Case Law Update Dec 2009 – Dec 2010

Table of Contents

JURISDICTION

Carroll v. Louisiana Workers Compensation Corp., (2010) 38 CWCR 176 (WCAB Panel) Jurisdiction – out of state employment.

The Workers' Compensation Appeals Board has reversed a WCJ's award of compensation to a out-of-state professional football player who claimed that playing in three games in California contributed to his cumulative injury to multiple parts of his body. The Workers' Compensation Appeals Board indicated that a non-resident employee hired out of state is exempted from California Compensation laws while temporarily in California if the conditions specified in Labor Code §3500.5(b) have been met.

Labor Code §3600 5 (b) provides that an employee who has been hired outside California is exempted from California Workers Compensation provisions while temporarily in California if (1) the employer has furnished Workers' Compensation insurance coverage under the workers' compensation laws of another state that covers the employee's employment while in this state, (2) the extraterritorial provisions of California Law are recognized in the other state, (3) employees and employers covered in California are likewise exempt from the application of the workers compensation laws of the other state. The benefits under the workers compensation laws of the other state are the exclusive remedy against the employer for any injury received by the employee while working for the employer in this state. The code section goes on to state that a certificate from the duly authorized officer of the appeals board or similar department in the other state certifying the out-of-state employer has coverage insuring employees are covered working within this state shall be prima facie evidence that such employer has coverage. Because the evidence concerning these criteria had been incomplete, further evidence was necessary and the matter was therefore remanded to the trial level.

EMPLOYMENT

Lara v. Workers' Compensation Appeals Board, (2010) 182 Cal. App. 4th 393; 75 Cal. Comp. Cases 91. Employment – Independent Contractor – gardener an independent contractor

Applicant had been working as a gardener, painter and pipe repairman for twenty five years. He had been hired twice in the year prior to injury to prune bushes around a diner. He was employed on a hourly or daily basis for different people each day. On March 12, 2000, applicant was working from a roof pruning bushes along the roofline when he fell injuring his head, neck, right shoulder and upper extremity, right hand and thumb, and his low back. Lara sought workers' compensation benefits and also filed a civil suit against the land owner (hotel). Applicant had been paid cash for his first period of employment, and was unpaid and did not complete the work or bill for the second period. He provided his own tools and equipment. He was given no specific directions on how to complete the job. After hearing, the WCJ found that defendant had not overcome the presumption of employment. Defendant sought reconsideration.

The Appeals Board in a 2 to 1 panel decision found that Lara was an independent contractor. It noted applicant's response to interrogatories in the civil case that he was "self-employed as a gardener," and that Metro had no means to control the manner or details of Lara's work. Applicant sought review.

The Court of Appeal in a 2 to 1 decision held that Metro's lack of right to control the manner and details of work made applicant an independent contractor as a matter of law. The Court examined the factors of control outlined in the leading case of *Borello v. DIR*, (1989) 54 Cal. Comp. Cases 80. The dissent by PJ Klein cites cases involving a tree trimmer and an apartment cleaner reaching the contrary result where a commercial operation hired a relatively unskilled individual to perform relatively unskilled tasks.

Narayan, et. al. v. EGL, Inc., Eagle Freight Systems, (2010) 616 F 3rd 895; 75 Cal. Comp. Cases 724. Employment – standard on summary judgment.

EGL, Inc., the alleged employer is a Texas corporation engaged in global transportation, supply and information services at 400 facilities in 100 countries. Narayan, Rahawi, and Heath (Drivers) were California residents engaged to provide domestic freight pick up and delivery services in California. Each signed agreements indicating that they leased equipment and provided services as independent contractors for EGL, Inc. The agreement recited that Drivers were to exercise independent discretion and judgment to determine the method, manner, and means of performance, subject to EGL, Inc.'s instructions. The agreement also provided that it was to be interpreted under the laws of the State of Texas.

The Drivers filed a wage and hour claim with DIR alleging that they were employees of EGL and had been deprived of overtime pay, business and meal expense reimbursement and reimbursement of deductions from their compensation, and penalties. As to choice of law, the Texas law provides that provisions such as that contained in the agreement controlled only interpretation and enforcement of the contract itself; not entitlement to benefits under the Labor Code of California. The case was removed to U. S. District Court based on diversity jurisdiction under 28 U. S. C. §1332, and EGL, Inc. moved for summary judgment on the ground that the Drivers were, by terms of the agreement, not entitled to California Labor Code protections for employees.

The trial court, U.S. District Court for the Northern District of California, held that under the agreement the Drivers were not employees as a matter of law and granted EGL Inc's motion for summary judgment. The Drivers appealed.

The U. S. Ninth Circuit Court of Appeal found that under California law, a plaintiff who comes forward with substantial evidence of having provided services for another has established a prima facie case of an employer/employee relationship. (*Robinson v. George*, (1940) 16 Cal. 2nd 238; 5 Cal. Comp. Cases 233.) Once the employee has established a prima facie case, the burden shifts to the employer to prove that the presumed employee was an independent contractor. (*Cristler v. Express Messenger Sys., Inc.*, (2009) 171 Cal. App 72, at 84; 74 Cal. Comp. Cases 167.) The Court of Appeal found that the Drivers had

established a prima facie case. In the Court's view it would be difficult or impossible for EGI, Inc. to get a record devoid of indicia of employment under the leading case of *S. G. Borello & Sons v. Department of Industrial Relations*, (1989) 48 Cal. 3rd 341; 54 Cal. Comp. Cases 80. That case outlines the various criteria derived from Restatement (2nd) of Agency listed in the decision at 75 Cal. Comp. Cases 729-730. The Court then summarized training videos, EGL's drivers' handbook, and directions as to a morning report to work time, which it concluded were indicia of directing the manner, method and details of the Drivers' work activities not likely consistent with an independent contractor relationship. The District Court had failed to apply the relevant standards under California law, and relied on the agreement recitation of independent contractor status which are not significant under *Borello*. "There existed at the very least sufficient indicia of an employment relationship…such that a reasonable jury could find the existence of such a relationship." (75 Cal. Comp. Cases 724, at 734.) The order granting summary judgment was reversed and the matter remanded.

INSURANCE, INSURANCE COVERAGE, CALIFORNIA INSRUANCE GUARANTEE ASSOCIATION:

City of Laguna Beach v. California Insurance Guarantee Association, (2010) 182 Cal. App. 4th 711; 75 Cal. Comp. Casers 232. Insurance Coverage -- CIGA not liable for contribution to self insured employer.

A City of Laguna Beach (City) employee sustained cumulative trauma from 1986 to June 18, 1999. The City's liability on the claim after reopening exceeded $275,000.00. Continental Casualty Company (Continental) insured the City for liability over $275,000 from May 1, 1998 to May 1, 1999; the Reliance National Indemnity Company provided similar re-insurance from May 1, 1999 to July 18, 2001. Reliance then went into receivership and liability on its covered claims was assumed by CIGA.. The City filed a civil suit against Continental and CIGA. CIGA sought and obtained summary judgment that it was not liable to reimburse self insured employer for compensation awarded based on *Denny's Inc. v. Workers' Compensation Appeals Board*, (2003) 104 Cal. App. 4th 1433 (consent to self insure for workers' compensation issued by DIR is "other insurance under Insurance Code §1063.1 (c) (13). The Court of Appeal affirmed the judgment holding that either the City or Continental was other insurance exculpating CIGA from liability.

Fireman's Fund Insurance Co. v. Workers' Compensation Appeals Board (Allen), (2010) 181 Cal. App. 4th 752; 75 Cal. Comp. Cases 1. A 2001 stipulation of CIGA to administer medical award not subject to reopening in 2008.

In 2001, the California Insurance Guarantee Association (CIGA) entered into a stipulation with Fireman's Fund Insurance Company (FFIC) in which it agreed to be liable for 50 percent of an injured employee's workers' compensation medical treatment award and to administer the medical award, subject to claims of contribution from FFIC. At the time of the stipulation there was no appellate decision or Workers' Compensation Appeals Board decision considering CIGA's liability in a successive injuries case such as this. In 2001, the

law was then unsettled as to whether CIGA was liable for any portion of the cumulative trauma award or for Allen's future medical treatment. It was unclear whether CIGA or FFIC should be primarily liable for administration of the award. In this context, CCIG and FFIC decided to settle the case by entering into stipulations that provided FFIC was solely liable for the cumulative trauma claim, CIGA was solely liable for the specific injury claims, and CIGA and FFIC would split the liability for the joint medical award. The stipulation was approved by order by a WCJ for the Workers' Compensation Appeals Board. In 2008, CIGA petitioned for a change of administrator and dismissal after several appellate court cases decided years after its settlement with FFIC indicated CIGA should not be responsible for the medical award. The Workers' Compensation Administrative Law Judge granted CIGA's petition concluding the 2001 stipulation and order were illegal and contrary to public policy.

The Workers' Compensation Appeals Board denied reconsideration. FFIC sought a writ of review. The Court of Appeal granted review and found that the Workers' Compensation Appeals Board erred in denying reconsideration. FFIC contends the 2001 stipulations should not have been set aside as they were voluntarily entered, public policy supports enforcement of the stipulations, CIGA failed to show good cause to set them aside, it was not illegal for CIGA to enter the stipulations, the order entered on the stipulations was entitled to res judicata effect, and there was no "change in law" that permitted CIGA to avoid its responsibility to pay pursuant to the stipulations. CIGA contends its 2001 stipulations were a nullity and void, as well as unenforceable for lack of consideration. CIGA claims the order entered on the stipulations was likewise void and unenforceable.

Labor Code §5803 provides the Workers' Compensation Appeals Board with "continuing jurisdiction over all its orders, decisions, and awards" and authorizes the Workers' Compensation Appeals Board to "rescind, alter, or amend any order, decision, or award, good cause appearing therefor." Labor Code §5804, however, provides "[n]o award of compensation shall be rescinded, altered, or amended after five years from the date of injury except upon a petition by a party in interest filed within such five years . . . ." CIGA had Statutory Authority to Enter Into the 2001 Stipulations. "A stipulation is '[a]n agreement between opposing counsel . . . ordinarily entered into for the purpose of avoiding delay, trouble, or expense in the conduct of the action,' and serves 'to obviate need for proof or to narrow [the] range of litigable issues' in a legal proceeding." (*County of Sacramento v. Workers Compensation Appeals Board (Weatherall)*, (2000) 77 Cal. App. 4th 1114, 1118. A "stipulation furthers the public policies of settling disputes and expediting trials" (*Estate of Burson*, (1975) 51 Cal. App. 3rd 300, 307) "and their use in workers' compensation cases should be encouraged." (*Robinson v. Workers Compensation Appeals Board*, (1987) 194 Cal. App. 3rd 784, 791.) Having assessed the likelihood of a decision in their favor and the accompanying risk of a decision against them, parties in workers' compensation proceedings, as in other cases, may settle a case, accepting less than they want in order to limit the risk of receiving even less or nothing at all. From the record before us, it appears counsel for CIGA and FFIC entered into the stipulations to settle the issues raised by CIGA's petition before trial for just such purposes.

CIGA now questions in retrospect its statutory authority to enter the stipulations. CIGA argues that in discharging its statutory obligations, it "has authority to make binding

agreements to resolve doubtful claims, those in which the trier of facts must resolve factual issues to determine whether a claim is a 'covered claim' or not. But where, as here, a final award has made 'other insurance' undeniably available to the claimant, CIGA thereafter simply cannot agree to pay what is a not covered claim. CIGA has the duty to 'deny a noncovered claim,' and cannot waive that duty." CIGA's argument assumes the law was clear at the time of its settlement that FFIC was "other insurance" on the cumulative and medical treatment awards. If it had been, there is no question CIGA would have been required to refuse liability and it undoubtedly would not have settled with FFIC. But the law was not clear. Therefore, the issue, more properly framed, is CIGA's authority to stipulate and enter a binding settlement of a claim where its liability is uncertain. Insurance Code §1063.2, subdivision (b), provides in relevant part:

> "[CIGA] shall be a party in interest in all proceedings involving a covered claim, and shall have the same rights as the insolvent insurer would have had if not in liquidation, including, but not limited to, the right to: (1) . . . , (2) receive notice of, investigate, adjust, compromise, settle, and pay a covered claim, and (3) investigate, handle, and deny a non-covered claim." (Italics added.)

> The Court noted criteria for statutory construction as set forth in *City of Santa Monica v. Gonzalez*, (2008) 43 Cal. 4th 905, 919. Applying these principles, it is clear section 1063.2, subdivision (b), broadly authorizes CIGA to investigate claims with the object of paying covered claims and denying non-covered claims. The statute gives CIGA express authority to settle covered claims. Section 1063.2, subdivision (b), does not expressly grant CIGA authority to settle claims when coverage is reasonably disputed factually or legally. However, this is not conclusive since the statute provides CIGA "shall have the same rights as the insolvent insurer would have had if not in liquidation, including, but not limited to," the enumerated rights. A private insurer has a duty "to settle in an appropriate case." (*Comunale v. Traders & General Insurance Co,.* (1958) 50 Cal. 2d 654, 659.)

The Court held that the dispositive issue here is whether the Workers' Compensation Appeals Board, acting through a WCJ, lacked fundamental jurisdiction to enter an order on a stipulated settlement of a case involving CIGA under circumstances where the law was uncertain as to CIGA's liability at the time, when it was later determined to preclude CIGA's liability. The Court concluded the Workers' Compensation Appeals Board did not lack fundamental jurisdiction to enter the order. An action "in excess of jurisdiction" by a Court that has jurisdiction in the "fundamental sense" (i.e., jurisdiction over the subject matter and the parties) is not void, but only voidable." (*Pajaro Valley Water Management Agency v. McGrath*, (2005) 128 Cal. App. 4th 1093, 1101; see *Safer v. Superior Court of Ventura County*, (1975) 15 Cal. 3d 230, 242.) Errors of substantive law are within the jurisdiction of a court and are not typically acts beyond the court's fundamental authority to act. The Workers' Compensation Appeals Board's express statutory authority to enter orders based on the parties' factual stipulations is also clear. (Labor Code § 5702.) In addition, at a mandatory settlement conference, the WCJ has the express "authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial."

(Labor Code, §5502(e)(2).) In fact, this court has concluded the Workers' Compensation Appeals Board may only reject a stipulation clarifying the issues in controversy for good cause. (*County of Sacramento v. Workers' Compensation Appeals Board (Weatherall)*, supra, 77 Cal. App. 4th at p. 1119.) Given this general statutory authority to enter judgments based on stipulations and settlement of the case, it appears the Workers' Compensation Appeals Board had jurisdictional authority to enter the 2001 order based on the parties' stipulations here.

"Section 5803 accords the board continuing jurisdiction to rescind or revise its awards, 'upon good cause shown.' Such cause may consist of newly discovered evidence previously unavailable, a change in the law, or '. . . any factor or circumstance unknown at the time the original award or order was made which renders the previous findings and award "inequitable." More specifically, an award based [on] an executed stipulation may be reopened and rescinded if the stipulation has been "entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, where the facts stipulated have changed or there has been a change in the underlying conditions that could not have been anticipated, or where special circumstances exist rendering it unjust to enforce the stipulation." (*Brannen v. Workers' Compensation Appeals Board*, (1996) 46 Cal. App. 4th 377, 382; see *Robinson*, supra, 194 Cal. App. 3rd at p. 791; *Huston v. Workers' Compensation. Appeals Board*. (1979) 95 Cal. App. 3rd 856, 865-866.) CIGA's 2008 petition for change of administrator and dismissal did not argue any of these grounds for setting aside the 2001 stipulations. The petition merely cited *CIGA v. Workers' Compensation Appeals Board (Hernandez)*, supra, 153 Cal. App. 4th 524, and argued CIGA was not liable for Allen's medical treatment award as FFIC was jointly and severally liable for those benefits. "[A] subsequent clarification of the applicable law by a reviewing court which indicates that an employee was originally entitled to a different award than that given is 'good cause' to reopen a case and amend an award" under section 5803. (*LeBoeuf v. Workers' Compensation Appeals Board*, (1983) 34 Cal. 3rd 234, 241-242, citing *Knowles v. Workmen's Compensation Appeals Board*, (1970) 10 Cal. App. 3d 1027, 1030; *State Compensation Insurance Fund v. Industrial Accident Commission*, (1946) 73 Cal. App. 2d 248, 257-259.) It is also generally recognized that good cause exists for reopening earlier cases to rectify "mistakes of law" made by the Workers' Compensation Appeals Board. (*Ryerson Concrete Co. v. Workmen's Comp. Appeals Board*, (1973) 34 Cal. App. 3rd 685, 688.) However, when parties knowingly take the risk of unsettled law and their settlement agreement reflects such basis for their settlement, the Workers' Compensation Appeals Board has held there is no good cause to reopen. (*Schroedel v. Workers' Compensation Appeals Board*, (1997) 62 Cal. Comp. Cases 1173.) "Good cause consists of some ground or evidence, not originally within the knowledge of the Board, which renders the requested action just and equitable. It cannot consist of a mere change of opinion." (Id. at p. 1175.) Similarly, where parties knew or should have known the issue was then pending before an appellate court, the Workers' Compensation Appeals Board has held the parties' settlement cannot be reopened. (*Mackill v. Workers' Compensation. Appeals Board*, (2006) 71 Cal. Comp. Cases 1336.)

In this case, the stipulations and settlement were entered in apparent contemplation of the unsettled law regarding CIGA's liability. Nevertheless, the WCJ granted CIGA's petition to change administrator and dismiss on the basis that the 2001 stipulations were "illegal or

contrary to public policy" and so "must [be] disregard[ed]." In his report and recommendation on FFIC's petition to the Workers' Compensation Appeals Board for reconsideration, the WCJ repeated the stipulations were illegal and contrary to public policy and that rejection of the stipulations resulted in a correct application of the law.

The use of stipulations to settle disputes in workers' compensation proceedings, in turn, furthers this interest and is, therefore, to be encouraged. When parties stipulate and settle a workers' compensation case, they also have a justified interest in maintaining their resolution of the case. Of course, they settle with the knowledge of the Workers' Compensation Appeals Board's continuing jurisdiction to reopen and amend an award or order under Labor Code §5803 for good cause and in the case of proceedings involving CIGA, parties are chargeable with the knowledge of CIGA's limited statutory authority to pay only covered claims. But where the law is unsettled regarding CIGA's liability, a party negotiating with CIGA should ordinarily be entitled to rely on CIGA's reasoned evaluation of its own authority. If this were not the rule, then settlements involving CIGA would risk being meaningless and a prudent party knowing such risk would likely take all disputes to trial. No injustice results from requiring CIGA to abide by its own stipulations.

Under the circumstances present in this case, the court concluded the Workers' Compensation Appeals Board improperly exercised its discretion under Labor Code §5803 to set aside the order entered on the 2001 stipulations on the ground of illegality and public policy. Given this conclusion, the court stated we need not address whether the Workers' Compensation Appeals Board's authority to set aside the stipulations and order was subject to the time restriction set forth in Labor Code §5804."

The Court annulled the Workers' Compensation Appeals Board's order denying reconsideration and remand the matter to the Workers' Compensation Appeals Board for further proceedings.

Prescott Companies, Inc. v. Mt. Vernon Fire Insurance Co., (2010) 75 Cal. Comp. Cases 362. Insurance coverage – no duty of general liability insurer to defend on policy excluding coverage for bodily injury AOE-COE.

In 2005 Prescott Companies leased a property in Carlsbad, California. Mount Vernon issues a Commercial General Liability policy for the period 7/1/206-6/30/2007 to Prescott; the lessor was an additional named insured on the policy. The policy excluded coverage for bodily injury to an employee arising out of and occurring in the course of employment.

On April 20, 2007, an employee of Prescott Companies, Mayer, slipped and fell on the premises while leaving the premises to go to lunch. In August 2002 Mayer filed an Application for Adjudication of Claim with the Workers' Compensation Appeals Board. In March 2008, Zenith and Prescott entered into a Compromise and Release for $35,000 (above $14424.33 in medical expenses; the C&R was approved. On June 23, 2008, Mayer filed a civil personal injury suit against the property lessor because the slip and fall was on a wet, slick finished stone walkway. The lessor tendered defense to Mount Vernon; it also

requested Prescott to defendant and indemnify it. Mount Vernon denied coverage declined to defend either the lessor or Prescott. Lessor filed a cross complaint against Prescott and Mount Vernon; Prescott requested Mount Vernon defend it

In December 2009, lessor and Prescott settled with Mayer for $150,000, of which $125,000 was paid by general liability insurer, (Hartford). Prescott, lessor, and Hartford sued Mount Vernon, and it sought dismissal contending the duty to defend and any liability were barred by the exclusion. After examining the policy provisions, the Court found that even though Mayer was on her way to lunch at the time of injury, she was "in the course of employment while on the employer's premises, and her injury was therefore AOE-COE. Agreeing with Mount Vernon's motion for dismissal, the Court ordered the suit dismissed..

California Attorneys, et. al., v. Schwarzenegger, et. al., (2010) 182 Cal. App, 4th 1424, 75 Cal. Comp. Cases 313. Insurance. SCIF staffing needs are determined by its Board of Director, not the Governor

In December 2008, Governor Schwarzenegger issued Executive Order S-16-08 ordering that state employees with limited exemptions, regardless of the funding source of their salaries, be furloughed on certain workdays over an 18 month period. The California Attorney's, Administrative Law Judges and Hearing Officers (CASE) sued to prevent implementation of the furlough program. In February 2009, SCIF was denied exemption from the furlough program, and a separate suit was filed to prevent the program from being implemented against SCIF employees. An initial issue in the litigation dealt with whether the SIF suit should await outcome of the CASE suit under the doctrine of exclusive concurrent jurisdiction. The trial court found no basis for staying the SCIF proceedings.

The Court went on to find that while SCIF is subject to the Dills Act (Govt. Code §§3512 et. seq.) and DPA management of personnel classification, salaries, and benefits, SCIF employees are not generally "executive branch" employees. (Ins. Code §11873.) Authority relating to administration of the Fund is vested in its Board of Directors. (Labor Code §57.5, Ins. Code §11781.) The trial court concluded that Ins. Code §11873© limited the Governor's authority to impose furloughs on SCIF employees. That power, the court held is vested in the SCIF Board of Directors. The Court of Appeal affirmed.

INJURY ARISING OUT OF AND OCCURRING IN THE COURSE OF EMPLOYMENT:

Lobo v. Tamco, (2010) 182 Cal. App. 4th 297; 75 Cal. Comp. Cases 286. Going and Coming Rule.

Deputy San Bernardino County Sheriff Daniel Lobo while on motorcycle patrol duty was fatally injured on October 11, 2005 when Luis Rosario, an employee of Tamco, left Tamco's premises in his personal vehicle entering Arrow Highway in the path of three motorcycle deputies approaching with lights and sirens activated.

Lobo's widow and minor children sued Rosario and his employer Tamco on the theory of *respondeat superior* liability for wrongful death. Tamco sought summary judgment on the ground that Rosario was not in the course of employment, but subject to the going and coming rule when he left Tamco's premises for a commute home in his person vehicle. The trial court granted the summary judgment on the ground that Rosario was not in the course of employment during his commute at the time of the injury. Plaintiffs appealed.

Rosario was a metallurgist and manager for quality control employed for 16 years by Tamco. His written duty statement indicated that he was required to investigate customers' complaints and **visit their facilities** to investigate complaints, if necessary. No company car was furnished Rosario to make the facility visits. He would frequently ride with a sales engineer to make these visits, but used his own vehicle on occasions. When he used his own vehicle he was paid a mileage allowance. He had used his own car for such visits ten or fewer times in 16 years, more than one o which was in 2005. Site visits of Rosario were essential to Tamco's investigation of customer complaints; he was the sole employee with the expertise to determine whether certain defects were present in Tamco products. Rosario kept boots, helmet, and safety glasses for use in site visits in his car. The Court reversed the trial court's summary judgment for the employer, holding that employer's occasional requirement that the employee use his personal vehicle brought his homeward commute within an exception to the going and coming rule. The Court found no authority refusing to apply the exception based on infrequency of the requirement.

Zoucha v. Liberty Mutual Insurance Co., (2010) 38 CWCR 64 (WCAB Panel) Injury AOE-COE – Going & Coming Rule barred recovery.

Applicant was employed as an insulation installer. He would call the manger each evening to find out the location he would work at the next day. He would drive his own vehicle to the job site. He would carry his tool belt, bat hammer, safety harness and other personal equipment with him. He was not paid mileage or wages for the trips to the jobsite. He called the manger on the day of his injury and was told he could meet a co-employee at a coffee shop and ride to the job site with that employee. Applicant did not feel compelled to ride with the co-employee but did so to save gas. Applicant or his co-employee were required to have a vehicle available at the job site. While applicant was returning from a job site with the co-employee driving they were injured in auto accident. Defendants denied liability for the injury. The matter proceeded to trial. The applicant testified that only on one occasion had he been required to travel from one job site to another during a shift. The co-employee testified that having a vehicle at the job site was necessary for the job as an installer. The manager testified that vehicles were available for transportation between job sites. The applicant knew he would be at the same job site the entre day on which he was injured. The WCJ found the case compensable and found the claim was not barred by the going and coming rule because defendant employees used their vehicles as part of their jobs which use benefited the employer. Defendants filed a petition for reconsideration.

The Workers' Compensation Appeals Board agreed with the defendants that the case was barred by the going and coming rule and no exceptions applied based on the facts of this case. The Board stated the general rule is that recovery is not allowed for injuries during a local commute to a fixed place at a fixed time because the employee is not considered to be performing a service for the employer while so commuting. In this case the Board found that the WCJ was not justified in holding that applicant or co-employee were required to have a vehicle available at the job site. The Board found the case controlled by the decision in *Voice v. Workers' Compensation Appeals Board (Lockheed Martin),* (1988) 53 Cal. Comp. Cases 497 (writ denied) holding that when an applicant was occasionally asked to change locations would sometimes use his own vehicle for this purpose the applicant was found to be on his way to a fixed place of employment and the going and coming rule applied.

The Board went to state when the applicant was injured on his way home from the location at which he had been instructed to work the risk to which the applicant had been exposed was no greater than the risk to the public at large. Finally, the Board was not persuaded that the injury was made compensable by the mere fact that the applicant was transporting tools and materials to and from the jobsites. The co-employee and the manger testified that materials were usually taken to the job site by a warehouseman. Although the applicant asserted that he transported material 15 times, there was no evidence of any special route or mode of transportation was necessary or that any increased risk of injury was involved. Moreover he was not required to transport material on the date of injury. The Workers' Compensation Appeals Board granted reconsideration and found the applicant did not sustain and industrial injury and issued a take nothing.

Campos v. Workers' Compensation Appeals Board, (2010) 75 Cal. Comp. Cases 565 (unpublished) Psych injury - sudden & Extraordinary.

On February 5, 2005 applicant was working as a tree trimmer and was suspended 40 feet above ground level working on an 80 foot tall tree. The trunk of the tree collapsed hitting him in the chest causing physical and psychiatric injury. Applicant had not been employed by Expert Tree Service for six months, and defendant contested compensability of the psych injury. The WCJ found the injury was sudden and extraordinary, thus falling in an exception to the six months of employment requirement of Labor Code Section 3208.3. Defendant sought reconsideration.

The Appeals Board reversed finding that while the injury was sudden, the risk of such injury "could not be considered unusual, unexpected or extraordinary for a person whose occupation involves being suspended 40' to 50' in the air cutting down trees." Applicant sought review.

The Court of Appeal found no support in the record for the Appeals Board's conclusion that a falling tree trunk was "one of the obvious hazards of the job" of a tree faller. Here the record indicated that Campos had been a tree trimmer / cutter for a long time and had never seen an incident like this happen before. Under *Matea v. W.C.A.B.*, (2006) 144 Cal. App. 4th 1435; 71 Cal. Comp. Cases 1522, a sudden and extraordinary employment condition is one

which is uncommon, unusual, or unexpected, and of a type that would naturally be expected to cause psychic disturbances even in diligent and honest employees. On this record, the injury met that criteria of a sudden and extraordinary employment condition; the Board's decision was reversed, and the matter remanded.

San Francisco Unified School District v. Workers' Compensation Appeals Board (Cardozo), (2010) ___ Cal. App. 4th ____, 75 Cal. Comp. Cases 1251. Injury AOE-COE – Psyche – good faith personnel action exception.

Linda Cardozo suffered a psychiatric injury caused predominately by actual events of employment. The WCJ found that Cardozo's injury was caused 15 percent by nonindustrial causes, 51 percent by her activities as a classroom teacher, and 34 percent caused by lawful, nondiscriminatory, good faith personnel actions. The WCJ therefore concluded that Cardozo's claim for compensation was not barred by Labor Code §3208.3(h) after finding that lawful, nondiscriminatory, good faith personnel actions constituted less than 35 percent of all industrial and nonindustrial causes of her psychiatric injury. Defendant sought reconsideration.

The WCJ reported that resolving District's challenge required a determination whether the calculation of "substantial cause" should be limited to a consideration of only the industrial causes or should include consideration of the 15 percent apportioned to nonindustrial causes. The WCJ concluded that when read together, the plain meaning of section 3208.3(b)(3) and section 3208.3(h) is that " 'all causes,' whether industrial or not, must be taken into account in determining whether or not a psychiatric injury was substantially caused by 'good faith personnel actions.' " The WCJ also concluded that this interpretation is not inconsistent with the Legislature's stated intent of reducing psychiatric injury claims. "Section 3208.3(b)(1)'s requirements that actual events of employment be involved, as opposed to generalized concerns about the financial stability of the employer . . . , and that those events were the predominant cause of the injury, are not disturbed." The Workers' Compensation Appeals Board adopted and incorporated the WCJ's decision denying reconsideration.

Defendant filed a Petition for Writ of Review contending that the WCJ should only have considered the total of the industrial causes and disregarded the nonindustrial causes when calculating the percentage of the psychiatric injury attributable to good faith personnel actions. If this argument were correct, it would require a recalculation, leading to a denial of compensation to Cardozo under section 3208.3(b)(3) and section 3208.3(h). The court rejected the District's argument and affirmed. It held:

> "When a psychiatric injury is alleged and the 'good faith personnel action' defense has been raised, the ALJ must evaluate the Labor Code §3208.3(h) defense according to a multi-level analysis. First, the ALJ must determine whether the alleged psychiatric injury involves actual events of employment and, if so, whether competent medical evidence establishes the required percentage of industrial causation. If these first two conditions are met, the ALJ must then decide whether any of the actual employment events were

personnel actions. If so, the ALJ must next determine whether the personnel action or actions were lawful, nondiscriminatory, and made in good faith. Finally, if all these criteria are met, competent medical evidence is necessary as to causation; that is, whether or not the personnel action or actions are a substantial cause, accounting for at least 35 to 40 percent of the psychiatric injury as defined by Labor Code §3208.3(b)(3). (*Rolda v. Pitney Bowes, Inc.* (2001) 66 Cal. Comp. Cases 241, at 245-247; 1 Hanna, Cal. Law of Employee Injuries and Workers' Compensation (rev. 2d ed. 2008) § 4.69[3][d], p. 4-100.)"

The Court then rejected defendant's argument that the substantial cause calculation contained in Labor Code §3208.3(h) should not be interpreted to include nonindustrial causes, and that Dr. Baumbacher's opinion that 40 percent of applicant's psychiatric injury was due to good faith personnel actions should have barred her claim under Labor Code §3208.3(h). The Court stated:

"The plain language of Labor Code §3208.3 is determinative. Section 3208.3(b)(3) directs us to consider 'all sources combined' in calculating the percentage of psychiatric injury caused by good faith personnel actions. 'All sources combined' can only reasonably be interpreted to mean industrial and nonindustrial sources. In addition, as we noted above, the similar phrase 'all causes combined' in section 3208.3(b)(1) has been interpreted to mean 'the entire set of causal factors.' (See, *Department of Corrections v. Workers' Compensation Appeals Board (Garcia),* (1999) 76 Cal. App. 4th at p. 816; 64 Cal. Comp. Cases 1356.) Clearly, the entire set of causal factors includes the industrial and nonindustrial causes of the psychiatric injury. Thus, on its face, the statute contradicts District's argument that nonindustrial sources of an employee's injury should be excluded when determining whether the psychiatric injury was substantially caused by a good faith personnel action.

"District argues that Labor Code §3208.3(b)(3) applies only to subdivision (b), but, again, the plain language of Labor Code §3208.3(b)(3) undermines District's position. It defines ' "substantial cause" ' '[f]or purpose of the *section* . . . ,' which includes Labor Code §3208.3(h). (Italics added [by the Court].)"

The Court also rejected defendant's contention that this interpretation of section 3208.3(h) is inconsistent with the statutory intent, set out in the statute when it was first adopted in 1989, "to establish a new and higher threshold of compensability for psychiatric injury." The Court stated:

"Section 3208.3(b)(2), section 3208.3(b)(3) and section 3208.3(h) were enacted together in 1993. On balance, these subdivisions favored employers, but each separate piece of the legislation did not. … Thus, Labor Code §3208.3(b)(2) 'creates a slightly more employee-favorable rule for claims arising out of violent occurrences.' (*Wal-Mart Stores, Inc. v. Workers' Compensation Appeals Board*, (2003) 112 Cal. App.4th 1435, 1440, fn. 7.) Newly enacted section 3208.3(b)(1) elevated the level of industrial causation of a psychiatric injury from 10 percent of all causes to 'predominant as to all causes,' and section 3208.3(h) added the good faith personnel action defense. But the

legislative package also limited this defense by providing that it applied only where the personnel action 'substantially caused' the psychiatric injury. We decline District's invitation to ignore the plain language defining 'substantial cause' and impose a definition the Legislature could have but did not choose."

Finally, the Court concluded "that, when read together, the plain meaning of section 3208.3(b)(3) and section 3208.3(h) is that the entire set of industrial and nonindustrial causal factors must be taken into consideration in determining whether or not a psychiatric injury was substantially caused by 'good faith personnel actions.' "

Martinez v. Workers' Compensation Appeals Board, (2010) 75 Cal. Comp. Cases 381 (Writ Denied) Injury AOE-COE – Psyche – six month employment requirement.

At the MSC the parties stipulated that applicant sustained injury AOE-COE to his psyche and back. At trial the defendants raised Labor Code §3208.3(d) the six month employment requirement for compensability of injuries to the psyche. The WCJ ruled that defendants could not raise the 6 month rule The WCJ ruled the issue had been waived by not raising the issue prior to trial and defends showed no good cause to rescind its stipulation to psych injury. Defendants file a petition for removal.

The Workers' Compensation Appeals Board granted removal and remanded the matter to the WCJ amending the Workers' Compensation Appeals Board order to allow the defendants to raise the issue of the 6 month of employment rule (Labor Code §3208.3(d) as a defense to applicants psych claim. The Workers' Compensation Appeals Board rule that by it language the section assumes a psych injury has occurred. The section precludes payment of compensation for such and injury, if the injured employee has been employed by the defendant for less than 6 months. Because the section is concerned with the payment of compensation and not the existence of an industrial injury the WCJ's focus on the stipulation to injury is misplaced.

The Workers' Compensation Appeals Board cited the case of *James v. Workers' Compensation Appeals Board*, (1997) 55 Cal. App. 4th 1053; 62 Cal. Comp. Cases 757, which ruled when defendant had failed to deny the injury within 90 days, thus triggering the presumption of compensability and the defendants had provide TD and medical treatment for over a year and that neither of theses issues precluded the defendant for raising the 6 month rule. The court emphasized that the opening language of the section "not withstanding any other provisions of this division" indicates that the 6 month rule was intended to create an exception to other existing laws. The cases prohibiting the defendants from raising the issue involved cases when the defendants first raised the issue on reconsideration and introduced no evidence of the issue at trial. (*California Insurance Guarantee Association v. Workers' Compensation Appeals Board (Avila)*, (2004) 69 Cal. Comp. Cases 323 (writ denied). The Petition for Writ of Review was denied.

Trugreen Landcare v. Workers' Compensation Appeals Board (Gomez), (2010) 75 Cal. Comp. Cases 385 (writ denied) -- Injury AOE COE – Psyche – overall causation of injury to the psyche may include consideration of multiple work injuries & is a separate issue from apportionment of permanent disability.

The WCJ found that applicant sustained an industrial injury to his back and psyche as a result of a specific injury in which applicant witnessed a co-worker and friend run over by a car and killed, and found a cumulative injury to the psyche resulting from having to dig up the grass with the co-workers blood on it, to drive around with the grass, and having to drive the person home who ran over the co-worker. The WCJ found that the applicants psych disability was caused 40% by the back specific, 40% by the CT and 20% non-industrial. The WCJ found the psych disability compensable pursuant to Labor Code §3208.3(b) (1) since it was predominately caused by the combine result of the back injury and seeing his co-workers dead body and its aftermath. Defendants filed a petition for reconsideration.

Defendant argued that each injury must separately meet the predominant cause standard and you cannot combine the two injuries to meet the predominant requirement of Labor Code §3208.3. The WCJ indicated in his report that the apportionment was based on a physician's opinion based on apportionment pursuant to Labor Code §4663 that 40% of the disability was caused by the back specific, 40 % by the co-worker being killed and 20% non-industrial. The WCJ wrote that to try to apportion pursuant to Labor Code §4663 is contrary to the Workers' Compensation Appeals Board decision in *Reyesv. Hart Plastering, Fremont et. al.,* (2005) 70 Cal. Comp. Cases 223 (Significant Panel Decision)) which held that the determination of whether an injury arises out of and occurs in the course of employment is controlled by Labor Code §3600 and Labor Code §3208.3 and the case law interpreting those sections and not Labor Code §4663. The apportionment was based on Labor Code §4663 as to cause of disability not cause of injury. The physician was of the opinion that three events combined played a predominant role as to all causes of the psych injury. The WCJ pointed out that the combined effects of the actual events of the industrial injuries were the predominant cause of the psych injury. The defendant's petition for reconsideration and subsequent Petition for Writ of Review were denied.

Esquivel v. Workers' Compensation Appeals Board, (2010) ___ Cal. App. 4th ____; 75 Cal. Comp. Cases ____. Injury – Alleged compensable consequence injury in commute to medical treatment from a remote location not compensable.

Applicant Tania Esquivel, a correctional officer receiving, resided in the City of San Diego and was treated for her industrial injuries by medical providers located within eight miles of her home. For reasons unrelated to her need for that treatment, Esquivel drove about 130 miles to her mother's home in Hesperia, in San Bernardino County. Esquivel suffered serious new injuries when she drove through a stop sign in Hesperia while en route from her mother's home to the San Diego offices of the medical providers. The workers' compensation judge (the WCJ) found that Esquivel's motor vehicle accident injuries were a compensable consequence of her existing industrial injuries and awarded her temporary

disability indemnity and additional medical benefits. Defendants petitioned the Workers' Compensation Appeals Board for reconsideration.

