entered into a C & R for \$10,900 with deductions of \$2,070 for PD advances, \$2,070 to EDD and \$1,635 in attorney fees, leaving a balance of \$5,125 payable to the applicant. Defendant issued payment to applicant of \$1,376.08 which reflected credit for a lump sum PD advance. Applicant contended that the defendant waived credit for that payment. Neither the C & R nor the OAC & R indicated a waiver of credit for PD advances.

The WCJ found that there was a mutual mistake of fact concerning the amount of credit for the PD advances. He also stated that he wouldn't have found the C & R to be adequate had he known the applicant would only receive \$1,376.08 because that amount wasn't sufficient to cover the costs of medical treatment recommended by the AME. On this basis, he awarded the applicant the additional \$3,748.92 reflected in the C & R.

Defendant filed a Petition for Reconsideration. In his report and recommendation, the WCJ noted that since neither party had requested rescission, but rather a decision concerning the amount to which applicant was entitled, he gave the C & R the same meaning that he had understood it to have when he originally found it to be adequate. The WCAB summarily denied reconsideration. Defendant then sought judicial review which was denied.

WCAB Panel Decisions

Judicial notice of WCAB Panel decisions may be taken under Evidence Code 452(d) which provides that judicial notice may be taken of the records of any court of this state. They may serve as guidance, but do not constitute binding legal precedent.

Permanent Disability/Diminished Future Earning Capacity

Dahl v. Contra Costa County (2012) ADJ 1310387, 2012 Cal. Wrk. Comp. P.D. LEXIS 173, 40 CWCR 117, WCAB Panel Decision.

Applicant was evaluated by an AME who found 59% PD without apportionment. At trial, applicant contended that her PD should be awarded at a higher rate because her DFEC was greater than reflected in the PDRS rating. Both parties offered the testimony of vocational rehabilitation experts. The WCJ rejected applicant's argument on the premise that that under the Court of Appeal's holding in *Ogilvie v. City and County of San Francisco* (2011) 76 CCC 624, an injured worker could not rebut the Diminished Future Earning Capacity (DFEC) adjustment factor contained in the PDRS by expert testimony unless it was shown that the injury caused a total loss of future earning capacity. Applicant petitioned for reconsideration.

The WCAB noted that in *Ogilvie*, the Court set forth three methods of rebutting the DFEC portion of the rating: (1) a factual error in applying the formula (2) that the medical condition was not accurately reflected in the generalized data used for injuries and impairments (3) to show the applicant's injury had a negative effect on applicant's rehabilitation in accordance with *LeBoeuf v. WCAB* (1983) 48 CCC 587. The WCAB agreed with the WCJ's conclusion that neither the first nor the second method of rebuttal applied in this case. However, it disagreed with his pronouncement that the *LeBoeuf* analysis only applies to cases involving 100 percent PD.

The Board found the Court's opinion to be consistent with the opinion expressed by Commissioner Caplane in her dissent in its earlier en banc decisions in *Ogilvie* as follows:

“The percentage of her actual loss of future earnings as demonstrated by both parties' expert witnesses is the most accurate reflection of her diminished future earning capacity. Therefore, her permanent disability rating should be the percentage of her lost future earning capacity...

“The method that I propose is comprehensive, analytically sound, and operationally simple. It would require vocational or other experts to estimate the injured employee's post-injury earning capacity based upon medical opinions evaluating her permanent impairments and earning capacity had she

not suffered the industrial injury, both to be determined from the permanent and stationary date through her projected years in the work force. Such expert testimony is common in marriage dissolution cases, personal injury cases, and employment cases.”

Although the Court of Appeal annulled the en banc opinion in *Ogilvie*, it did not reject the opinion of Commissioner Caplane as expressed in her dissent. The WCAB believed that application of a *LeBoeuf* type of analysis in cases of partial permanent disability requires expert opinion on the effect of the injury’s impairment on the worker’s amenability to rehabilitation and the effect of that on DFEC. Such an analysis can be done even where there is less than total permanent disability as in this case where the Board found that applicant successfully rebutted the DFEC.

Therefore, the WCJ’s decision was rescinded and the matter was returned to the trial level for further proceedings and a new decision by the WCJ concerning applicant’s DFEC and its relationship to the percentage of her permanent disability.