The Board issued an order granting respondents' reconsideration petition and reversed the WCJ's findings and award, finding that the accident occurred too remotely from Esquivel's home and her destination to reasonably assign the risk of injury en route to the employer. Applicant then petitioned the Court of Appeal for review of the Board's order and decision.

The Court granted review. The Court stated that this was not the typical case in which an industrially injured employee suffers new injuries while traveling a relatively short distance to a medical provider's office for treatment of the existing injury. In this case the applicant suffered her new injuries shortly after she began an unusually long trip (over 100 miles) to her medical appointments from a location far away from her home, her place of work, and her medical providers' offices The issue the court must decide is whether there is a reasonable geographic limitation on an employer's risk of incurring compensability liability under the Act with respect to new injuries an employee suffers while en route to or from a medical appointment for examination or treatment of an existing industrial injury. The court concluded that a new injury that an employee suffers while traveling a reasonable distance, within a reasonable geographic area, to or from a medical appointment for examination or treatment of his or her existing compensable injury is also compensable under the Act. In the absence of a specific statutory or regulatory test for determining both the boundaries of the applicable "reasonable geographic area" limitation and what constitutes a "reasonable distance," the court held that such determinations must be made on a case-by-case basis considering all relevant circumstances. Esquivel contended that there is no geographic limit to an employer's risk of compensability liability for new injuries an employee suffers while en route to a medical appointment for treatment, so long as the employee does not materially deviate from a reasonably direct route to the medical appointment.

Esquivel's contentions and her reliance on *Laines* and *Durham* are unavailing. In *Laines*, the Court of Appeal held as a matter of first impression that an injury an employee suffers while traveling to a medical appointment for treatment of an industrial injury should be held to be an injury arising out of and in the course of employment within the meaning of Labor Code §3600, even if (1) the existing injury was not a factor contributing to the new injury, and (2) the journey to the medical appointment did not commence at the employee's place of employment. In *Laines* the industrially injured employee was injured again while en route from his attorney's office to a medical examination in connection with his existing injury. The *Laines* Court commented:

> "The most serious problem with providing coverage in the case of the trip to the doctor's office in a case such as petitioner's, is that the employer lacks the opportunity to exercise any control over the trip. The time the trip is made, the route followed, and the means of transportation employed are completely within the discretion of the employee, and the employer is thus unable to insure that the trip is reasonably safe and free of unnecessary hazards." (*Laines v. Travelers' Insurance Co.*, (1975) 48 Cal. App. 3rd 872; 40 Cal. Comp. Cases 365.)

Here, Esquivel contends that, as an industrially injured worker, she "has the same freedom of travel as all other citizens." Esquivel is correct in asserting that she has the same freedom to travel as all other citizens. (*In re White*, (1979) 97 Cal. App. 3rd 141, 148 ["[t]he right to intrastate travel (which includes intramunicipal travel) is a basic human right protected by the United States and California Constitutions as a whole."].) She correctly asserts that her status under the Act as an industrially injured employee entitled to treatment of her injuries does not curtail her right to visit her mother in Hesperia about 140 miles away from Esquivel's home, workplace, and medical treatment providers. Esquivel's reliance on *Laines*, however, is misplaced because *Laines* decision did not address the issue of whether there is a geographic limitation on an employer's risk of incurring liability regarding new injuries an employee may suffer while en route to a medical appointment for examination or treatment of an existing industrial injury. The fact that *Laines* did not address the issue presented here does not mean that such limitation on an employer's compensability risk in cases such as the instant one does not exist. "As is well established, a case is authority only for a proposition actually considered and decided therein." (*In re Chavez*, (2003) 30 Cal. 4th 643, 656; see also *Styne v. Stevens*, (2001) 26 Cal. 4th 42, 57.) "An opinion is not authority for a point not raised, considered, or resolved therein." (*Ginns v. Savage*, (1964) 61 Cal. 2nd 520, 524, fn. 2) Language used in any opinion is of course to be understood in the light of the facts and the issue then before the court, and an opinion is not authority for a proposition not therein considered."

The Court did not adopt here a specific test for determining either the boundaries of the reasonable geographic area limitation on an employer's compensability risk that we recognize herein or what constitutes a reasonable distance in cases such as this, but held that such determinations must be made on a case-by-case basis considering all relevant circumstances. Such determinations should take into consideration all relevant circumstances in a given case, including (but not limited to):

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

Applying our holdings to the facts of this case, we conclude that whether we deem Esquivel's trip to her medical appointments in San Diego to have commenced at her San Diego residence or at her mother's home in San Bernardino County, the Board did not err in

finding that Esquivel's motor vehicle accident injuries are not compensable under the Act because it is undisputed they occurred ─ for reasons unrelated to her need for medical treatment of her existing compensable injuries ─ near her mother's home in Hesperia more than 130 miles away from both her San Diego residence and the San Diego offices of her industrial medical providers; and thus her new injuries clearly occurred outside the reasonable geographic area, however delineated, of her employer's risk for incurring compensability liability for such injuries. The Board's order and decision were affirmed.

DISCOVERY

Coito v. Superior Court of Stanislaus County, (2010) 182 Cal. App. 4th 758; 75 Cal Compensation Cases 240. Discovery – work product.

Plaintiff's 13 year old son drowned in the Tuolumne River in Modesto on March 9, 2007. A wrongful death action was filed against the State of California, Department of Water Resources. In 2008 the Attorney General's office, representing Department of Water Resources, sent two investigators, with a set of questions drafted by counsel to interview four juveniles who had witnessed the drowning. The investigator recorded each witness' statement on a compact disc, and prepared a written summary for the Deputy Attorney General. The interview content was used as a basis for deposition of one of the witnesses taken by counsel for City of Modesto in January 2009. Plaintiff's counsel demanded production of the four witness' statements, but not the investigator's summaries. The Attorney General's office objected, claiming the statements were work product. After a hearing on the discovery motion, the trial court ruled that the identities of the witnesses was not subject to production in response to interrogatory, and that the interview recordings were entitled to absolute work product protection from discovery. Plaintiff filed a writ of mandate to compel production.

The Court held that the work product privilege in California is codified in §§2016.010 et. seq. of the Code of Civil Procedure. There are two levels of work product privilege – absolute and qualified. Writings that reflect an attorney's theories, opinions, legal research, tactical plans, or conclusions are absolutely privileged. Qualified work product privilege is not defined by statute, but has developed in case law. The decisions rely on the distinction between derivative or interpretive material [which is to be protected] on one hand versus evidentiary or non-derivative material. In the latter category a statement prepared by a witness does not become work product by transmittal of the statement to an attorney. Generally the text of statements taken from independent witnesses by an adjuster or investigator is discoverable; the notes reflecting impressions, conclusions, inferences, and commentary on the statements are protected. Here, even though the lie of inquiry of the witnesses was prepared by counsel, the witnesses statements are evidentiary in nature, and may be used at trial to refresh recollection or impeach inconsistent testimony. Here the Court in a 2 to 1 decision found that the state had failed to show that the statements taken revealed pans, theories, impressions or conclusions of counsel subject to protection, and the Court ordered the statements produced. The DISSENTING judge was of the opinion that, where the witnesses' identities were known (without resort to discovery) the statements disclosing

the particular questions or issues the attorney pursued should be protected unless such protection would unfairly prejudice the party seeking discovery.

Padilla v. Los Angeles Metropolitan Transit Authority, (2010) 38 CWCR 181 (WCAB Panel) Discovery – party employer right to representative present at deposition.

The WCJ issued an order allowing the employer to have the employer representative present at the deposition, but provided that applicant's manger could not be present at the deposition. Defendants filed a petition for removal.

The Workers' Compensation Appeals Board granted removal. In this case the Workers' Compensation Appeals Board ruled that the judge's order limiting defendants to have an employer representative from human resources present at the deposition and precluding applicant's manger or co-workers from attending the deposition was not a final order and the Workers' Compensation Appeals Board therefore dismissed defendant's petition for reconsideration, however they granted defendant's petition for removal finding that the defendant's would suffer significant prejudice as a result of the WCJ's discovery order. Applicant objected to having to answer questions about his medical history, psychiatric history and medical condition in front of managers, supervisors or co-employees. Applicant conceded that a person involved in the administration and adjusting of the claim, not a manager, not an employee of MTA, who the applicant works with, could be present at the deposition. The Workers' Compensation Appeals Board indicated that depositions are governed by Code of Civil Procedure §§2025.010, et seq. Protective orders may be granted as justice requires to protect a party, deponent, or other natural person or organization from unwarranted annoyance, embarrassment or oppression, or undue burden or expense based on a showing of good cause, accompanied by a meet and confer declaration stating facts showing a reasonable and good faith attempt at informal resolution of the issue. In this case the Workers' Compensation Appeals Board was not persuaded that applicant would be subjected to unwarranted annoyance, embarrassment, or oppression to support his request of exclusion. In his request for a protective order, applicant stated only that he had a problem discussing medical issues in font of the employer at his deposition.

Applicant gave a contradictory statement in his request for a protective order objecting to his manger being present and describing him as a perfect stranger. The statute provides that a protective order may include a direction that designated person other than the parties to an action and their offices and counsel can be excluded from a deposition. While the statute does not provide who may or may not be present at a deposition, it recognizes that a party has a right to be present. In the case of *Willoughby v. Superior Court*, (172 Cal. App. 3d 890) vacated a judges protective order excluding an employee's supervisor for her deposition. The Court of Appeal noted that the clear language of the statue authorizing a protective order states expressly precludes excluding parties. The Court noted that absence of a party would significantly and unreasonably impair an attorney's ability to represent his client. In this case there is no statutory basis to exclude defendant's representative from the deposition.

The Board went on to note that while the applicant has not specifically raised issues of privilege he has claimed a right to medical privacy. The applicant has alleged psyche and orthopedic injuries and therefore waived his rights to medical privacy. In his petition for protective order the applicant acknowledges his waiver of the privilege with respect to the conditions placed in issue.

The applicability of the privilege and any waiver, while relevant to the scope of discovery, is not relevant to the issue of who defendant may select as it representative to attend the deposition. Finally the Board noted that Labor Code §2762 provides that an insurer, third-party administrator of a self-insured employer and the employees of a self administered self-insured employer are precluded from disclosing individually, identifiable medical information of applicant to the employer, with specified exceptions regarding diagnosis and treatment of injuries that are subject of a workers' compensation claim, or information which is necessary for modification of a employee's job duties. This section does not deal with information disclosed in his deposition testimony. Removal was granted and the order rescinded.

Eutsey v. City and County of San Francisco, (2010) 38 CWCR 119 (WCAB Panel) Discovery -- Extent of duration of medical history subject to inquiry in deposition.

Applicant claimed injury to her right leg and psych. After a deposition resulted in the applicant's attorney instructing the applicant to not answer question about her past that are over ten years back. The deposition ended over the dispute. Defendants filed a petition to compel applicant to submit to a deposition and answer questions about her past. The petition further requested the applicant's attorney refrain from frivolous objections. The WCJ ruled applicant was not required to answer question to which applicants attorney objected, the deposition had been concluded and need not be rescheduled. The WCJ ruled the defense attorney had terminated the deposition when he walked out of the room. The WCJ found the defense attorney's conduct as that of bullying and intimidation. Defendant sought removal.

The Workers' Compensation Appeals Board stated that the scope of discovery is determined by the medical condition that has been put in issue. (*Allison v. Workers' Compensation Appeals Board*, (1999) 72 Cal. App. 4th 654; 64 Cal. Comp. Cases 624). The panel indicated that the applicant by asserting a psych claim placed her mental condition in issue. Defendant was engaged in reasonable and relevant questioning regarding her psych claim. The scope of the inquiry is not limited to asking questions that would elicit admissible evidence, but could include queries leading to discovery of such evidence. The WCJ ruling appears to be incorrectly based on whether the evidence would be admissible at hearing. The panel also concluded that the WCJ had mischaracterized the defense attorney's conduct. To the contrary, the record showed the applicant's attorney engaged in unprofessional conducts including ridicule and name calling. The Workers' Compensation Appeals Board rescinded the WCJ ruling and ruled that the deposition was to be rescheduled and the defense counsel would be permitted to obtain the answers to all unanswered questions as well as any similar questions. All of the questions asked by the defense attorney could have arguably led to the discovery of relevant information. There was no legal justification for barring questions on

the basis that they dealt with matters occurring more than ten years previously. The panel suggested that the parties might consider obtaining QME evaluations before determining the scope of further question to the applicant. The Workers' Compensation Appeals Board granted removal and returned the matter to the trial level for further proceedings consistent with the decision.

MEDICAL LEGAL PROCEDURES

Mendoza v. Huntington Hospital, (2010) 75 Cal. Comp. Cases 634 (en banc). Medical legal, access to QME Panel in denied injury cases.

Applicant, a patient care associate, was bitten by a hospitalized pediatric patient with an infectious disease on April 12, 2009, and allegedly sustained injury AOE-COE to her head, face, and arms. She admittedly suffered abrasions on her left arm. She was seen in the emergency room and discharged home. She alleged that she was attacked by the same patient again on April 14, 2009. Eight days after the first incident she returned to an industrial medical clinic but was not seen. Later on that eighth day after the incident she fell into a coma while eating at a restaurant. She has remained comatose since April 20, 2009. She was diagnosed with intracerebral hemorrhage with severe neurological damage.

Defendant denied both claims, and with respect to the alleged April 14, 2009 incident, claimed applicant had not been on duty on that day. Applicant's PTP Dr. Arthur Lipper, M. D., issued reports finding industrial causation for the injury. Dr. Lipper's reports were directed to an incorrect address for the claims administrator. In October defendant took the deposition of applicant's spouse, and received service of Dr. Lipper's reports. It objected to Dr. Lipper's opinion and proposed an Agreed Medical Examiner. Eight days after the deposition, the matter came for Priority Conference. Applicant requested that the matter proceed to trial; defendant requested time to obtain a QME. Applicant responded that defendant was not entitled to a QME because none had been requested within 90 days of injury. Defendant responded that its denial was not based on medical opinion evidence alone, but on the facts that applicant had not suffered time loss or need for treatment beyond first aid on April 12, and was not on duty on April 14th. The WCJ ruled that defendant was entitled to obtain a QME evaluation unless the parties agreed to an AME. Applicant sought removal, contending that where injury has been denied only the injured employee may request a QME panel, and that defendant did not timely object to Dr. Lipper's opinions. The WCJ reported that the objection and proposal of an AME had been timely due to service of Dr. Lipper's report on an incorrect address.

The Appeals Board granted removal and issued a notice of intention to admit documentary evidence. It found the WCJ correct in his opinion that there was timely objection to Dr. Lipper's reports, and found IMC Rule 30(d)(3) invalid as inconsistent with Labor Code Sections 4060, 4062.2, and 5402(b). Labor Code Section 4060(c) directs the parties at any time after filing of a DWC Form 1 (claim form), when compensability is disputed to follow the procedure in Labor Code Section 4062.2. Section 4062.2 allows either party to commence the AME / QME selection process. The Board noted that here defendant

had timely denied applicant's claims, so Labor Code Section 5402 was not applicable – there was no presumption of compensability. The Board further held that where a claim has been denied in its entirety, the 20 day limit on objection to a PTP's opinions does not apply. .

Alvarez v. Workers' Compensation Appeals Board, (2010) 187 Cal. App. 4th 575; 75 Cal. Comp. Cases 817; 38 CWCR 203. Medical legal – *Ex parte* communication with QME.

In a workers' compensation proceeding for death benefits, a panel qualified medical evaluator requested a copy of certain records in an ex parte telephone conversation with defense counsel. The claimant objected to the ex parte communication and petitioned, inter alia, for a new panel qualified medical evaluator under Labor Code §4062.3, subdivision (f), which prohibits ex parte communications between a party and a panel qualified medical evaluator and, in the event of a violation, allows the other party to seek a new panel qualified medical evaluator from another panel.

The Workers' Compensation Appeals Board denied the petition, reasoning that the ex parte communication was not prohibited by the statute because the communication was initiated by the panel qualified medical evaluator, not a party, and involved "administrative," not "substantive" matters or the merits of the claim. The claimant petitioned for writ of review, contending that Labor Code §4062.3, subdivision (f) explicitly precludes any ex parte communication between a panel qualified medical evaluator and a party, and that the Workers' Compensation Appeals Board may not add exceptions not contained in the statute. Claimant also asserted that the failure to enforce the prohibition against the ex parte communications denied him due process of law and was not based on substantial evidence.

The court held that Labor Code §4062.3 expressly prohibits ex parte communications with a panel qualified medical evaluator, with no exception based on the initiator of the communication or for "administrative" matters. Nevertheless, because a certain degree of informality in workers' compensation procedures has been recognized, not every conceivable ex parte communication permits a party to obtain a new evaluation from another panel qualified medical evaluator. The matter remanded to the Workers' Compensation Appeals Board to reconsider the matter in view of the courts interpretation of the applicable statute. Labor Code §4062.3, subdivision (e) provides in pertinent part,

> "All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party."

Labor Code §4062.3, subdivision (f) begins by stating, "Ex parte communication with an agreed medical evaluator or qualified medical evaluator selected from a panel is prohibited." That section adds that if there is such a communication, the aggrieved party may seek a new evaluation from another evaluator. The regulations pertaining to qualified medical evaluators, although effective February 17, 2009—after the event in issue here—reflect the prohibition of ex parte communications with a panel qualified medical evaluator as set forth

in Labor Code §4062.3, and provide that even a single violation can result in discipline. Labor Code §4062.3 does not provide that some classes of ex parte communications are permissible, as suggested by the WCJ and Workers' Compensation Appeals Board.

Although Labor Code §4062.3 sets forth detailed procedures by which parties are to disclose information and records to the medical evaluator and provides remedies for violations of those procedures. The statute does not distinguish between ex parte communications on the basis of whether the communication was initiated by a party or by the medical evaluator. To hold that the statute does not proscribe ex parte communications initiated by the medical evaluator would suggest that a party is excused from the proscriptions of Labor Code §4062.3 and may discuss the merits of the case with the medical evaluator based solely on the fortuity that the medical evaluator initiated the conversation. Although section 4062.3, subdivision (f) says, "If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e)," the aggrieved party has a remedy that provision does not specify that the prohibited communication must, as the Workers ' Compensation Appeals Board said, be initiated by the party. To allow unfettered ex parte discussions if initiated by the medical evaluator would undermine the statute. In addition, Labor Code §4062.3 does not state that ex parte communications are permissible if the subject matter is "administrative" or procedural rather than "substantive" or on the merits, or otherwise gives a party an advantage. The only statutory exception to the proscription against ex parte communications is set forth in Labor Code §4062.3, subdivision (h), which concerns communication by the employee or the deceased employee's dependent in the course of or in connection with the examination. Neither the WCJ nor the Workers' Compensation Appeals Board may graft exceptions to clear statutory prohibition language to accomplish a presumed legislative purpose or intent that does not appear on the face of the statute or from the legislative history. (See *Burden v. Snowden* (1992) 2 Cal.4th 556, 562; *California Teachers Assn. v. Governing Board of Rialto Unified School Dist.* (1997) 14 Cal.4th 627, 633; *California Teachers Assn. v. San Diego Community College Dist.* (1981) 28 Cal.3rd 692, 698.)

There is nothing in the legislative history of which we are aware that supports the interpretation by the WCJ or Workers' Compensation Appeals Board. When the Legislature has intends to provide an exception to the prohibitions on *ex parte* communications, it has expressly so stated. Moreover, California Code of Regulations, title 8, section 10718 prohibits *ex parte* communications with a "regular physician" (Labor Code §5701) or qualified medical evaluator when the employee is unrepresented (Labor Code §5703.5) "with respect to the merits of the case unless ordered to do so by the Workers' Compensation Appeals Board." With this background, the Legislature in Labor Code §4062.3 prohibited *ex parte* communications without limiting the prohibition to communications on the merits. That further suggests that the Legislature did not intend such a limitation in connection with Labor Code §4062.3. With regard to *ex parte* communications with a judge or arbitrator, the judge or arbitrator, based on his or her training and experience, would be expected to be able to draw a distinction between purely procedural and scheduling matters on the one hand and matters affecting the merits on the other hand. So it is understandable why the Legislature carved out the exceptions to ex parte communications in that context. But medical evaluators do not have the same background and experience that judges and arbitrators have to draw

such distinctions. In a field that is dependent on expert medical opinions, the impartiality and appearance of impartiality of the panel qualified medical evaluator is critical. Thus, there are justifications for a strict rule prohibiting all ex parte communications in this context.

Under the rule proposed by the WCJ and Workers' Compensation Appeals Board, the mere act of inquiring into who initiated the communication or whether the subject of an ex parte communication was substantive or procedural or administrative undermines the appearance of impartiality and the legitimacy of the medical evaluation process. It is to avoid such difficulties that Labor Code §4062.3 prohibits *ex parte* communications and mandates that all communications between counsel and the medical evaluator "shall be *in writing* and shall be served on the opposing party when sent to the medical evaluator." (Labor Code §4062.3(e), italics added.) Generally, as here, a violation of an unqualified prohibition on *ex parte* communications requires no showing of prejudice to invoke the appropriate remedy. (See *Rondon v. Alcoholic Beverage Control Appeals Board*,. (2007) 151 Cal. App. 4th 1274, 1290; see *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board.,* 40 Cal.4th at p. 17.)

Nevertheless, an *ex parte* communication may be so insignificant and inconsequential that any resulting repercussion would be unreasonable. The court stated that they should not interpret or apply statutory language in a manner that will lead to absurd results. A certain amount of informality is anticipated in Workers' Compensation Act proceedings. (Labor Code §5708 provides that the WCJ and Workers' Compensation Appeals Board "may make inquiry in the manner . . . which is best calculated to ascertain the substantial rights of the parties and carry out justly the spirit and provisions of this division." Labor Code §5709 provides that "no informality in any proceeding or in the manner of taking testimony shall invalidate any order, decision, award, or rule made and filed as specified in this division." (See *Northwestern R. Co. v. Industrial Acc. Com.* (1920) 184 Cal. 484, 489, and *County of Sacramento v. Workers' Compensation Appeals Bd.* (2000) 77 Cal. App. 4th 1114, 1116.) But even a 'flexible' system must have structure. Here, Dr. Miller called defense counsel requesting copies of records. Defense counsel said that she told Dr. Miller he should not be contacting her directly, that she would contact counsel for Alvarez about the communication, and that she terminated the call as soon as possible—within one minute. This communication might be so inconsequential so as not to be covered by Labor Code §4062.3. On the other hand, the connection between the call by Dr. Miller and his earlier testimony, any suggestion that Dr. Miller and defense counsel agreed on how to proceed, and Dr. Miller's willingness to initiate an *ex parte* communication with defense counsel may suggest that the remedy set forth in section 4062.3, subdivision (f) is required.

The Workers' Compensation Appeals Board should reevaluate its conclusion based on the principles the court discussed and not based on any distinction between "administrative" and "substantive" nature of the communication or on who initiated the communication. In view of the courts conclusions, the court did not do reach the due process or substantial evidence issues.

Quinn v. Macy's West, (2010) 38 CWCR 42 (WCAB Panel) – Medical Legal – non Treater, AME, or QME to rebut PD assessment

Applicant sustained and admitted industrial injury and went to a panel QME. The defendants' took the deposition of the panel QME. At the MSC defendants proposed to submit a report and the testimony of another physician. The applicant objected to the report and testimony being offered by another physician in rebuttal to the QME. The WCJ issued an order at the MSC that the rebuttal report was not admissible as the physician was not a treating physician, QME or AME. The WCJ further ruled defendants could not call the physician as a witness has they had failed to show good cause to allow the testimony. Defendants filed a petition for removal.

In his report recommendation on the petition for removal the WCJ affirmed that a petition for removal way the appropriate remedy for obtaining relieve from an evidentiary order, but concluded that the order would not cause substantial prejudice or irreparable harm. With respect to the admissible of the medical report the WCJ stated that defendants had failed to show any unique qualifications of the physician that would enable him to rebut the QME on the use of the AMA guides. Allowing this opinion in evidence the WCJ wrote would be tantamount to permitting doctor shopping contrary to the policy of SB 899 to reduce medical legal costs. Moreover Labor Code §4061 (i) expressly provides that with the exception of evaluations prepared by treating physicians no Permanent Disability evaluations may be obtained except for AME's and QME's in accordance with Labor Code §4062(1) or Labor Code §4062 (2). Evaluations obtained in violations of this prohibition are not admissible in and proceeding before the Workers' Compensation Appeals Board. The physicians report and testimony being offered by defendants was not a report of a treating physician nor an AME or report obtained in accordance with QME process. Finally the WCJ wrote that allowing the testimony would be contrary to Workers' Compensation Appeals Board rule 10606 which provides that the Workers' Compensation Appeals Board favors the production of medical evidence in the form of witness reports and that testimony of medical witnesses will not be received at trial except upon a showing of good cause. No good cause was shown by defendants in this case for the allowing the testimony of the physician obtained in rebuttal to the AME.

The Workers' Compensation Appeals Board dismissed the petition for not being verified. The panel indicated it would have denied the petition on the merits had it reached such a decision. The physician used by the defendants was an out of state physician who is an editor of the AMA guides newsletter and has served on the advisory committee to the AME guides 5th addition. The defendants were offering the report and testimony rebut the panel QME on the use of the AMA guides.

Moyers v. State Compensation Insurance Fund, (2010) 38 CWCR 70 (WCAB Panel) – Medical legal – QME procedures in Labor Code Sections 4060-4067 do not apply to SIBTF claims.

The applicant sustained and industrial injury and went to an AME. After the AME exam the parties resolved the normal issues by way of a Compromise and Release agreement. Applicant after the Compromise and Release was approved filed and application for additional compensation against the SIBTF. Applicant's attorney notified SIBTF that she would be evaluated by QME in various specialties. SIBTF objected to the evaluations and warned applicant's attorney they would not pay for the examinations and would object to the reports being received into evidence. Applicant filed a petition with the WCJ to allow the QME examinations. The WCJ issued an order allowing the QME exams and providing that SIBTF would be liable for the payment of the examinations. The WCJ ruled the applicant did not have to return to the AME used in the case in chief or use the QME procedure to obtain the medical legal evaluations. SIBTF filed a petition for removal.

The Workers' Compensation Appeals Board agreed that the WCJ was correct. The Workers' Compensation Appeals Board first pointed out no statute prescribes a specific procedure for obtaining medical evaluations for claims against the SIBTF. The panel indicated the issues involved in a claim for workers compensation benefits are different than those involved in claims against SIBTF and frequently involve body parts and medical conditions not involved in the case in chief. Labor Code §§4060-4068 are concerned with disputes between employee and employers regarding normal workers compensation issues. Applicant says the panel was not an employee of SIBTF and SIBTF was not applicant's employer as those terms are used in the statute. Although it is arguable that Labor Code §4067 describes a process that might apply to SIBTF claims, its provisions are directed to subsequent claims for additional workers compensation benefits, i.e., for new and further disability. Because there is no statute concerning the development of the medical record for claims against SIBTF the Workers' Compensation Appeals Board had to look to due process of law and other labor code provisions and ascertain the nature of the medical discovery process applicable to a SIBTF claim. The Workers' Compensation Appeals Board ruled a fundamentally fair process must allow both the applicant and SIBTF a reasonable opportunity to obtain medical evidence covering the unique issues involved in the claim. The applicant and SIBTF may either agree on an AME or each may obtain its own evaluation from a qualified physician, like a QME. In either event, the medical evaluators are entitled to a reasonable fee for their services to be paid by the SIBTF in accordance with the medical-legal fee schedule. The WCJ correctly determined the applicant was not required to return to the AME who reported on the normal issues but could select another medical expert to report on medical issues relating to her claim for benefits from the SIBTF. The order of the WCJ was upheld.

Banks v. Sacramento Bee/McClatchy Newspapers, Inc., (2010) (Lexis) (WCAB Panel) Medical Legal – medical reports to be provided to QME**Error! Bookmark not defined.**.

Defendants contended that the report if the QME in psychology is relevant to the eye injury and the report should be provided pursuant to Labor Code §4063.2. The WCJ found that there was no good cause why the report of the panel QME in psychology should be provided to the QME in Ophthalmology. The WCJ ordered the defendants to provide a copy of the decision to the QME in Ophthalmology and to ask if he disagrees. If the AME does disagree, he should explain why. The defendant was to tell the WCJ the response of the

QME and the WCJ would then reconsider his order. The defendants filed a petition for reconsideration and or removal.

The Workers' Compensation Appeals Board dismissed the petition for reconsideration as not being taken from a final order, however the Board then granted removal and rescinded the order of the WCJ and consistent with Labor Code §4063.2 which authorizes the delivery of relevant medical records and other records to a panel QME and only allows for objection to the provisions of non-medical records. The Workers' Compensation Appeals Board added that the WCJ encouraged the defendants to communicate with the QME and find out he disagreed. Such a communication is potentially inconsistent with Labor Code §4062.3(f) which prohibits *ex parte* communication with a QME. Although we would expect defendant's to comply with the provisions of Labor Code §4906.3(e) in initiating any communication with the QME, the method of response and the potential need for further communication cannot be assured to be in compliance with that section. Moreover the process described in Labor Code §4062.3 (f) is a cumbersome method of communicating the information described by the WCJ and would create and unnecessary delay in the proceedings in light of the provisions of Labor Code §4062(30 (b). Labor Code §4062.3 (b) limits the rights of the party's objection to medical records to be provided to the panel QME to nonmedical records. The Board see any reason to preclude the QME from receiving the medical records on grounds they were not relevant. In order to assure the QME is informed of applicant's psychological condition which is part of the applicant's relevant medical history the QME should have been provided the report. It is expected the QME, as an impartial medical evaluator, will independently inquire into applicant's medical history, and will allow applicant an opportunity to correct any misinformation before offering an opinion on the applicants' eye condition. The Board rescinded the order and returned the matter to the trial level for further proceedings in accordance with its decision.

EARNINGS / COMPENSATION RATES, 4658(d), COLA and SAWW

Duncan v. Workers' Compensation Appeals Board, (2009) 179 Cal. App. 4th 1009; 74 Cal. Comp. Cases **1427**. COLA adjustments to life pension & total permanent disability indemnity rates begin 1/1/2004.

John Duncan, as Administrator of the Subsequent Injuries Benefit Trust Fund of the State of California petitioned the Court of Appeal for review of a decision of the Workers' Compensation Appeals Board, which construed Labor Code §4659(c) to mean that the cost of living adjustment to total permanent disability payments and life pensions are retroactive to the date of injury, no matter when the first payment is actually received.

The SIBTF contends that Labor Code §4659(c) provides for annual increases in weekly benefit payments only after an injured employee is entitled to such benefits; the subdivision does not provide for increases prior to the entitlement to benefits. Furthermore, a worker does not have a right to receive total disability indemnity until he or she is permanent and stationary. Real party in interest, the Worker, contends that the cost of living adjustments should take place "per the very words of the statute, on January 1 following date of injury,

which is the only interpretation that will allow the injured workers' benefit level to keep pace with inflation over time." Accordingly, the resolution of this case depends on this court's interpretation of subdivision (c) of section 4649. The crux of this case is when does the state average weekly wage cost of living adjustment (COLA) begin for a worker who is totally permanently disabled or starts receiving a life pension.

The Court granted review. In this case of first impression, the court held that the cost of living adjustments pursuant to Labor Code §4659 (c), for life pensions and total permanent disability indemnity, are added to those payments, per the words of the statute, starting January 1, 2004, and every January 1 thereafter. Accordingly, they annulled the decision of the Workers' Compensation Appeals Board.

The Court stated that statute's plain language is a dispositive indicator of its meaning unless a literal reading would lead to absurd consequences the Legislature did not intend. There is a well settled principle of statutory interpretation that language of a statute should not be given a literal meaning if doing so would result in absurd consequences which the Legislature did not intend. (*Younger v. Superior Court*, (1978) 21 Cal. 3rd 102, 113.) Thus, our goal is to divine and give effect to the Legislature's intent. (*Elsner v. Uveges*, (2004) 34 Cal. 4th 915, 927.) Furthermore, "[w]e do not presume that the Legislature intends, when it enacts a statute, to overthrow long-established principles of law unless such intention is clearly expressed or necessarily implied." (*People v. Superior Court (Zamudio)*, (2000) 23 Cal. 4th 183, 199.) With this background in mind we turn to the words of the statute. Labor Code §4659(c) provides that when a worker's permanent disability is total, as in this case, for injuries occurring on or after January 1, 2003, again as in this case,

> "an employee who becomes entitled to receive a life pension or total permanent disability indemnity . . . shall have that payment increased annually commencing on January 1, 2004, and each January 1 thereafter, by an amount equal to the percentage increase in the 'state average weekly wage' as compared to the prior year. For purposes of this subdivision, 'state average weekly wage' means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred." (Labor Code §4659(c).)

At the outset, we must disagree with the Worker that "the very words of the statute" require that a COLA to the total permanent disability payment should take place on January 1 following the date of injury. The only time that the date of injury is mentioned is with regard to the definition of the state average weekly wage. We agree with the WCJ that for injuries occurring after January 1, 2003, the plain language of the statute requires that total permanent disability payments and life pensions be increased annually commencing January 1, 2004. However, as the WCJ noted, "[w]hile the language is clear enough, such a plain reading would require increases to begin some 19 days prior to the date of injury" in this case. The SIBTF makes much of the legislative history of Assembly Bill 749, the bill that created section 4659, subdivision (c). (Stats. 2002, ch. 6, pp. 91-95.) However, our reading of the assembly committee's legislative analysis of the bill reveals that the goal of enacting subdivision (c) was to increase benefits for the most seriously injured workers, without

increasing them too much. (Assem. Com. on Insurance, Analysis of Assem. Bill No. 749 (2001-2002 Reg. Sess.) Feb. 4, 2002, pp.1, 15-18.)

Subdivision (c) of section 4659 states an employee who becomes entitled to receive a total permanent disability indemnity or life pension shall have that payment increased annually commencing on January 1, 2004, and each January 1 thereafter. In order to interpret this section we must look to the key words of the statute— "who becomes entitled to receive a life pension or total permanent disability indemnity . . . ." The word "entitle" means "to give a right or legal title to: qualify one for something." (Webster's Third New English Dictionary (1993) p. 758, col. 1.) When a worker is injured, an employer must pay temporary disability compensation for the period the employee, while unable to work, is undergoing medical diagnostic procedure and treatment for an industrial injury. (*Granado v. Workmen's Compensation Appeals Board*, (1968) 69 Cal. 2nd 399, 403.) Generally, the employer's obligation to pay temporary disability ceases when either: 1) the injured employee returns to work, 2) the employee is deemed able to return to work, or 3) when the employee's condition becomes permanent and stationary. (*Department of Rehabilitation v. Workers' Compensation Appeals Board (Lauher)*, (2003) 30 Cal.4th at pp. 1291-1292; 68 Cal. Comp. Cases 831.) In those cases in which the worker has sustained a permanent disability, Labor Code §4650 provides that an employer must make the first permanent disability payment within "14 days after the date of the last payment of temporary disability indemnity." Accordingly, the California Supreme Court has inferred that the Legislature has anticipated that an employer has no legal obligation to pay permanent disability indemnity until the obligation to pay temporary disability indemnity has ceased. (*Department of Rehabilitation v. Workers' Compensation Appeals Board (Lauher)*, (2003) 30 Cal.4th at p. 1292; 68 Cal. Comp. Cases 831.) Previously, in *LeBoeuf v. Workers Compensation Appeals Board*, (1983) 34 Cal. 3rd 234, the Supreme Court held that "[t]he right to permanent disability compensation does not arise until the injured worker's condition becomes 'permanent and stationary.'" (Id. at p. 238, fn. 2.) The Legislature, of course, is deemed to be aware of judicial decisions already in existence, and to have enacted or amended a statute in light thereof. (*People v. Overstreet,* (1986) 42 Cal. 3d 891, 897; accord *People v. Harrison*, (1989) 48 Cal. 3rd.321, 329.) Accordingly, the court concluded that by using the words "an employee who becomes entitled to receive a life pension or total permanent disability indemnity" the Legislature meant **when the right to total permanent disability compensation or a life pension arises**; [emphasis added] and that is not until the worker's condition has become permanent and stationary for total permanent disability indemnity and for a life pension until after the number of weeks that permanent partial disability payments must be paid. However, this does not end our inquiry. The next question we must answer is when do the COLAs start? The statute goes on to say that in the case of a life pension or total permanent disability indemnity, an employee "shall have that payment increased annually commencing on January 1, 2004 and each January thereafter . . . ." (§ 4659, subd. (c), italics added.) By the plain words of the statute, once the life pension or total permanent disability payment is set, that payment has to be increased by COLAs starting from January 1, 2004. The SIBTF argues that the reference to "that payment" does not mean the benefit rate that is set. However, this argument ignores the fact that the definition of the word rate means "a charge, payment or price fixed according to a ratio, scale, or standard." (Webster's Third New English Dictionary (1993) p. 1884, col. 3.) Under the current statutory scheme,

the disability payment for temporary total disability is two-thirds of the "average weekly earnings" during the disability period. (Labor Code §4653.) Labor Code §4658 establishes the method of setting the permanent disability payments. That section provides as pertinent to this case: "(c) This subdivision shall apply to injuries occurring on or after January 1, 2004. Where the injured worker is totally permanently disabled i.e. has a disability rating of 100 percent, "the indemnity based upon the average weekly earnings determined under Labor Code §4453 shall be paid during the remainder of life." (Labor Code §4659(b).) As a result, for a totally permanently disabled worker, the calculation of payments starts for a full time employee with looking at the worker's average weekly wage at the time of injury. However, permanent disability indemnity payments are not increased by operation of law under Labor Code §4661.5 as are temporary disability indemnity payments. (*Duncan v. The Singer Co.*, (1978) 43 Cal. Comp. Cases 467, 468-470.) Thus, as to the worker whose injury leads to total permanent disability that does not become permanent and stable for a number of years, setting the COLAs from the permanent and stationary date causes that worker to see his or her payment exposed to the ravages of inflation over time, eroding the real value of the benefits.

For the permanently disabled worker who is entitled to a life pension, i.e. one whose injury is more than 70 percent, but less than 100 percent, delaying until the first life pension payment the addition of the COLAs is inexorably worse. Taking for example a partially disabled worker who is injured after January 1, 2004, and whose permanent disability is 99 percent, the number of weeks to pay out permanent disability payments before the life pension starts is just over 17 years. (Labor Code §4658, subd. (c).) By adding subdivision (c) to Labor Code §4659 it appears that the Legislature has tried to rectify the problem of total permanent disability payments and life pensions not keeping pace with inflation. Although total permanent disability indemnity and temporary disability indemnity start from the same point, i.e. based on the worker's average weekly earnings, they are not the same thing. (*Duncan v. The Singer Co.*, supra, 43 Cal. Comp. Cases 467, 468-470.)

The court presumed that the Legislature could have written the statute to include the date of injury, or the permanent and stationary date, or the date when the life pension starts to commence the COLAs, but the Legislature did not. Rather, the Legislature chose January 1, 2004, as the start date of the first COLA. " ' "If there is no ambiguity in the language, we presume the Legislature meant what it said and the plain meaning of the statute governs." (*Meyer v. Sprint Spectrum L.P.*, (2009) 45 Cal. 4th 634, 639-640.) As a reviewing court we " '[have] no power to rewrite the statute so as to make it conform to a presumed intention which is not expressed.'" (*California Teachers Assn. v. Governing Board, of Rialto Unified School Dist.*, (1997) 14 Cal. 4th 627, 633.) Thus, keeping in mind that workers' compensation statutes are to be liberally construed in favor of the injured worker (*Smith v. Workers' Compensation Appeals Board*, (2009) 46 Cal. 4th 272, 277), the court held that when an injured worker's total permanent disability payment, or life pension payment is calculated, that payment is subject to a COLA starting from January 1, 2004, and every January 1, thereafter. Here, there is nothing in the language of Labor Code §4659(c) that requires that COLAs start from the January 1 following the date of injury. The COLAs found in Labor Code §4659(c) should be applied to life pensions or total permanent disability compensation as the statute specifies, from January 1, 2004. Accordingly, the Decision of the Worker's

Compensation Appeals Board was annulled and the case remanded to the Workers' Compensation Appeals Board for further proceedings.

Allied Waste Industries, Inc. et al. v. Workers' Compensation Appeals Board (Rojas), C064914/ADJ608971/Sac 0345754) (12/7/2010) (Unpublished) – Permanent disability – COLA adjustments to life pension rate begin the January 1st after date of injury.

Applicant sustained an injury in February 2005. The WCJ found that applicant was entitled to a COLA as of 1/1/04, the date specified in section 4659(c) as the start date for the adjustment. Defendant sought reconsideration.

The Workers' Compensation Appeals Board affirmed the determination that applicant was entitled to a COLA as of 1/1/04. Both the WCJ and the WCAB felt constrained by the appellate decision in *Duncan,* which had determined this to be the COLA's effective date in all cases. Defendant filed a Petition for Writ of Review. Two days after the Workers' Compensation Appeals Board's decision, on the Supreme Court granted review in *Duncan*.

The Court granted the writ. It noted that Labor Code §4659(c) offers three possible start dates for this COLA: (1) January 1, 2004; (2) the January 1st following a rating of permanent total disability; or (3) the January 1st following the date of injury. It rejected defendant's contention that the adjustments should commence the year after applicant is found to be permanent and stationary, commenting:

> "Section 4659, subdivision (c) is designed to protect an injured employee from inflation. A finding of permanent and stationary disability may not happen for years after an injury occurs. Here, for example, applicant was injured in February 2005 but was not found to have a permanent and stationary disability until March 2009. Under petitioner's theory, applicant would not be entitled to a COLA until January 1, 2010, the January 1st following this determination. This interpretation does little to protect an employee against inflation and does not further the Legislature's aims as expressed in section 4659, subdivision (c)."

In the Court's analysis:

> "Section 4659, subdivision (c) first provides that eligible workers injured after January 1, 2003, are entitled to an annual COLA 'commencing on January 1, 2004, and each January 1 thereafter' in 'an amount equal to the percentage increase in the 'state average weekly wage' as compared to the prior year.' 'State average weekly wage' is defined in the statute's second sentence as the reported average weekly wage 'for the 12 months ending March 31 of the calendar year *preceding the year in which the injury occurred*.' (Italics added [by the Court].)
>
> "When these two sentences are read together, as they must be (*DuBois v. Workers' Compensation Appeals Board,* 5 Cal.4th at p. 388), it becomes clear that the critical period for determining the amount of the COLA (the subject of the first sentence) is the year in which the injury occurred (the subject of the second sentence). ….

"By using a COLA start date of the January 1st following the year of injury, the purposes behind the workers' compensation system are served: an injured employee receives inflation protection based on actual inflation rates from the time he or she is injured. The alternatives proposed--a standard effective date of January 1, 2004, or an effective date based on when an injury is determined to be permanent and stationary--do nothing to protect against inflation."

The Court concluded that "under the plain language" of section 4659(c), the COLA takes effect on the January 1st following the date of injury. Before being reversed by the 6th Appellate District, this is what the WCAB had held in *Duncan*. Thus, in this case, the COLA should be calculated as of January 1, 2006.

Arreola v. Suntreat Packing, State Compensation Insurance Fund, (2010) Lexis Nexus Workers Compensation eNews, v. 2 issue 1 (WCAB Panel). Seasonal Workers' Earnings.

Applicant sustained an admitted injury on March 20, 2006. A Pre-Trial Statement indicated that the parties stipulated to a $130.00 per week permanent disability indemnity rate, plus a 15% increase under Labor Code Section 4658(d). Applicant was seasonally employed November 1, through June 30 annually and had no off season earnings. In season earnings produced a compensation rate of $213.49 per week, and the WCJ used that rate for both temporary and permanent disability indemnity. Defendant sought reconsideration; applicant's counsel filed no response.

The Appeals Board granted reconsideration. It inferred that the WCJ had used Labor Code Section 4453(c)(4) in determining earnings, but found the WCJ had not properly considered the irregular employment over a long period as required by *Argonaut Insurance Co. v. Industrial Accident Commission (Montana)*, (1962) 57 Cal. 2nd 589; 27 Cal. Comp. Cases 130, at 132-133. In determining earnings for temporary disability one is concerned with the probable earnings had employment continued over the period of the temporary disability. In determining permanent disability actual earnings, including irregularities and voluntary or labor market driven interruptions in earnings over a substantial period of time must be considered. Here applicant's earnings of Between $7,427 and $11,987 per year over a three year period supported the stipulated minimum rate of $130.00 per week.

TEMPORARY DISABILITY

Oakland Unified School District v. Workers' Compensation Appeals Board (Little), (2010) 75 Cal. Comp. Cases ____ (Writ Denied**)** Temporary disability / Jurisdiction – 5 year commencement limit does not apply where there is original jurisdiction.

Applicant was injured on 5-14-2000 and 8-18-2000. The matter went to trial on a claim for temporary disability indemnity (TD) from 10-31-08 and continuing. Defendants denied the TD based on Labor Code §4656 because TD period was commencing more than 5 years

from the date of injury. The defendant in support of the claim they were not legally responsible for TD commencing beyond five years from the date of injury cited the cases of *Nickelsberg* (56 Cal. Comp. Cases 288 and *Hartsuiker* 58 Cal. Comp. Cases 19. The WCJ pointed out that both cases addressed the issue of the Workers' Compensation Appeals Board attempting to reserve jurisdiction beyond the 5 years or where the Td commenced over 5 years from the date of injury after and award and petition to reopen. The applicant cited the case of *Unigard v. Workers' Compensation Appeals Board* 59 Cal. Comp. Cases 96 W/D which distinguished *Hartsuiker* because it dealt with a case involving a prior final award, a petition to reopen and the Td commending beyond the 5 years period from the date of injury. The WCJ in the *Unigard* case held that absence an intervening award the Workers' Compensation Appeals Board has jurisdiction to award TD that commences beyond five years from the date of injury and the Workers' Compensation Appeals Board agree on reconsideration. In this case no previous award issued for PD or Td. Defendant filed a petition for reconsideration. In his report on reconsideration the WCJ emphasized that the decisions in *Nickelsberg* and *Hartsuiker* both addresses the 5 year limit to reopen a claim, and did not bar the applicant from making an initial claim for TD beyond 5 years from the date of injury. The petition for reconsideration and writ were denied.

CIGA v. Workers' Compensation Appeals Board (Carrigan), (2010) 75 Cal. Comp. Cases 293 (Writ Denied) Temporary Disability / Jurisdiction – Commencement over five years post injury not barred where there is original jurisdiction.

Applicant sustained injury on to both knees March 7, 2000 and December 14, 2001. The matter proceeded to expedited hearing with applicant claiming temporary disability (TD) from 3-1-07 the date she agreed to undergo a knee replacement and continuing. Applicant did undergo a knee replacement on 11-5-2008. WCJ issued and award of TD from 11-5-08 the date of her surgery to present and continuing. The issue of retroactive TD from 3-1-2007 was placed off calendar. CIGA filed a petition for reconsideration arguing that Labor Code §4656 bars TD for a period commencing more than 5 years from the date of injury and that the WCJ had no jurisdiction to award retroactive TD for the period following applicants surgery. The WCJ recommend that reconsideration be denied.

The WCJ concluded based on the case of *CIGA v. Workers' Compensation Appeals Board (Venegas)*, (2009) 74 Cal. Comp. Cases 668 (Writ denied) that there was jurisdiction to award TD more than 5 years from the date of injury when, although there was a finding of prior injury, there had been no final adjudication of all the issues. The WCJ also cited the case of *Unigard Insurance v. Workers' Compensation Appeals Board* (1994) 59 Cal. Comp. Cases 966 (Writ denied) in which it was found that the Workers' Compensation Appeals Board retained jurisdiction to award TD commencing more than five years from the date of injury because there had been no previous award and the case. It also noted that in *Denny, Inc. v. Workers' Compensation Appeals Board*, (2004) 71 Cal. Comp. Cases 831 (Writ denied) the WCJ awarded TD commencing more than 5 years from the date of injury.

The WCJ distinguished both *Nickelsberg v. Workers' Compensation Appeals Board* (1991) 56 Cal. Comp. Cases 476, and *Hartsuiker v. Workers' Compensation Appeals Board*

(1993) 58 Cal. Comp. Cases 19, relied on by CIGA because in *Nickelsberg* applicant field a petition to reopen for new and further temporary disability more than 5 years after the date of injury and the Supreme Court held that once there had been a final adjudication or other disposition of the issues, the 5 year statute in Labor Code 5804 applies to bar reopening. The Supreme Court held the Workers' Compensation Appeals Board lacked jurisdiction to award TD. Also, in *Hartsuiker* the Court of Appeal held the Workers' Compensation Appeals Board had no jurisdiction to award TD unless the petition to reopen had been filed within five years of the date of injury and the TD commenced within the 5 year period from the date of injury. The WCJ concluded that in case such as this, when no final adjudication or disposition closing the case has occurred, the period to TD did not have to commence within the 5 year period from the date of injury and no petition to reopen was required. The Workers' Compensation Appeals Board in this case had original jurisdiction and therefore the award of TD was appropriate. The Workers' Compensation Appeals Board denied reconsideration adopting the reasoning of the WCJ. A Petition for Writ of Review was denied.

Jusufbegovi v. Fiesta Ford and State Compensation Insurance Fund, (2010) 75 Cal. Comp. Cases _____ (WCAB Panel) Temporary disability – Application of Labor Code §4661.5 where TTD was paid at a wrong rate.

Applicant was injured on May 17, 2002. He was paid temporary disability indemnity for broken periods at different rates than were applicable when the belated temporary disability indemnity was paid. The applicant claimed temporary disability indemnity for the entire period from May 18, 2002 to July 26, 2007. The applicant also claimed that the defendants paid at the incorrect rate for broken period they paid temporary disability indemnity. The WCJ found that the based on applicants earning he was paid at the incorrect rate. The WCJ found the applicant earnings would have produced the maximum rates for all periods that were previously paid. The WCJ found that applicant was entitled to retroactive temporary disability indemnity for the entire period from May 18, 2004 to through July 26, 2007, however he awarded temporary disability indemnity the to be paid at the maximum rate in effect for each of those period, less credit for amounts paid at the lower rate. Applicant filed a petition for reconsideration arguing he was entitled to the rate of $847.25 for the entire period based on earning of $1,270.88 and pursuant to Labor Code §4661.5 as interpreted in the case *Hofmeister* (1984) 49 Cal. Comp. Cases 438.

The WCJ set aside his award under WCAB Rules of Practice and Procedure §10859 and ruled the applicant was entitled to temporary disability indemnity at the rate in effect at the time of the award. The WCJ determined applicant was not entitled to payment of temporary disability indemnity at the rate in effect on the date payment was made, distinguishing *Hofmesiter* on the ground the applicant had not been paid any temporary disability indemnity for 4 years, such an award was for the entire amount of temporary disability indemnity owed. The WCJ concluded that Labor Code section 4661.5 was not applicable because applicant received some temporary disability indemnity payments, though at an incorrect rate. The WCJ concluded because applicant was not deprived of all temporary disability indemnity benefits, the award of retroactive temporary disability indemnity did not trigger the

requirement of Labor Code §4661.5 that benefits be paid at the rate in effect on the date of payment. Applicant sought reconsideration.

The Workers' Compensation Appeals Board disagreed with thee WCJ stating that Labor Code §4661.5 provides that the increased rate applies when **any** temporary disability indemnity payments are made more than two years after the date of injury. The language does not distinguish between full or partial payments, as long as the payment is for temporary disability indemnity and is paid more than 2 years from the date of injury. The Workers' Compensation Appeals Board ruled that the policy protecting the financial interests of the injured workers underlying Labor Code §4661.5 is no less applicable under the circumstances of this case. Under the facts considered by the WCJ, applicant was entitled to receive temporary disability indemnity at a higher rate than paid by defendants. He is now entitled, by clear statutory language, to received increased indemnity rates available by virtue of the fact that he is being paid the correct rate more than two years from the date of injury. The Workers' Compensation Appeals Board awarded TD from May 18, 2004 through July 26, 2007 at the Maximum temporary disability indemnity rate of $847.25 less credit for sums paid.

Kimball v. Workers' Compensation Appeals Board (Metropolitan State Hospital), (2010) 75 Cal Comp. Cases 1022 (writ denied) Temporary disability – earnings and rate changes pending delayed payment.

Applicant suffered an assault by a patient on January 15, 2004, and sustained cumulative injury in the year ending March 11, 2004, both injured her right shoulder, neck, hands, temperomandibular joints, and psyche.

On July 14, 2005 a WCJ ordered defendant to serve on applicant's counsel within 45 days legible copies of checks or a computer print out of Industrial Disability Leave (IDL) payments, short or long term disability payments, retirement dental [insurance premiums or offset], vision [insurance premiums or offset], CalPERS [contributions], union [dues payments?], and long term care from January 15, 2004.

Defendant failed to provide the information, and no action to enforce the order was taken prior to trial. The case came to trial on July 5, 2006. Applicant was awarded temporary total disability for the periods from January 15, 2004 to February 10, 2004 and March 11, 2004 to October 6, 2004 at $728 per week for payments within two years of injury, and by amendment to the award, at the rate warranted by Labor Code Section 4661.5 for payments not made within two years from date of injury.

Defendant sought reconsideration contending that the WCJ failed to allow credit for IDL paid at full salary level. Defendant attached previously undisclosed payroll records showing payment(s) of IDL. The WCJ recommended that reconsideration be denied, and that sanctions be imposed for attaching its payroll records as newly discovered evidence. Defendant's counsel filed a response to the WCJ's recommendation alleging that the WCJ had indicated she would consider issuing a revised F&A if the defendant sought

Reconsideration and attached the payroll records. Defendant then filed a petition to augment the record, and represented that by attaching the payroll records he was only "trying to comply with his understanding of the WCJ's remarks."

The Board requested the WCJ issue a supplemental report responding to the defendant's rejoinder.

The WCJ in her supplemental Report and Recommendation recommended that reconsideration be granted, that the Board award temporary disability at $728 per week for the periods January 15, 2004 to February 10, 2004 and March 11, 2004 to October 6, 2004, plus $1,976.00 for indemnity unpaid from September 1, 2004 to September 30, 2004,plus sanctions for failure to comply with the July 14, 2005 order to serve an accounting of benefits.

After issuing a Notice of Intent to enter award in accord with the WCJs recommendations, the Board on December 13, 2007 issued an award of TTD for the periods provided, subject to Labor Code Section 4661.5, and remanded the sanction issue.

The case came for Status Conference hearing on April 17, 2008, and the WCJ noted in the Minutes that no temporary disability indemnity had been paid pursuant to the Board's December 13, 2007 Award. The WCJ ordered defendant's adjuster to appear at MSC on June 5, 2008. On May 30, 2008, defendant issued multiple payments to comply with the December 13, 2007 Award, and included an inadvertent duplicate payment of $23,539.07. The adjuster for defendant's claims administrator failed to appear at the June 5, 2008 hearing.

On December 8, 2009 the WCJ issued a Joint Findings and Award holding that defendant had paid temporary disability at the rate required by Labor Code Section 4661.5, declining to impose sanctions, and denying defendant credit for the $23, 539.07 duplicate payment. Both parties sought reconsideration.

Applicant contended that the temporary disability rate should have been increased to reflect a pay raise granted by union agreement for applicant's classification on January 1, 2008, and contended that sanctions and attorney's fees should have been imposed. Defendant contended that it should have been allowed credit for the duplicate payment. The WCJ recommended that the petitions be denied. She pointed out that the pay increase was effective 38 months after applicant's period of temporary disability ended. On the issue of sanctions and attorney's fees, the WCJ recommended that while the defendant's actions had delayed the case, applicant and her counsel took no action(s) to redress or remedy defendant's failure to comply with the July 14, 2005 Order. It appeared to the WCJ that the defendant's failure to comply was not done in bad faith, but due to excusable neglect. The WCJ further reported that credit for the duplicate payment should be denied because applicant was not at fault for the duplicate payment, and allowing them against penalties, interest, or permanent disability / life pension would disrupt permanent disability payments and frustrate the purpose behind Labor Code §§5800 and 5814. The Board denied both parties' petitions for reconsideration. Applicant sought review, but the writ was denied.

Collingwood v. Wausau Insurance, (2010) 38 CWCR 10 (WCAB Panel) Temporary Disability – Amputation exception to 104 week limitation..

On October 11, 2006, applicant sustained multiple injuries when she feel from a truck and came to rest on her chest. Prior to the work injury, in 2002 applicant had cosmetic surgery for the insertion of breast implants. In 2006 she had additional surgery to correct a deformity in the capsule around the implants and to further enlarge the breasts. After the work injury the defendant authorized left breast reconstruction, but declined to authorize bilateral surgery recommended by the treating physician. Following a hearing on the issue of the need for bilateral surgery the WCJ ordered the surgery. Surgery was performed on March 25, 2008. Complications led to the removal of both breast implants. Applicant was temporary totally disabled beyond 104 weeks and defendants refused to pay TD based on the 104 limitation contained in Labor Code section 4656.

The WCJ ruled that the additional period of temporary disability indemnity allowed for amputations pursuant Labor Code section 4656 (c) (3) was applicable based on the facts of this case. The WCJ stated that the definition of amputation was set forth in the leading case of *Cruz v. Mercedes Benz of San Francisco*, (2007) 72 Cal. Comp. Cases 1281 (WCAB en banc) which defined amputation as the severance or removal of a limb, part of limb, or other body appendage within the ordinary meaning, and includes the range of potentially compensable scenarios, including both dramatic loss of a body part in an industrial injury and surgical removal during treatment.

In this case the WCJ ruled that because the capsule had adhered to breast structure it was necessary to remove a portion of the muscle and breast tissue with the capsule. The resulting disfiguration was similar to that associated with a mastectomy. The WCJ ruled that Labor Code §4656 does not distinguish between whole and partial amputations and that section does not require severance of the entire body part. Under the definition of amputation found in the *Cruz* case the WCJ ruled that breasts are appendages and removal of one or a portion of one breast is and amputation within the meaning of Labor Code §4656 entitling the applicant to the temporary disability indemnity provided for in §4656 (c) (3) (C).

Defendants filed a petition for reconsideration which was denied by the Workers' Compensation Appeals Board adopting the reasoning of the WCJ contained in her report and recommendation on reconsideration.

Rasura v. Community Health Centers, SCIF, Gallagher Bassett, (2010) 38 CWCR 44 (WCAB Panel) Temporary disability – 4656 cap where there are successive injuries.

The WCJ found injury on April 30, 2004 and a CT through March 31, 2006. Temporary disability indemnity was awarded from April 1, 2006 to present and continuing. Defendant filed a petition for reconsideration claiming that WCJ erred by fining applicant sustained two independent injuries that resulted in the current period of temporary disability indemnity. Labor Code §4656(c) (1) limits temporary disability indemnity to no more than 104 weeks

within in two year period from the date of commencement of temporary disability indemnity. When independent injuries result in concurrent periods of temporary disability indemnity the two year limitation likewise runs currently. (*Foster v Workers' Compensation Appeals Board,* (2008) 161 Cal. App. 4th 1505; 73 Cal. Comp. Cases 466.) In *Hawkins v. Amberwood Products,* (2007) 72 Cal. Comp. Cases 807 (WCAAB en banc), it as held that the date of commencement of temporary disability indemnity means the date on which temporary disability indemnity is first paid not the date it is first owed. In this case applicant sustained two injuries nearly two years apart. The first injury caused broken periods of partial TD and the second injury caused applicant to be TD beginning April 1, 2006. Because there are two injuries, there are two separate 104 week/ 2 year caps. Assuming that both injuries contributed to applicant's need for TD during a particular time period, there may be a concurrent period of TD and both 104/ 2week caps would run simultaneously. However, it does not appear that defendant made any temporary disability indemnity payments after applicant's second injury. Pursuant to *Hawkins*, the Labor Code §4656 (c) (1) cap does not begin to run until the date on which TD was first paid. Therefore, it appears that the Labor Code §4656 (c) (1) cap for the first injury was reached before defendant commenced payments for the second injury and *Foster v Workers' Compensation Appeals Board,* (2008) 161 Cal. App. 4th 1505; 73 Cal. Comp. Cases 466, does not apply. Defendant argues that commencement of TD payments for the first injury should be deemed the date of commencement for second injury because the AME found that both injuries contributed to the applicant's need for TD. However the date of commencement of TD payments for second injury must occur at some point in time after the second date of injury. The Petition for Reconsideration was denied.

Harris-Boyd v. Liberty Mutual, (2010) 38 CWCR 120 (WCAB Panel**)** Temporary disability 4656(c) cap applies to all types of TD indemnity including TDI paid in another state.

The Workers' Compensation Appeals Board granted reconsideration and reversed a WCJ decision ordering more than 104 weeks of TD payments. The Workers' Compensation Appeals Board ruled that Labor Code §4656 (c) (1) provides for a 104 week limitation on the employers liability for the payment of TD for all types of TD caused by a single injury. In this case the applicant received some temporary partial disability in another state after the injury. Labor Code §4656 (c) (1) has no limitation for a TD payment whether paid to partial or total temporary disability. Additionally there is no restriction for TD paid under another state's workers compensation law.

PERMANENT DISABILITY

Ogilvie v. City & County of San Francisco, (2009) 74 Cal. Comp. Cases 248 and 74 Cal. Comp. Cases 1127 (WCAB en banc) Rebuttal of DFEC permitted, means

Division 3 of the 1st Appellate District has granted the petitions for writ of review of the Workers' Compensation Appeals Board' s second en banc decision (2009) 74 Cal. Comp. Cases 1127 in the above cases. The Court consolidated the cases for all purposes. The Court

also directed the parties to file briefs addressing the following questions: What must a party show to rebut the presumption in section 4660? Is a showing that a claimant's diminished earning capacity is different than the diminished earning capacity reflected in the PDRS for the claimant's scheduled rating sufficient to rebut the presumption in section 4660? Should a general rule be formulated that provides guidance on the showing necessary for a party to rebut the presumption in section 4660? If so, how should the general rule be articulated? In Ogilvie, after granting reconsideration of its prior en banc decision, the Workers' Compensation Appeals Board clarified that decision and held:

(1) the language of section 4660(c), which provides that "the schedule … shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule," unambiguously means that a permanent disability rating established by the Schedule is rebuttable;
(2) the burden of rebutting a scheduled permanent disability rating rests with the party disputing that rating; and
(3) one method of rebutting a scheduled permanent disability rating is to successfully challenge one of the component elements of that rating, such as the injured employee's DFEC adjustment factor, which may be accomplished by establishing that an individualized adjustment factor most accurately reflects the injured employee's DFEC.

The Workers' Compensation Appeals Board had stated further that the individualized DFEC adjustment factor must be consistent with section 4660(b)(2), the RAND data to which section 4660(b)(2) refers, and the numeric formula adopted by the Administrative Director (AD) in the 2005 Schedule, and it also must constitute substantial evidence that the Workers' Compensation Appeals Board determines is sufficient to overcome the DFEC adjustment factor component of the scheduled permanent disability rating.

The essential elements of an Ogilvie rebuttal are – (1) offering in evidence wage data for the injured and for comparable cohorts in the same employment field; (2) using that data to compute the injured's proportional earnings loss; (3) determining by mathematical computation that the employee's proportional earnings loss falls outside the DFEC range in the 2005 schedule (if it does not fall outside the range, the schedule applies); (4) compute an individualized DFEC adjustment factor using the prescribed formulas, and (5) offer substantial evidence that the individual's earnings loss is due to the post injury impairment and not to other "Montana factors" bearing on earnings history and capacity.

Blackledge v. Bank of America, Ace American Insurance Co., (2010) 75 Cal. Comp. Cases 613 (WCAB en banc). Permanent disability – rating instructions.

Applicant sustained injury to her right wrist, low back, right hip and right knee on October 26, 2005, when she slipped while descending a flight of stairs. The parties referred applicant to Dr. David Perlman as an Agreed Medical Examiner. Dr. Perlman evaluated applicant, and reported that her AMA impairments were 10% WP. He recommended a DRE-II 8% impairment for her back, no ratable wrist impairment, and 2% WP impairment for her

right hip and knee. After trial the WCJ issued rating instructions directing the disability evaluation specialist to rate for impairments of the low back, right wrist, right hip, and right knee as described by Dr. Perlman, and to "consider a 3% add on for pain."

The disability evaluation specialist returned a recommended rating of 0% final permanent disability. At a timely requested cross examination the disability evaluator testified that he disregarded Dr. Perlman's recommended 8% WPI for the back because the examination findings did not support the AMA Guides requirements of "radiculopathy, spasm and los of motion" required for a DRE-II impairment. He similarly rejected Dr. Perlman's assessment of 2% for paterllofemoral pain because of lack of history of direct trauma [to the patella]. After submission the WCJ issued Findings and Award of 10% permanent partial disability. ACE sought reconsideration.

The Appeals Board in an en banc decision, held that the physician's role in determining permanent disability is to assess the AMA Guides impairments and report percentages of impairments within applicable ranges, with supporting facts and reasoning. The Workers' Compensation Judge must then specifically and fully describe the impairments supported by substantial medical evidence, and may request the rater to offer opinion on what factors should or should not be rated, e.g. based on overlap. While the WCJ may direct the rater to refer to a report or charge for identification of measurable physical elements of disability, the instructions must specify the WPI percentage to be used for each injured body part or direct the rater to use the WPIs contained in the medical report by author, date and page of the report to be considered. The rater's role is to issue a recommended rating based solely on the WCJ's instructions, and should only indicate the rater's assessment of the medical evidence when specifically instructed to do so. A WCJ may reject a rater's recommendation or may rate the medical evidence without a formal instruction or rating. The WCJ's rating must be based on substantial medical evidence. The WCJ may not engage in ex parte communication with the rater.

In this case, the Board found the rating instructions insufficient in that they failed to describe the WPI's to be rated; had the instructions directed the rater to rate for 8% back WPI and 2% lower extremity WPI it would have been error on the part of the rater to disregard the instructions. Further, in this case, it is the WCJ's role and duty to assess whether the findings support the imposition of a DRE-II impairment. It is also the WCJ's responsibility to determine and instruct as to whether to apply an add on for pain, and to specify which body part or parts are to be assigned the additional pain factor. No pain add on is allowable where there is no underlying ratable impairment in the affected body part. The award of permanent disability and attorney's fees was stricken, and the matter remanded for further proceedings and decision.

Perchlak v. Wal-mart, (2010) (WCAB Panel) Permanent Disability; Rating Instructions.

The WCJ's rating instructions were to rate per the report of Dr. Lipper. The DEU rater gave no disability for the gastrointestinal and sleep/arousal impairments. On cross examination the disability evaluation specialist said this was intentional because the rating

described by the physician did not meet criteria set forth in AMA Guides. The DEU rater testified that she believed her conclusions were not inconsistent with the rating instructions of the WCJ. The disability evaluator did rate the gastrointestinal and sleep/arousal impairments at the cross examination. The WCJ found 44% PD with no disability given by the DEU rater for applicant's gastrointestinal and sleep/arousal impairment. Applicant filed a petition for reconsideration.

The Workers' Compensation Appeals Board panel reversed WCJ's rating and award. The Board stated the DEU rater is neither a medical expert nor a trier of fact. The rater must follow the instructions given by the WCJ. The rater must consider no more or less than the instructions given by the WCJ. The Board went on to state that although the rating in this case should have been more precise as required by the Balckledge decision, it was clear what the WCJ intended: a rating based on the factors described by Dr. Lipper. The rater did not indicate she did not know what the WCJ intended but rather was of the opinion the physician did not meet criteria set forth in AMA Guides. The rater had did not have the authority to disregard the rating instructions and independently access the WPI and prepare a rating based on he own assessment. The Board found that the DEU rater who prepared the formal rating disregarded the impairment rating described by the physician based on her belief that the description of applicant's sleep/arousal impairment did not meet criteria set forth in AMA Guides. The Board found that, pursuant to principles set forth in Blackledge decision, the rater had no authority to assess the merits of physician's impairment findings, to disregard rating instructions issued by WCJ, to independently assess applicant's WPI under AMA Guides, or to prepare rating based upon her own impairment assessment. The Workers' Compensation Appeals Board reversed and remanded to the WCJ for redetermination of the issue of PD.

Leprino Foods v. Workers' Compensation Appeals Board (Barela), (2010) 75 Cal. Comp. Cases 415 (unpublished) Permanent disability – higher rating after self procured back surgery.

Applicant sustained a low back injury on August 31, 2005. PTP E. Scott Conner, M. D., recommended discectomy and fusion back surgery. UR denied and a second opinion physician, Dr. Wrober also recommended against the surgery. Applicant was referred to Dr. Robert Ansel, M. D., as an Agreed Medical Examiner. Dr. Ansel also recommended applicant not undergo surgery, and recommended a DRE Category II 8% WPI impairment.

.Applicant obtained spinal surgery through private health insurance. Dr. Ansel re-evaluated and found that applicant had had a successful result, decreasing pain and increasing work capacity, as a result of the surgery. After the surgery applicant was found to be in DRE Category III, with 10% WPI. He later opined that the two level surgery would probably result in loss of segment integrity warranting a DRE Category IV 23% impairment. The WCJ awarded applicant permanent disability based on the DRE IV impairment. Defendant sought reconsideration contending that the increase from 8% WPI was a result of unauthorized medical treatment . The Workers' Compensation Appeals Board denied

reconsideration finding that the source of the medical treatment producing the impairment was irrelevant.

Leprino sought review and the Court of Appeal found that the higher rating was based on the spinal fusion surgery, but that the impairment determination was accurate and not precluded by the UR and AME recommendations against surgery. The Court held that surgery obtained in the face of a 4062(b) recommendation against surgery precludes recovery of the self procured treatment expense and temporary disability resulting from the surgery, but not from permanent disability resulting from the surgery. Leprino also overlooks Dr. Ansel's admission, albeit after the surgery was performed, that the procedure was a success and was both reasonable and necessary. (See *White v. Workmen's Compensation App. Board*, (1969) 270 Cal.App.2nd 447, 451 ["employee has the benefit of hindsight in proving" reasonableness of a successful self-procured surgery].) The fact that successful surgery resulted in a greater AMA impairment is inherent in the mandated schedule.

Macneil v. Petaluma Junior High School District, (2010) 38 CWCR 88 (WCAB Panel) Permanent Disability – Basis for applying *Almarez-Guzman.*

Applicant injured his right shoulder. The parties agree to an Agreed Medical Examiner on the issue of PD. In his report the AME found a WPI of 5% under the AMA guides by reference to figure 16-40 and 16-43. At the request of applicant's attorney to analogize to other portions of the guides as permitted by the board's decisions in *Almaraz* and *Guzman* the AME wrote the applicant had the equivalent of a 30% amputation or 18% WPI. The AME declined say whether *Almaraz/Guzman* applied to the fact situation, that matter, the AME said, was for the trier of fact. The WCJ found PD based on the AME's report which the rater gave a rating of 11 WPI modified to 18% Pd. The rater added that had *Almaraz/Guzman* had not been applied the rating would have been 9%. The WCJ issued an award of 18% finding based on the AME report and rating. Defendants filed a petition for reconsideration.

Defendant argued that the rating was not justified by the evidence and that the AME did not adequately explain has reasons for not strictly following the guides. The WCJ in his report on reconsideration pointed out the guides do not relegate the physician to the role of taking a few objective measurements and mechanically and uncritically assigning a WPI based on a rigid protocol that id devoid of any clinical judgment. As the court of appeal stated in the case of *Glass v. Workers' Compensation Appeals Board*, (1980) 105 Cal. App. 3rd 297; 45 Cal. Comp. Cases 441 which stated the Workers' Compensation Appeals Board may not rely on alleged limitations in the PDRS to deny an injured worker a PD award that accurately reflects his or her true disability. In this case the WCJ concluded that a rating by analogy was an appropriate method of reflecting applicant's actual disability. The method took into account his actual disabilities, i.e., his moderate pain, and difficulty working above chest level, manipulating objects with his hands and forcibly using his hands and arms. The WCJ went on that analogous rating under Almaraz/Guzman rebutted the presumably correct rating, 5% WPI solely based on loss of motion, and took into account the total picture of the impairment resulting from the loss of right arm function. The WCJ recommended that

reconsideration be denied. The Workers' Compensation Appeals Board denied reconsideration based on the WCJ report and recommendation.

Milpitas Unified School District v. Workers' Compensation Appeals Board (Guzman), (2010) 187 Cal. App. 4th 808; 75 Cal. Comp. Cases 837; 38 CWCR 197. Permanent disability – Rebutting strict application of the AMA Guides.

The Workers' Compensation Appeals Board ruled that (1) an employee's impairment may be determined by reference to any applicable portion of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition (Guides), and (2) this determination may be used to rebut the rating of permanent disability established by the 2005 Schedule for Rating Permanent Disabilities ("PDRS" or Schedule).

The court granted the Defendant's petition for review, but affirmed the Board's decision. The court concluded that the language of Labor Code §4660 permits reliance on the entire Guides, including the instructions on the use of clinical judgment, in deriving an impairment rating in a particular case. The statutory revision most significant for the resolution of Guzman's case is the new condition that the determination of " 'the nature of the physical injury or disfigurement' shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, 5th Edition)." (Labor Code §4660(b)(1).) First published in 1971 to provide "a standardized, objective approach to evaluating medical impairments," (AMA Guides § 1.1, p. 1) the AMA Guides sets forth measurement criteria that certified rating physicians and chiropractors can use to ascertain and rate the medical impairment suffered by injured workers. (Id. § 1.2, at p. 4.) "Impairment" is defined in the Guides as "a loss, loss of use, or derangement of any body part, organ system or organ function." (AMA Guides § 1.2, p. 2.) The impairment ratings provided in the Guides "were designed to reflect functional limitations and not disability." (AMA Guides § 1.2, p. 4.) They "reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), excluding work." (AMA Guides, § 1.2, p. 4.) A permanent disability, on the other hand, "causes impairment of earning capacity, impairment of the normal use of a member, or a competitive handicap in the open labor market." (*Brodie v. Workers' Compensation Appeals Board*, 40 Cal.4th at p. 1320.) "A disability is considered permanent when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment." (8 Cal. Code of Regs. § 10152.) Permanent disability is expressed as a percentage: Anything less than 100 percent (total disability) entitles the injured worker to a prescribed number of weeks of indemnity payments in accordance with that percentage. (Labor Code § 4658.) "Thus, permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future earning capacity." (*Brodie v. Workers' Compensation Appeals Board*, supra, 40 Cal.4th at p. 1320.)

"In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and

his or her age at the time of the injury, consideration being given to an employee's diminished future earning capacity." (Labor Code §4660(a).) The "nature of the physical injury" refers to impairment, which is expressed as a percentage reflecting the "severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), excluding work." (AMA Guides § 1.2, p. 4, italics in the original.) In each case impairment ratings are combined and converted to a "whole person impairment" (WPI) rating, which reflects the impact of the injury on the "overall ability to perform activities of daily living, excluding work." (AMA Guides, p. 603.) The WPI is then adjusted for diminished future earning capacity (DFEC), the employee's occupation classification at the time of the injury, and age. Of these four components, it is the "nature of the injury," expressed in terms of impairment, that is the source of the controversy in this case. The primary issue in this dispute is whether Labor Code §4660, following the 2004 revisions, permits deviation from a strict application of the descriptions, measurements, and percentages contained in the Guides for purposes of determining the impairment resulting from an employee's workplace injury. This question calls for construction and application of Labor Code § 4660, and more specifically, subdivisions (b)(1) and (c) of that statute. "Issues of statutory interpretation are questions of law subject to our independent or de novo review. Nonetheless, unless clearly erroneous the Workers' Compensation Appeals Board's interpretation of the workers' compensation laws is entitled to great weight." (*Genlyte Group, LLC v. Workers' Compensation Appeals Board*, (2008) 158 Cal. App. 4th 705, 714; see also *Vera v. Workers' Compensation Appeals Board*, (2007) 154 Cal. App. 4th 996, 1003; accord, *Tanimura & Antle* v. *Workers' Compensation Appeals Board*, (2007) 157 Cal. App. 4th 1489, 1494.)

At the same time, the workers' compensation statutes must be "liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." (Labor Code § 3202.) In determining Legislative intent, we "turn to the words in the statute and give effect to the statute according to the usual, ordinary import of the language used in framing it." (*Klee v. Workers' Compensation Appeals Board*, (1989) 211 Cal. App. 3rd 1519, 1523.) When the language is clear and there is no uncertainty as to the legislative intent, one looks no further and simply enforces the statute according to its terms. If possible, significance should be given to every word, phrase, sentence and part of an act in pursuance of the legislative purpose….When used in a statute [words] must be construed in context, keeping in mind the nature and obvious purpose of the statute where they appear. Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole." (*DuBois v. Workers' Compensation Appeals Board*, (1993) 5 Cal. 4th 382, 387-388.)