Panel QME Procedure

Flores v. United Domestic Workers of America (2012) ADJ 7343485, 2012 Cal. Wrk. Comp. P.D. LEXIS 282, 40 CWCRCR 219, WCAB Panel Decision.

After 30 days had elapsed from the date of a QME evaluation without the report having been served, the defendant filed and served a letter “reserving its right” to object to the late report and request a new panel. Shortly thereafter, the PQME served his report. Defendant requested a new panel which was granted by the WCJ. The applicant filed a Petition for Removal.

The WCAB cited 8 CCR §31.5(a)(12) which provides for a replacement panel where the evaluator failed to meet the 30 day deadline and the party requesting the replacement objected to the report on the grounds of lateness prior to the date the evaluator served the report. Defendant’s reservation of rights letter was not a proper objection. A party that objects to a QME report on the basis of timeliness must unequivocally object to that report and request a replacement panel prior to the date the report is served. A party cannot “reserve the right” to object to a QME report on the basis of lateness, wait until it receives the report, and then object if it does not like the content of the report. Therefore, applicant’s petition was granted and the WCJ’s order was rescinded.

Panel QME Procedure

Guillen v. Adir International (2012) ADJ 6896705, 2012 Cal. Wrk. Comp. P.D. LEXIS 288, WCAB Panel Decision.

A QME panel issued on August 9, 2011. On August 15, applicant crossed Dr. Schwartz off the panel list and faxed the list to defendant. On August 17, 2011 the defendants wrote a letter to applicant’s attorney proposing Dr. Schwartz as an AME. On August 17,

defense counsel wrote a letter striking Dr. Gumbs from the panel. In neither letter did defendants make reference to applicant striking Dr. Schwartz and in both letters defendant asked the applicant to make a timely striking of a physician from the list and if applicant failed to timely strike a physician defendants would select a physician from the list. Applicant failed to timely strike a physician from the panel other than the letter of August 15, 2012. Defendant scheduled an examination with Dr. Schwartz. Applicant failed to attend the exam. Both parties requested hearing before a WCJ on the issue. The WCJ found applicant's striking on August 15, 2011 a nullity as being premature and allowed the exam with Dr. Schwartz. Applicant filed a petition for reconsideration.

The WCAB dismissed the petition for reconsideration as not having been taken from a final order, but addressed it as a petition for removal. The Board indicated that while Labor Code §4062.2(c) does contemplate that the 10 day period from panel assignment shall be used to confer on an AME, the section does not provide that a strike during that time is automatically a nullity. If a party strikes a name during the 10 day period, the responding party has the remainder of the ten day period plus 3 working days to strike a name from the list. The responding party must communicate that strike on or before the 13th day after the assignment, without using the additional 10 days outlined in section §4062.2(d) to simultaneously issue notice of the PQME appointment and the strike implied by the making of the appointment. This will prevent the initial striking party from believing that the responding party has not timely stricken a name so as to allow it to select a physician.

Applicant had requested a new panel. However, since both sides timely struck a physician from the list, the WCAB ordered the QME exam with the third physician on the list.

Liens/Statute of Limitations

Villatoro v. Kern Labor Contracting (2012) ADJ 3637976, 2012 Cal. Wrk. Comp. P.D. LEXIS 321, 40 CWCR 194, WCAB Panel Decision.

Lien claimant provided applicant with outpatient surgery in 2001, billed \$7,500, and received approximately \$1,000 from the insurance carrier. The case was resolved by Compromise and Release in 2002. Lien claimant didn't file its lien until 2011. At trial, the parties stipulated that the reasonable value of the lien was \$6,100. However, the defendant contended that the lien was barred by the Statute of Limitations in Labor Code §4903.5. On this basis, the WCJ disallowed the balance of the lien claim.

The lien claimant petitioned for reconsideration contending that pursuant to §4904(a), defendant's timely receipt of billings and reports created an obligation to serve it with the C & R and that the failure to do so tolled the Statute of Limitations.

The WCAB noted that according to the first sentence of Labor Code §4904(a), a medical provider's bill that sets "forth the nature and extent of any claim that is allowable as a lien" constitutes a lien in proceedings before the Appeals Board. Thus, the lien claimant's

billing effectuated a lien prior to the enactment of §4903.5 which established a statute of limitations for lien claims. However, the statute of limitations was retroactive because lien claimants had a “reasonable time” within which to file their liens.

Lien claimant contended that the defendant was estopped to assert the statute of limitations with respect to its lien. However, the Board rejected that contention. In order to apply the doctrine of equitable estoppel, four elements must be present: (1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury. These elements were not present in this case.

In terms of detrimental reliance, since the lien claimant never object to the defendant’s payment at less than the face value of the bill, the defendant would have no way of knowing that the lien claimant was not satisfied with the payment. Furthermore, it was not good faith and reasonable conduct for the lien claimant to wait 9 years after the partial payment to assert its lien.

Lien claimant also relied on Labor Code §4903.1(b) which requires that “[w]hen a compromise of claim or an award is submitted to the appeals board, arbitrator, or settlement conference referee for approval, the parties shall file with the appeals board, arbitrator, or settlement conference referee any liens served on the parties.” However, the Board found that §4903.5 prevails over §4903.1(b) First, §4903.5 is more specific than §4903.1(b) as to the time limits within which a medical lien must be filed, and §4903.5, as the more specific statute, controls. Second, where earlier enacted and later enacted statutes cannot be harmonized, “the more recent enactment prevails as the latest expression of the legislative will.”

Finally, it was reasonable for the defendant to believe that there was no need to disclose the lien at the time of the C & R, because it had been “resolved” by the partial payment.

Therefore, the WCAB affirmed the WCJ’s decision that the lien was barred by the statute of limitations.

QME Procedure

Lecocq v. Associated Feed & Supply Company, ADJ 7987800, 2012 Cal. Wrk. Comp. P.D. LEXIS 361, 40 CWCR 197, WCAB Panel Decision.

Defendant requested a hearing to address a dispute over the proper specialty of the QME panel. The parties appeared at an MSC and the defendant requested a trial on the issue. However, the WCJ issued a Findings and Order designating the specialty requested by the applicant. Defendant filed a petition for removal claiming violation of due process and inability to create an evidentiary record.

The WCAB rejected defendant's argument that the AD Rules provide that only the parties and the Medical Director can select the specialty. The Board pointed out that 8 CCR §31.1(c) provides that where the Medical Director does not issue a panel within 30 days, the WCJ may order provision of a panel and may designate the specialty of the panel. However, the Board agreed that the WCJ should not have issued the decision out of an MSC. Pursuant to 8 CCR §10353(a), at an MSC, the WCJ "may submit and decide the dispute(s) on the record pursuant to the agreement of the parties." Here, there was no such agreement and the defendant objected to the issue being decided without a trial.

Furthermore, there was no record upon which a decision could be based as required by the WCAB's en banc decision in *Hamilton v. Lockheed Corporation* (2001) 66 CCC 473. Therefore the matter was returned to the trial level with instructions that prior to a trial, the parties must first prepare a pretrial conference statement setting out stipulations and issues and designating documents to be offered into evidence.

Liens/Medical Provider Networks

Chavez v. T. D. Hayes (2012) ADJ 6490669, 2012 Cal. Wrk. Comp. P.D. LEXIS 403, WCAB Panel Decision.

Applicant sustained an industrial injury for which he was promptly provided with treatment in defendant's MPN. The MPN notices were not provided by the employer, nor were they given at the time of the injury. However, the insurance carrier served him with all required notices 17 days after the injury. After treating in the MPN for 6 months, applicant retained counsel and was referred to out of network providers who filed liens. Applicant ultimately entered into a C & R in which he stipulated that the defendant had provided all required MPN notices and at all time had medical control.

At the lien trial, the lien claimants presented applicant's testimony in support of their claim that the MPN was not properly noticed and that applicant had been denied necessary treatment. The WCJ found that applicant's testimony was not credible and that he was repeatedly impeached by the defendant's representative. Finding that there was no denial of care, he decided against the lien claimants who then filed a petition for reconsideration.

The WCAB found no legal support for lien claimants' contention that an employer's alleged failure to provide proper notice of its MPN to the injured worker means that any and all medical treatment procured by the injured worker after he leaves the MPN is entitled to reimbursement. Even if the MPN had not been properly noticed, there was no neglect or refusal to provide medical treatment. Furthermore, the lien claimants failed to meet their burden of proving that their services were reasonably required and that their charges were reasonable.