The District's position on appeal is a narrow one: Whereas the PDRS is rebuttable, the criteria set forth in the Guides are not rebuttable for purposes of making a determination of whole person impairment. Relying primarily on subdivision (b)(1), the District points out that determination of an employee's impairment must incorporate the descriptions and measurements set forth in the Guides. This provision, in the District's view, mandates the application of the Guides "as written" and "as intended" and prohibits physicians from "rewriting the Guides by applying 'any chapter, table or method' he/she deems more

appropriate." Thus, the District argues, "the Guides, properly applied, are the final word on impairment. There is no other way to interpret the plain language of Labor Code § 4660." Several parties filed amicus curiae briefs arguing that the Guides must be used "as written" in order for the Schedule to promote consistency, uniformity, and objectivity. The Board's decision, they argue, defeats that objective by allowing impairment ratings to be based on chapters that do not apply to the employee's injury. The Insurance Commissioner adds that since the passage of SB 899 permanent disability costs have decreased and become "determinable, predictable, and quantifiable," an effect he believes will be lost with the current decision. Applying the settled rules of statutory construction, we agree with the District that the Guides must be applied "as intended" and "as written," but we take a broader view of both its text and the statutory mandate.

Section 4660, subdivision (b)(1), recognizes the variety and unpredictability of medical situations by requiring incorporation of the descriptions, measurements, and corresponding percentages in the Guides for each impairment, not their mechanical application without regard to how accurately and completely they reflect the actual impairment sustained by the patient. To "incorporate" is to "unite with or introduce into something already existent," to "take in or include as a part or parts," or to "unite or combine so as to from one body." (Webster's Third New International Dict. p. 1145 (1993); Random House Dict. of the Eng. Lang. 2d ed. (1987) p. 968; American Heritage Dict., 3d ed., p. 588.) Labor Code §4660, subdivision (b)(1), thus requires the physician to include the descriptions, measurements, and percentages in the applicable chapter of the Guides as part of the basis for determining impairment. The court cannot expand the statutory mandate by changing the word "incorporate" to "apply exclusively." Nor can the court read into the statute a conclusive presumption that the descriptions, measurements, and percentages set forth in each chapter are invariably accurate when applied to a particular case. Had the Legislature wished to require every complex situation to be forced into preset measurement criteria, it would have used different terminology to compel strict adherence to those criteria for every condition. A narrower interpretation would be inconsistent with the clear provision that the Schedule -- which itself incorporates the Guides (PDRS p. 1-2)--is rebuttable (Labor Code §4660(c)), and it would not comport with the legislative directive to construe the workers' compensation statutes liberally "with the purpose of extending their benefits for the protection of persons injured in the course of their employment." (Labor Code §3202.) The court therefore disagreed with the District and its supporting *amici* that this construction of Labor Code §4660(b)(1), would defeat the legislative objective of consistency, uniformity, and objectivity.

The District agrees with the statement by the authors of the Guides that its application "as intended" facilitates "an appropriate and reproducible assessment to be made of clinical impairment." (AMA Guides, p. 11.) However, the District in its argument fails to consider the rest of that paragraph, which makes a rather different point, an important one:

> "The physician's judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guides criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment. Clinical

judgment, combining both the 'art' and 'science' of medicine, constitutes the essence of medical practice." (AMA Guides §1.5, p. 11.)

The Guides itself recognizes that it cannot anticipate and describe every impairment that may be experienced by injured employees. The authors repeatedly caution that notwithstanding its "framework for evaluating new or complex conditions," the "range, evolution, and discovery of new medical conditions" preclude ratings for every possible impairment. (AMA Guides §1.5, p. 11.) The Guides ratings do provide a standardized basis for reporting the degree of impairment, but those are "consensus-derived estimates," and some of the given percentages are supported by only limited research data. (Guides, pp. 4, 5.) The Guides also cannot rate syndromes that are "poorly understood and are manifested only by subjective symptoms." (Ibid.)

To accommodate those complex or extraordinary cases, the Guides calls for the physician's exercise of clinical judgment to assess the impairment most accurately. Indeed, throughout the Guides the authors emphasize the necessity of "considerable medical expertise and judgment," as well as an understanding of the physical demands placed on the particular patient. (AMA Guides p. 18.) "The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing." (AMA Guides, p. 19.) The PDRS itself instructs physicians that if a particular impairment is not addressed by the AMA Guides, they "should use clinical judgment, comparing measurable impairment resulting from the unlisted objective medical condition to measurable impairment resulting from similar objective medical conditions with similar impairment of function in performing activities of daily living." (PDRS, pp. 1-4.)

Accordingly, while we agree with the District that the Guides should be applied "as intended" by its authors, such application must take into account the instructions on its use, which clearly prescribe the exercise of clinical judgment in the impairment evaluation, even beyond the descriptions, tables, and percentages provided for each of the listed conditions. The District and supporting *amici* nevertheless maintain that the Board's decision will result in burdensome litigation, inconsistent ratings, employer-employee conflicts, and "doctor shopping." The Board emphasized that its decision does not allow a physician to conduct a fishing expedition through the Guides "simply to achieve a desired result"; the physician's medical opinion "must constitute substantial evidence" of WPI and "therefore . . . must set forth the facts and reasoning [that] justify it."

> "In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. Further, a medical report is not substantial evidence unless it sets forth the reasoning behind the

physician's opinion, not merely his or her conclusions." (*E. A. Yeager Const. v. Workers' Compensation Appeals Board*, (2006) 145 Cal. App. 4th 922, 928.)

Accordingly, a physician's medical opinion that departs unreasonably from a strict application of the Guides can be challenged, and it would not be acceptable as substantial evidence or fulfill the overall goal of compensating an injured employee commensurate with the disability he or she incurred through the injury. If Guzman's carpal tunnel syndrome, for example, is adequately addressed by the pertinent sections of Chapter 16, an impairment rating that deviates from those provisions will properly be rejected by the WCJ. As the Board's decision does not disregard, retreat from, or compromise the requirement of substantial evidence, we cannot conclude that it erred to the extent that it allows physicians to use their clinical judgment in applying the Guides.

Unlike the District, which acknowledges the importance of the Guides instructions, amicus Employers Direct insists that Labor Code §4660 permits incorporation of only the " 'descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the [Guides]' into the definition of 'the nature of the physical injury or disfigurement.' " According to this theory, the Legislature did not intend to incorporate any other portions of the Guides, including the first two chapters instructing physicians on the proper use of the Guides to evaluate impairment. The court rejected this argument. Those first two chapters make it clear that an impairment rating based solely on the descriptions, measurements, and percentages in the succeeding chapters without the use of physicians' clinical judgment, training, experience, and skill would contravene the assumptions and intent of the authors. The failure to follow all of the instructions in the first two chapters could result in useless evidence, inadequate diagnostic reasoning, and inaccurate and inconsistent ratings. In the Board's view, the Administrative Director complied with the statutory mandate by adopting and incorporating the entire Guides without limitation. As a result, the Board concluded, "the entire AMA Guides is part of the Schedule." Given the comprehensiveness and precision attendant in the chapters pertaining to each system, in most cases a WCJ will credit ratings based strictly on the chapter devoted to the body part, region, or system affected.

The Workers' Compensation Appeals Board rested its decision in part on Labor Code §4660, subdivision (c), which states that the PDRS constitutes "prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." "A statute providing that a fact or group of facts is prima facie evidence of another fact establishes a rebuttable presumption." (Evidence Code §602.) Accordingly, as "prima facie evidence" the Schedule is not "absolute, binding and final. It is therefore not to be considered all of the evidence on the degree or percentage of disability. Being prima facie it establishes only presumptive evidence [which] may be controverted and overcome." (*Universal City Studios, Inc. v. Workers' Compensation Appeals Board*, (1979) 99 Cal. App.3rd 647, 662-663.) As the District acknowledges, the 2004 amendment of section 4660 did not alter the prior versions that deemed the rating schedule to be "prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." (See *Frankfort General Ins. Co. v. Pillsbury*, (1916) 173 Cal. 56, 58-60.) The Board noted pre-amendment decisions confirming the rebuttability of the Schedule. (See,

e.g., *Glass v. Workers' Compensation Appeals Board*, (1980) 105 Cal. App. 3rd 297, 307; 45 Cal. Comp. Cases 441 [where schedule does not accurately reflect true disability, "it may be controverted and overcome"]; compare *Universal City Studios, Inc. v. Workers' Compensation Appeals Board.*, supra, 99 Cal. App.3rd at p. 663 [presumption "totally overcome" by evidence that employee medically able to return to work but chose not to do so].) "The Legislature is deemed to be aware of judicial decisions already in existence and to have enacted or amended a statute in light thereof. [Citation.] When a statute has been construed by judicial decision, and that construction is not altered by subsequent legislation, it must be presumed that the Legislature is aware of the judicial construction and approves of it." (*Stavropoulos v. Superior Court*, (2006) 141 Cal. App. 4th 190, 196; *White v. Ultramar, Inc.*, (1999) 21 Cal. 4th 563, 572.)

To make an impairment determination in rebuttal of the Schedule, the physician is permitted by the Board to use the "four corners of the Guides." The Board stated that by having the latitude to use the "four corners" of the Guides, the physician "is not inescapably locked into any specific paradigm for evaluating WPI under the Guides." The statute, the Board reasoned, "does not mandate that the impairment for any particular condition must be assessed in any particular way under the Guides [or] relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment. Instead, the AMA Guides expressly contemplates that a physician will use his or her judgment, experience, training, and skill in assessing WPI."

In order to support the case for rebuttal, the physician must be permitted to explain why departure from the impairment percentages is necessary and how he or she arrived at a different rating. That explanation necessarily takes into account the physician's skill, knowledge, and experience, as well as other considerations unique to the injury at issue. In the Court's view, a physician's explanation of the basis for deviating from the percentages provided in the applicable Guides chapter should not a priori be deemed insufficient merely because his or her opinion is derived from, or at least supported by, extrinsic resources. The physician should be free to acknowledge his or her reliance on standard texts or recent research data as a basis for his or her medical conclusions, and the WCJ should be permitted to hear that evidence. If the explanation fails to convince the WCJ or Workers' Compensation Appeals Board that departure from strict application of the applicable tables and measurements in the Guides is warranted in the current situation, the physician's opinion will properly be rejected. Without a complete presentation of the supporting evidence on which the physician has based his or her clinical judgment, the trier of fact may not be able to determine whether a party has successfully rebutted the scheduled rating or, instead, has manipulated the Guides to achieve a more favorable impairment assessment. By using the word "incorporate" and retaining a prima facie standard for the introduction of the PDRS ratings, the Legislature obtained a more consistent set of criteria for medical evaluations while allowing for cases that do not fit neatly into the diagnostic criteria and descriptions laid out in the Guides. The Guides itself recognizes that it cannot anticipate and describe every impairment that may be experienced by injured employees. To accommodate those complex or extraordinary cases, it calls for the physician's exercise of clinical judgment to evaluate the impairment most accurately, even if that is possible only by resorting to comparable

conditions described in the Guides. The PDRS has expressly incorporated the entire Guides, thereby allowing impairment in an individual case to be assessed more thoroughly and reliably. The decision of the Workers' Compensation Appeals Board was affirmed.

The Supreme Court issued an order summarily denying defendant's petition for review from the Court of Appeal's published decision

Wong v. City of Los Angeles, (2010) (ADJ 6820873) (WCAB Panel) – Permanent disability – Rebutting FEC component of the 2005 PDRS.

Applicant was awarded 84% PD for injury in the form of hypertension, hypertensive heart disease and cardiomyopathy. Defendant contended the DFEC component of the 2005 PDRS was rebutted because the applicant lost no earnings as a result of this impairment. Defendants assert applicant was never Temporarily Disabled and that applicant's wage statements from January 1, 2005 to February 2010 represent empirical wage information showing that applicant incurred no wage loss as a result of his injury. However it is irrelevant that applicant was never temporarily disabled, because the issue is diminished future earning capacity**.** From 2005 to 2010 applicant was retired but participated in defendants deferred retirement option program. This program is unique to this employer, and there is nothing in the record to suggest that such programs are available to similarly situated employee in the general working population. The fact that applicant made out well under this program does not mean that absent the program, a similarly situated employee with applicants medical impairments would have no DFEC. The WCJ found that the defendants failed to meet their burden of proof pursuant to the case of *Ogilvie v. City and County of San Francisco*, (2009) 74 Cal. Comp. Cases 1127, of an alternative of an alternative diminished earning capacity by failing to produce witnesses or documentation consistent with that case. Defendant sought reconsideration.

The Workers' Compensation Appeals Board rejected defendant's contention that the DFEC component of the PDRS had been rebutted. The Board noted that in Ogilvie I the Workers' Compensation Appeals Board held in part that the DFEC portion of the 2005 PDRS maybe rebutted consistent with Labor Code §4660 including §4660 (b) (2) and the Rand data to which Labor Code §4660(b) (2) refers. In *Ogilvie II* (74 Cal. Comp. Cases 1127) the Board held, in part, that the burden of rebutting the schedule rests with the party disputing the rating, and that one method of rebutting the schedule is to successfully challenge one of the component elements of the rating, such as the injured workers DFEC adjustment factor. This may be accomplished by establishing that an individualized adjustment factor more accurately reflects the injured employee's DFEC. However the Workers' Compensation Appeals Board ruled that any individualized adjustment factor must be consistent with Labor Code 4660(b) (2), the Rand data to which Labor Code §4660(b)(2) refers, and the numeric formula adopted by the Administrative Director in the 2005 PDRS, and that any evidence presented in support of a proposed individualized DFEC adjustment factor must constitute substantial evidence upon which the Workers' Compensation Appeals Board may rely. Finally the Workers' Compensation Appeals Board held that even if this rebuttal evidence is legally substantial evidence, the Workers' Compensation Appeals Board

as the trier-of-fact may still determine that the evidence does not overcome the DFEC adjustment factor component of the PDRS. In this case the Workers' Compensation Appeals Board ruled that the defendants did not meet its burden of proving that an alternative DFEC factor should be used to rate applicant's permanent disability under the 2005 PRDS. Defendants ask the Workers' Compensation Appeals Board to assume that because applicant participated in this program and his ability to maintain his earnings in that program, applicant had no diminished future earning capacity. However assumption are not evidence and the defendants failed to show applicants individual earnings capacity remains unchanged with the cardiovascular disease he developed in defendants employment. For instance, defendant presented no evidence that applicant's education and job skills are such that his earning capacity is the same after these cardiovascular impairments as it was before. The Workers' Compensation Appeals Board denied reconsideration as defendants failed to meet the burden of proof under Ogilvie I and II.

Boatman v. Town of Windrow, (2010) 38 CWCR 9 (WCAB Panel) Permanent disability – indemnity rate adjustment under Labor Code §4658(d).

Applicant was paid temporary disability indemnity from January 8, 20008 to January 22, 2008 and returned to work on January 23, 2008. Applicant was found to be Permanent and Stationary in a report dated March 11, 2008 with a 3% WPI that was adjusted by DEU to 4% PD. The parties entered into stipulation for 4% PD. The defendants contended the award should be reduced by 15% pursuant to Labor Code §4658 (d) (3) (a). The issue was submitted and the WCJ found that defendants were not entitled to the reduction. Defendants filed a petition for reconsideration.

The Workers' Compensation Appeals Board concluded in a 2-1 decision that the WCJ was correct. In this case the Workers' Compensation Appeals Board found that defendants had made the formal offer of RTW to applicant 4 months after he had already returned to work. The return to work offer was not made within the 60 day time frame and was in fact made on 72 day after the P and S report of March 11, 2008. The Workers' Compensation Appeals Board held that strict adherence to the formal requirements of statute is required and substantial compliance is insufficient. Turning to the issue of the meaning of the phrase "each disability payment to be paid to the injured employee from the date the offer was made shall be decreased by 15%" the majority concluded that the word "remaining" can refer only to payments made after "the date the offer was made". Whether there were a PD payments remaining to be paid on May 22, 2008, depends on when they were first made and the extent of the PD. Under Labor Code §4650, if an injury causes PD the first payment shall made within 14 days after the date of the last TD payment. If the extent of PD cannot be determined on that date, payments shall continue until the employer's reasonable estimate of PD due has been paid. In this case the TD ended January 22, 2008, and applicant returned to work the next day. It was not clear the injury caused PD until March 11, 2008 when the P and S medical report was generated. As of that date defendants were obligated to begin PD payments and to continue payments for 12 weeks until June 1, 2008. As of May 22, 2008, therefore about 3 weeks of payments would have remained payable. If defendants had complied with Labor Code §4650 and 4658 (d) (3) (A), it would have been entitled to a 15%

reduction in these remaining payments. Because defendants did not comply they were entitled to no reduction. The Workers' Compensation Appeals Board denied reconsideration with one commissioner dissenting arguing that when an employer promptly returns an injured employee to work but does not complete the required paper work until later the employer should be entitled to the 15% reduction. The statute itself provides the incentive to return an injured employee to work regardless of the timing of the TD, P and S date, and PD payments.

Hisato Tsuchiya v. County of LA, (2010) (WCAB Panel) Permanent disability – Labor Code §4858(d) adjustment does not apply where there is no time lost due to injury.

Applicant sustained an injury which the WCJ found the injury caused no TD; that applicant remained continuously employed; that defendant employed more than 50 people, and that the injury caused 49% PD. In accordance with Labor Code 4658(d) the WCJ found that the weekly rate for PD was decreased by 15%. Applicant filed a petition for reconsideration.

Applicant argued that the decreased did not apply and that applicant was entitled to the 15% increase. The Workers' Compensation Appeals Board agreed with the WCJ that these provisions are intended to give employers an incentive to return injured employees to work. The necessary implication is that the injured employee is not in fact working. The provisions have no purpose if the employee is continuing to perform his or her regular work. The Workers' Compensation Appeals Board stated that they interpret Labor Code §4658(d) as being only applicable when the employee is not working. Since the applicant in this case lost no time from work, his employer was not required to give the offer of work described in Labor Code §4658(d). Therefore applicant is not entitled to a 15% increased based on defendant's failure to do so. Furthermore, since Labor Code §4658(d) is inapplicable in this situation defendant is not entitled to a 15% decrease. In this respect the Workers' Compensation Appeals Board concluded that while the decision in this case was inconsistent wit the decision in the case of *Audiss*, (1970) 35 Cal. Comp. Cases 123, a panel decision with no precedential value. The holding in the *Audiss* case was that the employer of an injured worker who lost no time from work was nevertheless obligated to provide the injured worker who lost no time from work with the Labor Code §4658(d) offer of regular, modified or alternative work. The Workers' Compensation Appeals Board indicated they disagreed with that conclusion. The matter was remanded to correct some other errors and for a decision finding hat no increase or decrease was warranted pursuant to Labor Code section 4658(d) under the facts of this case.

Rojas v. American Home Assurance, (2010) 38 CWCR 122 (WCAB Panel) Permanent disability – No 4658 adjustment on total disability awards.

The parties stipulated that the employer had made no offer of regular or modified work. Applicant received a Total Permanent Disability award paying the applicant indemnity at the temporary disability rate increased by 15% pursuant to Labor Code 4659 (d) (2) and subject

to the SAWW increase as provided for in Labor Code §4659 (c). In accordance with *Duncan* (2009) 74 Cal. Comp. Cases 1427, the SAWW increases commenced on 1-1-2004. Defendants filed a petition for reconsideration.

The Workers' Compensation Appeals Board pointed out that the 15% increase in PD applies to each disability payment reaming to be paid in accordance with paragraph one. It noted that paragraph one contained a chart covering the range of PD rating from 0.25 to 99.75 percent. Thus, the Workers' Compensation Appeals Board concluded that total PD payments are not paid in accordance with paragraph one but are paid at the temporary disability indemnity rate for life and therefore Labor Code §4658(d) is inapplicable to Total Permanent Disability awards. There is no basis is law or policy for mandating an increase in PD if an employer fails to make an offer of alternative or modified work to an employee who cannot work. As to the SAWW increase the Workers' Compensation Appeals Board followed Duncan concluding in the absence of contrary authority they were contained to follow Duncan. The Workers' Compensation Appeals Board reversed the order of the WCJ on the issue of the 15% increase in PD.

Lorenz v. Stowasser Pontiac and Intercare, (2010) (Writ denied) Permanent Disability – Almarez Guzman rating not justified by conclusory language of AME.

The WCJ issued awards of 13% and 8% on two injuries. Applicant filed a petition for reconsideration contending that a higher PD should have issues based on applicant's evidence on rebutting the AMA. The Workers' Compensation Appeals Board stated that the schedule is prima facie evidence of the percentage of PD to be attributed to each injury covered by the schedule and the schedule is rebuttable. The burden of proof on rebutting the schedule is on the party disputing the rating, one method of rebutting the schedule PD rating is to successfully challenge one of the component elements of that rating, such as the injured whole person impairment under the AMA guides, When determining an employees whole person impairment, it is impermissible to go outside the four corners of the guides; however a physician may utilize any chapter, table, or method in the AMA guides that more accurately reflects the injured employees impairment. The Workers' Compensation Appeals Board stated that they specifically rejected the "inequitable, disproportionate, and not a fair or accurate measure of the employees PD standard that had been established in Almaraz /Guzman I. In this case the AME stated that used table

Table 15-3 of the AMA Guides and the DRE categories to place applicant in category V. He stated that applicant had a WPI of 28%. The WCJ issues a decision of 13% and 8%. The Workers' Compensation Appeals Board held that the WCJ appropriately rejected the applicant's argument that it is the WCJ's duty to explain the 28% impairment rating is fair and equitable. The burden of proof on the issue of rebutting the schedule rests with the party disputing the rating. It is the burden of the party seeking to rebut the presumption to show that the scheduled rating Is not fair and equitable, the WCJ is not required to explain whey the presumptively correct rating is fair and equitable. The WCJ correctly determined that the conclusory statement contained in the AME report did not constitute substantial evidence and is insufficient to rebut the presumption of correctness of the schedule. Defendants point out

that the AME did not say the WPI from the guides was not a fair and accurate measure of applicant's impairment, he did not say, that based on his expertise, training and skill, he would find a different impairment rating, he did not depart from the specific recommendations in the AMA guides and draw analogies to the guides other chapters, tables, or methods, he did not access how the PD effects of the injury impaired applicant's ability to perform work activities or the medical consequences of performing certain work activities, he did not explain any alternative methodology, and he did not conduct an analysis of medical findings with respect to applicant's life activities and compare the results with the impairment criteria. There is certainly nothing to be gained at this point by sending this matter back for reconsideration by the WCJ in light of Almaraz/Guzman II, since applicants arguments fail under the even more generous standard of Almaraz/Guzman I. The petition for reconsideration was denied.

Shini v. Farmers Insurance Group, (2010) 38 CWCR 38 (WCAB Panel) Permanent disability – Requirements for Ogilvie alteration of rating.

Applicant sustained an admitted injury to this back and right let. The parties used an AME. The AME concluded under the AMA the disability was equivalent to 13% whole person impairment. A QME in psych concluded that the applicant had suffered a psych injury resulting in a rating of 67% on the Global Assessment of Functioning scale. He added however that applicant was malingering and that insofar as his emotional disability was concerned he could return to his usual work. At the trial received into evidence was occupational date from the EDD that established the wages for similarly situated automotive body repairmen in the Sacramento area. The applicant testified he had not worked or earned any income since the date of injury. He testified he would like to work but could not because he could hardly walk, and he could work on a computer if he had adequate computer skills although sitting bothers him. After trial he WCJ issued an Award finding that applicant had rebutted the DFEC adjustment and that the injury caused PD of 41%. Defendants filed a petition for reconsideration. The Workers' Compensation Appeals Board agreed with the defendants that the WCJ had fully analyzed the issues in the two Ogilvie decisions and therefore the matter would have to be remanded for a full Ogilvie analysis. In the two Ogilvie decisions the Workers' Compensation Appeals Board held that the DFEC portion of the 2005 PDRS can be rebutted in a manner consistent with Labor Code §4660 and the Rand Data to which that section refers. In the second Ogilvie decision the Workers' Compensation Appeals Board emphasized that the burden of rebutting a scheduled PD rating is on the party disputing the rating. Any evidence that is introduced to rebut the DFEC component of the schedule must be substantial evidence. Even if the rebuttal evidence is legally substantial the Workers' Compensation Appeals Board as the trier-of-fact may still determine that it does not overcome the DFEC adjustment factor component of the scheduled PD rating. In this case the WCJ mechanically applied the Ogilvie formula despite the fact that that Ogilvie grants the WCJ discretion regarding what evidence to rely on in determining post injury earnings and that the period on which to base lost darning calculations. The WCJ based his lost earning finding based solely on applicant's testimony. In light of the question raise about applicants credibility inn the psyche report this was not an appropriate case to stray from the type of evidence proposed by the Workers' Compensation Appeals Board in the

Ogilvie opinion. Furthermore the WCJ did not explain why he sued a three year period to calculate applicants post injury earning and loss of earnings. In the further proceedings the WCJ should more fully analyze the proper time period for earnings loss calculation and whether applicant's earnings during that period as more indicative of his earning capacity than the scheduled rating. In that connection the applicant's ability to work, his age, and health, and his willingness and opportunities to work, his skill and education, the general condition of the labor market, and employment opportunities for persons similarly situated are all relevant in determining post-injury earnings. (*Argonaut Insurance Co. v. Industrial Accident Commission (Montana)*, (1962) 57 Cal. 2nd 589; 27 Cal. Comp. Cases 130) The Workers' Compensation Appeals Board then went on to state that an individual employee should not be allowed to manipulate the proportional earning loss calculation by malingering or otherwise minimizing post-injury earnings. The trier-of-fact may need to consider a variety of factors such as motivation, retirement, and economic downturns. Although there was evidence that the applicant could not return to his previous employment, there was no evidence he could not work at all. The AME in Ortho said the applicant suffered only slight to moderate pain, and the AME in Psyche found only mild employment. Given that applicant had no earnings and his individual DFEC adjustment was so divergent from the scheduled adjustment factor, an analysis of the factors was necessary. Nor did he state the reasoning behind his conclusions. In further proceeding the WCJ must do a complete Ogilvie analysis explaining what evidence relied on to find loss and the period used. The WCJ should discus whether his adjusted DFEC factor truly reflects applicant's lost earning capacity, giving consideration to whether applicant was malingering and the factors spelled out in the Montana case. Finally, he must weigh the adjusted DFEC factor against the scheduled factor to determine which better reflects the applicant's diminished darning capacity. The Workers' Compensation Appeals Board granted reconsideration and ordered the matter returned to the trail level for further proceedings.

Baldridge v. Swinerton, (2010) (SAL 0114304) (WCAB Panel) Permanent disability – role of *LeBouef* in a AMA Guides setting.

Applicant, a pipe layer, sustained injury to his low back on August 29, 2005. The large drill he was operating jammed when it hit rebar, suddenly jerking applicant's spine. Applicant had a lumbar fusion with insertion of rods, but had complications from the surgery. He was left with difficulty concentrating, depression, and chronic pain. An AME recommended applicant be limited by orthopedic residuals to sedentary work with ability to stand or sit at frequent intervals. Under AMA Guides applicant sustained a 45% WPI spinal impairment. A psychiatric AME found compensable psychiatric injury, and was of the opinion that applicant's pain and neuromuscular disorder removed applicant from the labor market. An Agreed Vocational Evaluator concurred with the psychiatric AME and found applicant not feasible and had sustained a 100% loss of earning capacity. The WCJ instructed the DEU to rate for 100% loss of earning capacity and inability to return to the work force. The DEU returned a 100% rating. On cross examination the rater indicated reliance on pages 1.2 and 1.3 of the 2005 Schedule. The WCJ issued an award for total permanent disability.

The Workers' Compensation Appeals Board ruled in this case that the case of *LeBoeuf v. Workers' Compensation Appeals Board*, (1983) 48 Cal. Comp. Cases 587, does not directly apply to injuries that are subject to the 2005 permanent Disability Rating Schedule. At the time of LeBoeuf the chief component of permanent disability was the injured employee's diminished ability to compete on the open labor market. *LeBoeuf* concluded that a determination that an employee cannot be retrained for any suitable gainful employment may adversely affect the employee's ability to compete on the open labor market and therefore should be considered in rating permanent disability. In 2004 the legislature amended Labor Code §4660(a) so that diminished ability to compete in the open labor market concept is no longer and element in determining permanent disability. Under the current law the employee's diminished future earning capacity is one of the core elements of a PD rating. *LeBouef* supports the principle that an employee's disability may be affected when the industrial injury causes a total loss of earning capacity. The 2005 PD schedule expressly declares that permanent total disability represents a level of disability at which the employee has sustained a total loss of earning capacity. In this case the AME's indicate applicant has suffered a total loss of earning capacity resulting in 100% PD. The Board concluded that based on the factors of disability set forth by the orthopedic AME, Psych AME combined with the vocational factors would not present a viable employment candidate were he capable of securing an interview. The WCJ was upheld in finding 100% PD. Reconsideration was denied. A Petition for Writ of Review was filed by defendant on August 23, 2010.

APPORTIONMENT

Minvielle v. County of Contra Costa, (2010) 38 CWCR 7 (WCAB Panel) Apportionment – Labor Code §4664 overlap between 1950 and 2005 schedule disabilities.

Applicant, a fire fighter, injured his back on October 8, 1992 and in 1995 received an award of 27.5 % based on QME Dr. Frederick Newton's recommended disability precluding heavy lifting rated under the 1950 PD rating schedule. Applicant reinjured his back November 22, 2004. At maximum medical improvement applicant was reevaluated by the same QME, Dr. Frederick Newton, who found him with impairment of DRE III, 13% plus 2% add on for pain. The current disability based on the new PD schedule rated 31% after adjustment for FEC, occupation, and age. A WCJ awarded 4% PD after applying Labor Code §4664 apportionment. Applicant filed a petition for reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and concluded the WCJ erred by subtracting a rating calculated under a different PD schedule. The matter was remanded to see if the physician could rate the cases using the same PD schedule to permit the disability to be apportioned by subtraction. In his new report after reconsideration Dr. Newton wrote that when asked if he could bring the two schedules in harmony for apportionment, he said that he could not. The physician stated that in general the physical examination and evaluation requirements for AMA guides rating may be different than the requirements for a 1950 or 1997 PDRS rating. The rating itself under the AMA guides is based on loss of earning capacity (AMA Guides, at Table 1-1, says it assesses "a loss, loss of

use, or derangement of any body system or organ function resulting in an alteration of an individual's capacity to meet personal, social, or occupational demands."), whereas the rating under the prior PDRS is based on the loss of ability to compete on the open labor market. Given all the differences, he did not see how a doctor can simply look backward and assign and AMA guides rating to a PDRS case.

The WCJ following a hearing found 31% PD without apportionment. The WCJ stated for apportionment under Labor Code §4664 you need to find overlap and between the two disabilities and in this case the defendant failed to show overlap and he also found no Labor Code §4663 apportionment so the WCJ issued an unapportioned award. Defendants filed a petition for reconsideration.

The Workers' Compensation Appeals Board denied the petition for reconsideration. The Board indicated that in the first *Minvielle* decision (2008) 36 CWCR 199, apportionment is inapplicable when injuries are rated under different schedule because overlap cannot be shown. In order to properly apportion pursuant to Labor Code §4664, the issue of overlap must be developed buy using the same standard to calculate PD cause by each injury. This calculation must be supported by substantial evidence. The board in the first *Minvielle* case returned the case for an opinion from the physician on whether the disability from the 1993 injury could be re-rated under the AMA guides using ROM method. The Board noted that could not be done. The Board further noted that pursuant to the *Kopping v. Workers' Compensation Appeals Board*, (2006) 142 Cal. App. 4th 1099; 71 Cal. Comp. Cases 1229, defendant has the burden of proof on the issue of apportionment and to meet that burden the must prove the existence of a prior award and that the disabilities in the two cases overlap. Overlap is not proved by a mere showing that the second injury was to the same body part, it requires consideration of the factors of disability resulting from the two injuries. (*State Compensation Insurance Fund v. Industrial Accident Commission (Hutchinson)*, (1963) 59 Cal. 2nd 45; 28 Cal. Comp. Cases 20). This rule was not changed by the adoption of Labor Code §4664. The panel ruled that defendants had not proved overlap because they had presented no evidence that the permanent disability caused by the 1992 injury could be calculated using the same standard used to calculate the permanent disability caused by the 2004 injury. The Workers' Compensation Appeals Board held the WCJ properly concluded apportionment pursuant to Labor Code §4664 could not be applied to this injury. A note to the Workers' Compensation Appeals Board decision had indicated that defendant had not appealed the finding of no apportionment pursuant to Labor Code §4663, so that issue was not before the Workers' Compensation Appeals Board.

Perez v. State Compensation Insurance Fund, (2010) 38 CWCR 154 (WCAB Panel):
Apportionment – Labor Code §4664 usually precludes apportionment to an injury previously C&Rd without a F&A or Stipulated Award.

Applicant sustained a low back injury on August 2, 2000. The AME found disability resulting in constant slight pain increasing with [described] activity to occasional moderate, and warranting a prophylactic preclusion from heavy lifting, repeated bending and stooping, or prolonged sitting. The case was resolved by Compromise and Release for $37,000 in

which it was stated that permanent disability was based on 33% permanent disability. On May 3, 2004, applicant sustained injury to his neck, left shoulder, and left knee. He was evaluated by a different physician, QME, Dean Falltrick, D. C., who described disability in terms of the 1997 PDRS: Frequent slight neck pain becoming occasionally moderate; similar shoulder pain; intermittent slight knee pain, and preclusion from heavy lifting or work above shoulder level. WCJ found overall disability of 46% PD for applicant's neck, left shoulder and left knee. Defendant sought reconsideration.

The Workers' Compensation Appeal Board granted reconsideration. It found a computational error in the rating formula, and in analyzing apportionment under *Sanchez v. County of Los Angeles*, (2005) 70 Cal. Comp. Cases 1440 (en banc). In order to find apportionment pursuant to Labor Code §4664, the defendant must prove that there is overlap between the current disability and the disability that was subject of the prior award. (*Kopping v. Workers' Compensation Appeals Board*, (2006) 142 Cal. App. 4th 1099; 71 Cal. Comp. Cases 1229). The Board held that apportionment be determined substantially in accordance with the same overlap principles that were historically decided before the enactment of Senate Bill 899. (*Sanchez v. County of Los Angeles*, (2005) 70 Cal. Comp. Cases 1457). In this case the WCJ failed to do the analysis mandated by the Sanchez case. The case was returned to the trial level for further proceedings and decision.

The Board also indicated they agreed with the WCJ that an Order Approving Compromise and Release in this case constituted a prior award of permanent disability for purposes if Labor Code §4664(b). In *Pasquotto v. Connecticut Indemnity Insurance Co.,* (2006) 71 Cal. Comp. Cases 223 (en banc), the Board held that an order approving a compromise and release, without more, is not a prior award of permanent disability. *Pasquotto* is distinguishable for the current case, however, because in *Pasquotto*, nowhere in the compromise and release or in the or in the addendum was there any stipulation or representation by the parties as to the percentage of permanent disability, the factors of disability caused by the injury. In this case the Compromise and Release contained a representation regarding the agreed permanent disability, and a statement the rating was based on a specific report. Although it was true that the compromise and release stated that, among a number of issues, there was a serious and legitimate dispute as the nature and extent of permanent disability, this general statement was contradicted the specific statement that the settlement was based on the AME report.

The applicant had objected to the admission of the AME report from the prior case in the current case. The Board responded that in Pasquotto they held that extrinsic evidence outside the four corners of the Compromise and Release agreement should not be allowed in an attempt to show that some discrete portion of the settlement was for permanent disability. However, in this case, compromise and release itself established a portion of the settlement was for permanent disability and so the AME report in this case is not being admitted for that purpose. Once it is established there has been a prior award of permanent disability, it is permissible to examine the medical evidence underling that award to determine the issue of apportionment. In this case it appears the WCJ found no basis for apportionment because the defendant failed to give the physician in the current case, Dr. Falltrick, evidence regarding applicant's previous injury. It appears the WCJ is confusing apportionment pursuant to

Labor Code §4663 and with apportionment pursuant to Labor Code §4664. Although medical evidence regarding overlap may be appropriate in some cases, we do not believe medical opinion regarding overlap is necessary in all cases. Rather the mechanics of rating overlap generally provided that each separate factor of permanent disability for both the new industrial injury and the pre-existing condition be set fort, so it could be determined what elements, if any, of one disability were included in the other. The issue of apportionment would be resolved by determining the percentage of combined disability after the new injury, and then subtracting the percentage to the prior award which overlap-either partially or totally- the disability resulting from the new injury. (*Sanchez v. County of Los Angeles*, (2005) 70 Cal. Comp. Cases 1457.) This may generally be done by the trier of fact with the assistance, if necessary, of the DEU.

The WCJ should develop the record, if necessary. In this case the issue was complicated by the fact that the WCJ did not issue formal rating instructions. The Board acknowledged the WCJ may find the level of permanent disability without use of formal rating instructions and such rating is within the sound discretion of the WCJ. (*W. P. Fuller and Co., et. al. v. Industrial Accident Commission (Cassidy)*, (1962) 27 Cal. Comp. Cases 291; *West American Insurance Co. v. Workers' Compensation Appeals Board (Lopez)*, (1983) 48 Cal. Comp. Cases 652; *County of Los Angeles v. Workers' Compensation Appeals Board (Rangel)*, (1997) 62 Cal. Comp. Cases 683.) However, where as here, there are a number of complicated issues regarding rating the permanent disability, including the issue of overlapping disabilities, the expert opinion of a rating specialist maybe of great assistance, although the ultimate determination is made by the WCJ. (*Johns-Manville Products Corp. v. Workers' Compensation Appeals Board (Carey)*, (1978) 87 Cal. App. 4th 740; 43 Cal. Comp. Cases 1372.) The Board rescinded the decision and retuned the matter to the trial level for further proceeding and decision. In this further proceeding the WCJ should prepare disability evaluation instructions specifically listing the factors of permanent disability applicable to the current case and submit them to the DEU. Additionally, the WCJ should forward the factors of permanent disability underlying the prior award to the DEU. After a recommended rating is obtained, the parties shall have the right to object to the recommended rating and to cross-examine the rating specialist. The WCJ should then issue a decision on the ultimate issues of permanent disability and apportionment, including the issue of whether the defendant proved the existence of overlap pursuant to *Kopping*.

Hertz v. Workers' Compensation Appeals Board (Aguilar), (2010) ____Cal. Comp. Cases _____ (Unpublished) – Apportionment under Labor Code Section 4663 required.

Applicant testified at the hearing that he uses a cane to ambulate at home and when going back and forth from his car. He uses his walker, which has a seat, for outings with his children and when he goes somewhere he knows will have no place for him to sit or rest, and he uses a shopping cart for support while shopping. He has lost both strength and range of motion in his knees, he has wrist pain, and he has shoulder pain when he lifts his arms above shoulder level. However, he is able to drive his children to school daily. The certified rehabilitation counselors agreed that Applicant's disability, standing alone, did not make him unemployable. Westman testified that applicant's use of a walker and cane restrict the types of job training and employment he is eligible for. However, some types of training are also

ruled out by Aguilar's limited language skills and education. Thus, Aguilar's limited language skills and education affect his ability to benefit from vocational rehabilitation, just as they affected his ability to compete in an open labor market prior to his injuries. Huff testified that it is possible that Applicant might be employable despite his physical limitations and need to use a walker if he had better language skills and education. Customer service jobs, account-clerk, and home-based employment might be available with training, and these jobs make up perhaps 15 percent of the labor market. Huff concluded that Applicant's limited literacy and education played a large role in her opinion that Applicant is non-feasible for rehabilitation.

The Appeals Board found that applicant was 100 percent permanently disabled, and that all of the disability was due to his industrial injury. Defendant sought review.

The Court of Appeal granted the writ and found that in this case, applicant was not found to be permanent and stationary as to all of his industrial injuries until August 2005, after the effective date of the revisions to our workers' compensation system. However, he had received temporary disability indemnity for some of his industrial injuries for broken periods prior to his last date of work on January 29, 2002. Therefore, Hertz was "required to provide the notice required by Section 4061" (Labor Code § 4660, subd. (d)) to Aguilar prior to January 1, 2005, when it first stopped paying temporary disability indemnity and Hertz admittedly provided the notice under Labor Code §4061 in case No. SJO226456 prior to January 1, 2005. Accordingly, the exception in Labor Code §4660(d), applies and Aguilar's total permanent disability must be rated using the 1997, rather than the 2005, rating schedule. (*Vera v. Workers' Compensation Appeals Board*, (2007) 154 Cal. App. 4th 996, 1009; 72 Cal. Comp. Cases 1115; accord, *Energetic Painting & Drywall, Inc. v. Workers Compensation Appeals Board (Ramirez)*, (2007) 153 Cal. App. 4th 633, 639; 72 Cal. Comp. Cases 937; *Zenith Insurance Co. v. Workers Compensation Appeals Board (Azizi)*, (2007) 153 Cal. App. 4th 461, 465; 72 Cal. Comp. Cases 785; *Costco Wholesale Corp. v. Workers Compensation Appeals Board (Chavez)*, (2007) 151 Cal. App. 4th 148, at 157; 72 Cal. Comp. Cases 582.)

Even though Aguilar's permanent disability rating should be determined using the 1997 rating schedule, the rating must consider Aguilar's "diminished future earning capacity" rather than his diminished ability to compete in an open labor market. (Labor Code §4660, subd. (a).) In addition, the rating must consider what approximate percentage of Aguilar's disability was the direct result of his industrial injuries, and what approximate percentage was caused by other factors, including any pre-existing conditions. (Labor Code §4663(d).) Apportionment of permanent disability is based on causation, and is not limited to prior disabilities. (Labor Code §4663(a).) This is because Hertz is liable only for the percentage of Aguilar's permanent disability directly caused by his industrial injuries. (Labor Code §4664(a).) The Court found no evidence in the record to support the Board's finding that Aguilar's industrial injuries directly caused him to be 100 percent permanently disabled. No medical evaluator found Aguilar to be 100 percent permanently disabled. In fact, all the medical evidence indicates that Aguilar, even with his significant work restrictions, is medically eligible for vocational rehabilitation and that his permanent disability rating, according to the WCJ, should be around 60 percent. Therefore, the medical evidence does not support the Board's finding of 100 percent permanent disability. *LeBoeuf* holds that, where an employee is found non-feasible for rehabilitation due to disability directly caused

by an industrial injury or injuries, that fact must be taken into account in the employee's permanent disability rating. (*LeBoeuf*, supra, 34 Cal. 3d at p. 243.) However, *LeBoeuf* does not hold that an employee's permanent disability rating must reflect a finding of non-feasibility where the non-feasibility finding is due in part to pre-existing nonindustrial factors or conditions. An employer may only be found liable for permanent disability directly caused by the injured employee's industrial injury (§ 4664, subd. (a)), and apportionment is now based on causation (Labor Code § 4663, subd. (a)), so an employer may properly obtain apportionment of a permanent disability to factors that are not disabilities. (*Brodie v. Workers' Compensation Appeals Board*, (2007) 40 Cal. 4th at pp. 1325-1327; 72 Cal. Comp. Cases 565.) In conclusion, the court determined that the Board's finding of 100 percent permanent disability in this case was based in part on the finding of vocational non-feasibility, that is, a finding of permanent inability to compete in an open labor market. The finding of vocational non-feasibility was based in part on pre-existing, nonindustrial factors, that is, Aguilar's inability to read and write in English. As we have explained, Hertz is only liable for that portion of Aguilar's permanent disability that is directly caused by Aguilar's industrial injuries, and Hertz is not liable for that portion that is caused by pre-existing nonindustrial factors. The matter was remanded to the Board for a redetermination of Aguilar's permanent disability rating. An appeal was filed to the Supreme Court and on 5/20/10, but the Court dismissed the petition for review. Pursuant to CA Rule of Ct 8.528(b)(3), after an order dismissing review, the Court of Appeal opinion remains unpublished unless the Supreme Court orders otherwise. The Supreme Court has not issued an order finding this case should be published.

Gordon v. County of Los Angeles, (2010) (BPD) (ADJ 1655785): Apportionment – Labor Code §4664(c).

The applicant had received a prior stipulated award of 30:3% disabilities for a cardiovascular injury. The applicant received a second stipulated award of 49:1% PD for cardiovascular and hypertension. The current injury was to applicant's cardiovascular and gastrointestinal systems. The parties on the current case went to an AME who found PD based on the AMA guides of 8% for hypertension and 29% PD for coronary artery disease and 20% for cardiomyopathy. He also found 4% PD gastrointestinal of which 25% was non-industrial. The AME gave no opinion on apportionment in regards to the heart disability. After a supplemental report on the issue of apportionment the AME impairments for heart, circulatory, and gastrointestinal impairments rated 78% after the apportionment to the gastrointestinal. The WCJ awarded 78% PD without apportionment. Defendants filed a petition for Reconsideration.

Defendant contended that the award violated Labor Code 4664(c) which prohibits the accumulation of all PD awards issued with respect to anyone region of the body from exceeding 100% over the employee's lifetime. The defendants also argued for apportionment pursuant to Labor Code section 4664 (b).

The Workers' Compensation Appeals Board found the parties raised the Labor Code §3213 peace officer presumption as the applicant was a deputy sheriff but the WCJ did not

make a finding on that issue. The Workers' Compensation Appeals Board found the applicant was entitled the presumption. The Workers' Compensation Appeals Board further found that the §3212 peace officer presumption applies to apportionment pursuant to Labor Code §4663, and that apportionment was inapplicable in this case. Labor Code section 4664 (b) apportionment puts the burden of proof on defendant to prove a prior award and overlap. The Workers' Compensation Appeals Board citing the cases of *Kopping* (2006) 71 Cal. Comp. Cases 1099), *Minvielle* (2008) 36 CWCR 199) and *Sanchez* (2005) 70 Cal. Comp. Cases 1440, 71 Cal. Comp. Cases 1440) agreed with the WCJ that defendants failed to meet the burden of proof on overlap and therefore no apportionment was warranted pursuant to Labor Code section 4664(b). Nevertheless the Workers' Compensation Appeals Board found apportionment was warranted pursuant to Labor Code §4664 (c) (1). Section 4664 (c) (1) prohibits the award of the accumulation of all PD awards totaling more than 100% for a specific body region, including in the case pursuant to subsection (g) the cardio vascular system. The Workers' Compensation Appeals Board ruled that Labor Code §4664 (c) (1) does not contain language requiring need to establish overlap such as that contained in Labor Code section 4664 (b). The Workers' Compensation Appeals Board went on to state that Labor Code §4664 (c) (1) cuts off the accumulation of all PD awards issued with respect to anyone body region at a 100% unless the injury is conclusively presumed to be total pursuant to Labor Code §4662. In this case the two prior awards as well as the current award involve the same region of the body and there is no evidence in the record to support a finding of total disability. The Workers' Compensation Appeals Board concluded that apportionment pursuant to Labor Code §4664 (c) (1) was appropriate. In this case the Workers' Compensation Appeals Board concluded even though it involves "old schedule" and "new Schedule" disability you add them so as to not exceed 100% cap. Here the two prior awards add to 80% . If you add the 80% to the current award of PD of 78% for the cardiovascular you would exceed the 100% cap. Therefore the Workers' Compensation Appeals Board found that Labor Code §4664 (c) (1) apportionment must be applied by subtracting the prior 80% award from the total possible 100% for a current permanent disability award of 20%. The matter was remanded for the WCJ to issue a new decision applying 4664 (c) (1) apportionment

Delia v. County of Los Angeles, (2010) (ADJ 2246339) (WCAB Panel) Apportionment – Safety member anti-attribution preclusion of §4663; burden not met on §4664, exception to Benson.

The WCJ found applicant sustained and industrial injury to his lumbar and cervical spine, bilateral hands, cardiovascular, abdominal wall (hernia) and hearing loss resulting in 99% permanent disability. The WCJ specifically found that applicant was entitled to a single joint award rather than separate awards and the defendant failed to sustain their burden of proof on the issue of apportionment in accordance with Labor Code §4664. Applicant had a prior joint award of 45% permanent disability for specific injuries to spine left hand, left foot, hernia and tooth. Defendants filed a petition for reconsideration contending that the WCJ should have issued separate awards in accordance with *Benson v. Workers' Compensation Appeals Board,* (2009) 74 Cal. Comp. Cases 113, and that the earlier award of permanent disability should have been apportioned to pursuant to Labor Code §4664.

The Workers' Compensation Appeals Board held that because applicants injuries were incurred in course of his employment as a deputy sheriff, the anti-attribution provisions of Labor Code §§3213 and 3212.3 preclude apportionment pursuant to Labor Code §3663 with respect to the injuries to his spine, cardiovascular system and hernia. Defendants failed to prove overlap between the current injury and the prior award and therefore no apportionment could be made pursuant to Labor Code §4664. For these reasons the Workers' Compensation Appeals Board concluded the joint award was proper consistent with the exception to the issuance of separate awards that is recognized in *Benson*. An exception to *Benson* occurs in this case because of the anti-attribution provisions of Labor Code §§3212 and 3212.3 which preclude apportionment pursuant to Labor Code §4663. The Anti-attribution provisions of Labor Code §§3212 and 3212.3 preclude apportionment of causation of permanent disability pursuant to Labor Code §4663. (*Dept. of Corrections v. Workers' Compensation Appeals Board (Alexander)*, (2008) 166 Cal. App 4th 911; 73 Cal. Comp. Cases 1294).

Defendant did not meet its additional burden of proving the prior award 45% overlaps the 99% permanent disability found to have been caused by the later industrial injuries. The Workers' Compensation Appeals Board pointed out the prior award was based on subjective factors of disability and no work restrictions and the current factors of disability are based on objective factors of disability and work restrictions found by the AME. The Workers' Compensation Appeals Board stated it has long been recognized that even if a second injury occurs to the same part of the body, that fact alone does not establish overlap of permanent disability caused by the two injuries. (*State Compensation Insurance Fund v. Industrial Accident Commission (Hutchinson)*, (1963) 28 Cal. Comp. Cases 20). Because the earlier injury caused no work restrictions, overlap was not shown by defendants in this case and there is no basis for apportionment pursuant to Labor Code §4664. Apparently Labor Code §4664(c) was not raised or did not limit the award due to the multiple body parts involved. The award was affirmed.

Cocio v. Mountain View School District, ACE, Fremont Ins., in liquidation, CIGA*,* (2010) 38 CWCR 150 (WCAB Panel**)** Apportionment – successive CTs, exception to *Benson*, inadequate basis for §4663 apportionment, CIGA liability on award with co-defendant insurer.

Applicant was a food service worker or Mountain View School District. Applicant developed hernia and abdominal injury and missed time from work beginning September 23, 1997. She later returned to modified work, and in 1999 returned to regular work until November 29, 2000. She alleged cumulative trauma injuries ending on the dates of commencement of compensable time loss. For the first cumulative injury coverage was with Fremont. For the second industrial injury the coverage was with Fremont for 214 days and ACE for the remainder of the year. Fremont became insolvent and CIGA assumed liability for claims against Fremont. Applicant was seen by a AME in internal medicine. In his report he reported applicant sustained two cumulative injuries and apportioned 75% of the permanent disability to other factors. The WCJ found one industrial cumulative injury

ending September 23, 1997 and apportioned 75% of the PD to non-industrial causes. In the WCJ's view the recurrence of disability in 2000 was a mere continuation disability from the original cumulative injury. Applicant and CIGA filed petitions for reconsideration.

Applicant claimed the apportionment was not justified by the evidence and CIGA argued the WCJ erred in finding one CT ending September 23, 1997 and either the CT ended November 30, 2000, or there were two cumulative trauma injuries.

The Workers' Compensation Appeals Board granted reconsideration and reversed the WCJ's decision. The Workers' Compensation Appeals Board found that there were two separate cumulative injuries (see *Aetna Casualty & Surety Co. v. Workers Compensation Insurance Fund (Coltharp)*, (1973) 35 Cal. App. 3rd 329; 38 Cal. Comp. Cases 720) and returned the case to the trial level for further proceeding on all other issues. Specifically the Workers' Compensation Appeals Board asked for further evidence on apportionment and apportionment between industrial injuries. Following reconsideration the parties deposed the AME, Dr. Ng. The AME in his deposition indicated he had no reason to change his opinion on apportionment to other factors: childbirths and obesity. He admitted he struggled with the concept of distinguishing cause of disability from cause of injury. He was unable to distinguish between them. Asked to discuss the how and why of apportionment of other factors, he recited what the other factors were. When asked to apportion between the two cumulative injuries the AME stated that, based on the fact there no information for us to make any other determination, the only way you could apportion is passage of time. The exposure in 1997 and the exposure in 2000 were so inextricably interwoven that it would be speculative to come up with any division of the overall disability. It was not speculative the AME went on to say that one could not state which period was more important, but passage of time would be the logically, medically, and legally correct way to think about it. He was unable to say if the number of days of the various exposure periods was a way to apportion between the two injuries. To do so would be in the realm of speculation. The matter came to hearing and the deposition was admitted into evidence and the matter submitted. The WCJ found no Labor Code §4664 apportionment and no evidence was found of any prior award. The WCJ found defendants failed to meet their burden of proof on the issue of apportionment. The WCJ found liability based on Labor Code §5500.5 finding two one year cumulative trauma injuries, and liability based on time of coverage between CIGA and ACE. The parties again filed petitions for reconsideration. The Workers' Compensation Appeals Board ruled that no issue of Labor Code §4664 apportionment had been raised by the parties. With regard to apportionment pursuant to Labor Code §4663 the Workers' Compensation Appeals Board ruled the report of the AME did not meet the standard for apportionment set forth in *Escobedo v. Marshalls,* (2005) 70 Cal. Comp. Cases 704 (writ denied). The AME listed the other factors but did not sate how and why the other factors were responsible for 75% of the permanent disability, as opposed to some other percentage. As to the *Benson* issue the Workers' Compensation Appeals Board ruled that in *Benson v. Workers' Compensation Appeals Board,*(2009) 170 Cal. App. 4th 1535; 74 Cal. Comp. Cases 111, that there were limited circumstances when the evaluating physician cannot allocate with reasonable medical probability the approximate percentage to which injury contributed to the overall disability. In those cases a combined award of permanent disability might be justified. Although the *Benson* cases did not involve separate insurers and their respective

liabilities, the court anticipated that there would be cases where the evaluating physician could not parcel out the extent to which each injury contributed to the disability. The panel upheld the WCJ's award of 37% permanent disability with no apportionment. The Workers' Compensation Appeals Board ruled that because *Benson* did not apply and the awards were combined, CIGA had no liability because there was other insurance. The Workers' Compensation Appeals Board indicated if the AME could have allocated the permanent disability between the two cumulative trauma injuries, CIGA would have had liability as there would have been no other insurance on the first cumulative trauma and CIGA would have had no liability on the second lative trauma as that there was other coverage (ACE) during that period of injury. The Workers' Compensation Appeals Board awarded 37% permanent disability with no apportionment and all of the liability was the responsibility of ACE alone.

United Airlines v. Workers' Compensation Appeals Board (Dodson), (2010) 75 Cal. Comp. Cases 388 (Writ Denied) Apportionment – failure of proof

Applicant worked ten years as a flight attendant and was exposed to chemicals and pesticides that were sprayed in the airplane cabins. She sustained an admitted CT injury to her internal, musculoskeletal, respiratory, and immune systems, heart, sinuses, psyche, back, and neck. Applicant had a prior award of 15% PD based on a stipulation for injuries to her back and neck. The parties agreed on an AME, who found that the applicant as a result of the chemical exposure was Permanent and Stationary and had cognitive problems, fatigue, and chronic pain syndrome (fibromyalgia) and she could only work one hour an entire week and she was prevented from permanent or part time employment. Following trial the WCJ issued an award for 100% PD with no apportionment. Defendants filed a petition for reconsideration.

The WCJ in his report and recommendation indicated that the prior 15% disabilities for the neck and back were different than the current disabilities, the applicant had returned to work following the first injury and now, as result of the disabilities from the current injuries, applicant was essential home bound. The WCJ concluded the applicant could not compete on the open labor market and the disabilities from the prior injury did not overlap the disability from the current injury. The Workers' Compensation Appeals Board denied reconsideration citing the *Kopping v. Workers' Compensation Appeals Board,* (2006) 142 Cal. App. 4th 1099; 71 Cal. Comp. Cases 1299, and *Sanchez v. County of Los Angeles,* (2005) 70 Cal. Comp. Cases 1440, that the defendants proved a prior award but failed under their burden of proof on the issue overlap between the two injuries. The Workers' Compensation Appeals Board also stated it was clear the AME was of the opinion that applicant's multiple chemical sensitivities alone caused the 100 PD and resulted in her inability to work outside her home. Defendants filed a petition for writ of review which was denied.

MEDICAL TREATMENT, ACOEM/MTUS & UR, MPNs

Cervantes v. El Aguila Food Products, Safeco, Superior National, CIGA, (2009) 74 Cal.

Comp. Cases 1336 (en banc) Medical treatment – spinal surgery.

The Workers' Compensation Appeals Board held that the procedures and timelines governing objections to a treating physician's recommendation for spinal surgery are contained in Labor Code §§4610 and 4062, and in Administrative Director (AD) Rules 9788.1, 9788.11, and 9792.6(o) and are as follows: (1) when a treating physician recommends spinal surgery, a defendant must undertake utilization review (UR); (2) if UR approves the requested spinal surgery, or if the defendant fails to timely complete UR, the defendant must authorize the surgery; (3) if UR denies the spinal surgery request, the defendant may object under section 4062(b), but any objection must comply with AD Rule 9788.1 and use the form required by AD Rule 9788.11; (4) the defendant must complete its UR process within 10 days of its receipt of the treating physician's report, which must comply with AD Rule 9792.6(o), and, if UR denies the requested surgery, any Labor Code §4062(b) objection must be made within that same 10-day period; and (5) if the defendant fails to meet the 10-day timelines or comply with AD Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery.

The Workers' Compensation Appeals Board expressly disapproved of the pre-*Sandhagen* decision in *Brasher v. Nationwide Studio Fund*, (2006) 71 Cal. Comp. Cases 1282 (WCAB significant panel decision) to the extent it holds: (1) a defendant may opt out of UR and instead dispute the requested spinal surgery using only the procedure specified in section 4062(b); and (2) if a defendant's UR denies spinal surgery, it is the employee that must object under section 4062(a). When a treating physician recommends spinal surgery, a defendant must undertake utilization review based on Labor Code §§4062(a) and 4610 and the Supreme Court's decision in *State Comp. Ins. Fund v. Workers' Compensation Appeals Board, (Sandhagen)*, (2008) 44 Cal. 4th 230; 73 Cal. Comp. Cases 981. The Board concluded that a defendant must conduct UR whenever an injured employee's treating physician recommends spinal surgery. Therefore, contrary to *Brasher*, the Workers' Compensation Appeals Board conclude that when a treating physician requests authorization to perform spinal surgery, a defendant must assess that request through Utilization Review. If Utilization Review approves the requested surgery, or if the defendant fails to timely complete Utilization Review, the defendant must authorize the surgery. The Workers' Compensation Appeals Board concluded that if UR approves the spinal surgery request, or if the defendant fails to timely complete UR, the defendant must authorize the surgery. Given the purpose of section 4610, the Workers' Compensation Appeals Board concluded that if UR approves the recommended spinal surgery, the defendant must authorize it. If a defendant fails to complete UR in a timely manner, it must authorize the recommended spinal surgery.

A Defendant may object under Labor Code §4062(b) to a spinal surgery request, but any objection must comply with Administrative Director Rule 9788.1 and use the form required by Administrative Director Rule 9788.11. The Workers' Compensation Appeals Board concluded that in the sole context of a recommendation for spinal surgery, it is only the defendant, and not the injured employee, that may object under Labor Code §4062. A defendant's objection under Labor Code §4062(b) to a treating physician's spinal surgery request may be made only after that request has been denied by UR. Labor Code §§4062(b)

and section 4062(a) refer only to "employer" and not "employee" objections in spinal surgery cases; Labor Code §4062(b) establishes a unique 45-day fast-track procedure for resolving spinal surgery disputes; and the generic "employee" objection procedure of Labor Code §§4062(a), 4062.2, and 4062.1 takes substantially longer than 45 days and does not require that an orthopedic surgeon or a neurosurgeon be used. Accordingly, The Workers' Compensation Appeals Board concluded that the Legislature's specific intent as expressed by Labor Code §4062(b)'s spinal surgery provisions controls over the Legislature's more general intent as expressed in section Labor Code §4062(a)'s non-spinal surgery provisions. Thus, it is only the defendant which may initiate the Labor Code §4062(b) spinal surgery second opinion process. In reading Labor Code §4062(b) to mean that it is the defendant, and not the injured employee, that may initiate the spinal surgery second opinion procedure, we are aware Sandhagen repeatedly said that defendants cannot use Labor Code §4062 to dispute treatment requests; instead, Labor Code §4062 is available only to employees who are dissatisfied with a defendant's UR decision. (*Sandhagen*, 44 Cal.4th at pp. 234, 237, 244-245 [73 Cal. Comp. Cases at pp. 982, 985, 985-986, 992].) *Sandhagen*, however, was not a spinal surgery case and it did not directly involve the provisions of Labor Code §4062(b). "It is axiomatic that language in a judicial opinion is to be understood in accordance with the facts and issues before the court. An opinion is not authority for propositions not considered." (*Steele*, supra, 19 Cal.4th at p. 1195 [64 Cal. Comp. Cases at p. 28].) Therefore, *Sandhagen*'s statements that only an injured employee (and not a defendant) may use Labor Code §4062 in a non-spinal surgery case have no bearing on the question of whether it is the defendant (and not the employee) that may initiate the spinal surgery second opinion procedure of Labor Code §4062(b). The Workers' Compensation Appeals Board recognized Brasher held that when a defendant's UR denies spinal surgery it is the injured employee who must object within 10 days of the denial. (*Brasher v. Nationwide Studio Fund*, (2006) 71 Cal. Comp. Cases 1282, at 1287 (WCAB significant panel decision). However, the *Brasher* decision acknowledges that it arrived at this conclusion using a "convoluted" method that had the employee begin on the Labor Code §4062(a) track and then switch over to the Labor Code § 4062(b) track. (Id.) Yet, nothing in the statutory language of Labor Code §4062 provides for any such track-switching procedure. Moreover, importing an "employee" objection into Labor Code §4062(b) would mean the employee has 10 days to object to the spinal surgery recommendation of the employee's own physician, even though there is a possibility that defendant's UR process might approve the requested surgery. (Labor Code §4610(a).) Accordingly, based on our analysis above, we now expressly reject the Brasher holding that, if a defendant's UR denies spinal surgery, the applicant must timely object under Labor Code §4062(a), after which the applicant is switched over to the Labor Code §4062(b) track. The Workers' Compensation Appeals Board observed that, if a defendant objects under Labor Code §4062(b), it must comply with AD Rules 9788.1 and 9788.11. Rule 9788.1 is expressly framed in mandatory terms and it provides, in relevant part:

> "(a) An objection to the treating physician's recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in Section 9788.11. The employer shall include with the objection a copy of the treating physician's report containing the recommendation to which the employer objects. The objection shall include the employer's reasons, specific to the employee, for the

objection to the recommended procedure. The form must be executed by a principal or employee of the employer, insurance carrier, or administrator." (Cal. Code Regs., tit. 8, § 9788.1.)

Rule 9788.1 also sets forth certain requirements for: (1) a declaration under penalty of perjury regarding when the defendant received the treating physician's spinal surgery recommendation; (2) a declaration under penalty of perjury regarding when the defendant served its objection; and (3) service of the objection. Rule 9788.11 adopts the form that, under Rule 9788.1, "shall" be used for a defendant's spinal surgery objection. The Defendant Must Complete its Utilization Review Process within 10 days of its Receipt of the Treating Physician's Report, Which Must Comply with Administrative Director Rule 9792.6(o), and, if Utilization Review Denies the Requested Surgery, any Section 4062(b) Objection Must Be Made within the Same 10-day Period. A defendant must both complete its UR and, if there is a UR denial, make its section 4062(b) objection within 10 days of its receipt of the treating physician's report recommending spinal surgery. Labor Code §4062(b) states, "The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report." (Emphasis added.) Therefore, based on its clear and unambiguous language, the 10-day time limit for a Labor Code §4062(b) objection starts running when the defendant receives the treating physician's report recommending spinal surgery. However, Labor Code §4062(a) states that "[e]mployer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610" (emphasis added). Similarly, Labor Code §4610(g)(3)(A) states that "[i]f a request to perform spinal surgery is denied [by utilization review], disputes shall be resolved in accordance with subdivision (b) of Labor Code §4062." (Emphasis added.) Therefore, Labor Code §4062(a) and 4610(g)(3)(A) both plainly and unequivocally provide that the spinal surgery second opinion process of Labor Code §4062(b) cannot be initiated unless and until the UR process of Labor Code §4610 has denied the requested spinal surgery. The Workers' Compensation Appeals Board stated that they are cognizant that Labor Code §4610(g)(5) allows the deadlines of Labor Code §4610(g)(1) to be exceeded in some circumstances. In spinal surgery cases only, the UR determination always must be made within 10 days of receipt of the treating physician's report, so that the defendant may still timely object under Labor Code §4062(b) if there is a UR denial. A defendant must both complete its UR and make any Labor Code §4062(b) objection within 10 days of receipt of the treating physician's report recommending spinal surgery, and they further held that these 10-day timelines are triggered only by a treating physician's report that complies with AD Rule 9792.6(o). Therefore, if a treating physician seeks authorization for spinal surgery through a narrative report, the narrative report must clearly state at the top that authorization for spinal surgery is being requested. Rule 9792.6(o) is part of the "Utilization Review Standards" adopted by the Administrative Director. It implicitly recognizes that claims adjusters routinely receive numerous medical reports from treating physicians. Therefore, if in a spinal surgery case a particular report might trigger the 10-day deadlines for a defendant to both complete UR and make a Labor Code §4062(b) objection, then the defendant should be given clear notice that authorization for spinal surgery is being requested. Although Rule 9792.6(o) is part of the AD's "utilization review" standards, we conclude that its requirement that a narrative report "shall

be clearly marked at the top that it [contains] a request for authorization" applies with equal force to Labor Code §4062(b)'s 10-day deadline for objecting to requests to authorize spinal surgery. Accordingly, a narrative report that requests authorization for spinal surgery will not trigger the 10-day UR and Labor Code §4062(b) unless it is "clearly marked at the top" that it requests authorization for spinal surgery.

If the Defendant fails to meet the 10-day timelines or to comply with Administrative Director Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery. A defendant must authorize the spinal surgery if it fails to comply with AD Rule 9788.1 or if it fails to use the form prescribed by AD Rule 9788.11. A failure to comply with those Rules is the functional equivalent of no timely objection. Rule 9788.1 expressly requires a defendant to include: (1) a copy of the treating physician's report; (2) an employee-specific reason for its objection; and (3) distinct and particularized declarations under penalty of perjury regarding when the treating physician's report was received and when the defendant served its objection. If a defendant breaches either of the first two mandates, then the basis of its objection cannot be determined. This is tantamount to not having made an objection. If a defendant does not declare under penalty of perjury when it received the physician's report and when it made its objection, then the AD cannot determine whether the objection was timely. Furthermore, requiring use of the form adopted by Rule 9788.11 gives clear notice to the AD – and to the employee or the employee's attorney – that an objection to the treating physician's spinal surgery recommendation is being made. In this case, it was not until February 25, 2009 that Dr. Dureza first sent Safeco a report that was clearly marked at the top that it was a "WRITTEN REQUEST FOR SURGERY AUTHORIZATION." Dr. Deutsch's UR report denying the requested spinal surgery issued on March 4, 2009, which was well within the 10-day UR deadline set forth above.

However, although Safeco's UR denial issued within 10 days of its receipt of the first report requesting spinal surgery that complied with AD Rule 9792.6(o), defendant did not initiate the spinal surgery second opinion process within that 10-day period as required by Labor Code §4062(b). Instead, Safeco took the position that it was applicant's obligation to timely object under Labor Code §4062(b). Nevertheless, the Workers' Compensation Appeals Board recognized that defendant's position was then fully consistent with the Appeals Board's significant panel decision in *Brasher v. Nationwide Studio Fund*, (2006) 71 Cal. Comp. Cases 1282, at 1287 (WCAB significant panel decision). Moreover, at that time, there was no binding opinion – either a published appellate opinion or an en banc decision of the Board – that expressly or implicitly disapproved of this aspect of Brasher. Accordingly, they rescinded the May 13, 2009 Findings and Order determining that applicant is entitled to lumbar spinal fusion surgery and they gave Safeco 10 days from the date of its receipt of this opinion within which to object to Dr. Dureza's spinal surgery recommendation (cf. Lab. Code, § 4062(b)) and commence the spinal surgery second opinion process. Safeco's objection shall comply with AD Rule 9788.1 and shall be on the form prescribed by AD Rule 9788.11.

The California Supreme Court denied a request to review the en banc decision

Elliott v. Workers' Compensation Appeals Board, (2010) 182 Cal. App. 4th 355; 75 Cal Compensation Cases 81. Medical Treatment – Spinal Surgery.

Applicant was employed as a working merchandiser supervisor in June 2005, and sustained injury to her back when stacked totes of magazines fell on her. On May 20, 2008 a consulting physician, Dr. Rovner, recommended that applicant undergo spinal surgery, lumbar fusion. The report was submitted to Gallagher Bassett by FAX and on May 29, 2008 its utilization review physician, DR Agnew, denied authorization. Applicant was unrepresented and not advised of need to object to the utilization review denial. Neither party requested a spinal surgery second opinion.

Dr. Rovner objected or again recommended spinal surgery, and a different doctor issued a Utilization Review denial on August 1, 2008. Applicant retained counsel in late August 2008, and the attorney demanded surgery be authorized. When authorization was not forthcoming, a Declaration of Readiness for Expedited Hearing was filed. The WCJ found the utilization review to have been timely and without timely objection to the denial. However due to lack of notice of need for the applicant to object, the WCJ ordered the defendant to authorize the surgery. Defendant sought reconsideration, contending that after a timely and appropriate utilization review denial, the onus is on the injured to object and seek a second spinal surgery opinion under Labor Code section 4062(b). The Appeals Board agreed and annulled the order to authorize the surgery. Applicant sought review.

Special procedures and timeframes govern the situation calling for the employer to instigate the spinal surgery second opinion process detailed in section 4062, subdivision (b) (section 4062(b)); however, they were not followed in this case. Instead, the Workers' Compensation Appeals Board ruled that under *Brasher v. Nationwide Studio Fund*, (2006) 71 Cal. Comp. Cases 1282 (*Brasher*), when an employer responds to a treating physician's recommendation for spinal surgery by timely denying that request pursuant to its utilization review, the employee must object to the denial and the dispute will then be resolved under section 4062(b). Because petitioner Vickie Elliott did not object to the utilization review denial or seek a spinal surgery second opinion report, the board decided her employer was not obligated to provide the requested spinal surgery. After this matter became fully briefed, the Workers' Compensation Appeals Board issued its en banc decision in *Cervantes v. El Aguila Food Products, Inc.*, (2009) 74 Cal. Comp. Cases 1336 (*Cervantes*), explicitly denouncing the Brasher holding relied on by the Workers' Compensation Appeals Board in this case. This court also rejected that holding, and reversed the decision of the Workers' Compensation Appeals Board, and remand with directions that the board immediately order respondents to authorize the requested spinal surgery or object to the treating physician's spinal surgery recommendation under section 4062(b) within 10 days of receipt of the order, thereby commencing the spinal surgery second opinion process.

Under the governing regulations, the employer's objection to the treating physician's recommendation for spinal surgery must be served on the administrative director and lodged on the prescribed "DWC Form 233" which, not surprisingly, is designed only for completion and submission by the employer. (Cal. Code Regs., tit. 8, §§ 9788.1, 9788.11.) Disregarding

the plain language of the above statutes, the Workers' Compensation Appeals Board in the present case ruled that if the request for spinal surgery is denied under the utilization review process, it is the employee's obligation to seek a spinal surgery second opinion report under section 4062(b), citing Brasher.

The *Sandhagen* court concluded, in light of the comprehensive nature of section 4610 and the goals of controlling costs while ensuring workers' access to prompt, quality, standardized care, that the Legislature intended for employers to use the statutory utilization review process "to review and resolve any and all requests for treatment. Thus, an employer may not elect to bypass utilization review and instead invoke the section 4062(a) provisions to dispute an employee's treatment request. (*Sandhagen.*, supra, at p. 237.) This is so because the section 4062(a) dispute procedure is not available to employers to object to a treating physician's medical determination concerning medical issues "subject to Section 4610." (Labor Code § 4062(a).) On the other hand, the same statute allows employees to invoke section 4062(a) to resolve disputes concerning an employer's Labor Code § 4610 utilization review decision to modify, delay or deny a treatment recommendation. In her concurring opinion, Justice Kennard made it clear that Labor Code §§4610 and 4062 establish a two-step process for settling medical treatment disputes. Utilization review is a threshold procedure governing the employer's evaluation of whether to approve or deny the treating physician's recommendation. (*Sandhagen*, supra, 44 Cal. 4th at pp. 245-246 (conc. opn. of Kennard, J.).) Because any decision to delay, modify or deny a treatment request must be consistent with detailed treatment guidelines, that decision must be made by a qualified licensed physician. (Labor Code § 4610, subd. (e).) A dispute does not legally arise unless the employer prompts the utilization review in a timely fashion. Where that process leads to a modification, delay or denial of the requested treatment, the employee is the aggrieved party. In all cases except those recommending spinal surgery, the employee may invoke the section 4062(a) dispute resolution mechanism. (Labor Code §§ 4062(a), 4610(g)(3)(A); see *Sandhagen*, supra, 44 Cal. 4th at p. 246 (conc. opn. of Kennard, J.)

The Court found that while only employees can invoke the QME process under Labor Code Section 4062(a), and the employer MUST use utilization review to contest a treatment recommendation, objections to a request for spinal surgery are, under Labor Code Section 4062(a) and (b) subject to employer objection. The required form for objection to the treating physician's recommendation for spinal surgery, Form 233, is for the employer's submission only. The Appeals Board en banc decision in *Cervantes*, was correct in requiring defendant (1) to timely conduct utilization review, if not authorized, for the defendant's utilization review, (2) to timely obtain a second opinion report, and (3) if not recommended by the timely second opinion report to file a Declaration of Readiness. The utilization review and request for second opinion physician must be made within ten days of receipt of the treating physician's recommendation. Here, there was no timely request for the second opinion physician, and the Board's decision to reverse the WCJ was set aside with direction that defendant be directed to authorize the surgery.

County of Sonoma v. Workers' Compensation Appeals Board (Fifer), (2010) 75 Cal. Comp. Cases 1018 (writ denied) -- Medical treatment - Spinal surgery

Applicant injured her neck and thoracic spine on February 18, 1992. Applicant was evaluated by Dr. Richard Baker in the capacity of an Agreed Medical Examiner. She received a 12% permanent partial disability with further medical treatment award in June 1995. In 2006 applicant's PTP referred applicant to Dr. Joseph Grant. On June 8, 2007, Dr. Grant issued a report requesting authorization for a anterior cervical discectomy and fusion from C5 to C7. On June 20, 2007, the Utilization Review physician, Dr. Lester Sacks, issued a UR denial. Defendant denied any liability for any charges related to the proposed surgery until applicant was reevaluated by the AME, Dr. Baker. Dr. Baker reexamined applicant on October 23, 2007, and reported on January 2, 2008, that applicant's need for spinal surgery was unrelated to the 1992 work injury.

On July 6, 2007 Dr. Grant requested authorization for a two level discectomy and fusion internally. A UR denial issued on July 12, 2007.

Applicant filed a petition for penalties, and in December 2009, the case was tried on issues of compensability of the surgery under the 1995 award, 5814 penalties, identity of applicant's PTP, and whether defendant's UR could be offered on the issue of need for surgery. On March 29, 2010 the WCJ issued an F&O determining that defendant was liable for the surgery but not for penalties. Both parties sought reconsideration. The WCJ reported that the defendant was liable for the surgery because it had failed to follow the procedures in Labor Code Section 4062(b) Here defendant's objection was not on the form required by 8 Cal. Code of Regs. §§9788.1 and 9788.11, the objection did not assert that Dr. Grand was not the PTP, and the objection was not served on applicant or her attorney. Because Dr. Baker's evaluation was performed outside of the 45 day period prescribed for spinal surgery disputes, it could not be considered. The WCJ further reported that the defendant should not be found liable for 5814 penalty because there was a bona fide legal issue, prior to issuance of the *Cervantes* decision, based on Labor Code §4062(a) and Brasher v. W.C.A.B., (2007) 72 Cal. Comp. Cases 229. The Board denied both parties' petitions, and defendant sought review contending that the AME opinion on causation of need for surgery should be considered, and that there was no current evidence that applicant remained a surgical candidate. The Writ of Review was denied.

Vervalin v. Travelers Ins. (2010) 38 CWCR 178 (WCAB Panel) Medical treatment – spinal surgery. Where there is no agreement on AME for 4062(b), WCJ cannot rely on a later AME opinion on the issue.

Applicant injured his back on April 20, 2007. The applicant was referred by the parties to an AME who in turn referred applicant to an orthopedic surgeon. The orthopedic surgeon requested authorization for surgery. Defendants submitted the request to UR and the UR physician recommended against surgery. Defendants obtained another report recommending against surgery after following the "second surgery procedure" provided in Labor Code §4062(b). The AME later wrote a supplemental report recommending the surgery. The matter went to trial on the issue of need for surgery. The WCJ found that applicant was entitled to spinal surgery based on the AME report. Defendant sought reconsideration.