Venue

Ramiro Valdez-Lopez v. Valley Crest Landscape, Inc. (2012) ADJ 2096625, 2012 Cal. Wrk. Comp. P.D. LEXIS 493, WCAB Panel Decision.

Defendant filed a Petition for Removal after receiving a Notice of Hearing that a lien conference had been scheduled at the Oxnard District Office concerning a case that was venued in Los Angeles. It contended that venue was changed without notice and that the new location presented a hardship and inconvenience.

In denying the petition, the WCAB noted that there had been no venue change. Rather there was merely a transfer of the location of proceedings that fell within the Board's powers to control its own calendars and dockets. Labor Code §5700 allows the Board to adjourn hearings "from time to time and place to place." The inconvenience and hardship on the defendant did not outweigh the public interest in taking necessary means to relieve the backlog of undecided lien issues.

Utilization Review/Attorney Fees

Becerra v. Jack's Bindery, ADJ 3283011, 2012 Cal. Wrk. Comp. P.D. LEXIS 451, WCAB Panel Decision.

Applicant received a Stipulated Award with need for future medical treatment. Her PTP submitted two requests for authorization for treatment based on a worsening of her symptoms which the PTP attributed to both her industrial injury and her current job duties with another employer. Defendant denied the PTP's requests based on the opinions of their UR doctors.

An expedited hearing was conducted. Defendant did not offer its first UR report into evidence. The second UR report was timely but had not been served on the PTP. The WCJ found that the treatment was reasonably required and awarded attorney fees. Defendant filed a petition for reconsideration arguing that its UR denial should have been upheld, that the worsening of applicant's symptoms was caused by a CT injury during her subsequent employment, and that the award of attorney fees was improper.

The WCAB noted that in *SCIF v. WCAB (Sandhagen)* (2008) 73 CCC 981, the Supreme Court held that utilization review of treatment requests is mandatory and failure to meet the deadlines means that, with respect to the particular medical treatment dispute in question, the employer is precluded from using the UR process or any UR report it obtained to deny treatment. An employee is entitled to challenge a procedural defect in the UR process denial by proceeding in an expedited hearing pursuant to Labor Code §5502 in addition to objecting and initiating the §4062 AME/QME process. The defendant is obligated to conduct a timely and proper UR review in order to rely on the UR report to deny the treatment request. Defendant has the burden of proof that the UR procedure was timely and proper. If the defendant does not meet the burden of proof and

the applicant presents substantial medical evidence on the treatment issue a WCJ may properly determine the issue of medical treatment at an expedited hearing.

The defendants in this case did not meet their burden of proving that they conducted timely and proper UR, nor did they prove that they followed UR procedure. The first UR report was not offered into evidence and the other was not properly transmitted to the treating physician as required by 8 CCR §9792.9(b)(4). Thus, the defendant could not rely on the UR report to deny authorization for the treatment. The applicant presented substantial medical evidence to support the requested treatment. Therefore, the WCJ was correct in finding the requested treatment to be reasonably required.

The Board found defendant's argument that it had no liability for the medical treatment to be without merit. There was no evidence in the record that the need for treatment was solely caused by a subsequent CT. In fact, the treating physician specifically stated that applicant's worsening symptoms were caused by both the defendant's injury and a subsequent CT injury.

Regarding the award of the attorney fees the WCAB found that because the UR denial was procedurally defective the failure to authorize the medical treatment was unreasonable. As such an award of fees was proper under Labor Code §5814.5 for the enforcement of an award. Therefore, the petition for reconsideration was denied.

Procedure/Declarations of Readiness to Proceed

Morvari v. Securitas Security Systems, ADJ 2753128, WCAB Panel Decision.

At an MSC, the WCJ set the matter for trial over defendant's objection. Defendant filed a Petition for Removal. The WCAB granted the petition and ordered the matter off calendar on the ground that the DOR filed by applicant was defective. Title 8 CCR 10250(b) requires a declaration stating with specificity what genuine good faith efforts were made to resolve the dispute before the DOR was filed. Here, applicant's attorney merely stated: "CONFERENCE WILL HELP FACILITATE SETTLEMENT ON ALL ISSUES." The panel noted that the case could be returned to calendar with the filing of a proper DOR. However, the Board warned the parties that if any new DOR is defective, the matter may be summarily ordered off calendar by the MSC judge or the WCAB if another petition for removal is filed.