The Workers' Compensation Appeals Board reversed the finding of the trial judge. The Board noted that Labor Code §4610 requires that spinal surgery disputes be resolved as provided in Labor Code §4062(b). The Board applying Labor Code §4062(b) found that in this case the defendants timely objected to the spinal surgery recommendation of the treating physician, defendants undertook UR, the applicant was represented, there was no agreement to a California Board certified orthopedic or neurological surgeon to prepare a second opinion report, the defendant obtained a second opinion from a from a physician randomly selected by the AD, the WCJ must rely either on the treating physician or the second opinion physician. The Board further stated that if neither the report of treating physician nor the second opinion physicians were substantial evidence, due process would require further development of the record.

The Board concluded that here neither the report of the treating physician nor the report of the second panel physician were substantial evidence because they did not adequately review applicant's medical record. The Board indicated that the WCJ could not rely on the AME because he was not a board certified orthopedic surgeon or neurosurgeon. The Board also seemed to indicate that the AME was not agreed to as part of the second surgery procedure but was agreed to prior to the request for surgery so could not be used on the issue of the need for surgery. The Board indicated the matter should be remanded to get a supplemental report for the UR physician selected by the AD after the physician has reviewed all necessary medical records. The Board remanded the matter to the WCJ to have further proceedings consistent with its decision.

Davis v. Board of Chiropractic Examiners, (2010) 75 Cal. Comp. Cases 465 (unpublished) medical treatment / billing errors, discipline of chiropractor for

An employee sustained a 1996 injury to his wrists and sought chiropractic treatment from Dr. Davis. In 1999 the employee fell at Honey Baked Hams and injured his back. He sought chiropractic treatment from Dr. Davis for that injury, also. In March 2000, while working for Cal State University, Fullerton, the employee fell down a flight of stairs injuring his ankle and further injuring his back. The employee obtained over 100 treatments from Dr. Davis. It was alleged that in 20 years of Dr. Davis practice, this employee was the only one who had sustained multiple injuries to different body parts in the course of distinct employments with different insurers. Dr. Davis' wife was in charge of billing and hired Norma Rosales from a "welfare-to-work" program. Rosales billed for the employee's treatments. The practice received no complaints concerning the billings.

On May 22, 2002, Dr. Davis deposition was taken by counsel for on of the defendants in the employee's cases. Following the deposition, Ms. Davis audited the bills and found 114 billing errors, some favoring the defendant and some favoring the defendant. Defendant's counsel hired a chiropractor, Dr. Stahl, who was not a QME who testified that Dr. Davis had double billed defendants and upcoded billings for treatment services. The Board of Chiropractic Examiners' expert, Dr. Philip Rake, found Dr. Davis treatments excessive,

wholly palliative and unnecessary. Dr. Rake opined that Dr. Davis treatments violated the standard of practice.

Dr. Davis had a 20 year history of practice without complaint by patients or insurance carriers. Dr. Davis admitted that he entrusted billing to his staff, did not understand the nuances, and did not check the accuracy of billings prepared by his staff. He characterized the employee as "a high-maintenance patient" requiring an unusual amount of time and patience. He found it difficult to segregate treatment for one part or injury from another, particularly the successive injuries involving the employee's back. Dr. Davis believed the employee was entitled by his workers' compensation award(s) to palliative treatment and treatments to relieve occasional flare ups. He provided the employee with 160 back treatments and 100 ankle treatments.

Dr. Michael Martello, a well credentialed chiropractor with 23 ears of practice, found Dr. Davis treatment plan did not violate a standard of care, and that the course of treatment was wonderful, …the treatment plan I would want applied to me" if he had a multiple level spinal injury.

The Board of Chiropractic Examiners' administrative law judge conducted a ten day hearing found that Davis had not reviewed the billings, did not have the knowledge to determine whether the proper CPT codes were reflected on the HCFA forms, and that failure to ensure accuracy of the billings constituted negligent acts, and in the aggregate gross negligence. IN 2000 – 2002 there were 114 billing errors, including billing multiple carriers for the same service; treatments after the initial course were provided by assistants with scheduling entrusted or delegated wholly to the patient. The course of treatment allowed the patient to become dependent, and fostered chronicity constituting gross negligence. Dr. Davis was disciplined for gross negligence in billing and over treatment, both of which constituted unprofessional conduct. The Board adopted the ALJ's findings.

Dr. Davis sought administrative mandamus. Dr. Davis contended that the regulations on which his discipline were based were unconstitutionally vague and that he was not subject to finding of wrongdoing or discipline if billing errors were corrected within 30 days of the chiropractor's actual discovery. The court found that 18 Cal Code of Regs 318 does not provide a "30 day safe harbor for negligence." §318 imposes a duty on chiropractors to "ensure accurate billing for … chiropractic services." The Court found the regulations, reviewed in light of the facts of this case, not unduly vague, and sustained the discipline and award of $72, 242.80 in costs.

Krause v. Workers' Compensation Appeals Board, (2010) 38 CWCR 175 (Unpublished)
MPN – Cure of defective notice

Cynthia Krause petitions for a writ of review from a decision of the Workers' Compensation Appeals Board. (Labor Code § 5950; Cal. Rules of Court, rule 8.495.) Krause contends the Workers' Compensation Appeals Board erred by adding an employer's workers' compensation insurer as a party defendant to a prior award and by failing to treat

notification errors regarding a medical provider network (MPN) as a basis for the employee to treat outside the MPN. The Workers' Compensation Appeals Board denied the writ.

Krause sustained an industrial injury nearly 10 years ago while working for Wal-Mart Stores, Inc. Taking judicial notice of the court's August 10, 2006, decision arising out of the same industrial injury, the court recalled that "Krause slipped and fell on a wet floor while working as a janitor/maintenance employee for a Turlock Wal-Mart store on July 12, 2000. Wal-Mart admitted Krause injured her left lower extremity and provided her with appropriate medical benefits. She later alleged, and Wal-Mart disputed, that the slip and fall accident further resulted in a psychological injury." On September 8, 2005, a workers' compensation administrative law judge awarded Krause 53-percent permanent disability plus future medical treatment to her lower left extremity, notwithstanding the WCJ's findings that Krause was not credible and had presented disingenuous arguments in bad faith. By way of a petition for writ of review, Krause contended the Workers' Compensation Appeals Board erred in finding she did not also sustain a psychological injury and by not authorizing a referral for a gastric bypass evaluation. This court denied the writ on August 10, 2006, concluding substantial evidence supported the absence of a compensable psychological injury and that there was "nothing to review" where there was no evidence Wal-Mart had denied Krause's request for gastric bypass evaluation because the Workers' Compensation Appeals Board never issued a final determination on the issue. Wal-Mart continued to provide Krause with medical treatment from her primary treating physician, Dr. Amsden, who referred her to orthopedic surgeon, Dr. Robert Caton, for a total knee replacement. According to Wal-Mart, Krause last saw Dr. Amsden on June 25, 2007, and instead continued to treat with Dr. Caton on eight occasions following her knee surgery over the following year. On September 12, 2008, a claims adjuster from Wal-Mart's workers' compensation servicing company, Avizent, sent Krause a letter in English only entitled "NOTICE TO INJURED WORKER TO SEEK ANOTHER MEDICAL PROVIDER". The Notice explained Avizent "is the authorized representative for American Home Assurance Company," which had "implemented the Wal-Mart – First Health Primary MPN." Concluding Krause had been obtaining treatment from a non-network physician; the claims adjuster asked her to seek further care from an MPN provider and offered assistance in locating such a physician. Avizent's Notice acknowledged a process to object and noted treatment outside the MPN would be appropriate if her injury involved an acute medical condition, a serious chronic condition, a terminal illness, or recent surgery within 180 days of the MPN coverage date. (See Labor Code §4616.2, subd. (d)(3); 8 Cal. Code Regs. §9767.9.) According to Krause, Dr. Amsden is a member of Wal-Mart's MPN, but Dr. Caton is not. Without responding as requested in the Notice, Krause instead served a September 19, 2008, deposition notice on the Avizent's claims adjuster. After Wal-Mart moved to quash the deposition for lack of notice of a dispute, Krause filed for an expedited hearing claiming Wal-Mart was interfering with her medical treatment and asking the Workers' Compensation Appeals Board to resolve the dispute and award sanctions and attorney fees.

The WCJ directed Krause to provide "a specific and detailed exposition of what benefit is allegedly being denied" and subsequently conducted an expedited hearing on December 16, 2008. In the hearing minutes, the WCJ summarized three grounds in which Krause

contended should excuse her from treatment restricted within the MPN: 1) the Notice advising Krause to select an MPN treating physician was defective, despite having been corrected before the hearing; 2) at least three orthopedic doctors are not currently available within the MPN; and 3) Krause has a "serious chronic condition" statutorily exempted from MPN treatment. On January 14, 2009, the WCJ disagreed with Krause and found she had "not shown good cause to seek medical care outside Defendant's Medical Provider Network." Krause petitioned the Workers' Compensation Appeals Board for reconsideration. Among her complaints, Krause objected to American Home Assurance Company's appearance as "an officious intermeddler in this matter" imposing its MPN on Krause and claimed Wal-Mart misrepresented itself and failed to follow the law by not disclosing that it was insured at the time of the medical award Krause also contended: the WCJ illegally shifted the burden of proof to her to demonstrate good cause to seek care outside the MPN; Wal-Mart should be held liable for its defective MPN Notice; allowing Wal-Mart to rehabilitate its defective notice renders the Labor Code and regulations a "nullity" and "frivolity;" the existence of the MPN is a fiction based on insufficient treating physicians available; the WCJ failed to address all of the issues raised at the expedited hearing; and that she was entitled to an exemption from the MPN for being treated for a "serious chronic condition." The WCJ subsequently vacated the prior decision to address the issues raised.

In June 2009, the WCJ ruled that any alleged defects in Wal-Mart's MPN process that may have existed in the past had, by the time of hearing, been corrected and Krause presented "no authority in support of her apparent 'there were errors that they cannot later fix' argument." The WCJ also found "no real issue here" regarding the identity of American Home Assurance Company, who presented overwhelming evidence as Wal-Mart's insurer at the time of injury, and concluded Krause failed to demonstrate she qualified for any exception to treatment under the MPN. Krause again petitioned for reconsideration, complaining she was aggrieved by the WCJ's delay in the proceedings and by requiring her to file a "specific and detailed exposition" outlining her objections and explaining what benefits were allegedly denied. She objected to defendant being allowed to amend its MPN list, and to the substitution of insurers. In August 2009, the WCJ indicated in the Report and Recommendation on Reconsideration that there was difficulty of adjudicating a claim without knowing the specific issues raised, indicating that there was no evidence of a lack of available physicians within the MPN, and stating that "All of the evidence presented by either party demonstrate[d] that Applicant received every single workers' compensation benefit from Avizent and none from the employer in any 'self-insured' status." The WCJ also recommended that the Board impose sanctions against Krause for improperly trying to "backdoor" evidence refuting the existence of Wal-Mart's MPN that had not been submitted at trial.

The Board granted reconsideration and issued its own decision after reconsideration, concluding that Krause did not establish she was entitled to continued treatment outside the MPN and that Wal-Mart was not liable for any medical treatment obtained outside the network. Here American Home Assurance Company (AHA) did appear early in the litigation process. According to the Workers' Compensation Appeals Board, "Our review of the record clearly reveals AHA has been identified as the insurer in this matter beginning in

March of 2001, when it first entered its appearance through counsel. Subsequently, all captions in defendant's filings in this case have named AHA as a party defendant." Krause does not dispute the Board's findings. Moreover, the Board relied on a letter from the Workers' Compensation Insurance Ratings Bureau indicating American Home Assurance Company was Wal-Mart's insurer on Krause's date of injury. The Board concluded, Krause "cannot claim to be aggrieved by the inclusion of AHA at this time." Krause presents no legal authority for the proposition that the defective Notice, once corrected, forever exempts her from Wal-Mart mandating treatment within the MPN. Krause relies on another en banc Workers' Compensation Appeals Board decision, *Knight v. United Parcel Service*, (2006) 71 Cal. Comp. Cases 1423, which held that an employer's failure to provide adequate notification rendered the employer liable for self-procured medical treatment outside the MPN. However, in Knight, the notice was more than technically deficient:

> "In none of the correspondence described above did [the insurer] explain where or how applicant was to obtain medical treatment. He was never notified that treatment had or had not been initiated in the MPN. He was never notified that an MPN physician had or had not been designated as primary treating physician. He was never notified of his right to change any designated primary treating physician and his right to select a new primary treating physician of his choice within the MPN. He was never notified of his right to obtain second and third medical opinions within the MPN or of his right to obtain review by an independent evaluator. Instead, [the insurer] wrote only that the medical treatment he sought was unauthorized, without tendering any information about how he was to obtain treatment for the admitted injury." (*Knight v. United Parcel Service*, (2006) 71 Cal. Comp. Cases 1423 at 1429.)

Here, the Notice was defective primarily in that it was not sent in Spanish, a language in which there is no indication would have aided Krause's understanding. Moreover, Knight did not declare that a defective notice could not be corrected.

The Board ordered the matter remanded, however, to further develop the record with regard to Krause's access to available physicians under the MPN. (Labor Code § 4616, subd. (a)(2); 8 Cal. Code of Regs., § 9767.5.) The Board also ordered that the record be reopened to consider whether Krause had sought and been denied treatment after the initial defective Notice, potentially warranting a penalty award.

Applicant filed a Petition for Writ of Review. The petition raised two substantive issues for the court's review. She claimed that American Home Assurance Company "should not be permitted to meddle" with her medical care because it was never a party to the original award for medical care and it is now too late to set aside a prior stipulation or amend the record." She also claimed the initial defective Notice forever bars her from the statutory framework requiring treatment under the MPN. Krause relies on the en banc decision in *Coldiron v. Compuware Corp.*, (2002) 67 Cal. Comp. Cases 289, where the employer stipulated it was permissibly self-insured and waited six years to disclose to the Workers' Compensation Appeals Board that it was actually insured at the time of injury under a policy that provided coverage above the employer's primary liability. The Workers' Compensation Appeals Board sanctioned the employer's third-party administrator and noted the issue was

relevant because the previously unnamed insurer was in liquidation and had come under the authority of the California Insurance Guarantee Association. (Insurance Code §1063 et seq.) The Workers' Compensation Appeals Board had held that "The responsible entity must be divulged at the earliest opportunity, and certainly no later than the commencement of the litigation process and formal proceedings." (*Coldiron v. Compuware Corp.*, (2002) 67 Cal. Comp. Cases 289, at 294.) The Board in *Coldiron* reasoned early disclosure "avoids unnecessary delays in the prompt delivery of benefits awarded." The court found no merit to Krause's contention. The petition for writ of review was denied.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS

DEATH BENEFITS

PRESUMPTIONS and SPECIAL BENEFITS

PUBLIC EMPLOYEE DISABILITY RETIREMENT

Acosta v. Sacramento County Employees Retirement System, (2010) 75 Cal. Comp. Cases 109 (unpublished) Public employee disability retirement.

Appellant sustained injuries in back in 1993, and 1996, and to her ankle, neck, low back, and right wrist in 2001 while employed by County of Sacramento as a public health nurse. She developed psychiatric problems diagnosed as a somatoform disorder , and she had a lumbar spine fusion in 2003. She applied for disability retirement, and was found by an ALJ not to have completed treatment required to reach maximum medical improvement. The retirement board denied the application for retirement. Applicant filed a Petition for Writ of Mandate alleging that it was error for the retirement board to have relied on defendant's vocational expert rather than her own. The Court found that the decision was supported by substantial evidence, and that it was the exclusive province of the trier of fact to determine the credibility of the witness. Applicant had failed to undergo treatments her physician as well as forensic physicians recommended. The denial of retirement was sustained. .

EVIDENCE / FORM, TIME, and MANNER OF FILING OF DOCUMENTARY EVIDENCE

HEARINGS & VENUE, WALKTHROUGH PROCEDURE

Guerrero v. Zenith Insurance Co., (2010) 38 CWCR 93 (WCAB Panel) Hearings -- Applicant's choice to self procure treatment outside the MPN is not subject to expedited hearing under Labor Code Section 5502(b).

The WCJ ruled that an issue of the need for medical treatment should be dropped from the calendar with the explanation that the issue (MPN) was not appropriate for an expedited hearing when applicant was willing to pay for his medical treatment. Although a party is entitled to an expedited hearing on entitlement to medical treatment pursuant to Labor Code §4600, an expedite hearing is not available for determination under Labor Code §4616 of weather should treatment maybe provided only through and MPN when the applicant is willing to self procure the treatment. Defendants filed a petition for reconsideration/removal.

The WCJ in his report indicated that a party is entitled to an expedited hearing establishing a bona fide, good faith dispute as to the employee's entitlement to medical treatment pursuant to Labor Code §4600. Defendant however was seeking a determination under Labor Code §4616 not Labor Code §4600. The parties did not want adjudication of whether applicant was in need of medical treatment, but of whether medical treatment could be provided only through an MPN.

The Workers' Compensation Appeals Board indicated that pursuant to Labor Code §5900 reconsideration may be had only from a final order. The WCJ's order taking the matter OTOC was not a final order. The Workers' Compensation Appeals Board went on that to the extent this was a petition for removal is would be dismissed as defendants failed to show that the extraordinary circumstances justifying removal had been shown. The Workers' Compensation Appeals Board agreed with the WCJ that under Labor Code §4605 an injured worker may obtain medical treatment from a physician of his or her own choice at the workers own expense. (*Bell v. Samaritan medical Clinic, Inc.,* (1976) 60 Cal. App. 3rd 486; 41 Cal. Comp. Cases 415.) Self financed care is different from an employee's right to free choice of physician at the employer's expense pursuant to Labor Code §§4600)a), 3600(a)(10), 4601 and 4616.3)b). Because the physician that applicant selected to treat him was a treating physician, his reports were unquestionably admissible in evidence. The petition for reconsideration/removal was dismissed.

Amaya v. Faustino Limon's Chair Factory, (2010) (BPD) (Lexis) Hearings -- Walkthrough procedure

Defendant presented a Petition to Suspend Proceedings and Compel Medical Examination to the WCJ on a walk-through basis. The WCJ issued an order compelling the applicant to attend a panel QME exam 15 days scheduled for fifteen days after the date of the walkthrough. A copy of the petition on file in EAMS does not contain a proof of service reflecting service on the applicant.

Defendants did not file the petition to compel for almost 2 months after the applicant's attorney informed the defendants the applicant's attorney had instructed the applicant not to

attend the exam. Applicant filed a petition for removal arguing they did not have sufficient time to object or be heard on the matter.

Workers' Compensation Appeals Board granted the petition for removal and rescinded WCJ's Order compelling applicant to attend the examination because defendant the petition to compel attendance at medical examination on did not contain a proof of service showing service on applicant as required by 8 Cal. Code Reg. § 10280(d)(2)(C), and because the proposed order did not contain a notice of intention nor did it contain a self-destruct clause as required under 8 Cal. Code Reg. §§10280(i) and 10349, and Workers' Compensation Appeals Board found that removal was appropriate because applicant suffered significant prejudice.

COMPROMISE & RELEASE

Marchese v. the Home Depot, (2009) 37 CWCR 282 (WCAB Panel) Compromise & Release – due execution, rescission, sanctions

The parties negotiated a compromise and release for $20,000 less credit for PD advances. Defendants drew up the compromise and release and by mistake sent the settlement to applicant who signed and returned the settlement to defendants. Defendants sent the signed settlement to the applicant's attorney. Applicant's attorney signed the settlement and had two secretaries' sign as witnesses to applicant's signature. Defendants had not initialed any issues in the column for issues included in the settlement. Applicant's attorney initialed apportionment, PD, and future medical treatment. After obtaining defendants signature applicant's attorney walked-through the settlement and it was approved by the WCJ.

Applicant obtained and new attorney who filed a petition to reopen and to set aside the approval of the compromise and release agreement. The matter went to hearing on the petition to set aside the settlement agreement. The former applicant's attorney testified at the hearing that she telephoned the applicant and told her she was requesting a fee of $3,000, that the applicant would receive $12,137.14, and that she was adding the items to the compromise and release agreement. The Workers' Compensation Appeals Board set aside a compromise and release when the attorney obtained approval of a compromise and release agreement that had not been properly witnessed. The WCJ following the hearing at which applicant, his father and the secretary testified found that the compromise and release failed to resolve any issues and also lacked proper authentication and that the applicant's former attorney provided valuable services of $3000 and awarded defendants credit for its payments mad under the compromise and release agreement. Both sides filed petitions for reconsideration.

The Workers' Compensation Appeals Board granted reconsideration. It issued a notice of intention to impose sanctions on the former attorney and set the matter for commissioner's conference. Prior to the conference the former attorney requested an order allowing her to reveal attorney-client privileged communications pursuant to evidence code section 958. At the commissioners conference that former attorney admitted she authorized her staff to execute the compromise and release and that it was improper. Her excuse was she was

dealing with a difficult client, but she admitted her conduct was wrong. Her legal argument was that there was no requirement that witnesses see the applicant sign the compromise and release. The secretary to the former attorney testified she took it on herself to backdate the signatures and the attorney did not ask her to do it. The Board denied the attorneys request that the attorney client privilege be waived. The Board found that the issue before the was the attorney's conduct executing and securing approval of the Compromise and release agreement. Resolution of the issue did not involve any communication between the attorney and the client. The Board indicated that the attorney admitted her conduct was wrong and that she was remorseful concerning the manner in which the compromise and release was completed and approved. Although the Board appreciated the difficulties they could not endorse the unprofessional handling of the matter. The Board imposed a sanction limited to $250 based on the attorney's remorsefulness and her assurance such conduct would not occur again. Applicant's petition for reconsideration was denied. The Board stated that although it seems inconsistent to issues sanctions and a fee of $3,000, there was little doubt that the attorney was dealing with a difficult client and negotiated and substantial settlement. Turing to the defendant's petition, the Board noted that it has continuing jurisdiction to rescind, alter, or amend any order, decision or award if a petition is filed within 5 years of the date of injury and good cause is shown. The Board pointed out order approving compromise and release is such and award and that the petition was filed within five years. It stated good cause was shown to set aside the award as the Compromise and Release was unenforceable because it did not settle any issues and was not properly executed.

LIENS, LIEN CLAIMANTS & LIEN CLAIMS

Comprehensive Outpatient Surgery Center v. Workers' Compensation Appeals Board (Osborne), (2010) 75 Cal. Comp. Cases 49 (Lck of UR on pre-Sandhegan outpatient surgery did no overcome AME opinion that surgery was not necessary.

Pursuant to a referral from her PTP, applicant underwent treatment in lien claimant's pain management program that included ''percutaneous epidural and decompression neuroplasties, local facet blocks and rhizotomies.'' Apparently without UR of the pain management program treatments, but before the date of the *Sandhagen* decision, applicant was referred to an AME who issued a report indicating that the pain management treatments were not indicated on an industrial basis under the ACOEM Guidelines. After the case in chief resolved, the matter proceeded to a lien trial in which no evidence was presented regarding whether UR was conducted before Applicant was referred to an AME. The WCJ denied recovery of the lien on the ground that the treatment was not reasonably medically required.

Lien claimant filed a Petition for Reconsideration, contending that it was entitled to recover on its lien since the defendant failed to conduct UR in accordance with *State Compensation Insurance Fund v. W.C.A.B. (Sandhagen)/Sandhangen v. Workers' Compensation Appeals Board* (2008) 73 Cal. Comp. Cases 981. The WCJ recommended that reconsideration be denied on the ground that the AME referral predated the Supreme Court's decision in *Sandhagen*. However, even if *Sandhagen* were applicable, there was

nothing to preclude applicant from seeking an AME opinion. The WCJ commented that the parties should be encouraged to resolve disputes through the AME process, and lien claimants should not be rewarded, based on alleged procedural defects, for providing unreasonable and unnecessary treatment to injured workers.

The Workers' Compensation Appeals Board denied reconsideration and adopted and incorporated the WCJ's report without further comment. Lien claimant's petition for writ of review was denied.

Dykes v. Robinsons May Federated Retail, (BPD) (MON 0239013) -- Liens – Development of the record – order to use bill review service.

Mary Dykes sustained injury on April 9, 1998. The case in chief settled by Compromise & Release filed and approved at a hearing on January 8, 2007. The case participant list contains names of twelve lien claimants. Two liens were set for trial. In March 2007 a lien trial was held and the WCJ issued orders that the medical bills be submitted to a bill review service, Pac Med, to determine the reasonableness of the charges. The WCJ also ordered the parties were to take the depositions of the AME to determine necessity of the treatment. The trial judge advised the parties to each submit a list consisting of three names of bill reviewers the proposed to be used in this case and submit the list to each other. Each side was to strike two names from the other parties the list and the court would choose one of the two names to review the case. Following the failure of lien claimant to submit a list the WCJ choose Pac Med as the independent reviewer. A Lien Claimant filed a petition for removal.

The WCJ in his report indicated Labor Code §4903 provides that the Workers' Compensation Appeals Board may determine and allow liens. The power to determine reasonableness value of medical treatment is granted to the Workers' Compensation Appeals Board by Labor Code §4906(a). The Workers' Compensation Appeals Board determined reasonableness of liens based on evidence. (*Bentley v. Industrial Accident Commission (Martin)*, (1946) 75 Cal. App. 2nd 547; 11 Cal. Comp. Cases 204.) The WCJ has the power to develop the record and obtain additional evidence. The WCJ can develop the record when the trial record is deficient and the WCJ has this same power in lien cases. Further the WCJ has used experts to develop the record when the state of the record is deficient. (See the cases of *Tyler v. Workers' Compensation Appeals Board*, (1997) 56 Cal. App. 4th 389; 62 Cal. Comp. Cases 924; *McClune v.* Workers' Compensation Appeals Board, (1998) 62 Cal. App. 4th 1117; 63 Cal. Comp. Cases 261, and *McDuffy v. Los Angeles County RTD,* (2002) 67 Cal. Comp. Cases 138. In this case the WCJ ordered the parties to return to the AME on the issue of the necessity of the surgery. Since the parties disagreed on what charges are allowable under the OMFS and the determination of the cost of the treatment provided, the court was left with dueling experts, ordering the parties to independent bill review provides the court with appropriate and reasonable guide lines for making these determinations. The WCJ concluded he properly ordered the development of the record on reasonableness and necessity of treatment. The WCJ indicated the parties would suffer no irreparable harm as a result of the order to develop the record. The WCJ concluded this was the fairest and most

expeditious method of determining the reasonableness and necessity of the treatment provided in this case. The Workers' Compensation Appeals Board denied removal.

Accord on use of bill reviewers to resolve fee and value disputes: *Acosta v. Peterson Family, Barkerville v. UCLA Medical Center, Raine v. City of Burbank,* and *Timms v. State Compensation Insurance Fund* (all WCAB Panel decisions not published in Cal. Comp. Cases or CWCR.)

Medina v. Santa Ana Plating, State Compensation Insurance Fund, (2010) 38 CWCR 182 (WCAB Panel). Lien Claims – Statutes of Limitations – claimant must meet both Statutes of Limitations for case-in-chief filing and Labor Code §4903.5.

Applicant sustained injury but did not file an Application for Adjudication of Claim or other case opening document. More than five years after the injury Main Street Specialty Surgery Center filed an Application and lien. The WCJ based his decision on the premise that Labor Code §5405 is not applicable when defendants' admit injury and furnish benefits. The WCJ also reasoned that Labor Code §4903.5 (a) is a specific statue as opposed to the more general statute, §5405, and that it, therefore, controls the relevant time period for filling a line, in case of conflict. The WCJ found that the lien of Main Street Specialty Surgery Center was not barred by the Statue of Limitation or laches. Defendants filed a petition for reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and found that he lien claim was by Labor Code §5405. Labor Code §5405 provides that proceeding for the collection of benefits must commence within one year of the date of injury or one year from the last payment of PD or the last date medical benefits were furnished. When the injured worker is not pursuing the claim the lien claimant stands in the shoes of the injured worker. The lien claimant must initiate the claim by the filling of an application in a timely manner. In *Kaiser Foundation Hospital v. Workers' Compensation Appeals Board (Martin)*, (1985) 50 Cal. Comp. Cases 411, the stated that neither the Labor Code no any California cases creates a different statute of limitation for medical lien claimants as opposed to an injured employee in workers compensation claims. Labor Code §4903.5(a) provides that no lien may be filed after 6 months from the date of a final decision, findings, including an order approving compromise and release, or award, on the merits, after five years from the date of injury, or after one year from the date the service are provided, which ever is later. In this case applicant did not file an application. Main Street was entitled to file the application to recover the costs of the medical treatment it provided. Main Street was bound by the same statute of limitations as the applicant. There appears to be no dispute in this case that Main Street did not file the application within the period describe in Labor Code §5405. The Board held that Labor Code §5405 does apply to the commencement of proceeding to collect benefits in this case, regardless of who filed the application. Moreover, Labor Code §5405 expressly refers to the payment of disability medical treatment benefits in determining the one-year period, so it cannot be interpreted to exclude all cases where the defendant provided benefits. Because Main Street application was filed more than a year, in fact more than five years, after the date of injury and the provision of benefits, it is barred by Labor Code section

5405. The Board further stated that they did not see a conflict between Labor Code §§5405 and 4903.5. Labor Code §5405 governs the commencement of proceedings for the collection of benefits, by the filling of an application. Labor Code §4903.5(a) governs the time for timely filling a lien. While, in this case, those two events happened simultaneously, in most cases they do not. Where the injured worker files a timely Application for Adjudication of Claim the lien claimant would need to be concerned with Labor Code §5405, and §4903.5(a) alone would determine the time period within which it must file it lien. In the present case, because the injured worker did not file an application the lien claimant had to file the application to seek compensation. Labor Code §5501 and regulations 10360 and 10364 govern and allow the lien claimant to file the application. The Board further disagreed with the WCJ suggestion that defendant should have obtained a dismissal order, when it realized applicant was not going to file an application. This suggestion makes no sense and puts the burden on defendants to do the impossible. For injuries after 1-1-1994, defendant could only petition for an order dismissal of an application of adjudication. The Board agreed with defendants without an application having been filed there was no case to dismiss. Because Main Street failed to invoke the Board's jurisdiction in a timely manner, they are barred from proceedings to recover compensation.

Garcia v. Service Performance Corporation; Zurich American Insurance Co., (2010) Lexis Nexis Workers Comp. e-Newsletter, Vol. 2 Issue 2 (WCAB Panel) Liens – elements of proof for interpreters' liens

Applicant, a monolingual Spanish speaker, injured her right wrist in September 2007. Her Primary Treating Physician (PTP) was Randolph P Rhodes, D. C., of Rhodes-Jacobs Chiropractic. Word of Mouth filed a lien for $4,400.00 in interpreting services at applicant's appointments with her PTP. Defendant had objected to the services. After the case in chief settled, a lien trial was conducted. It was admitted that the interpreters were not certified; the service dated coincided with applicant's dates of visits to Dr. Jacobs, D.C. Defendant contended the treatment was not reasonable and necessary; it produced advertising of Rhodes-Jacobs Chiropractic that it could accommodate Spanish speaking patients, and testimony that the staff represented that Dr. Jacobs spoke Spanish. The WCJ awarded $2,200.00 on the lien. Defendant sought reconsideration.

The Board granted reconsideration, and held that the lien claimant had the burden of proof of reasonableness of its lien under Labor Code Sections 5705 and 3202.5. Labor code Section 4600(f) requires a "qualified interpreter." "Qualified interpreter means a language interpreter certified or deemed certified under Govt. Code §68566 or the Article commencing at §11435.05. Liability for interpreter services at medical treatment appointments are not guaranteed by statute or regulation, but are allowable if necessary for effective communication between physician and patient. Here lien claimant did not produce evidence that its interpreters were present at the examinations, or that an interpreter was necessary for effective physician patient communications. The issue of certification was not reached; the lien was disallowed for failure of the lien claimant to meet its burden of proof.

FINDINGS AND AWARD AND ORDERS

Colleran v. Workers' Compensation Appeals Board (City of Los Angeles), (2010) ADJ4402731 (Unpublished, 12/16/2010) Finality of Award or Order – D&O of Rehab Unit in 2008 not appealed is final even if time for timely appeal ran into 2009.

Applicant was injured on April 28, 1999, and applied for vocational rehabilitation benefits on December 2, 2008. She obtained a Determination and Order of the Rehabilitation Unit on December 29, 2008 ordering provision of vocational rehabilitation benefits. On January 1, 2009 Labor Code Section 139.5 (providing vocational rehabilitation as a mandatory benefit for injuries between 1975 and was repealed.) In *Weiner v. Ralphs Company*, (2009) 74 Cal. Comp. Cases the appeals board held that the right to any vocational rehabilitation benefit terminated on December 31, 2008, unless supported by an order or award final before January 1, 2009. Defendant did not file an appeal from the December 29, 2008 Determination and Order. The City disputed liability for the benefits, contending that the Determination and Order was not final before January 1, 2009, because it was, by its terms, subject to appeal within twenty days. At a hearing on June 28, 2009, there was an offer of proof that defendant's adjuster did not receive a copy of the Determination and Order until April 10, 2009, and was stipulated that no appeal was taken from the order within twenty days of its actual receipt. The WCJ found that the order had become final as of the date it issued when it was not appealed. Defendant sought reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and reversed. , Relying on the en banc decisions in *Weiner v. Ralph's Company* (2009) 74 Cal. Comp. Cases 736 and *Weiner v. Ralphs Company* (2009) 74 Cal. Comp. Cases 958, the Appeals Board found that the 12/29/08 determination of the RU was not a "final enforceable Order" because Colleran's right to VR benefits and services "did not become vested" before 1/1/09, and, accordingly, that Colleran was not entitled to VR benefits. Applicant sought review.

The Court of Appeal granted review. It noted that in *Los Angeles County Fire Dept. v. Workers' Compensation Appeals Board* (*Norton*), (2010) 184 Cal.App.4th 1287; 75 Cal. Comp. Cases 421 that part of a 2008 Rehabilitation Unit D&O imposing VRMA at the delay rate was appealed, but the entitlement to VRMA itself was not appealed. It was held in *Norton* that the worker's right to vocational rehabilitation maintenance allowance ended with the repeal of Labor Code §139.5 **only to the extent of the award that had not become final**. (I.e. applicant was entitled to VRMA at $246 per week, not the disputed "delay rate.")

The Court rejected defendant's argument that the repeal of Labor Code §4645(d) deprived it of a means of appeal, noting 8 Cal. Code of Regs. §10293 and Labor Code §5502(b)(3) providing an expedited hearing as a basis for resolving vocational rehabilitation disputes. Based on decisions on date of finality of an unappealed decision or order in *Lomeli v. Department of Corrections*, (2003) 108 Cal. App. 4th 788, *Pressler v. Donald L. Bren Co.*, (1982) 32 Cal. 3d 831, and 3 WCAB panel decisions the majority (2-1) held that the determination of the RU became final when no appeal was filed.

RECONSIDERATION & REMOVAL

Los Angeles County v. Workers' Compensation Appeals Board (Norton), (2010) 184 Cal. App. 4th 1287; 75 Cal. Comp. Cases 421. Reconsideration finality of award of VRMA.

Applicant sustained injury to his neck, back, and right arm on July 21, 1997. He requested reinstatement of vocational rehabilitation in 2007, and the Rehabilitation Unit determined that his request was untimely. He appealed. The WCJ reversed the Rehabilitation Unit determination, and remanded the matter for determination of benefits due. Defendant sought reconsideration of the WCJ determination that the claim for further benefits was not barred by the statute of limitations, and the Board denied reconsideration in September 2007. The parties then settled liability for future vocational rehabilitation under former Labor Code §4646.

The Rehabilitation Unit issued a Determination and Order on March 12, 2008 that applicant was entitled to vocational rehabilitation maintenance allowance (VRMA) from September 8, 2005 to August 28, 2007. Defendant appealed the determination.

The Appeal was tried, and on December 5, 2008, the WCJ issued Findings and Award affirming the Rehab Unit D&O. On December 30, 2008, defendant filed a Petition for Reconsideration contending that applicant was not entitled to VRMA at the delay rate, but at $246.00 per week. Defendant contended the delay rate was inapplicable to applicant's VRMA until the date of his request for services on September 26, 2006, but did not, in the Petition for Reconsideration contest liability for VRMA at some rate.

On January 1, 2009 rights under Labor Code §1395. were completely extinguished, and any vocational rehabilitation benefits not awarded by final decision prior to that date became unenforceable. The County contended that the repeal while the WCJ's award was subject to reconsideration became unenforceable due to the repeal.

The Appeals Board denied the defendant's Petition for Reconsideration on January 30, 2009. The defendant sought review. Applicant contended that because the repeal of Labor Code §139.5 was not raised in the Petition for Reconsideration the award of VRMA at the delay rate is final and enforceable. The Appeals Board entered an appearance and admitted that is should have granted defendant's Petition for Reconsideration and annulled the award of VRMA due to repeal of Labor Code Section 139.5.

The Court of Appeal granted the writ of review. It held that the VRMA at the non-delay rate for the September 27,2006 to August 28, 2007, was not appealed and became final on December 29, 2008, was final by January 1, 2009 and is enforceable. The remained of the VRMA award was reversed.

RES JUDICATA & COLLAERAL ESTOPPEL

REOPENING

California Highway Patrol v. Workers' Compensation Appeals Board (Griffin), (2010) _____Cal. Comp. Cases ____; 38 CWCR 294(Writ Denied): Reopening – disability in parts not previously found to have been injured.

Griffin worked for the California Highway Patrol as a peace officer from July 1969 to August 1999. While so employed, Griffin sustained cumulative trauma industrial injuries through July 22, 1999 to his "neck, back, right hand, gastrointestinal, headaches, bilateral knees and feet, right hip." On July 23, 2003, the parties agreed to a Stipulated Award, which included an award of 25 percent permanent disability and future medical treatment. On May 11, 2004, Griffin filed a Petition to Reopen his claim based on new and further disability under Labor Code §§ 5803, 5804 and 5410. In this petition, Griffin claimed that from the time of the previous award, his "condition has worsened and deteriorated so as to cause new and further disability, need for medical care and vocational rehabilitation including further injury to his left thumb and left hand (trigger finger)."

On July 14, 2005, Griffin filed a First Amended Petition to Reopen for New and Further Disability also under Labor Code §§5803, 5804, and 5410. This petition alleged that since the time of the July 2003 award, his "condition has worsened and deteriorated so as to cause new and further disability, need for medical care and vocational rehabilitation including further injury to his left thumb and left hand (trigger finger) and heart."

The matter came on for trial on September 23, 2008. As to the injured body parts which had been a part of the original stipulated award, Dr. Adelberg found there was no increased disability. Dr. Adelberg concluded there was a cumulative industrial injury to the left thumb, which first became clinically significant in April 2004. Surgery was performed on April 15, 2005, and the condition became permanent and stationary on August 30, 2005. The only permanent disability indications were a preclusion of very forceful gripping. The WCJ found Griffin had not met his burden of proof as to new and further disability for the left hand and thumb, because Dr. Adelberg's report did not address how these injuries were new and further disabilities originating from the stipulated injury or whether these injuries were a compensable consequence of the original stipulated injury. As to Griffin's claim for new and further disability related to his heart, Dr. Blau noted Griffin's cardiovascular symptoms followed an evaluation by Dr. Drell, from which he was referred to a cardiologist. Griffin underwent a coronary bypass on June 26, 2006. He was permanent and stationary, and ratable, with a disability rating of 44 percent. Dr. Blau found the injury to be 100 percent industrially caused. The WCJ found Griffin had not met his burden of proof as to the heart injury, as Dr. Blau's reports did not address the causation of Griffin's heart condition to either the original stipulated injury or as a compensable consequence of those injuries. Griffin filed a petition for reconsideration, contending he had met his burden of proof regarding the industrial nature of his heart injury because he was entitled to the heart presumption of Labor Code §3212.3, that he met his burden of proof of industrial causation of his left thumb based on Dr. Adelberg's report and that on reopening a claim for new and

further disability, newly discovered body parts injured in the same period as the original cumulative trauma period should be combined as one injury.

The Workers' Compensation Appeals Board granted reconsideration. In its Opinion and Decision on Reconsideration, the Board determined the left thumb was claimed in a timely filed Petition to Reopen, and thus jurisdiction was preserved if Griffin had demonstrated good cause. Relying on Dr. Adelberg's opinion that "jamming the gun magazines into the weapon on numerous occasions by [Griffin] was the cause of a cumulative trauma injury with no other causes," the Board found substantial evidence as to causation of the thumb injury during Griffin's CHP employment. The Board specified its assertion of continuing jurisdiction was not "based on a theory of new and further disability arising as a compensable consequence of a previously awarded injury as analyzed by the WCJ. It is a newly disclosed cumulative injury that had not manifested itself by the time [Griffin] received the July 13, 2003 stipulated award." As such, the Board found "where an injurious industrial condition develops during employment but the manifestation of that injury occurs after a stipulated award, good cause exist[s], as here, to reopen a stipulated award upon a timely filed petition to reopen . . . . The newly discovered condition need not be a compensable consequence of one of the original body parts injured under the previous award in order to constitute good cause to reopen." As to the heart, the Board found it also had jurisdiction over this claim. The Board found Griffin had timely filed a petition to reopen, which included the heart by amendment. The Board also found Griffin had met his burden of proof regarding the industrial causation of the heart injury, because he was entitled to the presumption of Labor Code §3212.3. In finding the heart condition had developed within the time limits of Labor Code §3212.3, the Board specifically relied on reports of "chest pain" taken on May 3, 2004, which led to a cardiac diagnosis. Relying on Dr. Blau's reports, the Board further found, even without application of the presumption, Griffin had established his heart condition developed during, and was caused by, his CHP employment. CHP filed a Petition for Reconsideration of the Workers' Compensation Appeals Board's decision.

CHP challenged the Board's determination that the newly claimed injuries did not have to be a compensable consequence of the originally claimed injuries, disputed the dates of injury, and disputed the applicability of the heart presumption and the heart injury's industrial causation. The Board issued an opinion and order denying reconsideration, reiterating their conclusions in the earlier decision on reconsideration. It further noted "[i]t is true that the heart and left hand injuries pertain to new body parts, but they involve the same period of cumulative injury, the same theory of injury and the same cumulative trauma, as originally claimed. [Griffin] established a nexus between the original injury and the new body parts claimed."

CHP Filed a Petition for Writ of Review in which it claims that it is presenting "a pure question of law: the interpretation of statutes governing proceedings for new and further disability." CHP contends "the [Board] incorrectly interpreted the statutes and decisional law to allow Griffin's claim of injury to the left hand and to the heart to be added to a new and further petition from a prior award involving other body parts; when there has been no showing of any causal connection between the injuries involved in the original award and those involving the left hand and heart." CHP further contended that its position relied solely

on Labor Code §5410, making no mention of the fact that the Board expressly rested its original decision on reconsideration on Labor Code §5803.

The Court of Appeal granted the writ and requested supplemental briefing on the propriety of the Workers' Compensation Appeals Board's decision under Labor Code§5803. "[S]ections 5410, 5803 and 5804 permit reopening of a case, within the limits set forth below, upon a petition to reopen filed within five years of the date of injury." (*Aliano v. Workers' Compensation Appeals Bd*. (1979) 100 Cal. App. 3d 341, 365.) Labor Code §5410 provides an injured worker may "institute proceedings for the collection of compensation within five years after the date of the injury upon the ground that the original injury has caused new and further disability. Under Labor Code §5803, the Workers' Compensation Appeals Board has "continuing jurisdiction over all its orders, decisions, and awards made and entered under the provisions of this division . . . . At any time, upon notice and after an opportunity to be heard is given to the parties in interest, the appeals board may rescind, alter, or amend any order, decision, or award, good cause appearing therefor. [¶] This power includes the right to review, grant or regrant, diminish, increase, or terminate, within the limits prescribed by this division, any compensation awarded, upon the grounds that the disability of the person in whose favor the award was made has either recurred, increased, diminished, or terminated." Under Labor Code §5804, the Board retains jurisdiction to rescind, alter or amend an award only where a petition to reopen is filed within five years of the date of injury. "[S]upplemental claims for 'new and further disability' . . . are governed by section 5410, not sections 5803-5805." (*J. T. Thorp, Inc. v. Workers' Compensation Appeals Board*, (1984) 153 Cal. App. 3d 327, 335.) "Although long the subject of misunderstanding and controversial litigation, it is now clear that Labor Code section 5410, and not section[s] 5804 [and 5803], control the Appeals Board's continuing jurisdiction over new and further disability claims." (*Zurich Ins. Co. v. Workmen's Compensation Appeals Board*, (1973) 9 Cal. 3d 848, 857 (conc. opn. of Sullivan, J.).) The phrase "new and further disability" is not defined in the statute and judicial interpretation has not flushed out all its potential permutations. Thus, its meaning is not entirely clear. However, it has been judicially defined "to mean disability . . . result[ing] from some demonstrable change in an employee's condition, including a gradual increase in disability." (*Nicky Blair's Restaurant v. Workers' Compensation Appeals Board*, (1980) 109 Cal. App. 3d 941, 955.) Common examples of "new and further disability" are a recurrence of temporary disability, a change of a temporary disability into a permanent disability, a gradual increase in disability, or a new need for medical treatment all constitute new and further disability. (Ibid., 109 Cal. App. 3d 941, 955.) The Supreme Court has also suggested it is "a disability in addition to that for which the employer previously provided benefits as required by the statute." (*Nickelsberg v. Workers' Compensation Appeals Board*, (1991) 54 Cal. 3d 288, 301; see also *Nicky Blair's Restaurant v. Workers' Compensation Appeals Board*, supra, 109 Cal. App. 3d at p. 955; *Pizza Hut of San Diego, Inc. v. Workers' Compensation Appeals Board*, (1978) 76 Cal. App. 3d 818, 825 fn. 4.) It is clear from both the statutory language and judicial interpretations that under Labor Code §5410, there must be a causal connection between the original injury and the claimed new and further disability. The statute expressly requires the petition allege that the "original injury has caused new and further disability." Furthermore, in the cases applying the statute the claimed new and further disability has either been to the same body part (see *Sarabi v. Workers' Compensation Appeals Board*, supra, [industrial injury to right

shoulder with additional claimed period of temporary disability related to shoulder on right shoulder after five year period]) or injury to a new body part which is alleged as a compensable consequence of the original injury. (See *Liberty Mutual Ins. Co. v. Industrial Acc. Commission*. (1964) 231 Cal. App. 2d 501, 504 [development of asthma found to be directly attributable to industrial injury to the back].) Based on the statute's express language, and the judicial interpretations of that language, the court concluded that a petition to reopen for new and further disability under section 5410 requires there to be a causal connection between the alleged "new and further disability" and the original industrial injury. This causal connection may be in the way of further injury to the same body part or injury to a new body part as a compensable consequence of the original injury. In its decision denying reconsideration, the Board concluded while Griffin had established a "nexus" between his originally claimed injuries and the left hand and heart, because the injuries "involve[d] the same period of cumulative injury, the same theory of injury, and the same cumulative trauma, as originally claimed." Labor Code §5410 requires more than a nexus, it requires a causal connection between the claimed new and further disability and the original injury. That the injuries share the same cumulative trauma period and theory of industrial causation does not establish the kind of causal connection to the original injury that a petition for new and further disability under Labor Code §5410 requires. There is nothing in the records which suggests a causal connection to the previously claimed injuries and the currently claimed left hand and heart injuries. The body parts claimed are entirely distinct and therefore the claim does not represent further disability arising from the original injuries. Nor is there any evidence that the heart and left hand injuries were compensable consequences of the previously claimed injuries to Griffin's "neck, back, right hand, gastrointestinal, headaches, bilateral knees and feet, right hip." That is, the new disabilities to the heart and left hand are not ones for which compensation benefits had previously been awarded or voluntarily furnished. As such, the Board did not have jurisdiction to reopen the previous award based on a claim of new and further disability to the heart and left hand.

That the Petition to Reopen could not be made under section 5410 does not, of necessity, preclude the Board from asserting its continuing jurisdiction relative to the left hand and heart claims. As indicated in the Board's opinion granting reconsideration, the Board found good cause to reopen the petition "not based on theory of new and further disability arising as a compensable consequence of a previously awarded injury," but rather as a "newly disclosed cumulative injury that had not manifested itself by the time" of the stipulated award. In finding good cause to reopen, the Board expressly relied on Labor Code §5803, not Labor Code §5410. The Petition to Reopen relied on Labor Code §§5410, 5803 and 5804. Thus, the claims asserted both "new and further disability" and "good cause." As discussed above, despite the fact that the concepts of new and further disability and good cause to reopen may be intertwined, they are distinct. Thus, where §5410 is not available for a claim of new and further disability, if there is a showing of good cause, section 5803 may be available as an alternate source of supplementary relief. (*Beaida v. Workmen's Compensation Appeals Board*, (1968) 263 Cal. App. 2d 204, 210; *Liberty Mutual Insurance Co. v. Industrial Accident Commission*, (1964) 231 Cal. App. 2d 501, 506.) The Workers' Compensation Appeals Board's determination as to what constitutes "good cause," while not conclusive, is entitled to great weight. (*Pullman Co. v. Industrial Accident Commission*, supra, 28 Cal. 2d 379, 388.) "[I]t is well settled that any factor or circumstance unknown at the time the

original award or order was made which renders the previous findings and award 'inequitable,' will justify the reopening of a case and amendment of the findings and award." (*Leboeuf v. Workers' Compensation Appeals Board*, (1983) 34 Cal. 3d 234, 242; *Aliano v. Workers' Compensation Appeals Board*, (1979) 100 Cal. App. 3d 341, 366; *Walters v. Industrial Accident Commission*, (1962) 57 Cal. 2d 387, 395.) "'Good cause' includes a mistake of fact, a mistake of law disclosed by a subsequent appellate court ruling on the same point in another case, inadvertence, newly discovered evidence, or fraud." [Citation.]" (*Sarabi v. Workers' Compensation Appeals Board*, (2007) 151 Cal. App. 4th 920, 926-927.) Newly discovered evidence which could not have been discovered prior to the issuance of the award can be good cause to reopen a claim. (*Brannen v. Workers' Compensation Appeals Board*, (1996) 46 Cal. App. 4th 377, 382.) "'[I]n order to constitute "good cause" for reopening, new evidence (a) must present some good ground, not previously known to the Appeals Board, which renders the original award inequitable, (b) must be more than merely cumulative or a restatement of the original evidence or contentions, and (c) must be accompanied by a showing that such evidence could not with reasonable diligence have been discovered and produced at the original hearing." (*Nicky Blair's Restaurant v. Workers' Compensation Appeals Board*, supra, 109 Cal. App. 3d 941, 956-957.) "'[G]ood cause' may be established by newly discovered evidence which could not have been produced at the original hearing and which indicates a more extensive disability than that recognized by the original findings." (*Leboeuf v. Workers' Compensation Appeals Board*, supra, 34 Cal. 3d 234, 241.) Here, the Workers' Compensation Appeals Board found an industrial injury to Griffin's left hand and heart developed during employment but each manifested itself after the issuance of the stipulated award. The injury to Griffin's left hand did not begin to manifest until April 2004, nine months after the stipulated award. The injury to Griffin's heart did not begin to manifest until, at the earliest, May 2004, 10 months after the stipulated award. Because the left hand and heart injuries did not begin to manifest until after the entry of the award, Griffin could not have produced evidence of those injuries at the original proceedings. Further, both Dr. Adelberg and Dr. Blau provided evidence that these injuries have increased Griffin's level of disability. Thus, there was evidence supporting the Board's determination that there was good cause to reopen under the provisions of §5803, because there was newly discovered evidence which could not have been produced earlier and which demonstrated Griffin had a more extensive disability than recognized at the time of the stipulated award. We reiterate and clarify, Labor Code §§5410 and 5803 offer distinct bases upon which the Board may exercise its continuing jurisdiction. A petition to reopen for good cause, other than new and further disability, under section 5803 does not require a causal connection to the original injury. In its original decision on reconsideration the Board expressly found good cause to reopen as to both the heart and hand claims. This finding was not "based on a theory of new and further disability arising as a compensable consequence of a previously awarded injury." Rather, the Board relied upon section 5803, to find under the facts in this case, where newly discovered evidence reveals a period of cumulative trauma during which industrially caused injuries developed, but the injuries did not manifest until after the issuance of the award, the original award is inequitable. Where the original award is inequitable because of facts unknown and unknowable at the time of the original award, the Workers' Compensation Appeals Board can assert its continuing jurisdiction under section 5803. The Workers' Compensation Appeals Board order denying reconsideration was affirmed.

State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Hancock), (2010) 75 Cal. Comp. Cases _____; 38 CWCR 296 (unpublished) Reopening – new body parts -- effect of general release in stipulations.

In 2002 Hancock filed a cumulative trauma claim of injury to his low back, both knees, and both hands while employed as an ironworker by D & M Hancock, his family's business. Based on the medical reports of agreed medical examiner (AME) Dr. Michael Sommer, the parties settled Hancock's claim in 2005 by way of stipulations with a request for award. As pertinent here, the parties stipulated Hancock sustained industrial cumulative injury through July 31, 2001, to his low back, left and right knees, and bilateral carpal tunnel. The parties stipulated for 49 percent permanent disability and the need for further medical treatment of such injuries. Paragraph 8 of the parties' stipulated award contained, among other things, the following language: "This agreement resolves all issues of liability for any injury specific or cumulative for plaintiff's entire period of employment with this employer." The WCJ made an award to Hancock consistent with and expressly incorporating the stipulations of the parties.

In 2005, Hancock filed a petition to reopen for new and further disability. Hancock alleged his injury had worsened and that he had sustained new and further disability as a result of said injury. He alleged his disability had increased in his subjective complaints, objective findings, and increased work restrictions. As a result, he had a need for further temporary disability, permanent disability, medical treatment, and vocational rehabilitation. Finally, he also alleged injury to previously unmentioned body parts: his bilateral shoulders. Hancock was reevaluated by AME Sommer in November 2006. Sommer noted in his 2006 report history that Hancock told him "of continuing troubles with his knees and low back, but also with his shoulder, principally left-sided, since [they] talked last two and a half years ago. While when we first spoke, [Hancock] clearly placed symbols on the body image to show pain in his left shoulder, that anatomic part is never cited in my 13 page report. There is one citation to his right shoulder only[.]" Further discussing Hancock's left shoulder, Sommer said Hancock "recalls sometime in the early 1990s that he was working as a steel erector and grabbed the flange of something with his left hand and had a real jerking injury to the left shoulder, was briefly off work and just sort of sucked it up and lived with it since then. He says that it has been a continuing problem and in the last couple of years, has been worse[.]"

Dr. Michael Sommer examined Hancock's shoulders and reviewed a CT scan and X-rays of his left shoulder. Sommer diagnosed Hancock with glenohumeral arthritis in his left shoulder. Sommer found "solid reason for [Hancock] to be symptomatic in the left shoulder, given the extent of osteoarthritis in the glenohumeral joint." Dr. Sommer believed the shoulder condition was work related, that it should properly be included with the cumulative July 31, 2001 injury, and that Hancock would probably need a shoulder arthroplasty eventually, but in the meantime, it was appropriate to view Hancock as permanent and stationary with respect to his left shoulder.

Hancock's Petition to Reopen was submitted to the WCJ for decision based on the reports of Sommer, Norris and Hancock's deposition. The WCJ initially found that Hancock did not sustain an industrial injury to either shoulder, that Hancock had not shown good cause to

reopen his award of low back or carpal tunnel disability, and that the record was inadequate to determine Hancock's claimed increase in disability to his knees. The denial of Hancock's claim of industrial injury to his bilateral shoulders was based on the WCJ's legal conclusion that the claim was waived by the parties' stipulation in the prior award. The WCJ stated: "Simply to illustrate the situation a bit more thoroughly, if medical evidence existed that showed that [Hancock's] shoulder(s) problems had arisen by sequelae, from the original cumulative injury, they could upon that basis now be found to be compensable. This is not, of course, the case here, the AME is essentially saying that the shoulders were industrially injured via the same cumulative trauma mechanism as the back, both knees and both carpal tunnels. Applicant filed a Petition for Reconsideration, and the WCJ vacated his decision and order. In a new Supplemental Findings and Order, the WCJ found the parties had stipulated that Hancock sustained injury to his low back, both knees, and bilateral carpal tunnels as the result of cumulative trauma through July 31, 2001. The WCJ found Hancock had also sustained injury to his left shoulder and he may have sustained injury to his right shoulder. With respect to Hancock's shoulder claim(s), the WCJ explained that "[d]iscussion between the parties and this WCJ at the trial on 10/22/09 had lead this WCJ to the (erroneous) understanding that medical evidence of a cumulative injury to either or both shoulders existed at the time of the Stipulated Award and that [Hancock] had thereby knowingly waived such a claim of injury, by entrance into the Stipulated Award. [Hancock's] Petition for Reconsideration and [SCIF's] Answer have clarified that misunderstanding." The WCJ rejected SCIF's argument that Hancock had sufficient knowledge to produce a legally-valid waiver of his shoulder claim. This time SCIF petitioned for reconsideration.

SCIF argued Hancock waived his shoulder claim, that it was not a new and further disability, and a petition to reopen was improper without the existence of evidence of a new and further disability at the time of the filing the petition to reopen. The WCJ recommended the Board deny SCIF's petition. After repeating his opinion on decision, the WCJ concluded "the fundamental question is whether a worker may waive something that he has no knowledge of. [Hancock] and this WCJ believe that he cannot. [SCIF] believes that he can and has. This WCJ believes that [SCIF] is incorrect."

The Workers' Compensation Appeals Board denied SCIF's petition for reconsideration. The Board stated Hancock's "left shoulder injury, and allegedly the right shoulder injury, is a newly disclosed injury which AME Sommer had not commented upon at [the] time the parties entered into the Stipulated Award[.]" Noting Sommer's conclusion that the left shoulder problem has an industrial genesis and should be on the list of anatomic parts contributing to Hancock's disability and for which he should be receiving treatment, the Board concluded the circumstances presented by Hancock's petition to reopen gave it jurisdiction over his claim, "including the bilateral shoulders by amendment, pursuant to Labor Code sections 5803, 5804, and 5410." State Fund filed a Petition for Writ of Review.

State Fund's petition presented two questions: (1) "Did the Workers' Compensation Appeals Board err in allowing Hancock's Petition for New and Further Disability to include body parts that were not part of the original award and were not compensable consequences

of the injuries to the body parts of the original award?" (2) "Did the Workers' Compensation Appeals Board err in rejecting the parties' stipulation resolving all issues of liability for any injury during Hancock's entire period of employment with this employer despite no good cause to do so?"

The Court of Appeal granted review and concluded the Board did not err in determining the parties' stipulation did not preclude Hancock's petition, but did err in authorizing the reopening of the prior stipulated award to add Hancock's shoulder injuries. The parties had stipulated in Paragraph 8 of the 2005 stipulated award that: "This agreement resolves all issues of liability for any injury specific or cumulative for plaintiff's entire period of employment with this employer." SCIF contends this language was agreed to in exchange for SCIF's acceptance of liability for future medical treatment for Hancock's left knee and was effective to resolve any and all potential claims of liability, not just "known" claims of liability. SCIF argues the Workers' Compensation Appeals Board therefore erred in rejecting the stipulation by reopening Hancock's award. Civil Code section 1542 (section 1542) provides: "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

According to the California Supreme Court, Civil Code §1542 "was intended by its drafters to preclude the application of a release to unknown claims in the absence of a showing, apart from the words of the release of an intent to include such claims." (*Casey v. Proctor*, (1963) 59 Cal. 2d 97, 109.) Whether the parties intended to release unknown claims is a question of fact. (*Carmichael v. Industrial Accident Commission,* (1965) 234 Cal. App. 2d 311, 315; see *Jefferson v. Dept. of Youth Authority*, (2002) 28 Cal. 4th 299, 304 [attachment to settlement agreement made it clear the parties intended to settle matters outside scope of workers' compensation] (Jefferson); *Gray v. Workers' Compensation Appeals Board*, (1987) 52 Cal. Comp. Cases 536 (writ denied) [applicant's knowledge from medical evidence combined with wording of compromise and release showed intent to release death benefits].) In fact, a number of cases involving workers' compensation releases either note the presence of Civil Code §1542 waivers or discuss the effect of section 1542 on releases. (*Jefferson*, supra, 28 Cal.4th at pp. 306-307; *Sumner v. Workers' Compensation Appeals Board,* (1983) 33 Cal. 3d 965, 973, fn. 9; Gray, supra, 52 Cal. Comp. Cases 536 [release did not violate section 1542 where the wording and evidence indicated an intent to release death benefits].) And while we agree our Supreme Court has been "particularly rigorous about strictly enforcing broad release language in workers' compensation settlements, because in that context, Workers' Compensation Appeals Board oversight helps to ensure fairness[,]" the Supreme Court has at the same time "sought to protect the interests of workers who execute workers' compensation settlement documents without a full appreciation of what claims or rights might later arise." (*Jefferson*, supra, at p. 304.) In the context of workers' compensation, "'[a] waiver of a right cannot be established without a clear showing of an intent to relinquish such right, and doubtful cases will be decided against a waiver.' [Citation.]" (*Roberson v. Industrial Accident Commission*, (1956) 146 Cal. App. 2d 627, 629.) Here the language of the stipulation is broad, encompassing "all issues of liability for any injury specific or cumulative for plaintiff's entire period of employment with this employer." The Workers' Compensation Appeals Board reviewed the record and found

the evidence outside the language of the stipulation insufficient to establish Hancock intended to relinquish his claim of bilateral shoulder injury in the stipulated award because Hancock did not have knowledge that his shoulder problems were industrial until AME Sommer's January 2007 report. We may not redetermine this factual issue because the Board's finding is supported by substantial evidence. (Labor Code §§ 5952, 5953; *Dept. of Rehabilitation v. Workers' Compensation Appeals Board* , (2003) 30 Cal. 4th 1281, 1290 (Dept. of Rehabilitation); 2 Herlick, Cal. Workers' Compensation Law, 6th ed., 2009, § 20.04[1], pp. 20-8 to 20-9.)

In his January 2007 report, the AME, Dr. Sommer, noted Hancock had placed symbols on a body image drawing to show pain in his shoulders (principally in his left shoulder) when he first spoke with Sommer. But Sommer apparently did not investigate or consider whether Hancock's cumulative trauma injury included his shoulder problems. Sommer made no mention of Hancock's left shoulder and only included a brief citation to the right shoulder in his 13-page report, on which the stipulated award was based. The stipulated award references only the industrial injuries to Hancock's lower back, knees and carpal tunnels. SCIF points out that prior to the stipulated award Hancock not only knew he had shoulder pain, he remembered a specific work-related incident that injured his left shoulder. He was living with the continuing symptoms. This is apparently true. In 2007, Hancock told Dr. Sommer that he remembered injuring his left shoulder sometime in the 1990s when he "grabbed the flange of something with his left hand and had a real jerking injury to the left shoulder." Hancock reported he was briefly off work and then just sort of sucked it up and lived with it since then. Hancock told Sommer it had been a continuing problem that had gotten worse in the last couple of years. If Hancock remembered the work-related incident in 2007, it is likely he knew of it prior to the stipulated award entered in 2005. Nevertheless, it is undisputed Sommer did not opine in his original reports that Hancock's shoulder injuries had an industrial cause, despite the injuries being pointed out to him. He did not include an opinion on the issue until 2007. Under these specific circumstances, we cannot say the Workers' Compensation Appeals Board unreasonably found Hancock did not know in 2005 that he had a claim for cumulative trauma to his shoulders. (See *Nielsen v. Workers' Compensation Appeals Board*, (1985) 164 Cal. App. 3d 918, 927-930; *City of Fresno v. Workers' Compensation Appeals Board*, (1985) 163 Cal. App. 3d 467, 471-473.) Thus, the Workers' Compensation Appeals Board was justified in finding that, since Hancock did not know he had an industrial injury to his shoulders when he entered into the stipulation in paragraph 8, there was no clear evidence he intended to waive that claim. The stipulation did not preclude Hancock's petition to reopen to add his shoulder injuries. The Board did not err in making this finding.

The record in this case, however, does not support the reopening of Hancock's award The Board is authorized to reopen a decision or award upon a showing of "new and further disability" (§ 5410) or for "good cause" (§ 5803). (*County of San Bernardino v. Workers' Compensation Appeals Board*, (1981) 125 Cal. App. 3d 679, 684.) Section 5410 provides an injured worker may "institute proceedings for the collection of compensation . . . within five years after the date of the injury upon the ground that the original injury has caused new and further disability . . . ." Under Labor Code §5803, the Board has "continuing jurisdiction over all its orders, decisions, and awards made and entered under the provisions of this

division . . . . At any time, upon notice and after an opportunity to be heard is given to the parties in interest, the appeals board may rescind, alter, or amend any order, decision, or award, good cause appearing therefor. [¶] This power includes the right to review, grant or regrant, diminish, increase, or terminate, within the limits prescribed by this division, any compensation awarded, upon the grounds that the disability of the person in whose favor the award was made has either recurred, increased, diminished, or terminated." (Italics added.) Under section 5804, the appeals board retains jurisdiction to rescind, alter or amend an award only where a petition to reopen is filed within five years of the date of injury. We consider each statutory basis in turn.

Defendant claimed that Hancock's claim of shoulder injury is not a new and further disability that permits reopening of an award under Labor Code §5410. Specifically, SCIF contends the Board erred as a matter of law in allowing Hancock's petition for new and further disability to include body parts that were not part of the original award and were not compensable consequences of the injuries to the body parts of the original award. The Court agreed, noting: "'Although long the subject of misunderstanding and controversial litigation, it is now clear that Labor Code §5410, and not Labor Code §§5804 [and 5803], control the Appeals Board's continuing jurisdiction over new and further disability claims." (*Zurich Insurance Co. v. Workers' Compensation Appeals Board*, (1973) 9 Cal. 3d 848, 857 (conc. opn. of Sullivan, J.).) Based on the statute's express language, and the judicial interpretations of that language, the court had no difficulty concluding that a petition to reopen for new and further disability under Labor Code §5410 requires there to be a causal connection between the alleged "new and further disability" and the original industrial injury. Here, nothing in the record supports a conclusion that Hancock's shoulder injuries, an injury to a new body part, were a compensable consequence of his original injuries. There is no evidence that they were a result or an effect of the industrial injuries to his low back, knees or carpal tunnels. To the extent the Workers' Compensation Appeals Board relied on Labor Code §5410 in allowing the reopening of Hancock's stipulated award to include his shoulder injuries, it erred.

Reopening of Hancock's case was not justified under Labor Code §5803. "[I]rrespective of whether or not there has been 'new and further disability,' 'good cause' to reopen under Labor Code §5803 may exist." (*Nicky Blair's*, supra, 109 Cal. App. 3rd at p. 955; *Beaida v. Workers' Compensation Appeals Board*, (1968) 263 Cal. App. 2nd 204, 210 ["section 5803 is available as an alternate source of supplementary relief"].) The Workers' Compensation Appeals Board in this case relied on Labor Code §5803 as an alternative basis for permitting the reopening of Hancock's case. "[I]t is well settled that any factor or circumstance unknown at the time the original award or order was made which renders the previous findings and award 'inequitable,' will justify the reopening of a case and amendment of the findings and award." (*LeBouef v. Workers' Compensation Appeals Board*, (1983) 34 Cal. 3d 234, 242; see *Walters v. Industrial Accident Commission*, (1962) 57 Cal. 2nd 387, 395; *Aliano v. Workers' Compensation Appeals Board*, (1979) 100 Cal. App. 3rd 341, 366.) "'What constitutes "good cause" depends largely upon the circumstances of each case.'" (*Pullman Co. v. Industrial Accident Commission*, (1946) 28 Cal. 2nd 379, 387-388; accord *Nicky Blair's*, supra, 109 Cal. App. 3rd at p. 955.) "Grounds commonly urged as good cause for reopening are (1) mistake of fact, occasioned by failure or inability to produce certain

evidence at a prior hearing; (2) mistake of law disclosed by a subsequent appellate court ruling on the same point in another case; (3) inadvertence, such as when the Board issues a decision under the mistaken impression that a party appearing as a witness had been served with notice of joinder as a party defendant; (4) newly discovered evidence that is more than merely cumulative; and (5) fraud, such as may be perpetrated through perjury and false statements." (2 Hanna, Cal. Law of Employee Injuries and Workers' Compensation, Rev. 2d ed. 2010, § 31.04[2][c], pp. 31-16 to 31-17, fns. omitted (Hanna); see Nicky Blair's, supra, 109 Cal. App. 3rd at p. 956.) Similarly, "an award based [on] an executed stipulation may be reopened and rescinded if the stipulation 'has been "entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, where the facts stipulated have changed or there has been a change in the underlying conditions that could not have been anticipated, or where special circumstances exist rendering it unjust to enforce the stipulation." (*Brannen v. Workers' Compensation Appeals Board*, (1996) 46 Cal. App. 4th 377, 382.) Here the Board stated, "[t]he left shoulder injury, and allegedly the right shoulder injury, is a newly disclosed injury which AME Sommer had not commented upon at [the] time the parties entered into the Stipulated Award[.]" "'[I]n order to constitute "good cause" for reopening, new evidence (a) must present some good ground, not previously known to the Appeals Board, which renders the original award inequitable, (b) must be more than merely cumulative or a restatement of the original evidence or contentions, and (c) must be accompanied by a showing that such evidence could not with reasonable diligence have been discovered and produced at the original hearing." (*Nicky Blair's*, supra, 109 Cal. App. 3d at pp. 956-957 ; accord, *LeBouef v. Workers' Compensation Appeals Board*, supra, 34 Cal.3rd at p. 241; 2 Hanna, supra, § 31.04[2][d], pp. 31-17 to 31-18.) Hancock's petition for new and further disability contains no showing of diligence. In fact, the record before the WCJ and Board suggests a lack of diligence. The evidence reflects Hancock had shoulder pain before the entry of the stipulated award and had indicated such pain to AME Sommer in his first visit to Sommer. Hancock remembered a specific incident when he injured his left shoulder at work, which resulted in him taking time off work. He also testified at a deposition that he believed the problems with his shoulder were part of his work-related cumulative injury. Given these circumstances, when Sommer produced a report that entirely failed to address Hancock's left shoulder and made only one brief mention of the right shoulder, Hancock, represented by counsel, should have brought to Sommer's attention his mistaken omission. Instead, the record reflects Hancock agreed to submit his claim and stipulate to an award based, in part, on Sommer's existing report. If Hancock had shoulder pain and believed it could be work-related, he should have done something more to obtain a medical opinion regarding its industrial origin. In the absence of evidence of due diligence, there was an insufficient basis for finding good cause to reopen under section 5803 on the ground of newly discovered evidence. "While the Workers' Compensation Appeals Board's determination of what constitutes 'good cause' may be accorded great weight it is not conclusive." (*Aliano v. Workers' Compensation Appeals Board*, supra, 100 Cal. App. 3d at p. 366.) "In the absence of 'good cause,' the appeals board is powerless to act." (Ibid.) The order of the Workers' Compensation Appeals Board denying State Compensation Insurance Fund's petition for reconsideration was annulled and the matter is remanded to the Board with directions to grant reconsideration consistent with this opinion.

Avila-Gonzalez v. Workers' Compensation Appeals Board,, (2010) 37 CWCR 284 (WCAB Panel); 75 Cal. Comp. Cases 1069 (Unpublished). Good Cause to Reopen for Change in Law – not shown on split of authority.

The WCJ found PD and ruled based on the case of *Vera v. Workers' Compensation Appeals Board*, (2007) 72 Cal. Comp. Cases 1115) used the new PD schedule because no medical report indication PD was a permanent and stationary report. Applicant filed a petition to reopen based on change of law different court of appeal division rejected *Vera* and ruled the report indicating PD prior to 2005 need not be a P and S report. The WCJ following hearing found good cause to reopen based on a change of law and awarded PD based on the schedule in effect in 2004. The WCJ based his decision on the subsequent cases of *Genlyte Group, LLC v. Workers' Compensation Appeals Board. (Zavala)*, (2008) 73 Cal. Comp. Cases 6) and *Zenith Ins. Co. v. Workers' Compensation Appeals Board (Cugini)*, (2008) 73 Cal. Comp. Cases 81). The WCJ applied the 1997 PDRS. Defendants filed a petition for reconsideration.

The WCJ in his report on reconsideration indicated that numerous cases had ruled differently then *Vera* and there was now a split of authority allowing the Workers' Compensation Appeals Board to rule either way. The WCJ found no cases on weather a split in law was sufficient for a petition to reopen based on change of law. The WCJ pointed that out change of law is good cause to reopen and based liberal construction of the law (Labor Code 5803) when the first case contrary to *Vera* was published there was a change of law sufficient for the WCJ to change the award.

The Workers' Compensation Appeals Board granted reconsideration and in a 2-1 decision ruled that because *Vera* had not been overruled, there had been no change in the law, and thus no good cause to reopen had been established. An appellate decision that shows and earlier decision to be erroneous provides good cause to reopen but a later decision that merely disagrees with an earlier decision does not provide good cause to reopen. Because in this case you have different decision form different divisions of the court of appeal critical of *Vera* but not overruling *Vera* and the Supreme Court has not resolved the conflict among the different divisions and since Vera was not overruled and still citable no good cause to reopen based on change of law exists. There was no contrary law to cite as no change of law exists. One commissioner dissented and would have affirmed the WCJ. Applicant filed a Petition for Writ of Review.

The Court of Appeal granted the writ and reversed the Board. The Court agreed with the WCJ, concluding that the interpretations of Labor Code section 4660(d) that were adopted after the WCJ's original decision constitute a change in the law and good cause to reopen the decision. The Court also concluded that the interpretation of section 4660(d) adopted in the later appellate decisions (*Zavala* and *Cugini*, referred to as *Genlyte* and *Zenith* by the Court) should govern the determination of which PDRS applies in this case. The Court therefore annulled the Workers' Compensation Appeals Board's decision and remanded the matter for further proceedings consistent with its opinion, to apply Genlyte. The Court rejected the applicant's argument that because his permanent disability rating will not be determined until

after January 1, 2010, the 1997 PDRS should apply based on the failure of the Administrative Director to have amended the 2005 PDRS by January 1, 2010, pursuant to section 4660(c).

Patrick v. Marina City Club, (2010) 38 CWCR153 (WCAB Panel) Reopening – New and Further Disability to internal systems resulting from psyche stress.

Applicant sustained an admitted psyche injury and received and award of 26% Pd and further medical treatment. Applicant filed a petition to reopen for increased psyche disability and the injury extended to her internal systems. The parties settled some of their disputes for $95,000 but not the petition to reopen. The parties went to an AME on the issue of the petition to reopen. The WCJ found that the applicant's admitted psych injury did not cause new and further disability or extend as a compensable consequence of the psyche injury to applicant's heart, cardiovascular system, or in the form of hypertension, atrial fibrillation or coronary artery disease. The WCJ found that applicant's internal condition was caused by the litigation process and therefore was not a compensable consequence of applicant's injury citing the case of *Rodriguez v. Workers' Compensation Appeals Board*, (1994) 59 Cal. Comp. Cases 14, an unpublished case. Applicant filed a petition for reconsideration.

The Workers' Compensation Appeals Board concluded that the *Rodriquez* case found the applicant's psyche injury non-compensable because it was caused by his emotional reaction to litigation, specifically when the worker learned that an evaluating physician provided an opinion that was contrary to the worker's assertion that he was entitled to vocational rehabilitation benefits. Thus it was found that the worker's psyche injury was the result if the litigation process and non compensable. The Board found the *Rodriquez* case distinguishable for this case as it involved the significantly higher threshold of compensability of psyche claims (predominant cause) pursuant to Labor Code §3208.3 rather than the standard of (contributory cause) pursuant to Labor Code §3600 that is applicable to applicant's physical or internal body system injuries arising as a consequence of the initial industrial injury. The Board stated that based on the report of the AME in internal medicine it appears that applicant's cardiovascular condition was caused, in part, as a consequence of the stress of her industrial psyche injury and additionally the stress of the process of getting defendant to comply with the prior award of benefits. The stresses of the process also involved worry about paying bills and housing costs during the time that defendants failed to comply with the award of benefits. Thus, it appears that the cardiovascular consequences are compensable because they were caused by the stress of the underlying psyche injury (*Maher v. Workers' Compensation Appeals Board*, (1983) 48 Cal. Comp. Cases 329), as well as the stress of worrying about paying bills during the two year period that defendants failed to comply with the prior award of benefits. (*California Youth Authority v. Workers' Compensation Appeals Board*, (1995) 60 Cal. Comp. Cases 1099 (writ denied)

The Board noted that the WCJ had impermissibly cited an unpublished case in violation Rule 8.1115 of the California Rules of Court. However, even if the case was properly cited, it is inapplicable to this case as it involves the issue of cause of permanent disability for apportionment purposes and not the issue of cause of an injury or compensable consequences of an injury. Therefore the Board granted reconsideration and remanded the matter for

further hearing. It indicated that while they neither make nor intend to imply a final decision; it appears that applicant's further psyche and cardiovascular conditions are compensable consequences of the admitted industrial injury.

Hansen v. State of California Department of Correction and Rehabilitation, (2010) (Lexis) (WCAB Panel) Permanent disability – WCJ raising issue of rate adjustment under Labor Code §4658(d).

The WCJ issued an award of 28% PD and a rate increase of 15% pursuant to Labor Code §4658(d)(2). Defendants filed a petition for reconsideration arguing that the WCJ erred in raising the issue of rate adjustment under Labor Code §4659(d) *sua sponte* and arguing that there was insufficient evidence to support the finding 15% increase. The Workers' Compensation Appeals Board ruled that the WCJ did not err in raising section 4658(d)(2) adjustment issue despite the fact that the precise issue of 4658(d)(2) was not raised by the parties. In *Bontempo* v. *Workers' Compensation Appeals Board*, (2009) 173 Cal. App. 4th 689, 74 Cal. Comp. Cases 419, the Court of Appeal held that raising the general issue of permanent disability the party is impliedly raising the issue of Labor Code §§4658(d)(2) or (d)(3)(a). The Workers' Compensation Appeals Board went on however in this case unlike *Bontempo* in which the record contained sufficient evidence on the issue of Labor Code §4658(d)(2) in this case no evidence was offered on the issue by either side. The Workers' Compensation Appeals Board returned the matter to the trial level to develop the record on this issue.

COMMUTATION

Martinez-Reyes v. State Compensation Insurance Fund, (2010) 38 CWCR 68. Commutation

The two issues were submitted at trial: 1) Applicant's requested for a $50,000 commutation, and (2) calculation and commutation of the applicant's attorney fee. The WCJ requested DEU furnish a recommendation on the proper calculation of the commutation and the attorney fee. The DEU noted that they were two alternative methods of making the requested calculation (1) the uniform reduction UR method which calls for uniform or constant weekly reduction of the weekly PD rate averaged over the life of the award or (2) UR method which calls for increasing weekly reductions of the PD tied to the annual SAWW increased start on the January 1, following the date of injury. The WCJ found the UR method was proper and that the question of the SAWW was moot. Applicant filed a petition for reconsideration. The Workers' Compensation Appeals Board remanded the case to the trial level to determine the commencement date of the SAWW and to recalculate the commutation using the UR method. The panel noted that when an injured worker is totally permanently disabled, he or she has a 100 PD rating, indemnity based on this or her average weekly earnings is payable for his or her life. The panel observed that under the UR method of commutation, the injured worker received the smallest PD check at the outset because the commutation is a higher percentage of her check than it is later when the SAWW

adjustments raise the weekly PD rate. Under the UR method, the injured worker starts with a higher net check. The SAWW increases, moreover, causes the net checks to more uniform year after year because the increases in the commutation deduction are balanced by the increasing underlying rate. Thus, the goal of consistent periodic payments would be best served by the UR method in this case. Turning to the relevance of the SAWW commencement date, the panel noted that the Court of Appeal decision in *Duncan v. Workers' Compensation Appeals Board*, (2009) 179 Cal. App. 4th 1009; 74 Cal. Comp. Cases 1427, (that life pension and total Pd payments are subject to cost of living adjustments beginning January 1, 2004, and every January 1 thereafter) has not been finally decided as the supreme court has granted review in the case, thereby suspending its precedential value. Thus, the panel explained, under Labor Code §4659(c) for injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a life pension or TPD may have that payment increased annually beginning January 1, 2004, and each January 1 thereafter by an amount equal to the percentage increase in the state average weekly wage over the prior year. The Workers' Compensation Appeals Board ruled is was necessary to grant reconsideration and rescind the order of the WCJ and remand the matter to the trial level for further proceedings to determine the commencement date of the of the SAWW adjustments and to recalculate the commutation using the UR method.

SERIOUS & WILLFUL MISCONDUCT, LABOR CODE §132a

Bigge Crane and Rigging Co. v, Workers' Compensation Appeals Board (Hunt), (2010) 188 Cal. App. 4th 1330; 75 Cal. Comp. Cases 1089. Serious and Willful Misconduct not found

Paul Hunt was injured while assisting with the dismantling of a truck crane used during a shutdown operation at a refinery. Hunt had been helping on another crane at the job site, and, along with two ironworkers on the rigging crew, was told by the general foreman to help with the dismantling. Hunt was injured when a section of the boom fell eight inches to the ground and onto his lower leg and ankle. Bigge Crane contends Mom, the crane operator, was not "an executive, managing officer or general superintendent" of the corporation and therefore his conduct cannot be the basis for an award of additional compensation for "serious and willful misconduct." Hunt contends Mom qualifies as "a managing officer" because he was in charge of all facets of operating the crane and gave instructions to the oiler and ironworkers helping him disassemble it. The WCJ made an award of additional compensation to Hunt under Labor Code §4553, concluding his injuries were caused by the "serious and willful misconduct" of the operator of the crane and the general foreman, both of whom were determined to be "managing officers" of petitioner, Bigge Crane & Rigging Co.. Defendant sought reconsideration.

Bigge Crane contends the award of additional compensation in this case cannot be sustained because no "executive, managing officer or general superintendent" of the company engaged in "serious and willful misconduct." It asserts the crane operator, was not a "managing officer" of the company, and its general foreman, Embry, even assuming he was a "managing officer," did not engage in "serious and willful misconduct." Hunt maintains

the WCJ's determinations that both Mom and Embry qualify as "managing officers" of Bigge Crane, and that both engaged in "serious and willful misconduct," are supported by the record.

The Workers' Compensation Appeals Board sustained the award, and defendant filed a Petition for Writ of Review. Bigge Crane contests the award, contending (a) the operator of the crane was not a "managing officer" of the company within the meaning of Labor Code §4553 and therefore his conduct cannot support an award of additional compensation and (b) the general foreman, even assuming he qualifies as a "managing officer," did not engage in "serious and willful misconduct."

The Court granted the writ and agreed with defendant on both points. It annulled the award of additional compensation. The court concluded that under the governing legal standards, Mom the crane operator was not a "managing officer" of Bigge Crane and Embry's conduct did not rise to the level required to constitute "serious and willful misconduct."

The court concluded Mom, as the operator of a single piece of heavy equipment, performing a specific, assigned task, was not "an executive, managing officer, or general superintendent" of the company within the meaning of section 4553 and therefore the award of additional compensation cannot be sustained on the basis of his conduct " '[a]n executive or managing officer' is 'a person in the corporation's employ, either elected or appointed, who is invested with the general conduct and control at a particular place of the business of a corporation.' (*E. Clemens Horst Co. v. Industrial Accident Commission*, (1920) 184 Cal. 180, 190.) A 'managing agent or a managing representative is one who has general discretionary powers of direction and control—one who may direct, control, conduct or carry on his employer's business or any part or branch thereof.' (*Gordon v. Industrial Accident Commission,* (1926) 199 Cal. 420, 427.)" (*Bechtel*, supra, 25 Cal.2d at p. 174.) The [L]egislature has refrained from making the employer liable for the misconduct of every person exercising authority on the employer's behalf. On the contrary, the class of persons whose misconduct will result in the imposition of such liability still remains limited.' " (Ibid., quoting *Green v. Industrial Accident Commission*, (1933) 130 Cal. App. 337, 340-341 [19 P.2d 1029].) Mom was told where he was to work and what his specific task was, in this case disassembling the truck crane so it was ready to move to another location. Mom was not told how to do his assigned task. Mom gave directions to five other employees. The fact that a minor supervisory employee, like Mom, provides direction to a handful of workers assigned to help with a specific task, does not make that employee a "managing officer, or general superintendent" of the company. Indeed, in many instances where more than one worker is sent to perform a specific task, one of the workers will coordinate and/or direct the work. That is not the kind of "supervising" employee contemplated by Labor Code §4553 whose conduct is reflective and representative of the company and can thereby subject the company to an award of additional compensation. However, as the Supreme Court stated in Bechtel, " 'the class of persons whose misconduct will result in the imposition' " of liability under Labor Code §4553 " 'still remains limited.' " (*Bechtel*, supra,25 Cal.2d at p. 174, quoting *Green v. Industrial Accident Commission*, supra, 130 Cal. App. at pp. 340-341.)

Whether an employee is "an executive, managing officer, or general superintendent" is not determined by euphemism, but by the actual scope and nature of the employee's job responsibilities. As noted above, the fact an employee may have some supervisory authority and the "power of direction" over some employees does not make that employee a "managing officer" of the company for purposes of section 4553. A "managing officer" may not be on the scene at the precise moment a safety order is violated and an injury occurs.

Turning to the conduct of Embry, who was Bigge Crane's general foreman at the Chevron job site when the accident occurred, the court did not decide, but rather assume for purposes of analysis, that Embry would qualify as a "managing officer" of the company. The watershed case on "serious and willful misconduct" is *Mercer- Fraser v. Industrial Accident Commission (Soden)*, (1951) 40 Cal. 2d 102; 16 Cal. Comp. Cases 168. In *Mercer-Fraser*, the Supreme Court assumed, without holding, that the deliberate decision of the company's chief engineer and superintendent of maintenance and construction to not provide additional bracing to prefabricated sections of a building under construction, despite numerous warnings about the stability of the sections and the fact the weather was windy, would be sufficient to support a finding of "serious and willful misconduct." (Id. at pp. 120-121.) The Court concluded the findings actually made by the commission in *Mercer-Fraser*, however, were consistent with a determination of negligence only and thus could not support the award of additional compensation. (Id. at pp. 124-127.) The Supreme Court discussed the meaning of serious and willful misconduct at length, contrasting such conduct with conduct that is negligent or even grossly negligent. (*Mercer-Fraser v. Industrial Accident Commission (Soden)*, 40 Cal. 2nd 102, at pp. 116-118.) " 'Willful misconduct' . . . necessarily involves deliberate, intentional, or wanton conduct in doing or omitting to perform acts, with knowledge or appreciation of the fact, on the part of the culpable person, that danger is likely to result therefrom." "Willfulness necessarily involves the performance of a deliberate or intentional act or omission regardless of the consequences." "Willful misconduct" means something different from and more than negligence, however gross. The term "serious and willful misconduct" is described . . . as being something "much more than mere negligence, or even gross or culpable negligence" and as involving "conduct of a quasi-criminal nature, the intentional doing of something either with the knowledge that it is likely to result in serious injury or with a wanton and reckless disregard of its possible consequences." To constitute "willful misconduct" there must be actual knowledge, or that which in the law is esteemed to be the equivalent of actual knowledge, of the peril to be apprehended from the failure to act, coupled with a conscious failure to act to the end of averting injury. . . ." (*Mercer-Fraser v. Industrial Accident Commission (Soden)*, 40 Cal. 2nd 102 at p. 117, quoting *Porter v. Hofman*, supra, 12 Cal. 2d at pp. 447-448.) " 'While the line between gross negligence and willful misconduct may not always be easy to draw, a distinction appears . . . in that gross negligence is merely such a lack of care as may be presumed to indicate a passive and indifferent attitude toward results, while willful misconduct involves a more positive intent actually to harm another or to do an act with a positive, active and absolute disregard of its consequences. But willful misconduct as used in this statute means neither the sort of misconduct involved in any negligence nor the mere intent to do the act which constitutes negligence. Willful misconduct implies at least the intentional doing of something either with a knowledge that serious injury is a probable (as distinguished from a possible) result, or the intentional doing of an act with a wanton and reckless disregard of its

possible result.' " (*Mercer-Fraser v. Industrial Accident Commission (Soden)*, 40 Cal. 2nd 102 , at p. 118, quoting *Meek v. Fowler*, (1935) 3 Cal. 2d 420, 425-426 [45 P. 2d 194].) " 'Such intent and knowledge of probable injury may not be inferred from the facts in every case showing an act or omission constituting negligence for, if this were true, any set of facts sufficient to sustain a finding of negligence would likewise be sufficient to sustain a finding of willful misconduct. "Manifestly, 'serious and willful misconduct' cannot be established by showing acts any less culpable, any less deliberate, or any less knowing or intentional, than is required to prove willful misconduct." (*Mercer-Fraser*, at p. 118.)

Measured against this rigorous standard, the Supreme Court concluded the commission's findings were "significant of nothing more culpable than negligence." (Citing *Mercer-Fraser v. Industrial Accident Commission (Soden)*, 40 Cal. 2nd 102; 16 Cal. Comp. Cases 168.) For example, "findings . . . that the employer, through its general superintendent, failed and neglected to 'exercise that degree of prudence, foresight and caution which, under the circumstances, a prudent employer would then and there have' exercised and, . . . statements concerning what a 'prudent employer' would have done 'had it turned its mind to the fact' obviously do not establish serious and willful misconduct, which, as has been shown, requires an act or omission to which the employer has 'turned its mind.' " (Id. at pp. 124-125.) "There [was] no suggestion that [he] was incompetent or inexperienced or that his employer . . . was itself guilty of misconduct in employing [him] for the job at hand." (Id. at p. 127.) Thus, "[a] 'reckless disregard' of the safety of employees is not sufficient in itself unless the evidence shows that the disregard was more culpable than a careless or even a grossly careless omission or act. It must be an affirmative and knowing disregard of the consequences. Likewise, a finding that the 'employer knew or should have known had he put his mind to it' does not constitute a finding that the employer had that degree of knowledge of the consequences of his act that would make his conduct willful. Looking at the record, the court concluded "it [was] devoid of any substantial evidence that the employer intended to do harm, or that it had actual knowledge of the probable consequences of its failure to provide more adequate safety devices or a safer place to work or that it exercised an affirmative and knowing disregard for the safety of the injured employee." (*Hawaiian Pinea*pple, supra, 40 Cal.2d at p. 664.) While there was evidence a similar accident was avoided shortly before the accident at hand, the employer thereafter took additional steps to remove the hazard. "There [was] no evidence that the employer had knowledge of any kind that this remedy was inadequate, nor [did] the record reveal that there was any reason for it to believe that the circumstances which nearly caused the first accident continued to exist." (Id. at p. 665.) Embry may have been negligent in not asking Mom to spend a few minutes going over the disassembly procedure with Hunt and the ironworkers Embry sent to help with the task. But his failure to do so was not sufficiently egregious to depart from the realm of negligence or gross negligence, and enter the realm of "serious and willful misconduct."

The Court noted that Bigge Crane was issued two OSHA citations for violating safety orders requiring employee training and instruction, one a "general" citation and the other a "serious" citation. It also noted, following an administrative hearing, that the ALJ amended the "serious" citation to only a "general" one on the ground there was "a lack of evidence that there was a substantial probability that death or serious physical harm could exist as a result of [the] alleged violation." Thus, it is apparent the alleged safety order violation was

found not be overly serious and was so treated by the Division. It certainly is not comparable to the violation of the safety order at issue in *Grason Electric*, prohibiting work within six feet of high voltage lines and protecting against the "deadly and immediate peril" inherent in such "ultra-hazardous activity." (See *Grason Electric*, supra, 238 Cal. App. 2d at pp. 53-54.) The Court concluded that this alleged safety order violation did not suffice to move Embry's conduct across the scale from negligence or gross negligence, to "serious and willful misconduct." The court concluded the crane operator, Mom, was not a "managing officer" of Bigge Crane and, therefore, that the award of additional compensation could not be sustained on the basis of his conduct. The Court further conclude Bigge Crane's general foreman, Embry, even assuming he was a "managing officer" of the company, did not engage in "serious and willful misconduct." Accordingly, the award of additional compensation is annulled.

STATUTE OF LIMITATIONS

Santa Barbara County v. Workers' Compensation Appeals Board (Santos), (2010) 75 Cal. Comp. Cases 56 (writ denied). Statute of limitations – Estoppel -- Effect of using non-approved benefit notices.

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

The WCJ found that defendant was estopped from asserting the statute of limitations as a defense because it failed to establish that it gave Applicant adequate notice of her rights or to establish that Applicant had actual knowledge of those rights.

Defendant then filed a petition for reconsideration contending that it was error to conclude that the case was not barred as having been filed more than one year after the date of her injury, since Applicant received adequate notice of her rights upon receipt of a pamphlet issued by the California Workers' Compensation Institute (CWCI) describing her rights and responsibilities with regard to the one-year statute of limitations in Labor Code § 5405.

The Workers' Compensation Appeals Board agreed with the WCJ, finding that defendant was required by 8 CCR §9882 to provide applicant with specific notices, including written information concerning the time limits for filing a claim. The panel found the CWCI

pamphlet, rather than give adequate notice, leads to "good faith confusion." Defendant filed a petition for writ of review that was denied.

May v. West Valley/Mission College, (2010) 38 CWCR 244 (WCAB Panel) Statute of Limitations -- Subsequent Injuries Benefits Trust Fund (SIBTF)

Applicant had a prior back injury, and it was found that applicant was put on notice of a possible SIF case by a medical report in 2002. She sustained a subsequent back and psych injury, part of which was resolved by Compromise and release in March 2009. The application for SIBTF benefits was filed on December 10, 2008. WCJ found that applicant was not entitled to subsequent injuries fund benefits because the application for SIBTF benefits was not filed within a reasonable time after the applicant know or should have known that she might be entitled to such benefits.

The Workers' Compensation Appeals Board reversed holding that the delay in seeking SIBTF following the receipt of the medical report was not unreasonable based on the complexity of the issue of apportionment and causation. The Workers' Compensation Appeals Board cited the case of *Subsequent Injuries Fund v. Workers' Compensation Appeals Board (Talcott)*, (1970) 2 Cal. 3rd 56; 35 Cal. Comp. Cases 80, which held the five year limitation period of Labor Code §5410 does not apply to bar claims against SIF filed more than five years after the date of injury. There is not statutory limitation of the time to file a claim for SIF benefits, but the vacuum has been filed by case law. The court held that where, before the expiration of the five year period from the date of injury, an applicant does not know and could not have reasonably known there will be a substantial likelihood he or she would become entitled to SIF benefits, his or her application against the fund will not be barred if he or she files a proceeding against he SIBTF within a reasonable time of after learning the boards findings on the PD issue that the fund has probable liability.

Applying the law to the facts in this case the Workers' Compensation Appeals Board indicated that in this case no PD award ever issue. This back injury case settled by way of a compromise and release on March 26, 2009. In March of 2008 the WCJ issued a decision that the Psyche portion of the case was not the result of an industrial injury. The complex issues of causation and apportionment may well have contributed to the case being settled by compromise and release agreement rather then by a PD award. Applicants delay following receipt of the physicians report in 2002 indicating possible cause of action for SIF benefits to the date of application inn December 2008 was not unreasonable in light of the complex issues. The application for SIF benefits was in fact filed less than a year after the WCJ decision on applicant's psych claim on March of 2008 finding no psych injury. In summary the WCAB ruled that no statute compelled it to bar applicants claim for SIBTF benefits as untimely. There had been no award of PD before the claim was filed. There was no evidence that SIBTF was surprised or sustained prejudice. Barring applicants claim would be contrary to the constitutional mandate to provide substantial justice. A claim for SIF benefits will not be barred if the application is filed within a reasonable time after learning of the boards finding on the PD that the fund has probable liability.

SUBROGATION & THIRD PARTY ACTIONS

PENALTIES, SANCTIONS & COSTS, and CONTEMPT

All Lube & Tune, Erie Insurance Group, Crawford & Co. v. Workers' Compensation Insurance Fund (Derboghossian), (2010) 75 Cal. Comp. Cases 503 (writ denied) Contempt.

Applicant sustained injury involving his musculo-skeletal system, psyche, and vision, rendering him blind on June 12, 1994. He was awarded total permanent disability and further medical treatment. The latter included at least 12 hour per day nursing services and transportation services. Penalties were imposed on permanent disability. Additional penalties were claimed on health care and transportation and settled by Compromise and Release in August 2002 for $235,000, and additional penalty claims on June 9, 2003 for an additional $235, 000, and additional penalty claims on February 23, 200 for a stipulated $142,349. On March 14, 2007 further disputes as to non-payment of benefits and penalties was subject of a third C&R for $36,000. A sixth petition for penalties was filed May 3, 2007, for delay or denial of transportation or medical treatment. Findings and Order issued October 3, 2008, and was amended on three subsequent dates. It found benefits of $36,353.25 plus interest and penalties of $9,118.30 and $180.47, plus attorney's fees and interest and penalty thereon.

On January 30, 2009 the WCJ issued an Order to Show Cause why defendant's attorney, Michale Masurek, and its adjuster, Charlotte Briones, should not be found in contempt based on the adjustor's trial testimony that she had not paid transportation expenses previously awarded on defendant's counsel's direction. Defendant in a shot gun petition for reconsideration, removal, and disqualification, sought, among other things, to exclude the WCJ from hearing the contempt issue. The WCJ recommended denial of the petition, with correction in a computational issue of the amount of a penalty. The Board granted removal, struck the award of attorney's fees for attendance at deposition of applicant's wife. The Board reviewed the three bases of contempt – direct, hybrid, and indirect, and found that the WCJ did not have power to hear or determine the contempt issue because it was an indirect contempt.

Defendant filed a petition for writ of review on the issues of penalty and transportation costs, the wrist was denied.

Speight v. Zurich North America Insurance Co., (2010) 38 CWCR 208 Med Legal – QME panel, Removal, Sanctionable conduct.

Speight filed an Application for Adjudication of Claim against Vulcan Materials Company and its insurer, Zurich North America Insurance for alleged cumulative injury ending March 10, 2008. The claim form was filed with the Application. The claim was timely denied. On February 3, 2009 defendant sent applicant's former attorney a letter proposing two orthopedic surgeons, both QME's as potential Agreed Medical Examiners.

On February 13, 2009, defendant requested a Qualified Medical Examiner panel in orthopedics from the Medical Unit, and attached to its request a copy of the February 3, 2009 letter proposing AMEs. On May 20, 2009, the Medical Unit responded that the requested panel would not issue because defendant had requested the panel prior to the required time for applicant's counsel to respond to the February 3, 2009 letter. The Medical Unit also advised that due to volume they were unable to save or return incomplete requests, and if reapplying, all prior communications should be resubmitted.

On June 5, 2009 defendant submitted another panel request without attaching the materials previously submitted, but asserting that the Unit had failed to issue a panel pursuant to a February 13, 2009 request.

On June 12, 2009, applicant's counsel filed a Declaration of Readiness to Proceed. Defendant filed an objection on the ground that the Medical Unit had failed to issue a panel on the February 13, 2009 request; that a new request for panel had been submitted, and requesting no hearing be set until a QME evaluation had been obtained.

On July 22, 2009, the Medical Unit advised that it would not issue a panel on the June 5, 2009 panel request because no showing of an AME offer was attached to the request. On July 30, 2009 defendant submitted a third request for QME panel; in response to the July 30, 2009 request, the Medical Unit issued a panel on September 28, 2009. An MSC was held on August 19, 2009. Defendant objected on the Pre-Trial Statement to the matter proceeding to trial, and offered the February 13, 2009 panel request letter, but failing to offer the Medical Unit's responses. The case was scheduled for trial hearing on September 24, 2009.

On September 9, 2009 defendant filed a verified Petition for Removal alleging that the case should have been taken off calendar, avowing that defendant had requested QME panels on February 13, 2009 and June 5, 2009, but the Industrial Medical Council or Industrial Medical Unit had never issued one, and that its request for a QME panel had been timely and proper. Petitioner neglected to mention that it had been served responses to its QME Panel requests. It alleged "extreme violation of due process right" and that "extreme prejudice" would result were the matter allowed to proceed to trial. Because the Petition for Removal was pending, the WCJ vacated the hearing date.

On December 21, 2009 the Board granted removal and gave notice of intention (NOI) to admit exhibits filed with the petition, including the defendant's successive panel requests. No response was received. Neither party advised the Board that a panel had issued by the medical unit on September 28, 2009.

On March 9, 2010, the Board issued a Decision and Orders After Removal. It ordered the proposed exhibits admitted to evidence, vacated the order setting the case for trial, and ordered the Medical Unit to provide a QME panel. On March 30, 2010, the Division of Workers' Compensation filed a Petition for Reconsideration from the March 9, 2010 Decision and Orders After Removal. It appended the Medical Unit responses of May 20, 2009 and July 22, 2009, and the September 28, 2009 letter designating a QME panel.

Defendant's counsel filed a verified answer contending that DWC's counsel had failed to read its Petition for Removal before seeking Reconsideration; that the Petition unjustly and unfairly accused defendant's counsel of fraud in "blatant disregard for the truth and relevant facts;" that the Petition was "replete with misstatements and material misrepresentations," and that the Medical Director did not understand the defendant's basis for seeking removal, and that it was "abundantly clear that the DWC Medical Director or … counsel had absolutely no understanding or comprehension of the legal issues, [and constituted] irresponsible and egregious conduct…" (38 CWCR 208, at 210-211.) The answer denied any allegation that the Medical Unit had not responded to its first two panel requests, and alleged that it had not sought to rely on Rule 30(d)(3), but mentioned it only because it wanted the Board to review its validity.

On May 24, 2010, the panel denied Reconsideration because the decision appealed from was not a final determination. However, it granted removal, rescinded the December 21, 2009 Order Granting Removal, rescinded its March 9, 2010 Order directing the Medical Director to issue a QME Panel, ordered that the matter be set for trial, and remanded the matter to be set for trial. Defendant's Petition for Removal and Answer to Petition for Reconsideration had violated WCAB Rules of Practice and Procedure Section 10842(a), which requires a fair statement of all material evidence; that it contained half truths by omitting materials unfavorable to it (e.g. the basis for the Medical Unit's denial of the first panel request (it issued prior to expiration of time for response to the AME offer letter); the Medical Unit's basis for denial of the second request (failure to enclose a copy of the QME offer letter). It stated that representations in defendant's verified Answer to the DWC's Petition for Reconsideration were deceptive and misleading.

Failure to comply with WCAB Rules without good cause is a basis for sanctions. (WCAB Rules of Practice and Procedure §10564.) Verifying a document with substantially misleading statements of facts or concealing material facts are among grounds for sanctions. WCAB Rules of Practice and Procedure Section 10561(b).) The Board issued a 15 day notice of intention to sanction Hanart (who signed the Petition for Removal) and his firm, up to $2,500.00; Hansen (who signed the verified Answer to DWC's Petition for Reconsideration) and the firm, up to $2,500.00, Seti (the attorney who filed the verified Objection to Declaration of Readiness) and the firm, up to $1,000.00, and White (who appeared at the MSC and objected to the matter being set for trial) and the firm, up to $1,000.00,

WORKERS' COMPENSATION FRAUD

The People v. Alvarez, (2010) 75 Cal. Comp. Cases 118 (unpublished). Workers' compensation fraud.

Alvarez was employed by Dept. of Corrections at Calipatria State Prison beginning in July 2001. On February 20, 2002, a concrete pumping machine malfunctions and Alvarez was thrown against a cement wall. On March 29, 2002 Alvarez represented to a treating physician that he had been placed by another doctor on temporary disability and was not

working. The physician continued Alvarez TTD status through April 26, 2002. In March and April 2002 Alvarez did construction work, including cement work at an apartment complex that was under construction. During the Summer of 2002 applicant did some work operating a backhoe while constructing a parking lot. In July and August 2002 applicant was paid ~$12,000 for construction work at the apartment complex construction site. In December 2002 applicant changed physicians and represented to his new physician that he had not been working since February 2002. The new physician, Dr. Shoemaker, reported applicant's condition was temporarily partially disabling from December 202 until September 2004. Applicant's history to his second and third treating physicians was that he had no preexisting injuries. Alvarez ex-wife testified he had complained of back pain since 1993. Alvarez testified that when he said on March 29, 2002 that he was not working he meant "on that day," and when he said to Dr. Shoemaker in December 2002 that he had not worked since February he meant for the Department of Corrections. At trial, the jury was instructed, in part, that mistake of law is not a defense; the jury convicted applicant of five counts of violation of Insurance Code 1871.4 and one count of Penal Code Section 550. Alvarez was sentenced to three years probation. The Court of Appeal rejected a challenge to the convictions based on alleged confusion of the instruction on mistake of law, noting the instructions and opening directions to the jury had also included language of CALCRIM 220 on standard of proof for criminal conviction.

ARBITRATION AND CARVEOUTS

Cruz (deceased), et. al. v. Kretschmar and State Compensation Insurance Fund, (2010) 38 CWCR 40 (WCAB Panel) – Carve out proceedings do not apply to dependents.

The WCJ issued an order of dismissal finding that that the injured worker's dependent claim for death benefits was subject to the "carve-out" agreement between the worker's union and the employer pursuant to Labor Code §3201.5. Applicant sought reconsideration. The applicant's petition claimed that the WCJ erred in dismissing the claim for death benefits arguing that the "care-out' agreement between the union and the employer does not apply to non-employee dependents, such as the applicant in this case.

The Workers' Compensation Appeals Board reversed the dismissal concluding death claims are not subject to a Labor Code §3201.5 "carve-out" based on the plain language of the section. Labor Code §3201.5 allows alternative dispute resolution systems between certain union represented-employees and employers and employers or their insurers. The Board held that the plain language of the statue does not extend to "carve-out" agreements to claims of dependents of employees, but expressly allows them only for employers. Dependents are not members of or represented by, and have no relationship to, an employee's union. Thus, the union's right to subject dependents' claims to death benefits, which claims are independent and severable from the employee's claim for disability compensation, to ADR, absent express legislative permission, would be, at best, legally questionable. Moreover, because a dependent's right to death benefits is not derived from the rights of the deceased worker, but is independent and severable from the employee's claim for disability compensation, and because providing for the compensation of the deceased-workers'

dependents is constitutionally-required, it would appear had the legislature intended to allow death benefits claims to be "carved-out" it would have expressly so stated. The Board concluded that dependents death claims are not subject to carve-out agreements and therefore the WCJ erred in dismissing applicants claim. The matter was remanded.

ATTORNEYS & ATTORNEY'S FEES

Pratt v. Wells Fargo Bank, (2010) (ADJ 579864) Attorney's fees on C&R proceeds to fund Medicare set aside trust where there was a prior award for medical treatment.

Applicant's Attorney sought reconsideration of a WCJ award of $15,000 as an attorney fee for services rendered in connection with a Compromise and Release. The WCJ had reduced a requested fee of $45,440.00 by $30,440.

Applicant on March 5, 2009 settled her claim by a stipulated award of 82% PD and future medical treatment, entitling her to the sum of $122, 935 at the rate of $230 per week, plus a life pension of $85.04 per week. Applicant's attorney received a fee of $37,204.00, equal to 15% of the PD award and present value of the life pension. On July 9, 2009, the parties agree to a Compromise and Release in the total of $485,000. According to applicant's petition the sum represented $177, 885.54 still owed to the applicant from the stipulated award of PD and $307,144.46 new money to buy out the award of future medical treatment. Of that new money, $20,994 was payable to applicant as seed money for a MediCare set-a-side Account (MSA), and $141,109 was payable to Pacific Life and Annuity Company to fund the MSA. Applicant's attorney requested a fee of $45,440, nearly equivalent to 15% of the new money paid to applicant under the Compromise and Release Agreement. Applicant was to receive the remaining balance of $277,457.00. The WCJ awarded a fee of $15,000 calculated based on the present value of the remaining PD and the life pension, deducting that amount because those benefits were that have been already awarded. The Workers' Compensation Appeals Board concluded that the proper method for calculating the applicant's reasonable attorney fee for efforts in securing a Compromise and Release should not include the sums paid to set up and fund applicant's MSA. Applicant had previously obtained an award for further medical treatment in the stipulated award, entitling her to lifetime medical treatment for her industrial injury paid for by defendants. The MSA supplants that award and requires that she fund her own medical treatment outside MediCare. By settling her medical; treatment award, she ahs not placed herself in a more advantageous position, and her attorney should not benefit thereby. Rather applicant has taken on all the responsibility for her medical treatment and to maintain accurate records documenting all of her medical payments for the medical treatment received on account of her industrial injury. The Workers' Compensation Appeals Board took the total amount of the Compromise and Release agreement, $485,000 and deducted $162,103 which is the total MSA seed money of $20,994 and the annuity fund of $141,109, leaving a balance of $322,897. According to the attorney's petition, the remaining value of applicant's stipulated award, after payment of the prior attorney fee of $37,204 is $177,885.54. This is the sum the applicant would have received had the parties not agreed to a buy out of applicants medical award through the compromise and release agreement. The amount remaining, $145,011.46 constitutes the new

money due to the applicant from which an additional attorney's fee may be deducted. A reasonable fee was found by the Workers' Compensation Appeals Board to be 15% of the new money or $21,752 which was awarded by the Workers' Compensation Appeals Board to the applicant's attorney as his reasonable fee.

Kozdin v. State Compensation Insurance Fund, (2010) 186 Cal. App. 4th 480; 75 Cal. Comp. Cases 711. Attorneys – Class action on interest on attorney's fees

The Superior Court's dismissed with prejudice six class actions brought by two applicant's attorneys alleging that various employers and insurance carriers had failed to pay interest on attorney's fee awards issued by the Workers' Compensation Appeals Board. The Court of Appeal first addressed whether the applicant's attorneys had standing in Superior Court to seek unpaid interest on their attorney's fee awards. The defendants asserted there was no standing because the attorney's fee awards in question did not direct any payment of interest to the attorneys. The defendants argued that under Labor Code §4902, which provides that all compensation must be paid directly to the injured worker unless otherwise ordered by the Board, the right to recover interest belonged solely to the injured workers. The Court of Appeal cited Labor Code §5800, which provides that all Workers' Compensation Appeals Board awards for the payment of compensation shall carry interest. The Court stated that because the statute is mandatory in nature, the computation and payment of interest is required in every case by Labor Code §5800. The court citing *Tucker v. Workmen's Compensation Appeals Board*, (1975) 44 Cal. App. 3d 330, 332; 40 Cal. Comp. Cases 38, stated that the parties do not dispute that attorney fee awards issued by the Board are 'compensation' within the meaning of the Workers' Compensation Act. The Court stated that the Board has the authority to order the payment of attorney fees directly to the injured worker's counsel as a lien against the employee's compensation, citing to Labor Code §§4903, 4905 and 4906 and *State Comp. Ins. Fund v. Workers Compensation Appeals Board (LaFavor)*, (1981) 117 Cal. App.3d 143, 145 [46 Cal. Comp. Cases 348]. The Court held that the Board's fee awards issued to Appellants in this case were "awards for the payment of compensation pursuant to section 5800, and as such, they accrued interest at the same rate as judgments in civil actions.(§ 5800.) In a footnote to this holding, the Court added that some Board decisions have concluded that no interest is owed on attorney fee awards. Other Board decisions have reached a contrary conclusion. The Court stated that based on their reading of the relevant statutory provisions, attorney fees awarded by the Board do constitute payments of compensation under section 5800, for which accrued post-award interest must be paid. Furthermore, the Court emphasized that pursuant to Labor Code §5800, the underlying compensation payment and accrued interest are 'integrated components' of the same class of benefits, the court citing *California Highway Patrol v. Workers Compensation Appeals Board (Erebia)*, (2001) 89 Cal. App. 4th 1201, 1206; 66 Cal. Comp. Cases 687, and *Gellie v. Workers' Compensation Appeals Board*, (1985) 171 Cal. App. 3d 917, 920; 50 Cal. Comp. Cases 470.) The Court of Appeal also cited to *Soto v. Workers Compensation Appeals Board*, (1996) 46 Cal. App. 4th 1356, 1361; 61 Cal. Comp. Cases 578, which held that when an employer failed to timely pay both a benefit award and a fee award in a workers' compensation case, 10 percent interest, the legal rate due on judgments, should have been included in the payments made to the injured worker and his counsel."

The Court of Appeal in a published decision held that the applicant's attorneys had standing to seek interest on the attorney's fee awards because: (1) interest is mandatory on all awards under Labor Code §5800; (2) the Workers' Compensation Appeals Board is authorized to make a fee award payable directly to the attorney; and (3) therefore, any post-award interest that accrues on the attorney's fees must also be paid directly to that attorney.

However, the Court of Appeal held that, under Labor Code §5806, the Superior Court's authority is limited to enforcing Workers' Compensation Appeals Board awards according to their precise terms. Here, the particular Workers' Compensation Appeals Board's fee awards produced erroneously failed to expressly order the payment of interest to the attorneys. Therefore, the Superior Court lacked jurisdiction to entertain the class-action claims.

Johnson v. Automated Teller Accessories, et al., UEBTF, (2010) (BPD) (ADJ 3745795) – Attorneys – duty to appear until dismissed, due process.

Robert Johnson sustained injury on November 13, 2007. An Application for Adjudication of Claim was filed in March 2008. UEBTF was joined in August 2008. A lawfirm appeared for defendant employer in November 2009. The firm subsequently filed a letter stating that the firm is no longer representing the employer, and states as the reasons: non-payment of fees and failure to cooperate in the defense of the case. A Trial Hearing was held on January 13, 2010, the employer's lawfirm failed to appear. The WCJ on his own motions at the trial raised the issue of failure to appear by the attorney and costs and sanctions against the attorney. The WCJ issued a ten day notice of intent to submit. The attorney firm was not present when the issues were framed. The WCJ in the minutes indicated they would hold a hearing after the decision on employment on the costs, sanctions for the attorney's failure to appear. The WCJ issue his finding on the failure to appear with the decision on employment. Law firm filed a petition for reconsideration contending that it had provided proper notice of withdrawal as attorney of record for the employer and that the issue was not properly before the WCJ.

The Workers' Compensation Appeals Board granted reconsideration. It agreed with the WCJ that the law firm had not yet successfully withdrawn as counsel for the employer, but struck the finding that there was no reasonable basis for non-appearance. The lawfirm's reasons for withdrawing may justify a permissive withdrawal, however the attorney of record in this case was never granted a withdrawal nor was a substitution of attorney received. The only issue submitted at the trial was employment. The Board ruled to issue the finding prior to the hearing was denial of due process and reversed the finding of fact and remanded for trial for future proceedings consistent with this decision.

Chavez v. City of Los Angeles, (2010) 47 Cal 4th 970; 75 Cal. Comp Cases 215. FEHA – Attorney's fees award is discretionary when plaintiff's recovery is >$25,000

Plaintiff brought an action under the California Fair Employment and Housing Act (FEHA, Cal. Govt. Code §§ 12900 et. seq.), but not as a "limited civil case." The trial court

awarded plaintiff $11,500.00; less than half the limit recoverable in a limited civil case. (Code of Civil Procedure §86.) Plaintiff then sought $870.935.50 in attorney's fees. Generally, the prevailing party in litigation is entitled to recover costs, and such costs include attorney's fees when authorized by statute. (Code of Civil Procedure §§1032(b) and 1033.5.) However, when the judgment could have been rendered within the limits of a limited civil case, but the action was not brought as such, the award of attorney's fees is discretionary, to be determined by the court. (Code of Civil Procedure §1033(a).) The trial court here denied the plaintiff's motion for award of attorney's fees. Plaintiff appealed.

The Court of Appeal granted the appeal. It held that in exercising its discretion under Code of Civil Procedure §1033(a), the trial court must consider the policies and objectives of the FEHA. However, the Court concluded that, given the plaintiff's minimal success and the grossly inflated attorney fee request, the trial court did not abuse its discretion in denying fees in this case.

CASE INDEX